HEMODIALYSIS SERVICES

Chapter Nine of the Medical Services Manual

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

REISSUED MAY 1, 1993

PARAMAX

PREFACE

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

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

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

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

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

TABLE OF CONTENTS

GENERAL MEDICAID INFORMATION

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

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

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

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

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

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

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

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

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

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

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

UNDERSTANDING MEDICAID OF LOUISIANA

WHAT IS MEDICAID?

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

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

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

HOW DOES MEDICAID WORK?

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

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

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

ADMINISTRATION OF THE PROGRAM

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

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

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

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

STANDARDS FOR PARTICIPATION

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

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

  NOTE: Records must be retained for a period of three years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHHS, or the state Attorney General's Medicaid Fraud Control Unit.
- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the ***1964 Civil Rights Act***, Section 504 of the ***Rehabilitation Act of 1973***, and, where applicable, Title VII of the ***1964 Civil Rights Act***.

PICKING AND CHOOSING SERVICES

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

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

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

INDICATION OF AGREEMENT

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

OUT-OF-STATE MEDICAL CARE

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

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

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

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

RECIPIENT ELIGIBILITY

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

CLASSIFICATIONS OF ELIGIBLE RECIPIENTS

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

Categorically Needy

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

Medically Needy

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

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

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

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

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

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

La. OFS Form 110-MNP
Revised 1/89

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

Recipients listed on the medical card are eligible FROM: 07 / 15 / 90 (spend-down date) THROUGH: 10 / 31 / 90

3601012345601 — ID NO.

Anna M. Doar — CASE NAME

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

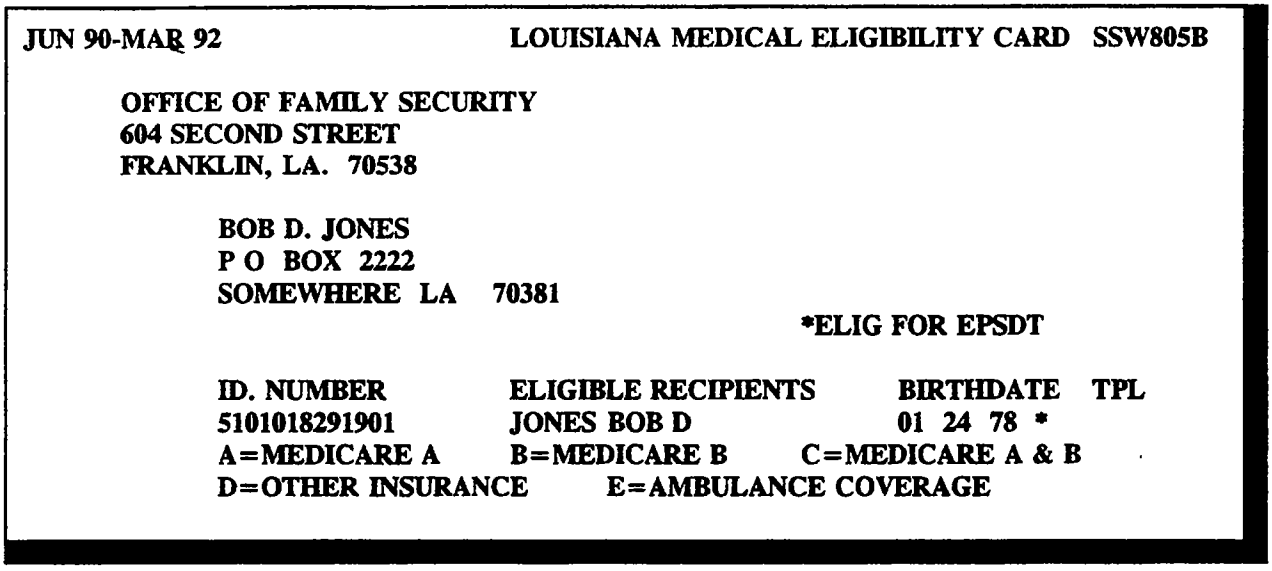
Patient Name and ID No. (include Recipient No.)	Date of Service	Provider Name and Vendor No.	Service or R_x Received On Spend-Down Date	Total Unpaid Charges for Services Received	Recipient Liability	OED Liability (Amt. and FI's actual payment may differ)
Anna M. Doar 3601012345601	07/15/90 mo/dy/yr	1312345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

Figure 4-1. Spend-Down Medically Needy Notice

IDENTIFICATION OF ELIGIBLE RECIPIENTS

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

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



JUN 90-MAR 92 LOUISIANA MEDICAL ELIGIBILITY CARD SSW805B

OFFICE OF FAMILY SECURITY
604 SECOND STREET
FRANKLIN, LA. 70538

BOB D. JONES
P O BOX 2222
SOMEWHERE LA 70381

*ELIG FOR EPSDT

ID. NUMBER	ELIGIBLE RECIPIENTS	BIRTHDATE	TPL
5101018291901	JONES BOB D	01 24 78	*

A=MEDICARE A B=MEDICARE B C=MEDICARE A & B
D=OTHER INSURANCE E=AMBULANCE COVERAGE

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

9PE LOUISIANA MEDICAL ELIGIBILITY CARD PAD163
PRESUMPTIVE ELIGIBILITY

P.O. BOX 2343
BATON ROUGE LA 70896

ERMA SMITH
555 BROWN STREET
ANYTOWN, LA 70000

ID NUMBER	NAME	BIRTHDATE
17-16-0-012350-20	ERMA SMITH	10-30-73

PRESUMPTIVE ELIGIBILITY PERIOD BEGINS ***01-02-89***
SERVICES LIMITED TO AMBULATORY PRENATAL CARE ONLY
HOSPITALIZATION, LONG TERM CARE SERVICES NOT AUTHORIZED
**MAY NOT EXCEED 45 DAYS AND MAY BE SHORTENED IF RECIPIENT IS
INELIGIBLE OR FAILS TO COMPLY WITH ELIGIBILITY REQUIREMENTS H

Figure 4-3. Sample Presumptive Eligibility Card

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

LOUISIANA MEDICAL ELIGIBILITY CARD PAD973

ISSUE DATE: 09/25/91
A=MEDICARE A B=MEDICARE B
C=MEDICARE A & B

OFFICE OF FAMILY SUPPORT
P.O. BOX 51870
NEW ORLEANS, LA. 70151

D=PRIVINS/DRUGS
E=AMBULANCE COVERAGE
F=PRIVINS/NO DRUGS
G=PRIVINS/IV-D/PAYCHASE

000262
LONG TERM CARE SERVICES NOT AUTHORIZED
SPEND-DOWN NEEDY ELIG PERIOD 08-13-90 THRU 09-90

NEIL BUSH
4000 LOAN STREET
NEW ORLEANS, LA 70126

ID. NUMBER	ELIGIBLE RECIPIENTS	BIRTHDATE	TPL
3904568290101	BUSH NEIL	01 11 54	

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

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

BHSF Form 9
REV. 03/92
Prior Issue Usable

Eligible From
Through

LOUISIANA MEDICAL ELIGIBILITY CARD

ID NUMBER	ELIGIBLE BENEFICIARY(IES)	BIRTHDATE	T.P.L.*

Agency Representative Signature | Date of Issue

IMPORTANT: Show this card to each provider who has provided or will provide service(s) to you during the dates shown above.
* SEE CODES ON REVERSE

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

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

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

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

IMPORTANT: PATIENT MUST SHOW THIS CARD WHEN APPLYING FOR MEDICAL SERVICES
The person(s) shown on the reverse side is (are) eligible for the payment of certain medical services authorized by Medicaid of Louisiana. Benefits under other insurance coverage, including Medicare, must be used first. Eligibility for medical services is effective only for the dates shown on the reverse side.

