Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

Hospital

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PART II
HOSPITAL FEE-FOR-SERVICE PROVIDER MANUAL

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FORMS All forms pertaining to this provider manual can be found on the KMAP public and secure websites.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

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PART II
HOSPITAL FEE-FOR-SERVICE PROVIDER MANUAL

Updated 01/18

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to hospital providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendices.

The **Billing Instructions** subsection provides directions on how to complete and submit the billing forms applicable to hospital services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of hospital services allowed within KMAP.

The **Appendices** contain information concerning codes, the hospital cost report, and DRG Weights and Rates.

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance
Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

KMAP Audit Protocols
The KMAP Audit Protocols are available on the Provider page of the KMAP website under the *Provider Documents* heading.

7000. UB-04 Updated 05/17

Introduction to the UB-04

Hospital providers must use the UB-04 paper or equivalent electronic claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider.

An example of the UB-04 paper claim form and instructions are available on the KMAP public and secure websites on the Forms page under the **Claims (Sample Forms and Instructions)** heading.

The fiscal agent does not furnish the paper UB-04 claim form to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual*.

7010. MS-2126 Updated 05/17

Notification of Nursing Facility Admission/Discharge MS-2126
The completion of the MS-2126 (Notification of Nursing Facility Admission/Discharge) must be completed by the provider. The facility retains the original MS-2126 and submits a copy to the KanCare Clearinghouse. Submission of the MS-2126 is not required as a prerequisite for a hospital "reserve day". However, the MS-2126 must be retained in the member's file for documentation. Completion of the MS-2126 is not required for payment of a therapeutic reserve day.

The form and instructions are available on the KMAP public and secure websites on the Forms page under the **Member Information** heading. This form will need to be copied or duplicated by providers since neither the fiscal agent nor the State will furnish the form to providers.

7020. HOSPITAL SPECIFIC BILLING INFORMATION Updated 9/19

Inpatient

Accommodation and Ancillary Charges

If the individual accommodation and ancillary services exceed the detail lines on the UB-04 claim form, providers may combine all similar revenue code charges together (e.g. lab, radiology) when necessary. Accommodation codes may also be 'lumped' together when necessary. This will not affect the reimbursement of the claim.

Admission MCO Responsibility

If the Medicaid member's inpatient hospital dates of service include both an MCO assignment and fee-for-service (FFS) coverage or is during a transition from one MCO to another, the entire stay will be considered for payment by the entity the member was assigned to at the time of admission. All other non-inpatient (ancillary) charges are the responsibility of the new MCO at the beginning of the first (1st) month of enrollment. Care coordination must take place between the transitioning MCOs. This applies to the following provider types and specialties for DRG payment.

PT	PT DESC	PS	PS DESC
01	Hospital	010	Acute Care
01	Hospital	011	Psychiatric
01	Hospital	012	Rehabilitation
01	Hospital	017	Tuberculosis
01	Hospital	400	Screening Brief Intervention Referral Treatment (SBIRT)

Admission and Readmission (Same Day)

Admission

An inpatient admission starts when the physician writes an order for an inpatient admission. It is not considered inpatient until the order has been written. Documented verbal admission orders are considered the same as written orders.

- Scenario #1: A patient is sent to the medical floor on September 23 at 11:00 p.m. The physician writes an order to admit the patient on September 24 at 3:00 a.m. According to KMAP, the inpatient admission starts on September 24 at 3:00 a.m.
- Scenario #2: A physician writes an order for a patient to be admitted inpatient on September 23 at 11:00 p.m. The patient arrives on the medical floor on September 24 at 3:00 a.m. According to KMAP, the inpatient admission starts on September 23 at 11:00 p.m.
- Scenario #3: A physician contacts a hospital on September 23 at 11:00 p.m. about a direct admission and gives a verbal order for admission once the patient arrives at the hospital. The patient arrives at the hospital on September 24 at 3:00 a.m. According to KMAP, the inpatient admission starts on September 24 at 3:00 a.m.

Readmission (Same Day)

When a patient is discharged or transferred from an inpatient hospital and is readmitted to the same inpatient hospital on the same day for symptoms related to or for evaluation and management of the prior stay's medical condition, hospitals must combine onto a single claim. If a claim for the first stay has already been filed and paid, the hospital must initiate an adjustment and combine both the original and subsequent stay onto a single claim.
When a patient is discharged or transferred from an inpatient hospital and is readmitted to the same inpatient hospital on the same day for symptoms unrelated to or not for evaluation and

7020. HOSPITAL SPECIFIC BILLING INFORMATION Updated 09/21

Admission and Readmission (Same Day) continued

management of the prior stay's medical condition, hospitals must bill for two separate stays on two separate claims.

When a member is transferred from inpatient acute care using patient discharge status 62 (Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital) or code 65 (Discharge/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) it will be considered a transfer if a patient is admitted to a distinct unit (rehabilitation or psychiatric) within the same facility. The facility will bill two separate claims and each claim will be paid on the DRG specified.

Attending Provider

The attending provider's National Provider Identifier (NPI) and name are required on all institutional claims. All institutional claims submitted on paper, through PES, electronically, or through the KMAP web portal must have both the attending provider's NPI and name. Providers are required to submit this information correctly for the institutional claim to be accepted for processing. The attending provider must be enrolled with KMAP and have a valid NPI for claims to be considered for payment.

Donor Human Breast Milk

- Kansas Medicaid reimburses a medical care facility for prescribed medically necessary donor human breast milk for a critically ill infant under the age of 3 months who is in a neonatal intensive care unit of a hospital.
- A person who is licensed to practice medicine and surgery will order the donor human milk using established medical necessity guidelines. The parent or legal guardian of the member must sign and date an informed consent form indicating the risks and benefits of using banked human donor breast milk.
- The human donor breast milk must be obtained from a milk bank accredited by the Human Milk Banking Association of North America (HMBANA) or a milk bank in compliance with federal regulations governing the production and labeling of such items as covered by statutes in 21 CFR 100-169, and parts 105-107 dealing with infant foods.
- The milk must not be altered in composition, other than pooling with multiple donor mothers' milk to achieve target energy or protein goals and should provide a nutritionally complete product for a term infant, which does not have to be mixed with human milk to make it safe to feed. The milk must be pasteurized and remain in a frozen state.
- The appropriate revenue code for donor breast milk is 0220.

Emergency Renal Dialysis

Inpatient emergency renal dialysis must be billed using revenue code 809 in FL 42 of the UB-04 paper or equivalent electronic claim form.

End Stage Renal Disease

Providers can enroll to perform end-stage renal disease (ESRD) services with KMAP as a provider type and specialty 30/300 (Renal Dialysis Center).

7020. HOSPITAL SPECIFIC BILLING INFORMATION Updated 11/19

Hospice

Payment for services related to the terminal illness or related conditions is the responsibility of the hospice provider. If the inpatient stay was not related to the terminal illness, submit a claim with a copy of the admission and discharge summary. If the member is only assigned to a hospice provider for a portion of the inpatient stay, submit a claim for the entire stay. The claim and documentation will be reviewed to determine if KMAP can reimburse for all or a portion of the stay or if the stay is the responsibility of the hospice provider.

Interim Billing

- Interim inpatient hospital billing is restricted to a frequency of no more than one interim claim every 30 days. Providers can bill less frequently if desired. Interim bills received more frequently than 30 days will be denied, except for those from state institutions. There is not a limitation on the frequency for state institutions.
- When interim billing, be sure to enter the appropriate "Type of Bill" code (e.g. 112, 113, 114). A "Patient Status" code of 30 (current patient) must be indicated when Type of Bill is 112 or 113.
- Each interim claim will be processed as its own "encounter" and reimbursement will be based on the DRG base rate and any applicable day or cost outlier payments. Upon submission of the final bill, the entire length of the stay will be reconciled, and a final payment will be issued, or overpayment will be recouped, whichever is appropriate.

Maternity Center Services

Labor and delivery in a maternity center setting is covered for Medicaid and MediKan members. The appropriate procedure code to be billed is 59409. To receive reimbursement, maternity centers must be licensed be the State of Kansas (or equivalent if located in another state) and enrolled as a provider in KMAP. Maternity Center fees should be billed on a UB04, using type of bill 84X and revenue code 0724. All other billing instructions will remain the same.

The list below is inclusive and applicable to the service provided:

- Reimbursement is on a fee-for- service basis.
- Maternity center services are exempt from member copayment.
- Maternity center services are exempt from primary care case manager (PCCM) referral.
- Supplies are content of service of labor and delivery chargers.

Medicare A Exhaustion of Benefits

- Once Medicare Part A regular inpatient benefits are exhausted, dual-eligible members (those who have both Medicaid and Medicare) can only receive a Medicaid payment if they have already used their LTR days or elect to use their LTR days. A Kansas Medicaid member must make a written election not to use LTR days and cannot be "deemed" to have elected not to use LTR days. If a member makes a written election not to use LTR days after the regular inpatient days are exhausted, Medicaid will not issue payment for any part of the inpatient stay which would have been covered if the member had elected to use LTR days.
- After making a written election not to use LTR days, a member can still decide to use LTR days. KMAP will accept the written election form outlined by Medicare in Chapter 5 of the *Medicare Benefit Policy Manual*.

7020. HOSPITAL SPECIFIC BILLING INFORMATION Updated 12/20

Medicare A Exhaustion of Benefits continued

- If benefits were exhausted prior to hospital admission, LTR days are available for the entire stay, and the member elects not to use LTR days, submit a no pay bill (third digit of TOB is zero).
- If benefits were exhausted during the hospital stay and the member elects not to use available LTR days:
    - Bill condition code 67
    - Bill the number of covered days for which benefits were available
    - Bill the number of noncovered days for which the member elected not to use LTR days
- If benefits were exhausted during the hospital stay and the member elects to use LTR days:
    - Bill all days as covered if there were sufficient LTR days for the stay.
    - If LTR days are available for only a portion of the stay, bill occurrence code A3 with the from date indicating the day all benefits (including LTR days) were exhausted.
    - Bill all days as covered for Medicaid.
- If all benefits are exhausted (including LTR days):
    - Bill occurrence code A3 with the from date indicating the day benefits were exhausted.
    - Bill all days as coved for Medicaid.

Medicare B Services

When Medicare B payment is made on an inpatient claim, indicate the amount paid as Prior Payment in FL 54 on the UB-04 paper or equivalent electronic claim form.

Newborn Services (When the birth mother is assigned to an MCO)

Notify the managed care organization (MCO) that the mother is assigned to at the time of birth. The MCO will provide further instructions if the provider is part of that MCO's network. The mother's MCO will notify KMAP and the fiscal agent of the birth.

Newborn Services (When the birth mother is NOT assigned to an MCO)

- Only procedure codes which specifically state "newborn" in the code description according to the *CPT* codebook are considered newborn services. These services can be paid under the mother's member ID number for the first 45 days after the baby's date of birth. These services must be billed with a newborn diagnosis code to receive payment.
- When billing newborn services for a newborn who does not have a member ID number, use "Newborn", "Baby Girl", or "Baby Boy" in the first name field and enter the last name. Use the newborn's date of birth and the mother's member ID number.

  Claims for newborn services billed under the mother's member Identification (ID) number may be suspended for 30 days pending receipt of the newborn's member ID number from the eligibility system. If a newborn ID is received, the claim will be denied notifying the provider they must submit the claim using the newborn's ID number.

  If no newborn ID is received and the date of service is within 45 days of the newborn's date of birth, the claim may be paid using the mother's ID number. If the date of service is not within 45 days of the newborn's date of birth, the claim will be denied.

7020. HOSPITAL SPECIFIC BILLING INFORMATION updated 12/20

Outpatient/Inpatient

For all hospitals except critical access hospitals, outpatient procedures (including, but not limited to, surgery, X-rays, and EKGs) provided within three days of a hospital admission **for the same or similar diagnosis** are considered content of service and must be billed on the same inpatient hospital claim. The **Statement covers** period should encompass all services on the claim, except when an outpatient procedure is reported on the inpatient claim. In this specific instance, the date may not be more than three days prior to the date of admission.

Note: There is one exception to this policy: complications from an outpatient sterilization resulting in an inpatient admission. In this instance, the outpatient charges and the inpatient charges should be billed on two separate claims. This is necessary for the service dates on the claim form to match the service dates on the Sterilization Consent Form.

- KMAP will no longer consider critical access hospital outpatient procedures (including, but not limited to, surgery, X-rays, and EKGs) provided up to three days before a hospital admission for the same or similar diagnosis as content of service to the inpatient claim. Critical access hospitals must bill services prior to the point of admission as outpatient.

Outpatient Services Provided During Inpatient Admission

Outpatient services provided during an inpatient hospital stay must be included by the hospital on the UB-04 paper or equivalent electronic claim form and reimbursed through the DRG. The outpatient provider should receive reimbursement from the hospital. Outpatient services provided to residents of state institutions must be billed by the hospital providing the outpatient service.

Present on Admission Indicators

- All claims involving inpatient admissions to general acute care hospitals will require submission of present on admission (POA) indicator(s). POA is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA.
- POA and Health Care Acquired Conditions (HCAC) requirements apply to all inpatient settings, including critical access, long-term care, cancer, and children's hospitals as well as freestanding psychiatric and rehabilitation facilities.
- The POA indicator is assigned to principal and secondary or other diagnoses (as defined in Appendix I of the *Official Coding Guidelines for Coding and Reporting*) and the external cause of injury (ECI) codes (Chapter 19 ICD-10-CM). The validity of the POA indicator will be edited, and claims are subject to denying when the POA indicator is invalid. The hospital will need to supply the correct POA indicator(s) and resubmit the claim. ECI codes (Chapter 20 ICD-10-CM) are exempt from POA reporting.

- **POA Indicators and Definitions**
  - Y (for yes): Present at the time of inpatient admission.
  - N (for no): Not present at the time of inpatient admission.
  - U (for unknown): The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
  - W (for clinically undetermined): The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.

Present on Admission Indicators continued

- For those exempt from POA reporting:
  - For a 4010A1 claim billing an exempt diagnosis code, use POA indicator 1.
  - For a 5010 claim billing an exempt diagnosis code, leave the POA indicator field blank.
  - For a hardcopy claim billing an exempt diagnosis, use POA indicator 1.

Note: The *ICD-10-CM Official Guidelines for Coding and Reporting* includes a list of diagnoses codes that are exempt from POA reporting.

- KMAP will not pay the complication comorbidity/major complication comorbidity (CC/MCC) DRG for those selected hospital acquired conditions (HACs) that are coded as "U" for the POA indicator. KMAP will not pay the CC/MCC for those selected HACs that are coded as "1" for the POA indicator or those left blank. The "1" or blank POA indicator should not be applied to any codes on the HAC list. These claims will deny as ungroupable, and providers will need to correct and resubmit the claim for reimbursement. HAC information is available on the CMS website.
- These POA guidelines are not intended to replace any found in the *ICD-10-CM Official Guidelines for Coding and Reporting* nor are they intended to provide guidance on when a condition should be coded. They should be used in conjunction with the *UB-04 Data Specifications Manual* and the *ICD-10-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the POA indicator for each “principal” diagnosis and “other” diagnoses codes reported on claim forms (UB-04 and 837 Institutional).

Psychiatric Observation Beds

When an inpatient hospital admission follows a psychiatric observation stay, the observation days should be billed on the inpatient claim. The observation bed days then become part of the DRG payment to the hospital.

Transfers

When billing medically necessary incoming transfers, enter "direct transfer from (hospital, city)" in FL 80 under "Remarks" on claims for incoming transfers from other hospitals.

Swing Bed Nursing Facility

When billing for a swing bed nursing facility (NF), the following must be observed:

- Your hospital must be certified by the Kansas Department of Health and Environment (KDHE) as a swing bed NF hospital.
- The facility retains the original MS-2126 and submits a copy to the KanCare Clearinghouse. (Refer to **Section 7010** of this manual.) The KanCare Clearinghouse will notify the facility when payment is approved or denied. The facility will also be notified of the effective date and any applicable patient liability.
- Providers must bill the full amount and patient liability will be deducted during processing. When billing for a swing bed, a separate claim must be submitted for each calendar month.

***Note*: Do not** attach a copy of either the MS-2126 or Notice of Action to your claim form.

- Bill all NF days for eligible Medicare patients to Medicare first. Medicaid can be billed for any remaining amounts using the inpatient Medicare claim crossover method. (Refer

Swing Bed Nursing Facility continued

to **Section 3200** of the *General TPL Payment Fee-for-Service Provider Manual*.) If Medicare will not pay for the NF days, a copy of either the Medicare Report of Eligibility (ROE) or a Medicare denial must be attached to the Medicaid billing supporting nonpayment by Medicare.

- Before a transfer to a swing bed NF occurs, the patient must be discharged from the inpatient unit. Use the appropriate three-digit type of bill code in FL 4 on the UB-04 paper or electronic equivalent claim form. (Refer to **Section 7000** of this manual.)
- Remember, the inpatient unit is not reimbursed for the date of discharge since the swing bed NF will be reimbursed for the date of admission.
- The appropriate accommodation revenue code applicable to the patient's level of care must be entered in FL 42. Bill the total number of days in FL 46 (units). In FL 47, place the total charge of days billed. For further information on per diem supplies and services, including durable medical equipment, pharmacy, therapy, transportation, and miscellaneous items, refer to **Section 8400** of the *Nursing/Intermediate Care Facility Fee-for-Service Provider Manual*.

  Ancillary charges: Cannot be billed on the swing bed NF claim. Any ancillary services received by the patient while in a swing bed NF, must be billed on a UB-04 paper or electronic equivalent claim form using the outpatient type of bill code (FL 4) and the correct Healthcare Common Procedure Coding System (HCPCS) code and revenue code for the ancillary services provided. Indicate condition code D9 (any other change) in FL 18-28 and enter the from and through dates of service in FL 6 on the UB-04 paper or electronic equivalent claim form. When multiple dates of service are being billed, enter only the first date of service in FL 45 on the UB-04 paper or electronic equivalent claim form.

  Pharmacy: Pharmacy services for swing bed claims need to be billed on a pharmacy claim form from a Medicaid-enrolled outpatient pharmacy. Refer to the *Pharmacy Fee-for-Service Provider Manual* for billing instructions and coverage information.

  Supplies: When billing for supplies provided by the swing bed facility over and above the supplies included in the reimbursement rate, use procedure code **99070 - bill one unit per day**. Claims must include both revenue codes and HCPCS codes.

- Except the billing guidelines addressed above, the remainder of the claim form is to be completed in the same manner as an inpatient submission. (Refer to instructions in **Section 7000** of this manual.)

Outpatient

Note: Outpatient hospital claims which require medical necessity documentation may be billed electronically. Medical necessity documentation must be retained in the provider's file and made available for review on a postpay basis. It is not required for providers to roll-up their charges into the covered code they are billing. Providers can bill the code they are providing, and the processing system will allow the covered charges and deny the services that are content or noncovered.

7020. HOSPITAL SPECIFIC BILLING INFORMATION Updated 08/20

Outpatient continued

Revenue codes should not be indicated for outpatient services. Use appropriate Current Procedural Terminology (CPT) and HCPCS codes. Enter the time of day using the continental time system if the services are provided between 6:00 p.m. and 8:00 a.m. (1800 and 0800 hours) in FL 13, admission hour.

Attending Provider

The attending provider's NPI and name are required on all institutional claims. All institutional claims submitted on paper, through PES, electronically, or through the KMAP web portal must have both the attending provider's NPI and name. Providers are required to submit this information correctly for the institutional claim to be accepted for processing. The attending provider must be enrolled with KMAP and have a valid NPI for claims to be considered for payment.

Bilateral Procedures

Bilateral procedures performed during the same operative session shall be billed with the appropriate code. To be consistent with Medicare, if a procedure is identified in the *CPT* codebook as one that should have modifier 50 added when performed bilaterally, bill the procedure as a single line item with modifier 50. For example, to bill the excision of bilateral nasal polyps, the provider should indicate code 3011050 on one detail line on the claim. Reimbursement will be made for the bilateral procedure.

DME Purchase/Rental

DME services (purchase or rental) are noncovered in nursing facilities, swing bed facilities, state institutions, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID), psychiatric residential treatment (PRTF) facilities, brain injury (BI) facilities, rehab facilities, and hospitals. For further information, refer to **Section 8400** of the *Nursing/ Intermediate Care Facility Fee-for-Service Provider Manual*.

External Cause of Morbidity Codes

External causes of morbidity codes are accepted on a claim as a secondary diagnosis when billed in conjunction with a covered primary diagnosis code.

Emergency Renal Dialysis

Outpatient emergency renal dialysis must be billed using the following diagnosis codes in FL 67 of the UB-04 paper or electronic equivalent claim form:

O084 T795XXA N170 N171 N172 N178 N179 O0382 O0482 O0732 O904

Emergency Room/Department Services

- Enter the time of day (using the continental time system, such as 0000-2300) in FL 13, admission hour.

7020. HOSPITAL SPECIFIC BILLING INFORMATION Updated 10/16

Emergency Room/Department Services continued

- Emergency services provided in the emergency department must be billed using the appropriate evaluation and management (E&M) emergency department or critical care procedure code from the *CPT* codebook.
- Reference the *CPT* codebook for information on the CMS and American Medical Association (AMA) documentation guidelines as well as directions for assigning codes for emergency services. Copies of "detailed" documentation guidelines have been published by CMS.
- E&M procedure codes applicable to emergency department services include:

  99281 99282 99283 99284 99285 99291 99292

  Modifier ET will be informational only. Hospitals will no longer need to bill modifier ET with these codes for facility charges.

  Note: Refer to the *CPT* codebook for procedure code nomenclature.
- Nonemergent emergency room encounters must be billed using 99281.
  - For one facility charge and one professional charge, only one ER code (99281-99285) will be allowed to be billed per day per member regardless of provider.
  - Medical necessity documentation must accompany the claim when more than one ER visit is made on the same day for the same individual.
  - Emergency room encounters must be billed appropriately.
  - Medical records may be reviewed for coding accuracy of professional claims.
  - Physician services provided in an outpatient hospital setting and ambulatory surgical centers must be billed on the CMS 1500 Claim Form paper version or electronic equivalent.
  - Outpatient hospitals must bill facility charges on the UB-04 paper or equivalent electronic claim form.
- **Type B Emergency Departments -** A Type B emergency department is defined as an emergency department that meets the definition of a “dedicated emergency department” as defined in 42 CFR 489.24 under the EMTALA regulations. The following codes are covered KMAP services and should be used by Type B Emergency Departments:

  G0380 G0381 G0382 G0383 G0384
- It must meet at least one of the following requirements:
  - It is licensed by the State in which it is located under applicable state law as an emergency room or emergency department.
  - It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
  - During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
- Medical supplies and injections (99070 and J7030- J7121) are considered content of service of the ER visit.

7020. HOSPITAL SPECIFIC BILLING INFORMATION Updated 10/16

Locum Tenens Physicians

- Locum tenens physicians must not be in place for more than one year.
- It is the provider's responsibility to ensure a locum tenens physician covering for a KMAP provider is not excluded from participation in governmental programs including Medicaid.
- Upon review of claims, payments will be recouped if it is determined that KMAP paid for a service that was provided by a locum tenens physician who was excluded from participation in governmental programs including Medicaid on the date of service.

Mid-Level Provider

- Physician assistants (PAs) and advanced practice registered nurses (APRNs) must be enrolled as Medicaid providers to bill for services. Indicate the PA's or APRN's number as the attending physician on the UB-04 paper or electronic equivalent claim form.
- APRNs and PAs are reimbursed 75% of the Medicaid allowed amount for services provided.

Observation Room

- Currently, code G0378 is billed for outpatient services. This code replaces 99218ET.
- Medical supplies and injections (99070, J7030-J7121) are considered content of service of the observation room services.

Physician Clinic Services

- Currently, some physicians make scheduled visits once or twice a week to rural hospitals and see patients in an outpatient hospital room which functions as their office. Physician clinic services provided in a hospital location are considered content of the physician service and should not be billed to Medicaid or the member.
- Currently, the hospital can bill G0463 for the use of the room. G0463 is not considered content of surgery.

Professional Fees

- The only physician services which can be billed by the hospital on the UB-04 paper or electronic equivalent claim form are hospital-based physicians assigned to the emergency department.
- Currently, the hospital is no longer allowed to bill hospital-based physician professional fees.

Professional/Technical Component Billing

- **Components**
  - **Professional**
    In Field 24D, enter the HCPCS base code for services rendered, including **modifier 26** (example: **7207026**). ***Note:*** Modifier 26 is not covered for a hospital provider.
  - **Technical**
    In Field 24D, enter the HCPCS base code of the service performed, including **modifier TC** (example: **72070TC**). ***Note:*** Hospitals billing the base code for radiology procedures will be reimbursed at the TC rate.
  - **Professional and Technical**
    In Field 24D, enter the HCPCS base code of the service performed (example: **72070**).
- **The same procedures performed on the same day:**
  - Must be billed on the same claim

7020. HOSPITAL SPECIFIC BILLING INFORMATION Updated 11/19

Professional/Technical Component Billing continued

- Must clarify the reason for billing more than one procedure (Example: two X-rays at two different times; left arm, right arm)

- When the same procedures are not billed on the same claim, the additional claim(s) will be denied as a duplicate. To seek reimbursement for additional services when this occurs, submit an underpayment adjustment using the internal control number (ICN) from the remittance advice (RA) of the paid claim **and** state on the adjustment request that more than one procedure was performed on the same day. Refer to **Section 5600** of the *General Billing Fee-for-Service Provider Manual* for details.

  Exception: Claims that have the same procedures performed on the same date of service but have different places of service should be billed on separate claims. Both claims must include the two-digit place of service code to process correctly and not deny as duplicate.

Prosthetic and Orthotic

- Hospitals must enroll as prosthetic and orthotic (P&O) providers and bill on the professional claim form (CMS 1500 paper or equivalent electronic claim form) or 837 professional transaction when providing these services. Contact Provider Enrollment at 1-800-933-6593.
- Prosthetic and orthotic items **cannot** be billed as ancillary services on the UB-04 paper or equivalent electronic claim form.
  Exception: Prosthesis implanted by a surgical procedure may be billed on the hospital claim form for inpatient services.

Sterilization Procedures

When a sterilization is performed in conjunction with or secondary to an **inpatient** procedure (such as delivery) and the sterilization is **not** covered (such as failure to obtain the Sterilization Consent Form), remove all codes and charges related to the sterilization from the claim and bill the primary procedure only. Carefully document in the medical record the reason the sterilization was not billed on the claim.

Supplies

- The hospital can bill code 99070 without the modifier ET for supplies. Modifier ET is no longer a valid modifier for 99070. Only one supply is allowed per day.

Unit Billing

When billing for outpatient hospital services, round units to the nearest whole number. Do not bill fractions of units.

Unlisted Procedure codes:

- Not Otherwise Classified (NOC) drug codes may not be used when other appropriate codes are available (Example: C-series or J-series codes), even if this results in using a code that is not covered by KMAP.
- NOC drug codes should only be used when no other appropriate drug code can be used based on the HCPCS Guidelines.
- C-series codes can only be reported for outpatient facilities.
- Billing of any HCPCS code is not a guarantee of coverage or payment status.

7020. HOSPITAL SPECIFIC BILLING INFORMATION Updated 12/18

Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient.

- KMAP will not cover a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicaid will also not cover hospitalizations and other services related to these noncovered procedures. None of the erroneous surgeries or services is billable to the member.
- All services provided in the operating room when an error occurs are considered related and therefore are not covered. All providers in the operating room when the error occurs who could bill individually for their services must submit claims for these services but are not eligible for reimbursement for these services. These providers must submit separate claims for these services using the appropriate methods.

Inpatient Claims

- Hospitals are required to bill two claims when the erroneous surgery(s) is reported.
    - One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a type of bill (TOB) 11X (except 110)
    - One claim with the noncovered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim)
        - The noncovered TOB 110 will be required to be submitted on the UB-04 (hard copy) claim form.

- Providers are required to report as an "other diagnosis" one of the applicable external cause of morbidity codes for wrong surgery performed:

  Y6551 Y6552 Y6553

  Note: These external cause of morbidity codes are **not** to be submitted in the external cause of morbidity codes field on the UB-04.

Outpatient, Ambulatory Surgical Centers, Other Appropriate Bill Types and Practitioner Claims:

Providers are required to append one of the following applicable modifiers to all lines related to the erroneous surgery(s):

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

7030. STATE INSTITUTION FOR MENTAL HEALTH Updated 05/17

Accommodation and Ancillary Charges

If the individual accommodation and ancillary services exceed the detail lines on the UB-04 paper or electronic equivalent claim form, providers may combine all similar revenue code charges together (e.g., lab, radiology) when necessary. Accommodation codes may also be 'lumped' together when necessary. This will not affect the reimbursement of the claim.

State institutions may bill for ancillary services without indicating an accommodation code.

Medicare B Services

When Medicare B payment is made on an inpatient claim, indicate the amount paid as Prior Payment in FL 54 on the UB-04 paper or electronic equivalent claim form.

Other Insurance

When a member has other insurance, proof of payment or denial is required. Enter the amount paid by the other insurance carrier in FL 54 on the claim form. Refer to **Section 3300** of the *General TPL Payment Fee-for-Service Provider Manual* for specific instructions on submitting claims when other insurance is involved.

Transfers

When billing medically necessary incoming transfers, the following should be entered on UB-04 paper claims for incoming transfers from other hospitals:
In FL 80, Remarks, enter "direct transfer from (hospital, city)."

Reserve Days

Indicate revenue code **189** in **FL 42** when billing for reserve days.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 01/18

General hospital inpatient services require a copayment of $48 per inpatient admission.

General hospital outpatient surgery requires a copayment of $3 per surgery.

General hospital nonemergency outpatient services in place of a doctor's office visit require a copayment of $3 per visit.

Ambulatory surgical center services require a copayment of $3 per day.

Inpatient free standing private psychiatric facility services require a copayment of $48 per admission.

Specialty hospital (rehabilitation facilities, teaching facilities, etc.) inpatient services require a copayment of $48 per inpatient admission.

State psychiatric facility members are exempt from copayment requirements.

Transferring inpatient hospital admissions are exempt from copayment requirements. Copayment will be deducted from the receiving hospital.

Bill all services occurring on the same date on the same claim form. If multiple claims are submitted for the same date(s) of service, the copayment requirement will be deducted for each claim submitted.

Do **not** reduce charges or balance due by the copayment amount. This reduction will be made automatically during claim processing.

BENEFITS AND LIMITATIONS

8200. MEDICAL ASSESSMENT Updated 01/22

Documentation

To verify services provided in a post payment review, documentation in the patient's medical record must support the service billed. Documentation can be requested at any time to verify that services have been provided within program guidelines. Refer to **Section 5000** of the *General Billing Fee-for-Service Provider Manual*. The information below indicates medical information which may be necessary to document medical necessity of those diagnoses designated as "sometimes payable" on the screen.

Abdominal Plain Films and Ultrasound

- Abdominal plain films and ultrasound are medically necessary if the diagnosis indicates abdominal pain, nausea/vomiting, complications associated with ulcers, intestinal obstruction, gall bladder disease, malignant neoplasm of the abdominal organs, injury to the abdomen or nephrolithiasis. It may be necessary to contact the ordering physician for medical necessity information.

- An abdominal plain film may be warranted in a pregnant patient if:
    - Fetal position is questionable.
    - Obstetrical ultrasound is unavailable, **and** patient is in labor.

Cardiac Rehabilitation

- Phase II Cardiac Rehabilitation is covered using procedure code 93798. This procedure is covered when performed in an outpatient or cardiac rehabilitation unit setting, with the following criteria:
    - Member must have a recent cardiology consultation within three months of starting the cardiac rehabilitation program.
    - Member must have completed Phase I Cardiac Rehabilitation.
    - Member must have one or more of the following diagnoses/conditions:
        - Acute myocardial infarction within the preceding three months, post inpatient discharge
            - Codes I2101, I2102, I2109, I2111, I2119, I2121, I2129, I213, I214, I220, I221, I222, I228, I229, I255, I256, I2589, and I259
        - Coronary bypass surgery within the preceding three months, post inpatient discharge
            - Code Z951
        - Stable angina pectoris within three months post diagnosis
            - Codes I200, I201, I208, and I209

Colorectal Screenings

KanCare will cover the colorectal cancer screening procedures recommended by American Cancer Society. One of the following colorectal cancer screening tests should be used based upon clinical presentation:

- Fecal occult blood testing (iFOBT),
- Fecal immunoassay testing (FIT),
- Multi-targeted stool DNA (mt-sDNA),

Colorectal Screenings continued

- Sigmoidoscopy or colonoscopy for adults 45 to 75 years of age.

