UNISYS

EarlySteps Provider Training

Fall 2007

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

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.** Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828.

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. Personal Care 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 must be ordered by a physician. The PCS 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.

Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

*Doctor's Visits
*Hospital (inpatient and outpatient) Services
*Lab and X-ray Tests
*Family Planning
*Home Health Care
*Dental Care
*Rehabilitation Services
*Prescription Drugs
*Medical Equipment, Appliances and Supplies (DME)
*Support Coordination
*Speech and Language Evaluations and Therapies
*Occupational Therapy
*Physical Therapy
*Psychological Evaluations and Therapy
*Psychological and Behavior Services
*Podiatry Services
*Optometrist Services
*Hospice Services
*Extended Skilled Nurse Services
*Residential Institutional Care or Home and Community Based (Waiver) Services
*Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
*Immunizations
*Eyeglasses
*Hearing Aids
*Psychiatric Hospital Care
*Personal Care Services
*Audiological Services
*Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
*Appointment Scheduling Assistance
*Substance Abuse Clinic Services
*Chiropractic Services
*Prenatal Care
*Certified Nurse Midwives
*Certified Nurse Practitioners
*Mental Health Rehabilitation
*Mental Health Clinic Services

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

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 225-342-5774.

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD Request for Services Registry, you may be eligible for support coordination services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office. If you are a Medicaid recipient under age 21, and it is medically necessary, you may be able to receive support coordination services immediately by calling SRI (toll free) at 1-800-364-7828.

You may access other services by calling KIDMED at (toll-free) 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

If you live in a CommunityCARE parish, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

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
Pamela Sund, CSRA
4615 Government St. – Bin#16 – 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Fee: 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
Celeste Larroque, 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
122 St. John St. – Rm. 343
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
Marie Gros, CSRA
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
Stephanie Campo, CSRA
Donna Francis, Asst CSRA
3300 W. Esplanade Ave. –Suite 213
Metairie, LA 70002
Phone (504) 838-5357
FAX: (504) 838-5400

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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

Deficit Reduction Act of 2005

Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC §1396(a)(68)), set forth in that subsection and as the Secretary of US Department of Health and Human Services may specify. As an enrolled provider, it is your obligation to inform all of your employees and affiliates of the provisions the provisions of False Claims Act. When monitored, you will be required to show evidence of compliance with this requirement.

- Effective July 1, 2007, the Louisiana Medicaid Program requires all new enrollment packets to have a signature on the PE-50 which will contain the above language.

- The above message was posted on LAMedicaid website, (https://www.lamedicaid.com/sprovweb1/default.htm), RA messages, and in the June/July 2007 Louisiana Provider Update

- Effective November 1, 2007, enrolled Medicaid providers will be monitored for compliance through already established monitoring processes.

- All providers who do $5 million or more in Medicaid payments annually, must comply with this provision of the DRA.

EPSDT HEALTH SERVICES

EPSDT Health Services for children with disabilities include health-related special education services and may only be provided by local school boards for children ages three (3) to 21, and by Early Intervention Centers or the EarlySteps Program for children from birth to age three (3). All EPSDT Health Services must be included on the child's individualized education program (IEP) or individualized family services plan (IFSP).

To remain compliant with court order, the Department of Health and Hospitals requires that all EPSDT Health Services Providers enrolled in Medicaid give the following statement in writing to Medicaid-eligible recipients at the time their IEP or IFSP is developed.

If your child is Medicaid eligible, and is eligible to receive audiologic services, occupational therapy evaluations and treatment services, physical therapy evaluations and therapy (individual and group), psychological evaluations and therapy (individual and group), and speech and language evaluations and therapy (individual and group), you may choose to obtain them either through your school, an early intervention center or the EarlySteps Program or other Medicaid enrolled provider of those services.

Children who do not qualify for these services for educational purposes may still be eligible for them through Medicaid. Services outside of or in addition to those provided at school or in an early intervention center/EarlySteps must be ordered by a physician. Once the services are ordered by a physician, the service provider must request approval from Medicaid. To locate a provider other than the school or early intervention center, please contact your case manager, physician, or call the Specialty Care Resource Line toll free at 1-877-455-9955 or the EarlySteps Program at 1-866-327-5978.

Again, this information must be supplied to the recipient and/or caregiver at the time the IEP or IFSP is developed.

<u>EarlySteps Providers Please Note:</u> Medicaid reimburses only for direct one-on-one patient contact services, billed as units of time, for physical, speech, and occupational therapy. Group therapy and co-therapy are not covered under physical, speech, and occupational therapy.

EARLYSTEPS PROGRAM (AGE BIRTH TO 3)

(The following information was received from the EarlySteps Program. Please contact the EarlySteps Program for additional information.)

EarlySteps is Louisiana's Early Intervention System which provides services to families with infants and toddlers who have special needs. These services are delivered in the recipient's home or "natural setting".

Eligibility criteria for the EarlySteps program are for children ages birth to age 3 and in two areas, Developmental Delay and Established Medical Conditions as follows:

Developmental Delay

The recipient must have a developmental delay of at least 1.5 SD (standard deviations) in one of the following developmental areas or in a specified subdomain;

- Cognitive development
- Physical development (vision, hearing, fine and gross motor)
  --fine motor
  --gross motor
- Communication development
  --receptive language
  --expressive language
- Social or emotional development
- Adaptive skills development (also known as self-help or daily living skills)

A child may also qualify using *informed clinical opinion* in any area of development if a developmental assessment alone does not indicate a delay of 1.5 standard deviations from the mean. In this case, the provider should document that the area of concern is atypical for the child's age, interferes with normal functioning, and makes day-to-day care of the child difficult. These developmental delay criteria are in effect as of July 1, 2007.

Established Medical Condition

EarlySteps utilizes the following medical conditions which have a high probability of resulting in developmental delay for eligibility.

Diagnosed Conditions List

If documented by a physician's signature (or that of an audiologist in the case of hearing impairment or a speech/language pathologist in the case of a child with developmental apraxia of speech) children with the following diagnoses are eligible for the EarlySteps System. These diagnoses have a high probability of resulting in developmental delay.

Genetic Disorders

A. Chromosomal Abnormality Syndromes

Down's syndrome, Trisomy 13, Trisomy 18
Autosomal deletion syndromes (includes Cri-du-chat, velo-cardio-facial, others)
Other micro-deletion syndromes (includes Miller Dieker syndrome, Smith-Magenis syndrome)
DiGeorge Syndrome
Fragile X
Prader-Willi
Other conditions due to autosomal anomalies
Conditions due to sex chromosome anomalies. This does not include Klinefelter's Syndrome (XXY) or Turner's Syndrome (XO)
Conditions due to anomaly of unspecified chromosome (includes Williams Syndrome)

B. Pre-natal exposures

Fetal alcohol syndrome
Narcotics exposure
Hallucinogenic agent exposure
Cocaine exposure
Anticonvulsant exposure

C. Neurocutaneous Syndromes

Incontinentia pigmenti
Neurofibromatosis
Sturge-Weber syndrome
Tuberous sclerosis

D. Inborn Errors of Metabolism

Disorders of amino-acid transport (includes PKU, Maple Sugar Urine Disease, urea cycle defects, organic acidemias, others)
Disorders of Carbohydrate metabolism
Disorders of Lipid Metabolism
Cerebral degenerations of the central nervous system (includes leukodystrophies; cerebral lipidoses such as TaySach's ; Fabry's, Gaucher's, Niemann Pick, sphingolipidoses, Hunter's and other mucopolysaccaridoses other cerebral degenerations in childhood

E. Prenatal Infections

"TORCH infections", including:
Congenital rubella
Congenital cytomegalovirus infection (CMV)
Congenital herpes simplex
Congenital toxoplasmosis

F. Other Syndromes

Chondrodystrophies
Congenital anomalies of central nervous system
Osteodystrophies
Cerebral gigantism
Other specified congenital anomalies affecting multiple systems (includes Beckwith Weiderman Syndrome, Cornelia de Lange's Syndrome, others

Sensory Impairments

Impairment can be congenital or acquired
Profound impairment, both eyes
Moderate or severe impairment, better eye, profound impairment lesser eye
Moderate or severe impairment, both eyes
Legal blindness, as defined in USA
Retinopathy of prematurity, (Grades 4 and 5), bilateral
Cortical Blindness, bilateral
Hearing impairment (25dB loss or greater), unilateral or bilateral
Auditory neuropathy
Central hearing loss

Orthopedic and Neurological Disorders

- Anoxic brain damage
- Anterior horn cell disease
- Arthrogryposis
- Brachial plexus palsy, perinatal origin and post-perinatal origin
- Cerebral cysts
- Cerebral palsy (all types)
- Cleft hand
- Congenital anomalies of the central nervous system
- Congenital anomalies of limbs
- Congenital musculoskeletal anomalies
- Degenerative progressive neurological conditions
- Developmental apraxia of speech
- Encephalopathy Not Otherwise Specified
- Fracture of vertebral column with spinal cord injury
- Hemiplegia and hemiparesis
- Hereditary and degenerative diseases of the central nervous system
- Hydrocephaly, congenital and acquired
- Infantile spasms
- Intraventricular hemorrhage (IVH) - Grade 3 & Grade 4
- Meningomyelocele / Myelomeningocele / Spina Bifida / Neural Tube Defect
- Muscular dystrophies and other myopathies
- Paralytic syndromes
- Spinal cord injury
- Stroke
- Traumatic Brain Injury

Social Emotional Disorders

- Childhood depression
- Reactive attachment disorder

Pervasive Developmental Disorders including:

- Asperger's syndrome / disorder
- Autism
- Childhood disintegrative disorder
- Unspecified pervasive developmental disorder-NOS
- Rett's syndrome

Medically Related Disorders

- Congenital or infancy-onset hypothyroidism
- Cleft palate (prior to the operation to repair the cleft and up to one-year post-operative)
- Craniosynostosis
- Premature closure of the sutures
- Lead intoxication (>45 µg/dL)
- Very low birth weight (<1500 grams at birth) up to 12 months corrected age only
- Preterm infants 32 weeks or less gestational age up to 12 months corrected age only
- Non-organic failure to thrive
- Chronic respiratory failure or ventilatory dependent
- Bronchopulmonary dysplasia

Note: The EarlySteps program is preparing an updated list of diagnosis codes to accompany the Diagnosed Condition List and will distribute it in the near future.

EarlySteps Supports and Services

EarlySteps provides the following Medicaid-covered services:

- Occupational Therapy
- Physical Therapy
- Speech/Language Therapy
- Audiology
- Psychology
- Support Coordination (Family Service Coordination)

Note 1: Medicaid reimburses only for direct one-on-one patient contact services, billed as units of time, for physical, speech, and occupational therapy. Group therapy and co-therapy are not covered under physical, speech, and occupational therapy.

Note 2: Physical, speech, and occupational therapy may have assistants rendering services. If this occurs, the assistants' services must be billed under the EarlySteps Medicaid Provider Number of the therapist; must be documented in the records that the assistant(s) rendered the services; and the documentation must be co-signed by the supervising, licensed therapist.

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 Services
- Sign language and cued language services

If providers identify recipients that may meet the qualifications noted above or for whom concerns are identified through developmental screening, they may refer them to the local System Point of Entry (SPOE) detailed in the Appendix, or have them call EarlySteps at 1-866-earlysteps.

All services are provided through a plan of care called the Individualized Family Service Plan (IFSP). Early intervention services are provided through EarlySteps in conformance with Part C of the Individuals with Disabilities Education Act.

The EPSDT Early Intervention Services (EarlySteps) Fee Schedule is available online at www.lamedicaid.com. This fee schedule lists the Louisiana Medicaid reimbursement for all direct services (occupational therapy, physical therapy, speech/language therapy, psychology, and audiology).

NOTE: If a Medicaid eligible child under the age of 3 years does not meet the eligibility requirements for early intervention services under the EarlySteps Program, medically necessary services are available through the Medicaid Infant and Toddler Support Coordination Program and the EPSDT Program for direct services. Medically necessary services must be prescribed by a physician and prior authorization is required. Families may be referred to Medicaid providers directly for these services and/or may contact Statistical Resources, Inc. at 1-800-364-7828 for referrals.

Requirements For Reimbursement

EarlySteps Program requirements for reimbursement include:

- All services must be furnished in the interest of establishing or modifying an infant or toddler's Individualized Family Services Plan (IFSP) or the services furnished must already be included in the current IFSP. **Non-IFSP services may not be billed to Medicaid under the EarlySteps Program.**

- When providing early intervention services to infants and toddlers, use the model IFSP forms found in the Appendix. DHH must approve any other IFSP form before it may be used for reimbursement for these services.

- The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicaid program, has issued clarification on requirements for provider qualifications. As a result, effective September 5, 2006, only services provided by Psychologists licensed under the Louisiana Licensing Law for Psychologists (RS 37, Chapter 28) are reimbursable by Louisiana Medicaid. These requirements can be found at the following website address: http://www.lsbep.org/laws.htm.

  Services provided by School Psychologist certified by the Department of Education not meeting the minimum criteria as outlined by the Louisiana Licensing Law for Psychologists are no longer billable to Medicaid.

- These services must be coordinated with other age appropriate preventive health services, including KIDMED screenings and immunizations.

  - Contact Louisiana KIDMED at (800) 259-8000 or (225) 928-9683 in Baton Rouge to determine the screening and immunization status of the child.
  - Louisiana KIDMED will follow up with the family to arrange for the screening and immunizations if due.

- These EPSDT services must also be coordinated with the Supplemental Food Program for Women, Infants, and Children (WIC) and Head Start. Make age-appropriate referrals for these services.

- Employ or contract with professional staff qualified to provide the services that meet state and Medicaid practitioner standards regarding certification, licensure, and supervision. Documentation of staff qualifications must be provided to Medicaid as part of the enrollment and monitoring process. Applicable qualifications are listed in Section 5 of the 1997 EPSDT Health Services manual.