Use of this card to obtain medical services to which a person is not entitled will subject that person to arrest and trial under state and federal laws and regulations.

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

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

LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-SEPT. 92

OFFICE OF FAMILY SUPPORT 26
ST. CHARLES * KIDMED/EPSDT
P.O. BOX 453
HAHNVILLE LA 70057

TYPE CASE: 01 ID. NUMBER	ELIGIBLE RECIP. NAME	BIRTH DATE	TPL	CARRIER CODE
4503495788301 *	FRAN SUE	09/28/89	F	126100
4509839202802 *	FRAN JANE	11/07/91	F	126100
4567284920020	FRAN DORA	01/26/60	F	126100

DORA FRAN
200 WEST ST.
DESTREHAN LA 70047

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

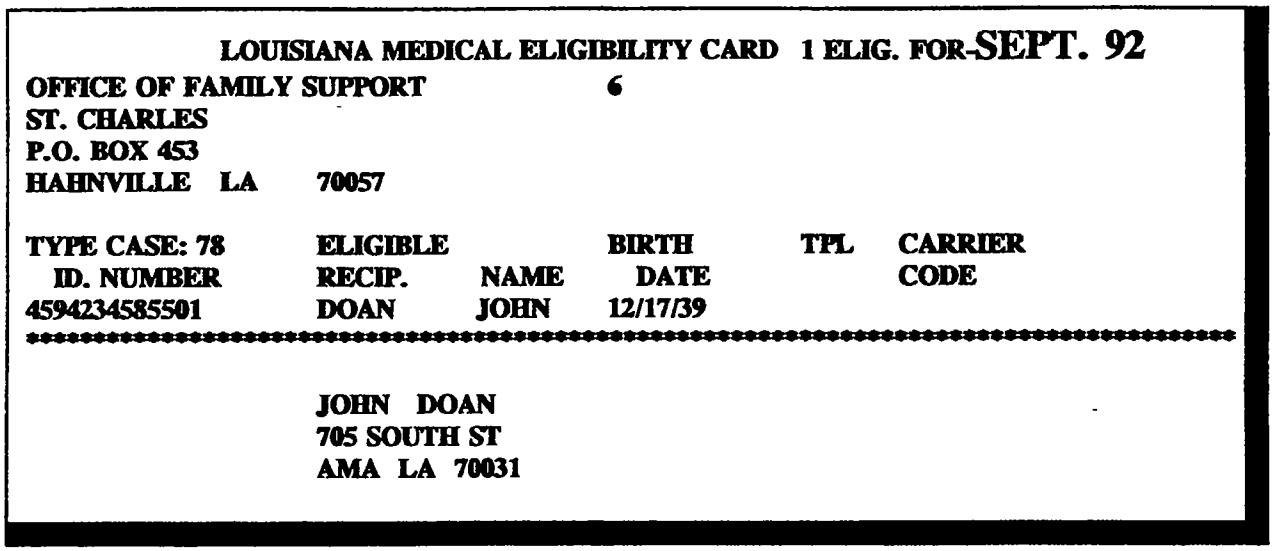
LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-SEPT. 92

OFFICE OF FAMILY SUPPORT 18
ST. CHARLES #MEDICARE / MEDICAID SERVICES
P.O. BOX 453
HAHNVILLE LA 70057

TYPE CASE: 78 ID. NUMBER	ELIGIBLE RECIP.	NAME	BIRTH DATE	TPL	CARRIER CODE
4501002011201#	SMITH	JOHN	10/15/26	C	

JOHN SMITH
700 SOUTH ST
DESTREHAN LA 70047

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

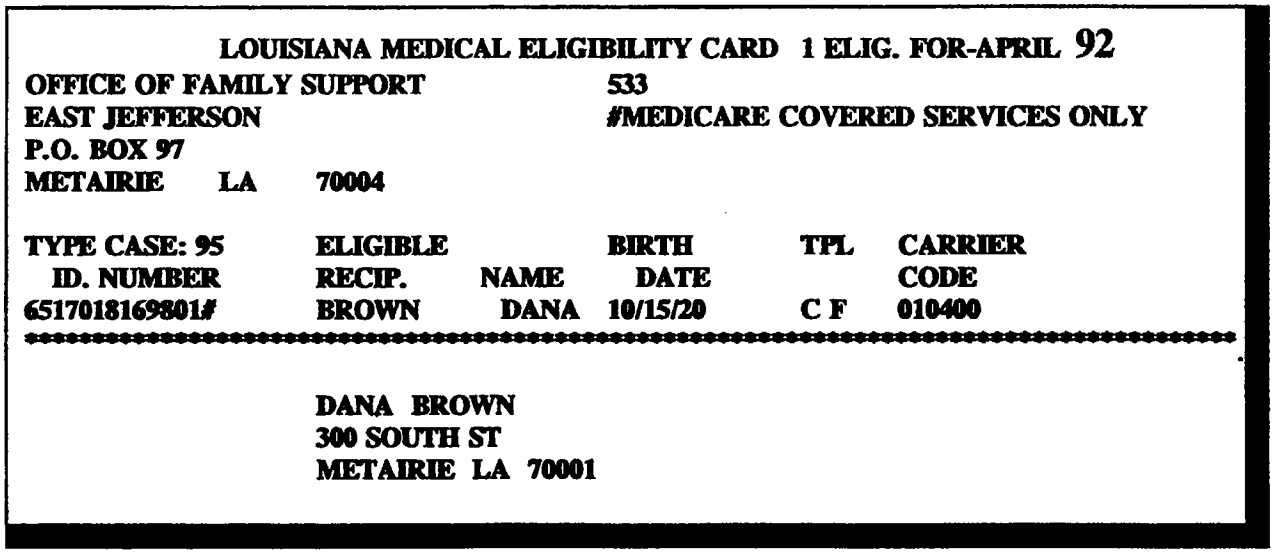


LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-SEPT. 92
OFFICE OF FAMILY SUPPORT 6
ST. CHARLES
P.O. BOX 453
HAHNVILLE LA 70057

TYPE CASE: 78 ID. NUMBER	ELIGIBLE RECIP.	NAME	BIRTH DATE	TPL	CARRIER CODE
4594234585501	DOAN	JOHN	12/17/39		

JOHN DOAN
705 SOUTH ST
AMA LA 70031

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



LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-APRIL 92
OFFICE OF FAMILY SUPPORT 533
EAST JEFFERSON #MEDICARE COVERED SERVICES ONLY
P.O. BOX 97
METAIRIE LA 70004

