

# **INDEPENDENT LABORATORY AND PORTABLE X-RAY SERVICES**

*Chapter Thirteen of the Medical Services Manual*

**MEDICAID OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS  
BUREAU OF HEALTH SERVICES FINANCING**

**REISSUED MAY 1, 1993**

**PARAMAX**

## PREFACE

Medicaid of Louisiana (Title XIX), formerly known as the Louisiana Medical Assistance Program, is designed to assist eligible Medicaid recipients in obtaining medical care within the applicable federal and state rules and regulations. Medicaid of Louisiana is administered by the Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF). Reimbursement may be made for independent lab and portable X-ray services when these services are provided to eligible Medicaid recipients by qualified, enrolled providers.

This manual is one of a series published for the use of medical services providers enrolled in Medicaid of Louisiana. It is not a legal description of all aspects of Medicaid of Louisiana or Title XIX rules and regulations, but it does set forth the conditions and requirements independent lab and portable X-ray providers must meet to qualify for reimbursement. In addition, the manual provides the procedural information providers will need to file claims for services promptly and accurately.

This manual is applicable to providers who file claims with the fiscal intermediary, Paramax, for recipients of Medicaid services. We suggest that you study the material and maintain it in a special file for future reference.

From time to time, policies governing independent lab and portable X-ray services may change. Providers will be notified via written memorandums and revised manual pages regarding revisions and updates to policies in this manual. All revisions received should be placed in the appropriate section of the manual. Should there be a conflict between manual material and pertinent laws or regulations governing Medicaid of Louisiana, the latter take precedence.

Providers may obtain copies of this manual by contacting the Provider Relations Unit at Paramax at ☎ (504) 924-5040.

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## GENERAL MEDICAID INFORMATION

The Louisiana Medical Assistance Program, now referred to as Medicaid of Louisiana, became effective on July 1, 1966, under provisions of Title XIX of the 1965 Amendments to the *Federal Social Security Act* and Article 18, Section 7, Subsection 1, of the *Louisiana Constitution*, as amended. The Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), is the designated state agency responsible for administering the program. Medicaid of Louisiana is designed to provide certain healthcare benefits for those *categorically needy* and *medically needy* recipients who are in need of medical services.

The BHSF is responsible for the overall management of Medicaid of Louisiana, including the following functions:

- Determining all necessary regulations and guidelines for Medicaid of Louisiana program policy;
- Administering the program;
- Determining the services covered by the program and setting the reimbursement rates within federal guidelines;
- Determining eligibility of recipients, maintaining the recipient eligibility file, and issuing identification cards to certain categories of recipients; and
- Enrolling providers who wish to participate in the program.

In addition, the DHH, BHSF, has contracted with Paramax to implement and operate a Medicaid Management Information System (MMIS) for Medicaid of Louisiana. The contract provides that the fiscal intermediary, Paramax, be reimbursed a fixed price for each claim which is paid.

Paramax is also responsible for performing portions of the work associated with the administration of the program. Duties include providing the following:

- Clerical staff to process claims,
- Computer systems designed to DHH standards for federal funding for administrative control,
- Computer equipment and program support,
- Management information tools to improve control of the program,
- Provider Relations personnel,
- Louisiana Drug Utilization Review (LADUR),
- A Surveillance and Utilization Review Subsystem (SURS) and SURS personnel,
- Prior Authorization personnel, and
- Pharmacy and nursing home audits.

## MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

As fiscal intermediary, Paramax is required to operate an approved Medicaid Management Information System (MMIS), consistent with guidelines established by the DHH.

MMIS is a claims processing and information retrieval system designed to improve the management and control of Title XIX expenditures. The system is designed to reduce program costs through effective claims processing and utilization control. The major objectives of the system are as follows:

- Improve services to recipients,
- Reduce payment time to providers,
- Provide faster responses to inquiries,
- Improve claims processing efficiency,
- Increase use of computer capabilities,
- Provide greater utilization of the information database,
- Improve control and audit trails,
- Improve ability to handle increased claims volume, and
- Improve ability to handle federal reporting requirements.

Automation serves as the foundation for the system. Data entry of claims is performed through the use of batch key-entry and online teleprocessing technology. The capability exists for online data entry and update of the informational files which support claims processing. Data security is provided through the employment of batch controls and audit trails. Backup and recovery procedures exist that support the security efforts. Manual operations provide a smooth interface with the automated aspects of the system.

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## UNDERSTANDING MEDICAID OF LOUISIANA

### WHAT IS MEDICAID?

Medicaid is a means of delivering medical care to eligible needy individuals. The term *Medicaid* is derived from the words *medical* and *aid*, and it indicates the financial, as well as the medical assistance, that many patients require.

The state's Medicaid plan is formally included within Medicaid of Louisiana. The legal basis for the plan is contained in Title XIX of the *Social Security Act*; and, therefore, the term *Title XIX* is also used to refer to the program. Thus, Medicaid of Louisiana may be referred to as The Medical Assistance Program or Title XIX.

The Medicaid system provides government funds for health professionals who perform and/or deliver medically necessary services and/or supplies for eligible Medicaid recipients.

### HOW DOES MEDICAID WORK?

**The Provider's Role:** The Provider's role is to render health care services within a specialized field to eligible Medicaid recipients. To receive reimbursement for these services, the provider must agree to abide by the rules and regulations set forth by the program.

**Medicaid Recipients:** The purpose of Medicaid is to make health services available to the needy. Determining eligibility of Medicaid recipients is the responsibility of the BHSF. The BHSF reports the eligible recipients to Paramax.

In Louisiana, Medicaid recipients are classified as *Categorically Needy* or *Medically Needy*. The recipients, in either classification, will be issued a medical eligibility card on a monthly basis. The purpose of this card is to serve not only as a notice to recipients of their eligibility for Medicaid, but also to identify eligible recipients to providers of medical care services. A detailed explanation of the Medicaid Eligibility Care can be found in the *Recipient Eligibility* section of this manual.



## **ADMINISTRATION OF THE PROGRAM**

The administration of Medicaid of Louisiana is a cooperative effort on the part of the federal and state government.

The United States Department of Health and Human Services (DHHS) publishes the guidelines for the states' participation in Medicaid and monitors the different state programs. These guidelines not only give Medicaid programs structure and direction, but they also allow for a degree of consistency in the scope of Medicaid from state to state. In addition, they allow the states to have flexibility with the administration of their Medicaid programs.

The Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), determines policies for complying with state laws and federal guidelines. It is directly responsible for the administration and monitoring of Medicaid of Louisiana and for distributing information to providers.

The BHSF determines who is eligible for Medicaid and forwards this information to Paramax to establish a computer eligibility file. Updates are transferred weekly.

## STANDARDS FOR PARTICIPATION

Provider participation in Medicaid of Louisiana is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. These standards are listed as follows:

- Provider agreement and enrollment with BHSF;
- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;
- Agreement to accept as payment in full the amounts established by the BHSF and not to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients;
- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services; and

**NOTE:** Records must be retained for a period of three years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHHS, or the state Attorney General's Medicaid Fraud Control Unit.

- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1973*, and, where applicable, Title VII of the *1964 Civil Rights Act*.

## PICKING AND CHOOSING SERVICES

On March 20, 1991, Medicaid of Louisiana adopted the following rule:

- *Practitioners who participate as providers of medical services shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by the provider as a Medicaid patient.*

This rule prohibits Medicaid providers from "picking and choosing" the services for which they agree to accept a client's Medicaid card as payment in full for services rendered. In other words, providers must bill Medicaid for all services covered by Medicaid that they provide to their clients.

**INDICATION OF AGREEMENT**

Although this is a voluntary program, providers should note that their signature on a claim form will serve as their agreement to abide by all policies and regulations of Medicaid of Louisiana. This agreement also certifies that, to the best of the provider's knowledge, information contained on the claim form is true, accurate, and complete.

## OUT-OF-STATE MEDICAL CARE

Medicaid of Louisiana provides medical care to eligible recipients who are residents of Louisiana but who may be absent from the state in the same manner that it furnishes assistance to eligibles in the state.

Medicaid of Louisiana, however, will honor out-of-state medical claims for services rendered to eligible recipients only under one of the following conditions:

- When an emergency is caused by accident or illness;
- When the health of the recipient would be endangered if the recipient undertook travel to return to Louisiana;
- When the health of the recipient would be endangered if medical care were postponed until the recipient returns to Louisiana;
- When it is the general practice of recipients in a particular local to use medical facilities in areas outside of Louisiana; or
- When medical care or needed supplemental resources are not available in Louisiana (However, prior approval of the Louisiana Medicaid Director is required.).

*These limitations do not apply to out-of-state independent laboratories when these services are ordered by a physician residing in Louisiana.*

## RECIPIENT ELIGIBILITY

Recipient eligibility is determined by the BHSF. Provided in this section is an explanation of the different types of Medicaid eligibles, as well as samples of the different types of Medicaid eligibility cards.

### CLASSIFICATIONS OF ELIGIBLE RECIPIENTS

There are two classifications for eligible recipients of Medicaid of Louisiana:

#### Categorically Needy

Recipients classified as Categorically Needy have met the requirements, including the income requirement, for Medicaid of Louisiana. No payment can be accepted from these recipients for benefits billed to Medicaid of Louisiana.

#### Medically Needy

The Medically Needy recipients may be either **Regular Medically Needy** or **Spend-Down Medically Needy**. In either classification, these recipients will be eligible for all Medicaid benefits, except for services provided by Long Term Care (LTC) Facilities.

**Regular Medically Needy.** No payment can be accepted from a Regular Medically Needy recipient for covered services.

**Spend-Down Medically Needy.** These recipients may, at times, be required to pay for a portion of their medical services.

**NOTE:** Eligibility for these recipients begins on the exact date that medical expenses incurred by these recipients allow them to "spend-down" to the level of income which will qualify them for Medicaid. These recipients are then responsible for co-payment on some of the expenses.

Any provider who has medical bills from the exact date of the recipient's spend-down will receive a **Spend-Down Medically Needy Notice (Form 110-MNP)** from the BHSF (A sample of this form is provided on the following page.). This form will notify the provider of the co-payment amount due by the recipient for the bill and of the amount to be billed to Medicaid of Louisiana. The provider should attach this form to the claim and submit it to Paramax for processing.

**NOTE:** The provider cannot bill the recipient for any amount over the amount specified on the 110-MNP Form under *Recipient Liability*.

**OFFICE OF ELIGIBILITY DETERMINATIONS  
MEDICAL ASSISTANCE PROGRAM  
SPEND-DOWN MEDICALLY NEEDY NOTICE**

Recipients listed on the medical card are eligible FROM 07/15/90 (spend down date) THROUGH 10/11/90


**3601012345601**

**Anna M. Doar**

**ID NO.**

**CASE NAME**

**NOTICE TO PROVIDERS:** Only the providers listed below are entitled to bill the Fiscal Intermediary (FI) for services rendered on the spend-down date (beginning date of eligibility). Payment by the FI will be made only for services listed below and only if a copy of this form is attached to the invoice. The FI shall only be billed for the amount indicated in the "OED Liability" column. Payment by the FI shall be made in accordance with the usual, reasonable, and customary payments made by the Medicaid program. The patient payment amount shall be indicated in the "Recipient Liability" column on the FI billing document.

Patient Name and ID No. (include Recipient No.)	Date of Service	Provider Name and Vendor No.	Service or R, Received On Spend-Down Date	Total Unpaid Charges for Services Received	Recipient Liability	OED Liability (Amt. and FI's actual payment may differ)
Anna M. Doar 3601012345601	07/15/90 mo/dy/yr	1312345 Dr. George Burns	Hospital Care	\$250.00	\$20.00	\$230.00
Anna M. Doar 3601012345601	07/15/90 mo/dy/yr	1223344 Rexall Drugs	Prescriptions	\$75.00	\$0.00	\$75.00
Anna M. Doar	07/15/90 mo/dy/yr	1732345 ABC Hospital	Inpatient Care	\$500.00	\$0.00	\$500.00
Anna M. Doar	7/15/90 mo/dy/yr	1412345 Home Health	Physical Therapy	\$45.00	\$0.00	\$45.00
Anna M. Doar	7/15/90 mo/dy/yr	1181234 Crit. Care Amb.	Ambulance	\$85.00	\$0.00	\$85.00
Anna M. Doar	7/15/90 mo/dy/yr	1801234 Dr. O. Verbite	Dental Exam	\$35.00	\$0.00	\$35.00
Worker: 	Title: Parish Worker		Parish: South		Date: 10/15/90	

**Figure 4-1. Spend-Down Medically Needy Notice**

## IDENTIFICATION OF ELIGIBLE RECIPIENTS

A Louisiana Medical Eligibility Card is issued to each eligible recipient and/or family each month. These cards may be issued by the Department of Social Services (DSS), the recipient's parish Office of Family Support, or the fiscal intermediary (FI), Paramax. Included in this section are reproductions of sample cards for both the Categorically Needy and the Medically Needy recipients. Providers may want to refer to these samples to assist in understanding the information appearing on the recipient monthly Medical Eligibility Card.