EPSDT EARLY STEPS PROCEDURE CODES

Procedure Codes	Descriptions
90810	INTAC PSYTX, OFF, 20-30 MIN
90812	INTAC PSYTX, OFF, 45-50 MIN
90846	FAMILY PSYTX W/O PATIENT
90847	FAMILY PSYTX W/PATIENT
90857	INTERACTIVE GROUP PSYCHOTHERAPY
92506	SPEECH/HEARING EVALUATION
92507	SPEECH/HEARING THERAPY
92508	SPEECH/HEARING THERAPY
92551	PURE TONE HEARING TEST, AIR
92552	PURE TONE AUDIOMETRY, AIR ONLY
92567	TYPANOMETRY
92568	ACOUSTIC REFLEX TESTING
92569	ACOUSTIC REFLEX DECAY TEST
92582	CONDITIONING PLAY AUDIOMETRY
92584	ELECTROCOCHLEOGRAPHY
92585	AUDITOR EVOKE POTENT, COMPRE
92586	AUDITORY EVOKED POTENT, LIMITED
92587	EVOKED AUDITORY TEST, LIMITED
92588	EVOKED AUDITORY TEST, COMPREHENSIVE
92592	HEARING AID CHECK; MONAURAL
92593	HEARING AID CHECK; BINAURAL
92594	ELECTROACOUSTIC EVAL F HEAR AID;MONA
92595	ELECTROACOUSTIC EVAL HEAR AID;BINAUR
96100	PSYCHOLOGICAL TESTING
96101	PSYCH TESTING BY PSYCH/PHYS
97001	PT EVALUATION
97003	OT EVALUATION
97032	ELECTRICAL STIMULATION
97110	THERAPEUTIC EXERCISES
97112	NEUROMUSCULAR REEDUCATION,EA 15 MIN
97116	GAIT TRAINING THERAPY,EACH 15 MIN
97124	MASSAGE THERAPY
97504	ORTHOTIC TRAINING, EACH 15 MIN
97530	THERAPEUTIC ACTIVITIES 15 MIN
97750	PHYSICAL PERFORMANCE TEST, 15 MIN
97760	ORTHOTIC MGMT AND TRAINING

For each of the Procedure Codes above, use the appropriate Place of Service (POS) and Modifier:

TOS 22 - For services rendered in the Natural Environment (Home & Community).
"Community": Environment where children of same age with no disabilities or Special needs participate such as childcare centers, agencies, libraries and other community settings.

POS/Modifier combination must be one of these two choices:

POS 12 (Home) and Procedure Modifier U8, or

POS 99 (Other Place of Service) and Procedure Modifier U8

TOS 27 - For services rendered in a Special Purpose Facility/Inclusive Childcare: Childcare center, nursery schools, preschools with at least 50% with no disabilities or developmental delays.

POS/Modifier combination must be:

POS 99 and Procedure Modifier TJ

TOS 28 - For services rendered in a Center Based Special Purpose Facility: Center where only children with disabilities or developmental delays are served.

POS/Modifier combination must be:

POS 99 and Procedure Modifier SE

Procedure Codes	Descriptions
92553	AUDIOMETRY, AIR & BONE
92555	SPEECH AUDIOMETRY; THRESHOLD ONLY
92556	SPEECH AUDIOMETRY; COMPLETE
92557	COMPREHENSIVE HEARING TEST
92563	TONE DECAY HEARING TEST
92564	SHORT INCREMENT SENSITIVITY INDEX
92565	STENGER TEST, PURE TONE
92571	FILTERED SPEECH TEST
92572	STAGGERED SPONDAIC WORD TEST
92575	SENSORINEURAL ACUITY TEST
92576	SYNTHETIC SENTENCE TEST
92577	STENGER TEST, SPEECH
92583	SELECT PICTURE AUDIOMETRY
92590	HEARING AID EXAM/SELECTION; MONAURAL
92591	HEARING AID EXAM & SELECTION BINAURA
For each of the Procedure Codes above, use only POS 99 with the TJ modifier: TOS 27 - For services rendered in a Special Purpose Facility/Inclusive Childcare: Childcare center, nursery schools, preschools with at least 50% with no disabilities or developmental delays. POS/Modifier combination must be: POS 99 and Procedure Modifier TJ	

NOTE: Providers should contact their EarlySteps Regional Coordinator with any questions concerning Place of Service concerns. Providers must request an exception through the EarlySteps Program when situations occur involving service delivery at a Place of Service (POS) that does not clearly fall within the outlined criteria and guidelines. These exceptions must be reviewed and approved by the EarlySteps Program as determined through the IFSP.

PRIOR AUTHORIZATION OF SERVICES

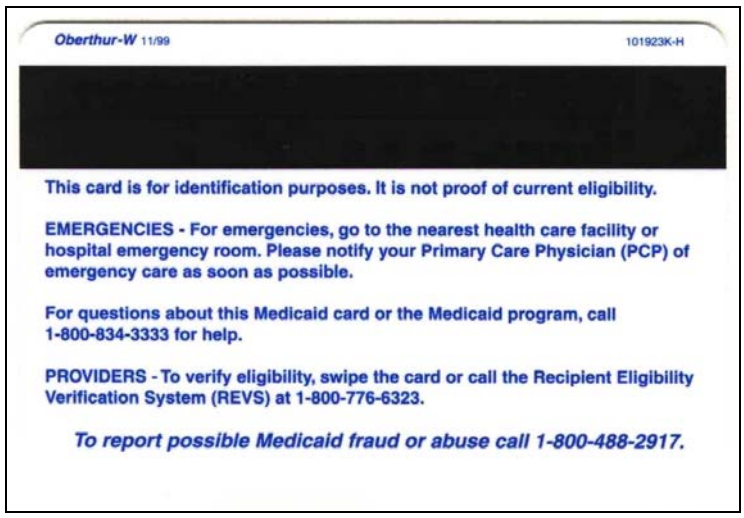
At this time, no changes are being made to the procedure for obtaining Prior Authorization of EarlySteps services.

Providers should continue to contact Covansys for Prior Authorization requests.

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. **It is the Provider's responsibility to check recipient eligibility prior to offering services.** The Department of Health and Hospitals (DHH) 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).



Verifying Eligibility

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)**.

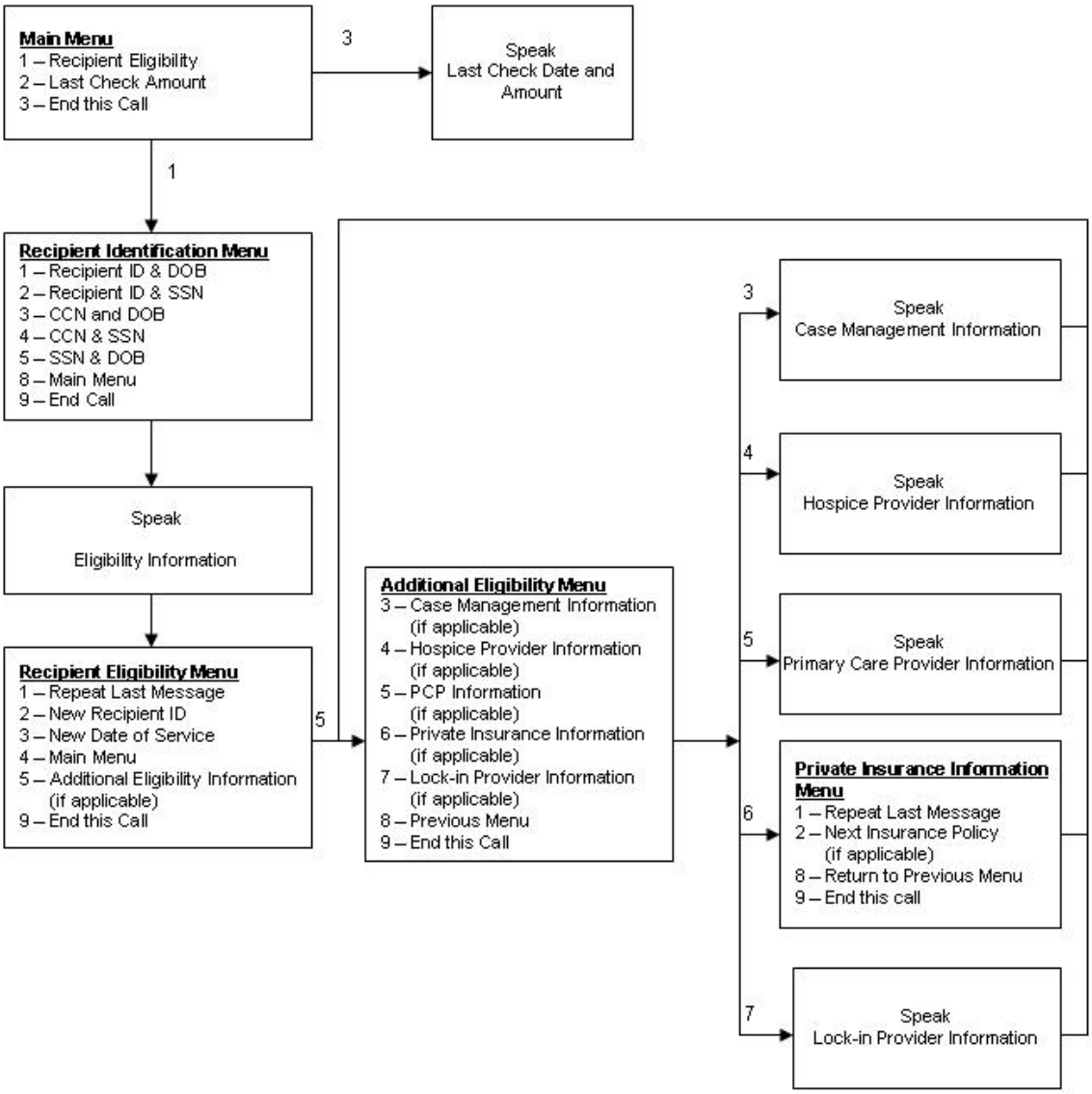
Accessing REVS

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.

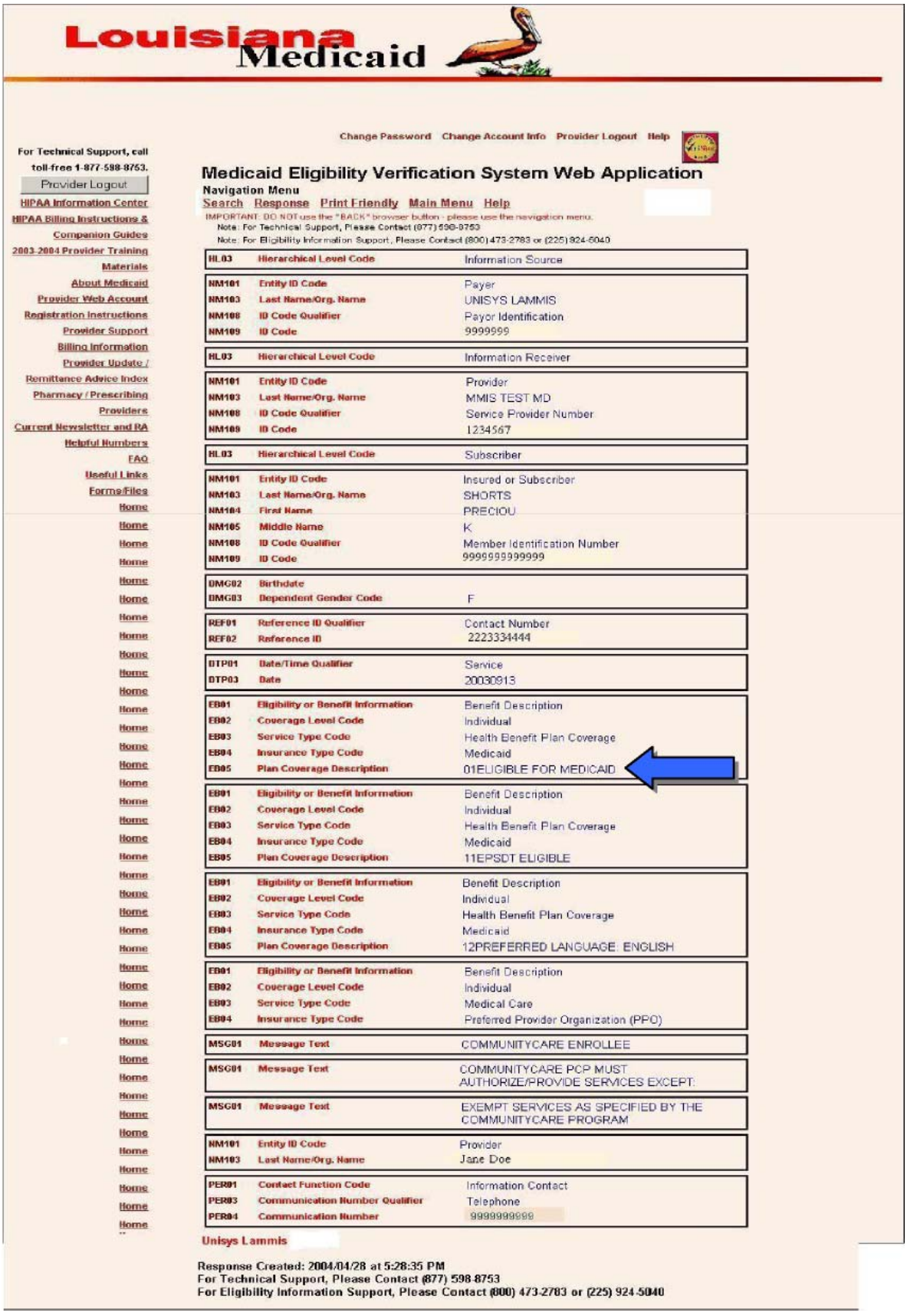
Accessing e-MEVS

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.



Louisiana Medicaid

Change Password Change Account Info Provider Logout Help

For Technical Support, call toll-free 1-877-598-8753.