TYPE CASE: 95 ID. NUMBER	ELIGIBLE RECIP.	NAME	BIRTH DATE	TPL	CARRIER CODE
65170181698O1#	BROWN	DANA	10/15/20	C F	010400

DANA BROWN
300 SOUTH ST
METAIRIE LA 70001

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

LOCK-IN PROGRAM

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

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

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

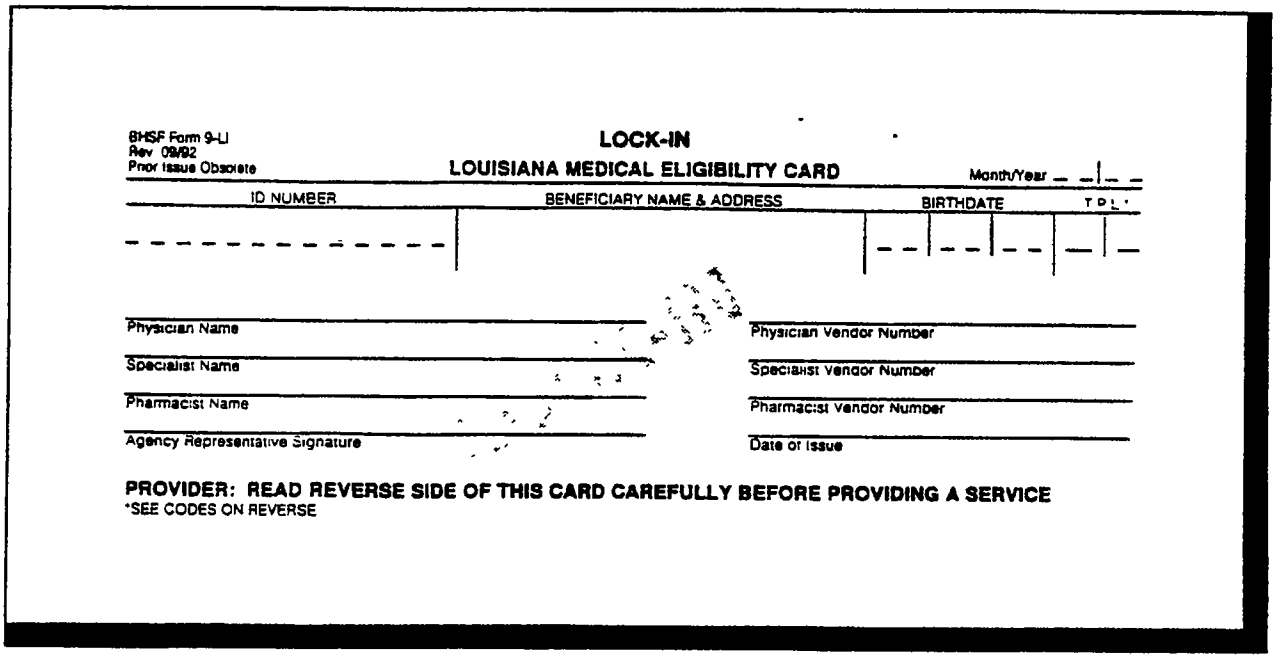
The BHSF recognizes that there will be unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In recipient when the provider is not named on the Medical Eligibility Card. Payment will be made to any physician or pharmacist enrolled in Medicaid of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

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

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

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

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



BHSF Form 9-LI
Rev 09/92
Prior Issue Obsolete

LOCK-IN
LOUISIANA MEDICAL ELIGIBILITY CARD

Month/Year _ _|_ _

ID NUMBER	BENEFICIARY NAME & ADDRESS	BIRTHDATE	T P L *
_ _ _ _ _ _ _ _ _ _ _		_ _ | _ _ | _ _	_ | _

Physician Name
Physician Vendor Number
Specialist Name
Specialist Vendor Number
Pharmacist Name
Pharmacist Vendor Number
Agency Representative Signature
Date of Issue

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

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

IMPORTANT: PATIENT MUST SHOW THIS CARD WHEN RECEIVING MEDICAL SERVICES

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

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

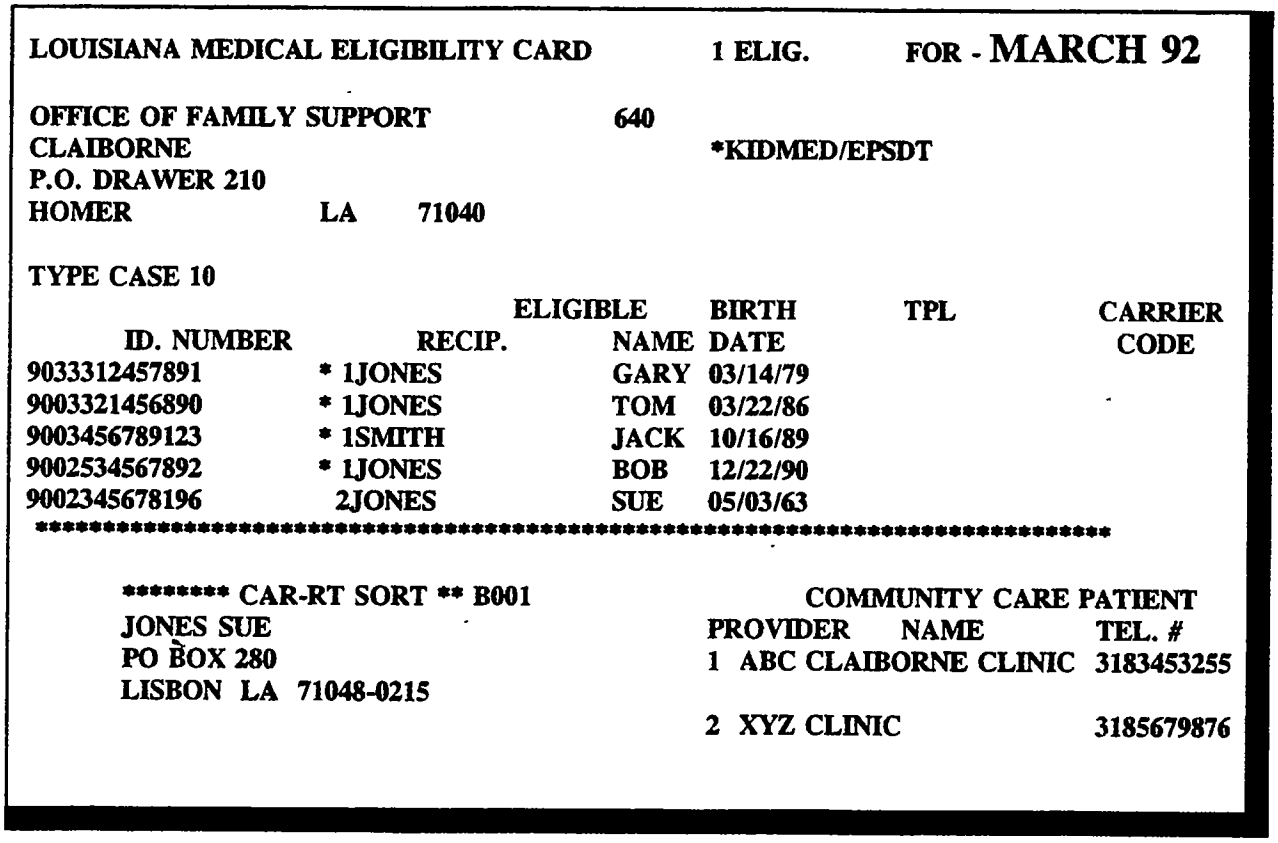
COLUMN 1
D=Private Health Insurance - Drug Coverage; E=Ambulance Insurance; F=Private Health Insurance - No Drug Coverage; G=Private Health Insurance (IV-D) - Pay & Chase
COLUMN 2
A=Medicare, Part A; B=Medicare, Part B; C=Medicare, Parts A & B