We begin with examples of the cards issued by DSS. These examples are only facsimiles of the cards; they do not represent the actual size of the cards.

JUN 90-MAR 92		LOUISIANA MEDICAL ELIGIBILITY CARD SSW805B	
OFFICE OF FAMILY SECURITY 604 SECOND STREET FRANKLIN, LA. 70538			
BOB D. JONES P O BOX 2222 SOMEWHERE LA 70381			
*ELIG FOR EPSDT			
ID. NUMBER	ELIGIBLE RECIPIENTS	BIRTHDATE	TPL
5101018291901	JONES BOB D	01 24 78 *	
A=MEDICARE A	B=MEDICARE B	C=MEDICARE A & B	
D=OTHER INSURANCE	E=AMBULANCE COVERAGE		

Figure 4-2. Sample One Medical Eligibility Card Issued by DSS



9PE	LOUISIANA MEDICAL ELIGIBILITY CARD		PAD163
PRESUMPTIVE ELIGIBILITY			
P.O. BOX 2343 BATON ROUGE LA 70896		ERMA SMITH 555 BROWN STREET ANYTOWN, LA 70000	
ID NUMBER 17-16-0-012350-20	NAME ERMA SMITH	BIRTHDATE 10-30-73	
PRESUMPTIVE ELIGIBILITY PERIOD BEGINS ***01-02-89*** SERVICES LIMITED TO AMBULATORY PRENATAL CARE ONLY HOSPITALIZATION, LONG TERM CARE SERVICES NOT AUTHORIZED **MAY NOT EXCEED 45 DAYS AND MAY BE SHORTENED IF RECIPIENT IS INELIGIBLE OR FAILS TO COMPLY WITH ELIGIBILITY REQUIREMENTS H			

**Figure 4-3. Sample Presumptive Eligibility Card**

NOTE: Authorized for outpatient services only. Card has a 45 day limit maximum.

LOUISIANA MEDICAL ELIGIBILITY CARD		PAD973
ISSUE DATE: 09/25/91	A=MEDICARE A	B=MEDICARE B
OFFICE OF FAMILY SUPPORT	C=MEDICARE A & B	
P.O. BOX 51870	D=PRIVINS/DRUGS	
NEW ORLEANS, LA. 70151	E=AMBULANCE COVERAGE	
000262	F=PRIVINS/NO DRUGS	
LONG TERM CARE SERVICES NOT AUTHORIZED	G=PRIVINS/TV-D/PAYCHASE	
SPEND-DOWN NEEDY ELIG PERIOD 08-13-90 THRU 09-90		
NEIL BUSH 4000 LOAN STREET NEW ORLEANS, LA 70126		
ID. NUMBER 3904568290101	ELIGIBLE RECIPIENTS BUSH NEIL	BIRTHDATE TPL 01 11 54

**Figure 4-4. Sample Two Eligibility Card Issued by DSS**

Provided below is a sample Medical Eligibility Card issued by the parish Office of Family Support. Both the front and the back of the card have been illustrated.

<b>BHSF Form 9</b> <b>REV. 03/92</b> <b>Prior Issue Usable</b> <b>LOUISIANA MEDICAL ELIGIBILITY CARD</b>		<b>Eligible From</b> <b>Through</b>				
<b>ID NUMBER</b>	<b>ELIGIBLE BENEFICIARY(IES)</b>	<b>BIRTHDATE</b>	<b>T.P.L.*</b>			
<b>Agency Representative Signature</b>				<b>Date of Issue</b>		
<b>IMPORTANT:</b> Show this card to each provider who has provided or will provide service(s) to you during the dates shown above. <b>* SEE CODES ON REVERSE</b>						

Figure 4-5. Sample Front Side of OFS Issued Medical Eligibility Card

<b>*THIRD PARTY LIABILITY (T.P.L.) CODES</b>	
<b>COLUMN 1</b> D=Private Health Insurance - Drug Coverage; E=Ambulance Insurance; F=Private Health Insurance - No Drug Coverage. G=Private Health Insurance (IV-D) - Pay & Chase	
<b>COLUMN 2</b> Medicare, Part A; B=Medicare, Part B; C=Medicare, Parts A& B	
<b>IMPORTANT: PATIENT MUST SHOW THIS CARD WHEN APPLYING FOR MEDICAL SERVICES</b> The person(s) shown on the reverse side is (are) eligible for the payment of certain medical services authorized by Medicaid of Louisiana. Benefits under other insurance coverage, including Medicare, must be used first. Eligibility for medical services is effective only for the dates shown on the reverse side.	
Use of this card to obtain medical services to which a person is not entitled will subject that person to arrest and trial under state and federal laws and regulations.	

Figure 4-6. Sample Back Side of OFS Issued Medical Eligibility Card

Provided below are four different examples of Medical Eligibility Cards issued by the fiscal intermediary, Paramax.

LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-SEPT. 92				
OFFICE OF FAMILY SUPPORT		26		
ST. CHARLES		* KIDMED/EPSDT		
P.O. BOX 453				
HAHNVILLE LA 70057				
TYPE CASE: 01	ELIGIBLE	BIRTH	TPL	CARRIER
ID. NUMBER	RECIP. NAME	DATE		CODE
4503495788301 *	FRAN SUE	09/28/89	F	126100
4509839202802 *	FRAN JANE	11/07/91	F	126100
4567284920020	FRAN DORA	01/26/60	F	126100
*****				
DORA FRAN				
200 WEST ST.				
DESTREHAN LA 70047				

Figure 4-7. Sample One Medical Eligibility Card Issued by Paramax

LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-SEPT. 92				
OFFICE OF FAMILY SUPPORT		18		
ST. CHARLES		#MEDICARE / MEDICAID SERVICES		
P.O. BOX 453				
HAHNVILLE LA 70057				
TYPE CASE: 78	ELIGIBLE	BIRTH	TPL	CARRIER
ID. NUMBER	RECIP. NAME	DATE		CODE
4501002011201#	SMITH JOHN	10/15/26	C	
*****				
JOHN SMITH				
700 SOUTH ST				
DESTREHAN LA 70047				

Figure 4-8. Sample Dual QMB Medical Eligibility Card Issued by Paramax

LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-SEPT. 92					
OFFICE OF FAMILY SUPPORT			6		
ST. CHARLES					
P.O. BOX 453					
HAHNVILLE LA 70057					
TYPE CASE: 78	ELIGIBLE	BIRTH	TPL	CARRIER	
ID. NUMBER	RECIP.	NAME	DATE	CODE	
4594234585501	DOAN	JOHN	12/17/39		
*****					
JOHN DOAN					
705 SOUTH ST					
AMA LA 70031					

Figure 4-9. Sample Three Medical Eligibility Card Issued by Paramax

LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-APRIL 92					
OFFICE OF FAMILY SUPPORT			533		
EAST JEFFERSON			#MEDICARE COVERED SERVICES ONLY		
P.O. BOX 97					
METAIRIE LA 70004					
TYPE CASE: 95	ELIGIBLE	BIRTH	TPL	CARRIER	
ID. NUMBER	RECIP.	NAME	DATE	CODE	
6517018169801#	BROWN	DANA	10/15/20	C F	010400
*****					
DANA BROWN					
300 SOUTH ST					
METAIRIE LA 70001					

Figure 4-10. Sample Pure QMB Medical Eligibility Card Issued by Paramax

## LOCK-IN PROGRAM

The BHSF has developed a program to educate recipients who may be unintentionally misusing program benefits and to ensure that program funds are used to provide optimum health services for recipients. Recipients who misuse pharmacy and physician benefits may be restricted to the use of one pharmacy and one physician.

A Lock-In recipient is asked to choose one physician provider and one pharmacy provider to be his Lock-In providers. Under most circumstances the recipients named on the Lock-In Medical Eligibility Card are restricted to receiving physician and pharmacy services from the providers named on their Lock-In Medical Eligibility Cards.

The Lock-In Medical Eligibility Card is larger than the regular card and is printed on green paper (See the sample provided on page 11.). Recipients who present this card to providers not named on the Lock-In Medical Eligibility Card should be reminded that only those providers named on the front of the card can offer those recipients services. No payment will be made to a physician or pharmacist whose name does not appear on the card for services provided under usual circumstances.

The BHSF recognizes that there will be unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In recipient when the provider is not named on the Medical Eligibility Card. Payment will be made to any physician or pharmacist enrolled in Medicaid of Louisiana who grants services to a Lock-In recipient in emergency situations or when life sustaining medicines are required. If a physician who is not named on the recipient's Medical Eligibility Card renders an emergency service to the recipient, the provider should submit a claim to Paramax and write **Emergency** in the diagnosis section of the claim form. The physician should also write **Emergency Rx** on any prescription resulting from such an emergency.

There may be circumstances under which it is necessary for a Lock-In physician to refer the Lock-In recipient for consultation on a one-time basis. The consulting physician may be reimbursed for the consultation if that consulting physician enters the name of the referring Lock-In physician in the **Referring Physician** block on the claim. If the consulting physician subsequently becomes the treating physician, that physician should remind the recipient to report this information to the BHSF because reimbursement cannot be made for continued services until the provider's name and number are entered on the recipient's Medical Eligibility Card.

Pharmacists other than those named on the Lock-In recipient's Medical Eligibility Card may fill prescriptions for life sustaining medication or upon receiving a prescription containing the term *Emergency Rx*. However, they should certify that the prescription is an emergency on their claim forms.

The Lock-In system affects the recipients only in the areas of physician and pharmacy services. Providers other than physicians or pharmacists may provide the services which they normally do for any eligible recipient.

**NOTE:** The Lock-In program and the CommunityCARE program are different programs set up to achieve different objectives (See explanation of CommunityCARE eligibility card.

LOCK-IN LOUISIANA MEDICAL ELIGIBILITY CARD			
ID NUMBER	BENEFICIARY NAME & ADDRESS	BIRTHDATE	Month/Year
-----		---	---
Physician Name		Physician Vendor Number	
Specialist Name		Specialist Vendor Number	
Pharmacy Name		Pharmacy Vendor Number	
Agency Representative Signature		Date of Issue	

**PROVIDER READ REVERSE SIDE OF THIS CARD CAREFULLY BEFORE PROVIDING A SERVICE**  
\*SEE CODES ON REVERSE

Figure 4-11. Sample Front Side of a Lock-In Eligibility Card

**IMPORTANT: PATIENT MUST SHOW THIS CARD WHEN RECEIVING MEDICAL SERVICES**

The person shown on the reverse side is eligible for the payment of certain medical services authorized by Medicaid of Louisiana. Benefits under other insurance coverage, including Medicare, must, with certain exceptions, be used first. Eligibility for medical services will terminate at the end of the month shown. This beneficiary is participating in a special program to educate him/her as to the most efficient use of medical benefits so as to assure maximum health benefits. **This beneficiary IS NOT eligible to receive routine physician or pharmacy services from providers other than those listed on this card.** Other physicians who provide emergency services to this beneficiary **MUST** certify that an emergency existed by writing "Emergency" in the remarks section of the claim form. He/she shall write "Emergency RX" on any prescription resulting from such a situation. Pharmacists filling a prescription from physicians who are not listed shall verify that the term "Emergency RX" is shown on the prescription by writing "Emergency" on the service claim. Pharmacists other than the one listed may fill prescriptions **ONLY** for life sustaining medication or upon receipt of a prescription containing the term "Emergency RX" and shall certify that the prescription was for an emergency on the service claim. Medical providers other than physicians or pharmacists are not restricted to these limitations. Use of this card to obtain medical services to which a person is not entitled will subject that person to arrest and trial under state and federal laws and regulations.