Provider Logout

HIPAA Information Center
HIPAA Billing Instructions & Companion Guides
2003-2004 Provider Training Materials
About Medicaid
Provider Web Account Registration Instructions
Provider Support
Billing Information
Provider Update / Remittance Advice Index
Pharmacy / Prescribing Providers
Current Newsletter and RA
Helpful Numbers
FAQ
Useful Links
Forms/Files
Home

Medicaid Eligibility Verification System Web Application

Navigation Menu

Search Response Print Friendly Main Menu Help

IMPORTANT: DO NOT use the "BACK" browser button - please use the navigation menu.
Note: For Technical Support, Please Contact (877) 598-8753
Note: For Eligibility Information Support, Please Contact (800) 473-2783 or (225) 924-5040

HL03	Hierarchical Level Code	Information Source
NM101	Entity ID Code	Payer
NM103	Last Name/Org. Name	UNISYS LAMMIS
NM108	ID Code Qualifier	Payor Identification
NM109	ID Code	9999999
HL03	Hierarchical Level Code	Information Receiver
NM101	Entity ID Code	Provider
NM103	Last Name/Org. Name	MMIS TEST MD
NM108	ID Code Qualifier	Service Provider Number
NM109	ID Code	1234567
HL03	Hierarchical Level Code	Subscriber
NM101	Entity ID Code	Insured or Subscriber
NM103	Last Name/Org. Name	SHORTS
NM104	First Name	PRECIOU
NM105	Middle Name	K
NM108	ID Code Qualifier	Member Identification Number
NM109	ID Code	999999999999
DMG02	Birthdate	
DMG03	Dependent Gender Code	F
REF01	Reference ID Qualifier	Contact Number
REF02	Reference ID	2223334444
DTP01	Date/Time Qualifier	Service
DTP03	Date	20030913
EB01	Eligibility or Benefit Information	Benefit Description
EB02	Coverage Level Code	Individual
EB03	Service Type Code	Health Benefit Plan Coverage
EB04	Insurance Type Code	Medicaid
EB05	Plan Coverage Description	01ELIGIBLE FOR MEDICAID
EB01	Eligibility or Benefit Information	Benefit Description
EB02	Coverage Level Code	Individual
EB03	Service Type Code	Health Benefit Plan Coverage
EB04	Insurance Type Code	Medicaid
EB05	Plan Coverage Description	11EPSDT ELIGIBLE
EB01	Eligibility or Benefit Information	Benefit Description
EB02	Coverage Level Code	Individual
EB03	Service Type Code	Health Benefit Plan Coverage
EB04	Insurance Type Code	Medicaid
EB05	Plan Coverage Description	12PREFERRED LANGUAGE: ENGLISH
EB01	Eligibility or Benefit Information	Benefit Description
EB02	Coverage Level Code	Individual
EB03	Service Type Code	Medical Care
EB04	Insurance Type Code	Preferred Provider Organization (PPO)
MSG01	Message Text	COMMUNITYCARE ENROLLEE
MSG01	Message Text	COMMUNITYCARE PCP MUST AUTHORIZE/PROVIDE SERVICES EXCEPT:
MSG01	Message Text	EXEMPT SERVICES AS SPECIFIED BY THE COMMUNITYCARE PROGRAM
NM101	Entity ID Code	Provider
NM103	Last Name/Org. Name	Jane Doe
PER01	Contact Function Code	Information Contact
PER03	Communication Number Qualifier	Telephone
PER04	Communication Number	9999999999

Unisys Lammis

Response Created: 2004/04/28 at 5:28:35 PM
For Technical Support, Please Contact (877) 598-8753
For Eligibility Information Support, Please Contact (800) 473-2783 or (225) 924-5040

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 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.

EPSDT SERVICES PAY AND CHASE

Louisiana Medicaid uses the “pay and chase” method of payment for EarlySteps services. This means that providers are not required to file health insurance claims with private carriers. The Bureau of Health Services Financing seeks recovery of insurance benefits from the carrier within sixty days after claim adjudication when the provider does not pursue health insurance payments.

CLAIMS FILING

EarlySteps services are billed electronically on the 837P format or hardcopy on the CMS-1500 (08-05) claim form.

Items to be completed are either required or situational. Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. Situational information may be required (but only in certain circumstances as detailed in the instructions below). Claims should be submitted to:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	**Required** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	

Locator #	Description	Instructions	Alerts
4	Insured's Name	**Situational** – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the recipient's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Patient Status	**Optional.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other coverage, the state assigned 6-digit TPL carrier code is **required** in this block (the carrier code list can be found at www.lamedicaid.com under the **Forms/Files** link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	

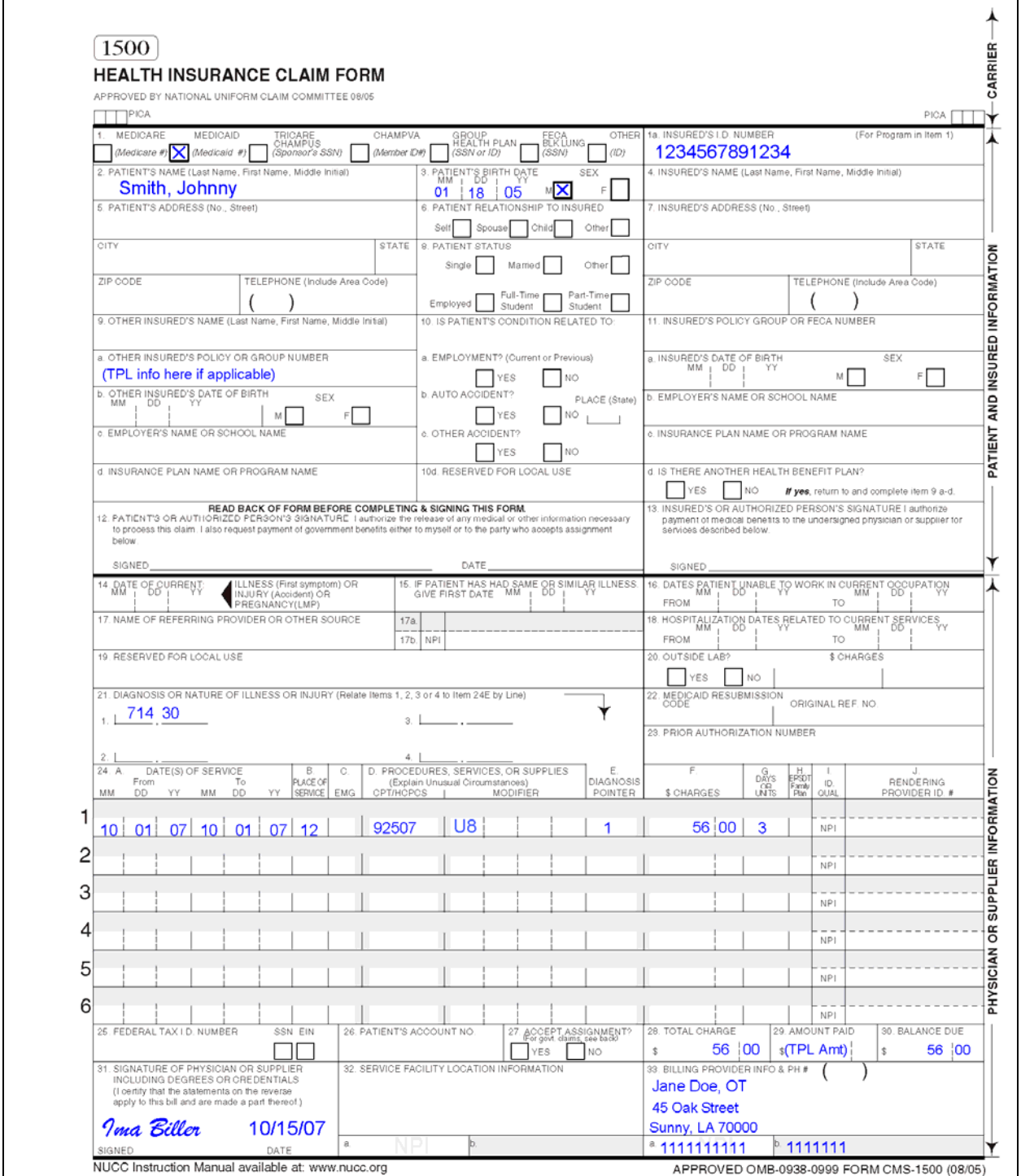
Locator #	Description	Instructions	Alerts
11b	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	**Optional.**	
15	If Patient Has Had Same or Similar Illness Give First Date	**Optional.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional.**	
17	Name of Referring Provider or Other Source	**Optional.** Enter the name of the referring physician or other source.	
17a	Unlabelled		
17b	NPI	**Optional.**	**The revised form accommodates the entry of the referring provider's NPI.**
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	Reserved for Local Use	Reserved for future use. Do not use.	**Usage to be determined.**
20	Outside Lab?	**Optional.**	

Locator #	Description	Instructions	Alerts
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	**The most specific diagnosis code must be entered.**
22	Medicaid Resubmission Code	**Optional**.	
23	Prior Authorization Number	**Leave Blank.**	**Service authorizations will continue to be handled through Covansys.**
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered. TOS: 22 – Natural Environment 12 = Home 99 = Other TOS: 27 – Special Purpose Facility / Inclusive Childcare 99 = Other TOS: 28 – Center Based Special Purpose Facility 99 = Other	
24C	EMG	**Leave Blank.**	

Locator #	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). Enter appropriate modifier following the CPT Code: TOS: 22 – Natural Environment Modifier = U8 TOS: 27 – Special Purpose Facility / Inclusive Childcare Modifier = TJ TOS: 28 – Center Based Special Purpose Facility Modifier = SE	
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral	
24I	I.D. Qual.	**Leave Blank.**	
24J	Rendering Provider I.D. #	**Leave Blank.**	
25	Federal Tax I.D. Number	**Optional.**	

Locator #	Description	Instructions	Alerts
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.	
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Balance Due	**Situational** – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Required** -- The claim form **MUST** be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI	**Leave blank.**	
32b	Unlabelled	**Leave blank.**	

Locator #	Description	Instructions	Alerts
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Optional.**	**The revised form accommodates the entry of the Billing's Provider's NPI.**
33b	Unlabelled	**Required** – Enter the billing provider's 7-digit Medicaid ID number.	**Format change with addition of 33a and 33b for provider numbers.**



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567891234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Johnny

3. PATIENT'S BIRTH DATE MM DD YY: 01 18 05 SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: (TPL info here if applicable)

a. EMPLOYMENT? (Current or Previous) YES | NO

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

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

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 714.30 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	10 01 07	10 01 07	12		92507	U8	1	56 00	3		NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 56 00

29. AMOUNT PAID $ (TPL Amt)

30. BALANCE DUE $ 56 00

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

Ima Biller 10/15/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Jane Doe, OT

45 Oak Street

Sunny, LA 70000

a. 1111111111 b. 1111111

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Note: Providers should always bill their Usual and Customary fee for "Charges"

UNISYS 213 ADJUSTMENT/VOID FORM

The Unisys 213 adjustment/void is used to adjust or void incorrect payments on the CMS-1500.

- These forms may be obtained from Unisys by calling Provider Relations at (800) 473-2783. Electronic submitters may electronically submit adjustment/void claims.

FORM COMPLETION

Only **one** (1) control number can be adjusted or voided on each 213 form.

Only an **approved claim** can be adjusted or voided.

Blocks 26 and 27 must contain the claim's most recently approved control number and R.A. date. For example:

1. A claim is approved on the R.A. dated 07/17/07, ICN 7266156789000.

2. The claim is adjusted on the R.A. dated 12/11/07, ICN 7345126742100.

3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (7345126742100) and R.A. date (12/11/07) must be used.

Provider numbers and recipient Medicaid ID numbers cannot be adjusted. They must be voided, then resubmitted.

Adjustments: To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, **changing the item that was in error to show the way the claim should have been billed.** The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the R.A. The original payment will be taken back on the same R.A. in the "previously paid" column.

Voids: To file a void, the provider must enter all the information from the original claim **exactly as it appeared on the original claim**. When the void claim is approved, it will be listed under the "void" column of the R.A. and a corrected claim may be submitted (if applicable).

Only one (1) claim line can be adjusted or voided on each adjustment/void form.

Completed 213 Adjustment/void forms should be mailed to the following address for processing:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

An example of a correctly completed 213 form is shown on the following pages. Only the blocks that are completed are required for claims processing.

213 ADJUSTMENT/VOID FORM INSTRUCTIONS

*1. ADJ/VOID—Check the appropriate block.

*2. Patient's Name

a. Adjust—Print the name exactly as it appears on the original claim if not adjusting this information.

b. Void—Print the name exactly as it appears on the original claim.

3. Patient's Date of Birth

a. Adjust—Print the date exactly as it appears on the original claim if not adjusting this information.

b. Void—Print the name exactly as it appears on the original claim.

*4. Medicaid ID Number—Enter the 13 digit recipient ID number.

5. Patient's Address and Telephone Number

a. Adjust—Print the address exactly as it appears on the original claim.

b. Void—Print the address exactly as it appears on the original claim.

6. Patient's Sex

a. Adjust—Print this information exactly as it appears on the original claim if not adjusting this information.

b. Void—Print this information exactly as it appears on the original claim.

7. Insured's Name— Leave blank.

8. Patient's Relationship to Insured—Leave blank.

9. Insured's Group No.—Complete if appropriate or blank.

10. Other Health Insurance Coverage—Complete with 6-digit TPL carrier code if appropriate or leave blank.

11. Was Condition Related to—Leave blank.

12. Insured's Address—Leave blank.

13. Date of—Leave blank.

14. Date First Consulted You for This Condition—Leave blank.

15. Has Patient Ever had Same or Similar Symptoms—Leave blank.

16. Date Patient Able to Return to Work—Leave blank.

17. Dates of Total Disability-Dates of Partial Disability—Leave blank.

18. Name of Referring Physician or Other Source—Leave this space blank.

18A. Referring ID Number – Enter the CommunityCARE authorization number if applicable or leave blank.

19. For Services Related to Hospitalization Give Hospitalization Dates—Leave blank.

20. Name and Address of Facility Where Services Rendered (if other than home or office)—Leave blank.

21. Was Laboratory Work Performed Outside of Office—Leave blank.

*22. Diagnosis of Nature of Illness

a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information.

b. Void—Print the information exactly as it appears on the original claim.

23. Attending Number—Enter the attending number submitted on original claim, if any, or leave this space blank.

24. Prior Authorization #—Enter the PA number if applicable or leave blank.

*25. A through F

a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information.

b. Void—Print the information exactly as it appears on the original claim.

*26. Control Number—Print the correct Control Number as shown on the Remittance Advice.

*27. Date of Remittance Advice that Listed Claim was Paid—Enter MM DD YY from RA form.

*28. Reasons for Adjustment—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.

*29. Reasons for Void—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.

*30. Signature of Physician or Supplier—All Adjustment/Void forms must be signed.

*31. Physician's or Supplier's Name, Address, Zip Code and Telephone Number—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. *The form will be returned if this information is not entered.*

32. Patient's Account Number—Enter the patient's provider-assigned account number.

Marked (*) items must be completed or form will be returned.