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

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

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

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



LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR - MARCH 92

OFFICE OF FAMILY SUPPORT 640
CLAIBORNE *KIDMED/EPSDT
P.O. DRAWER 210
HOMER LA 71040

TYPE CASE 10

ID. NUMBER	ELIGIBLE RECIP.	NAME	BIRTH DATE	TPL	CARRIER CODE
9033312457891	* 1JONES	GARY	03/14/79		
9003321456890	* 1JONES	TOM	03/22/86		
9003456789123	* 1SMITH	JACK	10/16/89		
9002534567892	* 1JONES	BOB	12/22/90		
9002345678196	2JONES	SUE	05/03/63		

******** CAR-RT SORT ** B001
JONES SUE
PO BOX 280
LISBON LA 71048-0215

COMMUNITY CARE PATIENT

PROVIDER	NAME	TEL. #
1	ABC CLAIBORNE CLINIC	3183453255
2	XYZ CLINIC	3185679876

Figure 4-13. Sample CommunityCARE Medicaid Card

THIRD-PARTY LIABILITY (TPL)

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

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

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

HEMODIALYSIS PATIENTS WITH MEDICARE COVERAGE

When Medicaid recipients begin receiving End Stage Renal Disease (ESRD) hemodialysis treatment, providers should refer them to the Social Security Administration to apply for Medicare Parts A & B. It is not necessary to refer the recipients, however, if they are presently enrolled in Medicare or if they applied for Medicare within the last year and were denied coverage.

For services rendered to recipients with Part B benefits, the physician should bill the Medicare carrier for Part B covered services before billing Medicaid, and the facility should bill Medicare for dialysis treatment and non-routine lab tests.

When billing Medicare, the provider should enter the recipient's Medicaid identification number on each claim, so each claim will crossover automatically to Paramax for processing and payment of the coinsurance and deductible amounts. If the claim does not crossover automatically, providers must submit the UB-82 claim form, with the Medicare Remittance Notice or Payment Register attached, to Paramax for processing.

Providers will be overpaid if payment is made on a crossover claim when a recipient has other insurance coverage. Therefore, to ensure that providers do not receive overpayment, Paramax will prevent payment of automatic tape crossover claims when a recipient's eligibility file indicates that he has other insurance coverage. To assist Paramax, providers should not enter the recipient's Medicaid identification number on claims submitted to Medicare, so the other third-party will be billed before Medicaid is billed for the coinsurance and deductible amounts.

In addition, institutional and professional crossovers should be billed separately. To determine the allocation of payments from the other insurance to the professional and institutional sources, if an additional payment is due after Medicare and the other insurance has made payment, providers should bill Medicaid with a copy of the original Medicare claim form, noting the third-party payments received and the resulting net billed payment amount. Providers should also submit the Medicare Payment Register and the private insurance EOB with the claim.

All Medicare crossover claims should be mailed to the following address:

Paramax
P.O. Box 91023
Baton Rouge, LA. 70821

PROVIDER ENROLLMENT

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

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

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

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

☎ (504) 924-5040

Completed forms should be submitted to the following address:

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

☎ (504) 342-9454

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

CHANGE OF ADDRESS/ENROLLMENT STATUS

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

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

DESCRIPTION OF SERVICES

Medicaid of Louisiana will reimburse Medicaid enrolled free-standing End Stage Renal Disease (ESRD) facilities for the services outlined in this section. To become enrolled in Medicaid of Louisiana, however, these facilities must be Medicare certified.

☞ ***The effective enrollment date for the facility will be either the date the PE-50 Medicaid enrollment form is signed or the date the facility receives Medicare certification (if certification has not already been granted), whichever date is the earliest.***

Once the facility is enrolled in Medicaid of Louisiana, reimbursement to the facility will be determined by the facility's charge for the service(s) rendered. These charges, however, should not exceed Medicare allowable charges for comparable services.

Reimbursement is made to free-standing hemodialysis facilities for the following services:

- Dialysis treatment (including routine laboratory services);
- Medically necessary non-routine lab services; and
- Medically necessary injections.

DIALYSIS SERVICES

Dialysis services will be reimbursed by Medicaid of Louisiana. Providers billing for dialysis treatment (**technical component**) should use revenue code 821 and bill on the UB-82 claim form. To bill for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) services, providers should use revenue codes 841 and 851, respectively.

Providers billing for physician supervision of dialysis (**professional component**) should use one of the codes listed in the table on the following page and bill on the HCFA-1500 claim form.

DIALYSIS PROCEDURE CODES
(PROFESSIONAL COMPONENT ONLY)

CODE	DESCRIPTION
90989	Dialysis training, patient, including helper where applicable, any mode, completed course
90935	Hemodialysis procedure with single physician evaluation
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
90945	Dialysis procedure other than hemodialysis; e.g., peritoneal, hemofiltration; with single physician evaluation
90947	Dialysis procedure other than hemodialysis; e.g., peritoneal, hemofiltration; requiring repeated evaluation, with or without substantial revision of dialysis prescription
90993	Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session
90995	End Stage Renal Disease (ESRD) related services, per full month
90997	Hemoperfusion, e.g., with activated charcoal resin

DIALYSIS EQUIPMENT AND SUPPLIES

Provided in the tables that follow are listings of the covered dialysis equipment and supplies, as well as a listing of the non-covered equipment and supplies.

Providers will be reimbursed for the covered items in accordance with Durable Medical Equipment (DME) program guidelines. That is, these items must be requested by a DME provider and prior authorized by the Prior Authorization Unit at Paramax. A copy of the DME provider manual which explains the prior authorization procedures for equipment and supplies may be obtained from Paramax.

Providers will not be reimbursed for the non-covered items unless they are billed for as part of a package that includes covered items.

We begin with the listing of non-covered items on the following page.

