UNISYS

BASIC SERVICES PROVIDER TRAINING

Spring 2006

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

ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the Spring 2006 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet presents general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability.

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS
FOR CHILDREN AND YOUTH

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES.
TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.
(See listing of numbers on attachment)

MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.**

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED.
TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955
(or TTY 1-877-544-9544)

MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive Mental Health Rehabilitation Services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by mental health prior authorization unit.

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES

Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. PCS services do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. The PCS service provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES

Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. *EARLYSTEPS* CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical Equipment and Supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

TRANSPORTATION

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544).
IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED,
CALL 1-888-758-2220 FOR ASSISTANCE.

OTHER MEDICAID COVERED SERVICES

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY

METROPOLITAN HUMAN SERVICES DISTRICT
1010 Common Street, 5th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660

CAPITAL AREA HUMAN SERVICES DISTRICT
4615 Government St. - Bin # 16 - 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-800-768-8824

REGION III
690 E. First Street
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

REGION IV
214 Jefferson Street - Suite 301
Lafayette, LA 70501
Phone: (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

REGION V
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Phone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

REGION VI
429 Murray Street - Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
3018 Old Minden Road
Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

REGION VIII
122 St. John St. - Room 343
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
21454 Koop Drive - Suite 2H
Mandeville, LA 70471
Phone: (985) 871-8300
FAX: (985) 871-8303
Toll Free: 1-800-866-0806

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
3101 W. Napoleon Ave – S140
Metairie, LA 70001
Phone: (504) 838-5357
FAX: (504) 838-5400

TABLE OF CONTENTS

STANDARDS FOR PARTICIPATION 1
- Picking and Choosing Services 1
- Statutorily Mandated Revisions to All Provider Agreements 2
- Surveillance Utilization Review 3
- Fraud and Abuse Hotline 4

PROVIDER ENROLLMENT 5
- Change of Address/Enrollment Status 5
- Protection of Provider Information 6
- Individual Provider Number Linkages to Group Numbers 6
- The PE-50 Form 6
- Correct Taxpayer ID Information 7
- Electronic Funds Transfer Requirements (MANDATORY) 7
- Changes of Ownership (CHOWs) 8

IDENTIFICATION OF ELIGIBLE RECIPIENTS 9
- Recipient Eligibility Verification System (REVS) 9
- Medicaid Eligibility Verification System (MEVS) 11
- e-MEVS 12
- MEVS, REVS, and e-MEVS Reminders 14
- Eligibility Verification Responses 15

MEDICAID PAPER ELIGIBILITY FORMS 16
- Presumptive Eligibility 16
- Illegal Aliens 16
- Retroactive Long Term Care (LTC) Coverage For Deceased Persons 16
- BHSF Form 18-PE 17

RETROACTIVE ELIGIBILITY 26
- BHSF Form 18-SSI 27

RECIPIENT REFUNDS DUE TO RETROACTIVE ELIGIBILITY POLICY 31

PARISH OFFICE PHONE NUMBERS 32

MEDICALLY NEEDY PROGRAM 33
- Medically Needy 33
- 110-MNP Form 34

LOCK-IN PROGRAM 36

THIRD PARTY LIABILITY 38
- TPL Billing Procedures 38
- Requests to Add or Remove Recipient TPL/Medicare Coverage 39
- Payment Methodology When TPL is Involved 39
- Prenatal and Preventive Pediatric Care Pay and Chase 40
- Voiding Accident-Related Claims for Profit 41
- Outgoing Medical Records Stamp 41
- Trauma Diagnosis Codes 41
- Third Party Liability Recovery Unit 41
- HMO TPL Codes 42
- HMO and Medicaid Coverage 42
- Qualified Medicare Beneficiaries (QMBs) 43
- Medicare Crossover Claims 44
- Medicare – Elimination of Paper Remittance Advices 44
- Medicare Advantage Plan Claims 45

Recoupments by TPL Collections Contractor – Health Management Systems 46
Louisiana Health Insurance Premium Payment (LaHIPP) program 46
ACT NO. 269 – NEWBORN CHILD HEALTH INSURANCE COVERAGE 46
Third Party Liability (TPL) Notification of Newborn Children Form 46
ACT No. 269 "Baby Bill" – Legislative Summary 46
MEDICARE PART D 51
Medicaid Coverage for Excluded Part D Drugs 51
Co-payments 51
Quarterly Medicare Recoveries By Unisys 52
TPL and Eligibility Reminders 55
COMMUNITYCARE 56
Program Description 56
Recipients 56
Primary Care Physician 57
Non-PCP Providers and Exempt Services 58
HOSPICE SERVICES 60
Overview 60
Payment of Medical Services Related to the Terminal Illness 60
Payment for Medical Services NOT Related to the Terminal Illness 60
PHARMACY SERVICES 62
Prior Authorization 62
Preferred Drug List (PDL) 62
Monthly Prescription Service Limit 62
ELECTRONIC DATA INTERCHANGE (EDI) 64
Claims Submission 64
Certification Forms 64
Electronic Data Interchange (EDI) General Information 65
Electronic Adjustments/Voids 66
CLAIMS PROCESSING REMINDERS 67
IMPORTANT UNISYS ADDRESSES 69
TIMELY FILING GUIDELINES 70
Dates of Service Past Initial Filing Limit 70
Submitting Claims for Two-Year Override Consideration 71
PROVIDER ASSISTANCE 72
Unisys Provider Relations Telephone Inquiry Unit 72
Unisys Provider Relations Correspondence Group 74
Unisys Provider Relations Field Analysts 75
Provider Relations Reminders 77
PHONE NUMBERS FOR RECIPIENT ASSISTANCE 81
LOUISIANA MEDICAID WEBSITE APPLICATIONS 82
Provider Login And Password 82
Web Applications 83
Additional DHH Available Websites 86
THE REMITTANCE ADVICE 87
The Purpose of the Remittance Advice 87
Remittance Advice Breakdown 88
Remittance Summary 88
Claims in Process 90
Denied Claims Turnarounds (DTAs) 90
TPL Denied Claims Notification List (CP-0-25) 90
Refund Checks 91

ORDERING INFORMATION 98
Remittance Advice And History Requests 98
Remittance Advice Copies 98
History Requests 98
Medicaid Claim Forms 99
CMS-1500 Ordering Information: 99
UB-92 Ordering Information: 100
Pharmacy Claim Form Ordering Information: 100
ADA Dental Claim Form Ordering Information: 100
REMITTANCE ADVICE CLAIM DENIAL RESOLUTION FOR LOUISIANA MEDICAID 101
General Claim Form Completion Error Codes 101
Recipient Eligibility Error Codes 102
Presumptive Eligibility Error Codes 103
Lock-In Program Error Codes 103
Spend-Down Medically Needy Error Codes 104
CommunityCARE Error Codes 104
Timely Filing Error Codes 105
Third Party Liability Error Codes 105
Adjustment/Void Error Codes 107
Miscellaneous Error Codes 107
Duplicate Claim Error Code 108
Provider Eligibility Error Codes 108

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 the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH);

- 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 refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.

- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services;

- **NOTE: Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, 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 1978*, 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 payment as payment in full for services rendered. Providers must bill Medicaid for **all** Medicaid covered services that they provide to their clients.

Providers continue to have the option of picking and choosing from which patients they will accept Medicaid. Providers are not required to accept every Medicaid patient requiring treatment.

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:

- comply with all federal and state laws and regulations;
- provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- have all necessary and required licenses or certificates;
- maintain and retain all records for a period of five (5) years;
- allow for inspection of all records by governmental authorities;
- safeguard against disclosure of information in patient medical records;
- bill other insurers and third parties prior to billing Medicaid;
- report and refund any and all overpayments;
- accept payment in full for Medicaid recipients providing allowances for copayments authorized by Medicaid;
- agree to be subject to claims review;
- the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- notification prior to any change in ownership;
- inspection of facilities; and,
- 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 immediately 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.

Surveillance Utilization Review

The Department of Health and Hospitals' Office of Program Integrity, in partnership with Unisys, perform the Surveillance Utilization Review function of the Louisiana Medicaid program. This function is intended to combat fraud and abuse within Louisiana Medicaid and is accomplished by a combination of computer runs, along with medical staff that review providers on a post payment basis. Providers are profiled according to billing activity and are selected for review using computer-generated reports. The Program Integrity Unit of DHH also reviews telephone and written complaints sent from various sources throughout the state, including the fraud hotline.

☞ Program Integrity and SURS would also like to remind all providers that they are bound by the conditions of their provider agreement which includes but is not limited to those things set out in Medical Assistance Program Integrity Law (MAPIL) R.S. 46:437.1 through 440.3, The Surveillance and Utilization Review Systems Regulation (SURS Rule) Louisiana Register Vol. 29, No. 4, April 20, 2003, and all other applicable federal and state laws and regulations, as well as Departmental and Medicaid policies. Failure to adhere to these could result in administrative, civil and/or criminal actions.

Providers should anticipate an audit during their association with the Louisiana Medicaid program. When audited, providers are to cooperate with the representatives of DHH, which includes Unisys, in accordance with their participation agreement signed upon enrollment. Failure to cooperate could result in administrative sanctions. The sanctions include, but are not limited to:

- Withholding of Medicaid payments
- Referral to the Attorney General's Office for investigation
- Termination of Provider Agreement

Program Integrity and the Unisys Surveillance Utilization Review area remind providers **that a service undocumented is considered a service not rendered**. Providers should ensure their documentation is accurate and complete. All undocumented services are subject to recoupment. Other services subject to recoupment are:

- Upcoding level of care
- Maximizing payments for services rendered
- Billing components of lab tests, rather than the appropriate lab panel
- Billing for medically unnecessary services
- Billing for services not rendered
- Consultations performed by the patient's primary care, treating, or attending physicians

Fraud and Abuse Hotline

The state has a hotline for reporting possible fraud and abuse in the Medicaid Program. Providers are encouraged to give this phone number/web address to any individual or provider who wants to report possible cases of fraud or abuse.

Anyone can report concerns at (800) 488-2917 or by using the web address at http://www.dhh.state.la.us/offices/fraudform.asp?id=92

PROVIDER ENROLLMENT

Change of Address/Enrollment Status

The mailing address for all Provider Enrollment related issues is:

Unisys Provider Enrollment
PO Box 80159
Baton Rouge, LA 70898-0159
(225) 216-6370

General Information

Policies and procedures include the following:

- Enrollment packets are revised continuously. Therefore, if the requested enrollment packet is not completed timely, or if a copy of the packet is kept on file and used later to enroll another individual, a new packet should be requested if 6 months or more have lapsed since the original enrollment packet was requested.
- All application forms **MUST** be completed in their entirety. Please review all instructions prior to completing forms. If an application is submitted with incomplete or inaccurate information, the entire application will be returned to the submitting provider with a cover letter identifying the needed information. The provider must correct the form(s) as needed and re-submit the entire enrollment application. Once corrections are made, the entire packet should be resubmitted to Provider Enrollment for processing. This process will be repeated until all information is correct.
- Applications, updates or any other changes to provider enrollment records must be submitted to the Unisys Provider Enrollment Unit **IN WRITING**. Unless specifically directed by the Provider Enrollment staff, no faxes will be accepted.
- Requests for linkages of individual providers to group numbers will continue to require a completed PE-50 form (if the linking professional is not currently enrolled) or a completed Group Linkage Form (if the linking professional is currently enrolled).
- All correspondence should contain a request that the provider's file be updated with current information and should include the 7-digit provider number, the old information currently on the Medicaid file and the new information. Please be advised that some information cannot be changed without additional information or completed enrollment packets.
- Providers should notify Unisys Provider Enrollment, **IN WRITING**, when a mailing or service address and/or phone number change occurs to allow Louisiana Medicaid correspondence (including rejected/approved claims) to be sent more quickly to providers.
- The Post Office returns excessive amounts of provider mail, including remittance advices, due to invalid addresses. In many cases, when attempts are made to contact these providers, the telephone numbers on file are also invalid or no longer in service. The mail is returned to Unisys because forwarding orders at the post office have expired. Any provider whose address and/or telephone number are not current and accurate should request an Address/Telephone Change Form to update the information. If the provider cannot be located, the provider number is closed.

- Please be aware that RAs and checks are mailed to the provider's "Pay To" address on our files, not the address written on a claim form; therefore, it is imperative that any change in address be reported to Unisys Provider Enrollment immediately
- It is important that the provider ensures the Pay-To Name on the provider file information is kept accurate. To change the Pay-To Name on file, a copy of a preprinted IRS document showing the name and taxpayer identification number as is on the file with the IRS must be attached. All documents requesting pay-to-names must match the IRS documentation exactly. Differences in the IRS documentation and the provider enrollment forms may result in delays in updating your provider file information. Any discrepancies will be returned to you for correction.
- All correspondence to the Unisys Provider Enrollment Unit **MUST** be mailed to the address above.

Protection of Provider Information

To protect provider identity theft, the Provider Enrollment Unit is **not** authorized to disclose any provider information to any third party. Third parties include billing companies and/or clearinghouses, management companies, and credentialing companies or other entities not directly associated with the provider. Requests for release of provider information to a third party must be submitted in writing with the provider's original signature (no stamps or initials).

Each provider receives a letter of notification from Unisys Provider Enrollment when the submitter number is linked to the provider number. This letter advises the provider to supply their billing agent with this information, as no other notice is sent from Provider Enrollment.

Individual Provider Number Linkages to Group Numbers

An individual's provider number can be "linked" to a group provider number for purposes of billing services provided under the relationship with the individual and the group. Claims submitted under the group number, with an individual's number included as the attending provider, will be processed and the remittance will be sent directly to the group's Pay-To address. *It is not necessary for the individual's Pay-To address to be the same as the group's Pay-To address for these Remittance Advice notices to be sent to the group if billed correctly.* **It is vital that the provider adequately identifies whether the request is for an individual number to be "linked" to a group number or to update the individual file with the group information. If the individual file is to be updated, the individual provider must initiate the request.** Requests of group representatives to update information on an individual's provider file are returned to the requestor.

The PE-50 Form

When completing the Provider Enrollment Form (PE-50), providers should submit a one-page form (front and back). In other words, **providers should NOT submit the form on two separate pages.** In addition, providers should ensure that the PE-50 has an original signature. Stamped or copied signatures are **NOT** accepted.
Providers who have questions pertaining to filing the PE-50 need to contact Provider Enrollment at (225) 237-3370.

Correct Taxpayer ID Information

An entity's Taxpayer Identification Number (TIN) is the IRS number assigned to a business entity by the IRS. The name and number in the Medicaid records must match the information on the IRS files. **The Pay-To Name on the PE-50 MUST match the first line of the entity's name on the pre-printed IRS document exactly. Any variations in the name submitted will result in the rejection of the enrollment application for corrections.**

Internal Revenue Service considers the TIN, also known as Employer Identification Number (EIN), as incorrect if either the name or number shown on an account does not match a name or number combination in their files or in the files of the Social Security Administration (SSA).

Providers who have submitted a Form SS-4 to the Internal Revenue Service for a new employer identification number and have obtained a new number should send a copy of the Notice of New Employer Identification Number Assigned to the Unisys Provider Enrollment Unit, with a letter indicating Medicaid provider numbers affected by any changes.

NOTICE: If appropriate action is not taken to correct the mismatches, the law requires the agency to withhold 31% of the interest, dividends and certain other payments that we make to your account. This is called backup withholding. In addition to backup withholding, you may be subject to a $50.00 penalty by the IRS for failing to give us your correct name/TIN combination. An individual may use their social security number in place of the taxpayer identification number.

Auto Closures

Under current policy, Louisiana Medicaid numbers are automatically closed for non-participation if there has been no billing or payment using the provider number for the previous 18 months. If a number is automatically closed, the provider will be required to re-enroll if they wish to participate in Louisiana Medicaid. Auto closures are done on a quarterly basis.

Electronic Funds Transfer Requirements (MANDATORY)

The Department of Health and Hospitals mandates electronic funds transfer (EFT), for the direct deposit of weekly (monthly for long term care) payments for Medicaid services.

Providers who need additional forms, or have any questions regarding the EFT payment process should contact Unisys Provider Enrollment at (225) 216-6370.

NOTICE: The EFT enrollment process requires that **a voided check or a letter** from the bank identifying your account number and routing number be submitted with the agreement papers. **Please be aware that a deposit slip for the account WILL NOT be accepted.** Once loaded to the file there are two (2) pay cycles for testing. During this period paper checks will be mailed to the "Pay-To" address.

Once completion of the electronic funds transfer process has been completed, the summary page of the remittance advice will indicate that direct deposit has been established and the date of deposit of funds. Deposits are credited to the account at the end of the business day indicated on the RA.

Provider file updates and/or changes should include the direct deposit agreement if appropriate**. For example, if an individual physician is currently employed by a hospital or clinic, payments for his services are being deposited into the bank account for that facility. If the physician chooses to open his own private practice, he must complete a new direct deposit agreement in order to have payments made to his own bank account.** Also, when changing bank accounts, you must notify the Unisys Provider Enrollment Unit in a timely manner in order for payments to be made to the appropriate account. Failure to submit the necessary forms timely may result in delays in payment or funds being deposited to incorrect accounts.

The monthly bank statement should be reviewed in order to determine the date and amount of the payment made by the Department of Health and Hospitals. The deposit account number on your bank statement consists of the middle five digits of your Medicaid provider number with two leading zeros plus the remittance advice number. The amount for the deposit for a particular date is the same as the total payment shown on the financial page of the remittance advice of the corresponding date.

Providers should attempt to resolve any EFT problems with their accounting departments or their banking institution prior to contacting the Unisys Provider Enrollment Unit at (225)216-6370.

Changes of Ownership (CHOWs)

All changes of ownership **MUST** be reported to Unisys Provider Enrollment 60 days prior to the change of ownership; this must be done **IN WRITING** and must include the current Medicaid provider number and the effective date of the CHOW. Failure to do so may result in closure of the provider number, delays in payment or sanctions and/or fines. **Direct Deposit information will not be changed when a CHOW has occurred without a full enrollment packet being completed.**

IDENTIFICATION OF ELIGIBLE RECIPIENTS

All recipients enrolled in Louisiana's Medicaid Program are issued **Plastic Identification Cards**. These permanent identification cards contain a card control number (CCN) which can be used by the provider to verify Medicaid eligibility. The Department of Health and Hospitals (DHH) now offers several options to assist providers with verification of current eligibility. Use of these options will require provider verification.The following eligibility verification options are available:

1. Medicaid Eligibility Verification System (MEVS), an automated eligibility verification system using a swipe card device or PC software through vendors.
2. Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system
3. e-MEVS, a web application accessed through www.lamedicaid.com
4. Pharmacy Point of Sale (POS).

These eligibility verification systems provide confirmation of the following:

- Recipient eligibility
- Third Party (Insurance) Resources
- Service limits and restrictions
- CommunityCARE
- Lock-In

Before accessing the REVS, MEVS, and e-MEVS eligibility verification systems, providers should be aware of the following:

- In order to verify recipient eligibility, inquiring providers must supply the system and Provider Relations with two (2) identifying pieces of information about the recipient.
- Specific dates of service must be requested. A date range in the date of service field on an inquiry transaction is not acceptable, and Provider Relations will not supply eligibility information for date ranges.

Recipient Eligibility Verification System (REVS)

The Recipient Eligibility Verification System (REVS) is a toll-free telephonic eligibility hotline that is used to verify Medicaid eligibility and is provided at no additional cost to enrolled providers. REVS can be accessed through touch-tone telephone equipment using the Unisys toll-free telephone number **(800) 776-6323** or the local Baton Rouge area number **(225) 216-REVS (7387)**.

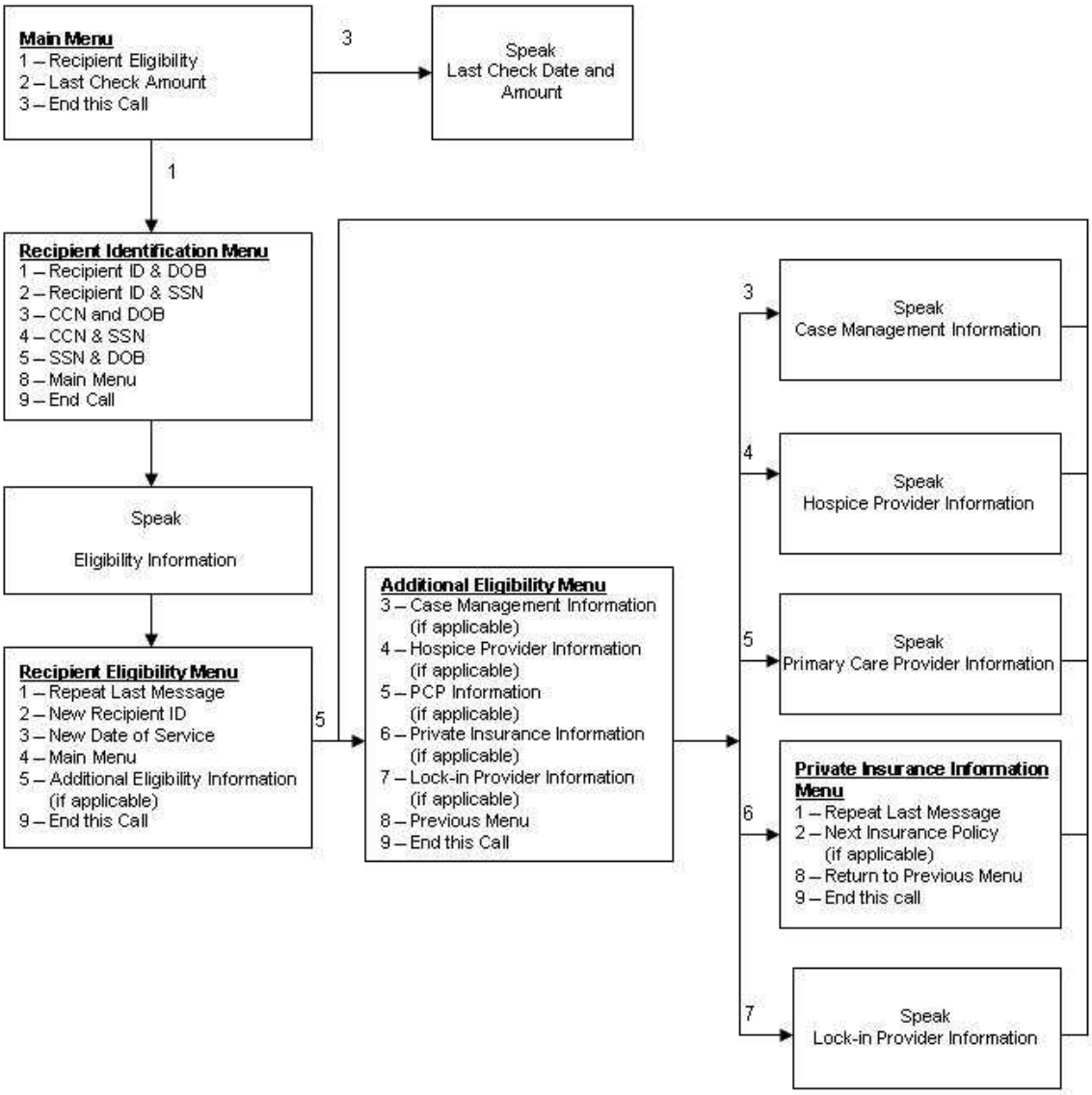
Accessing REVS

Providers may access recipient eligibility by using the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Medicaid ID number (valid during the last 12 months) and recipient birth date
- Medicaid ID number (valid during the last 12 months) and social security number
- Social Security number and recipient birth date

REVS MENU – (800) 776-6323

The 7-digit Louisiana Medicaid provider number must be entered to begin the eligibility verification process.



Medicaid Eligibility Verification System (MEVS)

The Medicaid Eligibility Verification System (MEVS) is an electronic system used to verify Medicaid eligibility. MEVS access is provided through contracts with approved "Switch Vendors" who are responsible for provision of the magnetic card reader, PC software, or computer terminal necessary to access this system. Providers are charged a fee for this service and this fee will depend on the type of service selected.

MEVS allows providers to retrieve printed verification by using one of the three following verification methods:

- point of sale technology, using "swipe card devices" similar to retail credit cards
- personal computer (PC) software tailored to fit the individual provider's specific needs; or
- computer terminal

Providers should keep hardcopy proof of eligibility.

The following vendors are approved by DHH:

Vendor	Contact	Telephone	Website
Emdeon Business Services formerly WebMD Business Services	Inside Professional Sales	(877) 469-3263 Option 3	www.emdeon.com
Healthcare Data Exchange	Lee Ledbetter	(610) 448-4133	www.hdx.com
Passport Health Communications	Cathy Cameron	(601) 605-0338 (601) 201-4377	www.passporthealth.com
HealthNet Data Link	Lucy Joseph	(954) 331-6500 (800) 338-1079	www.ehdl.com
NEBO Systems, Inc.	NEBO Help Desk	(866) 810-0000	www.ecare.com

NOTE: Except for a short time needed each week for maintenance, MEVS is available 24 hours a day, 7 days a week to allow providers easy and immediate retrieval of current recipient eligibility information.

Accessing MEVS

Providers may access recipient eligibility by using the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Medicaid ID number (valid during the last 12 months) and recipient birth date
- Medicaid ID number (valid during the last 12 months) and social security number
- Social Security number and recipient birth date
- Recipient name and recipient birth date
- Recipient name and social security number

e-MEVS

Providers can now verify eligibility and service limits for a Medicaid recipient using a web application accessed through www.lamedicaid.com. This application was implemented to provide eligibility verification capability in addition to MEVS swipe card transactions and REVS. An eligibility request can be entered via the web for a single recipient and the eligibility and service limits data for that individual will be returned on a web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Providers should keep hardcopy proof of eligibility.

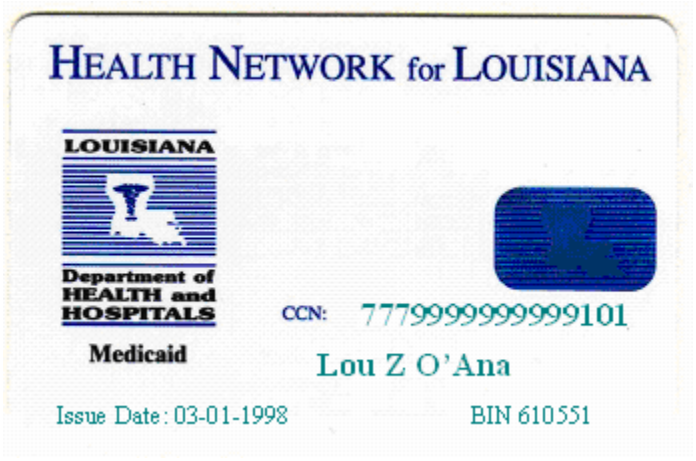
Accessing e-MEVS

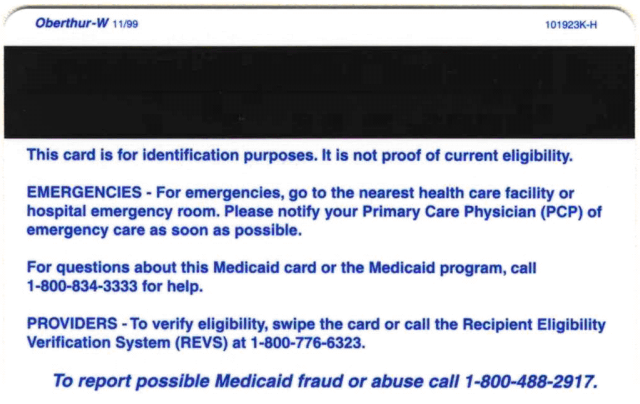
Providers may access recipient eligibility by using the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Social Security number and recipient birth date
- Recipient ID number (valid during the last 12 months) and recipient birth date
- Recipient ID number (valid during the last 12 months) and social security number
- Recipient name and social security number
- Recipient name and recipient birth date

Pharmacy Point of Sale (POS)

For pharmacy claims being submitted through the POS system, eligibility is automatically verified. Checking eligibility through REVS, MEVS, and e-MEVS is not necessary except in an instance of recipient retroactive eligibility.