**\*THIRD PARTY LIABILITY (T.P.L.) CODES**

**COLUMN 1**  
D=Private Health Insurance - Drug Coverage; E=Ambulance Insurance, F=Private Health Insurance - No Drug Coverage;  
G=Private Health Insurance (TV-D) - Pay & Chase

**COLUMN 2**  
A=Medicare, Part A; B=Medicare, Part B; C=Medicare, Parts A & B

Figure 4-12. Sample Back Side of a Lock-In Eligibility Card

CommunityCARE recipients receive a monthly Medicaid eligibility card showing the name and telephone number of the selected/assigned CommunityCARE provider in the lower right hand corner. A sample of the CommunityCARE card is provided on the following page. The recipient will receive the initial Medicaid card approximately 60 days after the selection or assignment of a primary care physician is made.

One Medicaid card will be issued for each certified household. Each eligible recipient in a certification may select or be assigned to a different CommunityCARE provider. If members of a family unit select different participating providers, each primary care physician will be listed on the card. For example, a pediatrician may be selected for an infant, and a general practitioner may be selected for the parents.

Reissuance of lost or stolen Medicaid cards is the responsibility of the parish offices. Replacement cards will be issued manually, listing the recipient's assigned primary care physician. Parish OFS facilities, Medicaid offices, and enrollment centers will receive monthly printouts showing primary care physician assignments for eligible recipients.



LOUISIANA MEDICAL ELIGIBILITY CARD		1 ELIG.	FOR - MARCH 92		
OFFICE OF FAMILY SUPPORT		640			
CLAIBORNE			*KIDMED/EPSDT		
P.O. DRAWER 210					
HOMER	LA	71040			
TYPE CASE 10					
ID. NUMBER	RECIP.	ELIGIBLE NAME	BIRTH DATE	TPL	CARRIER CODE
9033312457891	* 1JONES	GARY	03/14/79		
9003321456890	* 1JONES	TOM	03/22/86		
9003456789123	* 1SMITH	JACK	10/16/89		
9002534567892	* 1JONES	BOB	12/22/90		
9002345678196	2JONES	SUE	05/03/63		
*****					
***** CAR-RT SORT ** B001			COMMUNITY CARE PATIENT		
JONES SUE			PROVIDER	NAME	TEL. #
PO BOX 280			1	ABC CLAIBORNE CLINIC	3183453255
LISBON LA 71048-0215			2	XYZ CLINIC	3185679876

Figure 4-13. Sample CommunityCARE Medicaid Card

**THIRD-PARTY LIABILITY (TPL)**

Federal regulations and applicable state laws require that third-party resources be used before Medicaid is billed. *Third-party* refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, that can be applied toward the Medicaid recipient's medical and health expenses. The lack of a third-party code on the eligibility card does not negate the provider's responsibility for asking recipient's if they have insurance coverage.

In most cases, except for those services provided to EPSDT eligibles, it is the provider's responsibility to bill the third-party carrier prior to billing Medicaid. However, in those situations, where the insurance payment is received after Medicaid has been billed and has made payment, the provider must reimburse Medicaid, not the recipient. Reimbursement must be made **immediately** to comply with federal regulations. Providers may reimburse Medicaid by forwarding a check or by submitting an adjustment request. Checks must have identifying information, such as date of service, Internal Claim Number (ICN), recipient name and number, and the reason for the reimbursement.

EPSDT providers need not bill a third-party insurance carrier before billing Medicaid of Louisiana. Paramax will pay the provider for services rendered and "chase" or pursue collection on the portion of the bill that is due by another income source.

**PROVIDER ENROLLMENT**

Providers who wish to participate in Medicaid of Louisiana should contact Paramax, Provider Relations, to request an enrollment packet. They must then complete the packet and submit it to the Provider Enrollment Unit at the Bureau of Health Services Financing (BHSF). Enrollment will be approved if the provider meets all qualifications and licensure requirements, as well as the standards for participation in Medicaid of Louisiana.

Each enrolling provider must enter into an agreement with Medicaid of Louisiana. The agreement requires that providers adhere to regulations, including the requirements contained in this provider manual. To participate in Medicaid of Louisiana, providers must complete a Medicaid PE-50 enrollment form and a Medicaid Supplement Agreement.

Copies of enrollment packets may be obtained from the following address:

**Paramax Provider Relations  
P.O. Box 91024  
Baton Rouge, LA. 70821**

**☎ (504) 924-5040**

Completed forms should be submitted to the following address:

**Bureau of Health Services Financing  
Provider Enrollment Section  
P.O. Box 91030  
Baton Rouge, LA. 70821-9030**

**☎ (504) 342-9454**

If additional information is required, the applicant will be notified. Notification of provider enrollment in Medicaid of Louisiana is the assignment of a provider number to be used when submitting claims.

**CHANGE OF ADDRESS/ENROLLMENT STATUS**

Providers who have address changes should notify the Provider Enrollment Unit of Medicaid of Louisiana in writing. Giving notification of address changes will allow correspondence, checks, and rejected claims to be delivered to the appropriate providers in a timely manner (See the addresses and telephone numbers on the preceding page.).

Also, providers who change their group affiliation should notify Provider Enrollment to eliminate the possibility of payments being delivered to the wrong provider/group.

## INDEPENDENT LAB POLICY

Provided in this section is an explanation of the Medicaid policy for independent labs mandated by both federal and state regulations. The explanation includes a summary of the reimbursement guidelines and methodology, as well as a description of services and a list of applicable procedure codes.

### REIMBURSEMENT METHODOLOGY

An independent laboratory is defined as a laboratory that performs diagnostic tests and is independent of both the attending or consulting physician's office and/or the hospital where services are rendered. Medicaid of Louisiana reimburses registered independent labs that abide by regulations and/or conditions set by the facilities or physicians from which they are considered independent.

*Laboratories maintained by physicians performing diagnostic tests for their own patients are exempt from this policy unless they perform diagnostic tests on referral.*

However, in-state independent laboratories will be reimbursed only for laboratory tests that fall within the specialties and subspecialties approved by Medicare, and out-of-state independent laboratories will be reimbursed only for tests that are approved by their Clinical Interstate License.

In addition, effective September 1, 1992, Medicaid is required, in accordance with federal regulations, to edit all claims for lab services to ensure that providers of service have a current *Clinical Laboratory Improvement Amendment* (CLIA) certificate. Providers are not required to post CLIA numbers on their claim forms, but they must ensure that Medicaid of Louisiana receives notice of their CLIA certification and makes a record of their CLIA number.

Actual payment received by independent laboratories will be equivalent to either the actual billed charges, the state maximum amount, or the equivalent Medicare fee for billed charges, whichever is the lesser of the three amounts.

## DESCRIPTION OF SERVICES

Medicaid federal regulations prohibit payment to independent laboratories that perform tests in reference labs. Payment may be made only to the independent laboratory that actually performs the service.

Actual services that Medicaid will reimburse include specimen collections and chemistry tests.

### Billing for Specimen Collections

Recent clarifications received from HCFA have necessitated changes in Medicaid's policy and procedures governing reimbursement for specimen collections. HCFA has advised that Medicare no longer pays for the handling and conveyance of specimens; now, Medicare only pays for the actual collection of a specimen via venipuncture or catheterization. Thus, Medicaid will no longer reimburse for CPT-4 code 99001 (collection and conveyance), nor will it reimburse for packaging or shipment of a specimen.

To bill appropriately for the collection of a specimen, providers should use one of the codes in the following table.

SPECIMEN COLLECTION PROCEDURE CODES		
CODE	DESCRIPTION	PRICE
36415	Venipuncture for collection of specimen(s), lab/hospital or multiple patients in a nursing home	3.00
P9605	Venipuncture for collection of specimen(s), single homebound or nursing home patient	5.00
P9615	Catheterization for collection of specimen(s), lab/hospital or multiple patients in a nursing home	3.00
P9610	Catheterization for collection of specimen(s), single homebound or nursing home patient	5.00

■ *Providers should note that charges for collections of specimens will not be reimbursed in full if they exceed the Medicare fee for collection which is \$3.00 to \$5.00.*

### Billing for Chemistry Tests

Listed below are the various chemistry tests independent labs may bill for. Also provided is a table of the CPT-4 procedure codes that should be used to bill for a panel of these tests (three or more).

CHEMISTRY TESTS	
✓	Albumin
✓	Albumin/globulin ratio
✓	Bilirubin, direct
✓	Bilirubin, total
✓	Calcium
✓	Carbon dioxide content
✓	Chloride
✓	Cholesterol
✓	Creatinine
✓	Globulin
✓	Glucose (sugar)
✓	Lactic dehydrogenase
✓	Phosphatase, acid
✓	Phosphatase, alkaline
✓	Phosphorus (Inorganic phosphate)
✓	Potassium
✓	Protein, total
✓	Sodium
✓	Transaminase, glutamic oxaloacetic (SGOT)
✓	Transaminase, glutamic pyruvic (SGPT)
✓	Urea Nitrogen (BUN)
✓	Uric Acid

CPT-4 PROCEDURE CODES	
CODE	DESCRIPTION
80003	3 Clinical chemistry tests
80004	4 Clinical chemistry tests
80005	5 Tests
80006	6 Tests
80007	7 Tests
80008	8 Tests
80009	9 Tests
80010	10 Tests
80011	11 Tests
80012	12 Tests
80016	13-16 Tests
80018	17-18 Tests
80019	19 or more Tests

*When billing for three or more of the above tests, providers should not bill each test individually. These procedures apply to automated multichannel tests, as well as non-automated tests.*

## POLICY FOR PORTABLE X-RAY SUPPLIERS

Medicaid of Louisiana will reimburse enrolled portable X-ray suppliers who are Medicare certified for services rendered only if these services are medically necessary and ordered by a physician and only if the recipient is homebound.

Recipients are considered to be homebound only if they have conditions which are the result of illnesses or injuries which restrict their ability to leave their place of residence without the use of special transportation or the assistance of another person. Their place of residence may be their own home or a nursing home.

Services that will be reimbursed include the following:

- Skeletal films of recipients' arms, legs, pelvises, vertebral columns, and skulls;
- Chest films which do not involve the use of contrast media; and
- Abdominal films which do not involve the use of contrast media.

Medicaid of Louisiana will not pay for the following services:

- Any radiology procedures involving the use of contrast media or fluoroscopy;
- Procedures requiring the administration of a substance to the patient, the injection of a substance, or the spinal manipulation of the patient;
- Procedures requiring special medical skills or knowledge possessed by a doctor of medicine or osteopathy;
- Procedures requiring special technical competency and/or special equipment or materials;
- Routine screening procedures such as annual physicals;
- Procedures which are not of a diagnostic nature, e.g., therapeutic X-ray treatments; and
- Annual chest X-rays.



Tables of the procedure codes that should be used to bill for covered services are provided below and on the following pages.