DIALYSIS SUPPLIES NOT COVERED BY THE DME PROGRAM

✓	Phisohex (available through the pharmacy program only)
✓	Betadine and Betadine Swabs
✓	Alcohol and Alcohol Wipes
✓	Tincture Iodine (merthiolate)
✓	Peroxide
✓	Zephiran
✓	Local/Topical Anesthetics, such as Procaine, Xylocaine/ Lidocaine, and Ethyl Chloride (available through the pharmacy program only)
✓	Underpads
✓	Medications and Drugs (available through the pharmacy program only and only if they appear on an approved list)
✓	Cotton tipped applicators and cotton balls
✓	Clinitest or other reagent strips (available through the pharmacy program only)
✓	Non-medical Instruments and Supplies, including scales, scissors, stop watches, surgical brushes, thermometers, tool kits, tourniquets, and tubes (occluding forceps/ clamps)
✓	Dialysis chair
✓	Sterile Towels
✓	Dialysis Cart

NOTE: These items are not covered unless they are billed for as part of a kit or package that includes covered items.

Provided below and on the following pages is a listing of home dialysis supplies that are covered by the DME program.

HOME DIALYSIS ITEMS COVERED BY THE DME PROGRAM

✓ **Dialyzer**

Synthetic porous membrane or fibers, contained in a supporting structure, through which blood flows for the purpose of eliminating harmful substances and replacing useful ones when they are surrounded by dialyzate.

✓ **Blood Tubing**

Plastic tube attached to a fistula needle or shunt connector allowing blood to flow to and from the patient and dialyzer. Includes blood sets, venous/ arterial set, arteriovenous set, and drip chamber (bubble-trap holder).

✓ **Dialysate**

Electrolyte solution containing elements such as potassium, sodium, chloride, etc., surrounding the membrane or fibers allowing exchange of substances with the patient's blood contained in the dialyzer. Includes Dialysate mixer standard, Diasol concentrate, hemodialysis concentrate, bath concentrate, and electrolyte solution (Na, Cl, and K).

✓ **Saline - 30, 250, 500, 1000 cc/ml**

Solution of sodium, chloride, and water used to replace fluid in the body and to prepare the kidney machine for use. Includes sodium chloride/NaCl, normal saline/isotonic saline, viaflex, liquamin sodium, and dextrose.

✓ **Fluid Administration Set**

Plastic tube used for the flow of fluids, such as saline, directly into the dialysis system. Includes administrative set, I.V. administration set, Y type administration set, and anesthesia set.

DME COVERED HOME DIALYSIS SUPPLIES CONTINUED

✓ **Fistula Cannulation Set**

Needle or needles used to puncture a vein to provide an access to the patient's blood supply. Includes fistula needles/set; #14, 15, 16 ga needles; unipuncture fistula needle/catheter; medicut, angiocath; and #14, 15, and 16 butterfly.

✓ **Shunt Accessories**

Connectors or adapters attached to an artificial, external blood route providing access to the blood supply. Includes shunt/universal/teflon connectors, shunt/universal/teflon adaptors, and silastic tubing.

✓ **Heparin**

A drug used to prevent blood from clotting.

✓ **Dialysate Testing Supplies**

Includes quantabs/chloride indicator and hemastix.

✓ **Syringes**

Includes 3, 5, 10, 20, and 30 cc syringes.

✓ **Needles**

Includes 18, 19, 21, 22, and 25 gauge needles.

✓ **Sterilizing Agents for Equipment**

Includes formaldehyde and chlorox/sodium hypochlorite.

✓ **Cleansing Agents for Equipment**

Includes Alconex and Haemosol.

DME COVERED HOME DIALYSIS SUPPLIES CONTINUED

✓ **Declotting Equipment**

Includes declotting catheter/aspirator and teflon insert.

✓ **Dialysate Delivery System**

Usually includes pump, recirculating/proportioning; air removal system; flowrate meter; conductivity meter; power off alarm; heater and temperature control with alarm; I.V. poles, drip chamber holder; pressure gauge; and concentrate container/tub.

✓ **Accessory Items**

Include blood pump, infusion pump, unipuncture control system, pressure alarm, blood leak detector, air bubble detector, portable conductivity meter, centrifuge readacrit, and sphygmomanometer/blood pressure apparatus with cuff (and stethoscope).

✓ **Water Purification System**

Process includes reverse osmosis, deionization, and activated carbon filtration. Reverse osmosis is a process used to remove impurities from tap water utilizing pressure to force water through a porous membrane. Deionization is the removal of organic substances, mineral salts or magnesium and calcium (causing hardness), compounds of fluoride and chloride from tap water using the process of filtration and ion exchange. Activated carbon filtration removes unsafe concentrations of chlorine and chloramines.

✓ **Blood Testing Supplies**

Include clotting tubes/capillary tubes, Wintrobe tubes/hematocrit tubes, red top tubes/vacutainer/chemistry tubes, pipets, a suction bulb, and culture tubes.

✓ **Other Supplies**

Include sponges, gauze, telfa pads, tape (Dermicel, Micropore, paper, and adhesive), bandages (cling, kerlix, stockinette, ace, elastoplast), gloves, and masks.

CAPD AND CCPD SERVICES

Effective July 1, 1991, the BHSF approved reimbursement for Continuous Ambulatory Peritoneal Dialysis (CAPD) services provided to home dialysis patients. Providers approved for CAPD services may also provide Continuous Cycling Peritoneal Dialysis (CCPD) services.

For both services, the BHSF opted to use Medicare's composite rate reimbursement system, Method I only. Under this reimbursement system, the dialysis facility must assume responsibility for providing all home dialysis equipment, supplies, and home support services. Some of the support services include the administering of medications, training of the patient to perform the home dialysis treatment, and the delivery of supplies.

In addition, under this system, facilities approved for CAPD and CCPD services are reimbursed on a per diem basis. The per diem rate is determined by a formula designed to keep the monthly rate of pay for CAPD and CCPD services equal to the monthly rate of pay for hemodialysis treatments provided at the kidney center. The per diem rate for CAPD and CCPD services, multiplied by seven (the number of days in a week), will equal the amount of reimbursement allowed for three hemodialysis services. Three hemodialysis services per week is the number of services normally required by an ESRD hemodialysis patient over the period of one week.

In order to participate as a CAPD and CCPD services provider, a hemodialysis facility must be a Medicare approved ESRD facility and have approval from HCFA to furnish CAPD and CCPD training and support services. In addition, a facility must meet federal certification requirements before it can be approved. These requirements state that a facility furnishing CAPD and CCPD services must provide a full range of home dialysis support services as previously mentioned. Reimbursement for these services is included in the composite rate.

Support services specifically applicable to the home CAPD and CCPD patient include the following:

- Changing the connection tube (also referred to as an administration set);
- Watching the patient perform CAPD and CCPD and ensuring that it is done correctly, reviewing for the patient any aspects of the technique he may have forgotten, or informing the patient of modifications in the apparatus or technique;
- Documenting whether the patient has or has had peritonitis that requires physician intervention or hospitalization (Unless there is evidence of peritonitis, a culture for peritonitis is not necessary.);

- Inspection of the catheter site;
- Drawing blood samples;
- Administering medications prescribed by the patient's physician to treat a renal related condition;
- Administering blood or blood products prescribed by the physician;
- Social services consultation and/or intervention;
- Delivery, installation, maintenance, repair, and testing of the cycler; and
- Delivery of all dialysis related supplies.