HEALTH NETWORK for LOUISIANA
LOUISIANA
Department of HEALTH and HOSPITALS
Medicaid
CCN: 7779999999999101
Lou Z O'Ana
Issue Date: 03-01-1998
BIN 610551


Oberthur-W 11/99
101923K-H
This card is for identification purposes. It is not proof of current eligibility.
EMERGENCIES - For emergencies, go to the nearest health care facility or hospital emergency room. Please notify your Primary Care Physician (PCP) of emergency care as soon as possible.
For questions about this Medicaid card or the Medicaid program, call 1-800-834-3333 for help.
PROVIDERS - To verify eligibility, swipe the card or call the Recipient Eligibility Verification System (REVS) at 1-800-776-6323.
To report possible Medicaid fraud or abuse call 1-800-488-2917.

MEVS, REVS, and e-MEVS Reminders

It is important to remind you of areas that may potentially cause problem responses through MEVS, REVS and e-MEVS:

- You must listen to the menu and press the appropriate keys to obtain CommunityCARE or Lock-In information through REVS.

- When using a recipient's 13-digit Medicaid number, remember that all systems carry only recipient numbers which are valid for the last 12 months. If you are entering an old number (valid prior to the last 12 months), you will receive a response that indicates the recipient is not on file.

- An error message will be returned through the automated systems if the date is not a valid 8-digit date.

- Claims must be filed with the 13-digit Medicaid identification number.

- Providers cannot obtain KIDMED linkage through traditional forms of eligibility verification, such as REVS, MEVS, or e-MEVS. In order to obtain KIDMED linkage, providers must call Unisys or ACS. When requesting KIDMED linkage, providers must be specific as to whether they are requesting KIDMED or CommunityCARE linkage. In addition, when rendering a screening, the recipient must either be linked to the screening provider, or the screening provider must have a contractual agreement with the provider to whom the recipient is linked.

Eligibility Verification Responses

The eligibility verification systems for MEVS, REVS, and e-MEVS provide response messages that supply all information required to service the recipient. The following table is representative of the types of information received from these verification systems:

Recipient Eligibility	Response
Recipient is a CommunityCARE recipient	Message indicates that the recipient is CommunityCARE and includes the name of the recipient's PCP and the telephone number of the PCP to allow the inquiring provider to contact the PCP for a referral prior to providing services.
Recipient is eligible through a category of service that limits coverage of certain services or by certain providers	Information provided as part of eligibility response. For example: If the recipient is covered through the Medically Needy Program, which does not cover certain services, and the provider calling is a provider of a non-covered service, the response will include a message indicating that the recipient is Medically Needy and the services provided by the calling provider would not be covered.
Recipient is QMB eligible QMB Only QMB Plus Non QMB	In cases where the recipient is QMB Only, the REVS response will state: "This recipient is only eligible for Medicaid payment of deductible and co-insurance of services covered by Medicare. This recipient is not eligible for other types of Medicaid assistance." If the recipient is QMB Plus the REVS message will state "The recipient is eligible for both Medicare co-insurance and deductible and Medicaid services." Finally, if the recipient is a Non-QMB there will be no specific message, however REVS will indicate that the recipient has Medicare in the TPL segment of the response.
Recipient is presumptively eligible	Response will indicate: "This recipient may be eligible for outpatient ambulatory services only. Providers must call 1-800-834-3333 to verify current eligibility."
Recipient is a child	Message indicates that the recipient is EPSDT eligible, meaning the recipient is under 21 years of age and eligible for all services and service limits allowed for children.

All eligibility and service limitation information is related to the inquiring provider. However, it is the provider's responsibility to know and understand all policy limitations.

MEDICAID PAPER ELIGIBILITY FORMS

Some types of Medicaid eligibles will still receive paper eligibility forms. These groups of eligibles are *presumptive eligibles, illegal aliens (covered for emergency medical services, type case 47), and deceased retroactive eligibles.* Included in this section are examples of sample forms for these categories. Providers may want to refer to these samples to assist in understanding the information appearing on the eligibility forms.

Presumptive Eligibility

Pregnant women may have "**Presumptive Eligibility** (PE)" established by a "qualified provider" such as a state hospital or public health unit for a period of **up to (45) days**. The Form 18-PE (p.17) is issued for this eligibility type. During this period the "presumptively eligible" pregnant women will be eligible for ambulatory (outpatient) prenatal care including non-emergency transportation. **Once fully certified, she will be given a plastic ID card and can receive any pregnancy-related services including hospital and delivery until 60 days after** delivery. Pregnancy-related services cover any medical conditions that can impact the pregnancy by affecting the mother's health.

During the 45-day period of presumptive eligibility, coverage may expire at any time if eligibility requirements are not met. MEVS, REVS, and e-MEVS eligibility verification responses will alert providers that the recipient may be eligible for outpatient ambulatory services only and that providers must inquire to verify eligibility. **Verification should be made at the parish office during the 45-day period or by calling the Regional Office at (800) 834-3333.**

Illegal Aliens

These individuals are certified only for limited periods of eligibility via Form 18-EMS (p 19). Their dates of eligibility only cover dates of service on which emergency services were rendered. Once such a person's eligibility ceases, he must re-apply at the parish office if coverage for new emergency services is to be granted.

Retroactive Long Term Care (LTC) Coverage For Deceased Persons

If Medicaid eligibility determination is not made for a recipient until after the recipient has died in a long term care facility, Form 18-LTC (pages 21 – 25) is issued posthumously to allow the long term care provider to be paid.

BHSF Form 18-PE

BHSF Form 18-PE
Rev. 08/01
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Notice of Decision-**Presumptive Eligibility (PE)**

_____

_____, LA _____

_____, 20_____

Case ID # _____

SSN _____

Dear _____:

☐ You have been approved for **temporary** Medicaid coverage which is **limited** to pregnancy-related outpatient services, beginning _____. Coverage under this program **cannot** extend beyond _____, **unless** you have applied for regular Medicaid coverage and our decision on that application has not been made. This **temporary** coverage may be shortened to less than this time if you are found to be ineligible **or** if you fail to comply with eligibility requirements.

You **must** complete an application for Medicaid and comply with all eligibility requirements if you are interested in having Medicaid coverage continue throughout your pregnancy and for sixty (60) days after your pregnancy ends **and** for Medicaid to cover your labor and delivery charges.

☐ Please complete the enclosed application for continued Medicaid coverage and return it to us by _____ (seven days from the date of this notice) to protect your application date.

☐ An appointment has been scheduled for you at _____on _____ at _____ o'clock to discuss your application for CHAMP-Pregnant Woman coverage. **If you cannot keep this appointment, please let me know immediately so that other plans can be made.**

☐ Your coverage under this program is terminated effective _____ because _____
_____.
Policy reference for our decision is _____.

Please share the eligibility information found on this notice with any medical services provider who has (or will) provide covered out-patient care to you during this period. You will not receive any other proof of your eligibility for this coverage.

You are not entitled to advance notice and appeal rights with denial or termination of coverage under this program.

Sincerely,

_____
Agency Representative

_____
Phone Number

cc. Qualified Provider _____

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Louisiana's **Medicaid Program** Proof of Coverage for Presumptive Eligibility (Type Case 16-12)		
Recipient Name	Medicaid (Person) ID Number	Date of Birth

Presumptive eligibility period begins _____. Services are limited to outpatient prenatal care **only**. Eligibility under this program ends: when this recipient is determined eligible for other coverage; on the date shown on the front of this letter, if an application for other coverage has not been made; at any time ineligibility is established; or at any time this recipient fails to comply with program requirements.

Inpatient hospital care (including labor and delivery) and long term care services ARE NOT covered by this Proof of Coverage statement.

BHSF Form 18-EMS

BHSF Form 18-EMS
Rev. 09/04
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Notice of Decision-**Emergency Medical Services**

_____
_____, LA _____
_____, 20____
Case ID # _____
SSN _____

Dear _____:

The following decision has been made on your application for Emergency Medical Services Only coverage:

☐ _____ has been approved for Emergency Medical Services **Only**, beginning _____ and ending _____. Your case has automatically been closed.

Please share the eligibility information found on this notice with any medical services provider who provided covered outpatient care to you during this period. You will not receive any other proof of your eligibility for this coverage.

☐ _____is (are) not eligible for Medicaid coverage because _____.
Policy reference_____

Sincerely,

_____
Agency Representative
_____
Phone Number
_____
Fax Number

Louisiana's **Medicaid Program** Proof of Coverage for Aliens for Emergency Services **Only** (Type Case 47)		
Recipient Name	Medicaid (Person) ID Number	Date of Birth
The eligibility period for coverage of **Emergency Services Only** begins _____ and ends _____. **Coverage is limited to emergency care only provided during this period.**		

SEE NEXT PAGE FOR IMPORTANT INFORMATION

YOUR FAIR HEARING RIGHTS

If you disagree with this decision, you may discuss it with a supervisor in the **Medicaid Program** office. The supervisor can review this decision and give you any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you **must** do so by _____ (thirty days from the date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the **Medicaid Program** office at _____ **or** you may mail it directly to the DHH Appeals Bureau at P. O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the right to: review your case record and/or any other information which the agency plans to use before the hearing; appear in person; represent yourself or have anyone else you choose to represent you; present your own evidence or witnesses; and question any person who testifies against you.

You may be able to get free legal help by calling the nearest legal assistance office at _____.

COMPLETE THIS SECTION ONLY IF YOU WANT TO REQUEST A FAIR HEARING

I want to appeal the decision on my case as shown on this notice. I think it is unfair because:

Date: _____

Signature:_____
Applicant/Recipient/Representative
Phone No.(_____)_____
Address:_____
_____

BHSF Form 18-LTC
Rev. 01/06
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Adequate Notice of Nursing Facility Decision

_____
_____, LA _____
_____, 20 _____
Case ID# _____
Person ID# _____
SSN _____
Provider(s) _____
_____

Dear _____:

The following decision has been made on your application or existing certification for Medicaid health care **and/or** nursing facility vendor payment coverage:

☐ Your application for Medicaid health care coverage has been approved effective _____

☐ INFORMATION ABOUT THE MEDICAID CARD: The plastic Medicaid card you will get or now have is what you will use to show that you are eligible for Medicaid. Start using the Medicaid card to pay for medical services you get from medical providers like hospitals and doctors. It is a good idea to show the Medicaid card before you get the service.

☐ INFORMATION ABOUT PRESCRIPTIONS: If you do not have Medicare, the Medicaid card may also be used to pay for your prescription medicine. If you do have Medicare, then Medicare will pay for your prescriptions.

☐ INFORMATION ABOUT SERVICES ALREADY RECEIVED AND REIMBURSEMENT: For medical services you have already received and have paid for the time you are eligible, you can be paid back the money you have spent up to what Medicaid would have paid. Please look on the last page of this letter for information about retroactive reimbursement. For services you have already received that are not paid, give the Medicaid card to the medical providers, so that they can bill Medicaid.

☐ Our records show that you already have a plastic Medicaid card that can still be used to help pay for medical services for each month of eligibility. If you do not have a card, please call (____) _____ to get another card.

☐ Medicaid Co-Insurance has been authorized effective _____.

☐ You have been approved as a Qualified Medicare Beneficiary. Beginning _____, the **Medicaid Program** will pay for your Medicare premiums and deductibles, provide medically necessary ambulance transportation, and may provide the co-insurance for other Medicare-covered services if the medical services provider accepts you as a Medicaid patient. You will get a plastic Medicaid card to help pay for your medical expenses. The automated process used to pay your Medicare premiums may take up to 90 days after you are certified. You will be reimbursed by Social Security for any premiums you have paid, back to the effective month of coverage.

BHSF Form 18-LTC
Page 2
Rev. 01/06
Prior Issue Obsolete
IV

☐ INFORMATION ABOUT PRESCRIPTIONS: Prescription medicines will be paid by Medicare.

☐ You have been approved as a Specified Low-Income Medicare Beneficiary. Beginning _____, the **Medicaid Program** will pay **only** your Medicare Part B premiums. The automated process used to pay your Medicare premiums may take up to 90 days after you are certified. You will be reimbursed by Social Security for any premiums you have paid, back to the effective month of coverage.

☐ Your application for Medicaid coverage and vendor payment for nursing facility care was not approved because_____
_____
_____
Policy reference _____

☐ Your application for vendor payment for nursing facility care was not approved because _____
_____
_____
_____
Policy reference _____

☐ Nursing facility vendor payment to the provider(s) named above has been approved effective _____. Your responsibility toward the cost of your nursing facility care is $_____ for _____ days in _____ . Thereafter, your responsibility **each month** toward the cost of your care is $_____ for _____, $_____ for _____ ,and $_____ for _____ (continuing).

☐ Nursing facility vendor payment to the provider(s) named above has not been approved because you transferred resources for less than fair market value. You will remain **ineligible** for vendor payment to **any** nursing facility provider from _____through _____

When a resource is sold, given away, or transferred for less than what it is worth or less than the fair market value, we presume it was done to qualify for Medicaid, unless you give convincing proof the transfer was done for another reason. We must use the uncompensated value of the transferred item to decide how long you will be ineligible. The uncompensated value is the fair market value less what is owed on the item and the amount of money (if any) that was received for the transferred item.

☐ You didn't provide convincing evidence; ☐ The evidence you provided did not prove to us that the resource(s) was (were) transferred for some other reason other than qualifying for Medicaid. Policy reference _____

☐ Nursing facility vendor payment to the provider(s) named above is being:

☐ re-instated; ☐changed; ☐ terminated effective _____ because _____

_____

Effective _____, you will pay a total of $_____ toward the cost for your nursing facility care. Thereafter, your responsibility **each** month toward the cost of your care is $_____ for _____; $_____ for _____; and $_____ for _____
Policy reference _____

☐ You are entitled to keep $_____ of your monthly income. This amount includes $_____ for your needs, $_____ for the Medicare premiums that are deducted from your Social Security check, and $_____ for your other monthly medical insurance premiums or other medical expenses. It also includes $_____ to give to your spouse and/or other dependent(s) in the community.

☐ An SSI payment of $_____ will be made directly to you by the Social Security Administration.

☐ A State Supplemental payment of $_____ will be made to you to cover your personal care needs beginning _____.

☐ The State Supplemental payment for your personal care needs will be:

☐ increased to $_____; ☐ reduced to $_____; ☐ terminated effective _____

because _____
Policy reference _____

☐ Medicaid health care coverage and nursing facility services will be closed _____because we were informed that the recipient is:

☐ no longer a Louisiana resident ☐ deceased. Policy reference _____

☐ Persons eligible for Medicaid who are under age 21 are eligible to get EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services, including KIDMED screening services. KIDMED services include immunizations; medical, vision, and hearing screenings; dental services; laboratory tests; and nutritional/health education. These services are provided on a regular basis AND whenever health services are needed. More EPSDT services are available and MAY include: medically necessary medical supplies and equipment; speech, physical, and occupational therapy; audiological services; psychological evaluation and treatment; and other medically necessary healthcare, diagnostic or treatment services.

Medicaid recipients under age 21 who have a CommunityCARE primary care doctor will get KIDMED services from that doctor. If they DO NOT have a CommunityCARE doctor, they may

BHSF Form 18-LTC
Page 4
Rev. 01/06
Prior Issue Obsolete
IV

sign up for KIDMED services by calling toll-free 1-800-259-4444. People who are hearing impaired can call TTY 1-977-544-9544.

☐ If you are unable to make arrangements for non-emergency medical transportation, you may call 1+800+864-6034 toll free. You must call at least 2 days before the appointment to schedule transportation.

You need to let your local Medicaid office know about changes in where you live or get your mail and your phone number. You also need to report any changes in your situation. This includes changes in the income and resources (cash, property, vehicles, etc.) that you, your spouse or other dependents receive, your marital status, the number of persons who depend on you for support, and health insurance coverage. If you do not report such changes, you may get Medicaid health care/vendor payment coverage or money to which you are not entitled. You will be expected to repay any benefits received or paid on your behalf for which you are not eligible.

The Medicaid Program must renew your eligibility for continued assistance at certain times during the year. We will let you know when this must be done. If an agency representative whom you do not know visits you, ask to see an identification card.

Sincerely,

_____
Agency Representative

_____
Phone Number

_____
Fax Number

CC ☐ _____ (Provider)
☐ _____ (Other)

SEE NEXT PAGE FOR IMPORTANT INFORMATION

YOUR FAIR HEARING RIGHTS

If you disagree with this decision, you may discuss it with a supervisor in the **Medicaid Program** office. The supervisor can review this decision and give you any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you **must** do so by _____ (thirty days from the date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the **Medicaid Program** office at _____ **or** you may mail it directly to the DHH Appeals Bureau at P.O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the right to: review your case record and/or any other information which the agency plans to use before the hearing; appear in person; represent yourself or have anyone else you choose to represent you; present your own evidence or witnesses; and question any person who testifies against you.

You may be able to get free legal help by calling the nearest legal assistance office at _____.

COMPLETE THIS SECTION ONLY IF YOU WANT TO REQUEST A FAIR HEARING

I want to appeal the decision on my case as shown on this notice. I think it is unfair because:

Date: _____

Signature: _____
Applicant/Recipient/Representative

Phone No.: (_____)_____

Address: _____

_____

Name: _____
Case ID: _____
Medicaid Analyst: _____
SSN: _____
Date: _____
Office: _____

RETROACTIVE ELIGIBILITY

Recipients granted retroactive eligibility will receive both a plastic ID card and a paper eligibility form. The paper eligibility form will be used in a manner similar to that of the previous retroactive eligibility paper card. The paper retroactive eligibility form will indicate the period for which eligibility has been retroactively granted as well as the date the determination was made.

The issue/certification date and recipient Medicaid ID number are found in the upper right-hand block of the Eligibility Notice. Only the paragraphs applicable to the recipient's will be printed on the form.

For cases in which retroactive eligibility exceeds the one year timely filing limit, a copy of the Eligibility Notice should be attached to the claim and forwarded to

Unisys Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge, LA 70821

- ✓ A cover letter must be attached explaining that an override is being requested for proof of timely filing in a retroactive eligibility case.
- ✓ Additionally, claims which exceed the timely filing deadlines must be submitted for payment consideration within one year from the certification date on the Eligibility Notice. Any claim not filed within this time period cannot be considered for payment.
- ☞ For cases in which the recipient could not provide a copy of the retroactive Eligibility Notice, the claim and a cover letter requesting a timely filing override should be submitted to:

Attention: Claims Processing & Resolution Unit
DHH/MVA/MMIS
P. O. Box 91030
Baton Rouge, LA 70821-9030

NOTE: There are several different Eligibility Notice forms; however, on the following pages is an example of one of the most commonly used Eligibility Notice forms, the 18-SSI.

BHSF Form 18-SSI

BHSF Form 18-SSI
Rev. 01/06
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
SSI Notice of Decision

_____

_____, LA _____

_____, 20 _____

Case ID #_____

SSN _____

Dear _____:

☐ You are currently receiving monthly Supplemental Security Income (SSI) benefits. As an SSI recipient, you are eligible for Medicaid coverage beginning _____. For each month that you remain eligible for SSI, your plastic Medicaid card will help pay for that month's medical expenses. If your SSI check stops, we will review your situation to see if you can still get Medicaid in another program.

☐ You were eligible for SSI cash benefits for a prior period, beginning _____ and ending _____. You will receive a plastic Medicaid card to help pay for medical expenses you had during those months.

☐ You have been approved for retroactive Medicaid coverage for _____ , _____ , and _____. You will receive a plastic Medicaid card to help pay for medical expenses you had during this time.

☐ Although you **are not** currently getting SSI benefits, you have been found eligible for retroactive Medicaid coverage for _____, _____, and _____. You will receive a plastic Medicaid card to help pay for Medicaid expenses you had during this time, **only**.

☐ The Social Security Administration has told us that you were recently approved for SSI. At the time you applied with the Social Security Administration, you reported that you had medical bills for the 3 months before you applied for SSI. If you have medical bills for that time period and want Medicaid coverage, you may call the local Medicaid office at (_____)_____ for assistance by _____ (90 days from the date of this notice).

☐ As an SSI recipient eligible for Medicare, you have been approved as a Qualified Medicare Beneficiary. Beginning _____, the **Medicaid Program** will pay for your Medicare premiums and deductibles, and provide the co-insurance for Medicare-covered services if the medical services provider accepts you as a Medicaid patient. The automated process used to pay your Medicare premiums may take up to 90 days after you are certified. You will be reimbursed by Social Security for any premiums you have paid, back to the effective month of coverage.
INFORMATION ABOUT PRESCRIPTIONS: Prescription medicines will be paid by Medicare.

☐ Your Medicaid coverage will continue until _____, because children under age 19 who remain in Louisiana are eligible for one year of continuous coverage. At that time, your eligibility for other Medicaid programs will be reviewed.

☐ Our records show that you already have a plastic Medicaid card that can still be used to help pay for medical services for each month of eligibility. If you do not have a card, please call (____)_____ to get another card.

☐ In the next month, you will receive a letter from the CommunityCARE program asking you to pick a primary care doctor from a list of those participating in the program. Your CommunityCARE doctor will be your 'medical home' or the first place you turn for your health care needs. If you do not choose a doctor by the due date given in the letter, CommunityCARE will choose one for you. If you are under age 21, your CommunityCARE doctor will provide or arrange for EPSDT screening services. CommunityCARE can be contacted toll free at 1-800-359-2122.

☐ Persons eligible for Medicaid who are under age 21 are eligible to get EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services, including KIDMED screening services. KIDMED services include immunizations; medical, vision, and hearing screenings; dental services; laboratory tests; and nutritional/health education. These services are provided on a regular basis AND whenever health services are needed. More EPSDT services are available and MAY include: medically necessary medical supplies and equipment; speech, physical, and occupational therapy; audiological services; psychological evaluation and treatment; and other medically necessary healthcare, diagnostic or treatment services.

Medicaid recipients under age 21 who have a CommunityCARE primary care doctor will get KIDMED services from that doctor. If they DO NOT have a CommunityCARE doctor, they may sign up for KIDMED services by calling toll-free 1-800-259-4444. People who are hearing impaired can call TTY 1-977-544-9544.

☐ If you are unable to make arrangements for non-emergency medical transportation, you may call 1-800-864-6034 toll free. You must call at least 2 days before the appointment to schedule transportation.

☐ INFORMATION ABOUT THE MEDICAID CARD: The plastic Medicaid card you will get or now have is what you will use to show that you are eligible for Medicaid. Start using the Medicaid card to pay for medical services you get from medical providers like hospitals and doctors. It is a good idea to show the Medicaid card before you get the service.

☐ INFORMATION ABOUT PRESCRIPTIONS: If you do not have Medicare, the Medicaid card may also be used to pay for your prescription medicine. If you do have Medicare, then Medicare will pay for your prescriptions.

☐ INFORMATION ABOUT SERVICES ALREADY RECEIVED AND REIMBURSEMENT: For medical services you have already received and have paid for the time you are eligible, you can be paid back the money you have spent up to what Medicaid would have paid. Please look on the last page of this letter for information about retroactive reimbursement. For services you have already received that are not paid, give the Medicaid card to the medical providers, so that they can bill Medicaid.

BHSF Form 18-SSI
Page 3
Rev. 01/06
Prior Issue Obsolete
IV

☐ You have not been approved for retroactive Medicaid coverage for _____, _____, and _____ because _____
_____
Policy reference _____

☐ Your application for Medicaid coverage was not approved because _____
_____
_____.
Policy reference _____

You need to let your local Medicaid office and your local Social Security Office know about changes in where you live or get your mail, your phone number, income and resources (cash, property, vehicles, etc.), and health insurance coverage.

Sincerely,

_____
Agency Representative

_____
Phone Number

_____
Fax Number

SEE NEXT PAGE FOR IMPORTANT INFORMATION

YOUR FAIR HEARING RIGHTS

If you disagree with this decision, you may discuss it with a supervisor in the **Medicaid Program** office. The supervisor can review this decision and give you any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you **must** do so by _____ (thirty days from the date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the **Medicaid Program** office at _____ **or** you may mail it directly to the DHH Appeals Bureau at P.O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the right to: review your case record and/or any other information which the agency plans to use before the hearing; appear in person; represent yourself or have anyone else you choose to represent you; present your own evidence or witnesses; and question any person who testifies against you.

You may be able to get free legal help by calling the nearest legal assistance office at _____.

COMPLETE THIS SECTION ONLY IF YOU WANT TO REQUEST A FAIR HEARING

I want to appeal the decision on my case as shown on this notice. I think it is unfair because:

Date: _____

Name: _____
Case ID: _____
Medicaid Analyst: _____
SSN: _____
Date: _____
Office: _____

Signature: _____
Applicant/Recipient/Representative

Phone No. (_____) _____
Address: _____
_____

ELIGIBILITY FOR RETROACTIVE REIMBURSEMENT

The decision of the Federal Court of Appeals in New Orleans requires that we consider reimbursing recipients for any medical bills paid between _____ (the beginning date of eligibility) and _____ (the date the Medicaid Card is expected to be received). Louisiana's **Medicaid Program** will make reimbursements only up to the maximum allowable Medicaid rate.

In order to qualify for reimbursement:

1. The bill(s) must be for medical care, services or supplies received during the dates shown above.

2. The bill(s) must be for medical care, services or supplies covered by the **Medicaid Program** at the time of service.

3. The bill(s) must be for medical care, services or supplies furnished by a provider who was enrolled in the **Medicaid Program** at the time of service.

4. The bill(s) must have been paid during the dates shown above **AND** have not been reimbursed in full by the provider, a third party (such as an insurance company or charitable organization), or already by the **Medicaid Program**.

If your provider refuses to reimburse you the amount you paid and bill LA Medicaid for your retroactive date(s) of service, you may request reimbursement directly from LA Medicaid by sending copies of paid bills which meet the above criteria to the Retroactive Reimbursement Unit at P.O. Box 91030, Baton Rouge, LA 70821-9030 by _____(thirty days from the date of this letter). If you have questions or need additional time to send the bills, write to us or call us at our toll free number 1-866-640-3905 (local Baton Rouge callers must dial 342-1739).