Intervals for recommended screening strategies:

Visual (structural) exams of the colon and rectum:

- Colonoscopy every 10 years
  - G0105, G0120, or G0121
- Flexible sigmoidoscopy (FSIG) every five years
  - G0104 or G0106

Stool-based test:

- Highly sensitive fecal immunochemical test (FIT) 82274
- Highly sensitive guaiac-based fecal occult blood test (gFOBT) 82270
- Multi-targeted stool DNA (mt-sDNA) every three years 81528

CT SCANS - Abdominal

- A CT scan of the abdomen is medically necessary if the diagnosis indicates a malignant neoplasm of the intra-abdominal cavity, lung or genital organs, lymphoma, diseases of the spleen, liver abscess, peritonitis, pancreatitis, abdominal trauma, or abdominal mass.
- A CT scan of the abdomen **may** be medically necessary for abdominal pain, abdominal aneurysm, acute lymphocytic leukemia, or any malignant neoplasm not located in the intra-abdominal cavity, lung or genital organs. Inclusion of the following documentation will assist in the adjudication of your claim.
  - **Abdominal pain:** Indicate the severity and chronicity of the pain, presenting symptoms and suspected conditions or complications.
  - **Abdominal aneurysms:** Indicate the presenting symptoms and suspected complications.
  - **Acute lymphocytic leukemia:** Indicate the presenting symptoms and a detailed description of area(s) involved.
  - **Malignant neoplasm not located in the intra-abdominal cavity, lung, or genital organs:** Indicate pertinent symptoms and if performed as part of staging the disease process.
- It may be necessary to contact the ordering physician for medical necessity information.

CT Scans - Head or Brain

- A CT scan of the head or brain is medically necessary if the diagnosis indicates intracranial masses/tumors, intracranial congenital anomalies, hydrocephalus, brain infarcts, parencephalic cyst formation, open or closed head injury, progressive headache with or without trauma, intracranial bleeding, aneurysms, or the presence of a neurological deficit.
- A CT scan of the head or brain may also be medically necessary with the indication of headache, epilepsy, syncope, dizziness, or acute lymphocytic leukemia. Inclusion of the following documentation will assist in adjudication of your claim:
  - **Headache:** Indicate length of chronicity and any accompanying central nervous system (CNS) symptoms.

CT Scans - Head or Brain continued

- **Epilepsy:** Specify if initial or repeat scan, indicate if suspected injury occurred during seizure.
- **Syncope:** Specify if recurrent or single episode.
- **Dizziness:** Specify if recurrent or single episode.
- **Acute lymphocytic leukemia:** Indicate any accompanying CNS symptoms.

- It may be necessary to contact the ordering physician for medical necessity information.

Electrocardiograms

- Electrocardiograms (EKGs), up to 12 leads, are covered if medical necessity is met.
- Preoperative EKGs are medically necessary for patients over 40 years of age or those patients under 40 with a history of cardiac problems.
- It may be necessary to contact the ordering physician for medical necessity information.
- **History:** The age of a patient is a component of every medical record. Documentation of age in relationship to issues such as antisocial behavior or mental status is important; however, age alone is not considered a social history.
- **Examination:** A "comprehensive exam" is considered a "hands on" specialist examination. Telephone consultation with a specialist is not the equivalent of comprehensive exam.
- **Medical decision making:** Transfers from the emergency department to another facility for additional care should be considered in management options as either the "new problem, additional work-up" or the category of "established problem, worsening."

Emergency Department/Room

Guidelines for E&M Codes

- A vascular examination is included in the cardiovascular category.
- A notation that the patient should "follow-up" with his family physician in the morning or return to the physician's office for stitch removal does not justify use of the "additional work-up" statement when considering management options.
- In evaluating the "Table of Risk", infection is the usual risk that pops into mind when talking about minor surgery. To consider infection as a "risk" from minor surgery, there must be documentation to support increased risk due to the quality or condition of the injury or illness.
- "Self-limited/minor problems" are defined as being representative of basic emergency department care such as lacerations, stings, insect bites.
- "New problems with or without additional work-up" is defined as new, long-standing problems that will need attention again at some time.

Hospital - Outpatient

General Information

- The State of Kansas defines emergency services as follows:
  - KAR 30-5-58 (42) "Emergency services are those services provided after the sudden onset of a medical condition manifested by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part."
  - KAR 30-5-81 (b) (4) "Services provided in the Emergency Department shall be emergency services."

Hospital – outpatient continued

- Emergency status is determined based on conditions relating to the emergency visit, not the member's age and time of admission to the emergency department. Emergency department claims are limited to one visit per member, per date of service unless accompanying documentation verifies the necessity for more than one emergency room/department visit.
- Direct physical attendance by a physician or mid-level practitioner is required in "emergency" situations. If the physician or mid-level practitioner has not made entries on the record other than his/her signature and/or diagnosis and documentation does not indicate that he/she had examined the member, the visit will not be considered emergent. Phone or standing orders do not support emergency treatment.
- Axillary temperatures are not considered accurate and will be disregarded when determining emergent status.
- Members may go to the emergency room without a referral from their physician based on the definition of an emergency according to a prudent layperson (as defined by the Balanced Budget Act, 1997): What a layperson would consider an emergency in the absence of medical knowledge. Such an emergency could include but is not limited to serious impairment to bodily functions; serious dysfunction of any bodily organ or part; severe pain; or an injury/illness that places the health of the individual in serious jeopardy (and in the case of a pregnant woman, her health or that of her unborn child).

  Other examples of emergencies are:
  - Initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered "life-threatening".
  - Members who require transfer to another facility for further treatment or who expire.

  Nonemergent situations:
  - Intentional noncompliance with previously ordered medications and treatments resulting in continued symptoms of the same condition.
  - Refusal to comply with currently ordered procedures/treatments such as drawing blood for laboratory work.
  - Leaving the emergency room against medical advice.
  - Having previously been in the same or different emergency room or physician's office for the same condition and the condition had not worsened.
  - Scheduled visits to the emergency room for procedures, examinations, or medication administration. Examples include cast changes, suture removal, dressing changes, follow-up examinations, and second opinion consultations.
  - Visits made to receive a "tetanus" injection in the absence of other emergent conditions.
  - Visits made to obtain medication(s) in the absence of other emergent conditions.
  - Conditions/symptoms relating to the visit had been experienced longer than 48 hours or are of a chronic nature and emergency medical treatment to stabilize the condition was not required.

  The following conditions will not be considered emergent unless the criteria described has been met.

Hospital – outpatient continued

- **Alcoholism:** In and of itself is considered nonemergent unless documentation supports an emergent status (i.e., gastric bleeding or coma/stupor).
- **Ambulance:** A patient brought in by **ambulance** does not necessarily justify an emergency room visit.

Guidelines for Use of Air Ambulance Services:
Time: If time is a critical factor in the patient's recovery or survival, or duration of ground transport would be excessive and potentially detrimental, air transport may be indicated. In general, if the ground ambulance can arrive at the destination institution within 20 minutes, it is the preferred mode of transport.
Expertise: If the health care institution does not possess the expertise to provide the definitive care required to stabilize the patient (i.e., advanced life support) and the ground ambulance providers in the near vicinity cannot provide assistance in providing that care, air transport may be indicated.
Coverage: If ground ambulance utilization leaves the service area without adequate ground coverage and patient outcome will be compromised by arranging other ground transport, air transport may be indicated.
Documentation: The above guidelines serve as a guide to documentation which is necessary to determine proper reimbursement and must specify the indication and justification for air transport. If guidelines are not met, or are met but not documented, the billed transportation will be reimbursed at ground ambulance rates or denied altogether.

- **Depression/anxiety**: Documentation must support the member to be an **immediate** danger to self or others.
- **Disposition:** If a member's **disposition** is one of the following, the visit would be considered emergent:
  - Requires transfer to another facility for further treatment
  - Has expired, expires en route to the hospital or in the emergency room
  - Requires extended observation or admission
- **Fevers:** Must be considered with other documented symptoms. Generally, temperatures less than 103° rectally (children) or 102° orally (adults) are not considered emergent. Ear and axillary temperatures will be considered along with additional symptoms. Reported temperatures by patients are not acceptable for determining emergent status.
- **Insect bites, stings, embedded ticks: Minor insect bites** (tick) with simple local reactions only (i.e., erythema, local edema, itching) are not considered emergent.
- **Medical emergency:** Initial treatment and/or stabilization for **medical emergencies** including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus or other conditions considered "life-threatening" would be considered emergent. Just because these conditions may be considered "life-threatening" at times, does not automatically indicate a Level of Care III. The Level of Care assignment is dependent upon the severity of the situation and the services provided.
- **Mental disorders:** Such as depression or anxiety as an individual diagnosis is considered nonemergency unless the member is noted to be suicidal or of immediate risk to self or others.

Hospital – outpatient continued

- **Minor burns/sunburns**: Minor **burns**/sunburns are considered nonemergent unless documentation supports the presence of complications such as severe swelling, infection, or the young age of the patient. Eye and chemical burns are considered emergent.
- **Otitis media:** If tympanic membrane is bulging or ruptured, drainage from the ear(s), fever of 103 or above or is a child of age 3 or under and is crying inconsolably, a visit to the emergency room would be considered emergent for consideration of **otitis media**. If the physical examination reveals evidence of acute otitis media (after office hours or on the weekend), but does not meet any of the above criteria, the ED visit may be considered emergent because of the time of day/week.
- **Patient noncompliance:** Intentional noncompliance with previously ordered medications and treatments resulting in continued symptoms of the same condition are considered nonemergent. Refusal to comply with currently ordered procedures/treatments such as drawing blood for laboratory work will also be considered nonemergent.
- **Registered Nurse Services**: Hospitals can bill procedure code 99211 for registered nurse (RN) services and costs associated with the use of room and supplies when no other professional service is reimbursable. This includes but not limited to:
  - Wound care
  - Obstetrical check
  - Other treatments

  Code 99211 cannot be billed on the same day as codes G0463 or 31720.
- **Removal of cutaneous foreign bodies**: Removal of cutaneous foreign bodies (i.e., simple splinters, cactus needles) are considered nonemergent unless sedation or the use of extensive medical supplies such as cutdowns are required.
- **Seizures** are considered emergent when:
  - This is an initial seizure.
  - There is a secondary diagnosis noted (i.e. infection or headache).
  - The patient is 12 years old or younger.
  - The seizure is still in progress or status epilepticus.
  - This is a febrile seizure.
  - The condition is aggravated by alcohol/drug ingestion.
  - This is a previously undiagnosed condition.
- **Scheduled visits:** Scheduled visits to the emergency department for procedures, examinations, or medication administration (i.e. cast changes, suture removal, dressing changes, follow-up examinations and second opinion consultations) are considered nonemergent.
- When a member leaves the emergency department against medical advice (AMA) the service is generally considered nonemergent. However, if the facility provided considerable services before the patient left AMA, the visit will be given consideration as emergent.
- **Sickle cell anemia:** If a person has sickle cell anemia and presents with suspicion of an infectious or hypoxic process, or complains of pain, the visit may be considered emergent.
- **Skin rash/hives**: Documentation must support presence of systemic complications beyond the local skin discomforts resulting from the rash.

Hospital – outpatient continued

- If the rash causes eye complications or the member has a history of anaphylactic (allergic) reactions, the visit is considered emergent.
- If the rash causes eye edema or impairment to eye function and the visit is over a weekend when there is no access to a physician's office, the visit may be considered emergent.
- A history of anaphylaxis along with the rash is considered emergent.

- **Trauma/injury:** Recent trauma or injury is considered emergent. Recent is defined as an injury occurring within 48 hours prior to the emergency room visit.

  - Minor abrasions/lacerations not requiring suture or other injuries not requiring treatment are not emergent.
  - If the injury is older than 48 hours and symptoms have deteriorated to the point of requiring emergency care, consider as emergent.
  - An injury that requires only simple first aid treatment that can be done in the home (such as cleansing and/or bandaging an abrasion) is not considered emergent.
  - A laceration requiring steri-strips indicates a gaping wound and would be considered emergent.
  - X-rays do not define the level of care.
- **Tetanus injection:** A tetanus injection is not considered emergent and does not change the visit to emergent. However, the patient should not have to make two visits (one to the emergency room and one to an office or public health department) to receive the tetanus injection. When needed, a tetanus injection should be given within 48-72 hours of the injury, if possible.
- **Vital signs:** If the vital signs are outside a reasonable range for the age, consider the visit as emergent (see **Fever**).

Fetal Testing

Fetal aneuploidy testing codes 81420 and 81507 will be covered for at-risk pregnancies when billed with a covered ICD-10 diagnosis code. Fetal aneuploidy testing will be limited to coverage of one *CPT* code per pregnancy (270 days).

- DNA-based noninvasive prenatal tests of fetal aneuploidy are proven and medically necessary as screening tools for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome) or trisomy 13 (Patau syndrome) in any one of the following circumstances:
  - Maternal age of 35 years or older at delivery
  - Fetal ultrasound findings indicating an increased risk of aneuploidy
  - History of prior pregnancy with trisomy
  - Positive first or second trimester screening test results for aneuploidy
  - Parental balanced Robertsonian translocation with an increased risk of fetal trisomy 13 and 21
- DNA-based noninvasive prenatal tests of fetal aneuploidy are unproven and NOT medically necessary for all other indications including, but not limited to, the following:
  - Multiple gestation pregnancies
  - Screening for microdeletions
  - Screening for sex chromosome aneuploidies

8200. MEDICAL ASSESSMENT Updated 08/22

Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy is a covered service under KMAP with PA. The following criteria must be met before a PA will be approved.

1. The services must be for one of the following conditions:
    a. Acute carbon monoxide intoxication
    b. Decompression illness
    c. Gas embolism
    d. Gas gangrene
    e. Acute traumatic peripheral ischemia
    f. Compromised skin grafts
    g. Chronic refractory osteomyelitis
    h. Osteoradionecrosis
    i. Soft tissue radionecrosis
    j. Cyanide poisoning
    k. Actinomycosis
    l. Crush injuries and suturing of severed limbs
    m. Progressive necrotizing infections
    n. Acute peripheral arterial insufficiency
    o. Diabetic wounds of lower extremities
2. It must be documented that other treatments have been attempted with no improvement.

- Facilities can bill for this procedure using procedure code 99183or G0277 (one unit equals 30 minutes with a maximum of four units allowed per treatment session). The facility must choose which procedure code they will bill prior to the approval of the PA.
- If there are multiple treatment sessions on the same day, each subsequent session must be billed on a separate detail line with a 76 modifier.

Maternal Depression Screenings

Maternal Depression Screenings are reimbursable using the Current Procedural Technology (CPT) and Health Care Common Procedure Coding System (HCPCS) codes 96160, 96161, G8431, and G8510 when using one or more of the following validated screening tools:

- Edinburgh Postnatal Depression Scale (EPDS)
- Perinatal Grief Intensity Scale (PGIS)
- Postpartum Depression Screening Scale (PDSS)
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory II (BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Zung Self-Rating Depression Scale (SDS)

These screenings are reimbursable when a woman is pregnant or after a perinatal loss (stillbirth, miscarriage or neonatal death) that occurs during her Medicaid coverage period, and screenings are allowed postpartum up until the child is 12 months of age. Any screenings that occur prior to the birth of the child or after a perinatal loss, should be billed under the woman's Medicaid Identification (ID) number using CPT code 96160. Any screening that occurs after the child is born is considered an Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit per

Maternal Depression Screenings continued

Centers for Medicare and Medicaid Services (CMS) guidance, and should be billed under the infant's Medicaid ID number, using CPT code 96161. If the child does not have an assigned Medicaid ID number, CPT code 96161 can be billed under the mother's Medicaid ID number for up to 45 days postpartum. Rural Health Care/Federally Qualified Health Centers (RHC/FQHC) may perform these screenings and list this on their claims, but it will be included in the encounter rate.

The Maternal Depression Screenings can be administered by non-licensed staff. This includes home visitors, medical assistants, and community health workers since they are supervised by licensed professionals performing the primary service. These screenings should be reviewed by licensed professionals to ensure accuracy of the scoring and any necessary follow-up.

Approved Provider Type / Provider Specialty Codes:

08-080	08-081	08-083	08-183	09-093	09-095	10-100
11-111	11-112	11-115	11-116	11-122	11-176	13-131
13-181	31-316	31-318	31-323	31-328	31-335	31-339
31-345	31-348	31-349	31-350			

Approved Place of Service Codes

11	12	17	19	20	22	23
25	49	50	53	57	62	71
72						

Clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both. Evidence suggests that collaborative care models implemented in obstetrics and gynecology offices improve long-term patient outcomes.

Follow-up with these patients and clinical support and training offered to staff results in greater reduction in depression prevalence. Initiation of treatment or referral to mental health care providers offers maximum benefit.

Miscarriage, Stillbirth and Neonatal Loss; Bereavement Follow-up Recommendations:

Loss of a pregnancy or death of a newborn affects every aspect of a family's life. Every effort should be made to determine the cause of the loss, to understand the family's grief responses, and to facilitate healthy coping and adjustment. The consequences of intense grief due to perinatal loss may include significant couple relationship issues, depression, anxiety, social phobia, obsessive compulsive disorder and post-traumatic stress disorder (PTSD) that may extend into the subsequent healthy pregnancies.

When the Perinatal Grief Intensity Scale (PGIS) is given shortly after the loss, it can also predict women who will continue to have intense grief 3-5 months in the future, and have higher risk for developing clinical level anxiety, depression, PTSD and couple relationship issues.

Maternal Depression Screenings continued

It is recommended that healthcare providers routinely screen for symptoms of depression and anxiety among women after a perinatal loss, as well as subsequent pregnancies.

Studies have shown that women who had experienced a stillbirth are twice as likely to have a high depression score compared to women who had a live birth and that women with a history of depression are especially vulnerable to persistent depression after a stillbirth, even after the subsequent birth of a healthy child. One study was the first to show that women who have no history of depression may face a risk for depression many months after a stillbirth.

Depression after a miscarriage is usually most severe immediately after a pregnancy is lost and that the depression rates dropped over the course of the year.

One of the key recommendations is that every woman who has experienced a miscarriage, stillbirth or neonatal death should receive follow-up care.

Referral and Follow-up Process on Positive Screenings Recommended by the American Academy of Pediatrics (AAP):

Immediate action is necessary if:

- Possible suicidality indicated in screening tool
- Mother expresses concern about her or her infant's safety
- Provider suspects that the mother is suicidal, homicidal, severely depressed, manic or psychotic When a depression screen is positive, management varies according to the degree of concern and need.

Management of Postpartum Depression includes:

- Demystification (reducing guilt and shame by emphasizing how common these feelings are);
- Support resources (family and community); and
- Referrals for the mother (to a mental health professional or the mother's PCP or obstetrician), for the mother-infant dyad, for the child (for targeted promotion of social-emotional development and early intervention, and for the mother who is breastfeeding (for lactation support from an experienced provider).

Training Opportunities:

Optional training will be offered to screeners, including medical providers and their clinical staff, to increase timely detection of maternal depression.

The Mental Health Integration Toolkit on the KDHE website, will be updated by Public Health and will provide guidance on screening practices and patient and provider resources. There is also a national program, Mental Health First Aid, that teaches the skills to respond to the signs of mental illness and substance use.

MRI - Breast

- MRI of the breast will be covered with the following indications:
    - Staging and therapy planning in patients diagnosed with breast cancer

MRI - Breast continued

- Occult primary breast cancer when there are positive axillary nodes and no known primary tumor
- Inconclusive diagnosis after a standard mammography evaluation, for example when scar tissue from previous surgery, dense breast tissue of breast implants can render mammographic images inconclusive

- **MRI used for screening for breast cancer is not justified.**

MRI - Head or Brain

- MRI scan of the head or brain is medically necessary if the diagnosis indicates intracranial injury, intracranial mass/tumor, CNS malignancies, cerebrovascular disorder, cerebral malformations, disorders of the cerebral hemispheres and higher brain functions, demyelinating diseases, extrapyramidal and cerebellar disorders, brain abscesses, encephalitis, tuberculous meningitis, or the presence of a neurological deficit.
- MRI scan of the head or brain may also be medically necessary with the indication of headache, seizure disorders, syncope, dizziness, or non-CNS malignancies. Inclusion of the following information will assist in adjudication of your claim:
  - **Headache:** Indicate length of chronicity and any accompanying neurologic symptoms.
  - **Seizure:** Specify if initial or repeat scan, and if seizures (or convulsions) are of disorders of recent onset, frequency of their occurrence, and any accompanying neurologic symptoms.
  - **Syncope:** Specify if recurrent or single episode and any accompanying neurologic symptoms.
  - **Dizziness:** Specify if recurrent or single episode and any accompanying neurologic symptoms.
  - **Non-CNS malignancies:** Indicate any accompanying neurologic symptoms.
- It may be necessary to contact the ordering physician for medical necessity information.

Observation Room

- Observation in the outpatient setting is a service which requires monitoring the member's condition beyond the usual amount of time in an outpatient setting. Examples of the appropriate use of the observation room include:
  - Monitoring head trauma
  - Drug overdose
  - Cardiac arrhythmias
  - False labor
- The observation room stay must be medically necessary.
- Currently, the observation stay is limited to 48 hours. A physician must have personal contact with the member at least once during the observation stay. A registered nurse or an employee under his or her direct supervision must monitor members in the observation unit. A member can be in the observation unit no more than 48 hours. Observation hours in excess of 48 hours are not reimbursable. Ancillary charges (such as lab work or x-rays) can also be billed separately. Medical supplies and injections (99070 and J7030-J7121) are considered content of service of the observation room service.

Observation Room continued

- Observation services are considered content to any surgical procedure for which global surgery rules apply when performed by the same provider during the global surgery period. Observation services are considered content of service of respiratory services (94010-94700), when performed on the same date of service by the same provider unless the observation is a significantly, separately identifiable service.
- Observation room should **not** be billed for the following:
    - Recovery room services following inpatient or outpatient surgery
    - Recovery/observation following scheduled diagnostic tests, such as arteriograms or cardiac catherization
    - ER physician fee

  Note: **Additional information may be added to the face of your claim if applicable. Electronic billers who have had initial billings denied with EOB 548 (Service denied. This claim and all attachments have been reviewed by the medical staff and the medical necessity of the service rendered is not supported by the documentation provided. Refer to the provider manual section 8200 for further discussion.), may resubmit a paper claim with the applicable documentation noted on the face of the claim.**
- If the claim and/or attachments do not support the medical necessity of the service rendered, the service will be denied.

Sonograms - Non-Obstetrical Pelvic

- Non-obstetrical pelvic sonograms are determined medically necessary if the diagnosis indicates pelvic mass or pain, ovarian cyst, pelvic inflammatory disease, endometriosis, possible retained products of conception, or question/history of metastatic disease.

- Non-obstetrical pelvic sonograms may be medically necessary if there is an indication of vaginal bleeding or irregular menstrual cycles. It may be necessary to contact the ordering physician for medical necessity information.

Sonograms - Obstetrical Pelvic

- Obstetrical (OB) sonograms are not covered when performed solely to determine the fetal sex or to provide parents a view and/or photograph of the fetus. Only one routine OB sonogram per pregnancy is allowed. Medical necessity for more than one OB sonogram per pregnancy needs to be demonstrated with medical documentation available for review to support this necessity.
- A primary or secondary diagnosis must support medical necessity for an OB sonogram. ***Note:*** If applicable, this information should be submitted with the claim.
- The following OB sonogram procedures must be billed using a primary or secondary diagnosis code indicating this was an obstetrical procedure.

76801	76802	76805	76810	76811	76812	76813
76814	76815	76816	76817	76818	76819	76820
76821	76825	76826	76827	76828		

Upper Gastrointestinal Series

- Upper Gastrointestinal (UGI) series are medically necessary if the primary diagnosis indicates persistent dysphagia; melena; symptoms of UGI tract bleeding; or signs and symptoms of ulcers

Upper Gastrointestinal Series continued

affecting the UGI tract after a trial of medicinal therapy has failed to relieve the symptoms. State guidelines allow one UGI series per day, per member, regardless of provider.

- UGI series may also be medically necessary when diagnoses such as abdominal pain and dyspepsia are used. When these common nonspecific diagnosis codes are used, additional symptoms and/or circumstances that relate to the medical necessity of the procedure must be indicated. Examples of additional information which will assist in adjudication of your claim are as follows:
    - Is the symptom persistent? If so, how long has the symptom persisted?
    - Is the symptom recurrent? When was the last episode?
    - Has the symptom or condition increased in severity?
    - Was medicinal therapy initiated prior to any procedure being performed? If so, indicate the date each therapy was initiated, name(s) of medication (list all GI related medications tried) and the length of time each medication was tried. What was the patient's response to each treatment?
    - If a chronic condition, has there been a change in symptoms? If so, describe the change(s).
    - If cancer diagnosis codes are used, what symptoms are present that indicate UGI involvement?

- Claims for UGI X-rays are denied reimbursement when the diagnosis code on the claim is either too nonspecific or is the result, rather than the reason, for the procedure. Whenever possible, use the symptoms that most clearly describe the reason for the test. It may be necessary to contact the ordering physician for medical necessity information.

X-ray - Chest

- Chest X-rays are covered if medical necessity is met.
- Preoperative and routine admission chest X-rays are not covered unless documentation of medical necessity (one or more of the following factors) is noted on the claim:
    - Sixty years of age or older
    - Pre-existing or suspected cardiopulmonary disease
    - Smoker over age forty
    - Acute medical/surgical conditions such as malignancy or trauma
- Claims denied because other factors are listed will be reconsidered if appealed (refer to **Section 5300** of the *General Billing Fee-for-Service Provider Manual*).
- It may be necessary to contact the ordering physician for medical necessity information.

X-ray - Skull

- Skull X-rays are medically necessary if diagnosis indicates cranial trauma, primary or metastatic tumors of the skull, or tumors of the pituitary gland.
- A skull X-ray may also be medically necessary for indication of chronic sinusitis, trigeminal neuralgia, or anomalies relating to the head. Inclusion of the following documentation will assist in the adjudication of your claim:
    - **Chronic sinusitis:** Indicate any pertinent specific suspected complications resulting from chronicity.
    - **Trigeminal neuralgia:** Specify type of lesion suspected.

X-ray – Skull continued

- **Anomalies relating to the head:** Specify if done as a scout film for non-cosmetic reconstructive surgery. Indicate type of surgery under consideration.

- It may be necessary to contact the ordering physician for medical necessity information.

8300. BENEFIT PLANS Updated 12/22

KMAP members will be assigned to one or more benefit plans. These benefit plans entitle the member to certain services. If there are questions about service coverage for a given benefit plan, refer to **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* for information on eligibility verification.

For example, all policies and coverages under the current Medicaid program apply to the MediKan benefit plan except:

- Procedure codes for drugs and biologics deemed a Physician Administered Drug (PAD) will not be covered.
- Inpatient general hospital services are covered for MediKan members for the following conditions only:
    - Acute **psychotic** episodes
    - Substance abuse acute detoxification
    - Burns
    - Traumatic injury
    - Tuberculosis (TB)

- MS-DRGs for covered inpatient hospital services are:
  183 184 185 483 885 913 914 927 928 929 933 934 955
  956 957 958 959 963 964 965

- Additional MS-DRGs are covered when the hospital admission is related to TB and a TB diagnosis is billed on the claim.
  094 095 096

- Claims for MediKan members that group to any other MS-DRG will be reviewed. Coverage determination is based on the nature of the injury indicated by the diagnosis on the claim and by the medical documentation submitted. At a minimum, the history and physical accompanied by an admission note and the discharge summary must be submitted as part of the medical documentation. If this documentation is not submitted, the claim will be denied. Additional information may be submitted if the hospital considers it beneficial to support coverage of the DRG.

  Note: **Traumatic injury definition:** Physical harm to a person's body by an outside force that requires immediate hospitalization and medical interventions for the preservation of life and function.

Psychiatric Admission

Fee-for-service inpatient psychiatric admission claims no longer require a psychiatric preadmission assessment but are subject to a potential postpay review by the fee-for-service inpatient utilization review contractor. Coverage determinations are based on the emergent nature of the service.

8400. MEDICAID - INPATIENT/OUTPATIENT Updated 03/18

Change of Ownership

- Each hospital must notify Provider Enrollment in writing at least 60 days prior to the change of ownership closing transaction date. Failure to do so may result in:
    - The forfeiture of rights to payment for covered services provided to members by the previous owner or owners in the 60-day period prior to the date of the change of ownership.
    - The new owner or owners assuming responsibility for any overpayment made to previous owner(s) before the effective date of the change of ownership. (This shall not release the previous owner of responsibility for such overpayment).
- The new owner (and affiliated providers) must apply for a Medicaid provider number by contacting Provider Enrollment at:

  Provider Enrollment
  P.O. Box 3571
  Topeka, KS 66601-3571
- The new owner will receive the full reimbursement for any patients admitted before and discharged after the change of ownership effective date. The old owner shall not receive Medicaid payment for these services.

Advance Directives

Hospital providers participating in KMAP must comply with federal legislation (OBRA 1990, Sections 4206 and 4751) concerning advance directives. An advance directive is otherwise known as a living will or durable power of attorney. Every hospital provider must maintain written policies, procedures, and materials about advance directives.

Specific Requirements

- Each hospital must provide written information to every adult individual receiving medical care by or through the hospital. This information must contain:
    - The individual's right to make decisions concerning his or her own medical care
    - The individual's right to accept or refuse medical or surgical treatment
    - The individual's right to make advanced directives
    - KDADS "Description of the Law of Kansas Concerning Advance Directives" ***Note:*** KDADS does not provide copies of the description to providers. It is up to providers to reproduce the description. Providers are free to supplement this description so long as they do not misstate Kansas law.
- Additionally, each hospital must provide written information to every adult individual about the hospital's policy on implementing these rights.
- A hospital must document in every individual's medical record whether the individual has executed an advance directive.
- A hospital may not place any conditions on health care or otherwise discriminate against an individual based upon whether that individual has executed an advance directive.
- Each hospital must comply with state law about advance directives.

Advance Directives continued

- Each hospital must provide for educating staff and the community about advance directives. This may be accomplished by brochures, newsletters, articles in the local newspapers, local news reports or commercials.

Incapacitated Individuals

- An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether he or she has executed an advance directive. If this is the case, families of, surrogates for, other concerned persons of the incapacitated individual must be given the information about advance directives. If the incapacitated individual is restored to capacity, the hospital must provide the information about advance directives directly to him or her even though the family, surrogate or other concerned person received the information initially.
- If an individual is incapacitated, otherwise unable to receive information or articulate whether he or she has executed an advance directive, the hospital must note this in the medical record.

Mandatory Compliance with the Terms of the Advanced Directive

When a patient, relative, surrogate or other concerned/related person presents a copy of the individual's advance directive to the hospital, the facility must comply with the terms of the advance directive to the extent allowed under state law. This includes recognizing powers of attorney.

Description of the Law of Kansas Concerning Advance Directives

There are two types of "advance directives" in Kansas. One is commonly called a "living will" and the second is called a "durable power of attorney for health care decisions."

The Kansas Natural Death Act, K.S.A. 65-28,106, et seq.

This law provides that adult persons have the fundamental right to control decisions relating to their own medical care. This right to control medical care includes the right to withhold life-sustaining treatment in case of a terminal condition.

Any adult may take a declaration which would direct the withholding of life-sustaining treatment in case of a terminal condition. Some people call this declaration a "living will." The declaration must be:

1. In writing
2. Signed by the adult making the declaration
3. Dated; and
4. Signed in front of two adult witnesses, or notarized.

There are specific rules set out in the law about the signature in case of an adult who can't write. There are specific rules about the adult witnesses. Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may not serve as witnesses. A woman who is pregnant may not make a declaration.

Advance Directives continued

The declaration may be revoked in three ways:

1. By destroying the declaration;
2. By signing and dating a written revocation; and
3. By speaking an intent to revoke in front of an adult witness. The witness must sign and date a written statement that the declaration was revoked.

Before the declaration becomes effective, two physicians must examine the patient and diagnose that the patient has a terminal condition.

The desires of a patient shall at all times supersede the declaration. If a patient is incompetent, the declaration will be presumed to be valid.