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
3 PATIENT'S DATE OF BIRTH
4 MEDICAID ID NUMBER
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX MALE ☐☐ FEMALE
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES ☐☐ NO
B. AN AUTO ACCIDENT YES ☐☐ NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐☐ NO
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES ☐☐ NO CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1
2
3
23 ATTENDING NUMBER
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $

26 CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT
☐ 01 THIRD PARTY LIABILITY RECOVERY
☐ 02 PROVIDER CORRECTIONS
☐ 03 FISCAL AGENT ERROR
☐ 90 STATE OFFICE USE ONLY - RECOVERY
☐ 99 OTHER - PLEASE EXPLAIN

29 REASONS FOR VOID
☐ 10 CLAIM PAID FOR WRONG RECIPIENT
☐ 11 CLAIM PAID TO WRONG PROVIDER
☐ 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
32 YOUR PATIENT'S ACCOUNT NUMBER

UNISYS - 213
5/97

FISCAL AGENT COPY

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

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

FOR OFFICE USE ONLY

1 ADJ. [ ] VOID [X]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Smith, Johnny
3 PATIENT'S DATE OF BIRTH: 01/18/05
4 MEDICAID ID NUMBER: 1234567891234
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [X] FEMALE [ ]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO [ ] CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 714.30
2
3
23 ATTENDING NUMBER
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
07	01	07	07	01	07	12	92507	U8	1	56 00	3		

26 CONTROL NUMBER: 7266156789000
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 07/17/07

28 REASONS FOR ADJUSTMENT
- [ ] 01 THIRD PARTY LIABILITY RECOVERY
- [ ] 02 PROVIDER CORRECTIONS
- [ ] 03 FISCAL AGENT ERROR
- [ ] 90 STATE OFFICE USE ONLY - RECOVERY
- [ ] 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

29 REASONS FOR VOID
- [X] 10 CLAIM PAID FOR WRONG RECIPIENT — Claim billed under incorrect recipient number
- [ ] 11 CLAIM PAID TO WRONG PROVIDER
- [ ] 99 OTHER - PLEASE EXPLAIN

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Ima Biller 12/01/2007
32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Jane Doe, OT
123 Oak St
Allen, LA 70000 1111111

UNISYS - 213
5/97

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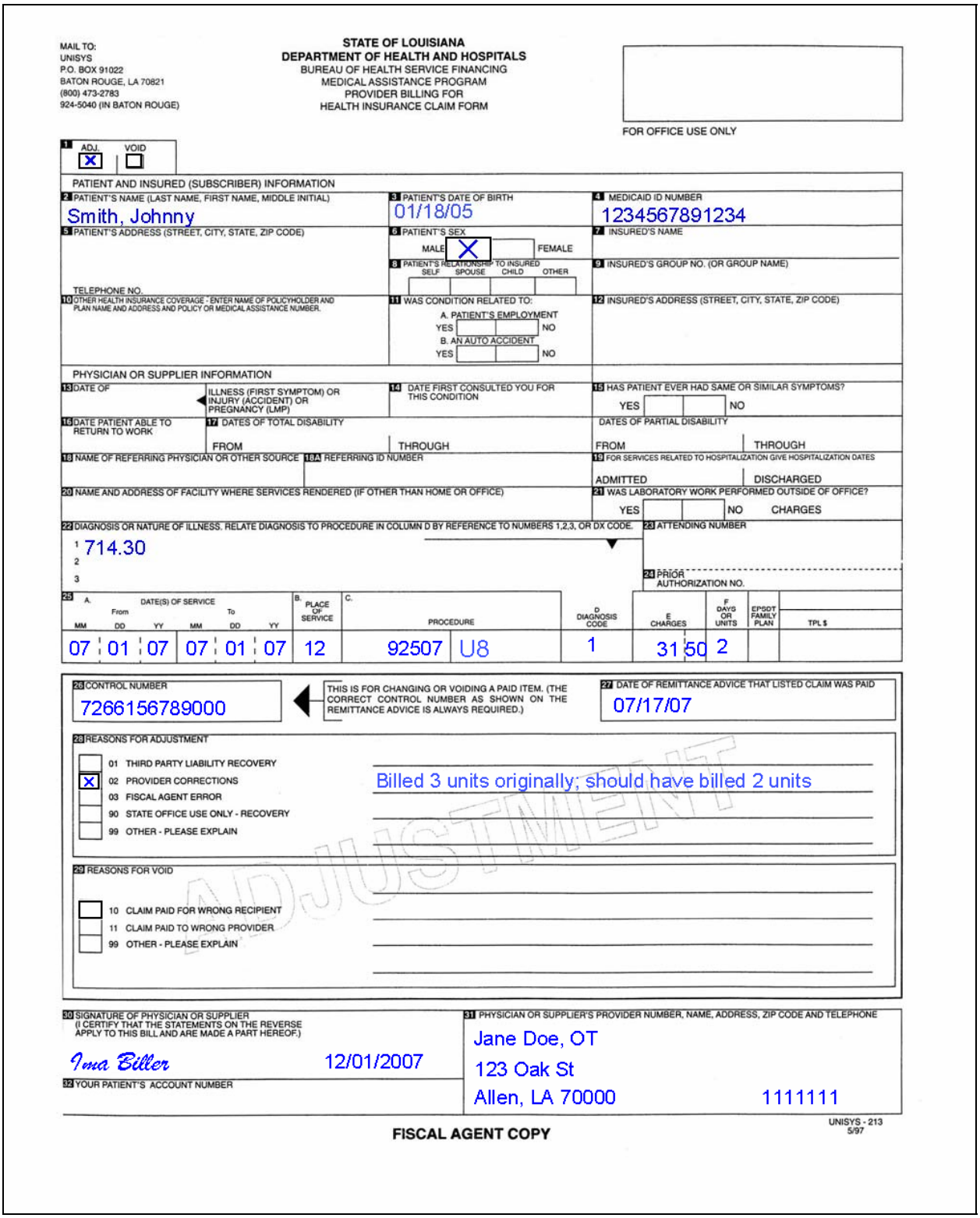

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

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

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Smith, Johnny
3 PATIENT'S DATE OF BIRTH: 01/18/05
4 MEDICAID ID NUMBER: 1234567891234
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO.
6 PATIENT'S SEX: MALE [X] FEMALE [ ]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO [ ] CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 714.30
2
3
23 ATTENDING NUMBER
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
07	01	07	07	01	07	12	92507	U8	1	31 50	2		

26 CONTROL NUMBER: 7266156789000
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 07/17/07

28 REASONS FOR ADJUSTMENT
- [ ] 01 THIRD PARTY LIABILITY RECOVERY
- [X] 02 PROVIDER CORRECTIONS — Billed 3 units originally; should have billed 2 units
- [ ] 03 FISCAL AGENT ERROR
- [ ] 90 STATE OFFICE USE ONLY - RECOVERY
- [ ] 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

29 REASONS FOR VOID
- [ ] 10 CLAIM PAID FOR WRONG RECIPIENT
- [ ] 11 CLAIM PAID TO WRONG PROVIDER
- [ ] 99 OTHER - PLEASE EXPLAIN

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Ina Biller 12/01/2007
32 YOUR PATIENT'S ACCOUNT NUMBER
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Jane Doe, OT
123 Oak St
Allen, LA 70000 1111111

UNISYS - 213
5/97

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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 Provider Enrollment link, click on Forms to Update Existing Provider Information.

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 EDI Department at Unisys, call (225) 216-6000 and select option 2. Providers may write to Unisys EDI 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 EDI Department.

With the exception of Non-Ambulance Transportation, all claim types may be submitted as approved HIPAA compliant 837 transactions.

Non-Ambulance Transportation claims may be submitted under proprietary specifications (not as HIPAA-compliant 837 transactions).

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.

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** (EDI 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** (EDI 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 EDI Contract and a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Note: A listing of vendors, billing agents, and clearinghouses is located on the Louisiana Medicaid web site (www.lamedicaid.com) under the HIPAA Information Center → VBC List for [current month].

Enrollment Requirements For 835 Electronic Remittance Advices

- All EDI billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EDI 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 EDI 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, 11/20/07
KIDMED Submissions	4:30 P.M. Tuesday, 11/20/07
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/21/07

Important Reminders For EDI 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.**

Louisiana Medicaid Program

INSTRUCTIONS FOR PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

The following must be completed by every submitter/provider who wants to submit claims electronically. The instructions are as follows:

EDI Contract

Provider Number – enter the Louisiana Medicaid provider number that will be submitting electronic claims to Unisys. Leave blank if applying for new number.
Submitter Number – enter the Louisiana Medicaid submitter number that will be submitting electronic claims to Unisys. Leave blank if applying for new number.
National Provider Identifier (NPI) – provider types that are required to obtain the NPI number must enter the number in this field. Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do for more information on obtaining an NPI.
Provider Name – enter the name of the provider associated with the provider number entered.
Name of Billing Agent / Submitter Name – enter the name of the submitting agent that is associated with the submitter number entered
Print Name of Person Completing Form – print the name of the person completing the form
Phone Number of Person Completing Form – enter the phone number of the person completing the form in case they must be contacted for additional information
Signature of Provider or Authorized Agent – the provider or the provider's authorized agent must sign the form for it to be processed
Date of Signature – enter the date the provider or the provider's authorized agent signed the form

PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (EDI CONTRACT)

								4	5	0				
Provider Number (7 digits)								Submitter Number (7 digits) (leave blank if applying for new number)						
National Provider Identifer (NPI) (10 digits)														
Provider Name:														
Billing Agent/Submitter Name:														
Contact Name of Person Completing the Form:												Contact Phone #		

The Medicaid File can hold a maximum of three Submitter Numbers per Provider Number at any one time. Current policy is to close old Submitter Numbers as new ones are opened unless otherwise notified. Since a new Submitter Number is being requested, please list any Submitter Numbers (up to a maximum of two) that are currently on file that need to remain open for this Provider Number. It is also vital to identify which Submitter Number will be used to download the 835 Electronic Remittance Advices (ERA).

The new Submitter Number will be automatically set to retrieve the 835 ERA. If a previously assigned Submitter Number is to be used for this purpose, then place it in the spaces provided below.

4	5	0				

List other Submitter Number(s) that are currently on file which will NOT be used for 835 ERA, but which need to remain open in the spaces below:

4	5	0				
4	5	0				

☐	I am an enrolled Louisiana Medicaid provider and wish to submit my own claims electronically to Louisiana Medicaid. (Put Provider Name in the Billing Agent/Submitter Name portion of the form above.)
☐	I am an enrolled Louisiana Medicaid provider and wish to use a Third Party (Clearinghouse, Billing Agent, Submitter etc.) to submit my claims electronically to Louisiana Medicaid. (Put Third Party Name in the Billing Agent/Submitter Name portion of the form above.) (Power of Attorney form is required.)

1. On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 16 below. This is done in consideration for the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing's (hereinafter referred to as "State Agency") processing of provider claims, as well as other valuable considerations.

Provider Name: _____

2. All published specifications set forth shall be met as to every entry sought to be processed. The effective date for my EDI submission will be set by Provider Enrollment once the contract has processed.
3. The Provider, or his agent, shall be responsible for total compliance with said specifications including 42CFR 447.10 which governs the payment options for Third Party Billers. The Provider's data processing agent for submission of medical assistance claims is stated above and any changes in the Provider's data processing agent shall be preceded by 30 days written notice to the State Agency.
4. The Provider shall provide upon request of the director of the State Agency supportive documentation to ensure that all technical requirements are being met, i.e. program listings, tape or diskette dumps, flow charts, file descriptions, accounting procedures and the like.
5. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to submit electronic claims and the Annual Certification form . A copy of the said certification statement is attached and is hereby incorporated by reference into this paragraph.
6. It is expressly understood that the State Agency or its Fiscal Intermediary (Unisys) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
7. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to your provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
8. The State Agency and the Provider mutually agree that this Agreement may be amended by mutual consent of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement shall not be verbally amended.
9. The Provider agrees to submit to the State Agency, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
10. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
11. The Provider and the State Agency agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.
12. Further, for a period of five years, during the course of a federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested and produce such for examination and copying.
13. The Provider agrees that this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify the State Agency's limited obligations as set in a certain Provider Agreement between the State Agency and the Provider.
14. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate and complete.
15. I understand that all claims submitted under the conditions of this Agreement will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.
16. I attest that all information supplied with this Agreement is true, accurate and complete.

Print Name of Person Completing Form		Signature of Provider or Authorized Agent
Phone Number of Person Completing Form		Date of Signature

Louisiana Medicaid Program

INSTRUCTIONS FOR PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

EDI Power of Attorney

Provider Number – enter the Louisiana Medicaid provider number that will be submitting electronic claims to Unisys. Leave blank if applying for new number.
Submitter Number – enter the Louisiana Medicaid submitter number that will be submitting electronic claims to Unisys. Leave blank if applying for new number.
National Provider Identifier (NPI) – provider types that are required to obtain the NPI number must enter the number in this field. Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do for more information on obtaining an NPI.
Provider Name – enter the name of the provider associated with the provider number entered.
Provider Address – enter the address associated with the provider name entered
Billing Agent Name – enter the name of the Billing Agent (or submitter)
Billing Agent Address – enter the address associated with the Billing Agent submitter name entered
Enter the Parish (or County) Name where the Notary Public is located
Enter City, State and Date of Notarization
Signature of Provider or Authorized Agent – the provider or the provider's authorized agent must sign the form for it to be processed
Notary Public Signature – the Notary Public should sign the form and affix his/her seal
Witnesses – the signatures of two (2) witnesses should be added

****If the provider will be using a Third Party Biller or Clearinghouse, a Limited Power of Attorney MUST be completed and notarized.**

MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY
(EDI POWER OF ATTORNEY)

This form is required by all providers who will have electronic claims submitted by a third party.

POWER OF ATTORNEY OR PROCURATION UNITED STATES OF AMERICA

		4 5 0	
Provider Number (7 digits)		Submitter Number (7 digits) (leave blank if applying for new number)	
National Provider Identifier (10 digits)			
Provider Name:		Billing Agent Name:	
Provider Address:		Billing Agent Address:	

BE IT KNOWN, that on this day, BEFORE ME, A Notary Public duly commissioned and qualified in and for the Parish of _____, State of Louisiana, therein residing and in the presence of the witness hereinafter named and undersigned:

PERSONALLY CAME AND APPEARED the above named provider, represented herein by the provider or its duly authorized representative who is of majority and a resident of and domiciled in the State shown under Provider Address above who declared unto me, Notary, that he does by these presents, name, constitute and appoint the above named Billing Agent, a person or entity with full legal capacity, to be his true and lawful agent and attorney-in-fact, to execute for him, and in his name, place and stand, the Louisiana Medical Assistance Program the applicable claims for the provider type for magnetic tape, diskette, or telecommunication submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

THUS DONE AND PASSED BEFORE ME, Notary, and the undersigned competent witnesses, in the City of _____, State of _____on the _____ day of _____ _____, 20___.