RECIPIENT REFUNDS DUE TO RETROACTIVE ELIGIBILITY POLICY

If a recipient was Medicaid certified on or after February 15, 1995, the recipient may be eligible for reimbursement of paid medical costs incurred from the first retroactive date of Medicaid eligibility up until the recipient received a medical card. This does not cover those recipients who had a medical card at the time service was delivered.

Providers who have provided Medicaid covered services to such recipients for periods of retroactive coverage may choose to accept the recipient as a Medicaid patient retroactively only after a Medicaid identification card is issued to the recipient.

Providers who agree to bill Medicaid must reimburse the patient immediately the full amount they paid for the Medicaid covered services. Providers do not have the option to refund only the Medicaid allowed amount for the covered Medicaid services; the recipient must be refunded the amount they paid for the services. Providers may not withhold a refund until Medicaid pays on the claim, nor may they apply the amount of the refund to another outstanding balance without the recipient's permission.

Providers who agree to reimburse recipients should follow established claim filing procedures. Claims for dates of service less than one year old may be submitted to Unisys as usual (EDI, pharmacy POS, or paper). Claims for dates of service between one and two years old, and those over two years old, should be filed in accordance with retroactive eligibility procedures on p. 25.

Providers who choose not to accept the recipient as a Medicaid patient retroactively should not reimburse the recipient; the State will reimburse the recipient directly. A provider's ability to participate in the Medicaid program will not be affected if they choose not to accept a Medicaid patient retroactively.

If the provider chooses not to accept the Medicaid recipient retroactively, the recipient should be instructed to contact the MMIS Retroactive Reimbursement Unit at (225)342-1739 or Toll Free 1-866-640-3905 to obtain reimbursement information.

*Please note that the Provider contact Letter (RRP-P) is now obsolete.

PARISH OFFICE PHONE NUMBERS

01	Acadia	(337) 788-7610
02	Allen	(337) 639-4173
03	Ascension	(888) 474-2070
		(225) 644-3700
04	Assumption	(800) 401-0132
		(985) 449-5021
05	Avoyelles	(318) 253-5946
		(318) 253-5947
06	Beauregard	(337) 463-9131
07	Bienville	(800) 256-3068
		(318) 263-9477
08	Bossier	(800) 256-3068
		(318) 862-9875
09	Caddo	(800) 256-3068
		(318) 862-9875
10	Calcasieu	(337) 491-2439
11	Caldwell	(800) 460-7726
		(318) 435-2930
12	Cameron	(337) 491-2439
13	Catahoula	(318) 339-4213
14	Claiborne	(800) 256-3068
		(318) 862-9875
15	Concordia	(318) 757-3202
16	DeSoto	(800) 873-8987
		(318) 357-2466
17	E. Baton Rouge	(225) 922-1542
18	E. Carroll	(888) 738-0792
		(318) 428-3252
19	E. Feliciana	(800) 259-9841
		(225) 683-4757
20	Evangeline	(337) 363-4262
21	Franklin	(800) 460-7726
		(318) 435-2930
22	Grant	(318) 627-5408
23	Iberia	(337) 373-0062
24	Iberville	(800) 631-0941
		(225) 692-7014
25	Jackson	(888) 436-6561
		(318) 251-5049
65	Jefferson-EB	(504) 846-6960
26	Jefferson-WB	(504) 361-6973
27	Jefferson Davis	(337) 824-2014
28	Lafayette	(337) 262-1424
29	Lafourche	(800) 401-0132
		(985) 449-5021
30	LaSalle	(318) 992-5320
31	Lincoln	(888) 436-6561
		(318) 251-5049
32	Livingston	(225) 665-1899
33	Madison	(318) 728-0344
		(800) 460-7701
34	Morehouse	(318) 556-7014
35	Natchitoches	(800) 873-8987
		(318)357-2466
36	Orleans	(504) 599-0656
		(866) 289-8303
37	Ouachita	(800) 510-5378
		(318) 362-3300
38	Plaquemines	(800) 259-5805
		(504) 361-6973
39	Pointe Coupee	(225) 638-6584
40	Rapides	(318) 487-5670
41	Red River	(800) 873-8987
		(318) 357-2466
42	Richland	(800) 460-7701
		(318) 728-0344
43	Sabine	(800) 873-8987
		(318) 357-2466
44	St. Bernard	(504) 599-0656
		(866) 289 8303
45	St. Charles	(800) 788-4827
		(985) 651-4809
46	St. Helena	(225) 665-1899
47	St. James	(800) 788-4827
		(985) 651-4809
48	St. John	(800) 788-4827
		(985) 651-4809
49	St. Landry	(337) 942-0155
50	St. Martin	(337) 394-3228
51	St. Mary	(800) 351-4879
		(337) 828-2611
52	St. Tammany	(337) 828-2611
		(985) 871-1359
53	Tangipahoa	(985) 543-4216
54	Tensas	(318) 766-9040
55	Terrebonne	(800) 723-1598
		(985) 873-2030
56	Union	(800) 510-5378
		(318) 362-3300
57	Vermillion	(337) 898-2854
58	Vernon	(337) 238-7022
59	Washington	(985) 732-6844
60	Webster	(800) 256-3068
		(318) 862-9875
61	W. Baton Rouge	(800) 631-0941
		(225) 692-7014
62	W. Carroll	(888) 738-0792
		(318) 428-3252
63	W. Feliciana	(800) 259-9841
		(225) 683-4757
64	Winn	(318) 648-9189

MEDICALLY NEEDY PROGRAM

Medically Needy

Recipients who meet all of the requirements of a specific Medicaid program except the income requirement, are classified as Medically Needy. There are two groups of Medically Needy recipients:

- Regular Medically Needy
- Spend-Down Medically Needy

Regular Medically Needy recipients are not financially responsible for any medical services which are reimbursed by Medicaid.

Spend-Down Medically Needy recipients may, in certain instances, be financially liable for a portion of their medical expenses. Eligibility for Spend-Down Medically Needy begins on the exact date that these recipients' medical expenses incurred, allowing them to "spend-down" to the level of income (MNIES) to qualify for Medicaid.

Any provider who has provided services to a Medicaid recipient on the recipient's spend-down date will receive a **Spend-Down Medically Needy Notice (Form 110-MNP)** from BHSF. This form will notify the provider of the amount due by the recipient (spend-down portion) and of the amount to be billed to the Medicaid Program. The provider should attach Form 110-MNP to the claim and submit it to the Fiscal Intermediary for processing.

Note: If any provider who rendered services to a patient on the spend-down date does not see his charges on the 110-MNP form, then the provider needs to contact the parish office and provide the information so that the form can be updated. Problems obtaining a Form 110-MNP from a parish office should be referred to: DHH Eligibility Field Operations Section at 225-342-5716.

Note: The provider CANNOT bill the recipient for any amount over the amount specified on the 110-MNP form under 'Beneficiary Liability'.

Note: Medically Needy Recipients are identified on the MEVS, REVS, and e-MEVS systems. MEVS, REVS, and e-MEVS denote the appropriate eligibility information based on the provider type of the inquiring provider. RECIPIENTS ELIGIBLE THROUGH PROGRAMS OTHER THAN THE MEDICALLY NEEDY PROGRAM ARE NOT AFFECTED. Recipients with questions should be advised to direct inquiries to BHSF Eligibility Operations Section at (888) 342-6207. Providers with inquiries should call Unisys Provider Relations at (800) 473-2783 or (225) 924-5040.

The Department of Health and Hospitals does not pay for the following services through its Medically Needy Program: 1) dental services or dentures, 2) alcohol and substance abuse clinic, 3) mental health clinic, 4) home and community based waiver services (HCBS), 5) home health (nurse aide and physical therapy), 6) case management, 7) mental health rehabilitation, 8) psychiatric inpatient hospital for persons under age 22, 9) sexually transmitted disease (STD), and 10) tuberculosis clinic.

110-MNP Form

The following form is used in conjunction with the Medically Needy Program. It is constructed by the Parish Office after receiving statements from providers who performed services to the recipient on the “from” date of service. The providers listed on the form who provided services on the "from" date should collect the amount shown under “Beneficiary Liability Amount”. This amount will be withheld from your billed claims for that date. In addition, the providers who rendered services on the “from” date must attach the 110-MNP to their hardcopy claims for that date of service.

NOTE: Problems obtaining a Form 110-MNP from a parish office should be referred to: DHH Eligibility Field Operations Section at 225-342-5716.

BHSF 110-MNP
Revised 12/99
Prior Issue Usable
IV

MEDICAID PROGRAM
Spend-Down Medically Needy Notice

Case Name _____ MEDS Case Identification Number _____ Parish _____

Recipients listed below are eligible for Medicaid coverage **from** _____ / _____ / _____ (spend-down date) **through** _____ / _____ / _____.

PROVIDER NOTICE: The services listed below occurred on the spend-down date (beginning date of Medicaid coverage) according to information available to us. Bill our Fiscal Intermediary (FI) for the services rendered on this date **only** if Medicaid Liability for the service is indicated by a ☑ in the Yes block of the last column below. Medicaid payment for services rendered on the spend-down date will be made **only** for the services listed below and **only** if a copy of this form is attached to your claim. Payment will be made in accordance with the limits established as **usual, reasonable,** and **customary** charges. Enter the Recipient Liability Amount shown below in the Recipient Liability column of the billing document.

Patient Name and MEDS Person No. (13 digits)	Provider Name and Vendor No.	Service or Rx Received on Spend-Down Date	Total Unpaid Charges for Services Received	Recipient Liability Amount	Medicaid Liability? Yes	Medicaid Liability? No
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑

Agency Representative Signature/Title _____ Telephone No. _____ Date _____

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/or physician benefits may be restricted to the use of **ONLY** one pharmacy provider **OR** one pharmacy provider and one primary care physician and specialists if needed.

A Lock-In recipient is asked to choose **ONLY** one pharmacy provider **OR** one pharmacy provider and one physician provider to be his Lock-In providers. Under most circumstances recipients with providers listed under the Lock-In segment of MEVS, REVS, and e-MEVS are restricted to receiving physician and/or pharmacy services from these providers. Patients choosing to change Lock-In providers or to add a specialist must do so at the local Parish Office. Providers wishing no longer to be a recipient's Lock-In provider should contact the Pharmacy Benefits Management Unit at DHH at (225) 342-9768 and fax a brief explanation to (225) 216-6334, or phone the Lock-In Unit at (225) 216-6245.

Providers not named on the Lock-In segment accessed through MEVS, REVS, or e-MEVS can provide services; however, no payment will be made to these providers. 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 MEVS, REVS, and e-MEVS. Payment will be made to any physician or pharmacist enrolled in Louisiana Medicaid 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 Lock-In segment renders an emergency service to the recipient, the provider should submit a claim to UNISYS and include "EMERGENCY" in the diagnosis section of the claim form. The physician or the dispensing pharmacist should also write "EMERGENCY" on any prescription resulting from such an emergency.

Providers that suspect that recipients are misusing the Medicaid Program services may contact Mary Wolf with Pharmacy Benefits Management at 225-342-9768 to ask for a review of a recipient's profile for possible inclusion in the Physician/Pharmacy Lock-In Program.

For cases in which a Lock-In physician wishes to refer the recipient for consultation on a one time basis, the consulting physician may be reimbursed if he enters the name and provider number of the referring Lock-In physician in the Referring Physician block on the claim form. If the consulting physician subsequently becomes the treating physician, that physician should remind the recipient to report this information to the BHSF local parish office, because reimbursement cannot be made for continued services until the provider's name and number are entered on the recipient's Lock-In segment.

Pharmacists other than those named in the recipient's Lock-In segment may fill prescriptions for life-sustaining medication or upon receiving a prescription containing the term "EMERGENCY" written by the prescribing or dispensing pharmacist. NCPDP Field 418-DI "Level of Service" should be used to indicate an emergency situation with a value of "3" – Emergency" submitted on the claim. True Emergency prescriptions will be exempt form Lock-In restrictions. If pharmacy providers need further assistance with submitting claims for emergency prescriptions they may contact Unisys Point Of Sale (POS) at (800)-648-0790.

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

NOTE: If a Lock-In recipient becomes eligible for Medicare Part D, DHH will remove the recipient from Lock-In restrictions. Providers should notify DHH of a Lock-In recipient's eligibility for Medicare Part D or questions concerning this Lock-In change should be directed to Unisys Point-Of-Sale (POS) at (800)648-0890.

THIRD PARTY LIABILITY

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, which can be applied toward the Medicaid recipient's medical and health expenses. Providers should check the recipient's TPL segment to verify that the third-party liability (TPL) codes are accurate according to the TPL listing and the name of the third-party insurance carrier. (TPL carrier code listings can be found on the Medicaid website at www.lamedicaid.com under "Forms/Files" or by contacting Unisys Provider Relations at (800) 473-2783 or (225) 924-5040). If the TPL code is not correct, the provider should instruct the recipient to contact his/her parish worker to correct the file, especially if the insurance has been canceled. Claims submitted for payment will deny unless the insurance coverage is noted on the claim with the appropriate TPL code or unless a letter explaining the cancellation of the insurance from the carrier is attached to the claim.

> **NOTE**: The lack of a third-party TPL code segment does not negate the provider's responsibility for asking the recipient if he/she has insurance coverage.

In most cases it is the provider's responsibility to bill the third-party carrier prior to billing Medicaid. 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.

TPL Billing Procedures

When billing Medicaid after receiving an Explanation of Benefits (EOB) from a TPL, the provider must bill a hard copy claim and:

Attach a copy of the EOB/EOMB, making sure any remarks/comments from the other insurance company are legible and attached.
Enter the amount the other insurance company paid in the appropriate block on the claim form (except for Medicare).
Enter the six-digit carrier code assigned by Medicaid in the correct block on the claim form (except Medicare).

> **NOTE**: The six-digit carrier code for traditional Medicare (060100) is not needed to process Medicare crossover claims. In fact, including the Medicare carrier code on these claims may cause processing errors. The Medicare EOB should be attached to each claim form. In addition, providers should not indicate the amount paid by Medicare on their claim forms.

Additionally, the dates of service, procedure codes and total charges **must match**, or the claim will deny. All Medicaid requirements such as precertification or prior authorization **must** be met before payment will be considered.

> **NOTE**: Claims submitted where the billing information does not match the EOB should be sent to the Provider Relations Correspondence Unit with a cover letter explaining the

discrepancy. Such instances would include payment for dates not precertified by Medicaid and privately assigned procedure codes not recognized by Medicaid.

Requests to Add or Remove Recipient TPL/Medicare Coverage

A request to add or remove TPL or Medicare coverage must include a cover letter indicating the action requested, the claim, and the EOB or proof of coverage termination and should be mailed to:

DHH Third Party Liability
Medicaid Recovery Unit
P.O. Box 91030
Baton Rouge, LA 70821

Payment Methodology When TPL is Involved

Medicaid payment is calculated by using cost comparison methodology after reimbursement is made from the TPL. The total payment to the provider from all resources will not be more than Medicaid allows for the service.

Example: A provider submits a claim to the private insurance company for procedure 99213 in the amount of $70.00. The private insurance allows $50.00 for this procedure, $10.00 is applied to the patient's deductible and the insurance payment to the provider is $40.00. When the claim and EOB are sent to Medicaid, the payment will be zero. Currently, Medicaid allows $36.13 for this procedure. The $40.00 insurance payment to the provider is more than the Medicaid allowable, thus the zero payment. This zero payment is considered an approved claim and is payment in full. The provider may not bill the recipient any remaining balance including co-payments and/or deductibles.

Prenatal and Preventive Pediatric Care Pay and Chase

Louisiana Medicaid uses the "pay and chase" method of payment for **prenatal and preventive care** for individuals with health insurance coverage. This means that most providers are not required to file health insurance claims with private carriers when the service meets the pay and chase criteria. The Bureau of Health Services Financing seeks recovery of insurance benefits from the carrier within 60 days after claim adjudication when the provider chooses not to pursue health insurance payments.

Service classes which do not require private health insurance claim filing by most providers are:

1. Primary prenatal diagnoses confined to those listed below. All recipients qualify. **Hospitals are not included and must continue to file claims with the health insurance carriers;**

V22.0	640.0 - 648.9
V22.1	651.0 - 658.9
V22.2	671.0 - 671.9
V23.0 - V23.9	673.0 - 673.8
V28.0 - V28.9	675.0 - 676.9

2. Primary preventive pediatric diagnoses confined to those listed below. Individuals under age 21 qualify. **Hospitals are not included and must continue to file claims with the health insurance carriers;**

V01.0 - V06.9	V77.0 - V77.7
V07.0 - V07.9	V78.2 - V78.3
V20.0 - V20.2	V79.2 - V79.3
V70.0	V79.8
V72.0 - V72.3	V82.3 - V82.4
V73.0 - V75.9	

3. EPSDT medical, vision, and hearing screening services (KIDMED screening services);

4. EPSDT dental services;

5. EPSDT services to children with special needs (formerly referred to as school health services) which result from screening and are rendered by school boards;

6. Services which are a result of an EPSDT referral, indicated by entering "Y" in block 24H of the CMS-1500 claim form or "1" as a condition code on the UB-92 (form locators 24 - 30).

7. Services for Medicaid eligibles whose health insurance is provided by an absent parent who is under the jurisdiction of the State Child Support Enforcement Agency. All providers and all services (regardless of diagnosis) qualify.

Voiding Accident-Related Claims for Profit

A provider who accepts Medicaid payment for an accident-related service or illness may not later void the Medicaid claim in order to pursue payment from an award or settlement with a liable third party. Federal regulations prohibit this practice. All providers enrolled in Louisiana's Medicaid Program are required to accept Medicaid payment as payment in full and are not to seek additional payment for any unpaid portion of the bill.

Outgoing Medical Records Stamp

Providers who furnish medical information to attorneys, insurers, or anyone else must obtain a 3"x3" ANNOTATION STAMP and must assure that all outgoing medical information bears the stamp, which notifies the receiver that services have been provided under Louisiana's Medicaid Program (see example below).

Medicaid Provider No. (7 digits)
(Optional Control Number)

Services have been provided under Louisiana's Medicaid Program and are payable under R.S. 46:446:1 to:

DHH Bureau of Health Services Financing
P. O. Box 91030
Baton Rouge, LA 70821-9030
ATTN: Third Party Liability Unit

Any additional authorization needed may be obtained from DHH/BHSF's TPL Unit at (225) 342-9250.

Trauma Diagnosis Codes

Providers are reminded to include the appropriate trauma diagnosis code when billing for accident-related injuries or illnesses. Provider cooperation is vital as trauma codes are used to help uncover instances of unreported third party liability.

Third Party Liability Recovery Unit

Providers with questions about medical services to Medicaid recipients involved in accidents with liable third parties, and providers wishing to refer information about Medicaid recipients involved in accidents with liable third parties may contact the DHH Third Party Liability, Trauma/Health Recovery Unit at (225) 342-9250 or fax information to (225) 342-1376.

HMO TPL Codes

Providers must determine, prior to providing a service, to which HMO the recipient belongs and if the provider himself is approved through that particular HMO. (If the provider is not HMO approved, the recipient should be advised that he/she will be responsible for the bill and be given the option of seeking treatment elsewhere.)

Questions regarding HMOs should be referred to the DHH Third Party Liability/Medicaid Recovery Unit at (225) 342-3855. The fax number is (225) 342-2703.

HMO and Medicaid Coverage

Louisiana Medicaid has adopted the following policy concerning HMO/Medicaid coverage based on CMS (Centers for Medicare and Medicaid Services) clarification.

- **The recipient must use the services of the HMO that they freely choose to join.** These claims must be submitted hard copy with a copy of the HMO EOB from the carrier that is on file with the state.

- If the HMO denies the service because the service is not a covered service offered under the plan, the claim will be handled as a straight Medicaid claim and processed based on Medicaid policy and pricing.

- If the HMO denies the claim because the recipient sought medical care outside of the HMO network and without the HMO's authorization, Medicaid will deny the claim with a message that HMO services must be utilized.

- If the recipient uses out of network providers for emergency services and the HMO does not approve the claim, Medicaid will deny the claim with a similar edit.

If the provider of the service plans to file a claim with Medicaid, copayments or any other payment cannot be accepted from the Medicaid recipient.

Qualified Medicare Beneficiaries (QMBs)

QMBs are covered under the ***Medicare Catastrophic Coverage Act of 1988***. This act expands Medicaid coverage and benefits for certain persons aged 65 years and older as well as disabled persons who are eligible for Medicare Hospital Insurance (Part A) benefits and who:

- Have incomes less than 90 percent of the Federal poverty level,
- Have countable resources worth less than twice the level allowed for Supplemental Security Income (SSI) applicants,
- Have the general nonfinancial requirements or conditions of eligibility for Medical Assistance, i.e., application filing, residency, citizenship, and assignments of rights.

Individuals under this program are referred to as Qualified Medicare Beneficiaries (QMBs). The three groups of recipients under this category are: QMB Only, QMB Plus and Non-QMB.

QMBs	Status
QMB Only (Formerly Pure QMB)	Identified through the REVS, MEVS, and e-MEVS systems and are eligible only for Medicaid payment of deductibles and coinsurance for all Medicare covered services.
QMB Plus (Formerly Dual QMB)	Individuals who are eligible for both Medicare and traditional types of Medicaid coverage (SSI, etc). QMB Plus is identified by the REVS, MEVS, and e-MEVS systems and are eligible for Medicaid payment of deductibles and coinsurance for all Medicare covered services as well as for Medicaid covered services.
Non QMBs	Identified in the TPL segment of REVS. Non QMBs are eligible for only Medicaid covered services.

In addition, for those persons who are eligible for Part A premium, but must pay for their own premiums, the State will now pay for their Part A premium, if they qualify as a QMB. The State will continue to also "buy-in" for Part B (Medical Insurance) benefits under Medicare for this segment of the population.

Medicare Crossover Claims

If problems occur with Medicare claims crossing over electronically, please follow the steps listed below:

- If your Medicare claims are not crossing electronically, please call Unisys Provider Relations at (800) 473-2783 or (225) 924-5040. Be very specific with your inquiry. You should indicate whether **all** of your claims are not crossing over or only claims for certain recipients. Were the claims crossing over previously and suddenly stopped crossing, or is this an ongoing problem? The more information you can give the better. The Unisys representative will check certain pieces of information against the provider and/or recipient files to determine if an identifiable file error exists. If a file update is required, the Unisys representative will route this information to the Unisys Provider Enrollment or Third Party Liability Unit to correct the Medicaid file. If a problem cannot be identified, you may be referred to the Third Party Liability Unit for further assistance.

- If you are not certain that you have supplied your Medicare provider number(s) to Unisys Provider Enrollment, please write to this unit to have your number(s) loaded correctly on your Medicaid provider file. Many Medicare providers have a primary provider number and one or more secondary provider numbers linked to this primary number. **Claims will cross electronically ONLY if the Medicare provider number(s) is cross-referenced to the Medicaid provider number.** If any or all of your Medicare provider numbers have not been reported to Unisys Provider Enrollment, please do so **immediately**.

Medicare adjusted claims **DO NOT** crossover. Providers must submit Medicaid adjustments with the Medicare adjustment EOB attached for corrected payment.

Providers are responsible for verifying on the Medicaid Remittance Advice that all Medicare payments have successfully crossed over. If Medicare makes a payment which is not adjudicated by Medicaid within 30 days of the Medicare EOB date, you should submit your crossover claim hard copy with the Medicare EOB attached. All timely filing requirements must be met even if a claim fails to cross over.

Also, if you are submitting a claim which Medicare has denied, the EOMB attached must include a complete description of the denial code.

Medicare – Elimination of Paper Remittance Advices

In June 2005, The Centers for Medicare and Medicaid Services announced their Remittance Advice Initiative which included plans to reduce the number of Standard Paper Remittance Advices printed and mailed, as well as increase the use of electronic remittance advices (ERA). As part of this initiative, CMS developed free software to enable providers to read and print HIPAA-compliant ERAs.

Beginning June 1, 2006, the Medicare Part B Standard Paper Remittance Advice received through the mail will no longer be available to providers/suppliers who also receive an Electronic Remittance Advice (ERA), whether the ERA is received directly or through a billing agent, clearinghouse, or other entity representing a provider/supplier.

This transition was effective for Part A providers in July 2005.

Providers who do not receive paper RAs from Medicare should access the Medicare software and print a copy of the RA for submission to Medicaid. The paper output generated by the software is similar to the paper format and provides the necessary information for Medicaid crossover claims processing.

Medicare Advantage Plan Claims

All recipients participating in a Medicare Advantage Plan must have both Medicare Part A and Medicare Part B.

The Medicare Advantage Care Plans currently participating in this program are: Humana Gold Plus, Kaiser Permante, SelectCare of Texas, Sterling Option One, Tenet PPO, Tenet 65, United Healthcare of Florida Medicare and Wellcare. These plans have been added to the Medicaid third Party Resource File for the appropriate recipients with six-digit alpha-numeric carrier codes that begin with the letter "H".

When possible these plans will cross the Medicare claims directly to Medicaid electronically, just as Medicare carriers electronically transmit Medicare crossover claims. These claims will be processed just as claims crossing directly from a Medicare carrier. If claims do not cross electronically from the carriers within 30-45 days from the Medicare plan EOB date, providers must submit paper claims with the Medicare plan EOB attached to each claim.

NOTE: Sterling Option One will not electronically transmit claims to Unisys. Providers in the Sterling Option One network should submit claims hard copy to Unisys.

When it is necessary for providers to submit claims hard copy, the appropriate carrier code must be entered on each hard copy claim form in order for the claim to process correctly. The carrier codes follow:

Humana Gold Plus	H19510	Kaiser Permante	H05240
SelectCare of Texas	H45060	Sterling Option One	H50060
Tenet PPO	H19010	Tenet 65	H19610
United Healthcare of Florida Medicare	H90110	Wellcare	H19030

Hard copy claims submitted without the plan EOB and without a six-digit carrier code beginning with an "H" will deny 275 (Medicare eligible). Both the EOB and the correct carrier code are required for these claims to process properly.

Providers may not submit these claims electronically. Electronic submissions directly from providers will deny 966 (submit hard copy claim).

When it is necessary to submit these claims hardcopy, a Medicare Advantage Plan Institutional or Professional cover sheet **MUST** be completed in its entirety **for each claim** and attached to the top of the claim and EOB. Claims received without this cover sheet will be rejected. A copy of these cover sheets are included on pages 48 – 50 of this packet and may also be obtained from the Louisiana Medicaid website at www.lamedicaid.com under "Forms/Files".

The calculated reimbursement methodology currently used for pricing Medicare claims will be used to price these claims. Thus, claims may price and pay a zero payment if the plan payment exceeds the Medicaid allowable for the service.

Timely filing guidelines applicable for Medicare crossover claims apply for Medicare Advantage Plan claims.