The Kansas Natural Death Act imposes duties on physicians and provides penalties for violations of the laws about declarations.

The Kansas Durable Power of Attorney for Health Care Decisions Law, K.S.A. 58-625, et seq.

A "durable power of attorney for health care decisions" is a written document in which an adult gives another adult (called an "agent") the right to make health care decisions. The power of attorney applies to health care decisions even when the adult is not in a terminal condition. The adult may give the agent the power to:

1. Consent or to refuse consent to medical treatment;
2. Make decisions about donating organs, autopsies, and disposition of the body;
3. Make arrangements for hospital, nursing home, or hospice care;
4. Hire or fire physicians and other health care professionals; or
5. Sign releases and receive any information about the adult.

A "durable power of attorney for health care decisions" may give the agent all those five powers or may choose only some of the powers. The power of attorney may **NOT** give the agent the power to revoke the adult's declaration under the Kansas Natural Death Act ("living will"). The power of attorney only takes effect when the adult is disabled unless the adult specifies that the power of attorney should take effect earlier.

The adult may **NOT** make a health care provider treating the adult the agent except in limited circumstances.

The power of attorney may be made by two methods:

1. In writing - Signed by the adult making the declaration;
2. Dated - Signed in front of two adult witnesses or written and notarized.

Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may **NOT** serve as witnesses. The adult, at the time the power of attorney is written, should specify how the power of attorney may be revoked.

Advance Directives continued

The Patient Self-Determination Act, Section 1902(w) of the Social Security Act

This federal law, codified at 42 U.S.C. Sec. 1396a(w), was effective December 1, 1991. It applies to all Medicaid and Medicare hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires these organizations to take certain actions about a patient's right to decide about health care and to make advance directives.

This law also required that each state develop a written description of the state law about advance directives. This description was written by the Health Care Policy section of KDADS to comply with that requirement. If you have any questions about your rights to decide about health care and to make advance directives, please consult with your physician or attorney, Third Edition: January 14, 2003

Abortions

- Abortions are covered only under the following conditions:
  - 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
  - If the pregnancy is the result of an act of rape or incest
- The physician must complete the **Abortion Necessity** form to certify that the woman's physical health is in danger or that the pregnancy is a result of rape or incest. The form, located on the Forms page of the public and secure websites, may be photocopied for your use. All blanks **must** be completed, including the patient's complete address.
- Claims submitted for abortions due to rape or incest must be accompanied by a statement signed by the physician stating that he or she was informed by the member that the pregnancy was the result of rape or incest. No further documentation is required to process the claim. However, all pertinent information must be retained with the medical record.

Add-On Codes

In accordance with National Correct Coding Initiative guidelines, procedure codes identified as add-on codes must be billed in addition to the primary procedure with which they are associated. An add-on code does not stand alone since it describes work in addition to the primary procedure. For more information on billing add-on codes, refer to **Appendix D** of the *CPT* codebook.

Bariatric Surgery

Open or laparoscopic Roux-en-Y bypass (RYGB), open or laparoscopic biliopancreatic diversion (BPD), with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) will be considered medically necessary when the selection criteria below are met:

1. Must meet either a (adults) or b (adolescents):
   a. For adults aged 18 years or older, presence of severe obesity that has persisted for at least the last 2 years (24 months), documented in contemporaneous clinical records, defined as any one of the following:
      i. Body mass index (BMI) exceeding 40
      ii. BMI greater than 35 in conjunction with either of the following severe comorbidities:

Bariatric Surgery continued

1. Clinically significant obstructive sleep apnea
2. Coronary heart disease
3. Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes)
4. Type 2 diabetes mellitus

b. For adolescents who have completed bone growth (generally age of 13 in girls and age of 15 in boys), presence of obesity with severe comorbidities:
   i. BMI exceeding 40 with one or more of the following serious comorbidities:
      1. Clinically significant obstructive sleep apnea
      2. Type 2 diabetes mellitus
      3. Pseudotumor comorbidities
   ii. BMI exceeding 50 with one or more of the following less serious comorbidities:
      1. Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes)
      2. Dyslipidemias
      3. Nonalcoholic steatohepatitis
      4. Venous stasis disease
      5. Significant impairment in activities of daily living
      6. Intertriginous soft-tissue infections
      7. Stress urinary incontinence
      8. Gastroesophageal reflux disease
      9. Weight-related arthropathies that impair physical activity
      10. Obesity-related psychosocial distress

Note: Provisional coverage of LASGB for members younger than 18 years of age is a covered service. These individuals may receive other bariatric procedures, but LASGB will only be approved on a case-by-case basis. The member must meet medical necessity criteria. The provider must submit documentation regarding the risk versus the benefit for individuals younger than 18 years of age. Procedure codes 43770, 43771, 43772, 43773, and 43774 are provisionally covered.

2. Member has attempted weight loss in the past without successful long-term weight reduction
3. Member must meet either the following Criterion a (physician-supervised nutrition and exercise program) **OR** Criterion b (multi-disciplinary surgical preparatory regimen):
   a. **Physician-supervised nutrition and exercise program:** Member has participated in physician-supervised nutrition and exercise program (including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification), documented in the medical record at each visit. This physician-supervised nutrition and exercise program must meet **ALL** the following criteria:
      i. Member's participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the member's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician.

Bariatric Surgery continued

Note: A physician's summary letter is not sufficient documentation.

ii. Documentation should include medical records of physician's contemporaneous assessment of patient's progress throughout the course of the nutrition and exercise program. For members who participate in a physician-administered nutrition and exercise program, program records documenting the member's participation and progress may NOT substitute for physician medical records.

iii. Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote).

iv. Nutrition and exercise program(s) must be for a cumulative total of 6 months (180 days) or longer in duration and occur within 2 years prior to surgery, with participation in one program of at least 3 consecutive months. (Precertification may be made prior to completion of nutrition and exercise program as long as a cumulative of 6 months participation in nutrition and exercise program[s] will be completed prior to the date of surgery.)

b. **Multi-disciplinary surgical preparatory regimen:** Proximate to the time of surgery (within 6 months prior to surgery), member must participate in organized multidisciplinary surgical preparatory regimen of at least 3 months (90 days) duration meeting **ALL** the following criteria, to improve surgical outcomes, reduce the potential for surgical complications, and establish the member's ability to comply with postoperative medical care and dietary restrictions:

i. Behavior modification program supervised by qualified professional

ii. Consultation with a dietician or nutritionist

iii. Documentation in the medical record of the member's participation in the multidisciplinary surgical preparatory regimen at each visit.
Note: A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the member, and the physician's assessment of the member's progress at the completion of the multidisciplinary surgical preparatory regimen.

iv. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by exercise therapist or another qualified professional

v. A substantial face-to-face component (must not be entirely delivered remotely)

vi. Reduced-calorie diet program supervised by dietician or nutritionist

4. For members who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, preoperative psychological clearance is necessary to exclude members who are unable to provide informed consent or who are unable to comply with the pre- and post-operative regimen.

   Note: The presence of depression due to obesity is not normally considered a contraindication to obesity surgery.

Bariatric Surgery - Repeat Bariatric Surgery

- Repeat bariatric surgery is considered medically necessary to correct complications from bariatric surgery, such as obstruction, stricture, erosion, or band slippage.

Bariatric Surgery continued

- Repeat bariatric surgery is considered medically necessary for members whose initial bariatric surgery was medically necessary (i.e., who met medical necessity criteria for their initial bariatric surgery) and who meet any one of the following medical necessity criteria:
    - Conversion to a RYGB or BPD/DS may be considered medically necessary for members who have not had adequate success (defined as loss of more than 50% of excess body weight) 2 years following the primary bariatric surgery procedure and the member has been compliant with a prescribed nutrition and exercise program following the procedure.
    - Revision of a primary bariatric surgery procedure that has failed due to dilation of the gastric pouch or dilation of the gastrojejunostomy anastomosis is considered medically necessary if the primary procedure was successful in inducing weight loss prior to the dilation of the pouch or GJ anastomosis, and the member has been compliant with a prescribed nutrition and exercise program following the procedure.
    - Replacement of an adjustable band due to complications (e.g., port leakage, slippage) that cannot be corrected with band manipulation or adjustments.

Experimental and Investigational Bariatric Surgical Procedures

Each of the following procedures is considered experimental and investigational because the peer reviewed medical literature shows them to be either unsafe or inadequately researched. These are not covered services.

- Bariatric surgery as a treatment for idiopathic intracranial hypertension
- Gastroplasty, more commonly known as "stomach stapling" (see below for clarification from vertical band gastroplasty)
- Intragastric balloon
- Laparoscopic gastric plication
- LASGB, RYGB, and BPD/DS procedures not meeting the preceding medical necessity criteria
- Loop gastric bypass
- Mini gastric bypass
- Roux-en-Y gastric bypass as a treatment for gastroesophageal reflux in non-obese persons
- Silastic ring vertical gastric bypass (Fobi pouch)
- Transoral endoscopic surgery (e.g., the StomaphyX device/procedure)
- Vertical banded gastroplasty (VBG)

Note: Bariatric surgery is not covered as a treatment for infertility.

Cholecystectomy

As a high incidence of gallbladder disease (28%) has been documented after surgery for morbid obesity, routine cholecystectomy is considered medically necessary when performed in concert with elective bariatric procedures.

Covered Services

Sleep studies and polysomnography (PSG) are covered services included in the preoperative process for bariatric surgery candidates. The member must meet criteria to be considered a candidate for bariatric surgery, which includes a six-month weight loss plan supervised by a physician. Prior authorization is required.

Covered Services continued

One of the following procedure codes can be billed preoperatively when other criteria are met for bariatric surgery: 95807, 95808, 95810, and 95811.

An open or laparoscopic sleeve gastrectomy (43775) is a covered service and considered medically necessary when the selection criteria documented in the original bariatric policy are met.

Kansas Medicaid will follow the lead of CMS by eliminating the certification requirement for facilities that provide bariatric procedures.

Bone Anchored Hearing Aid

- A bone anchored hearing aid (BAHA) is covered by KMAP with the following specifications and limitations. A BAHA is limited to one every four years, with one replacement. PA is required for all BAHA services. All providers must obtain a PA prior to providing service.

  Note: When a bone anchored hearing aid procedure is done in two stages, the charge for the procedure should only be billed once. If it is billed once for each stage, the second charge will be denied.

- Bone anchored hearing aid procedure codes are as follows:

  69710 69711 69714 69716 69719 69726 69727 69728 69729
  L8690 L8691

- A BAHA is covered with PA for a KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) member who meets all the following criteria:
  - **Each of items one, two, three, and four**
    1. The member must be five years of age or older.
    2. Standard hearing aids cannot be used due to a medical condition.
    3. The member must have good manual dexterity or have assistance to snap the device onto the abutment.
    4. The member is able to maintain proper hygiene at the site of the fixture.
  - **Either items five or six**
    5. Tumors of the external canal and/or tympanic cavity are present.
    6. Congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear are present.
  - **At least one of items seven, eight, or nine**
    7. There is **unilateral conductive or mixed hearing loss**.
       - Unilateral conductive or mixed hearing loss caused by congenital malformations of the external or middle ear. Conventional hearing aids cannot be worn. Member must have:
         - Average bone conduction threshold better (less) than 45 dB (at 500, 1000, 2000, 3000 Hz) in the indicated ear
         - A Speech discrimination score greater than 60% in the indicated ear
    8. There is **bilateral conductive hearing loss**.
       - Conductive and mixed hearing loss involving both ears which is not able to be treated with reconstructive surgery or conventional hearing aids. Members must meet all the following:
         - Moderate (40dB) to severe (70dB) conductive hearing loss symmetrically

Bone Anchored Hearing Aid continued

- Less than 10dB difference in average bone conduction (at 500, 1000, 2000, 4000 Hz) or less than 15 dB difference in bone conduction at individual frequencies.
- Mixed hearing loss with an average bone conduction better (less) than 45dB in either ear (at 500, 1000, 2000, 4000 Hz)

9. There is **unilateral sensorineural hearing loss (single-sided deafness)**.
    - Nerve deafness in the indicated ear making conventional hearing aids no longer useful. The implant is designed to stimulate the opposite (good ear) by bone conduction through the bones of the skill. Therefore, the audiometric criteria are for the good ear. Member must meet all the following:
        - Severe (70 dB) to profound (90dB) hearing loss on one side with poor speech discrimination and the inability to use a conventional hearing aid in that ear
        - Normal hearing in the good ear as defined by an air conduction threshold equal to or better (less) than 20 dB (at 500, 1000, 2000, 3000 Hz)

- A child younger than five years of age with unilateral congenital atresia of the ear canal or middle ear in the presence of a maximum conductive hearing loss and adequate cochlear (inner ear) function may be considered on an individual basis. Adequate cochlear function is demonstrated audiologically when stimulation through bone conduction results in significantly improved and functional hearing in the involved ear.

- For a child with congenital malformations, sufficient bone volume, and bone quality must be present for a successful fixture implantation. Alternative treatments, such as a conventional bone conduction hearing aid, should be considered for a child with a disease state that might jeopardize osseointegration.

Replacements

- One replacement BAHA is covered for a KBH-EPSDT member who meets the initial placement criteria.
- PA is required for all BAHA replacement services. All providers must obtain a PA prior to providing service.
- A replacement processor cannot be billed at the same time as the original processor or the original surgery.
- Replacements are limited to one every four years if lost, stolen, or broken.
- A replacement is not allowed for the purpose of upgrading. A BAHA can only be replaced if the current processor has an expired warranty, is malfunctioning, and cannot be repaired.

Children and Family Services (CFS) Contractors

Medicaid reimbursable services will not be paid by child welfare contractors. All services for children assigned to contractors, including behavior management and mental health, must be billed directly to KMAP and will be reimbursed at the approved Medicaid rate. Prior authorization (PA) and other restrictions apply.

8400. MEDICAID Updated 08/21

Immunization Administration

- Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered. Reimbursements of CPT codes for vaccines covered under the Vaccine for Children (VFC) program will not be allowed for children 18 years of age and younger.

- PACS software requires a charge on each line item being submitted. Providers who bill electronically through the PACS system will need to indicate a charge of $.01 on the line for the vaccine/toxoid code. MMIS will deny the service even though a charge was submitted.

Administration Codes

90460 90471 90472 90473 90474 0001A 0002A 0011A 0012A

- All vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are covered.

Intrathecal Baclofen

- Intrathecal baclofen pumps are covered for Medicaid members. This includes the initial and all subsequent implantation(s), revision(s), repairs, catheters, batteries, refills, removals, and maintenance of the intrathecal baclofen pumps when indicated. Three services require PA: 62350, 62351, and 62362. The following conditions must be met:
  - The member must have responded favorably to a trial of intrathecal baclofen and documentation of previously used medication.
  - The member's ICD diagnosis code must be a covered code and the source of the spasticity must be documented.
  - The member must be over the age of four years or there must be documentation that there is sufficient space within the child's chest wall for the pump to be implanted.
  - Contraindications include pregnancy and active infection at time of surgery.

- The following procedure codes do not require PA:

  62322 62323 62326 62327 62355 62365 62368 62369 62370 95990 95991

Screening, Brief Intervention, and Referral for Treatment

Screening, Brief Intervention, and Referral for Treatment (SBIRT) is an evidence-based approach for identifying patients who use alcohol and other substances at increased levels of risk, with the goal of reducing and preventing related health consequences, diseases, accidents, and injuries. SBIRT is designed to identify an individual who has an alcohol and/or other substance use disorder or is at risk for developing one by evaluating responses to questions about alcohol and/or other substance use.

- Practitioners providing SBIRT services to Medicaid-eligible patients in Kansas must meet the applicable KDADS requirements including the following:
  - Currently licensed and in good standing as an approved professional type
  - Submission of an attestation (facility) or certificate (individual) as proof of completion of an approved SBIRT training

Screening, Brief Intervention, and Referral for Treatment continued

- Services to patients must be provided in an approved service location.

- The following services are covered for this program:
  H0049 H0050 99408 99409

- Reference the *Substance Use Disorder Provider Manual* on the Provider Manuals page of the KMAP website for additional information on practitioner, facility, code, billing, and documentation requirements.

- More information on SBIRT can be found on the SBIRT page of the SAMHSA website or the Policies and Regulations page of the KDADS website.

Sleep Study and Polysomnography Services Criteria

1. **Description of the Procedure, Product, or Service:** Sleep studies and polysomnography refer to attended services for the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours. Sleep studies and polysomnography are performed with physician review, interpretation and report. Sleep studies and polysomnography are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as nasal continuous positive airway pressure (NCPAP).

   1.1 Polysomnography
   Polysomnography is the scientific evaluation of sleep that involves a physiologic recording in a specialized facility. Polysomnography is distinguished from sleep studies by the inclusion of sleep staging.

   1.2 Sleep Study
   A sleep study does not include sleep staging. A sleep study may involve simultaneous recording of ventilation, respiratory effort, EKG or heart rate, and oxygen saturation.

   1.2.1 Multiple Sleep Latency Test
   i. Measures daytime sleepiness.
   ii. The instruction is to try to fall asleep.
   iii. Involves four to five, 20-minute recordings of sleep–wake states spaced at 2-hour intervals throughout the day.

   1.2.2 Maintenance of Wakefulness Test
   i. Measures daytime sleepiness.
   ii. Involves multiple trials throughout a day of low-demand activity when the instructions are to resist sleep.

2. **Eligible Members**

   2.1 General Provisions: Kansas Medicaid members must be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

   2.2 EPSDT Special Provision: Exception to Limitations for Members under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]
   Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures

Sleep Study and Polysomnography Services Criteria continued

for Medicaid members under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician).

****EPSDT and prior approval requirements**

If the service, product, or procedure requires prior approval, the fact that the member is under 21 years of age does NOT eliminate the requirement for prior approval. This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the member's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the member's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

- That is unsafe, ineffective, or experimental/investigational.
- That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the member's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

3. When the Procedure, Product, or Service Is Covered

Note: This service is not covered by Kansas Medicaid but consideration is given to EPSDT members under 21 years of age for medically necessary services.

3.1 General Criteria: Procedures, products, and services are covered when they are medically necessary and all the following:

3.1.1 The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not to exceed the member's needs.

3.1.2 The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.

3.1.3 The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.

3.2 Specific Criteria: A supervised polysomnography or sleep study performed in a sleep laboratory may be considered medically necessary as a diagnostic test in patients who present with one of the following:

Sleep Study and Polysomnography Services Criteria continued

3.2.1 Narcolepsy

i. Narcolepsy is a syndrome that is characterized by abnormal sleep tendencies (excessive daytime sleepiness, disturbed nocturnal sleep, inappropriate sleep episodes or attacks).
ii. Polysomnography or sleep studies are covered as a diagnostic test for narcolepsy when the condition is severe enough to interfere with the patient's well-being and health.
iii. Ordinarily, a diagnosis of narcolepsy can be confirmed by three sleep naps.

3.2.2 Sleep Apnea

i. Sleep apnea is a potentially lethal condition where the patient stops breathing during sleep. The three types are central, obstructive, and mixed.
ii. Apnea is defined as a cessation of airflow for at least ten seconds.
iii. Hypopnea is defined as an abnormal respiratory event lasting at least ten seconds with at least a 30% reduction in thoracoabdominal movement or airflow with at least 4% oxygen desaturations.

3.2.3 Parasomnia

i. Parasomnia is a group of conditions that represent undesirable or unpleasant occurrences during sleep. These conditions may include sleepwalking, sleep terrors, and rapid eye movement (REM) sleep behavior disorders.
ii. Suspected seizure disorders as possible cause of the parasomnia are appropriately evaluated by standard or prolonged sleep EEG studies.

3.2.4 Periodic Limb Movement Disorder (PLMD)

i. PLMD is an involuntary, repetitive movement disorder during sleep, primarily in the legs that may lead to arousals, sleep disruption, and corresponding
daytime sleepiness.

3.2.5 Chronic Insomnia: At least one of the following conditions must be met.

i. Etiology is unknown
ii. Diagnosis is uncertain.
iii. Sleep-related breathing disorder or periodic limb movement disorder is suspected.
iv. A patient is refractory to treatment.
v. Violent behaviors are comorbid.
vi. Circadian dysrhythmias complicate the clinical picture.

3.2.6 Snoring: At least one of the following conditions must be met.

i. Disturbed sleep patterns
ii. Excessive daytime sleepiness
iii. Unexplained awake hypercapnia
iv. Apneic breathing
v. Cognitive problems
vi. Excessive fatigue

4. When the Procedure, Product, or Service Is Not Covered

***Note**:* Refer to Subsection 2.2 regarding EPSDT Exception to Limitations for Medicaid Members under 21 Years of Age.

Sleep Study and Polysomnography Services Criteria continued

4.1 General Criteria: Procedures, products, and services are not covered when one of the following apply:

4.1.1 The member does not meet the eligibility requirements listed in Section 2.0.

4.1.2 The member does not meet the medical necessity criteria listed in Section 3.0.

4.1.3 The procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service.

4.1.4 The procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Noncovered Criteria

4.2.1 Sleep studies and polysomnography are not covered when the service is an unattended home study.

4.2.2 Sleep studies and polysomnography are not considered medically necessary for the following indications:

i. Impotence.
ii. Chronic insomnia, except when an underlying physiology exists, such as those listed under **Subsection 3.2**.
iii. Snoring, except when an underlying physiology exists, such as those listed under **Subsection 3.2**.

5. Requirements for and Limitations on Coverage

Note: *Refer to* ***Subsection 2.2*** *regarding EPSDT Exception to Limitations for Medicaid Members under 21 Years of Age.*

5.1 Prior Approval

5.1.1 Prior approval is required.

5.2 Previous Testing

5.2.1 Previous testing performed by the attending physician, to the extent the results are still pertinent, should not be duplicated.

5.3 General Requirements

5.3.1 Sleep studies and polysomnography must include recording, interpretation, and reporting.

5.4 Polysomnography Requirements

5.4.1 For a study to be reported as polysomnography, sleep must be recorded and staged. Sleep staging includes but is not limited to the following:

i. 1 to 4-lead electroencephalogram (EEG)
ii. Electro-oculogram (EOG)
iii. Submental electromyogram (EMG)
iv. EKG
v. Airflow, ventilation, and respiratory effort
vi. Oximetry and/or CO2 measurements
vii. Extremity muscle activity
viii. Extended EEG monitoring
ix. Gastroesophageal reflux
x. Continuous blood pressure monitoring

Sleep Study and Polysomnography Services Criteria continued

xi. Snoring
xii. Body positions

6. Providers Eligible to Bill for the Procedure, Product, or Service

6.1 To be eligible to bill for procedures, products, and services related to this criteria, providers must:

6.1.1 Meet Kansas Medicaid qualifications for participation.
6.1.2 Be currently enrolled in Medicaid.
6.1.3 Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7. Additional Requirements

Note: Refer to **Subsection 2.2** regarding EPSDT Exception to Limitations for Medicaid Members under 21 Years of Age.

7.1 Compliance

7.1.1 Providers must comply with all applicable federal, state, and local laws and regulations, including the HIPAA and record retention requirements.

8. Billing Information

CPT codes, descriptors, and other data only are copyright 2017 American Medical Association. All rights reserved.

8.1 Diagnosis Codes

Providers must bill the diagnosis code(s) to the highest level of specificity that supports medical necessity.

Use the following ICD-10 diagnosis codes:

E515	E518	E6601	E678	G40101	G40109	G40111	G40119	G40501	G40509
G40802	G40803	G40804	G40811	G40813	G40814	G4089	G40B01	G40B09	G40B11
G40B19	G4710	G4720	G4730	G4733	G47411	G47419	G47421	G47429	G4761
G478	R0600	R0609	R063	R0683	R0689	R0901	R0902	R400	R401

8.2 Billing Codes

8.2.1 Providers are required to select the most specific billing code that accurately describes the service(s) provided. Refer to the *CPT* codebook for complete descriptions.

95782	95783	95805	95807	95808	95810	95811

8.3 Modifiers

8.3.1 Providers are required to follow applicable modifier guidelines.

8.4 Billing Units

8.4.1 Polysomnography and sleep studies may be billed as a complete procedure or as professional and technical components.

i. Polysomnography and sleep studies are limited to one procedure per date of service by the same or different provider.
ii. The technical or the professional component cannot be billed by the same or different provider on the same date of service as the complete procedure is billed.

Sleep Study and Polysomnography Services Criteria continued

iii. The complete procedure is viewed as an episode of care that may start on one day and conclude on the next day. When billing for the complete procedure, the date that the procedure began is the date of service that should be billed. The complete procedure should not be billed with two dates of services.

iv. If components are billed, the technical and the professional components should be billed with the date the service was rendered as the date of service.

8.4.2 Separate reimbursement is not allowed for the following procedures on the same date of service by the same or different provider.

i. CPT codes 93224 and 93245 add codes through 93272 with CPT codes 95805 through 95811

ii. CPT codes 94760, 94761, and 0631T with CPT codes 95805 through 95811

iii. CPT code 94772 with CPT codes 95805 through 95806)

iv. CPT code 94660 with CPT code 95811

v. CPT codes 95812 through 95827 with CPT codes 95808 through 95811

vi. CPT code 92516 with CPT codes 95808 through 95811

8.5 Place of Service

8.5.1 Inpatient hospital

8.5.2 Off campus outpatient hospital

8.5.3 On campus outpatient hospital

8.5.4 Physician's office

Surgery - Ambulatory/Outpatient

- Ambulatory surgery centers and outpatient hospitals will be reimbursed for multiple outpatient surgical procedures performed on the same day as follows: 100% of the current Medicaid rate for the highest value procedure, 50% of the current Medicaid rate for the second procedure, and 25% of the current Medicaid rate for all subsequent procedures.
- IVs, medications, supplies, and injections provided on the same day as an ambulatory/outpatient surgery procedure are considered content of service of the surgery and cannot be billed separately.
  EXCEPTION: The following thrombolytic enzymes are not considered content of service when billed in conjunction with outpatient surgery: J2997, J2993, J3364, J2995, and J0350.
- Anesthesia (equipment and supplies), drugs, surgical supplies and other equipment of the operating room and the recovery room are considered content of service of the ambulatory/outpatient surgical procedure.

Surgery - Breast Reconstruction

- Breast reconstruction is covered when the member had a mastectomy for breast cancer on or after March 1, 2005. Only the following breast reconstruction codes are covered. For the most current information and verification of coverage, access Reference Codes under the Provider tab on the public and secure websites.

Surgery – Breast Reconstruction continued

Outpatient Codes			Physician Codes			
11970	11971	19316	11970	11971	19316	19340
19340	19342	19350	19342	19350	19357	19361
19357			19364	19367	19368	19369
			69990	69990		

- This coverage is limited to one breast reconstruction process per breast per lifetime.

Surgery - Cosmetic

All surgeries which are cosmetic in nature (and related complications) are not covered. **Any medically necessary procedure which could ever be considered cosmetic in nature must receive PA**. The hospital must have a copy of the physician's PA for claim processing purposes.

Surgery - Elective

- The Medicaid program will not reimburse for inpatient/outpatient elective surgery unless the member is a KBH-EPSDT member.

- Certain surgical procedures will be reviewed on a postpay random sample basis. Retain all documentation supporting the nonelective nature of the surgery for review. Supporting documentation includes admission notes/history and physical, operative report and pathology report. If the documentation does not support the nonelective nature of the surgery, reimbursement for **all** claims relating to the surgery will be recovered.

Therapy

- Therapy treatments are not covered for a psychiatric diagnosis.

Habilitative - Therapy treatments performed in the LEA settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. Therapy of this type is covered only for members 0 to under 21 years of age. Therapy **must** be medically necessary. The purpose of this therapy is to maintain maximum possible functioning for children. LEAs billing for occupational, physical, or speech therapy must have the ordering, referring, or prescribing provider's NPI on the claim. The prescribing provider must be enrolled with KMAP and have a valid NPI for claims to be considered for payment.

Note: For additional information regarding developmental therapy services, reference General Therapy Guidelines and Requirements in **Section 2710** of the *General Benefits Fee-for-Service Provider Manual*.

Rehabilitative - All therapies **must** be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or physical illness and prescribed by the attending physician.

Therapy continued

- Therapy services are limited to six months for non-KBH-EPSDT members (except the provision of therapy under HCBS), per injury, to begin at the discretion of the provider. There is no limitation for KBH-EPSDT members.
- Providers of rehabilitative therapy can submit claims with a combination of the following rehabilitation therapy procedure codes and an appropriate diagnosis code.
    - Diagnosis code Z5189 can be used as the primary diagnosis. Providers are required to submit a secondary diagnosis code to describe the origin of the impairment for which rehabilitative therapy is needed when one of these V-codes or Z5189 is billed as a primary diagnosis.

97010	97012	97014	97016	97018	97022	97024
97026	97028	97032	97033	97034	97035	97036
97110	97112	97113	97116	97124	97140	97150
97161	97162	97163	97164	97165	97166	97167
97168	97530	97535	97750			

Wheelchair Seating Assessments

Physical Medicine and Rehabilitation procedure codes 97542, 97755, and 97760 will be covered as medically necessary for management of wheelchair seating assessments for all Medicaid members. Regardless of provider, reimbursement will not exceed $500 per member per year for seating assessment services.

Reimbursement for wheelchair seating assessments is limited to the following approved Kansas Medicaid Seating Clinic providers:

- Cerebral Palsy Research Foundation, Wichita, Kansas
- Children's Mercy Hospital Seating Clinic, Kansas City, Missouri
- KU Medical Center Seating Clinic, Kansas City, Kansas

Transplants

- Heart, lung, and heart/lung transplants performed in approved in state or border city hospitals are covered.
- Bone marrow, cornea, kidney, and pancreas transplants performed in approved in state or border city hospitals are covered and do not require PA.
- Pancreas transplants are only covered when performed simultaneously with or following a kidney transplant.
- Services related to donor complications after transplant surgery will be reimbursed up to and including 60 days following the transplant surgery.
    - These services must be billed under the recipient's Medicaid ID number.
    - Services related to donor complications more than 60 days after the surgery are the responsibility of the donor and not billable to Medicaid.

Transplants - Heart, Heart-Lung, and Lung

Heart, heart-lung, and lung transplants for adult members will require prior authorization and must be performed by Medicare-approved facilities or facilities that are members of the United Network for Organ Sharing (UNOS).

Transplants continued

Heart Transplant

Medicaid considers heart transplantation for adults medically necessary for the following indications when the selection criteria listed below are met and none of the absolute contraindications are present:

- Uncontrollable life-threatening arrhythmias
- Cardiac re-transplantation due to graft failure
- Cardiomyopathy due to nutritional, metabolic, hypertrophic, or restrictive etiologies
- Congenital heart disease
- End-stage ventricular failure
- Idiopathic dilated cardiomyopathy
- Inability to be weaned from temporary cardiac-assist devices after myocardial infarction or nontransplant cardiac surgery
- Intractable coronary artery disease
- Myocarditis
- Postpartum cardiomyopathy
- Right ventricular dysplasia/cardiomyopathy
- Valvular heart disease

Selection Criteria for Human Heart Transplantation

For members off protocol, **ALL** the following criteria must be met.

- New York Heart Association (NYHA) Class III and Class IV for heart failure *(see table on next page)
  Note: This does not apply to pediatric members.
- Member has potential for conditioning and rehabilitation after transplant (e.g. member is not moribund)
- Life expectancy (in the absence of cardiovascular disease) is greater than 2 years
- No malignancy (except for non-melanomatous skin cancers) or malignancy has been completely resected or (upon individual case review) malignancy has been adequately treated with no substantial likelihood of recurrence with acceptable future risks
- Adequate pulmonary, liver, and renal function
- Absence of active infections that are not effectively treated
- Absence of active or recurrent pancreatitis
- Absence of diabetes with severe end-organ damage (neuropathy, nephropathy with declining renal function, and proliferative retinopathy)
- No uncontrolled and/or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen
- No active alcohol or chemical dependency that interferes with compliance to a strict treatment regimen

Transplants continued

***NYHA Class III and Class IV for heart failure are defined as follows:**

Class III	Persons with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity (e.g., mild exertion) causes fatigue, palpitation, dyspnea, or anginal pain.
Class IV	Persons with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Contraindications
A heart transplant is not covered for persons with any of the following contraindications:

- Presence of systemic diseases (e.g., autoimmune, collagen vascular disease)
- Presence of irreversible end-organ diseases (e.g., renal, hepatic, pulmonary)
- Presence of severe pulmonary hypertension with irreversibly high pulmonary vascular resistance
- Presence of a recent intra-cranial cerebrovascular event with significant persistent deficit
- Presence of bleeding peptic ulcer
- Presence of hepatitis B antigen
- Presence of diverticulitis
- Presence of life-threatening neuromuscular disorders
- Presence of HIV/AIDS with profound immunosuppression (CD4 count of less than 200 cells/mm3)
- Presence of amyloidosis

Note: Although amyloidosis is considered a contraindication to heart transplantation, exceptions may be made in circumstances where curative therapy of amyloidosis has been performed or is planned (e.g., stem cell transplantation in primary amyloidosis, liver transplantation in familial amyloidosis).

