# Letter Examples

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 04/17/2009
PRIOR AUTH. NBR [redacted]

PROVIDER NAME [redacted]
PROVIDER NUMBER [redacted]

**********
* THIS IS NOT A BILL *
**********

ECIPIENT NUMBER [redacted]
N NUMBER

AR: [redacted]

IS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/
RVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.
ANY OF THE APPROVED ASTERISKED(*) SERVICES ARE REQUIRED BEYOND THE APPROVED DATES
SERVICE, YOUR SERVICE PROVIDER MUST FILE A REQUEST FOR A CONTINUATION OF APPROVED
RVICES BY 03/25/2009 (25 DAYS BEFORE THE END OF THE APPROVED SERVICE DATE). UNLESS
UR SERVICE PROVIDER SUBMITS DOCUMENTATION TO SUPPORT THE REQUEST FOR CONTINUATION
SERVICES BY 03/25/2009, THESE SERVICES WILL BE TERMINATED.

| OCEDURE/MOD1/MOD2/DESCRIPTION | UVS/AMOUNT | DATES OF SERVICE | STATUS |
|---|---|---|---|
| 4152/BO/ -ORAL FORMULA | $ 184.50 | 03/26/2009-04/19/2009 | APPROVED |

YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL THIS DECISION.
RING THE APPEAL PROCESS, YOU HAVE THE RIGHT TO A HEARING AT WHICH ADDITIONAL
IDENCE CAN BE SUBMITTED TO SUPPORT YOUR REQUEST FOR THE SERVICE.
YOU WISH TO APPEAL THIS DECISION, PLEASE WRITE TO THE OFFICE OF THE
CRETARY, BUREAU OF APPEALS, P.O.BOX 4183,BATON ROUGE, LA 70821-4183, BY 05/17/2009
O DAYS FROM THE DATE OF THIS NOTICE). IF CLARIFICATION ON THIS DECISION IS
EDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS, 1-800-488-6334.

IS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY. PAYMENT ON
CLAIM WILL ONLY BE MADE WHEN THE CLAIM IS BILLED CORRECTLY AND ALL CONDITIONS FOR
YMENT ARE MET.

CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE APPROPRIATE REFERRALS TO BE PAID.

UNISYS EDI
ISSUE DATE: 04/30/2009

XXXX XXXXXXXXXX XXXXXXXXXXXX PROVIDER #: XXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXX XX 00000

DEAR MEDICAID PROVIDER:

THE UNISYS EDI DEPARTMENT HAS RECEIVED ELECTRONIC CLAIMS FOR YOUR PROVIDER NUMBER THAT WERE SUBMITTED BY AN EDI SUBMITTER WHO IS NOT LINKED TO YOUR PROVIDER NUMBER. BECAUSE WE HAVE NO RECORD AUTHORIZING US TO ACCEPT CLAIMS FROM THE SUBMITTER ON YOUR BEHALF, THESE CLAIMS WERE DROPPED FROM PROCESSING AND DELETED FROM THE SYSTEM.

AS OF OCTOBER 1, 2001 EACH THIRD PARTY BILLER OR VENDOR WHO SUBMITS ELECTRONIC CLAIMS ON YOUR BEHALF MUST BE PROPERLY LINKED TO YOUR PROVIDER NUMBER. TO LINK YOUR PROVIDER NUMBER TO THIS SUBMITTER, YOU MUST DO THE FOLLOWING:

1) COMPLETE A "PROVIDERS ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM".

2) COMPLETE THE EDI CONTRACT IN ITS ENTIRETY, HAVE THE POWER OF ATTORNEY NOTARIZED AND MAIL THE CONTRACT TO:
UNISYS - PROVIDER ENROLLMENT
PO BOX 80159
BATON ROUGE, LA 70898-0159

TO REQUEST AN EDI SUBMISSION PACKET (INCLUDING THE ABOVE CONTRACT) CALL THE EDI DEPARTMENT AT (225) 216-6303. YOU MAY RESUME EDI CLAIM SUBMISSION AFTER THE CONTRACT HAS BEEN RECEIVED AND PROCESSED. ALL CLAIMS SUBMITTED DURING THE PAST WEEK BY THE SUBMITTER COPIED ON THIS LETTER MUST BE RESUBMITTED.

THANK YOU FOR YOUR PROMPT ATTENTION TO THIS MATTER.