Recoupments by TPL Collections Contractor – Health Management Systems

Recoupments are routinely made by Health Management Systems (HMS), a TPL Collections contractor. This private company is contracted by DHH to review payments and recoup any payment made as Medicaid primary when the recipient had Medicare or private insurance.

HMS identifies these claims and notifies the provider via letter with a claim report of Medicaid recipients whose claims paid as Medicaid primary when other resources were available. One week after the letter is mailed, the provider is contacted to verify receipt of the letter, to answer questions, and to discuss documentation. The providers are allowed approximately 60 days to bill Medicare or the private insurance company. Ten (10) days prior to date of recoupment, the provider will again be contacted by HMS ensuring that they understood requirements and time frames. At the end of the 60 days, information is sent to Unisys to recoup the payments. When an "H" appears at the beginning of the medical records number found on the Medicaid remittance advice, it is a HMS recoupment. For further information, the provider may call the HMS Provider Recoupment Team at (877) 259-3307.

Louisiana Health Insurance Premium Payment (LaHIPP) program

The Louisiana Health Insurance Premium Payment (LaHIPP) program is part of Louisiana Medicaid. This program provides group health insurance premium reimbursements to Medicaid recipients whenever it is formulaically determined to be less expensive than paying the total cost of health care services generally used by the recipient.

Providers may obtain information regarding the above rules from the LaHIPP Program at (225) 342-1737 or 866-362-5253.

ACT NO. 269 – NEWBORN CHILD HEALTH INSURANCE COVERAGE

Third Party Liability (TPL) Notification of Newborn Children Form

Hospitals must complete the Third Party Liability (TPL) Notification of Newborn Children (TPLN 1-2005) Form which will begin the process of potentially providing health insurance premium reimbursements to a Medicaid eligible recipient. A copy of Form TPLN 1-2005 is provided for reference.

The TPLN 1-2005 Form is located at www.lamedicaid.com under Forms/Files/User Guides.

ACT No. 269 "Baby Bill" – Legislative Summary

Effective Date: 06/15/2005. The purpose of the Baby Bill is to establish reasonable requirements for the enrollment of newborns as dependents for health insurance coverage by health insurance issuers.

A newborn child that has access to dependent coverage under a mother, father or caregiver's health insurance plan is considered enrolled as of the effective date of the birth of the child. This applies to individual and group policies.

If a newborn child has access to dependent coverage and is potentially eligible for Medicaid at the time of birth, then the hospital must notify DHH and the Health Insurance Issuer(s) (HIIs) by completing a Third Party Liability (TPL) Notification of Newborn Child(ren) form within seven (7) days. The notice should be sent to the Department of Health and Hospitals, Bureau of Health Services Financing, Third Party Liability/Medicaid Recovery. Notice to the Health Plans should be sent to a designated department that has been communicated to the provider or to the department that would normally be notified when a newborn child is added to a policy.

Upon receiving notice from the providers, HIIs must provide notice to the policyholder in the case of an individual policy, the employer and employee with regard to a group policy, and the healthcare facility that rendered any medical services provided to the newborn prior to discharge. The notice must include information:

1. verifying that coverage is available to the newborn child or if such coverage is not available, an explanation of why such coverage is not available;
2. determining the amount of additional premium due, if any
3. designating a contact including a telephone number and physical address to represent the HII to facilitate all matters relative to the newborn child.

HIIs must give DHH 90 day's prior written notice of the intent to cancel the newborn child's coverage due to non-payment of premium. Within 3 days of sending the letter to DHH, HII must notify each provider that has either submitted a claim, made the HII aware that it has treated, or requested/obtained a pre-certification to render services to the newborn child that the premium has been cancelled in which case the newborn would be covered under Medicaid. The notice must contain the following information:

1. group or individual identification / policy number
2. summary of benefits, including applicable co-pays and deductibles
3. amount of additional premium due
4. name(s) of the member subscriber of the newborn child, including, but not limited to, the names of any and all other dependents and the effective date of coverage for each person named as a dependent
5. designated point of contact

PLEASE NOTE: HOSPITALS ARE STILL OBLIGATED TO COMPLETE THE ELIGIBILITY INQUIRY FOR NEWBORNS (152N) FORM TO FACILITATE THE PROCESS OF ACQUIRING A MEDICAID IDENTIFICATION NUMBER FOR BABIES BORN TO MOTHERS WHO ARE MEDICAID ELIGIBLE.

MEDICARE ADVANTAGE INSTITUTIONAL CROSSOVER COVER SHEET UB-92

Review instructions in their entirety before completing this form.

Inaccurate/Incomplete Cover Sheets will not be processed and will be returned for correction.

1. Medicaid Assigned Carrier Code

H					0

2. Medicare Paid Date (MM-DD-YYYY)

		-			-				

3. Provider Number

4. Recipient Identification Number (13 digits)

5. Total Deductible Amount

6. Blood Deductible Amount

7. Medicare Per Diem Rate

8. Total Medicare Payment Amount

9. Co-Pay Amount

Instructions – please review in their entirety before completing this form.

This form is to be completed for all Institutional Crossover Claims provided by a Medicare Advantage Carrier. This form is to be attached to the top of each UB-92 and must be completed in its entirety before submission of the claim. **Inaccurate/Incomplete Cover Sheets will be not be processed and will be returned for correction.**

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1. **Medicaid Assigned Carrier Code** – enter the six- (6) digit carrier code assigned to the Medicare Advantage provider. All codes begin with H and ends with a trailing 0 (zero).
2. **Medicare Paid Date** – enter the date of the Medicare Advantage Carrier Explanation of Benefits.
3. **Medicaid Provider Number** – enter the seven (7) digit provider number of the billing provider
4. **Recipient Identification Number** – enter the thirteen (13) digit Louisiana Medicaid recipient identification number. (The sixteen (16) digit Card Control Number is not acceptable.)
5. **Total Deductible Amount** – enter the amount of Deductible identified on the Explanation of Benefits **IF** it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, do not enter anything in this box.
6. **Blood Deductible Amount** – enter the amount of blood deductible if identified on the Explanation of Benefits
7. **Medicare Per Diem Rate** – enter the Per Diem Rate as identified on the Explanation of Benefits, if applicable
8. **Total Medicare Payment Amount** – enter the amount paid by Medicare as identified on the Explanation of Benefits
9. **Total Co-Pay Amount** – enter the amount of Co-Pay identified on the Explanation of Benefits **IF** it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, enter the Deductible/Co-pay amount in this box.

MEDICARE ADVANTAGE PROFESSIONAL CROSSOVER COVER SHEET INSTRUCTIONS

Preparation

This form is to be completed for all Professional Crossover Claims provided by a Medicare Advantage Carrier. This form is to be attached to the top of each CMS1500 and must be completed in its entirety before submission of the claim. **Inaccurate/Incomplete Cover Sheets will not be processed and will be returned for correction.**

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1. **Medicaid Assigned Carrier Code** – enter the six- (6) digit carrier code assigned to the Medicare Advantage provider. All codes begin with H. and end with a trailing 0.(zero).
2. **Medicare Paid Date** – enter the date of the Medicare Advantage Carrier Explanation of Benefits.
3. **Medicaid Provider Number** – enter the seven (7) digit provider number of the billing provider
4. **Recipient Identification Number** – enter the thirteen (13) digit Louisiana Medicaid recipient identification number. (The sixteen (16) digit Card Control Number is not acceptable.)
5. **Information for Line 1**
    - **Line Medicare Allowed Amount** –enter the amount Medicare allowed for the charges on the line.
    - **Total Deductible Amount** – enter the amount of Deductible identified on the Explanation of Benefits **IF** it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, do not enter anything in this box.
    - **Total Co-Pay Amount** – enter the amount of Co-Pay identified on the Explanation of Benefits **IF** it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, enter the Deductible/Co-pay amount in this box.
    - **Total Medicare Payment Amount** – enter the total amount Medicare paid on this line charge.
6. **Information for Lines 2-6 –** enter the requested amount for each claim line as outlined in Information for Line 1

MEDICARE ADVANTAGE PROFESSIONAL CROSSOVER COVER SHEET CMS 1500

Review instructions in their entirety before completing this form.

Inaccurate/Incomplete Cover Sheets will not be processed and will be returned for correction.

Medicaid Assigned Carrier Code

H | | | | | 0

Medicare Paid Date (MM-DD-YYYY)

		-			-				

Provider Number

Recipient Identification Number (13 digits)

Information for Claim Line 1

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 2

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 3

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 4

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 5

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 6

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

* If EOB combines Total Deductible & Co-Pay Amounts, enter total in Co-Pay only (Leave Deductible Amount blank).

MEDICARE PART D

Medicare Part D covered drugs include most prescription drugs, biological products, certain vaccines, insulin, and medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze). Some drugs will be excluded from Medicare Part D coverage as they are part of the Medicaid non-mandatory coverage provisions under sections 1927 (d)(2) and (d)(3) of the Social Security Act or they are covered by Medicare Part A or B. The one exception is smoking cessation products, such as nicotine patches and gum, which will be covered by Medicare Part D. Reimbursement of prescription claims are determined by each individual prescription drug plan. Medicare Part D will not cover those medications reimbursed by Medicare Part B. However, should Medicare Part B deny coverage because the drug does not meet the criteria for a Part B covered indication, the pharmacy provider should contact the Part D prescription plan.

Medicaid Coverage for Excluded Part D Drugs

To the extent that the Louisiana Medicaid Program covers the following Medicare excluded drugs for Medicaid recipients who are not full benefit dual eligibles, Medicaid will be required to cover the excluded drugs for full benefit dual eligibles:

- Benzodiazepines;
- Barbiturates;
- Agents when used for anorexia, weight loss, weight gain;
- Agents when used to promote fertility;
- Agents when used for cosmetic purposes or hair purposes;
- Agents when used for symptomatic relief cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride;
- Nonprescription drugs; and
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated test or monitoring services be purchased exclusively from the manufacturer or its designee.

All existing Louisiana Medicaid Pharmacy Program limits, co-payments and reimbursement policies apply to the Part D excluded prescriptions paid by Louisiana Medicaid. Louisiana Medicaid will not cover PDP or MA PD non-preferred drugs, as there is a Medicare appeal process to obtain these medications.

Co-payments

The Medicaid co-payment schedule will apply for prescriptions for those Part D excluded drugs that are covered by Medicaid.

NOTE: **If a Lock-In recipient becomes eligible for Medicare Part D, DHH will remove the recipient from Lock-In restrictions. Providers should notify DHH of a Lock-In recipient's eligibility for Medicare Part D or questions concerning this Lock-In change should be directed to Unisys Point-Of-Sale (POS) at (800)-648-0790.**

Quarterly Medicare Recoveries By Unisys

Every quarter Unisys does a Medicare recovery where DHH has identified recipients who have Medicare coverage and Medicaid has paid claims which should have been submitted to Medicare for primary payment.

Approximately two weeks before these recoveries are made, the provider receives a letter with a listing of recipients for which the recoupments will be made. The recoupments are for Part A Medicare and appear as voids on the provider's Medicaid remittance advice. Examples of both the recoupment letter and a list of recipient recoupments follow.

********** MEDICARE RECOVERY ADJ/VOID NOTIFICATION **********

FEDERAL REGULATIONS REQUIRE THAT THE LA MEDICAL ASSISTANCE PROGRAM RECOVER MEDICAID PAYMENTS FOR SERVICES WHICH SHOULD HAVE BEEN COVERED BY MEDICARE PART A OR PART B WHICH MUST BE FILED TO THE PART A CARRIER. REVIEW THE ENCLOSED CLAIM LISTING WHICH SHOWS CLAIMS THAT WILL BE AUTOMATICALLY VOIDED (PART A SERVICES) OR ADJUSTED (DEDUCTION OF INPATIENT PART B ANCILLARY) BY UNISYS APPROXIMATELY 2 WEEKS AFTER RECEIPT OF THIS LETTER. CLAIMS WITH DATES OF SERVICE FROM JANUARY 1 THROUGH SEPTEMBER 30 CAN BE FILED TO MEDICARE UNTIL DECEMBER 31 OF THE FOLLOWING YEAR. CLAIMS WITH DATES OF SERVICE FROM OCTOBER 1 THROUGH DECEMBER 31 CAN BE FILED TO MEDICARE UNTIL DECEMBER 31 TWO YEARS FOLLOWING THE YEAR OF THE DATE OF SERVICE. IT IS RECOMMENDED THAT FILING TO MEDICARE BE DONE PROMPTLY UPON RECEIPT OF THIS NOTIFICATION. CLAIMS FILED TO PART A BLUE CROSS/BLUE SHIELD MISSISSIPPI, TO TEXAS BLUE CROSS (HEMODIALYSIS FACILITIES ONLY), OR TO MUTUAL OF OMAHA'S MEDICARE DIVISION AUTOMATICALLY CROSS TO LA MEDICAID FOR COINSURANCE AND DEDUCTIBLE PAYMENT RECONSIDERATION. CLAIMS FILED TO OTHER MEDICARE CARRIERS MUST BE REFILED HARDCOPY TO UNISYS WITH A COPY OF THE MEDICARE EOMB. ALL REFILES MUST BE PROCESSED EITHER BEFORE EXPIRATION OF ONE YEAR FROM DATE OF SERVICE OR SIX MONTHS FROM MEDICARE ADJUDICATION DATE. MAIL HARDCOPY CROSSOVERS TO UNISYS, PO BOX 91023, BATON ROUGE, LA 70821. THE INPATIENT PORTION OF YOUR CLAIM FOR A RECIPIENT WHO HAS PART B ONLY WILL REMAIN PAID AND YOU WILL BE ENTITLED ONLY TO COINSURANCE AND DEDUCTIBLE FOR THE ANCILLARIES ASSOCIATED WITH THE INPATIENT STAY. FOR A CLAIM THAT WAS VOIDED/ADJUSTED IN ERROR, MAIL TO ATTN: MEDICARE PROJECT COORDINATOR AT THE ADDRESS SHOWN BELOW (1) CLAIM FORM, (2) COPY OF CLAIM LISTING OR UNISYS REMITTANCE ADVICE SHOWING VOID, (3) OTHER PERTINENT INFORMATION - NOTATE IF CLAIM VOIDED IN ERROR. DO NOT SEND CLAIMS VOIDED IN ERROR TO UNISYS AS THEY WILL BE DENIED. QUESTIONABLE MEDICARE ENTITLEMENT WILL BE DETERMINED BY THE TPL/MEDICAID RECOVERY UNIT IN ORDER TO RESOLVE A CLAIM. IF PAYMENT FOR THE COINSURANCE AND/OR DEDUCTIBLE IS DENIED FOR ERROR CODE 911 (RECIPIENT HAS USED ALL ALLOWABLE HOSPITAL DAYS), SEND THESE CLAIMS TO ATTN: MEDICARE PROJECT COORDINATOR, ADDRESS SHOWN BELOW, AND INCLUDE (1) CLAIM FORM, (2) MEDICARE EOMB, (3) UNISYS REMITTANCE ADVICE SHOWING VOID AND 911 DENIAL.

ADDRESS - TPL/MEDICAID RECOVERY UNIT
PO BOX 91030
BATON ROUGE, LA 70821-9030

LAM2DO12 CP-O-12C
RUN:

LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS
DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAL (BHSF)

PROVIDER ID:

CYCLE:

MEDICARE RECOVERY PROJECT - CLAIM DETAIL LISTING

PAGE: 1

RECIPIENT ID	HIC	NAME	MEDICARE TYPE COVG	CLAIM ICN	PROC	DATES OF SERVICE	MEDICAID PAYMENT	HOSPITAL ANCILLARIES
			PART B		HR821	01/12/2004-01/12/2004	$123.99	$0.00
	*** TOTAL:	RECORDS 1					$123.99	$0.00

TPL and Eligibility Reminders

Many services covered under the Louisiana Medicaid Program require some form of prior authorization, pre-certification, or extension request. Please remember that authorization of services does not override any other Medicaid Program policy and does not guarantee payment of the claim. This includes, but is not limited to, the following examples:

- If a recipient is Medicare eligible, an authorization does not override the fact that the claim must be submitted to Medicare for consideration prior to being submitted to Medicaid. Please be aware of this fact when submitting your claims for processing.

- If a recipient is eligible for other insurance, a prior authorization or pre-certification does not override the fact that the claim must be submitted to the other insurance for consideration prior to being submitted to Medicaid.

- Likewise, other insurance coverage does not negate the need for prior authorization or pre-certification if the provider intends to bill Medicaid secondary.

- If a recipient is not eligible for services on the specified date of service, an authorization does not override ineligibility, and the claim will not be paid.

- Recipients with Medicare benefits, and recipients who have other primary insurance with physician benefits, (including HMOs) are exempt from CommunityCARE. However, until these benefits are loaded on the Unisys Medicaid files and the CommunityCARE linkage is closed, a referral is required.

NOTICE: IF YOU ARE SUBMITTING A CLAIM IN WHICH THE THIRD PARTY LIABILITY CARRIER HAS DENIED, THE EOB ATTACHED MUST ALSO INCLUDE A <u>COMPLETE DESCRIPTION</u> OF THE DENIAL CODE.

COMMUNITYCARE

Program Description

CommunityCARE is operated as a State Plan option as published in the Louisiana Register volume 32: number 3 (March 2006). It is a system of comprehensive health care based on a primary care case management (PCCM) model. CommunityCARE links Medicaid eligibles with a primary care physician (PCP) that serves as their medical home.

Recipients

Participation in the CommunityCARE program is mandatory for most Medicaid eligibles. Currently, seventy-five to eighty percent of all Medicaid eligibles are linked to a primary care provider. Recipients not linked to a CommunityCARE PCP may continue to receive services without a referral/authorization just as they did before CommunityCARE. Those recipient types that are **EXEMPT** from participation in CommunityCARE, and will not be linked to a PCP, are listed below. (This list is subject to change):

- Residents of long term care nursing facilities, psychiatric facilities, or intermediate care facilities for the mentally retarded (ICF/MR) such as state developmental centers and group homes
- Recipients who are 65 or older
- Recipients with Medicare benefits, including dual eligibles
- Foster children or children receiving adoption assistance
- Hospice recipients
- Office of Youth Development recipients (children in State custody)
- Recipients in the Medicaid physician/pharmacy 'Lock-In' program (recipients that are pharmacy-only 'Lock-In' are not exempt)
- Recipients who have other primary insurance with physician benefits, including HMOs
- Recipients who have an eligibility period of less than 3 months
- Recipients with retroactive only eligibility (CommunityCARE does not make retroactive linkages)
- BHSF case-by-case approved "Medically High Risk" exemptions
- Native American Indians residing in parish of reservation (currently Jefferson Davis, St. Mary, LaSalle and Avoyelles parishes)
- Recipients in pregnant woman eligibility categories
- Recipients in the PACE program
- SSI recipients under the age of 19
- Recipients under the age of 19 in the NOW and Children's Choice waiver programs

CommunityCARE enrollees are identified under the CommunityCARE segment of REVS, MEVS and the online verification system through the Unisys website – www.lamedicaid.com. This segment gives the name and telephone number of the linked PCP.

Primary Care Physician

As part of the PCPs' care coordination responsibilities they are obligated to ensure that referral authorizations for medically necessary healthcare services which they can not/do not provide are furnished promptly and without compromise to quality of care. The PCP shall not unreasonably withhold or deny valid requests for referrals/authorizations that are made in accordance with CommunityCARE policy. The PCP also shall not require that the requesting provider complete the referral authorization form. The State encourages PCPs to issue appropriately requested referrals/authorizations as quickly as possible, taking into consideration the urgency of the enrollee's medical needs, not to exceed a period of 10 days. Although this time frame was designed to provide guidance for responding to requests for post-authorizations, we encourage PCPs to respond to requests sooner than 10 days if possible. Deliberately holding referral authorizations until the 10th day just because the PCP has 10 days is inappropriate.

The PCP referral/authorization requirement does not replace other Medicaid policies that are in existence. For example, if the service requires prior authorization, the provider must still obtain prior authorization **in addition to** obtaining the referrals/authorizations from the PCP.

The Medicaid covered services, which do not require authorization referrals from the CommunityCARE PCP, are "**exempt**." The current list of exempt services is as follows:

- Chiropractic service upon KIDMED referrals/authorizations, ages 0-21
- Dental services for children, ages 0-21 (billed on the ADA claim form)
- Dental Services for Pregnant Women (ages 21-59), billed on the ADA claim form
- Dentures for adults
- The three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but **do require POST authorization**. Refer to "Emergency Services" in the CommunityCARE Handbook
- Inpatient Care that has been pre-certed (this also applies to public hospitals even without pre-certification for inpatient stays): hospital, physician, and ancillary services billed with inpatient place of service.
- EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program
- Family planning services
- Prenatal/Obstetrical services
- Services provided through the Home and Community-Based Waiver programs
- Targeted case management
- Mental Health Rehabilitation(privately owned clinics)
- Mental Health Clinics(State facilities)
- Neonatology services while in the hospital
- Ophthalmologist and Optometrist services (age 0-21)
- Pharmacy
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists services
- Transportation services

- Hemodialysis
- Hospice services
- Specific outpatient laboratory/radiology services
- Immunization for children under age 21 (Office of Public Health and their affiliated providers)
- WIC services (Office of Public Health WIC Clinics)
- Services provided by School Based Health Centers to recipients age 10 and over
- Tuberculosis clinic services (Office of Public Health)
- STD clinic services (Office of Public Health)
- Specific lab and radiology codes

Non-PCP Providers and Exempt Services

Any provider other than the recipient's PCP must obtain a referral from the recipient's PCP, **prior to rendering services**, in order to receive payment from Medicaid. Any provider who provides a non-exempt, non-emergent (routine) service for a CommunityCARE enrollee, without obtaining the appropriate referral/authorization prior to the service being provided risks non-payment by Medicaid. **DHH and Unisys will not assist providers with obtaining referrals/authorizations for routine/non-urgent care not requested in accordance with CommunityCARE policy.** PCPs are not required to respond to requests for referrals/authorizations for non-emergent/routine care not made in accordance with CommunityCARE policy: i.e. requests made after the service has been rendered.
When a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the patient's PCP to obtain the appropriate referral/authorization for any follow-up services the patient may need after discharge (i.e. Durable Medical Equipment (DME) or home health). Neither the home health nor DME provider can receive reimbursement from Medicaid without the appropriate PCP referral/authorization. **The DME and home health provider must have the referral/authorization in hand prior to rendering the services.**

General Assistance – all numbers are available Mon-Fri, 8am-5pm

Providers:

Unisys - (800) 473-2783 or (225) 924-5040 - CommunityCARE Program policy, procedures, and problems, complaints concerning CommunityCARE

ACS - (800) 259-4444 PCP - assignment for CommunityCARE recipients, inquiries related to monitoring, certification

ACS - (877) 455-9955 – Specialty Care Resource Line - assistance with locating a specialist in their area who accepts Medicaid.

Enrollees:

Medicaid provides several options for enrollees to obtain assistance with their Medicaid enrollment. Providers should make note of these numbers and share them with recipients.

- CommunityCARE Enrollee Hotline (800) 259-4444: Provides assistance with questions or complaints about CommunityCARE or their PCP. It is also the number recipients call to select or change their PCP.

- Specialty Care Resource Line (877) 455-9955: Provides assistance with locating a specialist in their area who accepts Medicaid.

- CommunityCARE Nurse Helpline (866) 529-1681: Is a resource for recipients to speak with a nurse 24/7 to obtain assistance and information on a wide array of health-related topics.

- www.la-communitycare.com

- www.lamedicaid.com

HOSPICE SERVICES

Overview

Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

A recipient must be terminally ill in order to receive Medicaid hospice care. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

Payment of Medical Services Related to the Terminal Illness

Once a recipient elects to receive hospice services, **the hospice agency is responsible for either providing or paying for all covered services related to the treatment of the recipient's terminal illness.**

For the duration of hospice care, an individual recipient waives all rights to Medicaid payments for:

- Hospice care provided by a hospice other than the hospice designated by the individual recipient or a person authorized by law to consent to medical treatment for the recipient.
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected OR a related condition OR that are equivalent to hospice care, except for services provided by: (1) the designated hospice; (2) another hospice under arrangements made by the designated hospice; or (3) the individual's attending physician if that physician IS NOT an employee of the designated hospice or receiving compensation from the hospice for those services.

Payment for Medical Services NOT Related to the Terminal Illness

Any claim for services submitted by a provider other than the elected hospice agency will be denied if the claim does not have attached justification that the service was medically necessary and **WAS NOT related to the terminal condition for which hospice care was elected.** If documentation is attached to the claim, the claim pends for medical review. Documentation may include:

- A statement/letter from the physician confirming that the service was not related to the recipient's terminal illness, or
- Documentation of the procedure and diagnosis that illustrates why the service was not related to the recipient's terminal illness.

If the information does not justify that the service was medically necessary and not related to the terminal condition for which hospice care was elected, the claim will be denied. If review of the claim and attachments justify that the claim is for a covered service not related to the terminal

condition for which hospice care was elected, the claim will be released for payment. *Please note, if prior authorization or precertification is required for any covered Medicaid services not related to the treatment of the terminal condition, that prior authorization/precertification is required and must be obtained just as in any other case.*

NOTE: Claims for prescription drugs will not be denied but will be subject to post-payment review.

PHARMACY SERVICES

Prior Authorization

The prescribing provider must request prior authorization for non-preferred drugs from the University of Louisiana – Monroe. Prior authorizations requests can be obtained by phone, fax, or mail, as listed below.

Contact information for the Pharmacy Prior Authorization department:

Phone: (866) 730-4357 (8 a.m. to 6 p.m., Monday through Saturday)
FAX: (866) 797-2329

University of Louisiana – Monroe
School of Pharmacy
1401 Royal Avenue
Monroe, LA 71201

The following page includes a copy of the "Request for Prescription Prior Authorization" form, as can be found on the LAMedicaid.com website under "Rx PA Fax Form".

Preferred Drug List (PDL)

The most current PDL can be found on the LAMedicaid.com website.

Monthly Prescription Service Limit

An eight-prescription limit per recipient per calendar month has been implemented in the LA Medicaid Pharmacy Program.

The following federally mandated recipient groups are exempt from the eight-prescription monthly limitation:

- Persons under the age of twenty-one (21) years
- Persons living in long term care facilities such as nursing homes and ICF-MR facilities
- Pregnant women

If it is deemed medically necessary for the recipient to receive more than eight prescriptions in any given month, the provider must write "medically necessary override" and the ICD-9-CM diagnosis code that directly relates to each drug prescribed on the prescription.

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).

Date of Request:*	Number of Fax Pages (including cover page):*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth:*
Call-Back Phone Number (include area code):*	
Fax Number (include area code):	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO
2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:
3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interaction(s) in the box below:
4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:*

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

CONFIDENTIALITY NOTICE
The documents accompanying this facsimile transmission may contain confidential information which is legally privileged. The information is intended only for the use of the individual or entity to which it is addressed. If you are not the intended recipient, you are hereby notified that any review, disclosure/redisclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy this information.