The following procedures are considered experimental and investigational because safety and effectiveness has not been established, or the clinical value has not been established:

- Xenotransplantation of the heart
- Left ventricular assist device as destination therapy
- Total artificial heart
- Breath test for heart transplant rejection
- AlloMap® molecular-expression blood test

The following CPT codes will be covered: 33940 and 33945.

Heart-Lung Transplant
Kansas Medicaid considers heart-lung transplantation for adults medically necessary for persons with severe refractory heart failure plus either end-stage lung disease or irreversible pulmonary

Transplants continued

hypertension, when the following selection criteria are met, and no absolute contraindications listed below are present. Examples of qualifying conditions include the following:

- Chronic obstructive pulmonary disease with severe heart failure*
- Congenital heart disease associated with pulmonary hypertension that are not amenable to lung transplantation and repair by standard cardiac surgery
- Cystic fibrosis with severe heart failure*
- Eisenmenger's complex with irreversible pulmonary hypertension and severe heart failure*
- Irreversible primary pulmonary hypertension with severe heart failure*
- Pulmonary fibrosis with uncontrollable pulmonary hypertension or severe heart failure*
- Severe coronary artery disease or cardiomyopathy with irreversible pulmonary hypertension
- Severe pulmonary fibrosis with severe heart failure*

* **NYHA Class III and Class IV for heart failure** (see table in **Heart Transplant** portion)

Note: Heart-lung transplantation may be considered medically necessary for other congenital cardiopulmonary anomalies upon individual case review.

Selection Criteria

The member must meet the transplanting institution's selection criteria. In the absence of an institution's selection criteria, Kansas Medicaid considers heart-lung transplantation medically necessary when **ALL** criteria below are met:

- Absence of chronic high-dose steroid therapy
  Note: Due to problems in bronchial healing, persons receiving high-dose steroids are considered inappropriate candidates.
- Absence of acute or chronic active infections that are not effectively treated
- Absence of malignancy (other than non-melanomatous skin cancers) or malignancy has been completely resected or (upon medical review) it is determined that malignancy has been treated with small likelihood of recurrence and acceptable future risks
- Adequate functional status
  Note: Active rehabilitation is considered important to the success of transplantation. Under established guidelines, mechanically ventilated or otherwise immobile persons are considered poor candidates for transplantation.
- Adequate liver and kidney function, defined as a bilirubin of less than 2.5 mg/dL and a creatinine clearance of greater than 50 ml/min/kg
- Life expectancy (in the absence of cardiopulmonary disease) of greater than 2 years
- No active alcohol or chemical dependency that interferes with compliance to a strict treatment regimen
- No uncontrolled and/or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen
- Absence of uncontrolled HIV/AIDS, defined as all the following:
  - CD4 count greater than 200 cells/mm3 for more than 6 months
  - HIV-1 RNA (viral load) undetectable
  - On stable anti-viral therapy more than 3 months
  - No other complications from AIDS, such as opportunistic infections (e.g., aspergillus, tuberculosis, Pneumocystis carinii pneumonia, toxoplasmosis encephalitis, cryptococcal meningitis, disseminated coccidioidomycosis, other

Transplants continued

resistant fungal infections) or neoplasms (e.g., Kaposi's sarcoma, non-Hodgkin's lymphoma).

Contraindications

A heart-lung transplant is considered not medically necessary for persons with any of the following contraindications because the risks of transplantation exceed the benefits:

- Gastro-intestinal disease (e.g., bleeding peptic ulcer, diverticulitis, chronic hepatitis, active or recurrent pancreatitis)
- Multisystem disease
  Note: Persons with potentially multisystem diseases such as systemic sclerosis (scleroderma) or other collagen vascular diseases such as systemic lupus erythematosus must be carefully evaluated to ensure that their disease is primarily confined to the lung. Persons with diabetes must be carefully evaluated to rule out significant diabetic complications such as nephropathy, neuropathy, or retinopathy.
- Other effective medical treatments or surgical options available
- Progressive neuromuscular disease
- Refractory uncontrolled hypertension
- Severe musculoskeletal disease with debilitating thoracic involvement
- Smoking
  Note: Persons with a history of smoking must be abstinent for at least 3 months before being considered a candidate for a lung transplant.
- Untreated or unstable cerebrovascular disease

The follow CPT codes will be covered for heart-lung transplantation: 33930 and 33935.

Lung Transplant

Kansas Medicaid considers lung transplantation for adults medically necessary for any of the qualifying conditions for members who meet the transplanting institution's selection criteria. In the absence of an institution's selection criteria, members must meet both the general selection criteria and any applicable disease-specific selection criteria (see General Selection Criteria portion) and any applicable disease-specific selection criteria (see the Disease-Specific Selection Criteria accompanying the following list of Qualifying Conditions).

Qualifying Conditions for Lung Transplantation (not an all-inclusive list):

- Alpha1-antitrypsin deficiency. Persons who meet the emphysema/alpha1-antitrypsin deficiency disease-specific selection criteria below.
- Broncho-pulmonary dysplasia.
- Congenital heart disease (Eisenmenger's defect or complex): Persons who meet the disease-specific criteria for Eisenmenger's below.
- Cystic fibrosis: Persons who meet the disease-specific selection criteria for cystic fibrosis.
- Graft-versus-host disease or failed primary lung graft.
- Lymphangioleiomyomatosis (LAM) with end-stage pulmonary disease.
- Obstructive lung disease (e.g., bronchiectasis, bronchiolitis obliterans, chronic obstructive pulmonary disease [COPD], emphysema): For persons with pulmonary fibrosis, see the disease-specific selection criteria for pulmonary fibrosis below.

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- Primary pulmonary hypertension: Persons who meet the disease-specific selection criteria for primary pulmonary hypertension.
- Restrictive lung disease (e.g., allergic alveolitis, asbestosis, collagen vascular disease, desquamative interstitial fibrosis, eosinophilic granuloma, idiopathic pulmonary fibrosis, post-chemotherapy, sarcoidosis, and systemic sclerosis [scleroderma]): For persons with sarcoidosis, see the **Disease-Specific Selection Criteria** below.

Disease-Specific Selection Criteria

- Lung transplant for cystic fibrosis (CF) is considered medically necessary for persons who meet the general selection criteria for lung transplantation and exhibit at least two of the following signs and symptoms of clinical deterioration:
    - Cycling intravenous antibiotic therapy
    - Decreasing forced expiratory volume in 1 second (FEV1)
    - Development of carbon dioxide (CO2) retention (pCO2 greater than 50 mm Hg)
    - FEV1 less than 30% predicted
    - Increasing frequency of hospital admission
    - Increasing severe exacerbation of CF, especially an episode requiring hospital admission
    - Initiation of supplemental enteral feeding by percutaneous endoscopic gastrostomy or parenteral nutrition
    - Noninvasive nocturnal mechanical ventilation
    - Recurrent massive hemoptysis
    - Worsening arterial-alveolar (A-a) gradient requiring increasing concentrations of inspired oxygen (FiO2)
- Lung transplant for emphysema (including alpha 1-antitrypsin deficiency) is considered medically necessary for persons who meet the general criteria for lung transplantation and both of the following clinical criteria:
    - Hospitalizations for exacerbation of COPD associated with hypercapnia in the preceding year. Hypercapnia is defined as pCO2 greater than or equal to 50 mm Hg with hospitalizations and/or the following associated factors:
        - Declining body mass index
        - Increasing oxygen requirements
        - Reduced serum albumin
        - Presence of cor pulmonale (defined as clinical diagnosis by a physician or any two of the following:
            - Enlarged pulmonary arteries on chest X-ray
            - Mean pulmonary artery pressure by right heart catheterization of greater than 25 mm Hg at rest or 30 mm Hg with exercise
            - Pedal edema or jugular venous distention
            - Right ventricular hypertrophy or right atrial enlargement on EKG
    - FEV1 less than 30% predicted
- Lung transplant for Eisenmenger's complex is considered medically necessary for persons who meet the general criteria for lung transplantation and any of the following disease-specific criteria:

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- Marked deterioration in functional capacity (NYHA Class III)
- Pulmonary hypertension with mean pulmonary artery pressure by right heart catheterization greater than 25 mm Hg at rest or 30 mm Hg with exercise
- Signs of right ventricular failure, progressive hepatomegaly, ascites

- Lung transplant for pulmonary fibrosis is considered medically necessary for persons who meet the general criteria for lung transplantation and any of the following disease-specific criteria:
  - Diffusing capacity for carbon monoxide (DLCO) less than 60% predicted
  - Presence of cor pulmonale (indicative of severe pulmonary fibrosis) or pulmonary hypertension
  - Total lung capacity (TLC) less than 70% predicted
- Lung transplant for pulmonary hypertension is considered medically necessary for persons who meet the general criteria for lung transplantation plus any of the following criteria, and valvular disease has been excluded by echocardiography:
  - Persons who are NYHA III, failing conventional vasodilators (calcium channel blockers or endothelin receptor antagonists)
  - Persons who are NYHA III, and have initiated or being considered for initiation of parenteral or subcutaneous vasodilator therapy
  - Pulmonary hypertension with mean pulmonary artery pressure by right heart catheterization of greater than 25 mm Hg at rest or 30 mm Hg with exercise, or pulmonary artery systolic pressure of 50 mm Hg or more defined by echocardiography or pulmonary angiography.

Note: NYHA Class III for heart failure is defined as: Persons with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity (i.e., mild exertion) causes fatigue, palpitation, dyspnea, or anginal pain.

General Selection Criteria

The member must meet the transplanting institution's selection criteria. In the absence of an institution's selection criteria, **ALL** the following selection criteria must be met, and none of the contraindications listed below should be present:

- Absence of acute or chronic active infection (pulmonary or non-pulmonary) that is not adequately treated
- Adequate cardiac status (e.g., no angiographic evidence of significant coronary artery disease, ejection fraction greater than 40%, no myocardial infarction in last 6 months, negative stress test). Persons with any cardiac symptoms may require heart catheterization to rule out significant heart disease
- Adequate functional status
  Note: Under established guidelines, active rehabilitation is considered important to the success of transplantation. Mechanically ventilated or otherwise immobile persons are considered poor candidates for transplantation
- Adequate liver and kidney function, defined as a bilirubin of less than 2.5 mg/dL and a creatinine clearance of greater than 50 ml/min/kg
- Limited life expectancy of less than 2 years
  - No active alcohol or chemical dependency that interferes with compliance to a strict treatment regimen

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Note: Persons with a history of drug or alcohol abuse must be abstinent for at least 3 months before being considered an eligible transplant candidate.

- No uncontrolled and/or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen
- Absence of inadequately controlled HIV/AIDS infection, defined as **ALL** the following:
  - CD4 count greater than 200 cells/mm3 for greater than 6 months
  - HIV-1 RNA (viral load) undetectable
  - No other complications from AIDS, such as opportunistic infection (e.g. aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections) or neoplasms (e.g. Kaposi's sarcoma, non-Hodgkin's lymphoma)
  - On stable antiviral therapy greater than 3 months

Contraindications

Lung transplantation is considered experimental and investigational for persons with the following contraindications to lung transplant surgery because the safety and effectiveness of lung transplantation in persons with these contraindications has not been established.

- Malignancy involving the lung (primary or metastatic)
  Note: Persons with a history of non-pulmonary cancer must be in remission before being considered a lung transplant candidate. Because of disappointing results, lung transplantation is considered experimental and investigational as a treatment for bronchioloalveolar carcinoma.
- Multi-system disease
  Note: Persons with potentially multisystem diseases such as systemic sclerosis (scleroderma), other collagen vascular diseases such as systemic lupus erythematosus, or sarcoidosis must be carefully evaluated to ensure that their disease is primarily confined to the lung. Persons with diabetes must be carefully evaluated to rule out significant diabetic complications such as nephropathy, neuropathy, or retinopathy.
- Other effective medical treatments or surgical options available
- Presence of gastrointestinal disease (e.g. bleeding peptic ulcer, chronic hepatitis, diverticulitis)
- Refractory uncontrolled hypertension
- Single-lung transplantation is contraindicated in persons with chronic pulmonary infections (e.g. bronchiectasis, chronic bronchitis, and cystic fibrosis)
- Smoking
  Note: Persons with a history of smoking must be abstinent for 6 months before being considered eligible for lung transplantation.
- Kansas Medicaid considers lobar (from living-related donors or cadaver donors) lung transplantation medically necessary for persons with end-stage pulmonary disease when selection criteria are met (see above).
- Kansas Medicaid considers lung xenotransplantation (e.g., porcine xenografts) experimental and investigational for any pulmonary conditions because of insufficient evidence in the peer-reviewed literature.

Transplants continued

- Kansas Medicaid considers prophylactic anti-reflux surgery to improve lung function and survival in lung transplant recipients without gastroesophageal reflux disease as experimental and investigational because of insufficient evidence in the peer-reviewed literature.

The following CPT codes will be covered for lung transplantation:
32850, 32851, 32852, 32853, and 32854.

Transplants - Renal Dialysis and Kidney

- When it has been determined a member has chronic renal disease (CRD) requiring renal dialysis, the member or his representative should apply for Medicare CRD eligibility.
- Medicare allows for payment of claims for eligible members with chronic renal disease and will reimburse for maintenance dialysis the third month after the maintenance dialysis starts. Medicare will reimburse for maintenance dialysis in the first three months if the member has been involved in self training in a self-care dialysis unit or through a self-care home dialysis support service provided by a qualified provider. They also reimburse for expenses incurred for a kidney transplant including those for the kidney donor.
- Medicaid will reimburse claims for services related to chronic renal dialysis and/or kidney transplants only after proof has been attached to one claim that the member has applied for Medicare and coverage has been approved or denied. The Medicare CRD eligibility information will be retained in the claims processing system. Therefore, subsequent claims do not need to have proof of Medicare CRD eligibility approval or denial attached.
- Acceptable proof of application and coverage or denial by Medicare are:
  - Medicare EOMB/RA
  - Member health insurance card
  - Report of Confidential Social Security Benefit Information
  - Letter from Medicare or Social Security explaining that the member has applied for Medicare and whether member is eligible

- **Hospitals Qualifying for Federal Renal Program** *Approved for dialysis only

University of Kansas Medical Center
39th & Rainbow Boulevard
Kansas City, Kansas 66103

St. Luke's Hospital
44th & Wornall Road
Kansas City, Missouri 64111

St. Francis Hospital & Health Center*
1700 West Seventh Street
Topeka, Kansas 66606

St. Francis Regional Medical Center
929 North St. Francis
Wichita, Kansas 67211

Research Hospital & Medical Center
Meyer Boulevard & Prospect
Kansas City, Missouri 64132

Children's Mercy Hospital
24th at Gillham Road
Kansas City, Missouri 64108
(CAPD Training & Support Services)

Transplants continued

Kansas City Dialysis & Training Center*
Located at Research Hospital
Meyer Boulevard & Prospect
Kansas City, Missouri 64132

Salina Regional Health Center
400 S. Santa Fe
Salina, Kansas 67406

FOR VETERANS

Kansas City V.A. Hospital
4801 Linwood Boulevard
Kansas City, Missouri 64128

Wichita V.A. Hospital
5500 East Kellogg
Wichita, Kansas 67218

Tuberculosis

- Inpatient services related to a TB diagnosis, including physician and laboratory services, may be covered for members with the TB benefit plan.
- Inpatient hospitalization, including physicians' services for diagnostic evaluation of members highly suspected of TB, may be covered for completion of the diagnosis.
- Acute problems, which are present on admission or arise during hospitalization and are related to the diagnosis of TB, may be covered.
- Hospitalization for monitoring toxicity of anti-tuberculosis drugs is covered.
- Claims for inpatient or outpatient services may be billed directly to KMAP.
- Coverage and payment of services provided to members on the TB benefit plan are coordinated by KDHE. Contact KDHE at 785-296-0739 for determination of coverage.
- Coverage and payment of inpatient or outpatient services are subject to compliance with infectious disease reporting requirements as directed by K.A.R. 28-1-2.
- Anti-tuberculosis drugs to treat the member and family members are provided at no cost by KDHE. Contact your local health department or KDHE at 785-296-2547.

Vagal Nerve Stimulators

- Vagal nerve stimulators (VNS) are covered for members with epileptic disorders. With exception of code 95970, all services must be prior authorized.
- VNS services must meet the following conditions:
    - VNS is restricted to members four years of age and older. The member's physicians are expected to determine if VNS surgery is appropriate and to document those findings in the medical record.
    - The member must have an epileptic disorder. VNS will not be covered for members with progressive disorders.
    - Mental retardation with epilepsy is not a contraindication for VNS but must be considered with other factors.
    - All other courses of treatment must be documented, such as conventional and anticonvulsant drugs.
    - Providers are expected to maintain adequate documentation, such as "decreased seizure activity" or "improvement in seizure condition."

Vacuum Assisted Wound Closure Therapy

Vacuum assisted wound closure therapy is covered for specific benefit plans. PA is required and criteria must be met. Refer to the *DME Fee-for-Service Provider Manual* for criteria. For

8400. MEDICAID Updated 12/18

Vacuum Assisted Wound Closure Therapy continued

questions about service coverage for a given benefit plan, contact the KMAP Customer Service Center at 1-800-933-6593. All PA must be requested in writing by a KMAP DME provider. All medical documentation must be submitted to the KMAP DME provider.

8410. MEDICAID - INPATIENT ONLY Updated 01/18

General Hospital Reimbursement Policies

- Payment for general inpatient hospital services is based on the following equation: DRG weight times (X) group payment rate plus (+) outlier costs, if appropriate. Inpatient claims are reimbursed based on the lesser of the DRG amount or the billed amount. Contractors may perform audits on inpatient claims. See the **Utilization Review** portion below for details.
- Medicaid does not reimburse for days not medically necessary or deemed "not payable" by federal or state laws, regulations, or state policy.
- All DRGs have the potential for day or cost outliers.
- When a stay is eligible for both day and cost outliers, the greater of the two is paid.
- If a Medicaid member is transferred from one hospital to another, the reimbursement to the transferring hospital will be the DRG daily rate for each covered day of stay. Total payment to the transferring hospital will be no greater than the standard DRG amount, except where the transferring hospital is eligible for outlier payments. The discharging hospital will be reimbursed the standard DRG amount. If the claim qualifies as an outlier, the discharging hospital will be eligible for an outlier payment based solely on the length of stay at the discharging hospital.
- When a Medicaid member is discharged prematurely and subsequently readmitted within 15 days, only the DRG payment for the first stay will be made if the discharging and readmitting hospital are the same. If the discharging and readmitting hospitals are not the same, only the readmitting hospital will be reimbursed.
- When the Medicaid member is not eligible for the entire inpatient stay, the DRG payment is prorated and reimbursement is made only for the days the member was eligible. Reimbursement shall not exceed the standard DRG payment plus any applicable outlier payment. (Only covered days are used to calculate outliers.) If the Medicaid member's inpatient hospital stay spans coverage between an MCO and fee-for-service (FFS), the entire stay will be considered by the entity in which the member was assigned to at the time of admission.
- Hospitals can issue a continued stay denial to a member only after the attending physician has written a discharge order. The hospital must supply the member with the necessary notification that the member will assume responsibility for payment since a continued stay is not considered medically necessary and is no longer a covered service.
- Admissions or day outliers found to be unnecessary by the utilization review contractor cannot be billed to the member.
- The discharge date indicated on each claim will determine the version to be used for DRG assignment and reimbursement.

Dental Admissions

Dental admissions are covered when medically necessary. Documentation supporting the medical or dental condition making hospitalization necessary must be in the medical record. PA is required for adults. Medical review is required for children 21 years of age and under. Claims for this service are to be billed with procedure code 41899 and must include a detailed description of the actual service provided.

8410. MEDICAID - INPATIENT ONLY Updated 03/18

Long-Term Care Units

Long-term care units **must** be a distinct or separate unit of a hospital certified to provide skilled and/or intermediate care under KMAP subject to the same federal and state rules and regulations as a free-standing adult care home. This includes compliance with federal regulations for standards of care and related reimbursement.

Noncovered Services

- Take home drugs
- Nonmedical hospital supplies (e.g. hospital kits, slippers, lotions, tissues, mouthwash)

Note: A consultation and a hospital visit are not covered when billed on the same date of service by the same provider.

Psychiatric

Institution of Mental Disease

Federal regulations classify free-standing psychiatric hospitals (provider specialty 011) as institutions for mental disease (IMDs). Medicaid reimbursement to IMDs and concurrent medical services are prohibited for members 22 to 64 years of age.

Substance Abuse

Acute detoxification is covered in any acute general hospital, when medically necessary. Alcohol and drug addiction treatment services provided in an inpatient hospital setting are not covered.

State Institutions for Mental Health

- State institution services are only covered for Medicaid members under 21 years of age or 65 years of age and older. (However, if a member is an inpatient in a state institution on their 21st birthday, state institution services will be covered until 22 years of age.)
- State institutions are reimbursed at a per diem rate.

Utilization Review of General Hospitals

- The utilization reviewer will not accept documentation including, but not limited to, admission orders that have been created after the claim has begun the utilization review (UR) process.
- Review of day or cost outlier cases are generally performed on a post-pay basis, unless interim bills are submitted, and the member is still inpatient. Stays billed on an interim basis will be reviewed as an entire stay once the final bill is processed and paid.
- Outlier reviews examine itemized bills to determine if the services are covered benefits, if charges are reasonable and medically necessary, and if the services should be bundled with the room and board charge. If there are itemized charges which should be denied on the outlier review, these charges will be deducted from the total billed amount. The resulting adjusted total billed amount will be used to perform the DRG payment calculation. Guidelines for outlier reviews include:

Utilization Review of General Hospitals continued

- The room and board revenue code, as defined by the UB-04 guidelines and Uniform Billing Editor, indicates the level of care provided to the patient. This code also provides information on the national "usual and customary" charges for that level of room and board. Normally, this rate includes the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.
- Routine supply items found in the "floor stock" would generally be available to all patients receiving supplies in that location. The supply items are included in the general cost of the room in which the services are delivered and are not separately billable.
- Services identified in this *Hospital Fee-for-Service Provider Manual* as denied in an outpatient setting may also be reviewed during inpatient cost outlier review to determine if these services are medically appropriate and separately billable from the room and board charge.
- If the charge is not a covered benefit, it will be denied during the outlier review.
- The item must be medically necessary, furnished at the direction of a physician, and delivered to or used on or for the patient for whom it was ordered.
- Charges for personal comfort items requested by the patient are excluded from coverage. The patient may be charged for such a service if he or she requested it with knowledge that they will be charged. If the patient is not informed, they may not be charged, and the provider will not receive any reimbursement for these charges.
- Pharmacy or implant charges greatly exceeding NADAC cost will be denied during the outlier review.

- Readmissions may be subject to utilization review. Utilization review of readmissions will occur for members who are readmitted as an inpatient to a general hospital between 1 and 15 days of discharge.
- Readmission guidelines for days 2-15 of a hospital stay, do not apply if Medicaid is not the primary payer of the initial inpatient stay claim.
- Shall be reviewed to determine if the readmission was the result of an inappropriate discharge from the initial admission based on one of the following criteria:
  - A medical readmission for a continuation or recurrence for the initial admission or closely related condition (e.g. readmission for diabetes following an initial admission for diabetes).
  - A medical complication related to an acute medical complication related to a care during the initial admission (e.g. patient discharged with urinary catheter readmitted for treatment of a urinary tract infection).
  - An unplanned readmission for a surgical procedure to address a continuation or a recurrence of a problem causing the initial admission (e.g. readmitted for appendectomy following a primary admission for abdominal pain and fever).
  - An unplanned readmission for a surgical procedure to address a complication resulting from care from the primary admission (e.g. readmission for drainage of a post-operative wound abscess following an initial admission for a bowel resection).

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Utilization Review of General Hospitals continued

- The unplanned readmission is the result of a need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards prior to discharge or during the post-discharge follow-up period.
- An issue caused by a premature discharge from the same facility.
- Readmission is medically unnecessary.

- The following are excluded from readmission review:
  - Readmission that is planned (such as for repetitive treatments, i.e. cancer chemotherapy, transfusions for chronic anemia, or other similar repetitive treatments).
  - Readmission due to malignancies, burns, cystic fibrosis, or anemia.
  - Readmission due to bone marrow transplants.
  - Obstetrical admission.
  - Readmission that stems from an initial stay discharge status of "left against medical advice."
  - Admission to a skilled nursing facility (SNF), long-term acute care facility (LTAC), or inpatient rehabilitation facility (IRF).
  - Admission for treatment when the primary diagnosis is psychiatric.
  - Transfer of patient to receive care not available at the first facility.
- All patient-initiated transfers are subject to utilization review.
- When a patient transfers from an inpatient hospital bed to a swing-bed unit and acute care continues to be provided, payment for the swing-bed will be denied or recouped. The only purpose for this type of transfer is for the hospital to obtain reimbursement beyond the DRG payment.
- Utilization reviewers may audit the diagnosis coding of a claim to make sure that the claim grouped to the correct MS-DRG code. The claim and all supporting medical documentation will be reviewed for correct coding of diagnoses, procedures, age, sex, discharge status, and the presence of complications or co-morbidities. Following DRG coding evaluation and adjustment by the utilization reviewer, payment of claims will be adjusted upward or downward.
- When an inpatient hospital admission is determined not to be medically necessary by the utilization reviewer and results in recoupment of payment, the provider may resubmit the claim as an outpatient service. Providers will need to review the inpatient admission recoupment letter for instructions and time frames for resubmittal.
- UR may be performed either onsite or by reviewing records sent as required to the UR contractor. If a hospital fails to provide the UR contractor with the complete requested information within the allowable time frames, the case will be denied, resulting in recoupment of payment. For FFS only, these "technical denials" are not eligible for reconsideration. If the facility supplies the UR contractor the information within 90 days of the "technical denial" date, the case may be reopened for review. Pending the review results, repayment for the case may occur.
- If the UR contractor elects to use an independent physician reviewer other than their inhouse medical director or staff, the identity of the physician reviewer will be kept confidential and not disclosed if the UR contractor does all the following:
  - The UR contractor or its staff reviews the same medical records as were used by the independent physician reviewer.
  - The UR contractor or its staff reviews the conclusions of the independent physician reviewer.

Utilization Review of General Hospitals continued

- The UR contractor reaches the same or substantially the same conclusions as the independent physician reviewer.
- The UR contractor or a member of its staff who participated in the review is present at and testifies in any administrative hearing, trial, or judicial proceeding concerning the UR review.

- The UR contractor or its staff may testify as to the qualifications of the independent physician reviewer without waiving the above identity protection of the independent physician reviewer.
- The UR contractor or its staff may offer a copy of the report from the independent physician reviewer where the identity of the independent physician reviewer is redacted and deleted from the report without waiving the above identity protection of the independent physician reviewer.

The "need to testify" requirement (as satisfied by the foregoing paragraph) shall not apply in reviews of administrative decisions or in judicial reviews unless the UR contractor or its staff are specifically subpoenaed to appear and testify in that proceeding. If the identity protection is allowed in the lower-level proceeding, that protection will continue throughout a review process. The purpose for the above identity protection is to ensure a forthright and candid peer review assessment of the medical records by a physician reviewer.

Discharge Day Not Medically Necessary

When a member's hospital discharge day is determined by the UR contractor to not be medically necessary, the discharge day is redefined as the last medically necessary day. This redefined discharge day is not reimbursed.

8420. MEDICAID - OUTPATIENT ONLY Updated 12/18

Blood

- Blood transfusions, including whole blood, red blood cells, plasma, platelets and cryoprecipitate, and IV infusions are covered services.
- Set-ups including volume controller cassettes are content of service of the procedure billed.

Care Coordination

Acceptable outpatient hospital referral documentation includes an entry in the hospital outpatient or emergency department medical record noting that the primary care provider (PCP) was contacted at the time the service was rendered and approval was given. The statement must be signed by the individual who received the approval. If the PCP cannot be reached, approval must be secured from one of his or her covering physicians.

Developmental Testing

Providers are reimbursed one visit per day, up to three visits per member per year, for codes 96112 and 96113. Codes 96112 and 96113 are only covered for KBH-EPSDT members.

Diagnostic Tests

Although not all codes are covered, most codes for laboratory, radiology, EKG, EEG, hearing, and speech testing (if provided following physical debilitation) are covered.

Drugs

- All drugs are content of service of surgery. Oral drugs are content of service of emergency treatment. Take-home drugs are noncovered.
- Injections, IVs, blood infusions, and aerosol inhalant additives are covered if not associated with surgery.
- Injections are not covered when billed on the same day as an office visit by the same provider. This applies to the following procedure codes:

Office visit

99056	99058	99201	99202	99203	99204	99205
99211	99212	99213	99214	99215	99281	99363
99364	99381	99382	99383	99384	99385	99386
99387	99391	99397	X9003WP			

Injection

95115	95117

Electro-Convulsive Treatments

Electro-convulsive treatments are covered and include all ancillary services needed to provide the treatment, including the charge for use of a bed.

8420. MEDICAID - OUTPATIENT ONLY Updated 09/21

Emergency Medical Services for Aliens (SOBRA)

In addition to inpatient hospital and emergency room hospital, emergency services performed in outpatient facilities and related physician, lab, and X-ray services will be allowed for the following places of service: office, outpatient hospital, Federally Qualified Health Clinic, state or local public health clinic, Rural Health Clinic, ambulance, and lab for SOBRA claims. Inpatient hospital reimbursement will not be limited to 48 hours. Follow-up care will not be allowed once the emergent condition has been stabilized. Refer to **Section 2040** of the *General Benefits Fee-for-Service Provider Manual* for specific information.

Emergency Room Services

- Medical necessity documentation must accompany the claim when more than one ER visit is made on the same day for the same individual.

Laboratory

- Handling fee (drawing/collection) is considered content of service of the outpatient visit/lab procedure and is not covered if billed separately. The member cannot be billed for the drawing or collection since it is considered content of another service or procedure.
- Laboratory procedures performed on inpatients are content of service of the DRG reimbursement to the hospital and should not be billed by either the independent laboratory or hospital.
- Pathologists not contracted by the hospital may bill modifier 26 for pathology services provided on inpatients.
- Reimbursement will only be made for one complete blood count (CBC) per day.
- When ordered laboratory tests make up a panel or profile, the all-inclusive code should be used to bill. Components should not be billed separately.
- Three or more multichannel tests are considered a SMA/SMAC profile when performed on the same date of service. Medicaid follows the guidelines outlined in the *CPT* codebook to identify automated multichannel tests (SMACs, profiles) performed. When billing for a multichannel test use the appropriate code:

80002	80003	80004	80005	80006	80007	80008
80009	80010	80011	80012	80013	80014	80015
80016	80017	80018	80019			

- Urinalysis (UA) is considered content of service of the reimbursement to the physician for antepartum care when the UA is obtained for a diagnosis of pregnancy. The hospital/independent laboratory will not be reimbursed by Medicaid for the UA in this situation.
- Cytogenetic (chromosome) studies are covered for **pregnant women** (when medically necessary) and **KBH-EPSDT** members only. A medical necessity form must accompany the claim when billing for a cytogenetic study for a pregnant woman older than 21 years of age.
- HIV testing limitations are as follows:
    - Code 87536 is covered with no limits.

Laboratory continued

- The following HIV testing codes are limited to four per calendar year, regardless of provider:

86689	86701	86702	86703	87390	87391
87534	87535	87537	87538	87539	87900
87903	87904	80018	80019		

- The following HIV testing codes are limited to two per calendar year, regardless of provider:

87901	87906

Medical necessity documentation for 87901 must include information that the patient meets at least one of the following criteria:

  - The patient presents with virologic failure during Highly Active Antiretroviral Therapy (HAART).
  - The patient has suboptimal suppression of viral load after initiation of antiretroviral therapy.