CODE	DESCRIPTION
<b>CHEST</b>	
71010	Chest, single view - EAP, EPA, or DAP
71020	Chest, two views - EPA or EAP & Lateral
71100	Ribs, unilateral, three views, one side
71110	Ribs, bilateral, four views, both sides
71120	Sternum, three views
71130	Sternoclavicular Joints, two views
<b>ABDOMEN</b>	
74000	Abdomen, single view, KUB
74010	Abdomen, two views, flat and erect
<b>UPPER EXTREMITIES</b>	
73000	Clavicle, two views, AP & Tile
73010	Acapula, two views, AP & Lateral
73020	Shoulder, two views, Interior and Exterior
73030	Shoulder, injury, AP & Auxillary
73050	Acromio-Clavicular Joints, two views w/wts.
73060	Humerous, two views, AP & Lateral
73070	Elbow, two views, AP & Lateral
73080	Elbow, four views, AP Lateral, Obliques
73090	Forearm, two views, AP & Lateral
73100	Wrist, two views, AP & Lateral
73110	Wrist, four views, AP, Lateral, Obliques
73120	Hand, two views, AP, Lateral, Obliques
73130	Hand, minimum of three views, Obliques
73140	Finger, three views, AP, Lateral, Obliques

CODE	DESCRIPTION
<b>LOWER EXTREMITIES</b>	
73500	Hip, one view, AP
73510	Hip, two views, AP & Lateral
73550	Femur, two views, AP & Lateral
73560	Knee, two views, AP & Lateral
73562	Knee, minimum of three views, AP, Lateral, Obliques
73570	Knee, four views, AP, Lateral, Obliques
73590	Lower Leg, two views, AP & Lateral
76600	Ankle, two views, AP & Lateral
73610	Ankle, four views, AP, Lateral, & Obliques
73620	Foot, three views, AP, Lateral, Obliques
73650	Heel, two views, AP & Lateral
73660	Toe, three views, AP, Lateral, Obliques
<b>SPINE AND PELVIS</b>	
72170	Pelvis, one view, AP
72180	Pelvis, two views, AP & Lateral
72050	Cervical Spine, three views, AP, Lateral, O.M.
72040	Cervical Spine, one view, Lateral
72070	Thoracic Spine, three views, AP, Lateral, Swin
72110	Lumbar Spine, four vies, AP, AP Pelvis, Lat & Swin
72100	Lumbar Spine, two views, AP & Lateral
72220	Sacrum, two views, AP & Lateral
72221	Coccyx, two views, AP & Lateral

CODE	DESCRIPTION
HEAD	
70260	Skull, three views, Townes, AP, Lateral
70250	Skull, one view, Lateral
70110	Mandible, four views, Reverse Townes, AP & Both Lateral, Oblique
70130	Facial Bones, three views, Waters Zygomatic Arch, Lateral
70160	Nasal Bones, three views, Waters, Both Lateral
70200	Orbits, three views, AP 10 degrees tilt, Waters, Lateral
70210	Sinus, three views, PA Waters, Exag. Waters, Lat.
70360	Soft Neck Tissue, one view, Lateral
USE THE FOLLOWING TO BILL FOR PORTAGE FEES	
	Portage fee - single patient per home per day
Y2002	Portage fee - two patients per home per day
Y2003	Portage fee - three patients per home per day
Y2004	Portage fee - four patients per home per day
Y2005	Portage fee - five patients per home per day

- Retroactive to January 1, 1992, Medicaid will reimburse providers for setting up equipment used to take X-rays of patients. To bill for this service, providers should use code Q0092 (Medicare's code). Medicaid will pay a maximum of \$7.21 on straight Medicaid claims for each patient receiving this service during both single patient and multiple patient trips. In addition, Medicaid will pay co-insurance and deductibles on Medicare crossover claims.*

## HCFA-1500 (12/90) BILLING INSTRUCTIONS

Providers should bill for independent lab and portable X-ray services on the HCFA-1500 claim form. Provided in this section are some general billing reminders and specific instructions for billing on the HCFA-1500 (12-90) claim form.

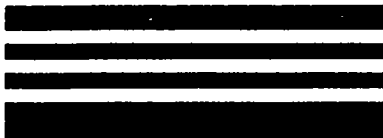
### GENERAL REMINDERS

Providers should note the following:

- Providers may submit more than one claim per envelope to reduce provider postage costs and to aid Paramax in handling mail.
- Providers should always notify the Bureau of Health Services Financing (BHSF) when a mailing address change occurs to allow rejected claims to be returned more quickly to providers. Many claims are returned to Paramax because forwarding orders at the post office have expired.
- Claims should be filed immediately after services have been provided.
- Medicaid is the payer of last resort.

 *A sample claim form is provided on the following page.*

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



## HEALTH INSURANCE CLAIM FORM

PICA										PICA																																																											
MEDICARE <input type="checkbox"/> (Medicare #)										MEDICAID <input type="checkbox"/> (Medicaid #)										CHAMPUS <input type="checkbox"/> (Sponsor's SSN)										CHAMPVA <input type="checkbox"/> (VA File #)										GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)										FECA BLK LUNG <input type="checkbox"/> (SSN)										OTHER <input type="checkbox"/> (ID)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)																				3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)																				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY										STATE										8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY										STATE																													
ZIP CODE										TELEPHONE (Include Area Code) ( )										Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										ZIP CODE										TELEPHONE (INCLUDE AREA CODE) ( )																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)																				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER																				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____										b. EMPLOYER'S NAME OR SCHOOL NAME																																							
c. EMPLOYER'S NAME OR SCHOOL NAME																				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME																				10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																							
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>																																																																					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																	
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE																				17a. I.D. NUMBER OF REFERRING PHYSICIAN										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. RESERVED FOR LOCAL USE																				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____																				23. PRIOR AUTHORIZATION NUMBER _____																																																	
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																																																																					
25. FEDERAL TAX I.D. NUMBER SSN EIN																				26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. BALANCE DUE \$									
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS certify that the statements on the reverse apply to this bill and are made a part thereof.																				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #																																							
SIGNED _____ DATE _____																				PIN# _____										GRP# _____																																							

# **SPECIFIC BILLING INSTRUCTIONS**

The instructions provided below should be followed carefully for accurate and prompt processing of claims.

1. Check the box that says "Medicaid" (Medicaid #).
- \*1a. **INSURED'S ID NUMBER** Enter the recipient's 13-digit Medicaid ID number exactly as it appears on the recipient's monthly medical identification card. In the case of a family, make certain that the last 2 digits of the identification number are the correct individual suffix for the family member who is being treated. If the number does not match the patient's name in Block 2, the claim will be denied. If this item is blank, the claim will be returned.
- \*2. **PATIENT'S NAME** Enter in this space the name of the recipient. Enter the last name first, the first name next, and the middle initial last. Spell the name exactly as it appears on the client's medical identification card.
3. **PATIENT'S BIRTH DATE AND SEX** Enter the patient's date of birth exactly as it appears on the medical identification card using the six-digit MM/DD/YY format. If there is only one digit in a field, precede that digit with a zero. Put an X in the appropriate box to indicate the patient's sex.
4. **INSURED'S NAME** Leave this space blank.
5. **PATIENT'S ADDRESS** Enter the client's permanent address.
6. **PATIENT RELATIONSHIP TO INSURED** Leave this space blank.
7. **INSURED'S ADDRESS** Leave this space blank.

8. PATIENT STATUS Leave this space blank.
9. OTHER INSURED'S NAME Enter the insured's name, if applicable.
- 9A. OTHER INSURED'S POLICY OR GROUP NUMBER Enter the TPL Carrier Code Number (if applicable).  
  
NOTE: The other resource must be billed first, with the exception of pay and chase claims, since Medicaid is the payer of last resort (*See page 4-14 for an explanation of Pay and Chase.*)
- 9B. OTHER INSURED'S DATE OF BIRTH Leave this space blank.
- 9C. EMPLOYER'S NAME OR SCHOOL NAME Leave this space blank.
- 9D. INSURANCE PLAN NAME OR PROGRAM NAME Leave this space blank.
10. WAS CONDITION RELATED TO:
  - A. Check the appropriate box.
  - B. Check the appropriate box.
  - C. Check the appropriate box.  
If the patient's condition is the result of an injury or illness and there is potential for insurance coverage or compensation as a result of accident or illness, check the appropriate blocks in Items A - C.  
  
The insurance must be billed first since Medicaid is the payer of last resort.

MEDICAL SERVICES MANUAL

HCFA-1500 (12/90) BILLING INSTRUCTIONS

- 11 a-d. Leave these spaces blank.
12. PATIENT'S OR  
AUTHORIZED  
PERSON'S SIGNATURE Leave this space blank.
13. INSURED'S OR  
AUTHORIZED  
PERSON'S SIGNATURE Leave this space blank.
14. DATE OF CURRENT ILLNESS Using the 6-digit MM/DD/YY format, enter the month, day, and year of the date of the illness (first symptom), injury (accident), or pregnancy. If there is only one digit in a field, precede that digit with a zero.
15. DATE OF SAME  
OR SIMILAR ILLNESS Leave this space blank.
16. DATES  
PATIENT UNABLE TO WORK Leave this space blank.
- \*17. NAME OF REFERRING  
PHYSICIAN OR OTHER SOURCE If you are billing for a consult, if the patient is a Lock-In and the provider is not indicated on the card, or if the provider is an independent laboratory, enter the physician's name. Also, all claims for CRNA services must have the name of the physician who provides the medical direction.
18. HOSPITALIZATION DATES  
RELATED TO CURRENT SERVICES Complete this block when a medical service is furnished as a result of or subsequent to a related hospitalization.
19. RESERVED FOR LOCAL USE Leave this space blank.



**20. OUTSIDE LAB**

**Was Lab Work Performed  
Outside Your Office:**

Check the appropriate box.

**Charges:**

Not applicable.

**\*21. DIAGNOSIS**

All claims must contain a medically accepted description of the diagnosis. You must enter the numeric code and literal description. Use of ICD-9-CM coding is mandatory. Accepted abbreviations are appropriate.

**22. MEDICAID RESUBMISSION CODE**

Leave this space blank.

**23. PRIOR AUTHORIZATION**

Enter the prior authorization number when applicable.

**24. \*A. DATE OF SERVICE**

Enter the month, day, and year for each item billed. If "from" and "to" dates are shown here for a series of identical services on the same day or on consecutive days, enter the number of services in Item 24G.

**NOTE:** Surgical procedures may not be span-dated.

**\*B. PLACE OF SERVICE**

Enter the appropriate place of service code. A table of the valid codes is provided on the following page.

## NEW PLACE OF SERVICE CODES

CODE	DEFINITION	CODE	DEFINITION
00-99	Unassigned	51	Inpatient Psych. Fac.
11	Office	52	Psych. Fac. Partial Hosp.
12	Home	53	Community Mental Health
10,13,19	Unassigned	54	Intermediate Care Fac./ Mentally Retarded
21	Inpatient Hospital	55	Residential Substance Abuse Treatment Facility
22	Outpatient Hospital	56	Psych Residential Treatment Facility
23	Emergency Room-Hospital	50,57-59	Unassigned
24	Ambulatory Surgical Ctr.	61	Comprehensive Inpatient Rehabilitation Facility
25	Birthing Center	62	Comprehensive Outpatient Rehabilitation Facility
26	Military Treatment Fac.	65	End Stage Renal Disease Treatment Facility
27-29	Unassigned	60,63,64	Unassigned
31	Skilled Nursing Facility	66-69	Unassigned
32	Nursing Facility	71	State or Local Public Health Clinic
33	Custodial Care Facility	72	Rural Health Clinic
34	Hospice	70,73-79	Unassigned
30,35-39	Unassigned	81	Independent Laboratory
41	Ambulance - Land	80,82-89	Unassigned
42	Ambulance - Air or Water	99	Other Unlisted Facility
40,43-49	Unassigned	90-98	Unassigned

- |                                       |   |
|---------------------------------------|---|
| <b>C. TYPE OF SERVICE</b>             | Leave this space blank.   |
| <b>*D. PROCEDURE CODE</b>             | Enter the procedures, services, or supplies using CPT-4 or HCPCS codes. Also, show applicable modifiers, if any are necessary. A description of the service is no longer required unless you are billing with a miscellaneous procedure code. In such instances, enter the description in Item 24D or on an attachment. |
| <b>*E. DIAGNOSIS CODE</b>             | Refer to the diagnosis entered in Item 21 and indicate the most appropriate diagnosis for each procedure by using either a 1, 2, 3, or 4.<br><br><b>NOTE:</b> More than one diagnosis may be related to a procedure/service. Do not put an ICD-9-CM diagnosis code in this item.  |
| <b>*F. CHARGES</b>                    | Enter your usual or customary charges for this service/procedure.   |
| <b>G. DAYS OR UNITS</b>               | Enter the number of services billed. For anesthesia, show the elapsed time in minutes.  |
| <b>H. EPSDT<br/>FAMILY PLANNING</b>   | Enter "Y" if the services are the result of an EPSDT referral or a family planning referral.  |
| <b>I. EMG</b>                         | Leave this space blank.   |
| <b>J. COB</b>                         | Leave this space blank.   |
| <b>*K. RESERVED<br/>FOR LOCAL USE</b> | Enter the individual physician number if the group is billing for the provider.   |
| <b>25. FEDERAL TAX ID NO.</b>         | Leave this space blank.   |

**26. YOUR PATIENT'S  
ACCOUNT NUMBER**

If you enter your patient's account (medical record) number, it will appear on your Remittance Advice. It may consist of letters and/or numbers, and it may be a maximum of 16 positions.

**27. ACCEPT ASSIGNMENT**

For Medicaid only claims, leave this space blank. Medicaid does not make payments to the recipient. Claim filing indicates acceptance by the provider.

**NOTE: Claims which require filing to Medicare must be completed in accordance with Medicare instructions. Assignment must be accepted for dual Medicare/Medicaid eligibles.**

**\*28. TOTAL CHARGE**

Total all charges listed on the claim. If more than one claim form is used, total each form separately and do not carry forward the total charge.