ELECTRONIC DATA INTERCHANGE (EDI)

Claims Submission

Electronic data interchange submission is the preferred method of submitting Medicaid claims to Unisys. With electronic data, a provider or a third party contractor (billing agent) submits Medicaid claims to Unisys on a computer encoded magnetic tape, diskette or via telecommunications.

Each claim undergoes the editing common to all claims, e.g., verification of dates and balancing. Each type of claim has unique edits consistent with the requirements outlined in the provider manuals. All claims received via electronic data must satisfy the criteria listed in the manual for that type of claim.

Advantages of submitting claims electronically include increased cash flow, improved claim control, decrease in time for receipt of payment, automation of receivables information, improved claim reporting by observation of errors and reduction of errors through pre-editing claims information.

Certification Forms

Any submitter - individual providers, clearinghouse, billing agents, etc. - that submits at least one claim electronically in a given year is required to submit an Annual EDI Certification Form. This form is then kept on file to cover all submissions within the calendar year. It must be signed by an authorized representative of the provider and must have an original signature (no stamps or initials.)

Third Party Billers are required to submit a Certification Form including a list of provider(s) name(s) and Medicaid Provider numbers. Additionally, all Third Party Billers **MUST** obtain a "Professional, Pharmacy, Hospital or KIDMED Services Certification" form on which the provider has attested to the truth, accuracy and completeness of the claim information. These forms **MUST** be maintained for a period of five years. This information must be furnished to the agency, the DHH Secretary, or the Medicaid Fraud Control Unit upon request.

Required Certification forms may be obtained from lamedicaid.com under the EDI Certification Notices and Forms HIPAA Information Center link. The required forms are also available in both the General EDI Companion Guide and the EMC Enrollment Packet.

Failure to submit the Annual Certification Form will result in deactivation of the submitter number. Once the Cert is received, the number will be reactivated. There will be a delay if the number is deactivated thus preventing timely payment to your providers. Failure to correctly complete the Certification Form will result in the form being returned for correction.

To contact the EMC Department at Unisys, call (225) 216-6000 and select option 2. Providers may write to Unisys EMC Department, P.O. Box 91025, Baton Rouge, LA 70821.

Electronic Data Interchange (EDI) General Information

Please review the entire General EDI Companion Guide before completing any forms or calling the EMC Department.

The following claim types may be submitted as approved HIPAA compliant 837 transactions:

- Pharmacy
- Hospital Outpatient/Inpatient
- Physician/Professional
- Home Health
- Emergency Transportation
- Adult Dental
- Dental Screening
- Rehabilitation
- Crossover A/B

The following claims types may be submitted under proprietary specifications (not as HIPAA-compliant 837 transactions):

- Case Management services
- Non-Ambulance Transportation

Any number of claims can be included in production file submissions. There is no minimum number.

EDI Testing is required for all submitters (including KIDMED) before they are approved to submit claims for production unless the testing requirement has been completed by the Vendor. LTC providers must test prior to submission to production.

Case Management Services and Non-Ambulance Transportation submitters who file via modem MUST wait 24 hours, excluding weekends, between file submissions to allow time for processing.

Enrollment Requirements For EDI Submission

- **Submitters wishing to submit EDI 837 transactions without using a Third Party Biller** - complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS** (EMC Contract).

- **Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse** – complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS** (EMC Contract) **and** a Limited Power of Attorney.

- **Third Party Billers or Clearinghouses** (billers for multiple providers) are required to submit a completed HCFA 1513 – Disclosure of Ownership form and return it with a completed EMC Contract and a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Enrollment Requirements For 835 Electronic Remittance Advices

- All EMC billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EMC billers to download their remittance advices weekly.

- 835 Transactions may not contain all information printed on the hardcopy RA, ex. blood deductible, patient account number, etc.

- To request 835 Transactions – Electronic Remittance Advice, contact Unisys EMC Department at (225) 216-6000 ext. 2.

Electronic Adjustments/Voids

Adjustments and voids can be submitted electronically. If your present software installation does not offer this option, please contact your software vendor to discuss adding this capability to your software.

SUBMISSION DEADLINES
Regular Business Weeks

Magnetic Tape and Diskettes	4:30 P.M. each Wednesday
KIDMED Submissions (All Media)	4:30 P.M. each Wednesday
Telecommunications (Modem)	10:00 A.M. each Thursday

Thanksgiving Week

Magnetic Tape and Diskettes	4:30 P.M. Tuesday, 11/21/06
KIDMED Submissions	4:30 P.M. Tuesday, 11/21/06
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/22/06

Important Reminders For EMC Submission

Denied claims may be resubmitted electronically unless the denial code states otherwise. This includes claims that have produced a denied claim turnaround document (DTA). Claims with attachments must be submitted hardcopy.

- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.

- The total amount of the submitted file must equal the amount indicated on the Unisys response file.

- **All claims submitted must meet timely filing guidelines.**

CLAIMS PROCESSING REMINDERS

Unisys Louisiana Medicaid images and stores all Louisiana Medicaid paper claims on-line. This process allows the Unisys Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

If claims cannot be submitted electronically, prepare paper claim forms according to the following instructions to ensure appropriate and timely processing:

- Submit an original claim form whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.
- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.
- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. **DO NOT use a highlighter to draw attention to specific information.**
- Paper claims must be legible and in good condition for scanning into our document imaging system.
- **Don't forget to sign and date your claim form. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.**
- Continuous feed forms must be torn apart before submission.
- Use high quality printer ribbons or cartridges-black ink only.
- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.
- Do not use italic, bold, or underline features.
- Do not submit two-sided documents.
- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

The recipient's 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic card is NOT acceptable.

Attachments

All claim attachments should be standard 81/2 x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper. If it is necessary to attach documentation to a claim, the documents must be placed directly behind each claim that requires this documentation. Therefore, it may be necessary to make multiple copies of the documents if they must be placed with multiple claims.

Changes to Claim Forms

Louisiana Medicaid policy prohibits Unisys staff from changing any information on a provider's claim form. Any claims requiring changes must be made prior to submission. Please do not ask Unisys staff to make any changes on your behalf.

Data Entry

Data entry clerks do not interpret information on claim forms-data is keyed as it appears on the claim form. If the data is incorrect, or **IS NOT IN THE CORRECT LOCATION**, the claim will not process correctly.

Rejected Claims

Unisys currently returns claims that are illegible or incomplete. These claims are not processed and are returned along with a cover letter stating why the claim(s) is/are rejected. During 2005, Unisys returned 273,291 rejected claims to providers. The most common reasons for rejection are listed as follows:

- A signature or handwritten initials were missing
- The recipient number was invalid or missing
- The provider # was missing or incomplete

The criteria for legible claims are:

- All claim forms are clear and in good condition
- All information is readable to the normal eye
- All information is centered in the appropriate block
- All essential information is complete

IMPORTANT UNISYS ADDRESSES

Please be aware that **different post office boxes** are used for the various Medicaid programs. If you are submitting an original "clean" hard copy claim for payment or adjustments/voids, please utilize the following post office boxes and zip codes.

Type of Claim	P.O. Box	Zip Code
Pharmacy	91019	70821
CMS-1500 Claims Case Management Chiropractic Durable Medical Equipment EPSDT Health Services FQHC Hemodialysis Professional Services Independent Lab Mental Health Rehabilitation PCS Professional Rural Health Clinic Substance Abuse and Mental Health Clinic Waiver	91020	70821
Inpatient & Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long Term Care	91021	70821
Dental, Home Health, Rehabilitation, Transportation (Ambulance and Non-ambulance)	91022	70821
ALL Medicare Crossovers and All Medicare Adjustments and Voids	91023	70821
KIDMED	14849	70898

Unisys also has different post office boxes for various departments. They are as follows:

Department	P.O. Box	Zip Code
EMC, Unisys business & Miscellaneous Correspondence	91025	70898
Prior Authorization	14919	70898
Provider Enrollment	80159	70898
Provider Relations	91024	70821

TIMELY FILING GUIDELINES

In order to be reimbursed for services rendered, all providers must comply with the following filing limits set by Medicaid of Louisiana:

- Straight Medicaid claims must be filed within 12 months of the date of service.
- KIDMED screening claims (KM-3 forms or 837P with K-3 segment) must be filed within 60 days from the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations.
- Claims which fail to cross over via tape and have to be filed hard copy MUST be adjudicated within six months from the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.
- Claims with third-party payment must be filed to Medicaid within 12 months of the date of service.

Dates of Service Past Initial Filing Limit

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

A Claims Status Inquiry (e-CSI) screen print indicating that the claim was processed within the specified time frame.

OR

A Remittance Advice indicating that the claim was processed within the specified time frame.

OR

Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the recipient.

NOTE 1: All proof of timely filing documentation must reference the individual recipient and date of service. RA pages and e-CSI screen prints must contain the specific recipient information, provider information, and date of service to be considered as proof of timely filing.

NOTE 2: At this time Louisiana Medicaid **does not** accept printouts of Medicaid Electronic Remittance Advice (ERA) screens as proof of timely filing. Reject letters are not considered proof of timely filing as they do not reference a specific individual

recipient or date of service. Postal "certified" receipts and receipts from other delivery carriers are not acceptable proof of timely filing.

To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible.

Submitting Claims for Two-Year Override Consideration

Providers requesting two-year overrides for claims with dates of service over two years old must provide proof of timely filing and must assure that each claim meets at least one of the three criteria listed below:

- The recipient was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted.
- The recipient won a Medicare or SSI appeal in which he or she was granted retroactive Medicaid Benefits.
- The failure of the claim to pay was the fault of the Louisiana Medicaid Program rather than the provider's each time the claim was adjudicated.

All provider requests for two-year overrides must be mailed directly to:

Unisys Provider Relations Correspondence Unit
P.O. Box 91024
Baton Rouge, La 70821

The provider must submit the claim with a cover letter describing the criteria that has been met for consideration along with all supporting documentation. Supporting documentation includes but is not limited to proof of timely filing and evidence of the criteria met for consideration.

Claims submitted without a cover letter, proof of timely filing, and/or supporting documentation will be returned to the provider without consideration. Any request submitted directly to DHH staff will be routed to Unisys Provider Relations.

PROVIDER ASSISTANCE

The Louisiana Department of Health and Hospitals and Unisys maintain a website to make information more accessible to Medicaid providers. At this online location, www.lamedicaid.com, providers can access information ranging from how to enroll as a Medicaid provider to directions for filling out a claim form.

Below are some of the most common topics found on the website:

New Medicaid Information
HIPAA Information Center
Provider Training Materials
Provider Web Account Registration Instructions
Provider Support
Billing Information
Fee Schedules
Provider Update / Remittance Advice Index
Pharmacy
Prescribing Providers
Current Newsletter and RA
Helpful Numbers
Useful Links
Forms/Files/User Guidelines

- ☞ The website also contains a section for Frequently Asked Questions (FAQ) that provide answers to commonly asked questions received by Provider Relations.

Along with the website, The Unisys Provider Relations Department is available to assist providers. This department consists of three units, (1) Telephone Inquiry Unit, (2) Correspondence Unit, and (3) Field Analyst. The following information addresses each unit and their responsibilities.

Unisys Provider Relations Telephone Inquiry Unit

(800) 473-2783 or (225) 924-5040
FAX: (225) 216-6334*

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification; ordering printed materials; billing issues; request a Field Analyst visit; etc.

The following menu options are available through the Unisys Provider Relations telephone inquiry phone numbers. Callers should have the 7-digit LA Medicaid provider number available to enter the system. Please listen to the menu options and press the appropriate key for assistance.

Press #2 - To order printed materials only**

Examples: Orders for manuals, workshop packets, enrollment packs, Unisys claim forms, fee schedules, TPL carrier code lists, and provider newsletter reprints.
To choose this option, press "2" on the telephone keypad. This option will allow providers to leave a message to request printed materials **only**. Please be sure to leave (1) the provider name, (2) provider number, (3) contact person, (4) complete mailing address, (5) phone number and (6) specific material requested.

- ☞ Only messages left in reference to printed materials will be processed when choosing this option. Please review the other options outlined in this section for assistance with other provider issues.

NOTE: Providers should access eligibility information via the Medicaid Eligibility Verification System (MEVS) or the automated Recipient Eligibility Verification System (REVS) at (800) 776-6323 or (225) 216-7387. Providers may also check eligibility by accessing the web-based application, e-MEVS, now available on the Louisiana Medicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

Provider Relations cannot assist recipients. The telephone listing in the "Recipient Assistance" section found on page 80 should be used to direct Medicaid recipient inquiries appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number bay be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

Press #3 - To verify recipient or provider eligibility; Medicare or other insurance information; Primary Care Physician information; or service limits.

- Recipient eligibility
- Third Party (Insurance) Resources
- CommunityCARE
- Lock-In

Press #4 - To resolve a claims problem

*Provider Relations will accept faxed information regarding provider inquiries on an **approved** case by case basis. However, faxed claims **are not acceptable** for processing.

Press #5 – To obtain policy clarification, procedure code reimbursement verification, request a filed analyst visit, obtain check amounts or for other information.

** Provider Relations staff mail each new provider a current copy of the provider manual and training packet for his program type upon enrollment as a Medicaid provider. An enrolled provider may also request a copy of the provider manual and training packet for the Medicaid program in which he is enrolled. A fee is charged for provider manuals and training packets ordered for non-providers (attorneys, billing agents, etc.) or by providers wanting a manual for a program for which they are not enrolled. All orders for provider manuals and training packets should be made by contacting the Provider Relations Telephone Inquiry Unit. Those requiring payment will be forwarded to the provider once payment is received.

Unisys Provider Relations Correspondence Group

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims. Staff in this unit also handles requests to update recipient files with correct eligibility. Provider Relations staff do not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence department, so these may take additional time for final resolution.

Providers who wish to submit problem claims for research and want to receive a written response, **must submit a cover letter** explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). A copy of the claim form along with applicable corrections/and or attachments must accompany all resubmissions.

All requests to the Correspondence Unit should be submitted to the following address:

Unisys Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge, LA 70821

> **NOTE**: Many providers submit claims that do not require special handling to the Provider Relations Department hoping to expedite processing of these claims. However, this actually delays claim processing, as the claims must pass through additional hands before reaching the appropriate processing area. In addition, it diverts productivity that would otherwise be devoted to researching and responding to provider requests for assistance with legitimate claim problems. Providers are asked to send claims that do not require special handling directly to the appropriate post office box for that claim type.

Provider Relations staff does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

Requests to update Third Party Liability (TPL) should be directed to:

DHH-Third Party Liability
Medicaid Recovery Unit
P.O. Box 91030
Baton Rouge, LA 70821

“Clean claims” should not be submitted to Provider Relations as this delays processing. Please submit “clean claims” to the appropriate P.O. Box. A complete list is available in this training packet under “Unisys Claims filing Addresses”.

NOTE: CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED “CLEAN” CLAIMS AND WILL NOT BE RESEARCHED.

Unisys Provider Relations Field Analysts

Provider Relations Field Analysts are available to visit and train new providers and their office staff on site, upon request. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However**, **since the Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for material, or other policy documentation. These calls should <u>not</u> be directed to the Field analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

FIELD ANALYST	PARISHES SERVED	
Kellie Conforto (225) 216-6269	Assumption Calcasieu Cameron Jeff Davis Lafourche	St. Mary St. Martin (**below Iberia**) Terrebonne Vermillion
Martha Craft (225) 216-6306	Jefferson Orleans Plaquemines St. Bernard	St. Charles St. James St. John the Baptist St. Tammany (**Slidell only**)
Sharon Harless (225) 216-6267	East Baton Rouge (**Baker & Zachary only**) West Baton rouge Iberville Pointe Coupee	St. Helena East Feliciana West Feliciana Woodville (MS) Centerville (MS)
Erin McAlister (225) 216-6201	Ascension East Baton Rouge (**excluding Baker & Zachary**) Livingston	St. Tammany (**excluding Slidell**) Tangipahoa Washington McComb (MS)
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin (**above Iberia**) Beaumont (TX)
Kathy Robertson (225) 216-6260	Avoyelles Beauregard Caldwell Catahoula Concordia Franklin Grant LaSalle	Natchitoches Rapides Sabine Tensas Vernon Winn Natchez (MS) Jasper (TX)
Anna Sanders (225) 216-6273	Bienville Bossier Caddo Claiborne DeSoto East Carroll Jackson Lincoln Madison	Morehouse Ouachita Red River Richland Union Webster West Carroll Marshall (TX) Vicksburg (MS)

Provider Relations Reminders

The Unisys Provider Relations inquiry staff strives to respond to provider inquiries quickly and efficiently. There are a number of ways in which the provider community can assist the staff in responding to inquiries in an even more timely and efficient manner:

- Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:
    - The correct 7-digit LA Medicaid provider number
    - The 13-digit Recipient's Medicaid ID number
    - The date of service
    - Any other information, such as procedure code and billed charge, that will help identify the claim in question
    - The Remittance Advice showing disposition of the specific claim in question

- Obtain the name of the phone representative you are speaking to in case further communication is necessary.

- Because of the large volume of incoming provider calls, Telephone Inquiry staff are not allowed to be put on hold after answering a call.

- PLEASE review and reconcile the remittance advice before calling Provider Relations concerning claims issues. Some providers call Provider Relations frequently, asking questions that could be answered if the RA was reviewed thoroughly. However, providers are encouraged to call Provider Relations with questions concerning printed policy, procedures, and billing problems.

- Provider Relations **WILL NOT** reconcile provider accounts or work old accounts for providers. Calls to check claim status tie up phone lines and reduce the number of legitimate questions and inquiries that can be answered. It is each provider's responsibility to establish and maintain a system of tracking claim billing, payment, and denial. This includes thoroughly reviewing the weekly remittance advice, correcting claim errors as indicated by denial error codes, and resubmitting claims which do not appear on the remittance advice within 30 - 40 days for hard copy claims and three weeks for EDI claims.

- Providers can check claim status through the e-CSI (Claim Status Inquiry) web application found in the secure area of the Louisiana Medicaid website at www.lamedicaid.com. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on e-CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the e-CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to e-CSI or hard copy remittance advices for this purpose. A LA Medicaid/HIPAA Error Code Crosswalk is available on the website by accessing the link, Forms/Files.

- If a provider has a large number of claims to reconcile, it may be to the provider's advantage to order a provider history. Please see the Ordering Information section for instructions on ordering a provider history.

- **Provider Relations cannot assist recipients.** The telephone listing in the "Recipient Assistance" section found on page 80 should be used to direct Medicaid recipient inquires appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

- Providers who wish to submit problem claims for a written response **must submit a cover letter** explaining the problem or question.

- Calls regarding eligibility, claim issues, requests for Unisys claim forms, manuals, or other policy documentation should not be directed to the Field Analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit.

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

Department	Toll Free Phone	Phone	Fax
REVS - Automated Eligibility Verification	(800) 776-6323	(225) 216-7387	
Provider Relations	(800) 473-2783	(225) 924-5040	(225) 216-6334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 216-6381	(225) 216-6334
Electronic Media Claims (EMC) - Unisys		(225) 216-6000 option 2	(225) 216-6335
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 216-6342
Dental P.A. - LSU School of Dentistry		(225) 216-6470	(225) 216-6476
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 216-6370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline – Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – **DHH**	(800) 834-3333 (225) 342-9808	Providers may request verification of eligibility for presumptively eligible recipients; recipients may request a new card or discuss eligibility issues.
Eligibility Operations – **BHSF**	(888) 342-6207	Recipients may address eligibility questions and concerns
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - **Vaccines for Children Program**	(504) 838-5300	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Specialty Care Resource Line - **ACS**	(877) 455-9955	Providers and recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED. Providers may inquire about PCP assignment for CommunityCARE recipients and CommunityCARE monitoring/certification, and obtain information on KIDMED linkage, referrals, monitoring, and certification.
CommunityCARE Nurse Helpline – **ACS**	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - **OPH**	(866) 327-5978	Providers and recipients may obtain information on EarlySteps Program and services offered
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4153	Providers may request termination as a recipient's lock-in provider.
Division of Long Term Supports and Services (DLTSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding waiver services to waiver recipients.

DHH PROGRAM MANAGER REQUESTS

Questions regarding the rationale for Medicaid policy, procedure coverage and reimbursement, medical justification, written clarification of policy that is not documented, etc. should be directed in writing to the manager of your specific program:

Program Manager - (i.e. DME, Hospital, etc.)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

The telephone listing below should be used to direct **recipient** inquiries appropriately.

Department	Phone	Purpose
Fraud and Abuse Hotline	(800) 488-2917	Recipients may anonymously report any suspected fraud and/or abuse.
Regional Office – DHH	(800) 834-3333 (225) 342-9808	Recipients may request a new card or discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns
LaCHIP Program	(877) 252-2447	Recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Specialty Care Resource Line - ACS	(877) 455-9955	Recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED.
CommunityCARE Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - OPH	(866) 327-5978	Recipients may obtain information on EarlySteps Program and services offered
LINKS	(504) 838-5300	Recipients may obtain immunization information.
Division of Long Term Supports and Services (DLTSS)	(225) 219-0200 (800) 660-0488	Recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 219-0200 (800) 660-0488	Recipients may request assistance regarding waiver services.

LOUISIANA MEDICAID WEBSITE APPLICATIONS

The newest way to obtain general and specific Medicaid information is on our Louisiana Medicaid Provider Website:

www.lamedicaid.com

This website has several applications that should be used by Louisiana Medicaid providers. These applications require that providers establish an online account for the site.

Provider Login And Password

To ensure appropriate security of recipient's patient health information (PHI) and provider's personal information, the secure area of the web site is available to providers only. It is the responsibility of each provider to become "Web Enrolled" by obtaining a login and password for this area of the site to be used with his/her provider number. Once the login and password are obtained by the provider who "owns" the provider number, that provider may permit multiple users to login using the provider number. This system allows multiple individuals to login using the same login and password OR a provider may have up to 500 individual logins and passwords established for a single provider number. The administrative account rights are established when a provider initially obtains a login and password, and should remain with the provider or designated office staff employed by the provider.

A login and password may be obtained by using the link, Provider Web Account Registration Instructions. Should you need assistance with obtaining a login and password or have questions about the technical use of the application, please contact the Unisys Technical Support Desk at 877-598-8753.

☞ Unisys has received inquiries from billing agents/vendors attempting to access this web application. DHH and CMS Security Policy restrictions will not permit Unisys to allow access of this secure application to anyone except the owner of the provider number being used for accessing the site. In cases where an outside billing agent/vendor is contracted to submit claims on behalf of a provider, any existing business partner agreement is between the provider and the billing agent/vendor. Unisys may not permit anyone except the provider to receive or ask for information related to a login and password to access secured information.

Web Applications

There are a number of web applications available on the Medicaid website, however, the following applications are the most commonly used:

- Medicaid Eligibility Verification System (e-MEVS) for recipient eligibility inquiries; and
- Claims Status Inquiry (e-CSI) for inquiring on claims status; and
- Clinical Data Inquiry (e-CDI) for inquiring on recipient pharmacy prescriptions as well as other medical claims data; and
- Prior Authorization (e-PA) for requesting prior authorizations electronically.

These applications are available to providers 24 hours a day, 7 days a week at no cost.

e-MEVS:

Providers can now verify eligibility, primary insurance information, and service limits for a Medicaid recipient using this web application accessed through www.lamedicaid.com. This application provides eligibility verification capability in addition to MEVS swipe card transactions and REVS. An eligibility request can be entered via the web for a single recipient and the data for that individual will be returned on a printable web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Since its release, the application has undergone some cosmetic and informational changes to make it more user-friendly and allow presentation of more complete, understandable information.

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to remittance advices for this purpose. A LA Medicaid/HIPAA Error Code Crosswalk is available on this website by accessing the link, Forms/Files.

Once enrolled in the website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

e-CDI:

The e-CDI application provides a Medicaid recipient's essential clinical history information at the authorized practitioner's finger tips at any practice location.

The nine (9) clinical services information components are:

1. Clinical Drug Inquiry
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a six-month period. These updates are based on Medicaid claims history. A print-friendly version of the information on each of the web pages will be accessible and suitable for the recipient's clinical chart.

The major benefits of the use of e-CDI by the practitioner will include:

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by all providers that have provided services to each individual recipient.
2. Provides the practitioner rapid access to current clinical data to help him/her evaluate the need for "modifications" of an individual Medicaid recipient's health care treatment.
3. Promotes the deliberate evaluation by a practitioner to help prevent duplicate drug therapy and decreases the ordering of duplicate laboratory tests, x-ray procedures, and other services.
4. Supplies a list of all practitioner types providing health care services to each Medicaid recipient.
5. Assists the practitioner in improving therapeutic outcomes and decreasing health care costs.

e-PA

The Electronic Prior Authorization (e-PA) Web Application has been developed for requesting prior authorizations electronically. E-PA is a web application found on the www.lamedicaid.com website and provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. This application is currently restricted to the following prior authorization types:

01 – Inpatient
05 – Rehabilitation
06 – Home Health
09 – DME
14 – EPSDT PCS
99 - Other

Providers who do not have access to a computer and/or fax machine will not be able to utilize the web application. However, prior authorization requests will continue to be accepted and processed using the current PA hard-copy submission methods.

NOTE: Dental electronic Prior authorization (e-PA) Web Application to be implemented at a later date. In order to utilize the Dental e-PA Web Application, the dental provider will be required to obtain the services of a vendor to submit the electronic attachment information to Medicaid. Complete Dental e-PA instructions will be provided upon implementation of Dental e-PA.

Reminders:

PA Type 01: Outpatient Ambulatory Surgery performed Inpatient on the first or second day of the stay. This is only for State Operated hospitals and Out-of-State hospitals that have a DHH approval letter for the out of state stay. Use ICD-9-CM procedure codes.

PA Type 99: Outpatient Ambulatory Surgery (CPT procedures) performed Inpatient on the first or second day of the stay. The surgery was performed at a State Operated hospital and Out-of-State hospital that has a DHH approval letter for the out of state stay. This is also used for specialized CPT procedures. This is for professional services only.

PA Type 05: Providers must always submit the PA02 Form with each request. Do not request authorization for the evaluation procedures, these do not require prior approval. Submit only units on the e-PA transaction, Do Not submit dollar amounts.

Home Health Providers submitting Rehab Services should use PA Type 05 and PA Type 09 when submitting DME Services.

PA Type 09: When submitting a request with a miscellaneous procedure code, the provider must submit a PA01 Form with the description of the item they are requesting.

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

RECONSIDERATION REQUESTS (RECONS) CANNOT BE SUBMITTED VIA THE e-PA WEB APPLICATION AND SHOULD BE SUBMITTED USING THE EXISTING PROCESS.