CC: SUBMITTER - XXXXXXX

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 04/30/2009
PRIOR AUTH. NBR 911750018
RECIPIENT NAME [redacted]
RECIPIENT NUMBER [redacted]

ERROR PROVIDER *
[redacted]

PROVIDER NUMBER [redacted]

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

| PROCEDURE/MOD1/MOD2/DESCRIPTION | UVS/AMOUNT | DATES OF SERVICE | STATUS |
|---|---|---|---|
| 97530 -THERAPEUTIC ACTIVITIES 15 | | 04/08/2009-10/08/2009 | DENIED |

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW, IN ACCORDANCE WITH POLICY REFERENCED IN CHAPTER 17 OF THE MEDICAL SERVICES MANUAL, PAGE 6-1 THROUGH 19-2.
* - RECIPIENT IS NOT ON FILE

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

# LOUISIANA DRUG UTILIZATION REVIEW
# LOUISIANA MEDICAID PHARMACY BENEFITS MANAGEMENT PROGRAM
# P.O. BOX 4169 BATON ROUGE, LA 70821

JANUARY 27, 2009 RE: [redacted], MEDICAID ID: [redacted]

[redacted] MD

The Louisiana Drug Utilization Review (LADUR) program, under the direction of the Department of Health and Hospitals (DHH), has identified Louisiana Medicaid recipients who may have a drug-related issue described on the reverse side of this letter. The prescription data displayed is based on paid pharmacy claims.

LADUR criteria are not intended to replace the judgment of the clinician. Please consider that our data is limited and that we recognize that patient-specific instances may account for drug utilization beyond our criteria. However, providers are not always aware that other physicians are involved in their patient's care or that a potential drug-related issue exists. Additionally, you may not be the prescribing physician but may otherwise be involved in the patient's care.

The LADUR program wishes to provide worthwhile information to assist in the care of Louisiana Medicaid recipients. The criteria, along with the patient's drug utilization profile, are provided for your evaluation. Your response is a valuable tool used to refine and update this educational program. **Please use the reverse side of this letter for your response and return it in the enclosed envelope or fax it to 225-216-6334 (attention: S. Delaville).**

We appreciate your service to Louisiana Medicaid recipients and your support of the LADUR program.

**UNISYS** *LOUISIANA MEDICAID*

*1-800-473-2783*

[redacted]

DEAR PROVIDER:

WE HAVE IDENTIFIED ONE OR MORE ERRORS ON THE ENCLOSED CLAIM FORM(S). WITHOUT THE REQUESTED INFORMATION, WE ARE NOT PERMITTED TO PROCESS YOUR CLAIM(S). PLEASE MAKE THE NECESSARY CORRECTIONS, REVIEW ALL DATA ON THE CLAIM FORM FOR ACCURACY, AND RETURN THE CORRECTED CLAIMS(S) TO THE P.O. BOX FOR YOUR PROVIDER TYPE AS LISTED IN YOUR PROVIDER MANUAL.

130 **7-DIGIT LOUISIANA MEDICAID PROVIDER NUMBER MISSING FROM BOX 33B.**

TO RESOLVE ANY QUESTIONS CONCERNING THIS REQUEST OR IF YOU NEED BILLING ASSISTANCE, REFER TO YOUR LOUISIANA MEDICAID PROVIDER MANUAL OR CONTACT THE UNISYS PROVIDER RELATIONS DEPARTMENT AT 1-800-473-2783. THIS LETTER CANNOT BE USED AS PROOF OF TIMELY FILING.

1004279

MD

PROVIDER ID:
MEDICAID ID:
BIRTH DATE:

PRODUCT NAME(S) 1)ABILIFY 12/22/2008
2)SEROQUEL 12/22/2008
PROBLEM DESCRIPTION: REFERENCE NUMBER 36199 EFF DATE 20081230
CONCURRENT USE OF ANTIPSYCHOTIC AGENTS (QUETIAPINE & ARIPIPRAZOLE)
PLEASE CHECK YOUR RESPONSE AND COMMENT WHEN APPROPRIATE
_____ AWARE OF ISSUE / NO ACTION NECESSARY
_____ PLAN TO TAKE ACTION (D/C DRUG; CHANGE DOSE; ORDER LAB)
_____ PLAN CONSULTATION (W/PATIENT, RPH, OR MD)
_____ DATA ACCURACY (PATIENT, MD, OR DRUG HISTORY DATA)
COMMENTS:

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PRODUCT NAME(S) 1)ABILIFY 12/22/2008
PROBLEM DESCRIPTION: REFERENCE NUMBER 36414 EFF DATE 20081230
ARIPIPRAZOLE: EXCEEDS MAXIMUM RECOMMENDED DOSE (30MG)
PLEASE CHECK YOUR RESPONSE AND COMMENT WHEN APPROPRIATE
___1___ AWARE OF ISSUE / NO ACTION NECESSARY
_____ PLAN TO TAKE ACTION (D/C DRUG; CHANGE DOSE; ORDER LAB)
_____ PLAN CONSULTATION (W/PATIENT, RPH, OR MD)
_____ DATA ACCURACY (PATIENT, MD, OR DRUG HISTORY DATA)
COMMENTS:

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LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
THERAPEUTIC DRUG UTILIZATION REVIEW SYSTEM

REPORT ND. TD-0-81

EXCEPTION PROFILE REPORT

Patient Info Section

Patient's primary care provider

RECIPIENT ID: [redacted] AGE: [redacted] SEX: [redacted] NURSING HOME: N GROUP: TDURS PCP [redacted]

CURRENT MONTH EXCEPTIONS

LINE NO. 1 REF NO. 36456 PROBLEM UNDERUTILIZATION

THERAPEUTIC CRITERIA
ASTHMA: CONSIDER STEROID INHALER FOR PATIENTS WITH PERSISTENT ASTHMA

DRUG / DIAGNOSIS

| DAYS | R | SERVICE - | PROC DESC / NDC ..GENERIC - - | --------- DIAGNOSIS -------- | EST. QTY | ---- PROVIDERS ---- |
|---|---|---|---|---|---|---|
| SUPP | 1 | MM/DD/YY | CODE | CODE DESCRIPTION | MG/DAY DISP STRENGTH | A/R/P MD PHRM/HSP CT TPL PCP |
| | | | 214 EST. PATIENT OFFICE VISIT | 4939 ASTHMA | | 7777777 |
| Profession & Hospital Outpatient Claim Section: | | | 214 EST. PATIENT OFFICE VISIT | 4019 HYPERTENSION UNSPEC | | 8888888 MD |
| | | | 213 OFFICE,EST PT, EXPANDED, LO | 4660 ACUTE BRONCHITIS | | 1111111 MD |
| | | 11/07/06 | 80053 EXECUTIVE PROFILE | 4660 ACUTE BRONCHITIS | | 3333333 MD |
| | | 11/07/06 | 80061 LIPID PROFILE | 4659 ACUTE UPPER RESPIRATORY IN | | 3333333 MD |
| | | 11/20/06 | 71010 X-RAY CHEST; POSTEROANTERIOR | | | 3333333 MD |
| | | 12/14/06 | 80050 GENERAL HEALTH SCREEN PANEL | | | 7777777 MD |
| | | 12/14/06 | 99214 OFFICE, EST PT,DETAILED, MO | 4939 ASTHMA | | |
| 030 | 2 | 12/31/06 | 00078036405 0229271 LOTREL (AMLODIPINE BESYLATE/BE | | 30 [redacted] | 7777777 [redacted] |
| 030 | 2 | 10/25/06 | 66336086940 030107 PREVACID (LANSOPRAZOLE CAPSULE | | 30 30M | [redacted] 0001000 |
| [redacted] | | | 336086940 030707 PREVACID (LANSOPRAZOLE CAPSULE | | 30 30MG | [redacted] 0001000 |
| 015 | 0 | 10/01/06 | 68115077615 029123 ALBUTEROL (ALBUTEROL SULFATE) | J5D | 14.7 18MCG | [redacted] 0001000 |
| 015 | 0 | 10/15/06 | 68115077615 029123 ALBUTEROL (ALBUTEROL SULFATE) | J5D | 14.7 18MCG | 7777777 5555555 |
| 015 | 1 | 10/30/06 | 68115077615 029123 ALBUTEROL (ALBUTEROL SULFATE) | J5D | 14.7 18MCG | 7777777 5555555 |

[redacted] RMACY ---------- TYPE ---------- ---------- SPECIALTY ----------

3333333 GAMMA LABS 26 PHARMACIES 87 ALL OTHER

1010 FIRST ST CITY

23 LAB SERVICES (PRIVATE) 69 INDEPENDENT LABORATORY LA 71212

3030 THIRD ST BIGCITY

26 PHARMACIES 87 ALL OTHER LA 71888

4040 FOURTH ST RURALVILLE

20 PHYSICIANS (MD) SERVICES 94 RURAL HEALTH CLINIC LA 71999

5050 FIFTH ST VILLAGE

20 PHYSICIANS (MD) SERVICES 70 CLINIC OR OTHER GROUP PRACTICE LA 71888

6060 SIXTH ST SMALLTOWN

20 PHYSICIANS (MD) SERVICES 08 FAMILY PRACTICE LA 71999

7070 70TH AVE MAINVILLE

LA 71201

Provider Section

[redacted] RUGS