**\*29. AMOUNT PAID**

If Item 9 is completed showing other health insurance, the amount paid will be the amount received from the other insurance, and it will require an Explanation of Benefits attached to the claim. When filing a Spend-Down Medically Needy claim, a Form 110-MNP must be attached for any service provided on the first date of the period of eligibility. This form will reflect patient liability. Do not enter patient payment from the 110-MNP in this item. Do not enter any amount paid by Medicare.

**\*30. BALANCE DUE**

Enter the balance due for services listed on the claim form.

**31. SIGNATURE OF  
PHYSICIAN/SUPPLIER & DATE**

The claim form must be signed. Signature stamps or computer-generated signatures are acceptable, but they must be initialed by the provider or the provider representative. If Item 31 is left blank, or if the stamped or computer-generated signature is not initialed, the claim will be returned to the provider. Also, enter the date the claim is signed.

**32. NAME AND ADDRESS WHERE  
SERVICES WERE RENDERED**

Enter the name and address of the facility where services were rendered if the facility was not the physician's office or the patient's home.

**\*33. PHYSICIAN'S OR MEDICAL  
ASSISTANCE SUPPLIER'S  
NAME, ADDRESS, ZIP CODE  
AND TELEPHONE NUMBER &  
PROVIDER ID NUMBER**

Enter the provider's name, address, and Medicaid provider number. This number must be entered in the space adjacent to "Grp. No." This is a 7-digit number.

**\* If these items are not completed, the claim will be denied.**

### TIMELY FILING GUIDELINES

To be reimbursed for services rendered, all providers must comply with the following timely filing guidelines set by Medicaid of Louisiana:

- **Straight Medicaid Claims** must be filed within 12 months of the date of service.
- **Medicare Crossover Claims** must be filed within 12 months of the date of service or 6 months from the date of the Explanation of Medicare Benefits (EOMB).
- **Claims with Third-Party Payment** must be filed within 12 months of the date of service.
- **Claims for Recipients with Retroactive Coverage**, e.g., spend-down medically needy recipients, should be sent to Paramax with a note of explanation or a copy of the recipient's Medicaid identification card as soon as possible. The mailing address for Paramax is as follows:

Paramax  
Provider Relations  
P.O. Box 91024  
Baton Rouge, LA. 70821

All claims for recipients with retroactive coverage will be forwarded to the BHSF for review and authorization.

Medicaid claims received after the maximum timely filing date cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include the following:

- A Remittance Advice indicating that the claim was processed earlier (within the specified timeframe)

OR

- Correspondence from either the state or parish Office of Family Support concerning the claim and/or the eligibility of the recipient.

When resubmitting the claim and documentation, providers must be certain that the claim is legible to ensure accurate processing. Documentation must reference the individual recipient and date of service. Claims which are over the two-year billing limitation cannot be considered for processing. Providers should not resubmit these claims.

## THE REMITTANCE ADVICE

The purpose of this section is to familiarize the provider with the design and content of the Remittance Advice (RA). This document plays an important communication role between the provider, the BHSF, and Paramax. Aside from providing a record of transactions, the Remittance Advice will assist providers in resolving and correcting possible errors and reconciling paid claims.

### THE PURPOSE OF THE REMITTANCE ADVICE

The RA is the control document which informs the provider of the current status of submitted claims. It is sent out with all provider checks.

On the line immediately below each claim a code will be printed representing denial reasons, pended claim reasons, and payment reduction reasons. Messages explaining all codes found on the Remittance Advice will be found on a separate page following the status listing of all claims. The only type of claim status which will not have a code is one which is paid as billed.

If you use a medical record number (It may consist of up to 16 alpha and/or numeric characters.), it will appear on the line immediately following the recipient's number.

### WHAT HAPPENS TO YOUR INVOICE?

When your invoice is received in the mailroom, addressed to the proper Post Office Box for the claim type, it will be edited for missing data. If the signature, recipient Medicaid identification number, service dates, or provider name and/or number is missing, the claim will be rejected and returned.

#### Returned Claims

If the invoice is rejected because of missing or incomplete items, the original invoice you submitted will be returned to you accompanied by a return letter. The return letter will indicate why the invoice has been returned. Complete the missing or incomplete items on the original invoice, and resubmit it. A returned claim will not appear on the Remittance Advice because it will not enter the processing system. In addition, it will not be microfilmed and given a unique 13-digit Control Number before being returned to the provider.

Claims which have all the necessary items for claims processing completed pass the first screening process, are microfilmed, are given a unique 13-digit Control Number, and are entered into the computer for processing.

### **WHAT HAPPENS TO A PROCESSED CLAIM?**

Claims which enter the processing system will be either approved (paid), pended to Medical Review, or denied.

All claims which have been processed will fall into one of these three classifications. You will receive a Remittance Advice for each payment cycle in which you have claims processed.

#### **Approved Claims**

A claim which is correctly completed for a covered service provided to an eligible recipient/patient by an enrolled provider will be approved for payment and paid. It will appear on the Remittance Advice on the first page or the page which lists all claims to be paid on that Remittance Advice. If the payment is different from the billed charges, an explanation will appear on the RA via a three-digit message code.

#### **Denied Claims**

A claim will be denied for the following reasons:

- If the recipient is not eligible on the date of service;
- If the provider is not enrolled on the date of service;
- If prior authorization is required, but not reflected;
- If the service is not covered by the program;
- If the claim is a duplicate of a prior claim;
- If the date is invalid or logically inconsistent; or
- If the program limitations are exceeded.

Three-digit message codes giving the reason(s) for the denial will be printed on the line immediately following the claim information. An explanation of all codes appearing on the Remittance Advice will be printed on a separate page.



### Pended Claims

Pended claims are those claims held for in-house review by Paramax. If after the claim is reviewed, it is determined that a correction by the provider is required, the claim will be denied. If the correction of a claim can be made during the review, the claim will be paid.

Claims can pend for many reasons. The following are a few examples:

- Errors were made in entering data from the claim into the processing system.
- Errors were made in submitting the claim. These errors can be corrected only by the provider who submitted the claim.
- The claim must receive Medical Review.
- Critical information is missing or incomplete.

### HOW TO CHECK THE STATUS OF A CLAIM - CONTROL NUMBER

A unique 13-digit number is given to each claim. The Control Number reflected on the RA can be used to track the status of your claims.

The first four digits of the Control Number are the actual year and day the claim was received. The next seven digits tell whether the claim is a paper claim or whether it was submitted on tape and what the batch and sequence numbers are which were entered into the processing system. All claim lines on a given claim form will have the same first 11 digits.

The last two numbers will help you to determine which line of a claim form is being referenced:

**EXAMPLE:** 1365023456700 - refers to first claim line  
                   1365023456701 - refers to second claim line  
                   1365023456702 - refers to third claim line

For those claim types which are not processed by line (inpatient hospital, screening, and pharmacy), the Control Number for the claim will always end in 00. All multiple-line claim forms with just one service billed on line 0 will also end in 00.

The unique 13-digit Control Number can be used to determine the status of claims from receipt to final adjudication.

**REMITTANCE ADVICE COPY REQUESTS**

A fee of \$0.25 per page, which includes postage, is charged to any provider who requests an additional copy of a Remittance Advice of one or more pages. RAs can be requested for any of the reasons listed below:

- The RA was lost, destroyed, or misplaced (by the provider or by Paramax).
- The provider needs an additional copy of the RA.
- The provider is requesting an advance copy pending receipt of the original from a central billing office.

Upon receipt of a written request, the provider will be notified of the number of pages to be copied and of the cost for the entire request. The Remittance Advice will be forwarded to the provider once payment has been received.

## ADJUSTING/VOIDING CLAIMS

Provided in this section are general reminders and specific billing instructions for adjusting or voiding a HCFA-1500 claim form.

### GENERAL REMINDERS

To adjust or void a HCFA-1500 claim form, the provider must use a 213 Adjustment/Void Form.

Only a paid claim can be adjusted or voided. If a paid claim is being adjusted, the Provider Identification Number and the Recipient/Patient Identification Number cannot be changed.

For those claims where multiple services are billed, the Adjustment/Void Form allows the adjustment or voiding of only one line. A separate Adjustment/Void Form is required for each claim line if more than one claim line on a multiple line claim form needs to be adjusted or voided.

The provider should complete the information on the adjustment form exactly as it appeared on the original claim, changing only the item that was in error and noting the reason for the change in the space provided on the claim.

If a paid claim is being voided, the provider must enter all the information from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the adjustment/void section.

An Adjustment/Void will generate Credit and Debit Adjustments which will appear in the Remittance Summary on the last page of the Remittance Advice.

A facsimile of 213 Adjustment/Void Form is provided on the following page.

MAIL TO  
UNISYS  
P O BOX 91020  
BATON ROUGE LA 70821  
(800) 473-2783  
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS  
BUREAU OF HEALTH SERVICE FINANCING  
MEDICAL ASSISTANCE PROGRAM  
PROVIDER BILLING FOR  
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

<input type="checkbox"/> JJ <input type="checkbox"/> VOID											
<b>PATIENT AND INSURED (SUBSCRIBER) INFORMATION</b>											
2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)				3 PATIENT'S DATE OF BIRTH				4 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)			
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)				6 PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>				7 INSURED'S ID MEDICARE AND/OR MEDICAID NO (INCLUDE ANY LETTER)			
TELEPHONE NO				8 PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>				9 INSURED'S GROUP NO (OR GROUP NAME)			
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER				11 WAS CONDITION RELATED TO A PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>				12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			
<b>PHYSICIAN OR SUPPLIER INFORMATION</b>											
13 DATE OF		ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		14 DATE FIRST CONSULTED YOU FOR THIS CONDITION		15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
16 DATE PATIENT ABLE TO RETURN TO WORK		17 DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH							
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G. PUBLIC HEALTH AGENCY)						19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED					
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)						21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES					
22 DIAGNOSIS OR NATURE OF ILLNESS RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 OR DX CODE						23 EPST FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
24 PRIOR AUTHORIZATION NO						25					
A DATE OF SERVICE FROM TO		B PLACE OF SERVICE		C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)		D DIAGNOSIS CODE		E CHARGES		F DAYS OR UNITS G TOS H LEAVE BLANK	
26 CONTROL NUMBER				THIS IS FOR CHANGING OR VOIDING A PAID ITEM (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)				27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID			
28 REASONS FOR ADJUSTMENT											
<input type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY											
<input type="checkbox"/> 02 PROVIDER CORRECTIONS											
<input type="checkbox"/> 03 FISCAL AGENT ERROR											
<input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY											
<input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN											
29 REASONS FOR VOID											
<input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT											
<input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER											
<input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN											
30 SIGNATURE OF PHYSICIAN OR SUPPLIER I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF						31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, AND TELEPHONE					
32 YOUR PATIENT'S ACCOUNT NUMBER											

**SPECIFIC INSTRUCTIONS FOR COMPLETION OF THE 213**

The instructions provided should be followed carefully for accurate and prompt processing of adjusted or voided claims:

**\*BLOCK 1 ADJ/VOID**

Check the appropriate box.

**\*BLOCK 2 PATIENT'S NAME**

**Adjust:** Enter the name exactly as it appears on the original invoice.

**Void:** Enter the name exactly as it appears on the original invoice.

**BLOCK 3 PATIENT'S DATE OF BIRTH**

**Adjust:** Enter the date exactly as it appears on the original invoice.

**Void:** Enter the date exactly as it appears on the original invoice.

**BLOCK 4 INSURED'S NAME**

**Adjust:** Enter the name exactly as it appears on the original invoice.

**Void:** Enter the name exactly as it appears on the original invoice.

**BLOCK 5 PATIENT'S ADDRESS  
AND TELEPHONE NUMBER**

**Adjust:** Enter the address and telephone number exactly as they appear on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**BLOCK 6 PATIENT'S SEX**

**Adjust:** Enter the patient's sex exactly as it appears on the original invoice.

**Void:** Enter this information exactly as it appears on the original invoice.

**\*BLOCK 7 INSURED'S ID,  
MEDICAID NUMBER**

**Adjust:** The ID number cannot be changed. If the number was entered incorrectly on the original claim form, the claim form must be voided.