Additional DHH Available Websites

www.lamedicaid.com: Louisiana Medicaid Information Center which includes field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, fee schedules, and program training packets

www.lamedicaid.com/provweb1/HIPAA/HIPAAindex.htm: Louisiana Medicaid HIPAA Information Center

www.dhh.louisiana.gov: DHH website – LINKS (includes a link entitled "Find a doctor or dentist in Medicaid")

www.dhh.state.la.us: Louisiana Department of Health and Hospitals (DHH)

www.la-kidmed.com: KIDMED – program information, Frequently Asked Questions, outreach material ordering

www.la-communitycare.com: CommunityCARE – program information, PCP listings, Frequently Asked Questions, outreach material ordering

https://linksweb.oph.dhh.louisiana.gov: Louisiana Immunization Network for Kids Statewide (LINKS)

www.ltss.dhh.louisiana.gov: Division of Long Term Community Supports and Services (DLTSS)

www.dhh.louisiana.gov/offices/?ID=77: Office of Citizens with Developmental Disabilities (OCDD)

www.dhh.louisiana.gov/offices/?ID=257: EarlySteps Program

www.dhh.state.la.us/offices/?ID=111: DHH Rate and Audit Review (nursing home updates and cost report information, Outpatient Surgery Fee Schedule, Updates to Ambulatory Surgery Groups, contacts, FAQ)

www.doa.louisiana.gov/employ_holiday.htm: State of Louisiana Division of Administration site for Official State Holidays

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 Unisys. 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 each week when the provider has adjudicated claims.

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 RA 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 the provider uses a medical record number (which may consist of up to 16 alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

At the end of each claim line is the 13-digit internal control number (ICN) assigned to that claim line. Each separate claim line is assigned a unique ICN for tracking and audit purposes. Following is a breakdown of the 13 digits of the ICN and what they represent:

Position 1	Last Digit of Current Year
Positions 2-4	Julian Date - ordinal day of 365-day year
Position 5	Media Code - 0 = paper claim with no attachments 1 = electronic claim 2 = systems generated 3 = adjustment 4 = void 5 = paper claim with attachments
Positions 6-8	Batch Number - for Unisys internal purposes
Positions 9-11	Sequence Number - for Unisys internal purposes
Positions 12-13	Number of Line within Claim - 00 = first line 01 = second line 02 = third line, etc.

Unisys Provider Relations responds to inquiries concerning particular claims when the provider has reconciled the RA and determined that the claim has denied, pended, paid or been rejected prior to entry into the system. It is not possible for Unisys Provider Relations to take the place of the provider's weekly RA by checking the status of numbers of claims on which providers, billers or collection agencies are checking.

In situations where providers choose to contract with outside billing or collection agencies to bill claims and reconcile accounts, it is the provider's responsibility to provide the contracted agency with copies of the RAs or other billing related information in order to bill the claims and reconcile the accounts.

When providers or contractors are attempting to reconcile old accounts, if RAs are not available through the provider, it is necessary for the provider to order a claims history, which is available through Unisys Provider Relations (see page 97).

Remittance Advice Breakdown

Claims presented on the RA can appear under one of several headings: Approved Original Claims (paid claims); Denied Claims; Claims in Process; Adjustment Claims; Previously Paid Claims; and Voided Claims. When reviewing the RA, please look carefully at the heading under which the claims appear. This will assist with your reconciliation process.

Always remember that claims appear under the heading "Claims in Process" to let the provider know that the claim has been received by the Fiscal Intermediary, and should not be worked until they appear as either "Approved Original Claims" or "Denied Claims." "Claims in Process" are claims which are pending in the system for review. Once that review occurs, the claims will move to a paid or denied status on the RA. If claims pend for review, they will appear on an initial RA as "Claims in Process" as they enter the processing system. After that point, they will appear only once a month under that heading until they are reviewed.

Remittance Summary

"Approved Original Claims" may appear with zero (0 dollar) payments. These claims are still considered paid claims. Claims pay a zero amount legitimately, based on other insurance payments, maximum allowable payments, etc.

When providers choose to return checks to adjust or void a claim rather than completing an adjustment/void form, the checks will initially appear as a financial transaction on the front of the RA to acknowledge receipt of that check. The provider's check number and amount will be indicated, as well as an internal control number (ICN) which is assigned to the check. If claims associated with the check are processed immediately, they will appear on the same RA as the check financial transaction, under the heading of "adjustment or void" as appropriate, as well as the corresponding "previously paid claim." The amount of the check posted to the RA should offset the amount recouped from the RA as a result of the adjustment/void, and other payments should not be affected. However, if the adjustments/voids cannot be processed on the same RA, the check will be posted and appear on the financial page of the RA under "Suspense Balance Brought Forward" where it will be carried forward on forthcoming RA's until all adjustments/voids are processed. As the adjustments/voids are processed, they will appear on the RA and the amount of money being recouped will be deducted from the "Suspense Balance Brought Forward" until all claims payments returned are processed.

It is the provider's responsibility to track these refund checks and corresponding claims until they are all processed.

When providers choose to submit adjustment/void forms for refunds, the following is an important point to understand. As the claims are adjusted/voided on the RA, the monies recouped will appear on the RA appropriately as "Adjustment Claims" or "Voided Claims." A corresponding "Previously Paid Claim" will also be indicated. The system calculates the difference between what has already been paid ("Previously Paid Claim") and the additional amount being paid or the amount being recouped through the adjustment/void. If additional money is being paid, it will be added to your check and the payment should be posted to the

appropriate recipient's account. If money is being recouped, it will be deducted from your check amount. This process means that when recoupments appear on the RA, the paid claims must be posted as payments to the appropriate recipient accounts through the bookkeeping process and the recoupments must be deducted from the accounts of the recipients for which adjustment or voids appear. If the total voided exceeds the total original payment, a negative balance occurs, and money will be recouped out of future checks. This also includes state recoupments, SURS recoupments and cost settlements.

Below are the summary headings which may appear on the financial summary page and an explanation of each.

Suspense Balance Brought Forward	A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed.
Approved Original Claim	Total of all approved (paid) claims appearing on this RA.
Adjustment Claims	Total of all claims being adjusted on this RA.
Previously Paid Claim	Total of all previously paid claims which correspond to an adjustment or void appearing on this RA.
Void Claims	Total of all claims being voided on this RA.
Net Current Claims Transactions	Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process).
Net Current Financial Transactions	Total number of all financial transactions appearing on the RA.
Prior Negative Balance	If a negative balance has been created through adjustments or voids processed, the negative balance is carried forward to the next RA. (This also includes state recoupments, SURS recoupments and cost settlements.)
Withheld for Future Recoveries	Difference between provider checks posted on the RA and the deduction from those checks when associated claims are processed on the same RA as the posting of the check. (This is added to Suspense Balance Brought Forward on the next RA.)
Total Payments This RA	Total of current check.
Total Copayment Deducted This RA	Total pharmacy co-payments deducted for this RA.
Suspense Balance Carried Forward	Total of Suspense Balance Brought Forward and withheld for future recoveries.
Y-T-D Amount Paid	Total amount paid for the calendar year.
Denied Claims	Total of all denied claims appearing on this RA.
Claims in Process	Total of all pending claims appearing on this RA.

Claims in Process

When the ICN of a claim appears on a remittance advice (RA), with a message of "Claim In Process," the claim is in the process of being reviewed. The claim has not been approved for payment yet, and the claim has not had payment denied. During the next week, the claim will be reviewed and will appear as a "paid" or "denied" claim on the next RA unless additional review is required. The "Claim In Process" listing on the RA appears immediately following the "Denied Claims" listing and is often confused with "Denied Claims."

Pended claims are those claims held for in-house review by Unisys. After the review is completed, the claim will be denied if a correction by the provider is required. The claim will be paid if the correction can be made by Unisys during the review.

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.

On the following pages are examples of remittance advice pages and a TPL denied claims notification list (this is normally printed at the end of the remittance advice).

Denied Claims Turnarounds (DTAs)

Denied claim turnarounds, also printed at the end of the remittance advice, are produced when certain errors are encountered in the processing of a claim. **(Not all denial error codes produce denied claim turnarounds.)** The denied claim turnaround document is printed to reflect the information submitted on the original claim. It is then mailed to the provider to allow him to change the incorrect items and sign and return the document to Unisys. Once the document is received at Unisys, the correction is entered into the claims processing system and adjudication resumes for the original claim. **Note, however, that the turnaround document must be returned to Unisys with appropriate corrections as soon as possible, as they are only valid for 30 days from the date of processing of the original claim.**

TPL Denied Claims Notification List (CP-0-25)

The TPL denied claims notification list is generated when claims for recipients with other insurance coverage are filed to Medicaid with no EOB from the other insurance and no indication of a TPL carrier code on the claim form. This list notifies the provider that third party coverage exists and gives the name and carrier code of all identified insurances. Once the private insurance has been billed, the claim may be corrected and resubmitted to Unisys with the third party EOB.

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:

Payment Management Section
Bureau of Fiscal Services
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 payment is greater than the Medicaid payment, the full amount of the Medicaid payment should be refunded.

CHECKS SHOULD <u>NOT</u> BE MADE PAYABLE TO UNISYS

Note: Adjustment/void claims should be done initially. A refund check should be a last option, as this process takes a much longer time period to be completed and does not provide a clear audit trail as the adjustment/void process does.

TO:

OUTPATIENT FACILITY REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 04/04/2006 PAGE: 48
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS		AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
APPROVED ORIGINAL CLAIMS											
260 2	A A N	031106	031106	1	302	IMMUNOLOGY 86403	4000	1317	00	1317	601 1600
(03 /(4	9430321)				527 116						
260 2	A A N	031106	031106	1	306	LABORATORY-HEMATOL 87184	8750	890	00	890	601 1601
(03 /(4	9430321)				527 116						
260 2	A A N	031106	031106	1	306	LABORATORY-HEMATOL 87070	4900	1113	00	1113	601 1602
(03 /(4	9430321)				527 116						
260 2	A A N	031106	031106	1	450	EMERGENCY ROOM-GEN 99282	17300	17300	11738	5562	601 1603
(03 /(4	9430321)				527						
888 4	ABB A	031106	031106	1	515	PEDIATRIC CLINIC 99211	3300	3300	00	3300	601 1200
(17 /(1	95MPC)				526						
185 0	ACC HC	031506	031506	1	300	LABORATORY-GEN CLA 87804	8000	1824	00	1824	601 1500
(16 /(1	82MPC)				526 116						
185 0	ACC HC	031506	031506	1	300	LABORATORY-GEN CLA 87420	4500	1824	00	1824	601 1501
(16 /(1	82MPC)				526 116						
185 0	ACC HC	031506	031506	1	515	PEDIATRIC CLINIC 99211	3300	3300	00	3300	601 1502
(16 /(1	82MPC)				526						
810 2	ACC KM	030806	030806	1	515	PEDIATRIC CLINIC 99211	3300	3300	00	3300	601 3600
(15 /(1	74MPC)				527						
170 1	ACC AL	032206	032206	1	320	RADIOLOGY-DIAGNOST 72010	33337	33337	22619	10718	601 1600
(01 /(2	0105401)				527						
170 1	ACC AL	032206	032206	2	320	RADIOLOGY-DIAGNOST 73590	30374	30374	20609	9765	60 1601
(01 /(2	0105401)				527						
170 1	ACC AL	032206	032206	1	320	RADIOLOGY-DIAGNOST 72170	24187	24187	16411	7776	60 1602
(01 /(2	0105401)				527						
003 4	ACH JJ	032206	032206	1	300	LABORATORY-GEN CLA 36415	1300	300	00	300	60 2000
(03 /(2	9596313)				527 116						
003 4	ACH JJ	032206	032206	1	305	HEMATOLOGY 85027	10550	837	00	837	60 2001
(03 /(2	9596313)				527 116						
003 4	ACH JJ	032206	032206	1	305	HEMATOLOGY 85007	3600	306	00	306	60 2002
(03 /(2	9596313)				527 116						
052 6	ACH MF	032106	032106	1	320	RADIOLOGY-DIAGNOST 72010	33337	33337	22619	10718	60 2900
(02 /(2	8032701)				527						
853 8	ACK RA	031206	031206	1	450	EMERGENCY ROOM-GEN	17300	17300	11738	5562	60 3400
(02 /(4	9431790)				527						
853 8	ACK RA	031706	031706	1	300	LABORATORY-GEN CLA 87880	8000	1824	00	1824	60 1400
(17 /(1	22MPC)				527 116						
853 8	ACK RA	031706	031706	1	515	PEDIATRIC CLINIC 99211	3300	3300	00	3300	60 1401
(17 /(1	22MPC)				527						
440 3	ACO JL	030806	030806	1	515	PEDIATRIC CLINIC 99211	3300	3300	00	3300	60 2300
(10 /(1	55MPC)				527						
672 0	ADA JI	031106	031106	1	450	EMERGENCY ROOM-GEN 99282	17300	17300	11738	5562	60 0400
(03 /(4	9430545)				527						
789 9	ADA JD	031506	031506	1	515	PEDIATRIC CLINIC 99211	3300	3300	00	3300	60 7500
(12 /(1	73MPC)				527						
975 9	ADA JB	031306	031306	1	515	PEDIATRIC CLINIC 99211	3300	3300	00	3300	60 9300
(11 /(1	49MPC)				527						
522 3	ADA NJ	031006	031006	1	515	PEDIATRIC CLINIC 99211	3300	3300	00	3300	60 8700
(16 /(1	41MPC)				527						
457 8	ADA TB	031206	031206	1	250	PHARMACY,GENERAL C	5100	5100	3460	1640	60 2700

TO:

OUTPATIENT FACILITY REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
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DATE: 04/04/2006 PAGE: 209
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS		AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
DENIED CLAIMS											
604 4	ALF	032206	032206	1	301 CHEMISTRY	83930	14500	00	00	00	60 03
(03	235	81406	)		805 116						
					CONFLICTING CONTROL NO:		ADJUDICATION DATE:20060404				
604 4	ALF	032206	032206	1	301 CHEMISTRY	83935	14500	00	00	00	60 04
(03	235	81406	)		805 116						
					CONFLICTING CONTROL NO:		ADJUDICATION DATE:20060404				
604 4	ALF	032206	032206	1	305 HEMATOLOGY	85027	10550	00	00	00	60 05
(03	235	81406	)		805 116						
					CONFLICTING CONTROL NO:		ADJUDICATION DATE:20060404				
604 4	ALF	032206	032206	1	305 HEMATOLOGY	85651	7650	00	00	00	60 06
(03	235	81406	)		805 116						
					CONFLICTING CONTROL NO:		ADJUDICATION DATE:20060404				
604 4	ALF	032206	032206	1	305 HEMATOLOGY	85007	3600	00	00	00	60 07
(03	235	81406	)		805 116						
					CONFLICTING CONTROL NO:		ADJUDICATION DATE:20060404				
008 9	ALF	032106	032106	16	250 PHARMACY,GENERAL C		264050	00	00	00	60 00
(03	44(	41492	)		774						
008 9	ALF	032106	032106	4	270 MED/SURG SUPPLY/DE		61200	00	00	00	60 01
(03	44(	41492	)		774						
008 9	ALF	032106	032106	5	272 STERILE SUPPPLY		418246	00	00	00	60 02
(03	44(	41492	)		774						
008 9	ALF	032106	032106	1	300 LABORATORY-GEN CLA	36415	1300	00	00	00	60 03
(03	440	41492	)		774 116						
008 9	ALF	032106	032106	1	301 CHEMISTRY	84703	10450	00	00	00	60 04
(03	440	41492	)		774 116						
008 9	ALF	032106	032106	1	306 LABORATORY-HEMATOL	87102	17850	00	00	00	60 05
(03	44(	41492	)		774 116						
008 9	ALF	032106	032106	1	306 LABORATORY-HEMATOL	87070	15050	00	00	00	60 06
(03	44(	41492	)		774 116						
008 9	ALF	032106	032106	1	306 LABORATORY-HEMATOL	87184	8750	00	00	00	60 07
(03	44(	41492	)		774 116						
008 9	ALF	032106	032106	1	306 LABORATORY-HEMATOL	87205	5550	00	00	00	60 08
(03	44(	41492	)		774 116						
008 9	ALF	032106	032106	1	312 LAB PATHOLOGIC/HIS	88312	7276	00	00	00	60 09
(03	440	41492	)		774						
008 9	ALF	032106	032106	1	760 TREATMENT/OBSERVAT		103900	00	00	00	60 11
(03	440	41492	)		774						
008 9	ALF	032106	032106	16	250 PHARMACY,GENERAL C		264050	00	00	00	60 00
(03	44(	41492	)		774						
008 9	ALF	032106	032106	4	270 MED/SURG SUPPLY/DE		61200	00	00	00	60 01
(03	44(	41492	)		774						
008 9	ALF	032106	032106	5	272 STERILE SUPPPLY		418246	00	00	00	60 02
(03	44(	41492	)		774						
008 9	ALF	032106	032106	1	300 LABORATORY-GEN CLA	36415	1300	00	00	00	60 03
(03	44(	41492	)		774 116						
008 9	ALF	032106	032106	1	301 CHEMISTRY	84703	10450	00	00	00	60 04
(03	44(	41492	)		774 116						
008 9	ALF	032106	032106	1	306 LABORATORY-HEMATOL	87102	17850	00	00	00	60 05
(03	44(	41492	)		774 116						

TO:

PROFESSIONAL REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/16/2005 PAGE: 2
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
APPROVED ORIGINAL CLAIMS										
(7: 28?)/					650					
65: 0 E S		080905	080905	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(2(9L)/					650					
36(2 E NM		080805	080805	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8(3?)/					650					
45: 3 E)N RF		080505	080505	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8' 27( )/					650					
45' 6 E JN		080905	080905	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8! 47)/					650					
65(2 E KA		080905	080905	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8! 41E)/					650					
65(1 E KR		080905	080905	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8! 43))/					650					
APPROVED ORIGINAL CLAIMS	TOTALS				31 CLAIMS	83392	33195	00	33195	
ADJUSTMENT CLAIMS										
SE		070505	070505	1	J7302 MIRENA	66000	38439	00	38439	5: 00
					650			REF.CONTROL NO.	51:	1
ADJUSTMENT CLAIMS	TOTALS				1 CLAIMS	66000	38439	00	38439	
PREVIOUSLY PAID CLAIMS										
SE		070505	070505	1	J7302 51 MIRENA	66000	19220	00	19220	5: 01
					FORMER REMITTANCE DATED : 08022005			REF.CONTROL NO.	62:	0
PREVIOUSLY PAID CLAIMS	TOTALS				1 CLAIMS	66000	19220	00	19220	
CLAIMS IN PROCESS										
DL		072005	072005	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	00	00	00	5: 00
(903211)/					250					
CLAIMS IN PROCESS	TOTALS				1 CLAIMS	8259	00	00	00	

TO:

PROFESSIONAL REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 07/05/2005 PAGE: 105
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
VOIDED CLAIMS										
64 01	JAC JJ	040405	040405	1	99232 SBSQNT HOSP,XPANDED,MOD	11000	4250	00	4250	51 02
((-6	/PHYS NO:							REF.CONTROL NO.		51 00
((-6	/PHYS NO:				FORMER REMITTANCE DATED : 04262005					
PA#	30536									
1: 90	MIT L	032805	032805	1	99232 SBSQNT HOSP,XPANDED,MOD	11000	4250	00	4250	51 00
((-2	/PHYS NO:							REF.CONTROL NO.		51 00
((-2	/PHYS NO:				FORMER REMITTANCE DATED : 05312005					
PA#	30293									
3(01	SAM BE	122204	122204	1	99213 OFFICE,EST PT, EXPANDED,	9000	3613	00	3613	5(00
((-2	/PHYS NO:							REF.CONTROL NO.		51 00
((-2	/PHYS NO:				FORMER REMITTANCE DATED : 01112005					
3(01	SAM BE	123104	123104	1	99233 SBSQNT HOSP,DETAILED, HI	15500	4250	00	4250	5(00
((-4	/PHYS NO:							REF.CONTROL NO.		51 00
((-4	/PHYS NO:				FORMER REMITTANCE DATED : 01252005					
PA#	30453									
5' 69	WAS ON OT	032805	032805	1	99232 SBSQNT HOSP,XPANDED,MOD	11000	4250	00	4250	51 00
(:	/PHYS NO:							REF.CONTROL NO.		51 00
(:	/PHYS NO:				FORMER REMITTANCE DATED : 06072005					
PA#	30421									
VOIDED CLAIMS	TOTALS				10 CLAIMS	113500	38593	00	38593	
DENIED CLAIMS										
3(01		061305	061305	1	99203	16000	00	00	00	51 00
((2	/PHYS NO:				215					
					PARTIAL RECIP NAME:					
4(5		061305	061305	1	99243	20000	00	00	00	51 00
((2	/PHYS NO:				215					
					PARTIAL RECIP NAME:					
3: 3		022605	022605	1	71020 26	2500	00	00	00	51 00
((3	/PHYS NO:				215					
					PARTIAL RECIP NAME:					
5: 1	AC CR	101104	101104	1	99213 OFFICE,EST PT, EXPANDED,	9000	00	00	00	51 00
((	/PHYS NO:				273					
6(5	AD D	053105	053105	1	20692 80 51	21400	00	00	00	51 01
((	/PHYS NO:				232 233					
1(3	AL T	031205	031205	1	99232 SBSQNT HOSP,XPANDED,MOD	11000	00	00	00	51 00
((6	/PHYS NO:				704					
PA	30648									
1(3	AL T	031305	031305	1	43235 UPPER GI ENDOSCOPY,DIAGN	8850	00	00	00	51 01
((6	/PHYS NO:				813					
					CONFLICTING CONTROL NO:			ADJUDICATION DATE:20050405		
3(0	AL ARRI AS	041505	041505	1	99238	14000	00	00	00	51 00
((6	/PHYS NO:				217					
2(1	AN AN	040405	040405	1	94720 26 CARBON MONOXIDE DIFFUSIN	3700	00	00	00	51 00
((2	/PHYS NO:				106					
5: 1	AN R	060805	060805	1	64585 51 REVISE/REMOVE NEUROELECT	65000	00	00	00	51 00
((	/PHYS NO:				299 299					

TO:

NON-INSTITUTIONAL TITLE XVIII REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/09/2005 PAGE: 123
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
				ERROR CODE	ERROR TRANSLATION					
				021	FORMER REFERENCE NUMBER MISSING OR INVALID					
				078	RESUB W/ DOCUMNTS CALL 800-473-2783					
				106	BILLING PROVIDER NOT PCP OR SERVICE NOT AUTHOR BY PCP					
				131	PRIMARY DIAGNOSIS NOT ON FILE					
				132	SECONDARY DIAGNOSIS NOT ON FILE					
				170	PRECERT REVIEW					
				171	NO HOSP PRECERT ON FILE RESUB WITH DOCUMENTATION					
				182	PROCEDURE CLAIM TYPE CONFLICT					
				191	PROCEDURE REQUIRES PRIOR AUTHORIZATION					
				212	ATTENDING PROVIDER MUST BE INDIVIDUAL					
				215	RECIPIENT NOT ON FILE					
				216	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE					
				217	NAME AND/OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD					
				232	PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM					
				233	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN					
				234	P/F AGE RESTRICTION					
				242	110-MNP REQUIRED FOR RECIP LIABILITY AMOUNT					
				249	SURGERY REQUIRES REVIEW FOR ATTACHMENTS					
				250	DIAGNOSIS/PROCEDURE REQUIRES REVIEW					
				259	ANESTHESIA UNITS/MINUTES REQUIRE MED REVIEW					
				272	CLAIM EXCEEDS 1 YEAR FILING LIMIT					
				273	3RD PARTY CARRIER CODE MISSING-REFER TO CARRIER CD LIST					
				275	RECIPIENT IS MEDICARE ELIGIBLE					
				280	MANUAL PRICING REQUIRED/HARD COPY BILL					
				290	NO EOB ATTACHED FOR RECIP WITH OTHER RESOURCE INDICATED					
				292	NO TPL AMOUNT INDICATED ON CLAIM/REQUIRES REVIEW					
				293	RECYCLED RECIPIENT INELIG ON DOS					
				299	PROC/DRUG NOT COVERED BY MEDICAID					
				330	QMB NOT MEDICAID ELIGIBLE					
				335	ATTACHMENT REVIEW SERVICE LIMITS					
				371	ATTACHMENT REQUIRES REVIEW/FILING DEADLINE					
				402	NUMBER OF SERVICES EXCEEDS STATE MAX/ CUTBACK APPLIED					
				403	MULTIPLE SURGERY - PENDED FOR MANUAL PRICING					
				470	ATTACH ANESTHESIA RECORD AND DOCUMENT MEDICAL NECESSITY					
				590	RECIPIENT IS MEDICARETCHOICE					
				621	RESUBMIT WITH OPERATIVE AND PATH REPORTS AND HISTORY					
				625	DOCUMENTATION OF MEDICAL NECESSITY INSUFFICIENT					
				643	EXCEEDS DAILY MAXIMUM ALLOWED VISITS					
				646	EXCEEDS DAILY MAXIMUM VISITS PER PROVIDER/SPECIALTY					
				648	RESUBMIT W/DOCUMENTATION SUBSTANTIATING CONCURRENT CARE					
				650	PAYMENT MADE AT STATE MAXIMUM					
				690	PAYMENT INCLUDED IN SURGERY FEE					
				691	VISIT PAID IN GSP.VOID VISIT;REBILL SURGERY					
				702	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT					
				704	ER VISIT ON DATE OF INP HOS SERVICES					
				726	MULTIPLE SURGERY-PENDED FOR REVIEW					
				730	ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY					

TO:

REMITTANCE SUMMARY
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/09/2005 PAGE: 125
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
				CURRENT NUMBER	TRANSACTIONS AMOUNT					
APPROVED ORIGINAL CLAIMS				2,241	132,047.31	LAST REMITTANCE NO:		DATED:	08022005	
ADJUSTMENT CLAIMS				23	468.21					
PREVIOUSLY PAID CLAIMS				23	238.04-					
VOIDED CLAIMS				20	707.39-					
NET CURRENT CLAIM TRANSACTIONS				2,724	131,570.09					
NET CURRENT FINANCIAL TRANSACTIONS					.00					
PRIOR NEGATIVE BALANCE					.00					
RECOUPMENTS BYPASSED BY D.H.H.					.00					
TOTAL PAYMENT THIS REMITTANCE					$131,570.09	EFT NO:	DIRECT DEPOSIT	DATE:	08/10/2005	
TOTAL COPAYMENT DEDUCTED THIS REMITTANCE					$.00					
YEAR-TO-DATE AMOUNT PAID					$4,249,992.86					
DENIED CLAIMS				372	102,781.20					
CLAIMS IN PROCESS				45	31,177.00					

ORDERING INFORMATION

Remittance Advice And History Requests

Provider participation in Medicaid of Louisiana is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. One of those standards is the agreement to maintain any information regarding payments to the provider for furnishing services for a period of five years.

Remittance Advice Copies

It is the responsibility of the provider to retain all remittance advices (RAs) for 5 years. Requests for additional copies of remittance advices will be provided at $.25 per page.

History Requests

History requests are necessary where providers or billing agents are attempting to reconcile a high volume or several months' worth of claims and when RA's have been destroyed, lost, etc. If providers are requesting remittance advices for multiple weeks or large volume remittance advices, Unisys will determine whether remittance advice copies or a claims history will be provided.