Note: Refer to the *CPT* codebook for complete descriptions of these procedures.

Hospitals, physicians, and independent laboratories must confirm the Clinical Laboratory Improvement Amendments (CLIA) status of the performing laboratory prior to billing the Kansas Medical Assistance Program (KMAP) for those services. Referring providers are required to confirm the CLIA status for the performing lab prior to billing KMAP for those services.

This is to be noted on the claim with the use of Modifier 90 - Reference (outside) Laboratory. When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

Life Sustaining Therapy

Chemotherapy, radiation therapy, and renal dialysis are covered.

Medically Recalled Items and Services

- KMAP allows reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. KMAP will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.
- Providers should code services with the appropriate modifier (FB or FC) or condition code (49 or 50) to indicate services have been medically recalled.
  - Modifier FB (item provided without cost to provider, supplier, or practitioner or credit received for replaced device) is used when items are provided without cost to the provider, supplier, or practitioner.
  - Modifier FC (partial credit or replaced device) is used when partial credit is received by the provider, supplier, or practitioner for the replacement device.
  - Condition code 49 signifies products replaced within the product lifecycle due to the product not functioning properly.

Medically Recalled Items and Services continued

- Condition code 50 is used for product replacement for a known recall of a product.

- In circumstances where KMAP has reimbursed the provider for repair or replacement of items or procedures related to items due to a medical recall, KMAP is entitled to recoup or recover fees from the manufacturer and/or distributor as applicable. In circumstances where KMAP has reimbursed the provider the full or partial cost of a replaced device and the provider received a full or partial credit for the device, KMAP is entitled to recoup or recover fees from the provider.

Noncovered Services

Medical supplies used in conjunction with outpatient surgery and/or the emergency room/observation room are considered content of service and cannot be billed separately. The rental or sale of DME and certain prosthetic and orthotic items are not covered.

Operating Room

Anesthesia (equipment and supplies), drugs, surgical supplies, and other equipment of the operating room, the recovery room and supplies are considered content of service of the operating and/or delivery room charges.

Outpatient Procedures

- Outpatient services provided within three days of an admission from the same hospital for the same or similar diagnosis are considered content of service of the inpatient hospital stay. In this instance, bill the outpatient charges together on an inpatient claim.
- There is one exception to this policy, complications from an outpatient sterilization resulting in an inpatient admission. In this instance, the outpatient charges and the inpatient charges should be billed on two separate claims.

Outpatient Prospective Payment System

- The 2018 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule (CMS -1678-FC) created two new modifiers:
  - JG (Drug or biological acquired with 340B Drug Pricing Program Discount)
  - TB (Drug or Biological Acquired With 340B Drug Pricing Program Discount, Reported for Informational Purposes)
- If a provider is required to report modifiers JG or TB to Medicare and the recipient has Kansas Medicaid, then these modifiers must also be reported to Kansas Medicaid.
- Modifier JG is used for separately payable drugs (status indicator "K") and will trigger a payment reduction when billed by a hospital paid under the OPPS that is not exempted from the payment adjustment.
- Drugs that were not acquired under the 340B Program should not be reported with modifier JG. Providers exempt from the Medicare 340B drug payment policy (rural school, children's hospital, and PPS cancer exempt hospital) should not report modifier JG to identify OPPS separately payable drugs purchased with a 340B discount but should use modifier TB instead.

Prosthetic & Orthotic Services

- Outpatient hospitals are allowed to bill the following prosthetic & orthotic code: L3980.

8420. MEDICAID - OUTPATIENT ONLY Updated 01/18

- DeFlux, an injectable medical device, is covered with PA. Use code L8606.

Psychiatric Observation Beds

- Psychiatric observation beds are covered up to three consecutive days. During the observation period, the member must receive:
    - A physical examination
    - History and psychiatric assessment containing recommendations for ongoing treatment
    - An initial nursing assessment
    - Nursing progress notes written each shift
    - A discharge summary

- A physician must admit the member to an observation bed. If, at the end of the observation period, the member is not admitted to the hospital or discharged, no additional payment will be made at the end of the observation stay. When an admission follows an observation stay, the physical examination report and the psychiatric assessment must be included in the member's medical record. The observation bed stay becomes part of the DRG payment to the hospital. Refer to **Section 7020** for billing instructions.
- Procedure code S9485 can used for psychiatric observation. Code H2013 is no longer covered. The appropriate revenue code to be utilized would be outpatient observation. The submitted claim for reimbursement of code S9485 should have a psychiatric diagnosis noted as either a primary or secondary designation.

Psychiatric Partial Hospitalization

These services are covered only in those hospitals where such a program has been approved by KDADS.

8430. FAMILY PLANNING and STERILIZATIONS Updated 12/18

Family Planning

- Family planning is any medically approved treatment, counseling, drugs, supplies, or devices which are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.
- Complete the family planning block on the claim form whenever a procedure or service is performed which relates to family planning.
- The following information is provided to facilitate coding the FL 18-28 of the UB-04 paper or electronic equivalent claim form. The two-digit indicator A4 is to be placed in this field.
- The following procedures are family-planning related. The Sterilization Consent Form must be attached to the surgeon's claim at the time of submission. Related claims (anesthesia, assistant surgeon, ambulatory surgery center, hospital, or rural health clinic) do not require an attached Sterilization Consent Form. However, if not attached, processing will be delayed until the consent form with the surgeon's claim is reviewed and determined to be correct.

ICD-10-CM Procedure Code and Code

IP	Code	Code	Code	Code	Code	Code	Code
63.70-.73	0V5N0ZZ	0VBN0ZZ	0VBQ4ZZ	0VLN0ZZ	0VLP3ZZ	0VLQ4ZZ	0VBQ3ZZ
	0V5N3ZZ	0VBN3ZZ	0VTN0ZZ	0VLN3CZ	0VLP4CZ	0VBN0ZZ	0VBQ4ZZ
	0V5N4ZZ	0VBN4ZZ	0VTN4ZZ	0VLN3ZZ	0VLP4ZZ	0VBN3ZZ	0VTN0ZZ
	0V5P0ZZ	0VBP0ZZ	0VTP0ZZ	0VLN4CZ	0VLQ0CZ	0VBN4ZZ	0VTN4ZZ
	0V5P3ZZ	0VBP3ZZ	0VTP4ZZ	0VLN4ZZ	0VLQ0ZZ	0VBP0ZZ	0VTP0ZZ
	0V5P4ZZ	0VBP4ZZ	0VTQ0ZZ	0VLP0CZ	0VLQ3CZ	0VBP3ZZ	0VTP4ZZ
	0V5Q0ZZ	0VBQ0ZZ	0VTQ4ZZ	0VLP0ZZ	0VLQ3ZZ	0VBP4ZZ	0VTQ0ZZ
	0V5Q3ZZ	0VBQ3ZZ	0VLN0CZ	0VLP3CZ	0VLQ4CZ	0VBQ0ZZ	0VTQ4ZZ
	0V5Q4ZZ						

IP	Code	Code
66.20-.21	0UL74ZZ	0UL78ZZ

IP	Code	Code	Code	Code	Code	Code	Code
66.29	0U574ZZ	0U578ZZ	0UL74CZ	0UL74DZ	0UL74ZZ	0UL78DZ	0UL78ZZ

IP	Code	Code	Code
66.31-.32	0UL70ZZ	0UL73ZZ	0UL77ZZ

IP	Code	Code	Code	Code	Code	Code	Code
66.39	0U570ZZ	0U577ZZ	0UL70CZ	0UL70ZZ	0UL73CZ	0UL73ZZ	0UL77DZ
	0U573ZZ		0UL70DZ		0UL73DZ		0UL77ZZ

IP	Code	Code	Code	Code	Code	Code	Code
66.92	0U550ZZ	0U563ZZ	0UL50DZ	0UL54CZ	0UL58DZ	0UL63CZ	0UL64ZZ
	0U553ZZ	0U564ZZ	0UL50ZZ	0UL54DZ	0UL58ZZ	0UL63DZ	0UL67DZ
	0U554ZZ	0U567ZZ	0UL53CZ	0UL54ZZ	0UL60CZ	0UL63ZZ	0UL67ZZ
	0U557ZZ	0U568ZZ	0UL53DZ	0UL57DZ	0UL60DZ	0UL64CZ	0UL68DZ
	0U558ZZ	0UL50CZ	0UL53ZZ	0UL57ZZ	0UL60ZZ	0UL64DZ	0UL68ZZ
	0U560ZZ						

IP	Code
V25.2	Z30.2

8430. FAMILY PLANNING and STERILIZATIONS Updated 12/19

Sterilizations

A copy of the Consent for Sterilization form **must** be attached to the surgeon's claim at the time of submission. The form is located on the public and secure websites on the Forms page under the Consent heading. It may be photocopied for your use. A copy of the Consent for Sterilization form does not have to be attached to related claims (anesthesia, assistant surgeon, hospital, or rural health clinic) at the time of submission. **However, a related claim will not be paid until the Consent for Sterilization form with the surgeon's claim has been reviewed and determined to be correct, unless the related claim has the correct Consent for Sterilization form attached.**

- Surgical procedures that render the member sterile (such as hysterectomies) but that are not performed for the purpose of sterilization do not require a Consent for Sterilization form. All requirements outlined in Hysterectomy Coverage Guidelines must be met, including the requirements related to the Hysterectomy Necessity form.

All Sterilization Guidelines

- Sterilizations on mentally incompetent individuals or individuals institutionalized for mental illness are not covered.
- The following guidelines must be accurately followed before reimbursement can be made for any sterilization procedure (including, but not limited to, tubal ligation sterilization and vasectomy). If each item is not followed completely, it will result in the denial of your claim. KMAP or other authorized agencies may ask for documentation at any time, either during the claims processing period or after payment of a claim, to verify services have been provided within program guidelines.

1. The Consent for Sterilization form, mandated by federal regulation, is located on the public and secure websites. Instructions on how to complete the Consent for Sterilization form are attached with the form. Providers may photocopy this form. All voluntary sterilization claims submitted without this specific Consent for Sterilization form will be denied. All fields must be completed, including the physician signature.
2. The Consent for Sterilization form must be signed at least 30 days prior to the date the sterilization is performed with the following exceptions:

   Premature Delivery
   - The date of the member's consent must be at least three calendar days prior to the date the sterilization was performed.
   - The expected date of delivery must be indicated on the consent form and the date of the member's consent must be at least 30 days prior to the expected date of delivery.

   Emergency Abdominal Surgery
   - The date of the member's consent must be at least three calendar days prior to the date the sterilization was performed.
   - The circumstances of the emergency abdominal surgery must be described by the physician sufficiently to substantiate the waiver of the 30-day requirement.

   Note: Three calendar days are used in the above exceptions to guarantee compliance with the minimum federal requirement of 72 hours.
3. The Consent for Sterilization form is valid for up to one year after the expiration date on the form. All signatures and dates have to be within the existing time frames.

Sterilizations continued

4. The individual must be at least 21 years of age or older on the date the consent form is signed, or the sterilization claim will be denied. (This **includes** those situations in which the individual has misrepresented his or her age on the consent form to the provider.) The birth date information provided by KEES will be used to determine whether the individual meets the age requirement. This information can be obtained through Customer Service.
5. Sterilizations on **mentally incompetent individuals** are not covered. "Mentally incompetent individual" is defined as an individual who has been declared mentally incompetent by a federal, state or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilizations" (42 CFR 441.251).
6. The sterilization is not covered when consent is obtained from anyone in labor, under the influence of alcohol or other drugs, or seeking or obtaining an abortion.
7. Interpreters must be provided when there are language barriers, and special arrangements must be made for handicapped individuals.
8. The physician's statement must be signed and dated no more than two days prior to the surgery, the day of the surgery, or any day after sterilization was performed. If this field is left blank, your claim will be denied.
9. The physician statement on the consent form must be signed by the physician who performed the sterilization. No other signatures will be accepted.

STERILIZATION CODES

00840	00851	00921	55250	58565	58579	58600	58605	58611	58615
58661	58670	58671	58700	58720	58940	0567T	0568T		

Transcervical Sterilizations

- Code 58579 is not covered for transcervical sterilization procedures. Codes 58565, 0567T, and 0568T should ~~is to~~ be used. The procedure must meet all sterilization requirements. PA is required.
- The Essure Kit is included in codes 58565, 0567T, and 0568T and should not be billed separately. The invoice does not need to be attached to the claim.
- If a member has had a transcervical hysteroscopy sterilization, a federal Consent for Sterilization form is required. Additionally, three months must have passed before performing code 58340. ICD-10 CM diagnosis code Z302 must be used. PA is not required.

Hysterectomy

- Hysterectomies are covered **only** for medically indicated reasons. Medicaid will reimburse for this service only if at least one of the following three conditions is met and documented.
  The Consent for Sterilization form:
  1. The Hysterectomy Necessity form is completed. The date requirements for the use of the Sterilization Consent Form do not apply to the use of the Hysterectomy Necessity Form.
     OR
  2. The physician shall certify in writing that the individual was already sterile and state the cause or reason for the sterility. This certification must be retained in the patient file and made available upon request. For the claim to process, a statement must be made on the claim indicating the patient was sterile prior to the surgery. There is not a specific location

Hysterectomy continued

to note this information on the claim, it just needs to be noted on the claim prior to submission for payment.

OR

3. The physician shall certify in writing that the surgery was performed under a life-threatening situation and individual certification was not possible, including a description of the nature of the emergency. This certification must be retained in the patient file and made available upon request. For the claim to process, a statement must be made on the claim indicating the situation was "life-threatening." There is not a specific location to note this information on the claim, it just needs to be noted on the claim prior to submission for payment.

- A total hysterectomy and the removal of tubes/ovaries cannot be billed as separate procedures when performed by the same provider.

HYSTERECTOMY CODES

00846	00944	01962	01963	01969	51925	58150	58152	58180	58200	58210
58240	58260	58262	58263	58267	58270	58275	58280	58285	58290	58291
58292	58294	58541	58542	58543	58544	58548	58550	58552	58553	58554
58570	58571	58572	58573	58951	58953	58954	58956	59525		

Retroactive Eligibility

- If a hysterectomy is performed during a retroactive eligibility period for a Medicaid member, the performing physician can sign and submit a statement indicating the retroactive eligibility. This statement must include the following verbiage:
  - The member has retroactive eligibility.
  - The member was informed prior to the surgery that the surgery would make her sterile.
- The document does not need to be signed by the member.
- This information can be documented on the claim; however, a signed statement by the physician must be kept on file and available on request.

APPENDIX I Updated 05/17

CODES

KDHE Division of Health Care Finance (DHCF) requires KMAP hospital billers to submit claims using the HCPCS. HCPCS is a combination of codes which includes CPT codes created and controlled by the American Medical Association (AMA); Centers for Medicare & Medicaid Services (CMS) codes created and controlled by CMS; and local codes created and controlled by the regional CMS office. HCPCS codes consist of a five-digit base code with the capability of being up to thirteen digits in length when modifiers are used. A modifier code is a two-digit code that identifies a specific type of service, for example, anesthesia, or a variation of the service identified by the base code. Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance Coding Modifiers Table are available on both the public and secure portions of the website. They can be accessed on the KMAP Reference Codes page. Information is available on the American Medical Association website.

Not all codes are covered. Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the member ID number or benefit plan.

- Information is available on the public website.
- Information is available on the secure website under Pricing and Limitations.

For further assistance, contact Customer Service at 1-800-933-6593. (Refer to **Section 1000** of the *General Introduction Fee-for-Service Provider Manual*.)

All claims must be coded with the appropriate codes. Claims which only describe the service and do not provide the code will be denied. When a code is not available, the service is noncovered by KMAP. Not otherwise classified (NOC) codes are usually noncovered. (Refer to **Section 4200** of the *General Special Requirements Fee-for-Service Provider Manual*.)

APPENDIX II Updated 09/11

Hospital Cost Report

To be eligible for payment from KMAP, each hospital located in Kansas must complete, sign, and submit a copy of the cost report form (CMS 2552-96). An electronic copy of the Electronic Cost Report (ECR) and Print Image (PI) files are required along with the signed certification page. This must be done annually.

The cost report and its instructions can be obtained from Medicare.

Numerous private vendors offer services to assist in completing this cost report. KDHE-DHCF has adopted this cost report since it is already used by hospitals enrolled in the Medicare program. KDHE-DHCF does not require any Medicaid specific schedules to be completed, although they may be referred to in the instructions. All general schedules of the report must be completed.

Submit the report to the following address:

Myers and Stauffer, LC.
Certified Public Accountants
4123 SW Gage Center Drive, Suite 200
Topeka, KS 66604-1833

For questions regarding the cost report, contact the above company at:

Telephone: 800-255-2309
785-228-6700
Fax: 800-228-6701
Email: KSCOST@mslc.com

DRG WEIGHTS AND RATES

State of Kansas - CY23 DRG Rebase and Recalibration
Final DRG Weights and Outlier Thresholds

DRG	MDC	Type	DRG Description	Transfer ALOS	DRG Relative Weight	DRG Daily Rate	Day Outlier Limit	Day Outlier Adj. %	Cost Outlier Limit	Cost Outlier Adj. %
001	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITH MCC	18.0	30.03	$ 11,236	37	78	$ 324,249	78
002	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITHOUT MCC	43.0	15.73	$ 2,463	88	78	$ 327,815	78
003	PRE	SURG	ECMO OR TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH AND NECK WITH MAJOR	31.0	20.34	$ 4,418	74	78	$ 282,683	78
004	PRE	SURG	TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH AND NECK WITHOUT MAJOR O.R.	18.0	12.24	$ 4,580	51	78	$ 176,449	78
005	PRE	SURG	LIVER TRANSPLANT WITH MCC OR INTESTINAL TRANSPLANT	15.0	10.75	$ 4,828	26	78	$ 122,661	78
006	PRE	SURG	LIVER TRANSPLANT WITHOUT MCC	12.0	4.93	$ 2,769	27	78	$ 98,265	78
007	PRE	SURG	LUNG TRANSPLANT	25.0	12.17	$ 3,277	53	78	$ 197,078	78
008	PRE	SURG	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT	14.0	5.71	$ 2,746	30	78	$ 111,959	78
010	PRE	SURG	PANCREAS TRANSPLANT	10.0	3.80	$ 2,561	22	78	$ 78,654	78
011	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITH MCC	13.0	5.28	$ 2,733	28	78	$ 102,144	78
012	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITH CC	7.0	4.03	$ 3,874	12	78	$ 61,668	78
013	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITHOUT CC/MCC	6.0	2.86	$ 3,212	13	78	$ 46,835	78
014	PRE	MED	ALLOGENEIC BONE MARROW TRANSPLANT	29.0	16.61	$ 3,858	41	78	$ 181,636	78
016	PRE	MED	AUTOLOGOUS BONE MARROW TRANSPLANT WITH CC/MCC	17.0	10.48	$ 4,152	28	78	$ 126,276	78
017	PRE	MED	AUTOLOGOUS BONE MARROW TRANSPLANT WITHOUT CC/MCC	10.0	7.56	$ 5,088	23	78	$ 83,304	78
018	PRE	MED	CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL AND OTHER IMMUNOTHERAPIES	16.0	58.27	$ 24,526	28	78	$ 122,479	78
019	PRE	SURG	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT WITH HEMODIALYSIS	11.0	7.02	$ 4,296	37	78	$ 133,308	78
020	01	SURG	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITH MCC	13.0	10.31	$ 5,341	27	78	$ 117,234	78
021	01	SURG	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITH CC	20.0	8.51	$ 2,865	42	78	$ 153,987	78
022	01	SURG	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITHOUT CC/MCC	12.0	5.46	$ 3,066	27	78	$ 97,706	78
023	01	SURG	CRANIOTOMY WITH MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS WITH MCC OR CHEMOTHERA	15.0	8.78	$ 3,944	53	78	$ 131,321	78
024	01	SURG	CRANIOTOMY WITH MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS WITHOUT MCC	11.0	4.44	$ 2,721	23	78	$ 85,151	78
025	01	SURG	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH MCC	6.0	4.49	$ 5,043	26	78	$ 67,950	78
026	01	SURG	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH CC	3.0	3.44	$ 7,712	13	78	$ 50,949	78
027	01	SURG	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITHOUT CC/MCC	2.0	2.81	$ 9,476	7	78	$ 37,953	78
028	01	SURG	SPINAL PROCEDURES WITH MCC	5.0	6.57	$ 8,848	13	78	$ 36,464	78
029	01	SURG	SPINAL PROCEDURES WITH CC OR SPINAL NEUROSTIMULATORS	7.0	3.63	$ 3,494	15	78	$ 35,870	78
030	01	SURG	SPINAL PROCEDURES WITHOUT CC/MCC	5.0	2.66	$ 3,581	12	78	$ 40,850	78
031	01	SURG	VENTRICULAR SHUNT PROCEDURES WITH MCC	11.0	2.57	$ 1,574	24	78	$ 86,394	78
032	01	SURG	VENTRICULAR SHUNT PROCEDURES WITH CC	2.0	2.45	$ 8,243	6	78	$ 20,141	78
033	01	SURG	VENTRICULAR SHUNT PROCEDURES WITHOUT CC/MCC	2.0	2.33	$ 7,851	6	78	$ 24,750	78
034	01	SURG	CAROTID ARTERY STENT PROCEDURES WITH MCC	10.0	4.49	$ 3,022	22	78	$ 81,769	78
035	01	SURG	CAROTID ARTERY STENT PROCEDURES WITH CC	6.0	2.64	$ 2,963	14	78	$ 49,997	78
036	01	SURG	CAROTID ARTERY STENT PROCEDURES WITHOUT CC/MCC	4.0	2.09	$ 3,518	11	78	$ 37,659	78
037	01	SURG	EXTRACRANIAL PROCEDURES WITH MCC	8.0	3.70	$ 3,113	18	78	$ 65,591	78
038	01	SURG	EXTRACRANIAL PROCEDURES WITH CC	2.0	2.02	$ 6,798	8	78	$ 28,289	78
039	01	SURG	EXTRACRANIAL PROCEDURES WITHOUT CC/MCC	1.0	1.15	$ 7,771	2	78	$ 14,539	78
040	01	SURG	PERIPHERAL, CRANIAL NERVE AND OTHER NERVOUS SYSTEM PROCEDURES WITH MCC	9.0	4.57	$ 3,417	27	78	$ 58,505	78
041	01	SURG	PERIPHERAL, CRANIAL NERVE AND OTHER NERVOUS SYSTEM PROCEDURES WITH CC OR PERIPHERAL NEUROSTIMULATOR	5.0	3.00	$ 4,035	18	78	$ 39,344	78
042	01	SURG	PERIPHERAL, CRANIAL NERVE AND OTHER NERVOUS SYSTEM PROCEDURES WITHOUT CC/MCC	5.0	2.14	$ 2,889	12	78	$ 40,799	78
052	01	MED	SPINAL DISORDERS AND INJURIES WITH CC/MCC	14.0	3.79	$ 1,825	28	78	$ 47,286	78
053	01	MED	SPINAL DISORDERS AND INJURIES WITHOUT CC/MCC	2.0	1.57	$ 5,292	6	78	$ 20,115	78
054	01	MED	NERVOUS SYSTEM NEOPLASMS WITH MCC	4.0	2.07	$ 3,491	16	78	$ 33,592	78
055	01	MED	NERVOUS SYSTEM NEOPLASMS WITHOUT MCC	2.0	1.44	$ 4,865	7	78	$ 23,844	78
056	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS WITH MCC	10.0	4.21	$ 2,832	37	78	$ 66,103	78
057	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS WITHOUT MCC	8.0	2.95	$ 2,487	44	78	$ 48,955	78
058	01	MED	MULTIPLE SCLEROSIS AND CEREBELLAR ATAXIA WITH MCC	4.0	2.40	$ 4,047	11	78	$ 38,520	78
059	01	MED	MULTIPLE SCLEROSIS AND CEREBELLAR ATAXIA WITH CC	3.0	1.56	$ 3,500	7	78	$ 24,363	78
060	01	MED	MULTIPLE SCLEROSIS AND CEREBELLAR ATAXIA WITHOUT CC/MCC	3.0	1.30	$ 2,913	8	78	$ 16,216	78
061	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA WITH THROMBOLYTIC AGENT WITH MCC	8.0	2.66	$ 2,235	17	78	$ 61,944	78
062	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA WITH THROMBOLYTIC AGENT WITH CC	2.0	2.53	$ 8,515	18	78	$ 27,254	78
063	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA WITH THROMBOLYTIC AGENT WITHOUT CC/MCC	4.0	2.41	$ 4,055	10	78	$ 36,085	78
064	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH MCC	6.0	3.20	$ 3,586	34	78	$ 53,858	78
065	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH CC OR TPA IN 24 HOURS	3.0	1.84	$ 4,124	19	78	$ 31,550	78
066	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITHOUT CC/MCC	2.0	1.48	$ 4,983	8	78	$ 21,772	78
067	01	MED	NONSPECIFIC CVA AND PRECEREBRAL OCCLUSION WITHOUT INFARCTION WITH MCC	3.0	1.97	$ 4,427	9	78	$ 30,759	78
068	01	MED	NONSPECIFIC CVA AND PRECEREBRAL OCCLUSION WITHOUT INFARCTION WITHOUT MCC	2.0	1.23	$ 4,140	6	78	$ 20,249	78
069	01	MED	TRANSIENT ISCHEMIA WITHOUT THROMBOLYTIC	1.0	0.87	$ 5,889	3	78	$ 10,393	78
070	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH MCC	5.0	2.61	$ 3,522	24	78	$ 41,595	78
071	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH CC	4.0	1.79	$ 3,019	14	78	$ 28,237	78
072	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITHOUT CC/MCC	2.0	1.07	$ 3,594	5	78	$ 17,343	78
073	01	MED	CRANIAL AND PERIPHERAL NERVE DISORDERS WITH MCC	3.0	2.01	$ 4,511	11	78	$ 23,503	78
074	01	MED	CRANIAL AND PERIPHERAL NERVE DISORDERS WITHOUT MCC	3.0	1.74	$ 3,897	9	78	$ 26,597	78
075	01	MED	VIRAL MENINGITIS WITH CC/MCC	3.0	2.25	$ 5,051	8	78	$ 21,706	78
076	01	MED	VIRAL MENINGITIS WITHOUT CC/MCC	1.0	0.84	$ 5,657	5	78	$ 10,323	78
077	01	MED	HYPERTENSIVE ENCEPHALOPATHY WITH MCC	4.0	2.12	$ 3,569	10	78	$ 36,070	78
078	01	MED	HYPERTENSIVE ENCEPHALOPATHY WITH CC	2.0	1.31	$ 4,424	7	78	$ 22,061	78
079	01	MED	HYPERTENSIVE ENCEPHALOPATHY WITHOUT CC/MCC	2.0	1.01	$ 3,394	5	78	$ 16,586	78
080	01	MED	NONTRAUMATIC STUPOR AND COMA WITH MCC	3.0	2.90	$ 6,506	8	78	$ 28,959	78

Kansas 2023 DRG Weights and Limits

Effective for dates of service on or after January 1, 2023

DRG	MDC	Type	DRG Description	Transfer ALOS	DRG Relative Weight	DRG Daily Rate	Day Outlier Limit	Day Outlier Adj. %	Cost Outlier Limit	Cost Outlier Adj. %
081	01	MED	NONTRAUMATIC STUPOR AND COMA WITHOUT MCC	2.0	1.07	$ 3,601	6	78	$ 18,014	78
082	01	MED	TRAUMATIC STUPOR AND COMA >1 HOUR WITH MCC	5.0	3.13	$ 4,217	13	78	$ 45,702	78
083	01	MED	TRAUMATIC STUPOR AND COMA >1 HOUR WITH CC	3.0	1.86	$ 4,173	9	78	$ 29,518	78
084	01	MED	TRAUMATIC STUPOR AND COMA >1 HOUR WITHOUT CC/MCC	2.0	1.25	$ 4,217	6	78	$ 21,594	78
085	01	MED	TRAUMATIC STUPOR AND COMA <1 HOUR WITH MCC	5.0	3.20	$ 4,306	13	78	$ 45,600	78
086	01	MED	TRAUMATIC STUPOR AND COMA <1 HOUR WITH CC	2.0	1.16	$ 3,922	11	78	$ 17,266	78
087	01	MED	TRAUMATIC STUPOR AND COMA <1 HOUR WITHOUT CC/MCC	1.0	0.59	$ 3,982	4	78	$ 7,718	78
088	01	MED	CONCUSSION WITH MCC	4.0	2.01	$ 3,388	10	78	$ 34,028	78
089	01	MED	CONCUSSION WITH CC	2.0	1.47	$ 4,953	7	78	$ 23,599	78
090	01	MED	CONCUSSION WITHOUT CC/MCC	1.0	0.65	$ 4,372	2	78	$ 7,175	78
091	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM WITH MCC	5.0	2.52	$ 3,391	21	78	$ 41,536	78
092	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	3.0	1.77	$ 3,975	16	78	$ 30,692	78
093	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM WITHOUT CC/MCC	2.0	1.12	$ 3,775	10	78	$ 16,676	78
094	01	MED	BACTERIAL AND TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM WITH MCC	10.0	5.03	$ 3,388	22	78	$ 78,552	78
095	01	MED	BACTERIAL AND TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM WITH CC	6.0	3.47	$ 3,892	15	78	$ 53,996	78
096	01	MED	BACTERIAL AND TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM WITHOUT CC/MCC	6.0	3.23	$ 3,621	14	78	$ 48,686	78
097	01	MED	NON-BACTERIAL INFECTION OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS WITH MCC	6.0	2.66	$ 2,986	9	78	$ 23,520	78
098	01	MED	NON-BACTERIAL INFECTION OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS WITH CC	5.0	2.53	$ 3,413	12	78	$ 41,381	78
099	01	MED	NON-BACTERIAL INFECTION OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS WITHOUT CC/MCC	3.0	2.41	$ 5,417	9	78	$ 29,402	78
100	01	MED	SEIZURES WITH MCC	3.0	1.67	$ 3,756	12	78	$ 26,979	78
101	01	MED	SEIZURES WITHOUT MCC	1.0	0.98	$ 6,573	6	78	$ 15,132	78
102	01	MED	HEADACHES WITH MCC	3.0	1.59	$ 3,580	7	78	$ 24,689	78
103	01	MED	HEADACHES WITHOUT MCC	2.0	0.99	$ 3,317	5	78	$ 13,577	78
113	02	SURG	ORBITAL PROCEDURES WITH CC/MCC	5.0	2.53	$ 3,406	12	78	$ 43,548	78
114	02	SURG	ORBITAL PROCEDURES WITHOUT CC/MCC	3.0	1.67	$ 3,745	7	78	$ 25,230	78
115	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	3.0	1.68	$ 3,769	8	78	$ 28,923	78
116	02	SURG	INTRAOCULAR PROCEDURES WITH CC/MCC	4.0	2.17	$ 3,653	9	78	$ 32,977	78
117	02	SURG	INTRAOCULAR PROCEDURES WITHOUT CC/MCC	2.0	1.20	$ 4,041	6	78	$ 18,260	78
121	02	MED	ACUTE MAJOR EYE INFECTIONS WITH CC/MCC	2.0	1.38	$ 4,652	7	78	$ 21,886	78
122	02	MED	ACUTE MAJOR EYE INFECTIONS WITHOUT CC/MCC	1.0	0.75	$ 5,045	4	78	$ 13,712	78
123	02	MED	NEUROLOGICAL EYE DISORDERS	2.0	0.89	$ 2,996	5	78	$ 9,917	78
124	02	MED	OTHER DISORDERS OF THE EYE WITH MCC	3.0	1.63	$ 3,652	7	78	$ 25,228	78
125	02	MED	OTHER DISORDERS OF THE EYE WITHOUT MCC	1.0	0.97	$ 6,541	5	78	$ 15,944	78
135	03	SURG	SINUS AND MASTOID PROCEDURES WITH CC/MCC	5.0	1.81	$ 2,438	12	78	$ 44,011	78
136	03	SURG	SINUS AND MASTOID PROCEDURES WITHOUT CC/MCC	3.0	1.06	$ 2,380	7	78	$ 24,642	78
137	03	SURG	MOUTH PROCEDURES WITH CC/MCC	3.0	1.28	$ 2,862	9	78	$ 31,268	78
138	03	SURG	MOUTH PROCEDURES WITHOUT CC/MCC	1.0	0.65	$ 4,410	2	78	$ 6,767	78
139	03	SURG	SALIVARY GLAND PROCEDURES	2.0	1.04	$ 3,510	7	78	$ 22,910	78
140	03	SURG	MAJOR HEAD AND NECK PROCEDURES WITH MCC	7.0	2.50	$ 2,407	14	78	$ 65,526	78
141	03	SURG	MAJOR HEAD AND NECK PROCEDURES WITH CC	3.0	2.38	$ 5,348	7	78	$ 43,096	78
142	03	SURG	MAJOR HEAD AND NECK PROCEDURES WITHOUT CC/MCC	1.0	2.27	$ 15,281	4	78	$ 24,346	78
143	03	SURG	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH MCC	6.0	2.52	$ 2,825	14	78	$ 44,432	78
144	03	SURG	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH CC	3.0	1.56	$ 3,495	6	78	$ 17,029	78
145	03	SURG	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITHOUT CC/MCC	1.0	0.91	$ 6,159	3	78	$ 10,999	78
146	03	MED	EAR, NOSE, MOUTH AND THROAT MALIGNANCY WITH MCC	4.0	2.20	$ 3,704	10	78	$ 35,300	78
147	03	MED	EAR, NOSE, MOUTH AND THROAT MALIGNANCY WITH CC	2.0	1.40	$ 4,723	7	78	$ 22,884	78
148	03	MED	EAR, NOSE, MOUTH AND THROAT MALIGNANCY WITHOUT CC/MCC	1.0	0.85	$ 5,713	5	78	$ 16,191	78
149	03	MED	DYSEQUILIBRIUM	1.0	0.74	$ 4,962	3	78	$ 7,248	78
150	03	MED	EPISTAXIS WITH MCC	2.0	1.43	$ 4,818	7	78	$ 23,325	78
151	03	MED	EPISTAXIS WITHOUT MCC	1.0	0.80	$ 5,360	2	78	$ 8,686	78
152	03	MED	OTITIS MEDIA AND URI WITH MCC	2.0	1.16	$ 3,922	5	78	$ 17,873	78
153	03	MED	OTITIS MEDIA AND URI WITHOUT MCC	1.0	0.74	$ 5,006	3	78	$ 11,998	78
154	03	MED	OTHER EAR, NOSE, MOUTH AND THROAT DIAGNOSES WITH MCC	3.0	1.67	$ 3,743	7	78	$ 24,735	78
155	03	MED	OTHER EAR, NOSE, MOUTH AND THROAT DIAGNOSES WITH CC	2.0	0.98	$ 3,301	4	78	$ 12,465	78
156	03	MED	OTHER EAR, NOSE, MOUTH AND THROAT DIAGNOSES WITHOUT CC/MCC	1.0	0.71	$ 4,779	4	78	$ 12,069	78
157	03	MED	DENTAL AND ORAL DISEASES WITH MCC	3.0	1.70	$ 3,814	8	78	$ 26,689	78
158	03	MED	DENTAL AND ORAL DISEASES WITH CC	2.0	1.13	$ 3,812	5	78	$ 15,224	78
159	03	MED	DENTAL AND ORAL DISEASES WITHOUT CC/MCC	1.0	0.71	$ 4,814	2	78	$ 12,261	78
163	04	SURG	MAJOR CHEST PROCEDURES WITH MCC	10.0	5.91	$ 3,979	32	78	$ 85,436	78
164	04	SURG	MAJOR CHEST PROCEDURES WITH CC	5.0	3.32	$ 4,477	15	78	$ 43,042	78
165	04	SURG	MAJOR CHEST PROCEDURES WITHOUT CC/MCC	3.0	2.23	$ 4,998	9	78	$ 26,892	78
166	04	SURG	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH MCC	8.0	4.21	$ 3,548	28	78	$ 65,013	78
167	04	SURG	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH CC	3.0	2.13	$ 4,792	8	78	$ 32,059	78
168	04	SURG	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITHOUT CC/MCC	3.0	1.59	$ 3,568	9	78	$ 30,099	78
175	04	MED	PULMONARY EMBOLISM WITH MCC OR ACUTE COR PULMONALE	4.0	1.91	$ 3,208	9	78	$ 25,643	78
176	04	MED	PULMONARY EMBOLISM WITHOUT MCC	2.0	1.09	$ 3,681	6	78	$ 16,622	78
177	04	MED	RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC	5.0	2.32	$ 3,125	16	78	$ 38,054	78
178	04	MED	RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH CC	4.0	2.21	$ 3,720	14	78	$ 25,219	78
179	04	MED	RESPIRATORY INFECTIONS AND INFLAMMATIONS WITHOUT CC/MCC	4.0	2.10	$ 3,543	13	78	$ 28,318	78
180	04	MED	RESPIRATORY NEOPLASMS WITH MCC	4.0	2.11	$ 3,548	18	78	$ 33,241	78
181	04	MED	RESPIRATORY NEOPLASMS WITH CC	3.0	1.48	$ 3,321	9	78	$ 18,372	78