Signature of Provider or Authorized Agent		Notary Public Signature
		Notary Seal (required)

EDI SUBMITTER
CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Unisys Provider Enrollment Unit in order to obtain a Louisiana Medicaid Program Submitter Number:

FOR LOUISIANA PROVIDER(S) (INDIVIDUAL OR ENTITIES) WISHING TO SUBMIT THEIR OWN CLAIMS – DIRECTLY TO LOUISIANA MEDICAID – NOT THROUGH A BILLING AGENT OR CLEARINGHOUSE:

Completed	Document Name
☐	1. A completed Provider's Election To Employ Electronic Data Interchange Of Claims For Processing In The Louisiana Medical Assistance Program (EDI Contract). The name on the EDI contract must match that of the enrolled provider.*
☐	2. A completed EDI Annual Certification Of Electronically-Submitted Medicaid Claims current year. *

FOR BILLING AGENTS / CLEARINGHOUSES WHO WILL BE SUBMITTING ELECTRONIC CLAIMS TO LOUISIANA MEDICAID ON BEHALF OF ENROLLED LOUISIANA MEDICAID PROVIDER(S):

Completed	Document Name
☐	1. Completed Form PE-50Sub* (Read instructions carefully before completing this form).
☐	2. A completed Provider's Election To Employ Electronic Data Interchange Of Claims For Processing In The Louisiana Medical Assistance Program* (EDI Contract) for a provider for whom you wish to submit electronic claims
☐	3. A completed Medicaid Electronic Media Limited Power Of Attorney* (EDI Power Of Attorney). This form is required for all EDI contracts where submissions will be made by a third party.
☐	4. A completed EDI Annual Certification Of Electronically-Submitted Medicaid Claims current year: January 1, To December 31, 200__*

FOR THOSE SUBMITTERS WISHING TO RETRIEVE 835s (ELECTRONIC REMITTANCES) ONLY:

Completed	Document Name
☐	1. A completed Provider's Election To Employ Electronic Data Interchange Of Claims For Processing In The Louisiana Medical Assistance Program* (EDI Contract)
☐	2. A completed Medicaid Electronic Media Limited Power Of Attorney* (EDI Power Of Attorney), if applicable. This form is required for all EDI contracts where submissions will be made by a third party.
☐	3. A completed EDI Annual Certification Of Electronically-Submitted Medicaid Claims current year: January 1, To December 31, 200__*

- Forms are included in this packet.

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT. INCOMPLETE/INACCURATE FORMS WILL BE RETURNED FOR CORRECTION.

ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS).

Please submit all required documentation to:
Unisys Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

Instructions for Louisiana Medicaid PE-50Sub Provider Enrollment Form

The following fields **MUST** be completed:

Medicaid Submitter Number – your seven- (7) digit Medicaid submitter number, if known. Indicate if this application is for a new enrollment or an update to an existing enrollment. A new enrollment is for a submitter with no prior Louisiana Medicaid submitter number. An update to an existing enrollment is for a submitter that has had a Louisiana Medicaid submitter number in the past and that number is either closed or contains old information.

Is this a Change of Ownership (CHOW)? – indicate whether or not this entity has had a change of ownership that has not been reported to Louisiana Medicaid.

** The Department of Health and Hospitals has defined a change of ownership (CHOW) as any change in: (1) Name; (2) Ownership; (3) Management; or (4) change in Taxpayer ID. This definition remains in effect even if the Internal Revenue Service, Secretary of State or Medicare does not recognize the change as a CHOW. Any change that meets the criteria above requires a full enrollment packet for updates to the Louisiana Medicaid submitter file.

SECTION A – SUBMITTER INFORMATION & PHYSICAL LOCATION

Submitter Name – enter the submitter name – either the "Doing Business As" (DBA) name

Area Code and Telephone # - enter the telephone number at the physical location of the business or individual named in the *Submitter Name*.

Social Security Number – enter the social security number assigned to the owner of the business identified in the *Submitter Name* field.

Physical Street Address - enter the physical location address of the business named in *Submitter Name*.

Mailing Address (if different) – enter the mailing address if mail cannot be received at the Physical Street Address. For example, if the Physical Street Address is 123 Main Street, Anywhere, LA but mail cannot be received there, enter the mailing address such as PO Box 85555, Anywhere, LA.

Physical City – enter the city in which your *Physical Street Address* is located.

Mailing Address City – enter the city in which your *Mailing Address* is located.

Physical State – enter the state in which your *Physical Street Address* is located.

Mailing Address State – enter the state in which your *Mailing Address* is located.

Physical Zip Code – enter the zip code in which your *Physical Street Address* is located.

Mailing Address Zip Code – enter the zip code in which your *Mailing Address* is located.

Parish/County – enter the parish / county in which your *Physical Street Address* is located.

Parish Code – the parish code of your physical location (see list below and enter appropriate code for the parish entered in the *Parish* field).

Acadia	01		E. Baton Rouge	17		Madison	33		St. Landry	49
Allen	02		E. Carroll	18		Morehouse	34		St. Martin	50
Ascension	03		E. Feliciana	19		Natchitoches	35		St. Mary	51
Assumption	04		Evangeline	20		Orleans	36		St. Tammany	52
Avoyelles	05		Franklin	21		Ouachita	37		Tangipahoa	53
Beauregard	06		Grant	22		Plaquemines	38		Tensas	54
Bienville	07		Iberia	23		Pointe Coupee	39		Terrebonne	55
Bossier	08		Iberville	24		Rapides	40		Union	56
Caddo	09		Jackson	25		Red River	41		Vermillion	57
Calcasieu	10		Jefferson	26		Richland	42		Vernon	58
Caldwell	11		Jefferson Davis	27		Sabine	43		Washington	59
Cameron	12		Lafayette	28		St. Bernard	44		Webster	60
Catahoula	13		Lafourche	29		St. Charles	45		W. Baton Rouge	61
Claiborne	14		LaSalle	30		St. Helena	46		W. Carroll	62
Concordia	15		Lincoln	31		St. James	47		W. Feliciana	63
DeSoto	16		Livingston	32		St. John	48		Winn	64

Out-Of-State

Texas	87		Mississippi	88		Arkansas	89		Other	99

State Status – check “In (0)” if your Provider Street Address is located within Louisiana or “Out (1)” if it is located outside Louisiana.
Location Type – check “Urban (1)” if your Provider City is an urban location or “Rural (2)” if it is a rural location.

SECTION B – OWNERSHIP INFORMATION

Practice Type – check the appropriate box for the individual/entity entered in Provider Name field.
Contact Information – enter the name and phone number of the person that can be contacted should additional information be required.

SECTION C - SUBMITTER ACCEPTANCE OF INFORMATION

Read the information included in this section.
Print Name of Authorized Agent - print the name of the authorized agent that will sign this document.
Submitter’s Authorized Agent’s Signature – **signatures must be original** (stamped signatures and initials are not accepted).
Date – enter the date this agreement was signed.

INACCURATE/INCOMPLETE FORMS WILL BE RETURNED FOR CORRECTION

Louisiana Medicaid Third Party Biller Form

This Form is Required for All Submitters Requesting a New Submitter Number

Submitter Provider # (if known) (Leave Blank for New Submitter Numbers)							Is this a Change of Ownership (CHOW)?
4	5	0					☐ Yes ☐ No *See Instructions for definition of CHOW per Louisiana Medicaid policy.* If yes, current LA Medicaid submitter number:

This enrollment packet is for a
- ☐ New Submitter Number
- ☐ Update to Existing Submitter Number or
- ☐ Other (Please specify)

☐	I am an enrolled Louisiana Medicaid provider and wish to submit my claims electronically directly to Louisiana Medicaid (I will submit the claims via modem from my office – not through a Billing Agent or Clearinghouse)
☐	I am a Billing Agent / Clearinghouse and wish to submit Louisiana Medicaid claims electronically for Louisiana Medicaid providers (these claims are claims received from enrolled Louisiana Medicaid providers and not claims for services that I have provided.)
☐	I wish to retrieve 835s (electronic remittances) only. (I will not be submitting any claims to Louisiana Medicaid.)

A Submitter Information & Physical Location

Submitter Name			Area Code & Telephone # ( ) -		Social Security # (Required) - -
Physical Street Address - Can Mail Be Received at this address: ☐ Y ☐ N			Mailing Address (if different)		
Physical City	State	Zip Code	Mailing Address City	State	Zip Code
Parish /County	Parish/County Code	State Status ☐ In (0) ☐ Out (1)	Location Type ☐ Urban (1) ☐ Rural (2)	IRS Reporting #	

B Ownership

Practice Type (All Providers)

- ☐ Individual (01)
- ☐ Partnership (02)
- ☐ Corporation (03)
- ☐ Hospital Based Physician (04)
- ☐ Health Maintenance Organization (05)
- ☐ Group Practice (Private) (06)
- ☐ Teaching Provider (Physician / Dentist) (07)
- ☐ Public Clinic or Group (08)

The following person may be contacted for additional information regarding this enrollment application:

Contact Person

Contact Phone # ( )

C Submitter Attestation of Information

I, the undersigned, certify to the following:

1. that the claim information submitted to Louisiana Medicaid is an exact duplicate of detailed claim line information received from the provider and has not been materially altered or revised except for translation to the current 837 transaction format or insertion of minor data such as provider number or recipient number.;
2. that the information submitted in electronic format is true, accurate and complete as received from the provider;
3. I understand that payment of these claims will be paid to the provider from Federal and State funds;
4. that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws; and
5. that I will notify the Provider Enrollment Unit whenever the above information needs to be updated.

Print Name of Authorized Agent	Signature of Authorized Agent	Date

ALL SUBMITTERS MUST COMPLETE ENTIRE FORM– INCOMPLETE FORMS WILL BE RETURNED FOR CORRECTION

Louisiana Medicaid Program

Instructions for Completing the EDI Annual Certification

Provider Number – enter the Louisiana Medicaid provider number that will be submitting electronic claims to Unisys. Leave blank if applying for new number. Leave blank if this is for a Third Party Biller.
Submitter Number – enter the Louisiana Medicaid submitter number that will be submitting electronic claims to Unisys. Leave blank if applying for new number.
Submitter Name – enter the name associated with the "450" submitter number. If the provider will submit their own claims, this would be the provider name. If claims are submitted through a third party, this would be the name of the third party who actually transmits claims to Louisiana Medicaid.
Claim Type – enter the type of claims this submitter number will submit to Louisiana Medicaid.
Date of Signature – enter the date the provider or the provider's authorized agent signed the form
Signature of Provider or Authorized Agent – the provider or the provider's authorized agent must sign the form for it to be processed

PE-50Sub
Louisiana Medicaid
Rev. 07/2006

EDI ANNUAL CERTIFICATION OF ELECTRONICALLY-SUBMITTED MEDICAID CLAIMS

Certification Period: January 1, to December 31, 200___

								4	5	0				
Provider Number (7 digits) - If submission contains files for more than 1 provider, list ALL provider numbers and attach to this Certification.								Submitter Number (7 digits)						
Submitter Name:														

o **Submissions by Provider Rendering Services Using their own Submitter ID:**

I certify that all services rendered during the above identified Certification Period were necessary, medically indicated and were rendered by me or under my personal supervision. I have reviewed the claims information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or otherwise required by law or regulation. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistance Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

o **Submissions by Third Party Biller (Billing Agents/Clearinghouses) Using their Submitter ID:**

I certify that the claim information submitted to Louisiana Medicaid is an exact duplicate of detailed claim line information received from the provider and has not been materially altered or revised except for translation to the current 837 transaction format or insertion of minor data such as provider number or recipient number. I certify that the information submitted in electronic format is true, accurate and complete as received from the provider. Additionally, I understand that payment of these claims will be from Federal and State funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

I also certify that provider(s) with whom I have a direct relationship have furnished me with an EDI Annual Certification of Medicaid Claims Submitted Electronically Form on which the provider has attested to the truth, accuracy and completeness of the claim information. If I do not have a direct relationship with submitting providers (for instance, if the relationship is with a vendor), Louisiana Medicaid understands that I will not have an EDI Annual Certification Form from the individual(s) or entity(ies) with whom I do not maintain a contractual relationship. I agree to maintain all forms I am required to collect for a period of five (5) years.

Attach a list of provider(s) name(s) and identification numbers.

Identify all claim types that will be submitted during this Certification Period:

CLAIM TYPE	☐ 837P	☐ 837 I	☐ 837 D	☐ Non-Ambulatory Transportation	☐ Case Management	☐ Other:

DATE	SUBMITTER SIGNATURE (ORIGINAL)

NOTE: Updated certification forms MUST be submitted annually. Failure to maintain a completed Certification Form on file will result in the closure of the submitter number without notice to submitter. All files submitted with closed submitter numbers will be dropped from the system without being processed.

Submit to: Unisys – EDI Department, PO Box 91025, Baton Rouge, LA 70821-9025

Revised 07/06

HARD COPY REQUIREMENTS

DHH has made the decision to continue requiring hardcopy claim submissions for all existing hardcopy attachments, as indicated in the table below.

HARDCOPY CLAIM(S) & REQUIRED ATTACHMENT(S)	BILLING REQUIREMENTS
Spend Down Recipient – 110MNP Spend Down Form	Continue hardcopy billing
Retroactive eligibility – copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing
Recipient eligibility Issues – copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing – letter/other proof i.e., RA page	Continue hardcopy billing

PLEASE NOTE: when a provider submits a claim, which has more than one page of procedures and charges, each claim page must be totaled and attachments must be submitted with each page of the claim.

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.

Electronic claims submission is the preferred method for submitting claims; however, 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. Claim forms **must be two sided** documents and include the standard information on the back regarding fraud and abuse. If a copy is submitted, it should be 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 <u>if the claim form requires a signature</u>. 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.

- Claims submitted should be two-sided documents and include the standard information on the back regarding fraud and abuse.

- **Do not use white out or a marking pen to omit claim line entries. To correct an error, draw a line through the error and initial it. 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. Claims with insufficient information are rejected prior to keying.

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, difficult to read, or **IS NOT IN THE CORRECT LOCATION**, the claim will not process correctly.

Rejected Claims

Each year, Unisys returns more than 250,000 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. The most common reasons for rejection are listed as follows:

- A signature or handwritten initials were missing **(except UB-04 claim forms)**
- The provider number 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

Correct Claims Submission

We have learned that some providers are incorrectly submitting claims directly to DHH at P.O. Box 91030 rather than correctly submitting claims to Unisys to the appropriate post office box for the program type. Unless specifically directed to submit claims directly to DHH, providers should cease this practice and submit claims to the appropriate Unisys post office box for processing. The correct post office boxes can be found on the following page of this packet and in training materials posted on the **Tracking** link of the www.lamedicaid.com website.

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.

NOTE: Claims over two years old will only be considered for processing if submitted in writing as indicated above. These claims may be discussed via phone to clarify policy and/or procedures, but they will not be pulled for research or processing consideration.