**Void:** Enter the number exactly as it appears on the original invoice.

**BLOCK 8 PATIENT'S  
RELATIONSHIP TO INSURED**

Leave this space blank.

**BLOCK 9 INSURED'S GROUP NUMBER**

Leave this space blank.

**BLOCK 10 OTHER HEALTH  
INSURANCE COVERAGE**

**Adjust:** If this information is not being adjusted, enter the information exactly as it appears on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**BLOCK 11 WAS CONDITION RELATED TO:**

**Adjust:** Enter the information exactly as it appears on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**BLOCK 12 INSURED'S ADDRESS**

**Adjust:** Enter the information exactly as it appears on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**BLOCK 13 DATE OF ILLNESS:**

**Adjust:** Enter the date exactly as it appears on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**BLOCK 14 DATE FIRST CONSULTED  
YOU FOR THIS CONDITION**

**Adjust:** Enter the date exactly as it appears on the original invoice.

**Void:** Enter the date exactly as it appears on the original invoice.

**BLOCK 15 HAS PATIENT EVER HAD  
SAME OR SIMILAR SYMPTOMS?**

**Adjust:** Enter the information exactly as it appears on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**BLOCK 16 DATE PATIENT ABLE TO WORK**

**Adjust:** Enter the date exactly as it appears on the original invoice.

**Void:** Enter the date exactly as it appears on the original invoice.

**BLOCK 17 DATE OF TOTAL DISABILITY/  
DATE OF PARTIAL DISABILITY**

**Adjust:** Enter the dates exactly as they appear on the original invoice.

**Void:** Enter the dates exactly as they appear on the original invoice.

**BLOCK 18 NAME OF REFERRING  
PHYSICIAN OR OTHER SOURCE**

**Adjust:** Enter the name exactly as it appears on the original invoice.

**Void:** Enter the name exactly as it appears on the original invoice.

**BLOCK 19 FOR SERVICES RELATED TO  
HOSPITALIZATION GIVE  
HOSPITALIZATION DATES**

**Adjust:** Enter the dates exactly as they appear on the original invoice.

**Void:** Enter the dates exactly as they appear on the original invoice.

**BLOCK 20 NAME AND ADDRESS OF  
FACILITY WHERE  
SERVICES WERE  
RENDERED (IF OTHER  
THAN HOME OR OFFICE)**

**Adjust:** Enter the name and address as exactly they appear on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.



**BLOCK 21 WAS LABORATORY  
WORK PERFORMED  
OUTSIDE YOUR OFFICE?**

**Adjust:** Enter the information exactly as it appears on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**\*BLOCK 22 DIAGNOSIS/NATURE OF ILLNESS**

**Adjust:** Enter the information exactly as it appears on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**BLOCK 23 EPSDT REFERRAL**

**Adjust:** Enter the information exactly as it appears on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**\*BLOCK 24 ATTENDING PHYSICIAN**

**Adjust:** Enter the information exactly as it appears on the original claim form.

**Void:** Enter the information exactly as it appears on the original invoice.

**NOTE:** When you enter a group number in Block 31, you must enter the individual provider number in this block.

**\*BLOCK 25 A THROUGH F**

**Adjust:** If you are not adjusting the information, enter the information exactly as it appears on the original invoice.

**Void:** Enter the information exactly as it appears on the original invoice.

**\*BLOCK 26 DATE OF REMITTANCE  
ADVICE THAT LISTED  
CLAIM WAS APPROVED**

Enter the correct Control Number shown on the Remittance Advice.

**\*BLOCK 27 DATE OF REMITTANCE ADVICE  
THAT LISTED CLAIM WAS PAID**

Enter the date of the Remittance Advice.

**\*BLOCK 28 REASONS FOR ADJUSTMENT**

Check the appropriate box and write a brief narrative to describe why this adjustment is necessary.

**\*BLOCK 29 REASONS FOR VOID**

Check the appropriate box and write a brief narrative to describe why this void is necessary.

**\*BLOCK 30 SIGNATURE OF  
PHYSICIAN OR SUPPLIER**

You must sign the form.

**\*BLOCK 31 PHYSICIAN OR  
SUPPLIER'S NAME, ADDRESS,  
ZIP CODE AND TELEPHONE NO.**

Enter the requested information. Enter the provider number. If you are billing for a group, enter the group number in this block and the individual provider number in Block 24.

**BLOCK 32 YOUR PATIENT'S ACCOUNT NO.**

If you enter the patient's account (medical record) number, it will appear on the Remittance Advice. The number may consist of letters or numbers, but it should have no more than 13 positions.

\* Providers must complete these marked items.

## **FRAUD AND ABUSE**

To maintain the integrity of Medicaid of Louisiana, providers must understand and follow Medicaid of Louisiana's policy concerning fraud and abuse. This section of the manual defines the different types of fraud and abuse, and it sets forth specific sanctions for providers who commit fraud and who abuse Medicaid.

### **GENERAL**

Federal regulations require that Medicaid of Louisiana establish criteria that are consistent with principles recognized as affording due process of law for identifying situations where there may be fraud or abuse, for arranging prompt referral to authorities, and for developing methods of investigation or review that ascertain the facts without infringing on the legal rights of the individuals involved.

### **FRAUD**

Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. The definition of fraud that governs between citizens and government agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.01. Legal action may also be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-3).

Prosecution for fraud and the imposition of a penalty, if the individual is found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts. All such legal action is subject to due process of law and to the protection of the rights of the individual under the law.

### **Provider Fraud**

Cases involving one or more of the following situations shall constitute sufficient grounds for a provider fraud referral:

- Billing for services, supplies, or equipment which are not rendered to, or used for, Medicaid patients;
- Billing for supplies or equipment which are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;
- Claiming costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items;
- Materially misrepresenting dates and descriptions of services rendered, the identity of the individual who rendered the services, or of the recipient of the services;
- Duplicate billing of the Medicaid Program or of the recipient, which appears to be a deliberate attempt to obtain additional reimbursement; and
- Arrangements by providers with employees, independent contractors, suppliers, and others, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from the Medicaid.

**Recipient Fraud**

Cases involving one or more of the following situations constitute sufficient grounds for a recipient fraud referral:

- The misrepresentation of facts in order to become or to remain eligible to receive benefits under Medicaid of Louisiana or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;
- The transferring (by a recipient) of a Medicaid Eligibility Card to a person not eligible to receive services under Medicaid of Louisiana or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits; and
- The unauthorized use of a Medical Eligibility Card by persons not eligible to receive medical benefits under Medicaid.

## **ABUSE**

Abuse of Medicaid of Louisiana by either providers or recipients includes practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.

### **Provider Abuse**

Cases involving one or more of the situations listed below constitute sufficient grounds for a provider abuse referral:

- The provision of services that are not medically necessary;
- Flagrant and persistent overuse of medical or paramedical services with little or no regard for the patient's medical condition or needs or for the doctor's orders;
- The unintentional misrepresentation of dates and descriptions of services rendered, of the identity of the recipient of the services, or of the individual who rendered the services in order to gain a larger reimbursement than is entitled; and
- The solicitation or subsidization of anyone by paying or presenting any person money or anything of value for the purpose of securing patients (Providers, however, may use lawful advertising that abides by BHSF rules and regulations.).

### **Recipient Abuse**

Cases involving one or more of the following situations constitute sufficient grounds for a recipient abuse referral:

- Unnecessary or excessive use of the prescription medication benefits of Medicaid of Louisiana;
- Unnecessary or excessive use of the physician benefits of the program; and
- Unnecessary or excessive use of other medical services and/or medical supplies that are benefits of the program.

## FRAUD AND ABUSE DETECTION

Provided in this subsection is the fraud and abuse detection process. The first step of the process is a referral of suspect claims to a review board.

### Referrals

Situations involving potential fraud and/or abuse which are to be followed up for review by Medicaid of Louisiana may include any or all of the following:

- Cases referred by the U.S. Department of Health and Human Services [Medicaid of Louisiana in turn refers suspected cases of fraud in the Medicare Program to the Health Care Financing Administration (HCFA) and works closely with that agency in such matters.];
- Situations brought to light by special review, internal controls, or provider audits or inspections; and/or
- Referrals from other agencies or sources of information.

### Recipient Verification Notices (REOMBs)

The federal regulations (Public Law 92-693, Sec 253 3) for MMIS require that Medicaid of Louisiana provides prompt written notice of medical services which are covered to the recipients of these services. The information contained in the notice includes the name of the person(s) furnishing medical services, the date on which the services were furnished, and the amount of payment required for the services. **A predetermined percentage of the recipients who have had medical services paid on their behalf during the previous month will receive the required notice, that is, the Recipient's Explanation of Medical Benefits (REOMB).** From time to time, Medicaid of Louisiana may send notices to 100% of the recipients receiving services from any provider for any given period.



The REOMB contains the following information:

- The recipient's Medicaid identification number,
- The recipient's name,
- The date of the REOMB (monthly, on the 15th),
- The date of the service for the services provided,
- A narrative description of the services provided,
- The place of service for the services provided
- The provider of the services, and
- The amount paid for the services by Medicaid of Louisiana.

On the reverse side of the REOMB, preprinted instructions request the recipients to use the space provided to call attention to any mistakes they feel were made on their bill. For example, if a service is listed on the REOMB that was not received by a recipient, or if the recipient were made to pay for a service that is covered by Medicaid of Louisiana, that recipient is expected to write a brief explanation of the error. The recipient should include his phone number, and he should return the REOMB, postage paid, to Paramax. Paramax will then research the **claim copy** and **provider remittance documents** to make sure that the recipient, provider, and services on the returned REOMB are accurately presented. If the information on the returned REOMB is not accurate, then the REOMB and all documentation will be reviewed by the **Paramax Surveillance Utilization Review System (SURS) Unit**.

All situations that require further inquiry are reviewed by SURS. Situations that require criminal investigation are referred to the State Attorney's General's Medicaid Fraud Control Unit.

### Computer Profiling

Paramax can identify potential fraud and abuse situations by means of **profile reports**. A profile report is produced by a computer from information gathered in the state's claims payment operation. Providers are classified into peer groups according to geographic location, medical specialties, and other categories.

Profile reports include the following information:

- A statistical profile of each peer group classification to be used as a base line for evaluation;
- A statistical profile of each individual participant compatible with the peer group profile;
- An evaluation of each individual participant profile against its appropriate group profile; and
- A listing of individual participants who deviate significantly from their group norm (These individuals are reported as exceptional and are flagged for analysis.).

Each profile reported as exceptional is reviewed and analyzed by a trained staff and by medical consultants. The analysis can include a review of the provider's paid claims, a review of the provider's reply to Medicaid of Louisiana's written request for information, a review of hospital charges and patient records, and a review of other relevant documents. The overall review is not necessarily limited to areas identified as exceptional on the profile report.

## ADMINISTRATIVE SANCTIONS

To ensure the quality, quantity, and need for services, Medicaid payments may be reviewed by Medicaid of Louisiana. **Administrative sanctions** may be imposed against any Medicaid provider who does not meet the guidelines listed in the following subsection. Administrative sanctions refer to any administrative actions taken by the single state agency against a medical service provider of Title XIX services. Any such administrative action is designed to remedy inefficient and/or illegal practices which are not in compliance with Medicaid of Louisiana policies and procedures, statutes, and regulations.

### Levels of Administrative Sanctions

Listed below are the different levels of administrative sanctions that Medicaid of Louisiana may impose against a Medicaid provider:

- Issuing a warning to a provider through written notice or consultation;
- Requiring that the provider receive education in policies and billing procedures;
- Requiring that the provider receive prior authorization for services;
- Placing the provider's claims on manual review status before payment is made;

**NOTE:** Any provider of Medicaid services may be placed on prepayment review as an administrative sanction of misuse of Medicaid of Louisiana. Prepayment review may be limited to those types of procedures for which misuse has been detected, or it may include a complete review of all of the provider's claims.

- Suspending the provider or withholding payments from the provider;

**NOTE:** Medicaid of Louisiana may suspend or withhold payment to any provider who fails to meet the requirements for participation in Medicaid of Louisiana.

- Recovering money from the provider by deducting from future payments or by requiring direct payment for money improperly or erroneously paid;
- Referring a provider to the appropriate state licensing authority for investigation;
- Referring a provider for review by the appropriate professional organizations;
- Referring a provider to the Attorney General's Medicaid Fraud Control Unit for fraud investigation;
- Suspending a provider from participating in Medicaid of Louisiana; and
- Refusing to allow a provider to participate in Medicaid of Louisiana.