Kansas 2023 DRG Weights and Limits

Effective for dates of service on or after January 1, 2023

DRG	MDC	Type	DRG Description	Transfer ALOS	DRG Relative Weight	DRG Daily Rate	Day Outlier Limit	Day Outlier Adj. %	Cost Outlier Limit	Cost Outlier Adj. %
282	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITHOUT CC/MCC	1.0	0.99	$ 6,653	4	78	$ 13,227	78
283	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED WITH MCC	5.0	2.48	$ 3,340	12	78	$ 40,688	78
284	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED WITH CC	2.0	0.96	$ 3,240	6	78	$ 18,665	78
285	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED WITHOUT CC/MCC	1.0	0.66	$ 4,431	4	78	$ 13,138	78
286	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, WITH CARDIAC CATHETERIZATION WITH MCC	5.0	2.67	$ 3,601	13	78	$ 33,671	78
287	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, WITH CARDIAC CATHETERIZATION WITHOUT MCC	2.0	1.58	$ 5,335	6	78	$ 18,554	78
288	05	MED	ACUTE AND SUBACUTE ENDOCARDITIS WITH MCC	8.0	3.57	$ 3,007	18	78	$ 66,155	78
289	05	MED	ACUTE AND SUBACUTE ENDOCARDITIS WITH CC	4.0	2.19	$ 3,681	11	78	$ 37,397	78
290	05	MED	ACUTE AND SUBACUTE ENDOCARDITIS WITHOUT CC/MCC	3.0	1.37	$ 3,066	9	78	$ 30,546	78
291	05	MED	HEART FAILURE AND SHOCK WITH MCC	3.0	1.71	$ 3,829	13	78	$ 26,796	78
292	05	MED	HEART FAILURE AND SHOCK WITH CC	3.0	1.51	$ 3,397	9	78	$ 24,570	78
293	05	MED	HEART FAILURE AND SHOCK WITHOUT CC/MCC	2.0	0.78	$ 2,642	5	78	$ 15,755	78
294	05	MED	DEEP VEIN THROMBOPHLEBITIS WITH CC/MCC	3.0	1.71	$ 3,830	8	78	$ 27,140	78
295	05	MED	DEEP VEIN THROMBOPHLEBITIS WITHOUT CC/MCC	2.0	1.31	$ 4,407	5	78	$ 16,793	78
296	05	MED	CARDIAC ARREST, UNEXPLAINED WITH MCC	4.0	2.12	$ 3,572	10	78	$ 33,153	78
297	05	MED	CARDIAC ARREST, UNEXPLAINED WITH CC	1.0	0.94	$ 6,333	5	78	$ 14,864	78
298	05	MED	CARDIAC ARREST, UNEXPLAINED WITHOUT CC/MCC	1.0	0.65	$ 4,378	4	78	$ 11,271	78
299	05	MED	PERIPHERAL VASCULAR DISORDERS WITH MCC	3.0	1.51	$ 3,384	11	78	$ 31,577	78
300	05	MED	PERIPHERAL VASCULAR DISORDERS WITH CC	2.0	1.44	$ 4,834	7	78	$ 16,183	78
301	05	MED	PERIPHERAL VASCULAR DISORDERS WITHOUT CC/MCC	2.0	1.37	$ 4,604	8	78	$ 17,493	78
302	05	MED	ATHEROSCLEROSIS WITH MCC	3.0	1.46	$ 3,269	7	78	$ 25,389	78
303	05	MED	ATHEROSCLEROSIS WITHOUT MCC	2.0	1.02	$ 3,435	6	78	$ 13,644	78
304	05	MED	HYPERTENSION WITH MCC	3.0	1.55	$ 3,470	8	78	$ 21,986	78
305	05	MED	HYPERTENSION WITHOUT MCC	2.0	0.93	$ 3,121	5	78	$ 11,771	78
306	05	MED	CARDIAC CONGENITAL AND VALVULAR DISORDERS WITH MCC	4.0	2.00	$ 3,376	10	78	$ 34,722	78
307	05	MED	CARDIAC CONGENITAL AND VALVULAR DISORDERS WITHOUT MCC	2.0	1.16	$ 3,898	6	78	$ 20,071	78
308	05	MED	CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH MCC	3.0	1.89	$ 4,235	10	78	$ 27,758	78
309	05	MED	CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH CC	2.0	1.24	$ 4,189	8	78	$ 17,577	78
310	05	MED	CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITHOUT CC/MCC	1.0	0.93	$ 6,273	4	78	$ 13,427	78
311	05	MED	ANGINA PECTORIS	1.0	0.93	$ 6,257	5	78	$ 15,768	78
312	05	MED	SYNCOPE AND COLLAPSE	1.0	0.97	$ 6,517	5	78	$ 13,246	78
313	05	MED	CHEST PAIN	1.0	1.00	$ 6,731	5	78	$ 14,296	78
314	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES WITH MCC	5.0	2.52	$ 3,388	18	78	$ 41,007	78
315	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES WITH CC	3.0	1.28	$ 2,879	7	78	$ 20,253	78
316	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES WITHOUT CC/MCC	2.0	0.96	$ 3,240	3	78	$ 15,075	78
319	05	SURG	OTHER ENDOVASCULAR CARDIAC VALVE PROCEDURES WITH MCC	3.0	5.05	$ 11,341	14	78	$ 91,300	78
320	05	SURG	OTHER ENDOVASCULAR CARDIAC VALVE PROCEDURES WITHOUT MCC	5.0	2.81	$ 3,791	14	78	$ 91,300	78
326	06	SURG	STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH MCC	14.0	6.18	$ 2,975	30	78	$ 179,529	78
327	06	SURG	STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH CC	3.0	2.18	$ 4,892	12	78	$ 34,025	78
328	06	SURG	STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITHOUT CC/MCC	2.0	1.45	$ 4,892	7	78	$ 23,082	78
329	06	SURG	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH MCC	10.0	6.00	$ 4,037	33	78	$ 91,952	78
330	06	SURG	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	5.0	3.07	$ 4,129	15	78	$ 43,277	78
331	06	SURG	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITHOUT CC/MCC	3.0	2.23	$ 5,005	7	78	$ 26,887	78
332	06	SURG	RECTAL RESECTION WITH MCC	13.0	4.84	$ 2,508	28	78	$ 101,262	78
333	06	SURG	RECTAL RESECTION WITH CC	6.0	2.49	$ 2,796	15	78	$ 53,255	78
334	06	SURG	RECTAL RESECTION WITHOUT CC/MCC	4.0	1.87	$ 3,151	10	78	$ 34,455	78
335	06	SURG	PERITONEAL ADHESIOLYSIS WITH MCC	7.0	3.42	$ 3,292	14	78	$ 39,316	78
336	06	SURG	PERITONEAL ADHESIOLYSIS WITH CC	5.0	2.67	$ 3,590	14	78	$ 45,908	78
337	06	SURG	PERITONEAL ADHESIOLYSIS WITHOUT CC/MCC	2.0	1.90	$ 6,413	7	78	$ 19,851	78
338	06	SURG	APPENDECTOMY WITH COMPLICATED PRINCIPAL DIAGNOSIS WITH MCC	7.0	3.25	$ 3,131	17	78	$ 61,109	78
339	06	SURG	APPENDECTOMY WITH COMPLICATED PRINCIPAL DIAGNOSIS WITH CC	3.0	1.76	$ 3,957	7	78	$ 19,795	78
340	06	SURG	APPENDECTOMY WITH COMPLICATED PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	2.0	1.62	$ 5,445	9	78	$ 22,030	78
341	06	SURG	APPENDECTOMY WITHOUT COMPLICATED PRINCIPAL DIAGNOSIS WITH MCC	5.0	2.70	$ 3,639	10	78	$ 28,030	78
342	06	SURG	APPENDECTOMY WITHOUT COMPLICATED PRINCIPAL DIAGNOSIS WITH CC	3.0	1.78	$ 3,998	6	78	$ 19,406	78
343	06	SURG	APPENDECTOMY WITHOUT COMPLICATED PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	1.0	1.03	$ 6,941	3	78	$ 12,140	78
344	06	SURG	MINOR SMALL AND LARGE BOWEL PROCEDURES WITH MCC	8.0	3.28	$ 2,760	19	78	$ 67,366	78
345	06	SURG	MINOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	4.0	1.84	$ 3,092	10	78	$ 35,791	78
346	06	SURG	MINOR SMALL AND LARGE BOWEL PROCEDURES WITHOUT CC/MCC	3.0	1.48	$ 3,331	5	78	$ 13,682	78
347	06	SURG	ANAL AND STOMAL PROCEDURES WITH MCC	12.0	2.87	$ 1,609	18	78	$ 50,287	78
348	06	SURG	ANAL AND STOMAL PROCEDURES WITH CC	2.0	1.24	$ 4,191	4	78	$ 13,358	78
349	06	SURG	ANAL AND STOMAL PROCEDURES WITHOUT CC/MCC	2.0	1.14	$ 3,836	6	78	$ 21,032	78
350	06	SURG	INGUINAL AND FEMORAL HERNIA PROCEDURES WITH MCC	6.0	2.86	$ 3,205	14	78	$ 51,907	78
351	06	SURG	INGUINAL AND FEMORAL HERNIA PROCEDURES WITH CC	3.0	1.74	$ 3,898	6	78	$ 13,797	78
352	06	SURG	INGUINAL AND FEMORAL HERNIA PROCEDURES WITHOUT CC/MCC	2.0	1.28	$ 4,326	7	78	$ 21,985	78
353	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITH MCC	7.0	3.52	$ 3,385	17	78	$ 61,318	78
354	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITH CC	3.0	2.21	$ 4,971	13	78	$ 26,507	78
355	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITHOUT CC/MCC	2.0	1.75	$ 5,908	4	78	$ 17,855	78
356	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH MCC	9.0	5.97	$ 4,468	32	78	$ 82,011	78
357	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	4.0	2.30	$ 3,875	12	78	$ 29,526	78
358	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITHOUT CC/MCC	3.0	1.57	$ 3,523	9	78	$ 29,409	78
368	06	MED	MAJOR ESOPHAGEAL DISORDERS WITH MCC	5.0	2.51	$ 3,375	12	78	$ 42,457	78
369	06	MED	MAJOR ESOPHAGEAL DISORDERS WITH CC	3.0	1.21	$ 2,724	6	78	$ 13,330	78
370	06	MED	MAJOR ESOPHAGEAL DISORDERS WITHOUT CC/MCC	2.0	0.96	$ 3,239	5	78	$ 17,551	78
371	06	MED	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS WITH MCC	4.0	1.88	$ 3,173	17	78	$ 31,804	78
372	06	MED	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS WITH CC	3.0	1.29	$ 2,888	9	78	$ 18,776	78
373	06	MED	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS WITHOUT CC/MCC	2.0	1.01	$ 3,412	7	78	$ 14,280	78
374	06	MED	DIGESTIVE MALIGNANCY WITH MCC	5.0	2.51	$ 3,382	21	78	$ 40,458	78
375	06	MED	DIGESTIVE MALIGNANCY WITH CC	4.0	1.99	$ 3,354	11	78	$ 30,421	78
376	06	MED	DIGESTIVE MALIGNANCY WITHOUT CC/MCC	2.0	1.16	$ 3,891	6	78	$ 19,753	78
377	06	MED	GASTROINTESTINAL HEMORRHAGE WITH MCC	4.0	2.36	$ 3,972	13	78	$ 34,941	78
378	06	MED	GASTROINTESTINAL HEMORRHAGE WITH CC	2.0	1.23	$ 4,149	5	78	$ 15,127	78
379	06	MED	GASTROINTESTINAL HEMORRHAGE WITHOUT CC/MCC	1.0	0.82	$ 5,517	3	78	$ 11,078	78
380	06	MED	COMPLICATED PEPTIC ULCER WITH MCC	3.0	1.46	$ 3,276	9	78	$ 18,922	78
381	06	MED	COMPLICATED PEPTIC ULCER WITH CC	3.0	1.36	$ 3,057	7	78	$ 24,745	78
382	06	MED	COMPLICATED PEPTIC ULCER WITHOUT CC/MCC	2.0	0.99	$ 3,327	3	78	$ 11,810	78
383	06	MED	UNCOMPLICATED PEPTIC ULCER WITH MCC	3.0	1.69	$ 3,788	9	78	$ 30,242	78
384	06	MED	UNCOMPLICATED PEPTIC ULCER WITHOUT MCC	2.0	1.19	$ 4,023	4	78	$ 13,252	78
385	06	MED	INFLAMMATORY BOWEL DISEASE WITH MCC	4.0	1.65	$ 2,770	7	78	$ 17,489	78
386	06	MED	INFLAMMATORY BOWEL DISEASE WITH CC	3.0	1.20	$ 2,696	9	78	$ 16,255	78
387	06	MED	INFLAMMATORY BOWEL DISEASE WITHOUT CC/MCC	2.0	1.11	$ 3,740	7	78	$ 15,559	78
388	06	MED	GASTROINTESTINAL OBSTRUCTION WITH MCC	4.0	1.71	$ 2,879	11	78	$ 26,228	78
389	06	MED	GASTROINTESTINAL OBSTRUCTION WITH CC	2.0	1.11	$ 3,751	7	78	$ 15,772	78
390	06	MED	GASTROINTESTINAL OBSTRUCTION WITHOUT CC/MCC	2.0	0.83	$ 2,799	5	78	$ 11,489	78
391	06	MED	ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITH MCC	3.0	1.88	$ 4,211	14	78	$ 31,473	78
392	06	MED	ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITHOUT MCC	2.0	1.01	$ 3,392	7	78	$ 14,914	78
393	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES WITH MCC	4.0	1.75	$ 2,948	11	78	$ 24,706	78
394	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES WITH CC	3.0	1.35	$ 3,027	8	78	$ 18,787	78
395	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES WITHOUT CC/MCC	2.0	0.87	$ 2,917	6	78	$ 12,945	78
405	07	SURG	PANCREAS, LIVER AND SHUNT PROCEDURES WITH MCC	6.0	5.67	$ 6,364	20	78	$ 116,636	78
406	07	SURG	PANCREAS, LIVER AND SHUNT PROCEDURES WITH CC	4.0	2.50	$ 4,203	9	78	$ 26,925	78
407	07	SURG	PANCREAS, LIVER AND SHUNT PROCEDURES WITHOUT CC/MCC	2.0	1.81	$ 6,084	5	78	$ 16,735	78
408	07	SURG	BILIARY TRACT PROCEDURES EXCEPT ONLY CHOLECYSTECTOMY WITH OR WITHOUT C.D.E. WITH MCC	9.0	3.71	$ 2,775	21	78	$ 75,237	78
409	07	SURG	BILIARY TRACT PROCEDURES EXCEPT ONLY CHOLECYSTECTOMY WITH OR WITHOUT C.D.E. WITH CC	5.0	2.09	$ 2,817	12	78	$ 43,050	78
410	07	SURG	BILIARY TRACT PROCEDURES EXCEPT ONLY CHOLECYSTECTOMY WITH OR WITHOUT C.D.E. WITHOUT CC/MCC	4.0	1.55	$ 2,609	9	78	$ 32,649	78
411	07	SURG	CHOLECYSTECTOMY WITH C.D.E. WITH MCC	8.0	3.71	$ 3,122	19	78	$ 68,931	78
412	07	SURG	CHOLECYSTECTOMY WITH C.D.E. WITH CC	5.0	2.25	$ 3,031	13	78	$ 46,217	78
413	07	SURG	CHOLECYSTECTOMY WITH C.D.E. WITHOUT CC/MCC	3.0	1.71	$ 3,839	5	78	$ 17,283	78
414	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE WITHOUT C.D.E. WITH MCC	8.0	3.59	$ 3,018	19	78	$ 67,917	78
415	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE WITHOUT C.D.E. WITH CC	5.0	2.01	$ 2,704	11	78	$ 39,565	78
416	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE WITHOUT C.D.E. WITHOUT CC/MCC	3.0	1.41	$ 3,155	8	78	$ 26,252	78

Kansas 2023 DRG Weights and Limits

Effective for dates of service on or after January 1, 2023

DRG	MDC	Type	DRG Description	Transfer ALOS	DRG Relative Weight	DRG Daily Rate	Day Outlier Limit	Day Outlier Adj. %	Cost Outlier Limit	Cost Outlier Adj. %
417	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH MCC	3.0	2.22	$ 4,988	9	78	$ 28,314	78
418	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH CC	2.0	1.74	$ 5,850	8	78	$ 20,277	78
419	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITHOUT CC/MCC	2.0	1.43	$ 4,813	5	78	$ 16,863	78
420	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES WITH MCC	8.0	3.47	$ 2,925	19	78	$ 67,218	78
421	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES WITH CC	4.0	1.88	$ 3,173	9	78	$ 33,065	78
422	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES WITHOUT CC/MCC	3.0	1.44	$ 3,224	8	78	$ 28,102	78
423	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITH MCC	11.0	4.14	$ 2,532	24	78	$ 86,469	78
424	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITH CC	5.0	2.26	$ 3,040	13	78	$ 45,894	78
425	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITHOUT CC/MCC	3.0	1.52	$ 3,422	9	78	$ 29,969	78
432	07	MED	CIRRHOSIS AND ALCOHOLIC HEPATITIS WITH MCC	4.0	2.32	$ 3,913	17	78	$ 37,091	78
433	07	MED	CIRRHOSIS AND ALCOHOLIC HEPATITIS WITH CC	3.0	1.31	$ 2,934	9	78	$ 17,698	78
434	07	MED	CIRRHOSIS AND ALCOHOLIC HEPATITIS WITHOUT CC/MCC	1.0	0.67	$ 4,526	3	78	$ 7,611	78
435	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITH MCC	4.0	2.00	$ 3,366	12	78	$ 27,224	78
436	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITH CC	3.0	1.43	$ 3,215	7	78	$ 18,993	78
437	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITHOUT CC/MCC	2.0	1.14	$ 3,852	7	78	$ 22,925	78
438	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH MCC	4.0	1.93	$ 3,255	13	78	$ 30,830	78
439	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH CC	2.0	1.16	$ 3,911	7	78	$ 16,479	78
440	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITHOUT CC/MCC	2.0	0.91	$ 3,071	4	78	$ 15,197	78
441	07	MED	DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITH MCC	5.0	2.21	$ 2,973	23	78	$ 34,022	78
442	07	MED	DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITH CC	3.0	1.26	$ 2,817	8	78	$ 17,916	78
443	07	MED	DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITHOUT CC/MCC	1.0	0.71	$ 4,750	3	78	$ 9,353	78
444	07	MED	DISORDERS OF THE BILIARY TRACT WITH MCC	4.0	2.13	$ 3,594	11	78	$ 38,669	78
445	07	MED	DISORDERS OF THE BILIARY TRACT WITH CC	3.0	1.81	$ 4,070	11	78	$ 28,562	78
446	07	MED	DISORDERS OF THE BILIARY TRACT WITHOUT CC/MCC	1.0	1.04	$ 7,022	3	78	$ 9,700	78
453	08	SURG	COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION WITH MCC	28.0	10.55	$ 2,537	57	78	$ 213,933	78
454	08	SURG	COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION WITH CC	4.0	5.83	$ 9,809	12	78	$ 72,682	78
455	08	SURG	COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION WITHOUT CC/MCC	2.0	4.30	$ 14,488	4	78	$ 46,390	78
456	08	SURG	SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH	5.0	7.82	$ 10,527	11	78	$ 91,569	78
457	08	SURG	SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH	4.0	7.11	$ 11,972	13	78	$ 71,734	78
458	08	SURG	SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH	3.0	5.07	$ 11,370	6	78	$ 45,557	78
459	08	SURG	SPINAL FUSION EXCEPT CERVICAL WITH MCC	16.0	7.73	$ 3,254	35	78	$ 129,637	78
460	08	SURG	SPINAL FUSION EXCEPT CERVICAL WITHOUT MCC	2.0	3.73	$ 12,572	5	78	$ 43,080	78
461	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF LOWER EXTREMITY WITH MCC	13.0	6.98	$ 3,617	28	78	$ 101,769	78
462	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF LOWER EXTREMITY WITHOUT MCC	8.0	3.61	$ 3,036	18	78	$ 65,358	78
463	08	SURG	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WIT	13.0	6.17	$ 3,194	29	78	$ 106,623	78
464	08	SURG	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WIT	4.0	3.03	$ 5,102	17	78	$ 48,374	78
465	08	SURG	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WIT	2.0	2.12	$ 7,129	5	78	$ 21,941	78
466	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT WITH MCC	3.0	6.14	$ 13,777	6	78	$ 39,198	78
467	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT WITH CC	3.0	4.62	$ 10,381	13	78	$ 51,782	78
468	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT WITHOUT CC/MCC	2.0	3.14	$ 10,573	5	78	$ 37,452	78
469	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITH MCC OR TOTAL ANKLE REPL	3.0	3.02	$ 6,788	9	78	$ 30,795	78
470	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	2.0	2.62	$ 8,819	8	78	$ 26,967	78
471	08	SURG	CERVICAL SPINAL FUSION WITH MCC	8.0	5.54	$ 4,662	18	78	$ 65,088	78
472	08	SURG	CERVICAL SPINAL FUSION WITH CC	2.0	2.97	$ 9,994	7	78	$ 34,958	78
473	08	SURG	CERVICAL SPINAL FUSION WITHOUT CC/MCC	1.0	2.30	$ 15,465	4	78	$ 28,680	78
474	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITH MCC	9.0	4.68	$ 3,502	20	78	$ 74,587	78
475	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITH CC	5.0	2.93	$ 3,953	16	78	$ 40,528	78
476	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	4.0	1.80	$ 3,034	8	78	$ 18,522	78
477	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC	12.0	4.61	$ 2,586	22	78	$ 52,333	78
478	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH CC	5.0	2.71	$ 3,647	13	78	$ 44,973	78
479	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT CC/MCC	4.0	2.08	$ 3,498	10	78	$ 35,283	78
480	08	SURG	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH MCC	4.0	3.24	$ 5,454	17	78	$ 44,397	78
481	08	SURG	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CC	4.0	2.97	$ 5,001	11	78	$ 36,904	78
482	08	SURG	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITHOUT CC/MCC	2.0	1.83	$ 6,177	6	78	$ 24,328	78
483	08	SURG	MAJOR JOINT OR LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITIES	1.0	2.95	$ 19,873	6	78	$ 33,024	78
485	08	SURG	KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF INFECTION WITH MCC	7.0	3.91	$ 3,766	17	78	$ 60,916	78
486	08	SURG	KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF INFECTION WITH CC	5.0	2.47	$ 3,324	12	78	$ 41,509	78
487	08	SURG	KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF INFECTION WITHOUT CC/MCC	3.0	1.88	$ 4,227	9	78	$ 31,224	78
488	08	SURG	KNEE PROCEDURES WITHOUT PRINCIPAL DIAGNOSIS OF INFECTION WITH CC/MCC	4.0	2.27	$ 3,819	10	78	$ 35,324	78
489	08	SURG	KNEE PROCEDURES WITHOUT PRINCIPAL DIAGNOSIS OF INFECTION WITHOUT CC/MCC	3.0	1.49	$ 3,346	8	78	$ 26,212	78
492	08	SURG	LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITH MCC	6.0	3.98	$ 4,471	18	78	$ 87,598	78
493	08	SURG	LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITH CC	3.0	2.73	$ 6,121	10	78	$ 33,964	78
494	08	SURG	LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITHOUT CC/MCC	1.0	1.60	$ 10,772	5	78	$ 22,124	78
495	08	SURG	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH MCC	7.0	4.18	$ 4,023	17	78	$ 61,458	78
496	08	SURG	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC	4.0	2.28	$ 3,840	10	78	$ 36,178	78
497	08	SURG	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC/MCC	2.0	1.67	$ 5,611	6	78	$ 18,675	78
498	08	SURG	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES OF HIP AND FEMUR WITH CC/MCC	6.0	2.97	$ 3,329	13	78	$ 47,465	78
499	08	SURG	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES OF HIP AND FEMUR WITHOUT CC/MCC	2.0	1.38	$ 4,635	7	78	$ 23,298	78
500	08	SURG	SOFT TISSUE PROCEDURES WITH MCC	8.0	3.66	$ 3,083	17	78	$ 62,275	78
501	08	SURG	SOFT TISSUE PROCEDURES WITH CC	4.0	2.29	$ 3,863	12	78	$ 30,369	78
502	08	SURG	SOFT TISSUE PROCEDURES WITHOUT CC/MCC	1.0	1.53	$ 10,305	4	78	$ 18,031	78
503	08	SURG	FOOT PROCEDURES WITH MCC	6.0	3.03	$ 3,403	14	78	$ 48,361	78
504	08	SURG	FOOT PROCEDURES WITH CC	5.0	2.33	$ 3,136	9	78	$ 25,967	78
505	08	SURG	FOOT PROCEDURES WITHOUT CC/MCC	2.0	2.04	$ 6,862	5	78	$ 17,176	78
506	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	3.0	1.70	$ 3,824	8	78	$ 26,873	78
507	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES WITH CC/MCC	5.0	2.37	$ 3,187	11	78	$ 39,295	78
508	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES WITHOUT CC/MCC	4.0	1.62	$ 2,725	10	78	$ 34,042	78
509	08	SURG	ARTHROSCOPY	4.0	1.94	$ 3,260	10	78	$ 35,574	78
510	08	SURG	SHOULDER, ELBOW OR FOREARM PROCEDURES, EXCEPT MAJOR JOINT PROCEDURES WITH MCC	6.0	3.15	$ 3,536	14	78	$ 49,132	78
511	08	SURG	SHOULDER, ELBOW OR FOREARM PROCEDURES, EXCEPT MAJOR JOINT PROCEDURES WITH CC	5.0	2.76	$ 3,713	9	78	$ 23,574	78
512	08	SURG	SHOULDER, ELBOW OR FOREARM PROCEDURES, EXCEPT MAJOR JOINT PROCEDURES WITHOUT CC/MCC	1.0	1.78	$ 12,019	2	78	$ 14,259	78
513	08	SURG	HAND OR WRIST PROCEDURES, EXCEPT MAJOR THUMB OR JOINT PROCEDURES WITH CC/MCC	3.0	1.73	$ 3,873	9	78	$ 19,417	78
514	08	SURG	HAND OR WRIST PROCEDURES, EXCEPT MAJOR THUMB OR JOINT PROCEDURES WITHOUT CC/MCC	2.0	1.15	$ 3,862	4	78	$ 10,896	78
515	08	SURG	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R. PROCEDURES WITH MCC	8.0	3.61	$ 3,035	17	78	$ 62,525	78
516	08	SURG	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R. PROCEDURES WITH CC	3.0	2.49	$ 5,600	10	78	$ 31,854	78
517	08	SURG	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R. PROCEDURES WITHOUT CC/MCC	2.0	2.25	$ 7,566	5	78	$ 31,434	78
518	08	SURG	BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITH MCC OR DISC DEVICE OR NEUROSTIMULATOR	7.0	4.12	$ 3,962	16	78	$ 57,767	78
519	08	SURG	BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITH CC	4.0	2.25	$ 3,788	13	78	$ 34,522	78
520	08	SURG	BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITHOUT CC/MCC	1.0	1.63	$ 10,966	4	78	$ 14,871	78
521	08	SURG	HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITH MCC	9.0	4.85	$ 3,631	17	78	$ 53,219	78
522	08	SURG	HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITHOUT MCC	4.0	3.54	$ 5,965	18	78	$ 41,367	78
533	08	MED	FRACTURES OF FEMUR WITH MCC	3.0	2.51	$ 5,627	8	78	$ 29,078	78
534	08	MED	FRACTURES OF FEMUR WITHOUT MCC	1.0	1.40	$ 9,419	2	78	$ 9,764	78
535	08	MED	FRACTURES OF HIP AND PELVIS WITH MCC	3.0	2.18	$ 4,898	8	78	$ 25,613	78
536	08	MED	FRACTURES OF HIP AND PELVIS WITHOUT MCC	2.0	1.18	$ 3,974	7	78	$ 15,768	78
537	08	MED	SPRAINS, STRAINS, AND DISLOCATIONS OF HIP, PELVIS AND THIGH WITH CC/MCC	2.0	1.66	$ 5,575	6	78	$ 20,007	78
538	08	MED	SPRAINS, STRAINS, AND DISLOCATIONS OF HIP, PELVIS AND THIGH WITHOUT CC/MCC	1.0	1.28	$ 8,620	5	78	$ 15,442	78
539	08	MED	OSTEOMYELITIS WITH MCC	5.0	3.45	$ 4,643	12	78	$ 41,029	78
540	08	MED	OSTEOMYELITIS WITH CC	3.0	2.30	$ 5,171	8	78	$ 28,125	78
541	08	MED	OSTEOMYELITIS WITHOUT CC/MCC	2.0	1.49	$ 5,025	6	78	$ 20,871	78
542	08	MED	PATHOLOGICAL FRACTURES AND MUSCULOSKELETAL AND CONNECTIVE TISSUE MALIGNANCY WITH MCC	4.0	3.20	$ 5,391	11	78	$ 39,088	78
543	08	MED	PATHOLOGICAL FRACTURES AND MUSCULOSKELETAL AND CONNECTIVE TISSUE MALIGNANCY WITH CC	2.0	1.85	$ 6,229	7	78	$ 23,807	78
544	08	MED	PATHOLOGICAL FRACTURES AND MUSCULOSKELETAL AND CONNECTIVE TISSUE MALIGNANCY WITHOUT CC/MCC	2.0	1.38	$ 4,635	5	78	$ 16,974	78
545	08	MED	CONNECTIVE TISSUE DISORDERS WITH MCC	6.0	4.43	$ 4,973	14	78	$ 51,604	78
546	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC	3.0	2.14	$ 4,800	9	78	$ 26,931	78
547	08	MED	CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	2.0	1.48	$ 4,968	5	78	$ 17,416	78
548	08	MED	SEPTIC ARTHRITIS WITH MCC	5.0	3.63	$ 4,889	11	78	$ 39,194	78
549	08	MED	SEPTIC ARTHRITIS WITH CC	3.0	2.21	$ 4,966	7	78	$ 24,799	78
550	08	MED	SEPTIC ARTHRITIS WITHOUT CC/MCC	2.0	1.08	$ 3,644	3	78	$ 9,263	78
551	08	MED	MEDICAL BACK PROBLEMS WITH MCC	5.0	2.36	$ 3,172	16	78	$ 33,293	78
552	08	MED	MEDICAL BACK PROBLEMS WITHOUT MCC	2.0	1.31	$ 4,414	10	78	$ 20,787	78
553	08	MED	BONE DISEASES AND ARTHROPATHIES WITH MCC	3.0	2.25	$ 5,052	8	78	$ 25,852	78
554	08	MED	BONE DISEASES AND ARTHROPATHIES WITHOUT MCC	3.0	1.33	$ 2,994	7	78	$ 15,856	78
555	08	MED	SIGNS AND SYMPTOMS OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC	3.0	2.42	$ 5,437	8	78	$ 27,188	78
556	08	MED	SIGNS AND SYMPTOMS OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT MCC	2.0	1.22	$ 4,104	8	78	$ 17,435	78
557	08	MED	TENDONITIS, MYOSITIS AND BURSITIS WITH MCC	3.0	2.48	$ 5,559	9	78	$ 29,339	78
558	08	MED	TENDONITIS, MYOSITIS AND BURSITIS WITHOUT MCC	3.0	1.39	$ 3,112	11	78	$ 22,245	78
559	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC	10.0	3.18	$ 2,143	26	78	$ 44,714	78
560	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH CC	10.0	3.03	$ 2,041	42	78	$ 60,379	78
561	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT CC/MCC	1.0	2.89	$ 19,441	16	78	$ 34,096	78
562	08	MED	FRACTURE, SPRAIN, STRAIN AND DISLOCATION EXCEPT FEMUR, HIP, PELVIS AND THIGH WITH MCC	3.0	2.50	$ 5,609	8	78	$ 28,268	78