Requests for remittance advices or claims histories may be made by phone to Unisys Provider Relations at (800) 473-2783 or (225) 924-5040, or in writing to:

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

All requests must contain the provider name and number, address, and name of the individual authorizing the request. Remittance advice requests must indicate the date(s) of the remittance advice(s) being requested. Claim history requests must indicate the date of service period needed ("from" and "through" dates of service). Upon receipt of a request, the provider will be notified of the number of pages to be copied and the cost of the request. The RA/history will be forwarded to the provider once payment is received.

Medicaid Claim Forms

Unisys supplies the following forms:

PROVIDER TYPE	FORM NAME/ NUMBER	ADJUSTMENT
Rehab Services	Unisys 102	Unisys 202
Ambulance (Claim form requires 105 Attachment)	Unisys 105	Unisys 205
Non-Ambulance Transportation	Unisys 106	Unisys 206
Dental EPSDT		Unisys 209
Dental Adult		Unisys 210
Pharmacy		Unisys 211
Patient Liability Adjustments		Unisys 148 PLI
Professional Adjustments (Originally billed on CMS-1500)		Unisys 213
KIDMED Screening Form	KM-3	KM-3

Claim forms can be ordered by writing:

Unisys
ATTN: Forms Distribution
8591 United Plaza Boulevard, Suite 300
Baton Rouge, LA 70809

CMS-1500 Ordering Information:

The **CMS-1500** claim form is used to bill professional services (including physician, audiologist, CRNA, chiropractor, optometrist, podiatrist, nurse practitioner, and nurse midwife, certified nurse specialists, waiver, case management, mental health rehabilitation, mental health clinics, substance abuse clinics, EPSDT health services, EPSDT PCS, and DME.

> **NOTE: DME claims must indicate "DME" in large letters at the top of the CMS-1500 form. Waiver services claims must indicate "WAIVER" in large letters at the top of the form.**

CMS-1500 forms may be purchased by sending a letter of order request and a check to the following address:

Superintendent of Documents
P. O. Box 371954
Pittsburgh, PA 15250-7954
Phone (866) 512-1800 or (202) 512-1800
http://bookstore.gpo.gov

UB-92 Ordering Information:

The UB-92 claim form is a proprietary form owned by the National Uniform Billing Committee (NUBC), and therefore cannot be provided by Unisys. Providers may purchase preprinted forms from most national form suppliers and office supply stores.

Pharmacy Claim Form Ordering Information:

NCPDP Universal Claim Forms may be purchased form:

Moore North America, Inc
Tom Eddington
Phone: (602) 220-4913
e-mail: tom.eddington@email.moore.com

or

NCPDP Website
www.ncpdp.org/standards_purchase.asp

ADA Dental Claim Form Ordering Information:

ADA Catalog Sales
211 East Chicago Ave.
Chicago, IL 60611
Phone: (800) 947-4746
www.adacatalog.org

CPT-4 and ICD-9-CM Code Book Order Information:

The CPT-4 Procedure Code Book may be ordered from the following web address or phone number:

www.amapress.com
(800) 621-8335

ICD-9-CM Code Books are to be used to obtain diagnosis codes. Volume 1 is a numeric listing of diagnosis codes, Volume 2 is an alphabetical listing, and Volume 3 is a listing of ICD-9-CM procedure codes that are used by hospitals only. All three volumes are available in a single book. These books may be obtained from the following web address or phone number.

www.ingenixonline.com
(800) 464-3649, Option 1

NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid. Claims with these codes will be denied with error code 252 (“diagnosis as coded not on file”). Claims denied with error code 252 may be resubmitted using three- to five-digit numeric or alpha/numeric codes (other than "E" or "M").

REMITTANCE ADVICE CLAIM DENIAL RESOLUTION FOR LOUISIANA MEDICAID

This section is designed to assist providers in resolving some of the more general claim denials appearing on the Louisiana Medicaid Remittance Advices. When claims deny and appear on a remittance advice, a three-digit error code is given with the claim information. At the end of the remittance advice, all error codes received are listed with a narrative description that gives an explanation of the error code. The purpose of this explanation is to aid providers in correcting errors and resubmitting their claim(s) for processing.

Some of the more common error codes are listed in this section, along with an explanation of the denials and suggestions on how to correct them. These error codes are grouped by category, and apply to most Medicaid programs. For additional denials specific to each Medicaid Program, please refer to that program's training packet.

☞ If the claim information on the remittance advice does not match the data on the claim (recipient ID number, date of service, procedure code, recipient name, charges, etc.), then a data entry error may have occurred. If the claim was submitted hard copy, then providers may call Unisys Provider Relations department to report the problem and request that the claim be reprocessed. If the claim was submitted electronically, providers will need to make the necessary corrections internally and resubmit the claim(s).

NOTE: Recipients may not be held responsible for claims denied due to provider errors such as failure to obtain a PCP referral, prior authorization or pre-cert number, failure to timely file, incorrect TPL carrier code, etc.

General Claim Form Completion Error Codes

ERROR CODE 003 – RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS
Cause: The recipient ID number on the claim form was less than 13 digits in length or included letters or other non-numeric characters.
Resolution: Verify the correct 13-digit recipient ID number using REVS, MEVS, and e-MEVS and enter this number where required on the claim form.

ERROR CODE 009 - SERVICE THRU DATE GREATER THAN DATE OF ENTRY
Cause: The claim was received by Unisys prior to one or more dates of service billed.
Resolution: Correct the date span on the claim and rebill OR wait until all dates of service on the claim have passed and rebill.

ERROR CODE 028 - INVALID OR MISSING PROCEDURE CODE
Cause: 1. No procedure code was entered on the claim form, OR
2. The procedure code entered on the claim form is invalid (e.g., usually because it has fewer than five characters).
Resolution: Enter the correct procedure code on the claim form and resubmit.

Recipient Eligibility Error Codes

ERROR CODE 215 - RECIPIENT NOT ON FILE
Cause: The recipient ID number on the claim form is not in the State eligibility files.
Resolution: Verify the correct 13-digit recipient ID number using REVS, MEVS, and e-MEVS and enter this number where required on the claim form. If there is a MEVS or e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 216 - RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE
Cause: The recipient ID number on the claim is in the State eligibility files, but the recipient's eligibility does not cover the date of service filed on the claim.
Resolution: Verify the recipient's eligibility using REVS, MEVS, and e-MEVS for all dates of service on the claim. If there is a MEVS or e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter explaining the problem.
Note: Prior authorization does not override eligibility issues. Only dates of service during a recipient's eligibility will be reimbursed.

ERROR CODE 217 – NAME AND OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD
Causes: 1. The name on the claim form does not match the recipient ID number as recorded in the Unisys eligibility files. (This is sometimes caused when a recipient marries and changes her surname, or if several family members have similar ID numbers.) OR
2. The first and last names have been entered in reverse order on the claim form.
Resolution: Verify the correct spelling of the name via REVS, MEVS, and e-MEVS using the 13-digit recipient ID number. Ensure that the first and last names are entered in the correct order on the claim. Make corrections if necessary and resubmit.

ERROR CODE 222 – RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE (S)
Cause: The recipient ID number on the claim is in the State eligibility files, but the recipient's eligibility does not cover all dates of service filed on the claim.
Resolution: 1. Verify the recipient's eligibility using REVS, MEVS, and e-MEVS for all dates of service on the claim. If there is a MEVS or e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.
2. If there is no verification of eligibility for the date of service, resubmit the claim for covered dates of service only.

ERROR CODE 223 – RECYCLED RECIPIENT NOT ON FILE
Cause: The recipient ID number on the claim form is not in the State eligibility files. The claim has been "recycled" a number of times looking for the ID number in the eligibility files.
Resolution: Verify the correct 13-digit recipient ID number using REVS, MEVS, and e-MEVS and enter this number where required on the claim form. If there is a MEVS or e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 364 – RECIPIENT INELIGIBLE/DECEASED
Cause: The State eligibility files indicate the recipient was deceased prior to the billed date of service.
Resolution: Verify the recipient's date of death with Unisys Provider Relations. If you have documentation proving the date of death on file is incorrect, submit the claim and your documentation, along with a cover letter explaining the problem, to Unisys Provider Relations Correspondence Unit.

Presumptive Eligibility Error Codes

ERROR CODE 225 – CLAIM NOT COVERED FOR PRESUMPTIVELY ELIGIBLE RECIPIENT
Cause: Services billed are not covered for presumptively eligible recipients.
Resolution: In this case there is no method for obtaining payment, as the recipient was ineligible for the services. If there is a MEVS or e-MEVS printout that verified normal eligibility (not presumptive) and was printed on the date of service in question, send a copy of the claim and a copy of the printout to Unisys Provider Relations Correspondence Unit with a cover letter stating the problem.

Lock-In Program Error Codes

ERROR CODE 218 – RECIPIENT IS MD, PHARMACY RESTRICTED--MD INVALID
Cause: The billing provider is not the provider to whom the recipient has been locked in.
Resolution: 1. If the billing provider saw the recipient at the request of the lock-in provider, the claim form must show the lock-in provider's name in block 17 of the CMS-1500.
2. If the billing provider saw the recipient for emergency services, the claim form must show "EMERGENCY" written in the diagnosis section of the claim form (block 21 of the CMS-1500).
3. If the billing provider did not have a referral from the lock-in physician, and the service was not an emergency, the claim is not payable.
Note: Lock-in restrictions should only affect physician and pharmacy claims.

Spend-Down Medically Needy Error Codes

ERROR CODE 919 – MEDICAID ALLOWED AMOUNT REDUCED BY RECIPIENT SPEND-DOWN
Cause: The recipient liability spend-down amount indicated on the 110-MNP form submitted with the claim has been subtracted from the amount Medicaid would usually pay.
Resolution: Ensure that the amount shown in the "deductions" column of the remittance advice is the same as the recipient liability indicated on the 110-MNP form. If so, the claim has processed correctly, and the recipient liability amount should be collected from the recipient.
Note: Code 919 is not a true "error" code, as the claim has not been denied. The message is to notify the provider why the payment is not the usual reimbursement amount.

ERROR CODE 943 – SPEND DOWN FORM 110MNP INVALID/MISSING
Cause: 1. No 110-MNP form was attached to the claim form for a spend down recipient, OR
2. A 110-MNP form was attached to the claim, but the 110-MNP form was invalid because critical information was missing from the form (such as provider name or recipient name), OR
3. The claim required a 110-MNP form to be attached but was filed electronically.
Resolution: 1. Obtain a 110-MNP form from the parish OFS and resubmit the claim hardcopy with the 110-MNP form.
2. If the 110-MNP form filed with the claim was invalid, contact the parish OFS to obtain a corrected 110-MNP form. Refile the claim hardcopy with the corrected 110-MNP form.
Note: If a service was provided on the first day of the recipient's spend-down period, it is necessary to attach the 110-MNP form to the claim form. If there is an amount on the 110-MNP in the 'Beneficiary Liability Amount' which corresponds with your provider name and number, it is your responsibility to collect that amount from the patient. When the claim is processed, Unisys will automatically deduct this amount from total charges due.

CommunityCARE Error Codes

ERROR CODE 106 – BILLING PROVIDER NOT PCP OR SERVICE NOT AUTHORIZED BY PCP
Cause: 1. No Primary Care Physician (PCP) authorization number was entered in the required block of the claim form.
2. The PCP authorization number entered in the appropriate field is not the correct authorization number. The number must be a seven-digit number beginning with "1." It may not be the Primary Care Physician's UPIN or Medicare provider number.
Resolution: 1. Ensure that the PCP authorization number is entered in the correct block of the claim form.
2. If the PCP authorization number entered on the claim is exactly the same as that of the hardcopy referral form, use REVS, MEVS, and e-MEVS to verify the recipient's Primary Care Physician. If the PCP according to REVS, MEVS, and e-MEVS is different from the PCP in the recipient's records, contact the PCP given by REVS, MEVS, and e-MEVS to obtain a correct referral.

Timely Filing Error Codes

ERROR CODE 272 – CLAIM EXCEEDS 1 YEAR FILING LIMIT
Cause: The date of service on the claim form is more than one year prior to the date the claim was received by Unisys. All such claims must be accompanied by proof of timely filing in order to be paid.
Resolution: Resubmit the claim with proof of timely filing attached. Proof of timely filing is usually a copy of an RA page that shows the claim was processed by Unisys within one year from the date of service. Such claims may be mailed with a cover letter requesting an override for proof of timely filing to the Unisys Correspondence Unit.
Note: When refiling claims over one year old, it is not enough for the provider to know or to believe that they have filed the claim to Unisys within one year from the date of service. The provider must attach proof of timely filing to the claim, or the claim will deny. A history can be ordered to assist in determining in payment has been made or if a claim has been filed timely. The Field Analyst for your territory may also assist in placing such an order.

ERROR CODE 030 – SERVICE "THRU" DATE MORE THAN TWO YEARS OLD
Cause: The date of service on the claim form is more than two years prior to the date the claim was received by Unisys.
Resolution: Timely filing guidelines dictate that, in general, claims with dates of service over two years old are not payable. Unisys staff does not have the authority to override such claims. In the case of retroactive eligibility, DHH must review the claim and approve any overrides for timely filing.

ERROR CODE 371 – ATTACHMENT REQUIRES REVIEW/FILING DEADLINE
Cause: The date of service on the claim form is more than one year prior to the date the claim was received by Unisys. The claim has pended in the Unisys computer system so that it can be checked for attached proof of timely filing.
Resolution: If the claim was submitted with proof of timely filing attached, no further action is required. If no proof of timely filing was attached to the claim form, attach proof of timely filing to the claim and mail it with a cover letter requesting an override for proof of timely filing to the Unisys Correspondence Unit.
Note: Code 371 is not a true "error" code, as the claim has not been denied. The message is to notify the provider why the claim is in process.

Third Party Liability Error Codes

ERROR CODE 273 - 3RD PARTY CARRIER CODE MISSING - REFER TO CARRIER CODE LIST
Cause: No carrier code was indicated on the claim for a recipient with other insurance coverage.
Resolution: Verify the recipient's third party liability carrier code using REVS, MEVS, and e-MEVS. Resubmit the claim with the six-digit carrier code in the appropriate block and attach the EOB from the third party liability.
If you have verification that the recipient was not covered by other insurance for the date(s) of service, send a copy of the claim and the verification to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 290 - NO EOB ATTACHED FOR RECIPIENT WITH OTHER RESOURCE INDICATED
Cause: 1. No EOB from the other insurance was attached to the claim for a recipient with other insurance coverage, OR
2. There is a carrier code indicated on the claim form, but no EOB from the carrier is attached to the claim.
Resolution : Resubmit the claim with a copy of the EOB from the third party carrier
If the carrier code was indicated on the claim form in error, remove it and resubmit the claim.
If you have verification that the recipient was not covered by other insurance for the date(s) of service, send a copy of the claim and the verification to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 292 - NO TPL AMOUNT INDICATED ON CLAIM/REQUIRES REVIEW
Cause: A carrier code was indicated on the claim form, but no TPL amount was entered on the claim.
Resolution: Indicate the amount paid by the third party carrier in the appropriate block on the claim form and resubmit the claim (including the third party carrier EOB).
If the carrier code was indicated on the claim form in error, remove it and resubmit the claim.

ERROR CODE 032 - EOB(S) ATTACHED/CARRIER CODE DOES NOT MATCH
Cause: The EOB attached to the claim does not appear to be from the third party carrier indicated on the State resource file for the recipient.
Resolution: Verify the recipient's third party liability carrier code using REVS, MEVS, and e-MEVS. Correct the carrier code if necessary and resubmit the claim (including the third party carrier EOB).
If the carrier code on the claim is correct, ensure that the EOB submitted with the claim is from the correct third party carrier. If not, attach the correct EOB if necessary and resubmit the claim. If the EOB submitted with the claim is from the correct third party carrier, submit the claim and the EOB to Unisys Provider Relations Correspondence Unit along with a cover letter explaining the problem.

ERROR CODE 918 – MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE
Cause: The amount paid by third party liability (as indicated on the claim form) has been subtracted from the amount Medicaid would usually pay.
Resolution: Ensure that the amount shown in the "deductions" column of the remittance advice is the same as the other insurance payment on the claim form. If the claim form was completed incorrectly, indicating an incorrect amount paid by other insurance, an adjustment must be filed to obtain correct payment.
Note: The message is to notify the provider why the payment is not the usual reimbursement amount.

Adjustment/Void Error Codes

ERROR CODE 798 – HISTORY RECORD ALREADY ADJUSTED
Cause: An adjustment/void form has been submitted for an internal control number (ICN) that has already been adjusted or voided. Therefore, the ICN cannot be adjusted or voided again.
Resolution: Review previous RA's to determine all activity for the particular claim. Only the most recent paid claim (either original or adjustment) can be adjusted or voided. If an adjustment or void is still required, resubmit the adjustment/void form for the most recent paid ICN.
Note: Only paid claims can be adjusted or voided. It is impossible to process an adjustment or void of a denied claim.

ERROR CODE 799 – NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
Cause: An adjustment/void form has been submitted for an internal control number (ICN) that is not in the Unisys claim history.
Resolution: Review previous RA's to determine the correct ICN to be adjusted. If the ICN submitted on the adjustment/void form is incorrect, submit a corrected adjustment or void. If the ICN on the claim is correct, send a copy of the adjustment/void form and all related documentation to Unisys Correspondence Unit with a cover letter explaining the problem.
Note: Adjustments and voids may only be processed if the adjudication date (RA date) of the last paid claim is under two years old.

Miscellaneous Error Codes

ERROR CODE 299 - PROCEDURE/DRUG NOT COVERED BY MEDICAID
Cause: The procedure code entered on the claim form is not a payable code.
Resolution: Review the claim that was filed, ensuring that the correct procedure code was entered on the claim form, including any modifiers that are appropriate. Make any necessary corrections and resubmit the claim.

ERROR CODE 232 - PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM
Cause: Usually this is caused by an error in entering the procedure code on the claim form (e.g., inadvertently reversing two digits of the procedure code).
Resolution: Verify that the procedure code entered on the original claim form is correct. If not, correct the procedure code and resubmit the claim. In addition, verify that the procedure code is one covered for your provider type.

Please be reminded that you cannot always bill the recipient for a service on which you have received a 299 or 232 denial.
Some CPT codes are in a non-payable status on our files because their services as described in CPT are included on other codes which are covered.

When the denied service is not payable on the file because it is a component of a payable service, it cannot be billed to the recipient. For example, Codes 92015 (determination of refractive state) and codes for venipuncture cannot be billed to the

recipient because their fee is included in the fee for the office visit. Therefore, these codes cannot be billed to the recipient if denied with a 299 or 232.

Duplicate Claim Error Code

VARIOUS ERROR CODES SPECIFIC TO EACH PARTICULAR MEDICAID PROGRAM
Cause: The claim is a duplicate of one that has already been paid by Unisys.
Resolution: On the remittance advice, the denial refers the provider to the conflicting control number and adjudication date of the previously paid claim. Refer to the remittance advice date indicated to find the claim that has already been paid. Do not resubmit the claim if it has already been paid.

Provider Eligibility Error Codes

ERROR CODE 202 - PROVIDER CANNOT SUBMIT THIS CLAIM TYPE
Cause: 1. The claim form used to bill the claim is not appropriate for the type of provider performing the service (e.g., a physician billing office visits under his own provider number on a UB-92 claim form); OR
2. The claim is for durable medical equipment and did not have "DME" written at the top of the CMS-1500 claim form; OR
3. The claim is for services other than hospice or pharmacy and the recipient is under hospice care.
Resolution: 1. Resubmit the claim on the appropriate claim form.
2. If the claim is for durable medical equipment, resubmit the CMS-1500 claim form with "DME" written at the top of the form.
3. **Only hospice and pharmacy services are payable for recipients under hospice care.** Other providers (physicians, hospitals, DME providers, etc.) who render services to a hospice recipient should look to the hospice provider for reimbursement if the treatment is related to the diagnosis for which the recipient is in hospice.

ERROR CODE 201 – PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
Cause: The billing provider number entered on the claim form is on the State provider files, but the provider's enrollment was not effective on the claim date(s) of service.
Resolution: Review the claim that was filed, ensuring that the correct Medicaid provider number was entered on the claim form. Make any necessary corrections and resubmit the claim.
Note: **Providers must be enrolled as** Medicaid providers in order to be reimbursed by Medicaid.

ERROR CODE 206 – BILLING PROVIDER NOT ON FILE
Cause: The billing provider number entered on the claim form is not on the State provider files.
Resolution: Review the claim that was filed, ensuring that the correct Medicaid provider number was entered on the claim form. Make any necessary corrections and resubmit the claim.
Note: Medicaid provider numbers are seven digits in length and begin with "1." All seven digits of the Medicaid provider number must be correct in order for the claim to be paid.

MEDICAID SERVICES CHART

March 31, 2006

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Adult Denture Services	*Dentist*	Medicaid recipients 21 years of age and older. **(Adults, 21 and over, certified as Qualified Medicare Beneficiary (QMB) only or through the Medically Needy Program are not eligible for dental services.)**	Dentures, denture relines, and denture repairs. Examination and X-rays are covered if in conjunction with the construction of a Medicaid-authorized denture.	All services other than repairs require **Prior Authorization**. The provider will submit requests for the **Prior Authorization**. Only one complete or partial denture per arch is allowed in a seven-year period. The partial denture must oppose a full denture. Two partials are not covered in the same oral cavity (mouth). Additional guidelines apply.	Terri Norwood 225/342-9403
Appointment Scheduling Assistance - *See KIDMED*					
Audiological Services - *See EarlySteps; KIDMED-EPSDT Services; Hospital-Outpatient services; Physician/ Professional Services; Rehabilitation Clinic Services; Therapy Services*					
Chemotherapy Services-*See Hospital-Outpatient Services; Physician/ Professional Services*	*Hospital* *Physician's office or clinic*	All Medicaid Recipients.	Chemotherapy administration and treatment drugs, as prescribed by physician.		

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Chiropractic Services	*KIDMED Medical Screening Provider/PCP*	Medicaid recipients 0 to 21years of age.	Spinal manipulations.	Medically necessary manual manipulations of the spine when the service is provided as a result of a referral from a KIDMED medical screening provider or Primary Care Provider (PCP).	Brian Bagdan 225/342-1461
CommunityCARE	*Recipient Toll Free: 1-800-259-4444*	Most low-income families with children, disabled adults and children who are Medicaid recipients are required to participate in CommunityCARE. For exceptions to this requirement contact the CommunityCARE Program.	CommunityCARE enrollees are entitled to the same Medicaid covered services as those eligibles not in CommunityCARE. Providers and CommunityCARE enrollees need to be familiar with the policies specific to CommunityCARE such as the referral/ authorization process and appropriate use of the emergency room which may determine the service being deemed "covered".	CommunityCARE is a Medicaid program designed to provide Medicaid recipients with a medical home. Each enrollee is linked to a PCP who is responsible for coordinating primary health care services, either through direct service or appropriate referral authorization to a specialist and /or ancillary providers. Most Medicaid covered services must be provided by the PCP or must be authorized by the PCP **prior** to the service being provided.	Leah Schwartzman 225/342-9520 Angela Mastainich 225/342-4810
Dental Care Services *- See Adult Denture Services; EPSDT Dental Services; and Expanded Dental Services for Pregnant Women*					
Durable Medical Equipment (DME)	*Physician*	All Medicaid recipients.	Medical equipment and appliances such as wheelchairs, leg braces, etc. Medical supplies such as ostomy supplies, etc.	All services must be prescribed by a physician and must be **Prior Authorized**. DME providers will arrange for the **Prior Authorization** request.	James Phillips 225/342-3935 Jackie Jackson 225/342-4839

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
EarlySteps *(Infant & Toddler Early Intervention Services)*	*Contact the local System Point of Entry (SPOE listed on our website: www.oph.dhh.state.la.us/childrensspecial/ (Click on EarlySteps) or call 1-866-327-5978*	Children ages birth to three who have a developmental delay of at least 2 SD (standard deviations) below the mean or are functioning at least 33% below their age in months in one of the following developmental areas, or children who have a developmental delay of 1.5 SD below the mean or are functioning at least 25% below their age in months in two or more of the following areas are eligible for EarlySteps: a. cognitive development b. physical development (vision, hearing, fine and gross motor) c. communication development d. social or emotional development e. adaptive skills development (also known as self-help or daily living skills)	**Covered Services (Medicaid Covered)** -Family Support Coordination (Service Coordination) -Occupational Therapy -Physical Therapy -Speech/Language Therapy -Psychology -Audiology **EarlySteps also provides the following services, not covered by Medicaid:** -Nursing Services/Health Services (Only to enable an eligible child/family to benefit from the other EarlySteps services). -Medical Services for diagnostic and evaluation purposes only. -Special Instruction -Vision Services -Assistive Technology devices and services -Social Work -Counseling Services/Family Training -Transportation -Nutrition -Sign language and cued language services.	All services are provided through a plan of care called the Individualized Family Service Plan. Early Intervention is provided through EarlySteps in conformance with Part C of the Individuals with Disabilities Act.	Nichole Dupree, Program Manager 504/568-7428
Expanded Dental Services For Pregnant Women (EDSPW)	*Medical professional providing pregnancy care and Dentist. (See Comment section.)*	The individual must be: 1) Medicaid eligible for full benefits*; 2) age 21 through 59; 3) pregnant and have an original BHSF Form 9-M completed by the medical professional providing pregnancy care. **Eligibility for the EDSPW Program ends at the conclusion of the pregnancy. The recipient must be pregnant on each date of service to be eligible for EDSPW Program services.** *(Medicaid eligibles, age 21 and over, certified as Qualified Medicare Beneficiary (QMB) only, or through the Medically Needy Program are not eligible for dental services.)	Periodontal Exam; Radiographs (x-rays); Prophylaxis (cleaning); certain restorative services when the location of the cavity to be restored is in an area that impacts the gum tissue and affects the periodontal health of the woman; certain periodontal services; and certain oral and maxillofacial surgery services. (Specific policy guidelines apply.)	Recipients must obtain a referral from the medical professional providing pregnancy care using the BHSF Form 9-M. The recipient must provide the original completed form to a participating dentist prior to receiving any dental services covered by Medicaid. Participating medical professionals and dental providers should have blank copies of the referral form; however, the printable form is located online at the following website: www.lamedicaid.com Some EDSPW Program services must be **Prior Authorized** by Medicaid. The dental provider is responsible for submitting the prior authorization request for these services to Medicaid on behalf of the patient. A prior authorization approval does not guarantee patient eligibility.	Terri Norwood 225/342-9403