### Grounds for Sanctioning Providers

Medicaid of Louisiana may impose sanctions against any provider of medical goods or services if it discovers that any of the following conditions apply:

- A provider is not complying with Medicaid of Louisiana's policy, rules, and regulations or with the terms and conditions prescribed by Medicaid of Louisiana in its provider agreement and signed claim that set the terms and conditions applicable to each provider group's participation in the program.
- A provider has submitted a false or fraudulent application for provider status.
- Such a provider is not properly licensed or qualified, or such a provider's professional license, certificate, or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated.
- Such a provider has engaged in a course or conduct; has performed an act for which official sanction has been applied by the licensing authority, professional peer group, or peer review board or organization; or has continued the poor conduct after having received notification by a licensing or reviewing, indication that his conduct should cease.
- Such a provider has failed to correct deficiencies in his delivery of services or his billing practices after having received written notice of these deficiencies from Medicaid of Louisiana.
- Such a provider has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142, or such a provider has been convicted of Medicaid fraud (Louisiana R.S. 14:70.1).
- Such a provider has been convicted of a criminal offense relating to performance of a provider agreement with the state, to fraudulent billing practices, or to negligent practice, resulting in death or injury to the provider's patient.
- Such a provider has presented false or fraudulent claims for services or merchandise for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

- Such a provider has engaged in a practice of charging and accepting payment (in whole or in part) from recipients for services for which a charge was already made to Medicaid of Louisiana and for which payment was already made.
- Such a provider has rebated or accepted a fee or a portion of a fee for a patient referral.
- Such a provider has failed to repay or make arrangements to repay an identified overpayment or otherwise erroneous payment.
- Such a provider has failed, after having received a written request from Medicaid of Louisiana, to keep or to make available for inspection, audit, or copying, records regarding payments claimed for providing services.
- Such a provider has failed to furnish any information requested by Medicaid of Louisiana regarding payments for providing goods and services.
- Such a provider has made, or caused to be made, a false statement or a misrepresentation of a material fact in connection with the administration of Medicaid of Louisiana.
- Such a provider has furnished goods or services to a recipient which are in excess of the recipient's needs, harmful to the recipient, or of grossly inadequate or inferior quality (This determination would be based upon competent medical judgement and evaluation.).
- The provider, a person with management responsibility for a provider, an officer or person owning (either directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate provider, an owner of a sole proprietorship which is a provider, or a partner in a partnership which is a provider is found to fall into one or more of the following categories:
  - Was previously barred from participation in Medicaid of Louisiana;

- Was a person with management responsibility for a previously terminated provider during the time of conduct which was the basis for that provider's termination from participation in Medicaid of Louisiana;
- Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a previously terminated corporate provider during the time of conduct which was the basis for that provider's termination from participation in Medicaid of Louisiana;
- Was an owner of a sole proprietorship or a partner of a partnership which was previously terminated during the time of conduct which was the basis for that provider's termination from participation in the program;
- Was engaged in practices prohibited by federal or state law or regulation;
- Was a person with management responsibility for a provider at the time that such a provider engaged in practices prohibited by state or federal law or regulation;
- Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a provider at the time such a provider engaged in practices prohibited by federal or state law or regulation;
- Was an owner or a sole proprietorship or partner or a partnership which was a provider at the time such a provider engaged in practices prohibited by federal or state law or regulation;
- Was convicted of Medicaid fraud under federal or state law or regulation;

- Was a person with management responsibility for a provider at the time that such a provider was convicted of Medicaid fraud under federal or state law or regulation;
- Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a provider at the time such a provider was convicted of Medicaid fraud under federal or state law or regulation; or
- Was an owner or a sole proprietorship or partner or a partnership which was a provider at the time such a provider was convicted of Medicaid fraud under federal or state law or regulation;



**APPEALS**

The Louisiana Department of Health and Hospitals (DHH) provides a hearing to any provider who feels that he has been unfairly sanctioned. Specifically, the Bureau of Appeals in the Department of Health and Hospitals is responsible for conducting hearings for providers who have complaints. Requests for hearings explaining the reason for the request should be made in writing and sent directly to the Bureau of Appeals.

Detailed information regarding the appeals procedure may be obtained from the Bureau of Appeals at the following address:

**DHH Bureau of Appeals  
P.O. Box 4183  
Baton Rouge, LA. 70821-4182**

**RETURN/REFUND CHECKS****RETURN CHECKS**

All return checks should be mailed to the following address:

**Division of Fiscal Management  
Financial Management Section  
P.O. Box 91117  
Baton Rouge, LA. 70821-9117**

**REFUND CHECKS**

When errors in billing occur, e.g., duplicate payments, instead of simply refunding payments, providers should initiate claim adjustments or voids. However, should providers find it necessary to refund a payment, they should make checks payable to the Department of Health and Hospitals, Bureau of Health Services Financing, and mail the refunds to the following address:

**Division of Fiscal Management  
Financial Management Section  
P.O. Box 91117  
Baton Rouge, LA. 70821-9117**

To reconcile an account with the Treasury Department, providers must attach a copy of the Remittance Advice to their return or refund. In addition, they must explain the reason for the return or refund.

To determine the amount of a refund, providers should consider the following rules:

- Whenever a duplicate payment is made, the full amount of the second payment must be refunded.
- If another insurance company pays after Medicaid has made its payment and the TPL is greater than the Medicaid payment, the full amount of the Medicaid payment should be refunded.

**CHECKS SHOULD NOT BE MADE PAYABLE TO PARAMAX.**

**PARAMAX PROVIDER RELATIONS**

Paramax has a Provider Relations staff ready to assist providers with any questions they may have. There are individuals in the Baton Rouge office whose primary responsibility is to respond to telephone inquiries. These individuals can be reached at the following telephone numbers:

**Baton Rouge Providers**

**(504) 924-5040**

**Providers Outside of Baton Rouge  
(Louisiana Providers only)**

**1-800-473-2783**

**Telephone service is available Monday through Friday  
from 8:00 A.M. to 5:00 P.M.**

In addition, providers can mail written inquiries to the following address:

**Attention: Provider Relations  
Paramax  
P.O. Box 91024  
Baton Rouge, LA. 70821**

Provider Relations also has a staff of Field Analysts who are available to help providers with billing problems and to help train new provider staff members. To request a visit with a Field Analyst, providers can call or write to Provider Relations.

**NOTE:** Written inquiries should contain a note or a letter explaining the nature of the problem. Inquiries submitted without explanations could be processed without additional consideration.

In addition, providers who are calling Paramax, Provider Relations, should telephone the Provider Relations directly; they should not call the main Paramax switchboard.

## RECIPIENT ELIGIBILITY VERIFICATION SYSTEM

The Provider Relations inquiry staff strives to respond to provider inquiries quickly and efficiently. Some provider inquiries, however, require lengthy policy discussions or file research, so providers who want to make a simple inquiry are having to hold until an operator becomes available.

However, there is a simple solution.

Providers who wish to ask the following questions may use our Recipient Eligibility Verification System (REVS) telephone service:

- Is a particular recipient eligible for services on a specific date of service?
- What are the service limits for a particular recipient?
- What other payment source does a particular recipient have?
- What is my current check amount?

The system is operational 24 hours a day, 7 days a week, except for a short period on Sunday when the system is being updated.

To access the system, you just have to dial **(800) 776-6323** on a touch-tone telephone and have your provider identification number, the appropriate recipient identification number, and date of service ready. Once you are connected to the system, you will receive procedural instructions via voice response prompt messages. If you are familiar with the procedures for entering information, you need not wait for the prompt messages. Just begin entering the required information as soon as you have accessed the system.

We understand that there may be times when you need to speak to one of our inquiry representatives. When you have questions concerning printed policy, claims processing problems, or when you need to determine the status of a particular claim, we encourage you to call Provider Relations. To expedite your inquiry, please have all of the necessary information available when you call.

When you do not have time to speak to one of our representatives, use REVS. It's quick and easy.

# MANUAL UPDATES

It is very important to read all the following documentation, as it contains information in addition to that found in the Independent Laboratory and Portable X-ray Services Manual issued May 1, 1993.

Please note that the following pages were issued after the printing of the manual.

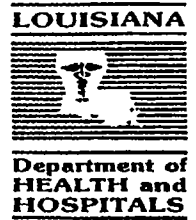
The information in the 1998 Basic Medicaid Provider Training packet, Medicaid Issues for 1998, was published in September, 1998.





M. J. "Mike" Foster, Jr.  
GOVERNOR

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



David W. Hood  
SECRETARY

May 20, 1998

To: All Medicaid Enrolled Providers

From: Thomas D. Collins

Re: Statutorily Mandated Revisions to all Provider Agreements

The 1997 Regular Session of the Legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437.14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

- (1) comply with all federal and state laws and regulations;
- (2) provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- (3) have all necessary and required licenses or certificates;
- (4) maintain and retain all records;
- (5) allow for inspection of all records by governmental authorities;
- (6) safeguard against disclosure of information in patient medical records;
- (7) bill other insurers and third parties prior to billing Medicaid;
- (8) report and refund any and all overpayments;
- (9) accept payment in full for Medicaid recipients providing allowances for copay authorized by Medicaid;
- (10) agree to be subject to claims review;
- (11) the buyer and seller of a provider are liable for any administrative sanctions or civil judgements;
- (12) notification prior to any change in ownership;
- (13) inspection of facilities; and,
- (14) posting of bond or letter of credit when required.





MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive.

The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

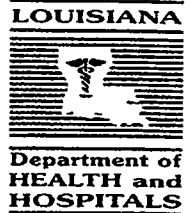
**Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify provider enrollment in writing within ten (10) working days of the date of this letter that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.**





M. J. "Mike" Foster, Jr.  
GOVERNOR

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS




David W. Hood  
SECRETARY

August 18, 1998

**MEMORANDUM**

TO: All Enrolled Medicaid Providers

FROM: Thomas D. Collins, Director of Bureau of Health Services Financing 

RE: Office for Civil Rights Policy Memorandum

The Department of Health and Human Services, Office for Civil Rights, recently issued a policy memorandum regarding nondiscrimination based on national origin as it relates to individuals who are limited-English proficient. Enclosed is the Health Care Financing Administration (HCFA) Civil Rights Compliance Statement which expresses our Agency's commitment to ensuring that there is no discrimination in the delivery of health care services through HCFA programs.

We have committed ourselves to full compliance with the requirements contained in this policy statement. As our partner with the administration of the Medicaid program you likewise are obligated to comply with those statutory civil rights laws. As stipulated in the policy statement, these laws include: Act of 1990 as amended and Title IX of the Education Amendments of 1972. The Office of Civil Rights of the Department of Health and Human Services has previously advised HCFA that detailed implementation regulations for the Rehabilitation Act of 1973, as amended, are located at 45 Code of Federal Regulations, Part 85.

It has been asked that we share this policy statement with you and that you do likewise with health care providers and all others involved in the administration of HCFA programs.

Questions regarding this memorandum should be directed to Don Fontenot at 342-1316.



## **HEALTH CARE FINANCING ADMINISTRATION (HCFA) CIVIL RIGHTS COMPLIANCE POLICY STATEMENT**

The Health Care Financing Administration's vision in the current Strategic Plan guarantees that all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all HCFA program operations and activities. I want to emphasize my personal commitment to and responsibility for ensuring compliance with civil rights laws by recipients of HCFA funds. These laws include: Title VI of the Civil Rights Act, as amended; Section 504 of the Rehabilitation Act, as amended; the Age Discrimination Act of 1975, as amended; the Americans with Disabilities Act of 1990, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all HCFA operating components. Promoting attention to and ensuring HCFA program compliance with civil rights laws are among my highest priorities for HCFA, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of HCFA programs.

HCFA, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability. HCFA will, with your help continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

To achieve its civil rights goals, HCFA will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities including: collecting data on access to, and the participation of, minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing HCFA publications, program regulations, and instructions to assure support for civil rights; and working closely with the Department of Health and Human Services (DHHS), Office of Civil Rights, to initiate orientation and training programs on civil rights. HCFA will also allocate financial resources to the extent feasible to: ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

DHHS will seek voluntary compliance to resolve issues of discrimination whenever possible. If necessary, HCFA will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

HCFA's mission is to assure health care security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries; i.e., our customers. We will enhance our communication with constituents, partners, and stakeholders. We will seek input from health care providers, states, contractors, and DHHS Office for Civil Rights, professional organizations, community advocates, and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability.