Reimbursement for some laboratory tests required monthly for CAPD and CCPD patients is also included in the composite rate. These laboratory tests include the following:

- Bun
- Creatinine
- Sodium
- Dialysate Protein
- Albumin Hgb
- Carbon Dioxide
- LDH
- Phosphate
- SGOT

- Magnesium Alkaline Phosphates
- Calcium
- Total Protein
- Potassium
- HCT

Providers approved to bill for CAPD and CCPD services should use revenue code HR841 and HR851, respectively, and bill on the UB-82 claim form.

LABORATORY SERVICES

Medicaid of Louisiana will reimburse hemodialysis providers for both routine and non-routine laboratory services.

Routine Laboratory Services

Routine lab work is an integral part of outpatient hemodialysis services. Thus, reimbursement for routine lab services is included in the dialysis session fee.

Many hemodialysis facilities have contracts with outside laboratories to perform these lab procedures. Routine lab services include those listed in the table below.

ROUTINE LABORATORY SERVICES

UTILIZATION	CODE	TEST
PER DIALYSIS	NA	Hematocrit
PER WEEK	NA	Prothrombin time for patients on anticoagulant
	NA	Therapy
	NA	Serum Creatinine
	NA	Bun
MONTHLY	NA	CBC
	NA	Serum Calcium
	NA	Serum Potassium
	NA	Serum Chloride
	NA	Serum Bicarbonate
	NA	Serum Phosphorus
	NA	Total Protein
	NA	Serum Albumin
	NA	Alkaline Phosphatase
	NA	SGOT & LDH

NON-ROUTINE LABORATORY PROCEDURES

Hemodialysis facilities may bill separately for additional non-routine laboratory services performed by approved Medicaid laboratories if the medical necessity for the additional lab services is documented by a physician.

The reimbursement for non-routine lab services will be either the lowest charge level, the current customary charge, or the prevailing charge, whichever is the lowest fee. Because the hemodialysis facility will bill for these services, laboratories may not bill for the lab procedures. The billed amount, however, should not exceed the amount paid to the outside laboratory.

Non-routine lab services should be billed as additional services to the technical component. The following codes should be used.

NON-ROUTINE LABORATORY TESTS

UTILIZATION	CODE	TEST
ONCE A MONTH	86280	Hemagglutination inhibition tests (HAI), each; e.g., amebiasis, Rubella, viral
	86285	Hepatitis associated agent (Australian Antigen) - (HAA); counterelectrophoresis method
	86286	Counterelectrophoresis with concentration of serum
	86287	RIA method
	86331	Gel Diffusion, Qualitative (Ouchterlony)
EVERY THREE MONTHS	95900	NCV - Nerve Conductor Velocity Test
	93000	EKG
EVERY SIX MONTHS	71010	Radiologic examination, chest; single view posteroanterior
	71015	Stereo, posteroanterior
	71020	Two views, posteroanterior and lateral
ANNUALLY	78300	Bone survey, bone imaging; limited area; e.g., skull, pelvis

HEMODIALYSIS INJECTIONS

Certain injections are covered under Medicaid of Louisiana that are usually billed in connection with hemodialysis treatments. Reimbursement for each of these items, however, covers the cost of the drug only. Reimbursement for the administration of the injection is included in the physician supervision of dialysis procedure.

The following codes should be used to bill for injections associated with hemodialysis.

HEMODIALYSIS INJECTION CODES	
CODE	**DESCRIPTION**
J0290	Ampicillin, up to 500 mg up to 3 injections/day
J1200	Benadryl, up to 3 injections/day
J0710	Cepadyl, up to 1 gm up to 3 injections/day
J0940	Deca-durabolin, 200 mg
J0930	Deca-durabolin, 150 mg
J0920	Deca-durabolin, 100 mg
J0910	Deca-durabolin, 50 mg
J0960	Delatestryl, 1 injection/day, up to 200 mg up to 3 injections/day
J0090	Demerol, up to 100 mg up to 3 injections/day
J1580	Garamycin, injection, up to 80 mg up to 3 injections/day
J1760	Inferum, up to 2 cc up to 3 injections/day
J2720	Protamine, up to 0.5 ml
J3070	Talwin, up to 30 mg up to 3 injections/day
J3360	Valium, up to 10 mg up to 3 injections/day
J3370	Vancomycin, up to 10 mg up to 3 injections/day
J3410	Vistaril
J3250	Tigan
J2720	Protamine
J7090	Albumin Transfusion, 5%, 500 ml vial
J7090	Albumin Transfusion, 25%, 50 ml vial

EPOETIN ALFA (EPO)

Epoetin Alfa (EPO), also referred to as Epoetin or Epogen, is covered under Medicaid of Louisiana when it is used to treat anemia associated with chronic renal failure. Patients with this condition include those who require renal dialysis and are eligible for Medicare under the end-stage renal disease (ESRD) provisions of the law. EPO may be administered either intravenously or subcutaneously for the treatment of anemia associated with chronic renal failure. Coverage can be made for facility-dialyzed recipients, as well as for recipients who dialyze at home and are competent to use the drug without medical or other supervision. The facility is required to limit the "on-hand" supply to home dialysis recipients up to a two-month's supply. Initially, the facility may bill for up to a two-month's supply. Subsequently, however, the facility must bill for only a one-month's supply at a time.

The following criteria should be adhered to for the selection and therapy of patients who can administer EPO to themselves in the home setting:

Criteria for Selection of Patients Qualified to Self-Administer EPO in the Home

The patient's dialysis facility or the physician responsible for furnishing all dialysis-related services to the patient can participate in patient selection, training, and monitoring. In considering EPO therapy in the home setting, it is important for the dialysis facility or the physician responsible for all dialysis-related services to assess the degree of self-care that is feasible; i.e., whether the patient will actually be able to administer the drug, and if not, whether the patient would have available the necessary assistance from a care-giver. In order to be selected for home use of EPO, the patient must meet the following criteria:

- Be a home dialysis patient (utilizing either CAPD or CCPD method);
- Have a hematocrit (or comparable hemoglobin) of less than 30%, unless medical documentation justifies a patient's need for EPO with a hematocrit higher than 30%;
- Be under the care of the physician who is responsible for the dialysis-related services and who prescribes EPO, and be under the care of the renal dialysis facility that establishes the plan of care for the services and monitors the progress of the home EPO therapy; and
- Be trained by the facility to inject EPO or have an appropriate care-giver who is trained to inject EPO.

In addition, the following requirements must be met:

- Prior to the determination that the patient is a candidate for use of EPO in the home, the patient's hematocrit (or hemoglobin), serum iron, transferrin saturation, serum ferritin, and blood pressure must be measured.
- The patient's physician or facility must develop an appropriately designed protocol for the patient for the safe and effective use of the drug. The protocol must include monitoring the patient's blood pressure.
- The patient must be capable of performing self-administration of EPO, be able to read the drug labeling, or have a primary care-giver who can perform these tasks.
- The patient must be able to adhere to a disciplined medical program.