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 60 1600
(03	/(4	94	30321	)		527 116						
260 2	A A	N	031106	031106	1	306	LABORATORY-HEMATOL	87184	8750	890	00	890 60 1601
(03	/(4	94	30321	)		527 116						
260 2	A A	N	031106	031106	1	306	LABORATORY-HEMATOL	87070	4900	1113	00	1113 60 1602
(03	/(4	94	30321	)		527 116						
260 2	A A	N	031106	031106	1	450	EMERGENCY ROOM-GEN	99282	17300	17300	11738	5562 60 1603
(03	/(4	94	30321	)		527						
888 4	ABB	A	031106	031106	1	515	PEDIATRIC CLINIC	99211	3300	3300	00	3300 60 1200
(17	/(1	95	MPC	)		526						
185 0	ACC	HC	031506	031506	1	300	LABORATORY-GEN CLA	87804	8000	1824	00	1824 60 1500
(16	/(1	82	MPC	)		526 116						
185 0	ACC	HC	031506	031506	1	300	LABORATORY-GEN CLA	87420	4500	1824	00	1824 60 1501
(16	/(1	82	MPC	)		526 116						
185 0	ACC	HC	031506	031506	1	515	PEDIATRIC CLINIC	99211	3300	3300	00	3300 60 1502
(16	/(1	82	MPC	)		526						
810 2	ACC	KM	030806	030806	1	515	PEDIATRIC CLINIC	99211	3300	3300	00	3300 60 3600
(15	/(1	74	MPC	)		527						
170 1	ACC	AL	032206	032206	1	320	RADIOLOGY-DIAGNOST	72010	33337	33337	22619	10718 60 1600
(01	/(2	01	05401	)		527						
170 1	ACC	AL	032206	032206	2	320	RADIOLOGY-DIAGNOST	73590	30374	30374	20609	9765 60 1601
(01	/(2	01	05401	)		527						
170 1	ACC	AL	032206	032206	1	320	RADIOLOGY-DIAGNOST	72170	24187	24187	16411	7776 60 1602
(01	/(2	01	05401	)		527						
003 4	ACH	JJ	032206	032206	1	300	LABORATORY-GEN CLA	36415	1300	300	00	300 60 2000
(03	/(2	95	96313	)		527 116						
003 4	ACH	JJ	032206	032206	1	305	HEMATOLOGY	85027	10550	837	00	837 60 2001
(03	/(2	95	96313	)		527 116						
003 4	ACH	JJ	032206	032206	1	305	HEMATOLOGY	85007	3600	306	00	306 60 2002
(03	/(2	95	96313	)		527 116						
052 6	ACH	MF	032106	032106	1	320	RADIOLOGY-DIAGNOST	72010	33337	33337	22619	10718 60 2900
(02	/(2	80	32701	)		527						
853 8	ACK	RA	031206	031206	1	450	EMERGENCY ROOM-GEN		17300	17300	11738	5562 60 3400
(02	/(4	94	31790	)		527						
853 8	ACK	RA	031706	031706	1	300	LABORATORY-GEN CLA	87880	8000	1824	00	1824 60 1400
(17	/(1	22	MPC	)		527 116						
853 8	ACK	RA	031706	031706	1	515	PEDIATRIC CLINIC	99211	3300	3300	00	3300 60 1401
(17	/(1	22	MPC	)		527						
440 3	ACO	JL	030806	030806	1	515	PEDIATRIC CLINIC	99211	3300	3300	00	3300 60 2300
(10	/(1	55	MPC	)		527						
672 0	ADA	JI	031106	031106	1	450	EMERGENCY ROOM-GEN	99282	17300	17300	11738	5562 60 0400
(03	/(4	94	30545	)		527						
789 9	ADA	JD	031506	031506	1	515	PEDIATRIC CLINIC	99211	3300	3300	00	3300 60 7500
(12	/(1	73	MPC	)		527						
975 9	ADA	JB	031306	031306	1	515	PEDIATRIC CLINIC	99211	3300	3300	00	3300 60 9300
(11	/(1	49	MPC	)		527						
522 3	ADA	NJ	031006	031006	1	515	PEDIATRIC CLINIC	99211	3300	3300	00	3300 60 8700
(16	/(1	41	MPC	)		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
PO BOX 3396
BATON ROUGE LOUISIANA 70821

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 I		S	080905	080905	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(2(9L)/						650					
36(2 I		NM	080805	080805	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8(37)/						650					
45: 3 I	)N	RF	080505	080505	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8' 27)/						650					
45' 6 I		JN	080905	080905	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8! 47)/						650					
65(2 ;		KA	080905	080905	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8! 41)/						650					
65(1 ;		KR	080905	080905	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5: 00
(8! 43)/						650					
							83392		00		
APPROVED ORIGINAL CLAIMS		TOTALS				31 CLAIMS		33195		33195	
ADJUSTMENT CLAIMS											
		SE	070505	070505	1	J7302 MIRENA	66000	38439	00	38439	5: 00
						650			REF.CONTROL NO.	51:	1
							66000		00		
ADJUSTMENT CLAIMS		TOTALS				1 CLAIMS		38439		38439	
PREVIOUSLY PAID CLAIMS											
		SE	070505	070505	1	J7302 51 MIRENA	66000	19220	00	19220	5: 01
						FORMER REMITTANCE DATED : 08022005			REF.CONTROL NO.	52:	0
							66000		00		
PREVIOUSLY PAID CLAIMS		TOTALS				1 CLAIMS		19220		19220	
CLAIMS IN PROCESS											
		DL	072005	072005	1	99213 TH OFFICE,EST PT, EXPANDED,	8259	00	00	00	5: 00
(903211)/						250					
							8259		00		
CLAIMS IN PROCESS		TOTALS				1 CLAIMS		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
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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					

PROVIDER ASSISTANCE

The Louisiana Department of Health and Hospitals and Unisys maintain a website to make information more accessible to LA 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
National Provider Identifier (NPI)
Disaster
Provider Training Materials
Provider Web Account Registration Instructions
Provider Support
Billing Information
Fee Schedules
Provider Update / Remittance Advice Index
Pharmacy
Prescribing Providers
Provider Enrollment
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

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification; ordering printed materials; billing denials/problems; requests for Field Analyst visits; etc.

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

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

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 provider manuals, Unisys claim forms, 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.

- ☞ Fee schedules, TPL carrier code lists, provider newsletters, provider workshop packets and enrollment packets may be found on the LA Medicaid website. Orders for these materials should be placed through this option **ONLY** if you do not have web access.

- ☞ 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.

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 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.

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

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

Press #4 - To resolve a claims problem

Provider Relations staff are available to assist with resolving claim denials, clarifying denial codes, or resolving billing issues.

NOTE: Providers must use e-CSI to check the status of claims and e-CSI in conjunction with remittance advices to reconcile accounts.

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

Unisys Provider Relations Correspondence Group

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims.

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.

Eligiblity File Updates: Provider Relations staff also handles requests to update recipient files with correct eligibility. Staff in this unit 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.

TPL File Updates: 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: "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". **CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.**

Claims Over Two Years Old: Providers are expected to resolve claims issues within two years from the date of service on the claims. The process through which claims over two years old will be considered for re-processing is discussed in this training packet under the section, Timely Filing Guidelines. In instances where the claim meets the DHH established criteria, a detailed letter of explanation, the hard copy claim, and required supporting documentation must be submitted **in writing** to the Provider Relations Correspondence Unit at the address above. **These claims may not be submitted to DHH personnel and will not be researched from a telephone call to DHH or the Provider Inquiry Unit.**

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 not 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	Jefferson Orleans Plaquemines	St. Bernard St. Tammany **(Slidell Only)**
Stacey Fairchild (225) 216-6267	Ascension Assumption Calcasieu Cameron Jeff Davis Lafourche St. Charles	St. James St. John St. Martin **(below Iberia)** St. Mary Terrebonne Vermillion Beaumont (TX)
Tracey Guidroz (225) 216-6201	West Baton Rouge Iberville Tangipahoa St. Tammany **(except Slidell**)	Washington Centerville (MS) McComb (MS) Woodville (MS)
Ursula Mercer (225) 216-6273	Bienville Bossier Caddo Caldwell Claiborne Catahoula Concordia East Carroll Franklin Jackson	LaSalle Lincoln Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Vicksburg (MS) Marshall (TX)
Kelli Nolan (225) 216-6260	East Baton Rouge East Feliciana Livingston	Pointe Coupee St. Helena West Feliciana
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin **(above Iberia)**
Sherry Wilkerson (225) 216-6306	Avoyelles Beauregard DeSoto Grant Natchitoches Rapides	Red River Sabine Vernon Winn Jasper (TX) Natchez (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. This includes provider's direct staff and billing agents or vendors. 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 in this packet 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.

PROGRAM MANAGER REQUESTS

Questions regarding the rationale for Medicaid policy and reimbursement should be directed in writing to:

Program Manager – EarlySteps Program
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

Questions regarding EarlySteps Program policy or issues should be directed in writing to :

Office of Citizens with Developmental Disabilities
EarlySteps Program
P.O. Box 3117, BIN #21
Baton Rouge, LA 70821

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) 925-6606	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 about the LaCHIP Program that 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.
Louisiana Medicaid 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 - OCDD	(866) 327-5978	Providers and recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4149	Providers may request termination as a recipient's lock-in provider.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (866) 758-5035	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) 342-0095 (866) 783-5553	Providers and recipients may request assistance regarding waiver services to waiver recipients.
Family Planning Waiver	(225) 219-4153	Providers may request assistance about the family planning waiver.
DHH Rate and Audit	(225) 342-6116	For LTC, Hospice, PACE, and ADHC providers to address rate setting and claims or audit issues.

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

Provider Relations cannot assist recipients. 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) 925-6606	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.
Louisiana Medicaid 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 – OCDD	(866) 327-5978	Recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Recipients may obtain immunization information.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (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) 342-0095 (866) 783-5553	Recipients may request assistance regarding waiver services.
Family Planning Waiver	(225) 219-4153	Recipients may request assistance regarding family planning waiver services.

NOTE: Providers should not give their provider 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.

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 www.lamedicaid.com web site; however, the following applications are the most commonly used:

- Medicaid Eligibility Verification System (e-MEVS) for recipient eligibility inquiries;
- 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
- 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 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.

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.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/offices/?ID=152: 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=334: EarlySteps Program

www.dhh.louisiana.gov/rar: DHH Rate and Audit Review (Information on Nursing Home, Adult Day Healthcare, Hospice, Administrative Claiming, Sub-Acute Care, PACE, and Assisted Living; Cost Reporting Information, Contacts and FAQ's.)

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

APPENDIX

- **EarlySteps Fee Schedule**
- **EarlySteps Place of Service Codes**
- **EarlySteps System Point of Entry (SPOE) List**
- **EarlySteps Regional Coordinators**
- **EarlySteps Individualized Family Service Plan (IFSP)**

EarlySteps FEE SCHEDULE

LOUISIANA MEDICAID EPSDT EARLY INTERVENTION SERVICES (EARLYSTEPS) FEE SCHEDULE
EFFECTIVE FOR DATES OF SERVICE FEBRUARY 1, 2005 AND FORWARD

COLUMN: 1	2	3	4	5
TOS	CODE	DESCRIPTION	FEE	UVS >001
22	90810	INTAC PSYTX, OFF, 20-30 MIN	31.50	X
27	90810	INTAC PSYTX, OFF, 20-30 MIN	27.00	X
28	90810	INTAC PSYTX, OFF, 20-30 MIN	25.50	X
22	90812	INTAC PSYTX, OFF, 45-50 MIN	63.00	
27	90812	INTAC PSYTX, OFF, 45-50 MIN	54.00	
28	90812	INTAC PSYTX, OFF, 45-50 MIN	51.00	
22	90846	FAMILY PSYTX W/O PATIENT	63.00	
27	90846	FAMILY PSYTX W/O PATIENT	54.00	
28	90846	FAMILY PSYTX W/O PATIENT	51.00	
22	90847	FAMILY PSYTX W/PATIENT	63.00	
27	90847	FAMILY PSYTX W/PATIENT	54.00	
28	90847	FAMILY PSYTX W/PATIENT	51.00	
22	90857	INTERACTIVE GROUP PSYCHOTHERAPY	21.00	
27	90857	INTERACTIVE GROUP PSYCHOTHERAPY	18.00	
28	90857	INTERACTIVE GROUP PSYCHOTHERAPY	17.00	
22	92506	SPEECH/HEARING EVALUATION	63.00	
27	92506	SPEECH/HEARING EVALUATION	54.00	
28	92506	SPEECH/HEARING EVALUATION	51.00	
22	92507	SPEECH/HEARING THERAPY	15.75	X
27	92507	SPEECH/HEARING THERAPY	13.50	X
28	92507	SPEECH/HEARING THERAPY	12.75	X
22	92508	SPEECH/HEARING THERAPY	15.75	X
27	92508	SPEECH/HEARING THERAPY	13.50	X
28	92508	SPEECH/HEARING THERAPY	12.75	X
22	92551	PURE TONE HEARING TEST, AIR	3.60	
27	92551	PURE TONE HEARING TEST, AIR	3.60	
28	92551	PURE TONE HEARING TEST, AIR	3.60	
22	92552	PURE TONE AUDIOMETRY, AIR ONLY	22.50	
27	92552	PURE TONE AUDIOMETRY, AIR ONLY	22.50	
28	92552	PURE TONE AUDIOMETRY, AIR ONLY	22.50	
27	92553	AUDIOMETRY, AIR & BONE	45.00	
27	92555	SPEECH AUDIOMETRY; THRESHOLD ONLY	9.00	
27	92556	SPEECH AUDIOMETRY; COMPLETE	22.50	
27	92557	COMPREHENSIVE HEARING TEST	54.00	
27	92563	TONE DECAY HEARING TEST	10.00	
27	92564	SHORT INCREMENT SENSITIVITY INDEX	20.00	
27	92565	STENGER TEST, PURE TONE	15.00	
22	92567	TYPANOMETRY	22.50	
27	92567	TYPANOMETRY	22.50	
28	92567	TYPANOMETRY	22.50	
22	92568	ACOUSTIC REFLEX TESTING	22.50	
27	92568	ACOUSTIC REFLEX TESTING	22.50	
28	92568	ACOUSTIC REFLEX TESTING	22.50	
22	92569	ACOUSTIC REFLEX DECAY TEST	36.00	