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
EPSDT Dental Services	*Dentist*	Medicaid recipients 0 to 21 years of age. Presumptive Eligible (Type case 12) recipients are not eligible for dental care services.	Annual dental screening consisting of an examination, radiographs (x-rays), prophylaxis (cleaning), topical fluoride application and oral hygiene instruction. The EPSDT Dental Program provides coverage of certain diagnostic; preventive; restorative; endodontic; periodontic; removable prosthodontic; maxillofacial prosthetic; oral and maxillofacial surgery; orthodontic; and adjunctive general services. Specific policy guidelines apply. Comprehensive Orthodontic Treatment (braces) require **Prior Authorization** and are paid only when there is a cranio-facial deformity, such as cleft palate, cleft lip, or other medical conditions which possibly results in a handicapping malocclusion. If such a condition exists, the recipient should see a Medicaid-enrolled orthodontist. Patients having only crowded or crooked teeth, spacing problems or under/overbite are not covered for braces.	Some EPSDT Dental Program services must be **Prior Authorized** by Medicaid**.** The dental provider will submit the request for Prior Authorization of these services to Medicaid on behalf of the patient**.** A prior authorization approval does not guarantee patient eligibility	Terri Norwood 225/342-9403
EPSDT Personal Care Services	*Physician* and *Personal Care Attendant Agencies*	All Medicaid recipients 0 to 21 **not** receiving Individual Family Support waiver services. However, once a recipient receiving Individual Family Support waiver services has exhausted those services they are then eligible for EPSDT Personal Care Services. Recipients of Children's Choice Waiver can receive both PCS and Family Support Services on the same day; however, the services may not be rendered at the same time.	Basic personal care-toileting & grooming activities. Assistance with bladder and/or bowel requirements or problems. Assistance with eating and food preparation. Performance of incidental household chores, only for the recipient. Accompanying, not transporting, recipient to medical appointments. Does **NOT** cover any medical tasks such as medication administration, tube feedings.	The Personal Care Agency must submit the **Prior Authorization** request. Recipients receiving Support Coordination (Case Management Services) must also have their PCS **Prior Authorized** by Unisys. PCS is *not subject to service limits*. Units approved will be based on medical necessity and the need for covered services. Recipients receiving Personal Care Services must have a physician's prescription and meet medical criteria. Does **not** include medical tasks. Provided by providers enrolled in Medicaid to provide Personal Care Attendant waiver services.	Lynda Wascom 225/342-9485

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
EPSDT Psychological and Behavioral Services (PBS)	*PBS enrolled Psychologist* *(For a list of providers in your area, contact the Referral Assistance Hotline at 1-877-455-9955)*	Medicaid recipients, under the age of 21, who meet the criteria for Pervasive Developmental Disorder (PDD), or other specific criteria.	Psychological and Behavioral Services include necessary assessments, evaluations, individual therapy and family therapy.		Pamela Brown 225/342-6255
Eyeglass Services - *See Optical Services*					
Family Planning Clinic Services	*Family Planning Clinics* *Office of Public Health-Family Planning Clinics*	Female Medicaid recipients between the ages of 10 and 60.	Doctor visits to assess the patient's physical status and contraceptive practices; nurse visits; physician counseling regarding sterilization; nutrition counseling; social services counseling regarding the medical/family planning needs of the patient; contraceptives; and certain lab services.	Medicaid will reimburse the family planning clinic for routine family planning services for family planning purposes only and not treatment of other medical conditions. Referrals should be made for other medical problems as indicated. **Family Planning Clinics do not provide services to pregnant women.**	Terri Norwood 225/342-9403
Federally Qualified Health Centers (FQHC)	*Nearest FQHC*	All Medicaid recipients.	Physician services, nurse practitioner, physician assistant, nurse midwife, clinical social work services, and clinical psychologist services.	FQHC's cover all services that are usual and customary for a physician visit. Some preventive services are also covered such as children's eye and ear examinations, perinatal services, well child services.	Carolyn Jones 225/342-2495
Hearing Aids - *See Durable Medical Equipment*	*Durable Medical Equipment Provider*	Medicaid recipients 0 to 21 years of age.	Hearing Aids and any related ancillary equipment such as earpieces, batteries, etc. Repairs are covered if the Hearing Aid was paid for by Medicaid.	All services must be **Prior Authorized** and the DME provider will arrange for the request of **Prior Authorization**.	James Phillips 225/342-3935

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Hemodialysis Services - *See Hospital-Outpatient Services*	*Dialysis Centers* *Hospitals*	All Medicaid recipients.	Dialysis treatment (including routine laboratory services); medically necessary non-routine lab services; and medically necessary injections.		LaShawn Junius 225/342-3930
Home Health	*Physician*	All Medicaid recipients. Medically Needy (Type Case 20 & 21) recipients are not eligible for Aide Visits, Physical Therapy, Occupational Therapy, Speech/Language Therapy.	• Intermittent/part-time nursing services including skilled nurse visits. • Aide Visits • Physical Therapy Services • Occupational Therapy • Speech/Language Therapy	Recipients receiving Home Health must have physician's prescription and signed plan of care. PT, OT, and Speech/Language Therapy require **Prior Authorization**.	Jackie Jackson 225/342-4839
Home Health - Extended	*Physician*	Medicaid recipients 0 to 21 years of age.	Multiple hours of skilled nurse services. Medical tasks not covered in PCS may be covered such as tube feeding, catheter maintenance, and medication administration.	Recipients receiving extended nursing services must have a letter of medical necessity and physician's prescription. Extended Skilled nursing services require **Prior Authorization**.	Jackie Jackson 225/342-4839
Hospice Services	*Hospice Provider/ Physician*	All Medicaid recipients.	Medicare allowable services.		Stephanie Young 225/342-2604 LaShawn Junius 225/342-3930
Hospital Claim Questions Inpatient and Outpatient Services, including Emergency Room Services	*Physician/ Hospital*	All Medicaid recipients. Medically Needy (Type Case 20 & 21) under age 22 are not eligible for Inpatient *Psychiatric* Services.	Inpatient and Outpatient Hospital Services, including Emergency Room Services	All Questions Regarding Denied Claims and/or Bills for Inpatient and Outpatient Hospital Services, including Emergency Room Services	Recipients should first contact the provider, then may contact an MMIS Staff Member at (225) 342-3855 if the issue cannot be resolved Providers should contact Provider Relations at 1-800-473-2783

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Hospital - Inpatient Services	*Physician/ Hospital*	All Medicaid recipients. Medically Needy (Type Case 20 & 21) under age 22 are not eligible for Inpatient *Psychiatric* Services.	Inpatient hospital care needed for the treatment of an illness or injury which can only be provided safely & adequately in a hospital setting. Includes those basic services that a hospital is expected to provide.	Inpatient hospitalization requires **Pre-certification and Length of Stay** assignment. Hospitals are aware of this and will submit the request to the **Prior Certification** Unit.	Darlene White 225/342-2119 Wendy Reardon 225/342-9475
Hospital - Outpatient Services	*Physician/ Hospital*	All Medicaid recipients.	Diagnostic & therapeutic outpatient services, including outpatient surgery and rehabilitation services. Therapeutic and diagnostic radiology services. Chemotherapy Hemodialysis	Outpatient rehabilitation services require **Prior Authorization**. Provider will submit request for **Prior Authorization**.	Darlene White 225/342-2119 Wendy Reardon 225/342-9475
Hospital - Emergency Room Services	*Physician/ Hospital*	All Medicaid recipients.	Emergency Room services.	**Recipients 0 to 21 years** - No service limits. **Recipients 21 and older -** Limited to 3 emergency room visits per calendar year (January 1 - December 31). CommunityCARE Recipients have no limit.	Darlene White 225/342-2119 Wendy Reardon 225/342-9475
Immunizations *See FQHC; KIDMED; Physician/Professional Services; Rural Health Clinics*					
KIDMED - EPSDT Services	*Louisiana* ***KIDMED (ACS)***	All Medicaid recipients 0 to 21 years of age.	Medical Screenings (including immunizations and certain lab services). Vision Screenings Hearing Screenings Dental Screenings Periodic and Interperiodic Screenings	Recipients are linked to KIDMED providers for screening services. The provider is usually the primary care physician (PCP) or someone designated by the PCP. KIDMED providers identify suspected conditions and make necessary referrals for treatment. ACS will link recipients to providers.	KIDMED Recipient Hotline (ACS) (800) 259-4444 Referral Assistance Line (877) 455-9955 Brian Bagdan 225/342-1461

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Laboratory Tests and X-Ray Services	*Physician*	All Medicaid recipients.	Diagnostic testing and X-Ray services ordered by the attending or consulting physician. Portable (mobile) x-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician ordered x-rays.		Judy Cain 225/342-9490
Long Term -Personal Care Services **(LT-PCS)** *(See EPSDT Personal Care Services* - for Medicaid recipients ages 0 to 21)	*Division of Long Term Supports & Services (DLTSS)* *Contact:* *Affiliated Computer Services (ACS)* *1-866-229-5222*	All Medicaid recipients age 65 or older, or age 21 or older with disabilities (meets Social Security Administration disability criteria), meet the medical standards for admission to a nursing facility, and be able to participate in his/her care and direct the services provided by the worker independently or through a responsible representative.	-Basic personal care-toileting & grooming activities. -Assistance with bladder and/or bowel requirements or problems. -Assistance with eating and food preparation. -Performance of incidental household chores, only for the recipient. -Accompanying, not transporting, recipient to medical appointments. -Grocery shopping, including personal hygiene items. Does **NOT** cover any medical tasks such as medication administration, tube feedings. Does **NOT** provide supervision for an individual who cannot be left at home alone or provide respite for a primary caregiver.	Recipients or the responsible representative must request the service. This program is **NOT** a substitute for existing family and/or community supports, but is designed to supplement available supports to maintain the recipient in the community. An in-home assessment must be conducted. The assessment results plus medical documentation from the recipient's primary physician are used in determining if the recipient qualifies for this service. Once approved for services, the selected PCS Agency must obtain **Prior Authorization**. Units approved will be based on medical necessity and the need for covered services. Provided by PCS agencies enrolled in Medicaid.	Janet St. Angelo 225/342-2777

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Medical Transportation (Emergency)	*Emergency ambulance providers*	All Medicaid recipients.	Emergency ambulance services may be reimbursed if circumstances exist that make the use of any conveyance other than an ambulance medically inadvisable for transport of the patient.		Stephanie Young 225/342-2604
Medical Transportation (Non-Emergency)	*Regional Dispatch Offices* ***Dispatch Office Phone Numbers:*** ***Alexandria*** *800-446-3490* ***Baton Rouge*** *800-259-1944* ***Lafayette/ Lake Charles*** *800-864-6034* ***Monroe*** *800-259-1835* ***New Orleans*** *800-836-9587* ***Shreveport*** *800-259-7235*	All Medicaid recipients except some who have Medicaid and Medicare.	Transportation to and from medical appointments. The medical provider the recipient is being transported to does not have to be a Medicaid enrolled provider but the services do have to be Medicaid covered services. Dispatch office will make this determination. Recipients under 16 years old must be accompanied by an attendant.	Recipients should call dispatch offices 48 hours before the appointment. Transportation to out-of-state appointments can be arranged but requires **Prior Authorization.** **Same day transportation can be scheduled when absolutely necessary.**	Stephanie Young 225/342-2604
Mental Health Clinics	*Contact the local Office of Mental Health*	All Medicaid recipients.	Clinic services including evaluations and assessments, treatment, and counseling services. Medication management and injections are also covered.		Pamela Brown 225/342-6255

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Mental Health Rehabilitation Services	*Contact a MHR provider.* *(For a list of providers in your area, contact the Referral Assistance Hotline at 1-877-455-9955)*	Medicaid recipients who meet the eligibility requirements for the program.	• Assessment • Service Planning • Community Support • Medication Management • Individual Intervention/Supportive Counseling • Group Counseling • Parent/Family Intervention-Counseling • Psychosocial Skills Group Training • Parent Family Intervention - Intensive	All services must be **Prior Authorized**.	Pamela Brown 225/342-6255
Midwife Services (Certified Nurse Midwife) - *See FQHC; Physician/ Professional Services; Rural Health Clinics*					
Occupational Therapy Services *See EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services*					

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Optical Services	*Optometrist, Ophthal-mologist or Optical Supplier*	All Medicaid recipients.	**Recipients 0 to 21** Examinations and treatment of eye conditions, including examinations for vision correction, refraction error. Regular eyeglasses when they meet a certain minimum strength requirement. **Medically necessary** specialty eyewear and contact lenses with **prior authorization**. Contact lenses are covered if they are the **only** means for restoring vision. Other related services, if medically necessary. --- **Recipients 21 and over** Examinations and treatment of eye conditions, such as infections, cataracts, etc. If the recipient has both Medicare and Medicaid, some vision related services may be covered. The recipient should contact Medicare for more information since Medicare would be the primary payer.	**Recipients 0 to 21** Specialty eyewear and contact lenses, if medically necessary for EPSDT eligibles requires **Prior Authorization**. The provider will submit requests for the **Prior Authorization**. A prior authorization approval does not guarantee patient eligibility. Prescriptions are required for all glasses/contacts. After a prescription is obtained, the recipient may see an optical supplier to receive the glasses/contacts. --- **Recipient 21 and over** **Routine eye examinations for vision correction, refraction error, are NOT covered.** Eyeglasses are **not** covered.	Terri Norwood (eyeglasses/eyewear) 225/342-9403 Deloris Young (Optical services other than eyeglasses/eyewear) 225/342-9319
Orthodontic Services - *See Dental Care Services*					
Nurse Practitioners/Clinical Nurse Specialists - *See FQHC; Physician/ Professional Services; Rural Health Clinics*					

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Program of All-Inclusive Care for the Elderly (PACE)* **Program in New Orleans area scheduled to open in October 2006.*	*Division of Long Term Supports & Services (DLTSS)* *Contact: Affiliated Computer Services (ACS) 1-866-229-5222*	Participants are persons age 55 years or older, live in the PACE provider service area and are certified to need nursing facility level of care. Participation is voluntary and enrollees may disenroll at any time.	ALL Medicaid and Medicare services, both acute and long-term care	- Emphasis is on enabling participants to remain in community and enhance quality of life. - Interdisciplinary team performs assessment and develops individualized plan of care. - Each PACE program serves a specific geographic region. - PACE programs bear financial risk for all medical support services required for enrollees. - PACE programs receive a monthly capitated payment for Medicaid and Medicare eligible enrollees.	Allison Vuljoin 225/219-0229
Pharmacy Services	*Pharmacies*	All Medicaid recipients except some who are Medicare/Medicaid eligible. Recipients who are full benefit dual eligible (Medicare/Medicaid) received their pharmacy benefits through Medicare Part D.	Covers prescription drugs except: Cosmetic drugs (Except Accutane); Cough & cold preparations; Anorexics (Except for Xenical); Fertility drugs when used for fertility treatment; Experimental drugs; Compounded prescriptions; Vaccines covered in other programs; Drug Efficacy Study Implementation (DESI) drugs;	Co-payments ($0.50-$3.00) are required except for some recipient categories. NO co-payments for recipients under age 21, pregnant women, or those in Long Term Care. Prescription limits: 8/month (The physician can override this limit when medically necessary.) *Limits do not apply to recipients under age 21*, pregnant women, or those in Long Term Care. **Prior Authorization** is required for *some* drug categories if the medication is not on the Preferred Drug List. **Children are not exempt from this process.**	M.J. Terrebonne 225/342-9768
Physical Therapy - *See EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services*					

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Physician Assistants - *See FQHC; Physician/ Professional Services; Rural Health Clinics*					
Physician/ Professional Services	*Physician* or *Healthcare Professional*	All Medicaid recipients.	Professional medical services including physician, nurse midwife, nurse practitioner, clinical nurse specialists, physician assistant, audiologist, chemotherapy, and other services. Immunizations are covered for recipients under age 21through the Physician's program.	Some services require **Prior Authorization**. Providers will submit requests for **Prior Authorization**. Services are subject to limitations and exclusions. Your physician or healthcare professional can help you with this. Recipients 21and over are limited to 12 outpatient visits per calendar year unless an extension is granted. Your physician or healthcare professional must request an extension if deemed necessary. Recipients under 21 are not limited to the number of outpatient visits.	Judy Cain 225/342-9490
Podiatry Services	*Podiatrist*	All Medicaid recipients.	Office visits. Certain radiology & lab procedures and other diagnostic procedures.	Some **Prior Authorization**, exclusions, and restrictions apply. Providers will submit request for **Prior Authorization**.	Deloris Young 225/342-9319
Pre-Natal Care Services	*Physicians & Certified Registered Nurse Midwives*	Female Medicaid recipients of child bearing age.	Office visits. Other pre- & post-natal care and delivery. Lab services.	Some limitations apply.	Judy Cain 225/342-9490
Psychiatric Hospital Care Services - *See Hospital-Inpatient Services*					

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Psychological Evaluation and Therapy Services -*See Earlysteps; EPSDT Psychological and Behavioral Services; FQHC; Rural Health Clinics; Therapy Services-School Boards*					
Rehabilitation Clinic Services	*Physician*	All Medicaid recipients	Occupational Therapy Physical Therapy Speech, Language and Hearing Therapy	All services must be **Prior Authorized**. The provider of services will submit the request for **Prior Authorization.**	Gail Williams 225/342-2542
Rural Health Clinics	*Rural Health Clinic*	All Medicaid recipients	Professional medical services including physicians, nurse practitioner, physician assistant, nurse midwife, clinical psychologist services. Immunizations are covered for recipients under age 21.	Rural Health Clinics cover all services that are usual and customary under a physician visit.	Carolyn Jones 225/342-2495
Sexually Transmitted Disease Clinics (STD)	*Local Health Unit*	All Medicaid recipients.	Testing, counseling, and treatment of all sexually transmitted diseases (STD=s). Confidential HIV testing.		Gail Williams 225/342-2542
Speech and Language Evaluation and Therapy – *See EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services*					
Substance Abuse Clinic Services	*Office of Addictive Disorders 1-800-662-4357* *Physician*	Medicaid recipient 0 to 21 years of age	• Individual, Group and Family Counseling • Medical treatment • Medical injections • Psychosocial, Psychiatric, Medical, and other evaluations	• Services are provided by the *Office of Addictive Disorders* • Recipients must be diagnosed with an addictive disorder prior to receiving services	Gail Williams 225/342-2542

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Support Coordination Services (Case Management) - **Children's Choice Waiver**	*Office for Citizens with Developmental Disabilities, Waiver Supports and Services (1-800-660-0488)*	**Medicaid recipients must be in the Children's Choice Waiver.** There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office (See Appendix for telephone numbers).	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the waiver are: Support Coordination, Family Support, Center-Based Respite, Environmental Accessibility Adaptations, Family Training and Specialized Medical Equipment and Supplies (diapers).	Services must be **prior authorized** by DHH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The provider will submit requests for the **Prior Authorization**.	Martha Manuel 225/219-0219 Jean Melanson 225/219-0236
Support Coordination Services (Case Management) - **Elderly and Disabled Adult (EDA) Waiver**	*Division of Long Term Supports & Services (DLTSS) (1-800-660-0488)*	**Medicaid recipients must be in the Elderly and Disabled Adult (EDA) Waiver.** There is a Request for Services Registry (RFSR) for those requesting EDA Waiver services. Contact Louisiana Options in Long Term Care at 1-877-456-1146 for information and assistance with the EDA RFSR.	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.	Services must be **prior authorized** by DHH, *Division of Long Term Supports & Services (DLTSS*). The provider will submit requests for the **Prior Authorization**.	Janet Thomason 225/219-9939 Yvette Moreno 225/219-1150
Support Coordination Services (Case Management) - **EPSDT Targeted Populations**	*SRI (1-800-364-7828)* *Must be on the Request for Services Registry for MRDD Waiver Population*	All Medicaid recipients, ages 0 to 21. **Must be on the MR/DD waiver Request for Services Registry prior to receipt of case management services.** To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office (See Appendix for telephone numbers).	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.	Services must be **prior authorized** by DHH, BHSF/Program Operations. The provider will submit requests for the **Prior Authorization**.	Traci Perry 225/342-8223

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Support Coordination Services (Case Management**) - HIV**	*Office of Public Health-HIV/Aids* and *HIV Support Coordination Agencies*	Medicaid recipient must have HIV as determined by a physician.	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.	Services must be **prior authorized** by DHH, Division of Long Term Supports & Services. The provider will submit requests for the **Prior Authorization**.	Janet Thomason 225/219-9939 Yvette Moreno 225/219-1150
Support Coordination Services (Case Management**) - Infants and Toddlers**	*Office of Public Health-EarlySteps Program* *1-800-730-8030*	Medicaid recipients must be 0 to 3 years of age and have a developmental delay or an established medical condition.	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.	Services must be **authorized** by DHH/OPH-EarlySteps. The provider will submit requests for the **Authorization**.	Nichole Dupree, Program Manager 504/599-1072
Support Coordination Services (Case Management**) - New Opportunities Waiver (NOW)**	*Office for Citizens with Developmental Disabilities, Waiver Supports and Services* *1-800-660-0488*	**Medicaid recipients must be in the MR/DD Waiver.** There is a **Request for Services Registry (RFSR**) for those requesting waiver services. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office (See Appendix for telephone numbers).	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Some services available through the Waiver are: Individual Family Support, Day and Night; Shared Supports, Day and Night; Center Based Respite Care; Community Integration Development; Environmental Accessibility Adaptions, Specialized Medical Equipment and Supplies; Substitute Family Care Services; Residential Habilitation/Supported Independent Living; Day Habilitation Supported Employment; Professional Services and Consultation, Transitional Expenses and Support Services and Skilled Nursing, Crisis Support.	Services must be **prior authorized** by DHH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The provider will submit requests for the **Prior Authorization**.	Martha Manuel 225/219-0219 Jean Melanson 225/219-0236

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Therapy Services	*Recipients have the choice of services from the following provider types: Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services*	Medicaid recipients birth to 21 years of age.	• Audiological Services (Available in Rehabilitation Clinic and Hospital-Outpatient settings only.) • Occupational Therapy • Physical Therapy • Speech & Language Therapy	Covered services can be provided in the home through Home Health and Rehabilitation Clinics. Services provided by Rehabilitation Clinics can also be provided at the clinic. Services provided through Hospital-Outpatient Services must be provided at the facility/clinic. All medically necessary services must be prescribed by a physician and **Prior Authorization** is required. The provider of services will submit requests for **Prior Authorization**.	Brian Bagdan 225/342-1461
Therapy Services continued	*EPSDT Health Services-Early Intervention Centers (EIC) or EarlySteps Program*	Medicaid recipients **birth to 3** years of age.	• Audiological Services • Occupational Therapy • Physical Therapy • Speech & Language Therapy • Psychological Therapy	All EPSDT Health Services through EICs and EarlySteps must be included in the infant/toddlers Individualized Family Services Plan (IFSP). If services are provided by an EIC or EarlySteps, **Prior Authorization** requirements are met through inclusion of services on the IFSP.	Brian Bagdan 225/342-1461
Therapy Services continued	*EPSDT Health Services-School Board*	Medicaid recipients **3 to 21** years of age.	• Audiological Evaluation and Therapy • Occupational Therapy Evaluation and Treatment services • Physical Therapy Evaluation and Treatment services • Speech & Language Evaluation and Therapy • Psychological Evaluation including a battery of tests, interviews, and behavioral evaluations that appraise cognitive, emotional, social, and behavioral functioning and self-concept. • Psychological Therapy includes diagnosis and psychological counseling for children and their parents.	Services are performed by the School Board. All EPSDT Health Services must be included in the child=s Individualized Education Program (IEP). If services are provided by a School Board, **Prior Authorization** requirements are met through inclusion of services on the IEP.	Brian Bagdan 225/342-1461

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Transportation *See Medical Transportation*					
Tuberculosis Clinics	*Local Health Unit*	All Medicaid recipients	Treatment and disease management services including physician visits, medications, and x-rays.		Gail Williams 225/342-2542
X-Ray Services - *See Laboratory Tests and X-Ray Services*					

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
WAIVER SERVICES:		There is a Request for Services Registry (RFSR) for those requesting any of the waiver services below.			**See Specific Waiver**
Adult Day Health Care (ADHC)	*Division of Long Term Supports & Services (DLTSS)* *Contact:* *Louisiana Options in Long Term Care* *(1-877-456-1146)*	Individuals 65 years of age or older, who meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility; or age 22-64 who are disabled according to Medicaid standards or SSI disability criteria, meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility	Adult Day Health Care	This is a home and community - based alternative to nursing facility placement.	Susan Jackson 225/219-0218
Children's Choice	*Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional Offices (SYSTEM ENTRY ONLY)* *(See Appendix for telephone numbers)*	Child must be on the NOW Request for Services Registry, less than 19 years old, disabled according to SSI criteria, require ICF/MR level of care, have income less than 3 times SSI amount, resources less than $2,000 and meet all Medicaid non-financial requirements.	Diapers for ages 3 years to 4 years old. Center Based Respite Environmental Accessibility Adaptation Family Training Family Support Crisis Support Non-Crisis Support	There is a $15,000 limit per individual plan year. ($1500 for Case Management and $13,500 for other services). *Call 1-800-660-0488 for status on the Request for Services Registry.	See Appendix for contact persons for Office for Citizens with Developmental Disabilities in each District/Authority/Local Regional Office.
Elderly and Disabled Adult (EDA)	*Division of Long Term Supports & Services (DLTSS)* *Contact:* *Louisiana Options in Long Term Care* *(1-877-456-1146)*	Individuals 65 years of age or older, who meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility; or age 21-64 who are disabled according to Medicaid standards or SSI disability criteria, meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility	- Support Coordination Service - Companion Service - Environmental Accessibility Adaptation - Personal Emergency Response System (PERS) -Transition Intensive Support Coordination -Transitional Service	This is a home and community- based alternative to nursing facility placement.	Kirsten Clebert 225/219-0213
New Opportunities Waiver (NOW)	*Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional Offices (SYSTEM ENTRY ONLY)* *(See Appendix for telephone numbers)*	Individuals disabled during the developmental period (before age 22) who meet both SSI Disability criteria and the level of care determination for an ICF/MR.	An array of services to provide support to maintain persons in the community. An alternative to an ICF/MR either large institution or small group home.	*Call 1-800-660-0488 for status on the Request for Services Registry.	See Appendix for contact persons for Office for Citizens with Developmental Disabilities in each District/Authority/Local Regional Office.

*** Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart**.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CSRAs

METROPOLITAN HUMAN SERVICES DISTRICT
Janise Monetta, CSRA
1010 Common Street, 5th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

CAPITAL AREA HUMAN SERVICES DISTRICT
Herman Bignar, CSRA
4615 Government St.- Bin #16 - 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-800-768-8824

REGION III
John Hall, CSRA
690 E. First Street
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

REGION IV
Richard Landry, CSRA
214 Jefferson Street - Suite 301
Lafayette, LA 70501
Phone: (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

REGION V
Connie Mead, CSRA
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Phone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

REGION VI
Nora H. Dorsey, CSRA
429 Murray Street-Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
Rebecca Thomas, CSRA
3018 Old Minden Road, Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

REGION VIII
Deanne W. Groves, CSRA
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FLORIDA PARISHES HUMAN SERVICES AUTHORITY
Marie Gros, CSRA
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JEFFERSON PARISH HUMAN SERVICES AUTHORITY
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Donna Francis, Asst CSRA
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