Patient Care Plan

To ensure adequate monitoring of home EPO therapy, the patient plan for a home dialysis patient who uses EPO in the home must include the following:

- A review of diet and fluid modification to monitor iron stores and hyperkalemia related to dietary indiscretion or elevated blood pressure;
- A re-evaluation of the patient's dialysis prescription, taking into account the patient's increased appetite and red blood cell volume;
- A method of teaching the patient to identify the signs and symptoms of hypotension and hypertension;
- The decrease or discontinuance of EPO if hypertension is uncontrolled; and
- A method of follow-up on blood work and a means to keep the physician informed of the results.

If a home patient is not competent to use EPO without supervision, and the drug has been prescribed, generally, the patient's dialysis facility should administer the drug.

Billing for EPO Services

Providers should use revenue code HR634 to bill for EPO when under 10,000 units are administered. Providers should use revenue code HR635 when 10,000 units or more are administered. However, when billing revenue code HR635, providers must complete and submit the ***Epoetin Alpha (EPO) Required Documentation*** form with the claim. A copy of this form is provided on the following page. Providers may copy this form or use Medicare's version of the form. Providers should address the following in their medical documentation:

- Iron deficiency (Most patients will need supplemental iron therapy while being treated, even if they do not start out iron deficient.);
- Concomitant conditions such as infection, inflammation, or malignancy (These conditions should be addressed insofar as possible for EPO to have maximum effect.);
- Unrecognized blood loss [Patients with kidney disease and anemia may have chronic blood loss (usually gastrointestinal) as a reason for the anemia; as a result, the effectiveness of EPO will be limited.];
- Concomitant hemolysis, bone marrow dysplasia, or refractory anemia for a reason other than renal disease, such as aluminum toxicity;
- Folic acid or vitamin B_{12};
- Circumstances in which the bone marrow is replaced with other tissue, such as malignancy or osteitis fibrosa cystica; and
- Patient's weight, the current dose required, a historical record of the amount that has been given, and the hematocrit response to date.

EPOETIN ALFA (EPO) REQUIRED DOCUMENTATION

PROVIDER NAME:_____

PROVIDER NUMBER:_____

PATIENT'S NAME:_____

MEDICAID NUMBER:_____

DATE OF SERVICE:_____

DIALYSIS METHOD:_____

CHARGES:_____

MEDICAL RECORD:_____

The information requested is being submitted for the following reason (check one):

- ☐ **EPO DOSAGE OF 10,000 OR ABOVE**
- ☐ **HEMATOCRIT LEVEL EXCEEDS 36**
- ☐ **FREQUENCIES EXCEED THREE TIMES A WEEK**
- ☐ **INITIAL CLAIM WHERE HEMATOCRIT LEVEL IS NOT LESS THAN 30 AND CREATINE LEVEL IS NOT THREE OR MORE**

DIAGNOSIS CODE(S):_____

PATIENT'S BODY WEIGHT IN KILOGRAMS:_____

EPO UNITS ADMINISTERED PER KILOGRAMS:_____

MOST RECENT HEMATOCRIT AND DATE:_____/_____

MOST RECENT CREATININE AND DATE (ON INITIAL CLAIM):_____/_____

DATE WHEN EPO THERAPY WAS INITIATED:_____

MEDICAL JUSTIFICATION FOR THE ADMINISTRATION OF EPO WHICH EXCEEDS THE STANDARDS OF NORMAL CLINICAL PRACTICE:_____

_____

_____

_____

_____

UB-82 BILLING INSTRUCTIONS

Provided below are the instructions for completing the UB-82 claim form. Hemodialysis providers should use this claim form to bill for the technical component of the hemodialysis services provided.

A sample UB-82 claim form is provided on the following page. Instructions for completing the UB-82 claim form are provided after the sample.

APPROVED OMB NO. 0938-0279

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 B... DATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A
											B
											C

	39 CODE	VALUE CODES AMOUNT		40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a							
b							
c							
d							

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
57		DUE FROM PATIENT ▶				

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
							OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X	

JB-92 HCFA-1450 OCR / Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

INSTRUCTIONS

Provided below are the instructions for completing the UB-82 claim form.

*1. **PROVIDER NAME AND ADDRESS.** Enter the name and address of the facility in this space.

3. **PATIENT CONTROL NUMBER.** Enter the patient control number in this space. It may consist of up to 10 letters and/or numbers. Patient account numbers entered in this space will appear on your Remittance Advice.

*4. **TYPE OF BILL.** Enter code **721** in this space.

*8. **MEDICAID PROVIDER NUMBER.** Enter your seven-digit Medicaid provider identification number in this space.

*10. **PATIENT'S NAME.** Enter the recipient's name exactly as it appears on the Medicaid Eligibility Card. Enter the last name first, the first name next, and the middle initial last.

11. **PATIENT'S ADDRESS.** Enter the patient's permanent address. Do not forget to enter the zip code.

12. **PATIENT'S BIRTH DATE.** Enter the patient's date of birth using six digits (MM/DD/YY format). If only one digit appears in a field, enter a leading zero.

13. **SEX OF THE PATIENT.** Enter the sex of the patient. **M = Male**
F = Female

*22. **STATEMENT COVERS PERIOD (FROM AND THROUGH DATES).** Enter the beginning and ending service dates of the period covered by this bill.

35. **CONDITION CODES.** Enter one of the following codes:

01 Military service related

02 Condition is employment related

03 Patient is covered by insurance note reflected here

04 HMO enrolled

05 Lien has been filed

06 End Stage Renal Disease (ESRD) in first year of entitlement covered by employer or group insurance

17 Patient is 100 years old

38 Semi private room is not available

39 Private room medically necessary

40 Same day transfer

44. **SPECIAL PROGRAM INDICATOR.** Identify the type of service rendered. The valid codes are listed below:

01 EPSDT/CHAMP

02 Physically Handicapped Children's Program

04 Family Planning

07 Induced abortion - danger to life

*50. **REVENUE DESCRIPTION OF SERVICE.** Enter the narrative description of the revenue code in the space preceding the dotted line, and enter the date of service (using the MM/DD/YY format) in the space after the dotted line.

*51. **REVENUE CODE.** Enter the appropriate revenue code.

*52. **UNITS OF SERVICE.** Enter the number of units.

*53. **TOTAL CHARGES.** Enter revenue code 001 and total the charges listed in block 50.

57. **PAYER IDENTIFICATION.** Enter ***Medicaid*** on line A and enter the other payers on lines B and C. In another insurance is a primary payer, enter the name of the insurer. If the patient is a Medically Needy Spend-down recipient or if the recipient has made payment for services, indicate the patient as a payer and enter the amount the patient has paid. Valid payer identification codes are listed below:

M Medicaid

Z Medicare

4 All other TPL carriers (specify)

60. **DEDUCTIBLE.** Leave this space blank.

61. **COINSURANCE.** Leave this space blank.

63. **PRIOR PAYMENTS.** Enter the amount the hospital has received toward payment of this bill from any other carrier noted in block 57. Do not indicate Medicaid payment.

65. **INSURED'S NAME.** If the patient is covered by insurance other than Medicaid, enter the name of the insured as it appears on the ID card. Enter the last name first, the first name next, and the middle initial last.