COLUMN: 1	2	3	4	5 UVS
27	92569	ACOUSTIC REFLEX DECAY TEST	36.00	
28	92569	ACOUSTIC REFLEX DECAY TEST	36.00	
27	92571	FILTERED SPEECH TEST	25.00	
27	92572	STAGGERED SPONDAIC WORD TEST	75.00	
27	92575	SENSORINEURAL ACUITY TEST	20.00	
27	92576	SYNTHETIC SENTENCE TEST	25.00	
27	92577	STENGER TEST, SPEECH	13.50	
22	92582	CONDITIONING PLAY AUDIOMETRY	45.00	
27	92582	CONDITIONING PLAY AUDIOMETRY	45.00	
28	92582	CONDITIONING PLAY AUDIOMETRY	45.00	
27	92583	SELECT PICTURE AUDIOMETRY	22.50	
22	92584	ELECTROCOCHLEOGRAPHY	200.00	
27	92584	ELECTROCOCHLEOGRAPHY	200.00	
28	92584	ELECTROCOCHLEOGRAPHY	200.00	
22	92585	AUDITOR EVOKE POTENT, COMPRE	180.00	
27	92585	AUDITOR EVOKE POTENT, COMPRE	180.00	
28	92585	AUDITOR EVOKE POTENT, COMPRE	180.00	
22	92586	AUDITORY EVOKED POTENT, LIMITED	50.00	
27	92586	AUDITORY EVOKED POTENT, LIMITED	50.00	
28	92586	AUDITORY EVOKED POTENT, LIMITED	50.00	
22	92587	EVOKED AUDITORY TEST, LIMITED	25.00	
27	92587	EVOKED AUDITORY TEST, LIMITED	25.00	
28	92587	EVOKED AUDITORY TEST, LIMITED	25.00	
22	92588	EVOKED AUDITORY TEST, COMPREHENSIVE	50.00	
27	92588	EVOKED AUDITORY TEST, COMPREHENSIVE	50.00	
28	92588	EVOKED AUDITORY TEST, COMPREHENSIVE	50.00	
27	92590	HEARING AID EXAM/SELECTION; MONAURAL	65.00	
27	92591	HEARING AID EXAM & SELECTION BINAURA	65.00	
22	92592	HEARING AID CHECK; MONAURAL	22.50	
27	92592	HEARING AID CHECK; MONAURAL	22.50	
28	92592	HEARING AID CHECK; MONAURAL	22.50	
22	92593	HEARING AID CHECK; BINAURAL	45.00	
27	92593	HEARING AID CHECK; BINAURAL	45.00	
28	92593	HEARING AID CHECK; BINAURAL	45.00	
22	92594	ELECTROACOUSTIC EVAL F HEAR AID;MON	22.50	
27	92594	ELECTROACOUSTIC EVAL F HEAR AID;MONA	22.50	
28	92594	ELECTROACOUSTIC EVAL F HEAR AID;MONA	22.50	
22	92595	ELECTROACOUSTIC EVAL HEAR AID;BINAU	45.00	
27	92595	ELECTROACOUSTIC EVAL HEAR AID;BINAUR	45.00	
28	92595	ELECTROACOUSTIC EVAL HEAR AID;BINAUR	45.00	
22	96100	PSYCHOLOGICAL TESTING	63.00	
27	96100	PSYCHOLOGICAL TESTING	54.00	
28	96100	PSYCHOLOGICAL TESTING	51.00	
22	96101	PSYCH TESTING BY PSYCH/PHYS	63.00	
27	96101	PSYCH TESTING BY PSYCH/PHYS	54.00	
28	96101	PSYCH TESTING BY PSYCH/PHYS	51.00	
22	97001	PT EVALUATION	63.00	
27	97001	PT EVALUATION	54.00	
28	97001	PT EVALUATION	51.00	
22	97003	OT EVALUATION	63.00	
27	97003	OT EVALUATION	54.00	
28	97003	OT EVALUATION	51.00	
22	97032	ELECTRICAL STIMULATION	15.75	X
27	97032	ELECTRICAL STIMULATION	13.50	X

COLUMN: 1	2	3	4	5 UVS
28	97032	ELECTRICAL STIMULATION	12.75	X
22	97110	THERAPEUTIC EXERCISES	15.75	X
27	97110	THERAPEUTIC EXERCISES	13.50	X
28	97110	THERAPEUTIC EXERCISES	12.75	X
22	97112	NEUROMUSCULAR REEDUCATION, EA 15 MIN	15.75	X
27	97112	NEUROMUSCULAR REEDUCATION, EA 15 MIN	13.50	X
28	97112	NEUROMUSCULAR REEDUCATION,EA 15 MIN	12.75	X
22	97116	GAIT TRAINING THERAPY, EACH 15 MIN	15.75	X
27	97116	GAIT TRAINING THERAPY, EACH 15 MIN	13.50	X
28	97116	GAIT TRAINING THERAPY,EACH 15 MIN	12.75	X
22	97124	MASSAGE THERAPY	15.75	X
27	97124	MASSAGE THERAPY	13.50	X
28	97124	MASSAGE THERAPY	12.75	X
22	97504	ORTHOTIC TRAINING, EACH 15 MIN	15.75	X
27	97504	ORTHOTIC TRAINING,EACH 15 MIN	13.50	X
28	97504	ORTHOTIC TRAINING, EACH 15 MIN	12.75	X
22	97530	THERAPEUTIC ACTIVITIES 15 MIN	15.75	X
27	97530	THERAPEUTIC ACTIVITIES 15 MIN	13.50	X
28	97530	THERAPEUTIC ACTIVITIES 15 MIN	12.75	X
22	97750	PHYSICAL PERFORMANCE TEST, 15 MIN	15.75	X
27	97750	PHYSICAL PERFORMANCE TEST, 15 MIN	13.50	X
28	97750	PHYSICAL PERFORMANCE TEST, 15 MIN	12.75	X
22	97760	ORTHOTIC MGMT AND TRAINING	15.75	X
27	97760	ORTHOTIC MGMT AND TRAINING	13.50	X
28	97760	ORTHOTIC MGMT AND TRAINING	12.75	X

LOUISIANA MEDICAID EPSDT EARLY INTERVENTION SERVICES (EARLYSTEPS) FEE SCHEDULE
EFFECTIVE FOR DATES OF SERVICE FEBRUARY 1, 2005 AND FORWARD
LEGEND

Listed below are some aids we hope will help you understand this fee schedule. If, after reading the information below, you need further clarification of an item, please call Unisys Provider Relations at 1-800-473-2783.

ALL CLAIMS MUST CARRY A POS (PLACE OF SERVICE) AND A VALID PROCEDURE MODIFIER.

COLUMN 1. TOS (Type Of Service): Definition: Files on which codes are loaded and from which claims are paid. The file to which a claim goes for pricing is determined by, among other things, the type of provider who is billing, the POS (Place of Service) and by the modifier appended to the procedure code.

Listed below is an explanation of the Types of Service found on this schedule. A combination of a Place of Service (POS) Code and a valid Procedure Modifier determine the Type of Service.

TOS 22 - For services rendered in the Natural Environment (Home & Community). "Community": Environment where children of same age with no disabilities or Special needs participate such as childcare centers, agencies, libraries and other community settings.

POS/modifier combination must be one of these two choices:

POS 12 (Home) and Procedure Modifier U8, or

POS 99 (Other Place of Service) and Procedure Modifier U8

TOS 27 - For services rendered in a Special Purpose Facility/Inclusive Childcare: Childcare center, nursery schools, preschools with at least 50% with no disabilities or developmental delays.

POS/modifier combination must be:

POS 99 and Procedure Modifier TJ

TOS 28 - For services rendered in a Center Based Special Purpose Facility: Center where only children with disabilities or developmental delays are served. POS/modifier combination must be:

POS 99 and Procedure Modifier SE

COLUMNS 2, 3 and 4. CODE, DESCRIPTION and FEE: Self-explanatory.

COLUMN 5. UVS>001: An ’X’ in this column means more than one unit of service per day can be billed.

Place of Service Codes

Current codes and descriptions are maintained at posinfo@cms.hhs.gov.

Place of Service Code	Place of Service Name	Place of Service Description
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
99	Other Place of Service	Other place of service not identified above.

NOTE: Providers should contact their EarlySteps Regional Coordinator with any questions concerning Place of Service concerns. Providers must request an exception through the EarlySteps Program when situations occur involving service delivery at a Place of Service (POS) that does not clearly fall within the outlined criteria and guidelines. These exceptions must be reviewed and approved by the EarlySteps Program as determined through the IFSP.

EarlySteps
Louisiana's Early Intervention System
System Point of Entry (SPOE's)

DHH Region	SPOE	Parishes	Contractor-Information
1	Jefferson Parish Human Service Authority	Orleans, St. Bernard, Jefferson , Plaquemines	**Lynne-Marie Ruckert, Program Supervisor** 201 Evans Road Bldg 1 Suite 100 Harahan, LA 70123 Phone (504) 888-7530 Toll Free 1-866-296-0718 Fax (504) 838-5284 E-mail: lruckert@fhfgno.org
2	Southeast Louisiana Area Health Education Center	East Baton Rouge, West Baton Rouge, East Feliciana, West Feliciana, Pointe Coupee, Iberville, Ascension	**Brian Jakes III, Program Manager** 3060 Teddy Drive Suite A Baton Rouge, LA 70809 Phone (225) 925-2626 Toll Free 1-866-925-2426 Fax (225) 925-1370 E-mail: ahecbpj@I-55.com
3	Southeast Louisiana Area Health Education Center	Assumption, St. John, St. Charles, St. James, Terrebonne, Lafourche, St. Mary	**Brian Jakes III, Program Manager** 602 Parish Road Thibodaux, LA 70301 Phone (985) 447-6550 Toll Free 1-866-891-9044 Fax (985) 447-6513 E-mail: ahecbpj@I-55.com
4	First Steps Referral and Consulting LLC	Lafayette, Iberia, St. Martin, Vermillion, St. Landry, Evangeline, Acadia	**Mary F. Hockless, CEO** 134 East Main Street, Suite 4 New Iberia, LA 70560 Phone (337) 359-8748 Toll Free 1-866-494-8900 Fax (337) 359-8747 E-mail: teamfsrc@bellsouth.net
5	First Steps Referral and Consulting LLC	Beauregard, Jefferson Davis, Allen, Cameron, Calcasieu	**Mary F. Hockless, CEO** 134 East Main Street, Suite 4 New Iberia, LA 70560 Phone (337) 359-8748 Toll Free 1-866-494-8900 Fax (337) 359-8747 E-mail: teamfsrc@bellsouth.net
6	Families Helping Families at the Crossroads of Louisiana	Vernon, Rapides, Winn, Grant, LaSalle, Catahoula, Concordia, Avoyelles	**Teresa Harmon, Program Supervisor** 2840 Military Highway Suite B Pineville, LA 71360 Phone (318) 640-7078 Toll Fee 1-866-445-7672 Fax (318) 640-5799 E-mail: tjharmon891@hotmail.com
7	Families Helping Families at the Crossroads of Louisiana	Caddo, Bossier, Webster, Claiborne, Bienville, Natchitoches, Sabine, DeSoto, Red River	**Rebecca Thornton, Program Supervisor** 2620 Centenary Blvd. Bldg. 2 Suite 249 Shreveport, LA 71104 Phone (318) 226-8038 Toll Free 1-866-676-1695 Fax (318) 425-8295 E-mail: jennifer@spoe.ntcmail.net
8	Easter Seals of Louisiana	Ouachita, Union, Jackson, Lincoln, Caldwell, Morehouse, West Carroll, East Carroll, Richland, Franklin, Tensas, Madison	**Peyton Fisher, Director** 1300 Hudson Lane, Suite B Monroe, LA 71201 Phone (318) 322-4788 Toll Free 1-877-322-4788 Fax (318) 322-1549 Email: pfisher@bayou.com
9	Southeast Louisiana Area Health Education Center	St. Tammany, Livingston, Tangipohoa, Washington, St. Helena	**Brian Jakes III, Program Manager** 1302 J.W. Davis Drive Hammond, LA 70403 Phone (985) 429-1252 Toll Free 1-866-640-0238 Fax (985) 429-1613 Email: ahecbpj@I-55.com

EarlySteps
Regional Coordinators
10-2007

Region 1
Joyce Ridgeway
Metropolitan Regional Office
1010 Common St., Suite 700
New Orleans, LA 70112
Office #: (504) 599-0235
Fax #: (504) 599-0236
Email: jridgeway@dhh.la.gov

Region 2
Valencia Allen
Region 2 OCDD Waiver Office
6554 Florida Blvd
Office #: (225) 925-6421
Fax #: 9225) 925-6298
Email: vallen@dhh.la.gov

Region 3
Timothy Butler
Region III OCDD Office
609 E. 1st Street
Thibodaux, LA 70301
Office #: (985) 449-5167
Fax #: (985) 449-5172
Email: tjbutler@dhh.la.gov

Region 4
Monica Dowden
Region IV OCDD Office
214 Jefferson Street
Bldg. 3, Suite 301
Lafayette, LA 70508
Office #: (337) 262-1890
Fax #: (337) 262-5233
Email: mdowden@dhh.la.gov

Region 5
Steven Ivey
Southwest Regional Office
707 A East Prien Lake Rd.
Lake Charles, LA 70601
Office #: (337) 475-4827
Fax #: (337) 475-8055
Email: SIvey@dhh.la.gov

Region 6
Penny Thibodeaux
Central Regional Office
429 Murray St. Suite B.
Alexandria, LA 71301
Office #: (318) 484-2449 or 2347
Fax #: (318) 484-2458
Email: pthibode@dhh.la.gov

Region 7
April Hearron
Regional VII OCDD Office
3018 Old Minden Rd. #1211
Bossier City, LA 71112
Office #: (318) 741-2729
Fax #: (318) 741-7445
Email: AHEARRON@dhh.la.gov

Region 8
Kathy Waxman
Northeast Regional Office
122 St. John St. Suite 343
Monroe, LA 71211
Office #: (318)-362-5197
Fax #: (318) 362-5305
Cell #: (318) 376-6826
Email: kwaxman@dhh.la.gov

Region 9
Wanda Stroud
Southeast Regional Office
21454 Koop Dr., Suite 2-H
Mandeville, LA 70471
Office#: (985) 871-8300
Fax #: (985) 871-8303
Cell #: (985) 320-3292
Email: wstroud@dhh.la.gov

Central Office—Provider Specialist
Leona White
(504) 599-0248
(504) 599-0236
lswhite@dhh.la.gov

Individualized Family Service Plan

*Indicates information to be entered and stored electronically at the System Point of Entry

Section 1 Child Information			
*Child's name: (Last/First/MI)	*Nickname:		*Gender: Circle one M or F
*Home address:	*Mailing address:		
*City/Town:	*Zip Code:	*Parish of Residence:	
*Date of Birth:	*Current Age/Adjusted Age:	Today's date:	

Child's Medicaid Number (if applicable): _ _ _ _ _ _ _ _ _ _ _ _ _

Section 1 A. General Contact Information		**Section 1 B. IFSP History & Family Support Coordinator**	
*Parent/Guardian:		Name of FSC:	
*Relationship to child:		Telephone:	
Telephone: Home: _____		IFSP History	
Work: _____		Date of Initial IFSP	Projected Date of Annual IFSP
Cell: _____			
Best time to call:	Other Contact:	***Type of IFSP and Date***	
	Name:	☐ Interim	☐ 6 month Review
	Relationship:	☐ Initial	☐ Transition
		☐ Annual	☐ Review/Revision
Telephone: Home: _____		Notes:	
Work: _____			
Cell: _____			

Notice of Action—IFSP Development: The IFSP is the documentation of a team discussion. The IFSP reflects the strategies and services needed to support the achievement of the outcomes identified by the team. We are proposing to implement this plan of early intervention services that have been individualized to meet the needs of the child and family listed above. The family has received a copy of the Parent's Rights.