Kansas 2023 DRG Weights and Limits

Effective for dates of service on or after January 1, 2023

DRG	MDC	Type	DRG Description	Transfer ALOS	DRG Relative Weight	DRG Daily Rate	Day Outlier Limit	Day Outlier Adj. %	Cost Outlier Limit	Cost Outlier Adj. %
563	08	MED	FRACTURE, SPRAIN, STRAIN AND DISLOCATION EXCEPT FEMUR, HIP, PELVIS AND THIGH WITHOUT MCC	1.0	0.86	$ 5,776	5	78	$ 12,675	78
564	08	MED	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DIAGNOSES WITH MCC	4.0	1.55	$ 2,609	10	78	$ 33,805	78
565	08	MED	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DIAGNOSES WITH CC	3.0	1.48	$ 3,313	7	78	$ 12,657	78
566	08	MED	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DIAGNOSES WITHOUT CC/MCC	1.0	1.41	$ 9,465	5	78	$ 15,937	78
570	09	SURG	SKIN DEBRIDEMENT WITH MCC	7.0	3.19	$ 3,070	15	78	$ 54,905	78
571	09	SURG	SKIN DEBRIDEMENT WITH CC	5.0	2.41	$ 3,241	21	78	$ 35,455	78
572	09	SURG	SKIN DEBRIDEMENT WITHOUT CC/MCC	3.0	1.24	$ 2,784	5	78	$ 19,408	78
573	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITH MCC	11.0	6.22	$ 3,809	23	78	$ 84,852	78
574	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITH CC	8.0	3.65	$ 3,069	18	78	$ 65,959	78
575	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITHOUT CC/MCC	4.0	1.98	$ 3,334	10	78	$ 34,611	78
576	09	SURG	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITH MCC	12.0	5.69	$ 3,192	27	78	$ 99,243	78
577	09	SURG	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITH CC	6.0	2.86	$ 3,214	15	78	$ 53,036	78
578	09	SURG	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITHOUT CC/MCC	4.0	1.79	$ 3,016	9	78	$ 32,429	78
579	09	SURG	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH MCC	8.0	3.53	$ 2,973	17	78	$ 62,840	78
580	09	SURG	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH CC	3.0	1.78	$ 3,987	9	78	$ 24,431	78
581	09	SURG	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITHOUT CC/MCC	2.0	1.29	$ 4,350	5	78	$ 17,075	78
582	09	SURG	MASTECTOMY FOR MALIGNANCY WITH CC/MCC	4.0	1.85	$ 3,107	10	78	$ 35,076	78
583	09	SURG	MASTECTOMY FOR MALIGNANCY WITHOUT CC/MCC	3.0	1.73	$ 3,886	9	78	$ 30,901	78
584	09	SURG	BREAST BIOPSY, LOCAL EXCISION AND OTHER BREAST PROCEDURES WITH CC/MCC	5.0	2.06	$ 2,778	12	78	$ 41,802	78
585	09	SURG	BREAST BIOPSY, LOCAL EXCISION AND OTHER BREAST PROCEDURES WITHOUT CC/MCC	4.0	1.95	$ 3,289	11	78	$ 37,074	78
592	09	MED	SKIN ULCERS WITH MCC	4.0	2.17	$ 3,656	9	78	$ 31,746	78
593	09	MED	SKIN ULCERS WITH CC	2.0	1.46	$ 4,923	7	78	$ 22,776	78
594	09	MED	SKIN ULCERS WITHOUT CC/MCC	2.0	1.05	$ 3,522	5	78	$ 17,024	78
595	09	MED	MAJOR SKIN DISORDERS WITH MCC	5.0	2.58	$ 3,481	13	78	$ 45,117	78
596	09	MED	MAJOR SKIN DISORDERS WITHOUT MCC	2.0	1.28	$ 4,293	7	78	$ 22,094	78
597	09	MED	MALIGNANT BREAST DISORDERS WITH MCC	5.0	1.45	$ 1,951	11	78	$ 39,390	78
598	09	MED	MALIGNANT BREAST DISORDERS WITH CC	2.0	1.38	$ 4,645	3	78	$ 8,817	78
599	09	MED	MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	2.0	1.31	$ 4,424	5	78	$ 16,461	78
600	09	MED	NON-MALIGNANT BREAST DISORDERS WITH CC/MCC	3.0	1.28	$ 2,869	5	78	$ 13,123	78
601	09	MED	NON-MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	1.0	0.88	$ 5,929	5	78	$ 15,406	78
602	09	MED	CELLULITIS WITH MCC	5.0	1.86	$ 2,503	25	78	$ 45,713	78
603	09	MED	CELLULITIS WITHOUT MCC	2.0	1.10	$ 3,705	7	78	$ 16,789	78
604	09	MED	TRAUMA TO THE SKIN, SUBCUTANEOUS TISSUE AND BREAST WITH MCC	3.0	1.89	$ 4,253	9	78	$ 30,424	78
605	09	MED	TRAUMA TO THE SKIN, SUBCUTANEOUS TISSUE AND BREAST WITHOUT MCC	1.0	0.90	$ 6,074	5	78	$ 12,378	78
606	09	MED	MINOR SKIN DISORDERS WITH MCC	4.0	1.94	$ 3,263	9	78	$ 31,692	78
607	09	MED	MINOR SKIN DISORDERS WITHOUT MCC	3.0	1.37	$ 3,086	10	78	$ 20,910	78
614	10	SURG	ADRENAL AND PITUITARY PROCEDURES WITH CC/MCC	5.0	2.71	$ 3,650	12	78	$ 42,149	78
615	10	SURG	ADRENAL AND PITUITARY PROCEDURES WITHOUT CC/MCC	3.0	1.79	$ 4,009	7	78	$ 25,215	78
616	10	SURG	AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH MCC	9.0	4.50	$ 3,365	19	78	$ 70,797	78
617	10	SURG	AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH CC	6.0	2.62	$ 2,940	16	78	$ 33,557	78
618	10	SURG	AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITHOUT CC/MCC	2.0	1.48	$ 4,976	7	78	$ 22,282	78
619	10	SURG	O.R. PROCEDURES FOR OBESITY WITH MCC	6.0	3.47	$ 3,897	15	78	$ 53,901	78
620	10	SURG	O.R. PROCEDURES FOR OBESITY WITH CC	2.0	2.03	$ 6,847	5	78	$ 26,022	78
621	10	SURG	O.R. PROCEDURES FOR OBESITY WITHOUT CC/MCC	1.0	1.63	$ 11,003	6	78	$ 20,118	78
622	10	SURG	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH MCC	8.0	4.10	$ 3,451	18	78	$ 64,089	78
623	10	SURG	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH CC	5.0	2.12	$ 2,858	19	78	$ 34,698	78
624	10	SURG	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITHOUT CC/MCC	2.0	1.25	$ 4,196	6	78	$ 19,342	78
625	10	SURG	THYROID, PARATHYROID AND THYROGLOSSAL PROCEDURES WITH MCC	6.0	3.22	$ 3,615	13	78	$ 46,864	78
626	10	SURG	THYROID, PARATHYROID AND THYROGLOSSAL PROCEDURES WITH CC	3.0	1.87	$ 4,208	8	78	$ 26,746	78
627	10	SURG	THYROID, PARATHYROID AND THYROGLOSSAL PROCEDURES WITHOUT CC/MCC	2.0	1.34	$ 4,516	5	78	$ 18,849	78
628	10	SURG	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITH MCC	7.0	4.17	$ 4,014	16	78	$ 58,404	78
629	10	SURG	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITH CC	5.0	2.65	$ 3,574	16	78	$ 33,599	78
630	10	SURG	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITHOUT CC/MCC	3.0	1.60	$ 3,587	8	78	$ 26,774	78
637	10	MED	DIABETES WITH MCC	3.0	1.61	$ 3,611	12	78	$ 26,283	78
638	10	MED	DIABETES WITH CC	2.0	1.07	$ 3,594	10	78	$ 15,625	78
639	10	MED	DIABETES WITHOUT CC/MCC	1.0	0.78	$ 5,272	4	78	$ 11,954	78
640	10	MED	MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND ELECTROLYTES WITH MCC	3.0	1.58	$ 3,551	15	78	$ 27,403	78
641	10	MED	MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND ELECTROLYTES WITHOUT MCC	2.0	1.12	$ 3,779	11	78	$ 19,176	78
642	10	MED	INBORN AND OTHER DISORDERS OF METABOLISM	3.0	1.82	$ 4,076	11	78	$ 28,936	78
643	10	MED	ENDOCRINE DISORDERS WITH MCC	4.0	2.16	$ 3,641	8	78	$ 31,053	78
644	10	MED	ENDOCRINE DISORDERS WITH CC	2.0	1.21	$ 4,083	7	78	$ 16,723	78
645	10	MED	ENDOCRINE DISORDERS WITHOUT CC/MCC	2.0	1.00	$ 3,356	5	78	$ 16,860	78
650	11	SURG	KIDNEY TRANSPLANT WITH HEMODIALYSIS WITH MCC	7.0	4.90	$ 4,714	24	78	$ 85,189	78
651	11	SURG	KIDNEY TRANSPLANT WITH HEMODIALYSIS WITHOUT MCC	6.0	4.01	$ 4,499	20	78	$ 69,720	78
652	11	SURG	KIDNEY TRANSPLANT	8.0	3.45	$ 2,906	17	78	$ 61,923	78
653	11	SURG	MAJOR BLADDER PROCEDURES WITH MCC	14.0	5.92	$ 2,846	29	78	$ 107,306	78
654	11	SURG	MAJOR BLADDER PROCEDURES WITH CC	7.0	3.15	$ 3,027	16	78	$ 57,897	78
655	11	SURG	MAJOR BLADDER PROCEDURES WITHOUT CC/MCC	5.0	2.25	$ 3,037	12	78	$ 40,969	78
656	11	SURG	KIDNEY AND URETER PROCEDURES FOR NEOPLASM WITH MCC	8.0	3.56	$ 2,997	18	78	$ 64,674	78
657	11	SURG	KIDNEY AND URETER PROCEDURES FOR NEOPLASM WITH CC	2.0	2.10	$ 7,061	7	78	$ 26,556	78
658	11	SURG	KIDNEY AND URETER PROCEDURES FOR NEOPLASM WITHOUT CC/MCC	2.0	1.71	$ 5,759	4	78	$ 13,553	78
659	11	SURG	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITH MCC	8.0	2.89	$ 2,433	17	78	$ 63,051	78
660	11	SURG	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITH CC	2.0	1.54	$ 5,189	7	78	$ 17,539	78
661	11	SURG	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITHOUT CC/MCC	2.0	1.34	$ 4,497	4	78	$ 16,148	78
662	11	SURG	MINOR BLADDER PROCEDURES WITH MCC	7.0	3.18	$ 3,063	15	78	$ 54,466	78
663	11	SURG	MINOR BLADDER PROCEDURES WITH CC	3.0	1.73	$ 3,892	8	78	$ 28,812	78
664	11	SURG	MINOR BLADDER PROCEDURES WITHOUT CC/MCC	2.0	1.28	$ 4,320	7	78	$ 23,418	78
665	11	SURG	PROSTATECTOMY WITH MCC	7.0	3.30	$ 3,172	16	78	$ 57,626	78
666	11	SURG	PROSTATECTOMY WITH CC	4.0	1.89	$ 3,175	10	78	$ 33,476	78
667	11	SURG	PROSTATECTOMY WITHOUT CC/MCC	2.0	1.08	$ 3,641	6	78	$ 19,481	78
668	11	SURG	TRANSURETHRAL PROCEDURES WITH MCC	5.0	3.04	$ 4,097	13	78	$ 46,332	78
669	11	SURG	TRANSURETHRAL PROCEDURES WITH CC	2.0	1.53	$ 5,168	6	78	$ 16,345	78
670	11	SURG	TRANSURETHRAL PROCEDURES WITHOUT CC/MCC	2.0	1.06	$ 3,571	6	78	$ 18,806	78
671	11	SURG	URETHRAL PROCEDURES WITH CC/MCC	3.0	1.93	$ 4,334	9	78	$ 29,849	78
672	11	SURG	URETHRAL PROCEDURES WITHOUT CC/MCC	2.0	1.25	$ 4,199	6	78	$ 19,110	78
673	11	SURG	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH MCC	7.0	3.60	$ 3,467	21	78	$ 51,439	78
674	11	SURG	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH CC	6.0	2.78	$ 3,124	16	78	$ 37,564	78
675	11	SURG	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITHOUT CC/MCC	3.0	1.90	$ 4,269	9	78	$ 29,579	78
682	11	MED	RENAL FAILURE WITH MCC	3.0	1.66	$ 3,729	12	78	$ 25,942	78
683	11	MED	RENAL FAILURE WITH CC	3.0	1.21	$ 2,722	9	78	$ 17,956	78
684	11	MED	RENAL FAILURE WITHOUT CC/MCC	1.0	0.89	$ 5,978	5	78	$ 11,399	78
686	11	MED	KIDNEY AND URINARY TRACT NEOPLASMS WITH MCC	4.0	2.47	$ 4,153	11	78	$ 37,898	78
687	11	MED	KIDNEY AND URINARY TRACT NEOPLASMS WITH CC	3.0	1.38	$ 3,101	7	78	$ 24,405	78
688	11	MED	KIDNEY AND URINARY TRACT NEOPLASMS WITHOUT CC/MCC	1.0	0.90	$ 6,075	5	78	$ 16,188	78
689	11	MED	KIDNEY AND URINARY TRACT INFECTIONS WITH MCC	3.0	1.72	$ 3,853	12	78	$ 27,115	78
690	11	MED	KIDNEY AND URINARY TRACT INFECTIONS WITHOUT MCC	2.0	1.09	$ 3,678	6	78	$ 15,863	78
693	11	MED	URINARY STONES WITH MCC	3.0	1.76	$ 3,944	9	78	$ 30,236	78

Kansas 2023 DRG Weights and Limits

Effective for dates of service on or after January 1, 2023

DRG	MDC	Type	DRG Description	Transfer ALOS	DRG Relative Weight	DRG Daily Rate	Day Outlier Limit	Day Outlier Adj. %	Cost Outlier Limit	Cost Outlier Adj. %
671	11	SURG	URETHRAL PROCEDURES WITH CC/MCC	3.0	1.93	$ 4,334	9	78	$ 29,849	78
672	11	SURG	URETHRAL PROCEDURES WITHOUT CC/MCC	2.0	1.25	$ 4,199	6	78	$ 19,110	78
673	11	SURG	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH MCC	7.0	3.60	$ 3,467	21	78	$ 51,439	78
674	11	SURG	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH CC	6.0	2.78	$ 3,124	16	78	$ 37,564	78
675	11	SURG	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITHOUT CC/MCC	3.0	1.90	$ 4,269	9	78	$ 29,579	78
682	11	MED	RENAL FAILURE WITH MCC	3.0	1.66	$ 3,729	12	78	$ 25,942	78
683	11	MED	RENAL FAILURE WITH CC	3.0	1.21	$ 2,722	9	78	$ 17,956	78
684	11	MED	RENAL FAILURE WITHOUT CC/MCC	1.0	0.89	$ 5,978	5	78	$ 11,399	78
686	11	MED	KIDNEY AND URINARY TRACT NEOPLASMS WITH MCC	4.0	2.47	$ 4,153	11	78	$ 37,898	78
687	11	MED	KIDNEY AND URINARY TRACT NEOPLASMS WITH CC	3.0	1.38	$ 3,101	7	78	$ 24,405	78
688	11	MED	KIDNEY AND URINARY TRACT NEOPLASMS WITHOUT CC/MCC	1.0	0.90	$ 6,075	5	78	$ 16,188	78
689	11	MED	KIDNEY AND URINARY TRACT INFECTIONS WITH MCC	3.0	1.72	$ 3,853	12	78	$ 27,115	78
690	11	MED	KIDNEY AND URINARY TRACT INFECTIONS WITHOUT MCC	2.0	1.09	$ 3,678	6	78	$ 15,863	78
693	11	MED	URINARY STONES WITH MCC	3.0	1.76	$ 3,944	9	78	$ 30,236	78
694	11	MED	URINARY STONES WITHOUT MCC	1.0	0.92	$ 6,164	4	78	$ 11,516	78
695	11	MED	KIDNEY AND URINARY TRACT SIGNS AND SYMPTOMS WITH MCC	3.0	1.50	$ 3,360	8	78	$ 27,874	78
696	11	MED	KIDNEY AND URINARY TRACT SIGNS AND SYMPTOMS WITHOUT MCC	1.0	0.91	$ 6,129	5	78	$ 16,294	78
697	11	MED	URETHRAL STRICTURE	2.0	1.31	$ 4,426	6	78	$ 19,753	78
698	11	MED	OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITH MCC	4.0	2.07	$ 3,491	44	78	$ 36,554	78
699	11	MED	OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITH CC	3.0	1.65	$ 3,702	16	78	$ 26,004	78
700	11	MED	OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITHOUT CC/MCC	2.0	0.98	$ 3,307	5	78	$ 17,387	78
707	12	SURG	MAJOR MALE PELVIC PROCEDURES WITH CC/MCC	4.0	1.70	$ 2,858	11	78	$ 37,696	78
708	12	SURG	MAJOR MALE PELVIC PROCEDURES WITHOUT CC/MCC	1.0	1.32	$ 8,867	2	78	$ 10,884	78
709	12	SURG	PENIS PROCEDURES WITH CC/MCC	5.0	2.04	$ 2,754	13	78	$ 45,124	78
710	12	SURG	PENIS PROCEDURES WITHOUT CC/MCC	3.0	1.41	$ 3,175	9	78	$ 30,709	78
711	12	SURG	TESTES PROCEDURES WITH CC/MCC	5.0	1.88	$ 2,535	12	78	$ 44,033	78
712	12	SURG	TESTES PROCEDURES WITHOUT CC/MCC	2.0	0.94	$ 3,152	7	78	$ 22,714	78
713	12	SURG	TRANSURETHRAL PROSTATECTOMY WITH CC/MCC	4.0	1.32	$ 2,220	10	78	$ 33,344	78
714	12	SURG	TRANSURETHRAL PROSTATECTOMY WITHOUT CC/MCC	2.0	0.82	$ 2,762	6	78	$ 18,034	78
715	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY WITH CC/MCC	5.0	1.79	$ 2,404	12	78	$ 42,907	78
716	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY WITHOUT CC/MCC	3.0	1.13	$ 2,529	8	78	$ 25,522	78
717	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES EXCEPT MALIGNANCY WITH CC/MCC	4.0	1.59	$ 2,677	10	78	$ 34,322	78
718	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES EXCEPT MALIGNANCY WITHOUT CC/MCC	2.0	1.09	$ 3,671	7	78	$ 22,126	78
722	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITH MCC	4.0	1.90	$ 3,206	10	78	$ 34,437	78
723	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITH CC	2.0	1.21	$ 4,088	7	78	$ 22,427	78
724	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	1.0	0.72	$ 4,853	5	78	$ 15,516	78
725	12	MED	BENIGN PROSTATIC HYPERTROPHY WITH MCC	3.0	1.43	$ 3,209	8	78	$ 27,133	78
726	12	MED	BENIGN PROSTATIC HYPERTROPHY WITHOUT MCC	1.0	0.83	$ 5,576	5	78	$ 15,273	78
727	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM WITH MCC	3.0	1.58	$ 3,547	8	78	$ 28,215	78
728	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM WITHOUT MCC	2.0	0.90	$ 3,017	5	78	$ 16,946	78
729	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES WITH CC/MCC	2.0	1.12	$ 3,772	7	78	$ 22,168	78
730	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES WITHOUT CC/MCC	1.0	0.63	$ 4,260	4	78	$ 13,923	78
734	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY AND RADICAL VULVECTOMY WITH CC/MCC	6.0	2.40	$ 2,693	14	78	$ 50,436	78
735	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY AND RADICAL VULVECTOMY WITHOUT CC/MCC	2.0	1.52	$ 5,134	7	78	$ 23,568	78
736	13	SURG	UTERINE AND ADNEXA PROCEDURES FOR OVARIAN OR ADNEXAL MALIGNANCY WITH MCC	10.0	1.95	$ 1,314	21	78	$ 76,906	78
737	13	SURG	UTERINE AND ADNEXA PROCEDURES FOR OVARIAN OR ADNEXAL MALIGNANCY WITH CC	3.0	1.86	$ 4,171	6	78	$ 15,998	78
738	13	SURG	UTERINE AND ADNEXA PROCEDURES FOR OVARIAN OR ADNEXAL MALIGNANCY WITHOUT CC/MCC	3.0	1.77	$ 3,972	8	78	$ 26,349	78
739	13	SURG	UTERINE AND ADNEXA PROCEDURES FOR NON-OVARIAN AND NON-ADNEXAL MALIGNANCY WITH MCC	8.0	4.12	$ 3,472	18	78	$ 64,630	78
740	13	SURG	UTERINE AND ADNEXA PROCEDURES FOR NON-OVARIAN AND NON-ADNEXAL MALIGNANCY WITH CC	3.0	1.62	$ 3,628	6	78	$ 15,108	78
741	13	SURG	UTERINE AND ADNEXA PROCEDURES FOR NON-OVARIAN AND NON-ADNEXAL MALIGNANCY WITHOUT CC/MCC	2.0	1.38	$ 4,648	7	78	$ 23,441	78
742	13	SURG	UTERINE AND ADNEXA PROCEDURES FOR NON-MALIGNANCY WITH CC/MCC	2.0	1.72	$ 5,781	6	78	$ 20,111	78
743	13	SURG	UTERINE AND ADNEXA PROCEDURES FOR NON-MALIGNANCY WITHOUT CC/MCC	2.0	1.41	$ 4,758	4	78	$ 17,946	78
744	13	SURG	D&C, CONIZATION, LAPAROSCOPY AND TUBAL INTERRUPTION WITH CC/MCC	3.0	1.94	$ 4,347	9	78	$ 31,375	78
745	13	SURG	D&C, CONIZATION, LAPAROSCOPY AND TUBAL INTERRUPTION WITHOUT CC/MCC	2.0	1.26	$ 4,249	6	78	$ 20,230	78
746	13	SURG	VAGINA, CERVIX AND VULVA PROCEDURES WITH CC/MCC	3.0	1.74	$ 3,902	8	78	$ 15,780	78
747	13	SURG	VAGINA, CERVIX AND VULVA PROCEDURES WITHOUT CC/MCC	2.0	1.01	$ 3,411	6	78	$ 17,994	78
748	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	2.0	1.45	$ 4,894	7	78	$ 22,682	78
749	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES WITH CC/MCC	4.0	2.93	$ 4,928	8	78	$ 31,329	78
750	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES WITHOUT CC/MCC	3.0	1.58	$ 3,544	7	78	$ 24,598	78
754	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH MCC	5.0	1.90	$ 2,561	11	78	$ 40,336	78
755	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	3.0	1.18	$ 2,639	7	78	$ 24,091	78
756	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	1.0	0.96	$ 6,439	5	78	$ 14,745	78
757	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM WITH MCC	3.0	1.59	$ 3,563	9	78	$ 30,686	78
758	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM WITH CC	2.0	1.00	$ 3,357	4	78	$ 11,433	78
759	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	2.0	0.73	$ 2,443	4	78	$ 8,436	78
760	13	MED	MENSTRUAL AND OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS WITH CC/MCC	2.0	0.96	$ 3,225	3	78	$ 7,800	78
761	13	MED	MENSTRUAL AND OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS WITHOUT CC/MCC	1.0	0.62	$ 4,142	4	78	$ 12,412	78
768	14	SURG	VAGINAL DELIVERY WITH O.R. PROCEDURES EXCEPT STERILIZATION AND/OR D&C	2.0	1.00	$ 3,381	6	78	$ 12,760	78
769	14	SURG	POSTPARTUM AND POST ABORTION DIAGNOSES WITH O.R. PROCEDURES	2.0	1.40	$ 4,726	9	78	$ 21,927	78
770	14	SURG	ABORTION WITH D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.0	0.77	$ 5,153	2	78	$ 9,276	78
776	14	MED	POSTPARTUM AND POST ABORTION DIAGNOSES WITHOUT O.R. PROCEDURES	2.0	0.81	$ 2,729	5	78	$ 11,758	78
779	14	MED	ABORTION WITHOUT D&C	1.0	1.30	$ 8,721	2	78	$ 12,652	78
783	14	SURG	CESAREAN SECTION WITH STERILIZATION WITH MCC	3.0	1.68	$ 3,781	15	78	$ 25,379	78
784	14	SURG	CESAREAN SECTION WITH STERILIZATION WITH CC	2.0	1.38	$ 4,642	11	78	$ 18,367	78
785	14	SURG	CESAREAN SECTION WITH STERILIZATION WITHOUT CC/MCC	2.0	1.24	$ 4,160	5	78	$ 14,558	78
786	14	SURG	CESAREAN SECTION WITHOUT STERILIZATION WITH MCC	3.0	1.47	$ 3,307	15	78	$ 21,271	78
787	14	SURG	CESAREAN SECTION WITHOUT STERILIZATION WITH CC	3.0	1.25	$ 2,804	8	78	$ 15,265	78
788	14	SURG	CESAREAN SECTION WITHOUT STERILIZATION WITHOUT CC/MCC	2.0	1.15	$ 3,878	5	78	$ 14,019	78
789	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.0	0.33	$ 2,251	2	78	$ 4,774	78
793	15	MED	FULL TERM NEONATE WITH MAJOR PROBLEMS	3.0	1.22	$ 2,732	18	78	$ 25,645	78
794	15	MED	NEONATE WITH OTHER SIGNIFICANT PROBLEMS	2.0	0.42	$ 1,425	7	78	$ 8,411	78
795	15	MED	NORMAL NEWBORN	1.0	0.25	$ 1,711	3	78	$ 3,775	78
796	14	SURG	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH MCC	2.0	1.42	$ 4,783	8	78	$ 27,695	78
797	14	SURG	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH CC	2.0	1.35	$ 4,555	3	78	$ 15,568	78
798	14	SURG	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITHOUT CC/MCC	1.0	1.29	$ 8,676	4	78	$ 14,811	78
799	16	SURG	SPLENECTOMY WITH MCC	9.0	4.09	$ 3,064	20	78	$ 73,786	78
800	16	SURG	SPLENECTOMY WITH CC	3.0	2.35	$ 5,274	8	78	$ 24,222	78
801	16	SURG	SPLENECTOMY WITHOUT CC/MCC	2.0	1.34	$ 4,510	3	78	$ 14,837	78