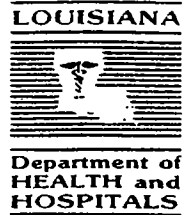
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M. J. "Mike" Foster, Jr.  
GOVERNOR

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS




David W. Hood  
SECRETARY

October 28, 1999

MEMORANDUM

To: All Providers of Laboratory Services

From: Thomas D. Collins   
Director

RE: Addition of Clinical Laboratory Improvement Amendment (CLIA) QW  
Modifiers

Previously, the Bureau has not required the use of QW modifiers when billing for certain laboratory procedures performed in physicians' offices that have CLIA waived or provider performed microscopy (PPM) certificates.

Effective for dates of service on or after February 1, 2000, waived (certification type 2) or PPM (certification type 4) providers will be required to use the QW modifier when billing the attached CPT laboratory procedure codes. The QW is a modifier which has been assigned by HCFA as a mandated addition to the CLIA waived codes.

For your information the list of tests granted waiver status under CLIA, which is periodically updated, may be found online at the following Internet address:

<http://www.hcfa.gov/medicaid/clia/waivetbl.htm>

If there are any questions concerning this matter, you may contact Kandis McDaniel Whittington, Program Manager, at (225) 342-9490 or Marie Smith, Program Specialist, at (225) 342-9319.





**TESTS GRANTED WAIVED STATUS UNDER CLIA**  
Revised 05/19/1999

TEST NAME	CPT CODE(S)	USE
Dipstick or tablet reagent urinalysis - non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	81002	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Fecal occult blood	82270	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)
Ovulation tests by visual color comparison for human luteinizing hormone	84830	Detection of ovulation (optimal for conception)
Urine pregnancy tests by visual color comparison	81025	Diagnosis of pregnancy
Erythrocyte sedimentation rate - non-automated	85651	Nonspecific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia
Hemoglobin by copper sulfate - non-automated	83026	Monitors hemoglobin level in blood
Blood glucose by glucose monitoring devices cleared by the FDA for home use	82962	Monitoring of blood glucose levels
Blood count; spun microhematocrit	85013	Screen for anemia
Hemoglobin by single instrument with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout	85018QW	Monitors hemoglobin level in blood
HemoCue B-Glucose Photometer	82947QW 82950QW 82951QW 82952QW	Diagnosis and monitoring of blood glucose levels
ChemTrak AccuMeter	82465QW	Cholesterol monitoring
Advanced Care	82465QW	Cholesterol monitoring
Boehringer Mannheim Chemstrip Micral	82044QW	Monitors low concentrations of albumin in urine which is helpful for early detection in patients at risk for renal disease.



TEST NAME	CPT CODE(S)	USE
Cholestech LDX	82465QW 83718QW 84478QW 82947QW 82950QW 82951QW 82952QW 80061QW	Measures total cholesterol, HDL cholesterol, triglycerides and glucose levels in whole blood.
Serim Pyloritek Test Kit	87072QW	Presumptive identification of <i>Helicobacter pylori</i> in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers).
QuickVue In-Line One-Step Strep A Test	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Boehringer Mannheim Accu-Chek InstantPlus Cholesterol	82465QW	Cholesterol monitoring
All qualitative color comparison pH testing - body fluids (other than blood)	83986QW	pH detection (acid-base balance) in body fluids such as semen, amniotic fluid and gastric aspirates
SmithKline Gastrocult	82273QW	Rapid screening test to detect the presence of gastric occult blood
QuickVue One-Step H. Pylori Test for Whole Blood	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood
Binax NOW Strep A Test	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Delta West CLOtest	87072QW	Presumptive identification of <i>Helicobacter pylori</i> in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers).
Wampole STAT-CRIT Hct	85014QW	Screen for anemia
SmithKline Diagnostics FlexSure HP Test for IgG Antibodies to H. pylori in Whole Blood	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood
Wyntek Diagnostics OSOM Strep A Test	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
GI Supply HP-FAST	87072QW	Presumptive identification of <i>Helicobacter pylori</i> in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers).



TEST NAME	CPT CODE(S)	USE
Abbott FlexPak HP Test for whole blood	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood
Chemtrak AccuMeter H. pylori Test (for whole blood)	Pending	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood
BioStar Aceava Strep A Test (direct specimen only)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
LXN Fructosamine Test System	82985QW	Used to evaluate diabetic control, reflecting diabetic control over a 2-3 week period. Not a useful test for screening diabetes mellitus.
ITC Prottime Microcoagulation System for Prothrombin Time	85610QW	Aid in screening for congenital deficiencies of factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for vitamin K deficiency.
CoaguChek PST for Prothrombin Time	85610QW	Aid in screening for congenital deficiencies of factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for vitamin K deficiency.
SmithKline ICON FxStrep A Test (from throat swab only)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Abbot Signify Strep A Test (from throat swab only)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Bayer Clinitek 50 Urine Chemistry Analyzer - qualitative dipstick for glucose, bilirubin, ketone, specific gravity, blood, pH, protein, urobilinogen nitrite leukocytes - automated	81003QW	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Bayer DCA 2000-glycosylated hemoglobin (HgbA1c)	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes.
Wampole Mono-Plus WB	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.



TEST NAME	CPT CODE(S)	USE
LXN Duet Glucose Control Monitoring System	82962 82985QW	Monitoring of blood glucose levels and measures fructosamine which is used to evaluate diabetic control, reflecting diabetic control over a 2-3 week period.
ENA.C.T Total Cholesterol Test	82465QW	Cholesterol monitoring
Genzyme Contrast Mono (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Applied Biotech SureStep Strep A (II) (direct from throat swab)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
STC Diagnostics Q.E.D. A150 Saliva Alcohol Test	Pending	Qualitative determination of alcohol (ethanol) in saliva
STC Diagnostics Q.E.D. A350 Saliva Alcohol Test	Pending	Qualitative determination of alcohol (ethanol) in saliva
Micro Diagnostics Spuncrit Model DRC-40 Infrared Analyzer for hematocrit	Pending	Screen for anemia
Chemstrip Mini UA - qualitative dipstick for glucose, bilirubin, ketone, specific gravity, blood, pH, protein, urobilinogen, nitrite, leukocytes - automated	81003/QW	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Litmus Concepts FemExam TestCard (from vaginal swab)	84999QW Priced manually, individual consideration	Qualitative test of a vaginal fluid sample for elevated pH (pH greater than or equal to 4.7) and the presence of volatile amines
Wyntek Diagnostics OSOM Mono Test (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Meridian Diagnostics ImmunoCard STAT Strep A (direct from throat swab)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Seradyn Color Q Mono (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Jant Pharmacal AccuStrip Strep A (II) (direct from throat swab)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.





TEST NAME	CPT CODE(S)	USE
BioStar Aceava Mono Test (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
LifeSign UniStep Mono Test (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Becton Dickinson LINK 2 Strep A Rapid Test (direct from throat swab)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
DynaGen NicCheck I Test Strips	80101QW	Detects nicotine and/or its metabolites in urine, which is used as an aid in indicating the smoking status of an individual and as an aid in the identification of a smoker as a low or high nicotine consumer.
Mainline Confirms Strep A Dots Test (direct from throat swab)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Quidel Cards O.S. Mono (for whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Bayer Clinitek 50 Urine Chemistry Analyzer - for HCG, urine	84703QW	Diagnosis of pregnancy
Bayer Clinitek 50 Urine Chemistry Analyzer - for microalbumin, creatinine	82044QW	Detection of patients at risk for developing kidney damage
Bayer DCA 2000+ - glycosylated hemoglobin (Hgb Alc)	83036QW	Measures the percent concentration of hemoglobin Alc in blood, which is used in monitoring the long-term care of people with diabetes.
GDS Diagnostics HemoSite Meter - for hemoglobin	85018QW	Measures hemoglobin level in whole blood.
ActiMed Laboratories ENA.C.T. Total Cholesterol Test (PDU)	82465QW	Cholesterol monitoring
Genzyme Contrast Strep A (direct from throat swab)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Roche/Boehringer Mannheim CoaguChek System for Professional Use	85610QW	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for Vitamin K deficiency.



TEST NAME	CPT CODE(S)	USE
Applied Biotech SureStep Mono Test (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Becton Dickinson Link 2 H. Pylori Rapid Test (for whole blood)	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood.
Bion Diagnostic Sciences BTA stat Test (for home use)	83518QW	Immunoassay for the qualitative detection of bladder tumor associated antigen in urine of persons diagnosed with bladder cancer and used as an aid in the management of bladder cancer patients.
Diatech Diagnostics Uriscreeen (for OTC use)	81007QW	Detects catalase in urine which is associated with urinary tract infections (UTIs). White blood cells and some bacteria associated with UTIs are positive for catalase.
Lifestream Technologies Cholesterol Monitor	82465QW	Cholesterol monitoring
Abbott TestPack Plus H. Pylori (for whole blood)	86318QW	Immunassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood.
Jant Accutest Infectious Mononucleosis Test (whole blood)	86308QW	Qualitative screening test for presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.

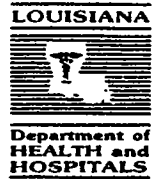
<http://www.hcfa.gov/medicaid/clia/waivetbl.htm>





M. J. "Mike" Foster, Jr.  
GOVERNOR

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



David W. Hood  
SECRETARY

July 12, 2000

NOTICE TO PROVIDERS OF PROFESSIONAL SERVICES

The Year 2000 CPT codes have been loaded and may be billed effective with date of service January 1, 2000.

Code 33140 (Transmyocardial laser revascularization, by thoracotomy) was made payable for cross-overs, only. It may be made payable for straight Medicaid claims at a later date.

Codes 58672 (Laparoscopy, surgical; with fimbrioplasty) and 58673 (Laparoscopy, surgical; with salpingostomy) were made payable for only cross-overs, as well, as these two procedures are performed on females with infertility problems. As you know, the Medicaid Program does not cover infertility procedures.

Some of the codes used in billing for maternity-related anesthesia were deleted and replaced by new codes. Code 62276 was replaced by code 62318, code 62278 was replaced by code 62311 and code 62279 was replaced by code 62319. You may use these new codes in billing for m-r anesthesia effective with date of service 1-1-2000. The reimbursement amounts did not change, however.

Reimbursement for the following codes is limited to 1 per 180 days UNLESS given for reasons OTHER THAN pain control, pain management or the alleviation of chronic pain:

62280, 62281, 62282; 62310, 62311, 62318, 62319; 64400, 64402, 64405, 64408, 64410, 64412, 64413, 64415, 64417, 64418, 64420, 64421, 64425, 64430, 64435, 64445, 64450, 64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484, 64505, 64508, 64510, 64520 and 64530.

Codes 62274, 62277, 62278, 62279 and 62289 were deleted from the list of codes for which anesthesiologists and CRNAs are paid a flat fee. Added to this list were codes 62310, 62311 and 62319.



Reimbursement for procedure code 77427 (Radiation treatment management, five treatments) will be driven by the number placed in the Units column on the HCFA 1500. For example, if the course of therapy totalled 14 treatments, place 14 in the units column. If the course of therapy totalled 7 treatments, place 7 in the units column. If the course of therapy consists of only one or two treatments, bill code 77431 rather than code 77427. The fee for each treatment will be \$31.28.

Respiratory Syncytial virus immune globulin (code 90378) is funded through the Pharmacy Program. Therefore, it was not made payable through the Physicians Program.

Code 99173 is funded via an "X" code in the EPSDT Program. It will not be funded in the Physicians Program.

The fees paid for the 2000 codes for dates of service 1-1-2000 through 1-31-2000 will be 7% higher than those paid for dates of services 2-1-00 through 6-30-00. Effective with date of service July 1, 2000, the fees for all codes previously reduced will be restored by 7% with the exception of codes 99212, 99213, 99214, 99215, Z9005 and 99283. The fees for these codes will be as follows:

99212 - \$30.13	99214 - \$41.13	Z9005 - \$33.43	99283 - \$35.23
99213 - \$36.13	99215 - \$49.63		

If questions arise, please call Kandis Whittington at 225-342-9490, Tracey Zimmerman at 225-342-9391 or Ida Duncan at 225-342-3932.