May 2006

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 2: Summary of Family Concerns, Priorities, and Resources to enhance the development of their child

Date Completed: _____

Check appropriate box: ☐ Family assessment completed with family concurrence

☐ Family declined family assessment of concerns, priorities and resources (Parent signature)_____

We have concerns about the routines and activities listed below. Please review the Family Assessment of CPR for details.

☐ Physical (Moving):	☐ Cognitive/Communication (Understanding and communicating - acquisition and use of knowledge and skills (including early language/ communication):	☐ Cognitive (Thinking/Learning-Acquisition and use of knowledge and skills):	☐ Social/ Emotional (Getting along with others-use of appropriate behaviors to meet his/her needs):	☐ Adaptive (Doing things for him or herself- use of appropriate behaviors to meet his/her needs):
☐Priority	☐Priority	☐Priority	☐Priority	☐Priority
Outcome #:	Outcome #:	Outcome #:	Outcome #:	Outcome #:
Strengths, resources that our family has to help meet our child's needs:				

Child's Name: _____ Last/First/MI	Date of Birth:_____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy	

Section 3: Present Level of Functioning/Development

Information from parent input/CPR, CBA CDA, ASQ

☐ Physical (Moving):	☐ Cognitive/Communication (Understanding and communicating - acquisition and use of knowledge and skills (including early language/ communication):
☐ Cognitive (Thinking/Learning-Acquisition and use of knowledge and skills):	☐ Social/ Emotional (Getting along with others-use of appropriate behaviors to meet his/her needs):
☐ Adaptive (Doing things for him or herself- use of appropriate behaviors to meet his/her needs):	Current health status: Summarize information from the most recent health history, health records & parent input
Vision Screening	***Hearing Screening***
Recently checked *(circle one)* Y or N	Recently checked *(circle one)* Y or N
Date of screening:	Date of screening:
By Whom:	By Whom:
Results:	Results:

Section 4a: Outcomes for child Complete and attach a separate page for each outcome.

Outcome Number ____:	What's happening now?	Our team will be satisfied that we are finished with this outcome when (criteria for measuring progress):

What skills and behaviors do we want this child and family to accomplish in the next 3-6 months? (timeline; 3 & 6 month required to be completed)

In 3 months:_____

In 6 months:_____

_____

These are the strategies we will use to enhance this child's pre-literacy and language skills (if applicable):

- ☐ encourage book handling behaviors, such as turning pages
- ☐ promote behaviors that encourage child to pay attention to pictures in a book, such as gazing at a picture or laughing at a favorite picture
- ☐ encourage behaviors that show the beginning understanding of "concepts", such as pointing to the pictures of all cars on a page, or identifying common objects
- ☐ encourage behaviors, which show the child's understanding of pictures and events in a story, such as imitating an action seen in a picture or talking about the events in the story
- ☐ encourage behaviors where the child interacts with the book, for instance babbling in imitation of reading or running his/her fingers along the printed words
- ☐ other

What strategies will the family use in their daily routines and activities to achieve the outcome?

☐ verbal prompting/ instructing	☐ with adaptive equipment	☐ with environmental modifications
☐ modeling (with verbal prompting)	☐ with adaptive equipment	☐ with environmental modifications
☐ gesturing (with verbal prompting)	☐ with adaptive equipment	☐ with environmental modifications
☐ physically assisting/supporting/guiding (with verbal prompting)	☐ with adaptive equipment	☐ with environmental modifications
☐ other		

With whom will these strategies be practiced?

☐ family members ☐ relatives ☐ child care staff
☐ other:_____

Where can these strategies be practiced?

☐ special purpose facility ☐ special purpose facility with inclusive childcare
☐ community setting ☐ other:_____
☐ home

We will measure progress towards the achievement of this outcome by:

☐ observation ☐ progress reports
☐ assessment/evaluation by team
☐ other:_____

Daily living routine addressed by this outcome:

☐ bathing ☐ dressing
☐ eating ☐ potty training
☐ playing indoors ☐ playing outdoors
☐ sleeping/napping ☐ other:_____

Section 4b: Outcomes for family Complete and attach a separate page for each outcome (if applicable).

Outcome Number ____:	What's happening now?	Our team will be satisfied that we are finished with this outcome when (criteria for measuring progress):

What skills and behaviors do we want this child and family to accomplish in the next 3-6 months? (timeline; 3 & 6 month required to be completed)

In 3 months: _____

In 6 months:

_____

What strategies will the family use in their daily routines and activities to achieve the outcome?

□ Action to be taken:

□ Counseling sessions to attend:

□ Skills/behaviors to be learned:

□ Classes/groups to attend:

□ Other:

With whom will these strategies be practiced?	Where can these strategies be practiced?
☐ family members ☐ relatives ☐ child care staff □ other:_____	☐ special purpose facility ☐ special purpose facility with inclusive childcare ☐ community setting ☐ other:_____ ☐ home
We will measure progress towards the achievement of this outcome by: ☐ observation ☐ parental report ☐ reports from (identify the individual): ☐ other	Notes:

Section 4c: Outcomes for child and family – Service Coordination

Outcome Number ____: Service coordination will be provided to ensure that services are provided according to the IFSP and that the family is aware of various appropriate community resources.	What's happening now?	Our team will be satisfied that we are finished with this outcome when (criteria for measuring progress):

What skills and behaviors do we want this child and family to accomplish in the next 3-6 months? (timeline; 3 & 6 month required to be completed)

In 3 months: _____

In 6 months:

_____

Strategies which the service coordinator will use:

☐ Telephone calls ☐ set up and hold meetings ☐ complete required paperwork ☐ link family to community resources, as needed

☐ Coordination of services ☐ other:_____

We will measure progress towards the achievement of this outcome by: ☐ observation ☐ progress reports ☐ case notes ☐ quarterly progress summary ☐ other:_____	Notes:

Child's Name: _____ Last/first/middle	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 5: Transition Planning: Early Transition and Transition at Age Three

A. Plan for Transition **Must be discussed at each IFSP meeting.**		**Sign/Initial**	**Date of Discussion**
Procedures we will use to prepare the child for the upcoming transition: ☐ Discussed procedures to prepare the child for changes in service delivery. ☐ Discussed with parents future placements and other matters related to the child's transition. ☐ Discussed with parents community programs available following transition from Part C.	Program options identified by the team (check all that apply): ☐ Part B ☐ Head Start/ Early Head Start ☐ Day Care ☐ Other community resources ☐ Other: _____	A plan for transition at Age 3 has been discussed: ☐ FSC: _____ ☐ Parent: _____	____/____/____
B. Early Transition Event and Issue Check the appropriate box, if applicable	***Early Transition Plan (1 & 2 required)***	***Sign/Initial***	***Date of Discussion***
☐ Child is coming home from hospital; need to ensure no disruption of necessary services ☐ Family will be experiencing a change that may affect the delivery of an IFSP service (birth or adoption of sibling, medical needs of other family members, employment or loss of employment) ☐ Child will be experiencing a change that may affect the delivery of an IFSP service (i.e., hospitalization, placement in child care setting, medication changes, etc) ☐ Changes in IFSP services (i.e., termination/addition of service, change in location of service) ☐ Early Exit Before Age Three: Child is exiting EarlySteps. ☐ Plan for disposition of Assistive Device, if applicable: ☐ Schedule AEPS-RV; Date AEPS-RV Requested:_____/_____/_____	1. We have held the following discussions concerning future services with the parents: 2. We will use the following procedures to prepare the child for the change in service delivery:	Early transition events and issues have been discussed: ☐ FSC: _____ ☐ Parent: _____	1. ___/___/___ 2. ___/___/___
C. Transition At Age Three			
☐ LEA was notified of child's upcoming transition: ☐ Child specific records were sent to the LEA ☐ Parent did not consent to releasing information to the LEA ☐ Schedule AEPS-RV; Date AEPS-RV Requested:_____/_____/_____	Date of Notification Letter Mailed to LEA: ____/____/____ Date consent to send records obtained: ____/____/_____	Date of Transition Meeting: ____/____/____	
This child requires a referral for OCDD eligibility determination ☐ yes ☐ no If yes, date referral packet sent: _____/_____/_____			

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 6: Early Intervention Services *This entire page is part of the electronic record. Attach page 6A if Assistive Technology and/or Transportation are necessary to achieve the IFSP outcomes. Use codes as listed here for completion.

Column A Early Intervention Service	**B Outcome Number**	**C Location**	**D Frequency**	**E** ***1.1.1.1.1 Intensity***	**F Start Date**	**G End Date**	**H Method**	**✓ one**	**I Funding Source**	**J Provider's Name/Payee Type (including name of agency)**
Service Coordination								☐ Individual ☐ Group		☐ Independent ☐ Agency ☐ No Provider Available Name:
								☐ Individual ☐ Group		☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):
								☐ Individual ☐ Group		☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):
								☐ Individual ☐ Group		☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):
								☐ Individual ☐ Group		☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):

Section K: Primary Setting: What is the setting where the majority of services will be provided? Choose one from list below.

☐ home ☐ community setting ☐ special purpose center ☐ hospital ☐ residential facility ☐ service provider setting ☐ other setting

****LEGEND**

Column C - Location	**Column H - Method**	**Column - Funding**
1= home/community setting	1 =Early intervention service	A= CFO
5=special purpose center w/inclusive childcare	2= Family education/training	C= MFP
6=special purpose center or clinic	3=Assessment	

Parent Consent for Services: The contents of this IFSP have been fully explained to me. I give informed, written consent to implement the services described in Section 7 of the IFSP. I have received a written copy of our Parent's Rights in EarlySteps. **I understand that EarlySteps must wait at least 3 calendar days before taking any action.** I understand that I can revoke the consent for any service at any time.

_____

Parent Signature Date

Section 7A. Complete this page as needed

Assistive Technology Device

Child's Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __

IFSP Outcome Number	*Name of Device	*Vendor Providing Device	Where is device used?	When is device used? *indicate activities	*Start date for device use	*End date for device use	*HCPCs Code	*Price/Cost
	Is this covered by Medicaid? Yes No Did Medicaid provide? Yes No If no - attach copy of Medicaid denial letter.		☐ Home ☐ Child care ☐ Relative's home ☐ Community setting: _____ ☐ Other:					
	Is this covered by Medicaid? Yes No Did Medicaid provide? Yes No If no - attach copy of Medicaid denial letter.		☐ Home ☐ Child care ☐ Relative's home ☐ Community setting: _____ ☐ Other:					
Approval required for any item costing over $500 or if total of all items is more than $500.00							Total cost for all AT Devices listed: $	

I understand that any equipment provided by EarlySteps over $500 is the property of the state of Louisiana and I may be required to return this equipment upon my child's exit from EarlySteps.

Parent Signature: _____

Section 7B: Transportation Necessary to access Early Intervention Services

IFSP Outcome Number	*Start Date	*End Date	*Provider (Parent Name)	*Frequency	*Maximum miles per trip expressed as round trip

Section 8: Other Services Needed to Enhance Child's Development

Service	Family or Child Service (circle)	Responsible Person Contact Information	Funding Source or Steps to secure service
Primary Medical Home or Physician	Child		
	Child Family		
	Child Family		
	Child Family		
	Child Family		

Section 9: IFSP Team (only those who assessed or tested the child may contribute by attending meeting, conference call or report)

Printed Name	Position/Role	Agency (if applicable)	Telephone Number	Signature or Method of Participation
	Parent			Signature:
	IC (only at initial IFSP)			Signature:
	EIC (requiredfor informed clinical opinion)			Signature:
	FSC			Signature:
	CDA Provider			☐ Telephone ☐ Report Signature:
	Provider			☐ Telephone ☐ Report Signature:
				☐ Telephone ☐ Report Signature:
				☐ Telephone ☐ Report Signature:

Section 10: Justification for Early Intervention Services Delivered Outside of the Natural Environment
Complete and attach to the IFSP only as required.

☐ **IFSP Revision**
☐ **6 Month Review w/ Revision**

Early Intervention Service Not Provided in Natural Environment	Child specific reason why early intervention can not be satisfactorily achieved in a natural environment: Data to support this team decision:	How will services be incorporated into the Natural Environment? ☐ Provider will send a note home after each session for the family ☐ Provider will talk with the parent every 2 weeks regarding the child's progress ☐ Provider will send home information on the strategies the child is learning, so the parent can incorporate these strategies into the child's routine at home ☐ The parent will call the provider if he/she is unclear on how to implement a new strategy ☐ Parent or caregiver will participate in sessions when possible ☐ Other: _____
Early Intervention Service Not Provided in Natural Environment	Child specific reason why early intervention can not be satisfactorily achieved in a natural environment: Data to support this team decision:	How will services be incorporated into the Natural Environment? ☐ Provider will send a note home after each session for the family ☐ Provider will talk with the parent 2 weeks regarding the child's progress ☐ Provider will send home information on the strategies the child is learning, so the parent can incorporate these strategies into the child's routine at home ☐ The parent will call the provider if he/she is unclear on how to implement a new strategy ☐ Parent or caregiver will participate in sessions when possible ☐ Other: _____
Early Intervention Service Not Provided in Natural Environment	Child specific reason why early intervention can not be satisfactorily achieved in a natural environment: Data to support this team decision:	How will services be incorporated into the Natural Environment? ☐ Provider will send a note home after each session for the family ☐ Provider will talk with the parent 2 weeks regarding the child's progress ☐ Provider will send home information on the strategies the child is learning, so the parent can incorporate these strategies into the child's routine at home ☐ The parent will call the provider if he/she is unclear on how to implement a new strategy ☐ Parent or caregiver will participate in sessions when possible ☐ Other: _____