Kansas 2023 DRG Weights and Limits

Effective for dates of service on or after January 1, 2023

DRG	MDC	Type	DRG Description	Transfer ALOS	DRG Relative Weight	DRG Daily Rate	Day Outlier Limit	Day Outlier Adj. %	Cost Outlier Limit	Cost Outlier Adj. %
802	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITH MCC	5.0	2.95	$ 3,976	13	78	$ 46,134	78
803	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITH CC	3.0	1.50	$ 3,368	8	78	$ 26,336	78
804	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITHOUT CC/MCC	2.0	1.09	$ 3,658	6	78	$ 18,611	78
805	14	MED	VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH MCC	2.0	0.97	$ 3,270	9	78	$ 12,917	78
806	14	MED	VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH CC	2.0	0.91	$ 3,069	7	78	$ 11,742	78
807	14	MED	VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITHOUT CC/MCC	1.0	0.81	$ 5,453	4	78	$ 9,839	78
808	16	MED	MAJOR HEMATOLOGICAL AND IMMUNOLOGICAL DIAGNOSES EXCEPT SICKLE CELL CRISIS AND COAGULATION DISORDERS	6.0	2.32	$ 2,603	14	78	$ 48,646	78
809	16	MED	MAJOR HEMATOLOGICAL AND IMMUNOLOGICAL DIAGNOSES EXCEPT SICKLE CELL CRISIS AND COAGULATION DISORDERS	3.0	1.28	$ 2,876	8	78	$ 19,156	78
810	16	MED	MAJOR HEMATOLOGICAL AND IMMUNOLOGICAL DIAGNOSES EXCEPT SICKLE CELL CRISIS AND COAGULATION DISORDERS	2.0	1.02	$ 3,436	6	78	$ 21,562	78
811	16	MED	RED BLOOD CELL DISORDERS WITH MCC	3.0	1.53	$ 3,431	9	78	$ 22,704	78
812	16	MED	RED BLOOD CELL DISORDERS WITHOUT MCC	2.0	1.04	$ 3,516	7	78	$ 14,393	78
813	16	MED	COAGULATION DISORDERS	2.0	0.89	$ 3,013	4	78	$ 12,711	78
814	16	MED	RETICULOENDOTHELIAL AND IMMUNITY DISORDERS WITH MCC	4.0	2.01	$ 3,379	11	78	$ 38,347	78
815	16	MED	RETICULOENDOTHELIAL AND IMMUNITY DISORDERS WITH CC	2.0	1.05	$ 3,549	5	78	$ 15,550	78
816	16	MED	RETICULOENDOTHELIAL AND IMMUNITY DISORDERS WITHOUT CC/MCC	2.0	0.70	$ 2,362	5	78	$ 17,106	78
817	14	SURG	OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITH MCC	3.0	1.63	$ 3,663	12	78	$ 48,591	78
818	14	SURG	OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITH CC	2.0	1.55	$ 5,233	5	78	$ 16,582	78
819	14	SURG	OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITHOUT CC/MCC	2.0	1.48	$ 4,984	7	78	$ 18,032	78
820	17	SURG	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURES WITH MCC	8.0	4.46	$ 3,758	17	78	$ 45,928	78
821	17	SURG	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURES WITH CC	6.0	1.69	$ 1,897	14	78	$ 48,294	78
822	17	SURG	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURES WITHOUT CC/MCC	1.0	0.98	$ 6,611	2	78	$ 9,354	78
823	17	SURG	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH OTHER PROCEDURES WITH MCC	11.0	3.53	$ 2,162	25	78	$ 90,936	78
824	17	SURG	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH OTHER PROCEDURES WITH CC	6.0	1.85	$ 2,082	13	78	$ 46,782	78
825	17	SURG	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH OTHER PROCEDURES WITHOUT CC/MCC	3.0	1.10	$ 2,468	8	78	$ 28,496	78
826	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH MAJOR O.R. PROCEDURES WITH MCC	13.0	3.96	$ 2,050	27	78	$ 99,835	78
827	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH MAJOR O.R. PROCEDURES WITH CC	6.0	1.96	$ 2,202	14	78	$ 48,649	78
828	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH MAJOR O.R. PROCEDURES WITHOUT C	3.0	1.31	$ 2,948	9	78	$ 30,889	78
829	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH OTHER PROCEDURES WITH CC/MCC	8.0	2.52	$ 2,119	19	78	$ 69,097	78
830	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH OTHER PROCEDURES WITHOUT CC/MCC	3.0	1.16	$ 2,610	9	78	$ 31,512	78
831	14	MED	OTHER ANTEPARTUM DIAGNOSES WITHOUT O.R. PROCEDURES WITH MCC	3.0	1.19	$ 2,681	12	78	$ 18,934	78
832	14	MED	OTHER ANTEPARTUM DIAGNOSES WITHOUT O.R. PROCEDURES WITH CC	2.0	0.80	$ 2,686	8	78	$ 11,829	78
833	14	MED	OTHER ANTEPARTUM DIAGNOSES WITHOUT O.R. PROCEDURES WITHOUT CC/MCC	1.0	0.68	$ 4,566	7	78	$ 9,957	78
834	17	MED	ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITH MCC	17.0	8.62	$ 3,414	52	78	$ 124,124	78
835	17	MED	ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITH CC	4.0	2.72	$ 4,576	11	78	$ 38,868	78
836	17	MED	ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITHOUT CC/MCC	2.0	1.51	$ 5,081	6	78	$ 21,320	78
837	17	MED	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS OR WITH HIGH DOSE CHEMOTHERAPY AGENT WITH MC	13.0	7.33	$ 3,797	28	78	$ 102,093	78
838	17	MED	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITH CC OR HIGH DOSE CHEMOTHERAPY AGENT	3.0	2.91	$ 6,524	11	78	$ 22,244	78
839	17	MED	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITHOUT CC/MCC	3.0	1.01	$ 2,269	6	78	$ 11,187	78
840	17	MED	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH MCC	6.0	4.14	$ 4,648	15	78	$ 53,515	78
841	17	MED	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH CC	3.0	2.09	$ 4,681	9	78	$ 29,462	78
842	17	MED	LYMPHOMA AND NON-ACUTE LEUKEMIA WITHOUT CC/MCC	2.0	1.41	$ 4,750	4	78	$ 12,074	78
843	17	MED	OTHER MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASTIC DIAGNOSES WITH MCC	3.0	2.45	$ 5,506	9	78	$ 31,315	78
844	17	MED	OTHER MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASTIC DIAGNOSES WITH CC	3.0	1.32	$ 2,971	6	78	$ 13,107	78
845	17	MED	OTHER MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASTIC DIAGNOSES WITHOUT CC/MCC	1.0	1.09	$ 7,351	5	78	$ 15,298	78
846	17	MED	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITH MCC	5.0	3.44	$ 4,629	12	78	$ 42,481	78
847	17	MED	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITH CC	3.0	1.70	$ 3,824	11	78	$ 29,547	78
848	17	MED	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITHOUT CC/MCC	1.0	1.33	$ 8,940	5	78	$ 16,328	78
849	17	MED	RADIOTHERAPY	3.0	3.21	$ 7,198	9	78	$ 30,451	78
853	18	SURG	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC	10.0	5.92	$ 3,989	35	78	$ 91,848	78
854	18	SURG	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH CC	5.0	2.62	$ 3,534	16	78	$ 36,514	78
855	18	SURG	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITHOUT CC/MCC	3.0	1.80	$ 4,050	6	78	$ 15,995	78
856	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITH MCC	10.0	4.25	$ 2,865	28	78	$ 60,737	78
857	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITH CC	3.0	2.50	$ 5,602	9	78	$ 24,340	78
858	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITHOUT CC/MCC	4.0	1.61	$ 2,717	10	78	$ 33,442	78
862	18	MED	POSTOPERATIVE AND POST-TRAUMATIC INFECTIONS WITH MCC	5.0	2.41	$ 3,248	20	78	$ 40,193	78
863	18	MED	POSTOPERATIVE AND POST-TRAUMATIC INFECTIONS WITHOUT MCC	4.0	1.57	$ 2,640	9	78	$ 21,045	78
864	18	MED	FEVER AND INFLAMMATORY CONDITIONS	1.0	0.69	$ 4,634	3	78	$ 8,811	78
865	18	MED	VIRAL ILLNESS WITH MCC	3.0	1.78	$ 4,000	8	78	$ 28,864	78
866	18	MED	VIRAL ILLNESS WITHOUT MCC	1.0	0.79	$ 5,306	5	78	$ 11,957	78
867	18	MED	OTHER INFECTIOUS AND PARASITIC DISEASES DIAGNOSES WITH MCC	7.0	2.70	$ 2,595	16	78	$ 56,635	78
868	18	MED	OTHER INFECTIOUS AND PARASITIC DISEASES DIAGNOSES WITH CC	4.0	1.29	$ 2,164	6	78	$ 14,304	78
869	18	MED	OTHER INFECTIOUS AND PARASITIC DISEASES DIAGNOSES WITHOUT CC/MCC	1.0	0.88	$ 5,915	5	78	$ 14,923	78
870	18	MED	SEPTICEMIA OR SEVERE SEPSIS WITH MV >96 HOURS	13.0	7.64	$ 3,959	36	78	$ 102,241	78
871	18	MED	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	4.0	2.27	$ 3,816	16	78	$ 35,312	78
872	18	MED	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	3.0	1.26	$ 2,825	8	78	$ 18,274	78
876	19	SURG	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	4.0	1.04	$ 1,755	7	78	$ 8,736	78
880	19	MED	ACUTE ADJUSTMENT REACTION AND PSYCHOSOCIAL DYSFUNCTION	2.0	0.74	$ 2,475	5	78	$ 10,611	78
881	19	MED	DEPRESSIVE NEUROSES	3.0	0.64	$ 1,443	8	78	$ 7,550	78
882	19	MED	NEUROSES EXCEPT DEPRESSIVE	3.0	0.57	$ 1,288	7	78	$ 7,496	78
883	19	MED	DISORDERS OF PERSONALITY AND IMPULSE CONTROL	3.0	0.78	$ 1,745	7	78	$ 12,235	78
884	19	MED	ORGANIC DISTURBANCES AND INTELLECTUAL DISABILITY	3.0	1.38	$ 3,103	32	78	$ 25,519	78
885	19	MED	PSYCHOSES	4.0	0.79	$ 1,337	17	78	$ 12,143	78
886	19	MED	BEHAVIORAL AND DEVELOPMENTAL DISORDERS	3.0	0.48	$ 1,087	6	78	$ 5,439	78
887	19	MED	OTHER MENTAL DISORDER DIAGNOSES	1.0	0.70	$ 4,690	4	78	$ 13,380	78
894	20	MED	ALCOHOL, DRUG ABUSE OR DEPENDENCE, LEFT AMA	1.0	0.77	$ 5,161	7	78	$ 12,501	78
895	20	MED	ALCOHOL, DRUG ABUSE OR DEPENDENCE WITH REHABILITATION THERAPY	4.0	0.99	$ 1,661	10	78	$ 11,018	78
896	20	MED	ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITH MCC	3.0	1.63	$ 3,670	13	78	$ 25,165	78
897	20	MED	ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITHOUT MCC	3.0	1.09	$ 2,442	9	78	$ 16,234	78
901	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES WITH MCC	10.0	5.12	$ 3,448	23	78	$ 82,611	78
902	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES WITH CC	5.0	2.38	$ 3,204	13	78	$ 32,008	78
903	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES WITHOUT CC/MCC	2.0	1.36	$ 4,586	7	78	$ 21,930	78
904	21	SURG	SKIN GRAFTS FOR INJURIES WITH CC/MCC	8.0	4.47	$ 3,763	17	78	$ 62,530	78
905	21	SURG	SKIN GRAFTS FOR INJURIES WITHOUT CC/MCC	3.0	1.98	$ 4,443	8	78	$ 26,997	78
906	21	SURG	HAND PROCEDURES FOR INJURIES	3.0	2.16	$ 4,857	9	78	$ 29,334	78
907	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES WITH MCC	7.0	4.74	$ 4,556	19	78	$ 100,015	78
908	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES WITH CC	4.0	2.45	$ 4,122	12	78	$ 30,929	78
909	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES WITHOUT CC/MCC	3.0	1.64	$ 3,692	8	78	$ 25,698	78
913	21	MED	TRAUMATIC INJURY WITH MCC	1.0	0.83	$ 5,596	2	78	$ 5,251	78

Kansas 2023 DRG Weights and Limits

Effective for dates of service on or after January 1, 2023

DRG	MDC	Type	DRG Description	Transfer ALOS	DRG Relative Weight	DRG Daily Rate	Day Outlier Limit	Day Outlier Adj. %	Cost Outlier Limit	Cost Outlier Adj. %
933	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITHOUT SKIN GRAFT	8.0	1.11	$ 937	17	78	$ 62,821	78
934	22	MED	FULL THICKNESS BURN WITHOUT SKIN GRAFT OR INHALATION INJURY	2.0	0.96	$ 3,216	4	78	$ 10,676	78
935	22	MED	NON-EXTENSIVE BURNS	3.0	0.95	$ 2,135	14	78	$ 46,318	78
939	23	SURG	O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES WITH MCC	8.0	3.89	$ 3,274	17	78	$ 62,087	78
940	23	SURG	O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES WITH CC	4.0	2.56	$ 4,310	7	78	$ 23,685	78
941	23	SURG	O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES WITHOUT CC/MCC	3.0	2.22	$ 4,976	8	78	$ 27,467	78
945	23	MED	REHABILITATION WITH CC/MCC	10.0	2.39	$ 1,612	25	78	$ 31,992	78
946	23	MED	REHABILITATION WITHOUT CC/MCC	8.0	1.71	$ 1,443	19	78	$ 22,382	78
947	23	MED	SIGNS AND SYMPTOMS WITH MCC	4.0	2.11	$ 3,546	12	78	$ 32,785	78
948	23	MED	SIGNS AND SYMPTOMS WITHOUT MCC	3.0	1.62	$ 3,645	11	78	$ 30,446	78
949	23	MED	AFTERCARE WITH CC/MCC	12.0	3.50	$ 1,963	30	78	$ 48,758	78
950	23	MED	AFTERCARE WITHOUT CC/MCC	6.0	1.34	$ 1,499	13	78	$ 23,711	78
951	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	1.0	0.78	$ 5,232	6	78	$ 10,678	78
955	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	14.0	8.11	$ 3,899	30	78	$ 112,333	78
956	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	11.0	7.44	$ 4,557	32	78	$ 104,442	78
957	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH MCC	14.0	8.70	$ 4,184	34	78	$ 126,231	78
958	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH CC	6.0	5.42	$ 6,084	14	78	$ 71,066	78
959	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITHOUT CC/MCC	6.0	3.53	$ 3,958	15	78	$ 52,287	78
963	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA WITH MCC	7.0	3.82	$ 3,674	26	78	$ 51,215	78
964	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA WITH CC	3.0	2.09	$ 4,684	8	78	$ 29,018	78
965	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA WITHOUT CC/MCC	2.0	1.28	$ 4,298	4	78	$ 13,953	78
969	25	SURG	HIV WITH EXTENSIVE O.R. PROCEDURES WITH MCC	15.0	6.74	$ 3,028	33	78	$ 120,301	78
970	25	SURG	HIV WITH EXTENSIVE O.R. PROCEDURES WITHOUT MCC	6.0	3.44	$ 3,866	14	78	$ 50,045	78
974	25	MED	HIV WITH MAJOR RELATED CONDITION WITH MCC	7.0	3.32	$ 3,191	23	78	$ 53,544	78
975	25	MED	HIV WITH MAJOR RELATED CONDITION WITH CC	3.0	1.58	$ 3,548	8	78	$ 26,155	78
976	25	MED	HIV WITH MAJOR RELATED CONDITION WITHOUT CC/MCC	2.0	1.17	$ 3,942	6	78	$ 18,342	78
977	25	MED	HIV WITH OR WITHOUT OTHER RELATED CONDITION	3.0	1.63	$ 3,665	7	78	$ 25,511	78
981	99	SURG	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC	9.0	5.55	$ 4,151	32	78	$ 77,682	78
982	99	SURG	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC	4.0	2.44	$ 4,110	18	78	$ 34,974	78
983	99	SURG	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	2.0	1.91	$ 6,426	7	78	$ 24,401	78
987	99	SURG	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC	9.0	3.86	$ 2,892	36	78	$ 56,023	78
988	99	SURG	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC	4.0	2.25	$ 3,796	14	78	$ 32,587	78
989	99	SURG	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	3.0	1.39	$ 3,130	5	78	$ 14,369	78
993	15	MED	BIRTH WEIGHT < 1000 GRAMS	43.0	18.83	$ 2,950	115	78	$ 274,089	78
994	15	MED	BIRTH WEIGHT 1000 - 1499 GRAMS	35.0	12.05	$ 2,318	82	78	$ 166,511	78
995	15	MED	BIRTH WEIGHT 1500 - 2000 GRAMS	15.0	4.99	$ 2,240	45	78	$ 80,045	78
996	15	MED	BIRTH WEIGHT > 2000 GRAMS, W RESPIRATORY DISTREES SYNDROME	9.0	3.62	$ 2,711	36	78	$ 62,716	78
997	15	MED	BIRTH WEIGHT > 2000 GRAMS, PREMATURE W MAJOR PROBLEM	7.0	2.76	$ 2,659	34	78	$ 53,398	78

State of Kansas - CY23 DRG Rebase and Recalibration
Hospital Base Rates

Notes: GME factors are reported as the decimal equivalent of the percent increase.
For example, a GME factor of 0.15 represents a 15% increase, and it is applied by multiplying the Base Rate w/o GME by 1.15.

Peer Group	Medicare ID	KMMS ID	NPI	Hospital Name	CCR	GME Factor	Base Rates w/o GME
Peer Group 1	170208		1316536253	AdventHealth Overland Park	0.2932		$ 3,847
Peer Group 1	170104		1023171634	AdventHealth Shawnee Mission Medical Center	0.1966	0.0040	$ 3,847
Peer Group 1	170200		1023334950	Ascension Via Christi Hospital St. Teresa	0.2704		$ 3,847
Peer Group 1	170122		1154314789	Ascension Via Christi Hospital Wichita	0.2737	0.3295	$ 3,847
Peer Group 1	173028		1083604789	Ascension Via Christi Rehabilitation Hospital	0.4670		$ 3,847
Peer Group 1	173300		1154400232	Children's Mercy Hospital Kansas	0.3362		$ 3,847
Peer Group 1	174020		1023403128	Cottonwood Springs	0.3069		$ 3,847
Peer Group 1	170194		1871698472	Doctors Hospital	0.2670		$ 3,847
Peer Group 1	170186		1114928108	Kansas Heart Hospital	0.3574		$ 3,847
Peer Group 1	173025		1982678827	Kansas Rehabilitation Hospital	0.5042		$ 3,847
Peer Group 1	170196		1417950650	Kansas Spine & Specialty Hospital	0.2240		$ 3,847
Peer Group 1	170183		1306827878	Kansas Surgery & Recovery Center	0.3525		$ 3,847
Peer Group 1	170188		1457364408	KC Orthopaedic Hospital LLC	0.2012		$ 3,847
Peer Group 1	172004		1114581550	KPC Promise Hospital of Overland Park	0.2012		$ 3,847
Peer Group 1			1629538483	KVC Hospitals Inc.	0.2932		$ 3,847
Peer Group 1			1851403240	KVC Prairie Ridge Psychiatric Hospital	0.2932		$ 3,847
Peer Group 1	173033		1285267146	Meadowbrook Rehabilitation Hospital	0.3180		$ 3,847
Peer Group 1	170182		1255378337	Menorah Medical Center	0.2121	0.0612	$ 3,847
Peer Group 1	173026		1609840545	MidAmerica Rehabilitation Hospital	0.5726		$ 3,847
Peer Group 1	170199		1619069275	Minimally Invasive Surgery Hospital	0.2012		$ 3,847
Peer Group 1	170049		1144266115	Olathe Medical Center	0.3135		$ 3,847
Peer Group 1	170176		1578500484	Overland Park Regional Medical Center	0.1204	0.0249	$ 3,847
Peer Group 1	170146		1528301900	Providence Medical Center	0.3044		$ 3,847
Peer Group 1	173032		1821404237	Rehabilitation Hospital of Overland Park	0.2934		$ 3,847
Peer Group 1	170204		1518454842	Rock Regional Hospital	0.2012		$ 3,847
Peer Group 1	170185		1154303337	Saint Luke's Community Hospital of KC Legends	0.4131		$ 3,847
Peer Group 1	170185		1154303337	Saint Luke's Community Hospital of Leawood	0.4131		$ 3,847
Peer Group 1	170185		1154303337	Saint Luke's Community Hospital of Roeland Park	0.4131		$ 3,847
Peer Group 1	170185		1154303337	Saint Luke's South Hospital	0.4131		$ 3,847
Peer Group 1	172005		1841290764	Select Specialty Hospital - Kansas City	0.2441		$ 3,847
Peer Group 1	172007		1124028550	Select Specialty Hospital - Wichita	0.2066		$ 3,847
Peer Group 1	170086		1194782409	Stormont-Vail Regional Health Center	0.2783	0.0003	$ 3,847
Peer Group 1	170016		1912423260	University Health Systems St. Francis Campus	0.3032	0.0104	$ 3,847
Peer Group 1	170123		1447299649	Wesley Medical Center	0.1365	0.2869	$ 3,847
				Average Peer Group 1	0.2932		$ 3,847

Kansas 2023 Hospital Rates

Effective January 1, 2023

Peer Group	Medicare ID	KMMS ID	NPI	Hospital Name	CCR	GME Factor	Base Rates w/o GME
Peer Group 2	170014		1972063758	Adventhealth Ottawa	0.7907		$ 3,585
Peer Group 2	170142		1760482517	Ascension Via Christi Hospital Manhattan Inc.	0.3802		$ 3,585
Peer Group 2	170006		1831125087	Ascension Via Christi Hospital Pittsburg	0.4727		$ 3,585
Peer Group 2	171354		1457351389	Community Healthcare System	1.0000		$ 3,585
Peer Group 2	170074		1932204385	Geary Community Hospital	0.5177		$ 3,585
Peer Group 2	170013		1881697043	Hays Medical Center	0.2971		$ 3,585
Peer Group 2	171319		1902805716	Holton Community Hospital	1.0000		$ 3,585
Peer Group 2	170020		1922039320	Hutchinson Regional Medical Center	0.3528		$ 3,585
Peer Group 2	17T020		1396776787	Hutchinson Regional Medical Center	0.3528		$ 3,585
Peer Group 2	17S020		1033141148	Hutchinson Regional Medical Center	0.3528		$ 3,585
Peer Group 2	171314		1235167750	Jefferson County Memorial Hospital	1.0000		$ 3,585
Peer Group 2	170197		1255380127	Kansas Medical Center	0.4314		$ 3,585
Peer Group 2	170137		1508883422	Lawrence Memorial Hospital	0.3088		$ 3,585
Peer Group 2	170190		1629053228	Manhattan Surgical Hospital	0.2797		$ 3,585
Peer Group 2	170109		1700824398	Miami County Medical Center Inc.	0.5187		$ 3,585
Peer Group 2	170103		1245238435	Newton Medical Center	0.5006		$ 3,585
Peer Group 2	170103		1386642304	Newton Medical Center	0.5006		$ 3,585
Peer Group 2	170103		1861442204	Newton Medical Center	0.5006		$ 3,585
Peer Group 2	174016		1295706729	Prairie View Inc.	1.0000		$ 3,585
Peer Group 2	170009		1568705267	Saint John Hospital	0.3010		$ 3,585
Peer Group 2	170012		1689635138	Salina Regional Health Center	0.3341	0.1055	$ 3,585
Peer Group 2	170187		1164420329	Salina Surgical Hospital	0.4019		$ 3,585
Peer Group 2	170198		1932117975	Summit Surgical	0.4853		$ 3,585
Peer Group 2	171329		1215094438	Sumner County Hospital District #1	1.0000		$ 3,585
Peer Group 2	170017		1700994977	Susan B. Allen Memorial Hospital	0.5562		$ 3,585
Peer Group 2	171337		1588657928	Wamego Hospital Association	1.0000		$ 3,585
				Average Peer Group 2	0.5989		$ 3,585

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Peer Group	Medicare ID	KMMS ID	NPI	Hospital Name	CCR	GME Factor	Base Rates w/o GME
Peer Group 3	171373		1639185457	Allen County Regional Hospital	0.9989		$ 3,223
Peer Group 3	171316		1316911878	Anderson County Hospital	1.0000		$ 3,223
Peer Group 3	171346		1467427674	Anthony Medical Center	1.0000		$ 3,223
Peer Group 3	171304		1265529614	Ashland Health Center	1.0000		$ 3,223
Peer Group 3	171382		1932151487	Atchison Hospital Association	0.6614		$ 3,223
Peer Group 3	170110		1811432594	Bob Wilson Memorial Grant County Hospital	1.0000		$ 3,223
Peer Group 3	170175		1689317190	Centura St. Catherine	0.2698		$ 3,223
Peer Group 3	171362		1386678431	Citizens Medical Center	0.7288		$ 3,223
Peer Group 3	171333		1114964111	Clara Barton Hospital	1.0000		$ 3,223
Peer Group 3	171371		1265485817	Clay County Medical Center	1.0000		$ 3,223
Peer Group 3	171349		1558364760	Cloud County Health Center	1.0000		$ 3,223
Peer Group 3	171385		1376548370	Coffey County Hospital	1.0000		$ 3,223
Peer Group 3	170145		1285600379	Coffeyville Regional Medical Center	0.5240		$ 3,223
Peer Group 3	171312		1003845652	Comanche County Hospital	1.0000		$ 3,223
Peer Group 3	171363		1902872997	Community Memorial Healthcare Inc.	0.9299		$ 3,223
Peer Group 3	171352		1619973468	Decatur County Hospital	1.0000		$ 3,223
Peer Group 3	171317		1851403869	Edwards County Medical Center	1.0000		$ 3,223
Peer Group 3	171327		1083614028	Ellsworth County Medical Center	1.0000		$ 3,223
Peer Group 3	171374		1285634006	Fredonia Regional Hospital	1.0000		$ 3,223
Peer Group 3	171370		1598839045	Goodland Regional Medical Center	1.0000		$ 3,223
Peer Group 3	171367		1932192465	Gove County Medical Center	1.0000		$ 3,223
Peer Group 3	171325		1588673297	Graham County Hospital	1.0000		$ 3,223
Peer Group 3	171310		1992736458	Great Plains - Cheyenne County Hospital	1.0000		$ 3,223
Peer Group 3	171301		1578676409	Great Plains - Ellinwood District Hospital	1.0000		$ 3,223
Peer Group 3	171328		1902914823	Great Plains - Ottawa County Health Center	1.0000		$ 3,223
Peer Group 3	171361		1396765145	Great Plains - Republic County Hospital	1.0000		$ 3,223
Peer Group 3	171338		1306875745	Great Plains - Sabetha Community Hospital	1.0000		$ 3,223
Peer Group 3	171377		1700985116	Great Plains - Smith County Memorial Hospital	1.0000		$ 3,223
Peer Group 3	171359		1285742536	Greeley County Health Services	1.0000		$ 3,223
Peer Group 3	171339		1629044961	Greenwood County Hospital	0.9628		$ 3,223
Peer Group 3	171300		1295778892	Grisell Memorial Hospital District #1	1.0000		$ 3,223
Peer Group 3	171322		1932136074	Hamilton County Hospital	1.0000		$ 3,223
Peer Group 3	171365		1285635425	Hanover Hospital	1.0000		$ 3,223
Peer Group 3	171340		1922677012	Herington Municipal Hospital	1.0000		$ 3,223
Peer Group 3	171341		1255421210	Hiawatha Community Hospital	1.0000		$ 3,223
Peer Group 3	171357		1740828912	Hillsboro Community Hospital	1.0000		$ 3,223
Peer Group 3	171369		1821098252	Hodgeman County Health Center	1.0000		$ 3,223
Peer Group 3	171376		1578505095	Hospital District #1 Crawford County	0.7373		$ 3,223
Peer Group 3	17M376		1245475946	Hospital District #1 Crawford County	0.7373		$ 3,223
Peer Group 3	171330		1710962014	Hospital District #1 of Rice County	1.0000		$ 3,223
Peer Group 3	171309		1336184647	Jewell County Hospital	1.0000		$ 3,223
Peer Group 3	171313		1821096322	Kearny County Hospital	0.8389		$ 3,223
Peer Group 3	171332		1942309166	Kiowa County Memorial Hospital	1.0000		$ 3,223
Peer Group 3	171331		1437152766	Kiowa District Hospital	1.0000		$ 3,223
Peer Group 3	170120		1578560421	Labette County Medical Center	0.4368		$ 3,223
Peer Group 3	171303		1437112687	Lane County Hospital	1.0000		$ 3,223
Peer Group 3	171360		1942265327	Lincoln County Hospital	1.0000		$ 3,223
Peer Group 3	171358		1881697811	Lindsborg Community Hospital	1.0000		$ 3,223
Peer Group 3	171326		1821087230	Logan County Hospital	1.0000		$ 3,223
Peer Group 3	170105		1730297409	McPherson Hospital Inc.	0.4070		$ 3,223
Peer Group 3	171321		1922004076	Meade District Hospital	1.0000		$ 3,223
Peer Group 3	171334		1407887193	Medicine Lodge Memorial Hospital	1.0000		$ 3,223
Peer Group 3	171381		1992759633	Memorial Hospital - Abilene	1.0000		$ 3,223
Peer Group 3	171308		1871829812	Mercy Hospital Columbus	1.0000		$ 3,223
Peer Group 3	170075		1083628911	Mercy Hospital Inc. - Moundridge	1.0000		$ 3,223
Peer Group 3	170203		1992341473	Mercy Specialty Hospital of SE Kansas	0.5118		$ 3,223
Peer Group 3	171368		1013009828	Minneola District Hospital	1.0000		$ 3,223
Peer Group 3	171375		1427151992	Mitchell County Hospital	0.9514		$ 3,223
Peer Group 3	171379		1750314720	Morris County Hospital	1.0000		$ 3,223
Peer Group 3	170166		1770511297	Morton County Hospital	1.0000		$ 3,223
Peer Group 3	171315		1669470712	Nemaha Valley Community Hospital	1.0000		$ 3,223
Peer Group 3	171380		1073566949	Neosho Memorial Regional Medical Center	0.4642		$ 3,223
Peer Group 3	171336		1457452898	Ness County Hospital	1.0000		$ 3,223
Peer Group 3	171384		1245643576	Newman Regional Health	0.6526		$ 3,223
Peer Group 3	171384		1578976825	Newman Regional Health	0.6526		$ 3,223
Peer Group 3	171378		1285629956	Ninnesca Valley Health Systems	1.0000		$ 3,223
Peer Group 3	171348		1801892740	Norton County Hospital	1.0000		$ 3,223
Peer Group 3	171364		1639261811	Osborne County Memorial Hospital	1.0000		$ 3,223
Peer Group 3	171345		1568401206	Pawnee Valley Community Hospital Inc.	1.0000		$ 3,223
Peer Group 3	171353		1639268246	Phillips County Health Systems	1.0000		$ 3,223
Peer Group 3	170027		1578596904	Pratt Regional Medical Center	0.5478		$ 3,223
Peer Group 3	171307		1942257431	Rawlins County Health Center	1.0000		$ 3,223
Peer Group 3	171311		1649278854	Rooks County Health Center	1.0000		$ 3,223
Peer Group 3	171342		1841240959	Rush County Memorial Hospital	1.0000		$ 3,223
Peer Group 3	171350		1417939729	Russell Regional Hospital	1.0000		$ 3,223
Peer Group 3	171324		1740230549	Satanta District Hospital	1.0000		$ 3,223
Peer Group 3	171372		1144263443	Scott County Hospital	1.0000		$ 3,223
Peer Group 3	171318		1033114277	Sedan City Hospital	1.0000		$ 3,223
Peer Group 3	171347		1184635229	Sheridan County Health Complex	0.9736		$ 3,223
Peer Group 3	170150		1609842681	South Central Kansas Regional Medical Center	0.5943		$ 3,223
Peer Group 3	170068		1538109251	Southwest Medical Center	0.3377		$ 3,223
Peer Group 3	170023		1659360196	St. Catherine Hospital	0.3171		$ 3,223
Peer Group 3	171356		1326087966	St. Luke Hospital	1.0000		$ 3,223
Peer Group 3	171323		1295840999	Stafford County Hospital	1.0000		$ 3,223
Peer Group 3	171343		1871695973	Stanton County Hospital	1.0000		$ 3,223
Peer Group 3	171335		1093774762	Stevens County Hospital	1.0000		$ 3,223
Peer Group 3	171355		1922001015	Trego County-Lemke Memorial Hospital	1.0000		$ 3,223
Peer Group 3	170191		1548750417	UKHS Great Bend Campus	0.9476		$ 3,223
Peer Group 3	171351		1962403584	Washington County Hospital	1.0000		$ 3,223
Peer Group 3	171306		1740271295	Wichita County Health Center	1.0000		$ 3,223
Peer Group 3	171383		1548229149	William Newton Memorial Hospital	0.5592		$ 3,223
Peer Group 3	171344		1669441176	Wilson Medical Center	1.0000		$ 3,223
				Average Peer Group 3	0.9150		$ 3,223

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Peer Group	Medicare ID	KMMS ID	NPI	Hospital Name	CCR	GME Factor	Base Rates w/o GME
KU	170040	[redacted]	1649259656	University of Kansas Medical Center	0.2482		$ 7,859
None	None			Out of State Hospitals	0.5989		$ 3,585