67. **PATIENT'S RELATIONSHIP TO INSURED.** Enter the patient's relationship to the insured by using one of the following codes:

01 Patient is insured

02 Spouse

03 National child/insured has financial responsibility

04 Natural child/insured does not have financial responsibility

05 Step child

06 Foster child

07 Ward of the court

08 Employee

09 Unknown

10 Handicapped dependent

11 Organ donor

13 Grandchild

14 Niece/nephew

15 Injured plaintiff

16 Sponsored dependent

17 Minor dependent of minor dependent

18 Parent

19 Grandparent

*68. **IDENTIFICATION NUMBER.** If other payers are listed in block 57, enter their identification numbers in this block. Otherwise, enter the recipient's 13-digit Medicaid identification number.

69. **INSURED GROUP NAME (MEDICAID NOT PRIMARY).** Enter the carrier code through which the insurance is provided to the insured.

70. **INSURANCE GROUP NUMBER (MEDICAID NOT PRIMARY).** Leave this space blank.

*76. **PRINCIPAL AND OTHER DIAGNOSIS DESCRIPTION.** Enter the narrative description of the primary diagnosis and other diagnoses.

*77. **PRINCIPAL DIAGNOSIS CODE.** Enter the ICD-9-CM code for the principal diagnosis. Codes beginning with E or M are not valid codes.

78-81 **OTHER DIAGNOSIS CODES.** Enter the other diagnosis codes.

*95. **PROVIDER SIGNATURE.** Enter the signature and title of the appropriate person at the facility who is authorized to submit Medicaid billing. You must initial stamped and computer-generated signatures.

*96. **DATE BILL SUBMITTED.** Enter the date the bill was signed and submitted for payment in MM/DD/YY format.

HCFA-1500 (12/90) BILLING INSTRUCTIONS

Hemodialysis providers should bill for the professional component on the HCFA-1500 claim form. Provided in this section are some general billing reminders and specific instructions for billing on the HCFA-1500 (12-90) claim form.

GENERAL REMINDERS

Providers should note the following:

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

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA ☐ PICA ☐

CARRIER

PICA

EDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ 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

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.

PATIENT AND INSURED INFORMATION

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 MM DD YY TO

ME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

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. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

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 $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS

SPECIFIC BILLING INSTRUCTIONS

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

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

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

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

20.	**OUTSIDE LAB**	
	Was Lab Work Performed Outside Your Office:	Check the appropriate box.
	Charges:	Not applicable.
*21.	**DIAGNOSIS**	All claims must contain a medically accepted description of the diagnosis. You must enter the numeric code and literal description. Use of ICD-9-CM coding is mandatory. Accepted abbreviations are appropriate.
22.	**MEDICAID RESUBMISSION CODE**	Leave this space blank.
23.	**PRIOR AUTHORIZATION**	Enter the prior authorization number when applicable.
24.	***A. DATE OF SERVICE**	Enter the month, day, and year for each item billed. If "from" and "to" dates are shown here for a series of identical services on the same day or on consecutive days, enter the number of services in Item 24G. **NOTE**: Surgical procedures may not be span-dated.
	***B. PLACE OF SERVICE**	Enter the appropriate place of service code. A table of the valid codes is provided on the following page.

NEW PLACE OF SERVICE CODES

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

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

26. YOUR PATIENT'S ACCOUNT NUMBER

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

27. ACCEPT ASSIGNMENT

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

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

***28. TOTAL CHARGE**

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

***29. AMOUNT PAID**

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

***30. BALANCE DUE**

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

31. SIGNATURE OF PHYSICIAN/SUPPLIER & DATE

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

32. NAME AND ADDRESS WHERE SERVICES WERE RENDERED

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

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

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

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

TIMELY FILING GUIDELINES

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

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

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

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

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

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

OR

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

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

THE REMITTANCE ADVICE

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

THE PURPOSE OF THE REMITTANCE ADVICE

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

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

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

WHAT HAPPENS TO YOUR INVOICE?

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

Returned Claims

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

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

WHAT HAPPENS TO A PROCESSED CLAIM?

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

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

Approved Claims

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

Denied Claims

A claim will be denied for the following reasons:

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

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

Pended Claims

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

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

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

HOW TO CHECK THE STATUS OF A CLAIM - CONTROL NUMBER

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

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

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

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

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

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

REMITTANCE ADVICE COPY REQUESTS

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

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

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

UB-82 ADJUSTMENTS/VOIDS

Unlike other types of adjustments/voids, a UB-82 adjustment/void is filed on the same type of claim form as the original claim; the claim and the adjustment/void are both filed on the UB-82 claim form. When filing an adjustment or void on the UB-82 (HCFA-1450) Form Locator 94 ***Remarks*** and Locator 4 ***Type of Bill*** must be completed.

LOCATOR 94

Providers should follow the instructions provided below:

1. Enter an A for an adjustment or a V for a void.

2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.

3. Enter one of the appropriate reason codes:

Adjustments

01 - Third Party Liability Recovery
02 - Provider Correction
03 - Fiscal Agent Error
90 - State Office Use Only - Recovery
99 - Other - Please Explain

Voids

10 - Claim Paid for Wrong Recipient
11 - Claim Paid to Wrong Provider
00 - Other

LOCATOR 4

Providers should follow the instructions listed below:

1. Enter a three-digit code indicating the specific type of facility, bill classification and frequency.

   - **First Digit - Type Facility**

     1 - Hospital
     8 - Special Facility

   - **Second Digit - Classification**

     1 - Inpatient Medicaid and/or Medicare Part A or Parts A & B
     2 - Inpatient Medicaid and Medicare Part B Only
     3 - Outpatient or Ambulatory Surgical Center
     4 - Other - (Non-patient)

   - **Third Digit - Frequency**

     6 - Adjustment for Prior Claim
     8 - Void of Prior Claim

Items which cannot be adjusted on the UB-82 claim form include the following:

- Recipient Number
- Provider Number

* To adjust or void more than one claim line on an outpatient claim form, a separate UB-82 form is required for each claim line as each line has a different Internal Control Number which must be indicated in Form Locator 94.

☞ ***If a TPL payment was not processed by the Fiscal Intermediary, and adjustment must be filed using reason code '01' (Third Party Liability Recovery) for your reason code instead of '03' (Fiscal Agent Error).***

ADJUSTING/VOIDING CLAIMS

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

GENERAL REMINDERS

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

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

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

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

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

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

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

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

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

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

FOR OFFICE USE ONLY

J ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

3 PATIENT'S DATE OF BIRTH

4 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

5 PATIENT'S ADDRESS (STREET, CITY STATE, ZIP CODE)

TELEPHONE NO

6 PATIENT'S SEX
MALE ☐ ☐ FEMALE

7 INSURED S I D MEDICARE AND/OR MEDICAID NO (INCLUDE ANY LETTER)

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 (E G PUBLIC HEALTH AGENCY)

19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

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

21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE?
YES ☐ ☐ 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

23 EPSDT YES ☐ ☐ NO
FAMILY PLANNING YES ☐ ☐ NO

24 PRIOR AUTHORIZATION NO

A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G TOS	H LEAVE BLANK

25 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

IGNATURE OF PHYSICIAN OR SUPPLIER
CERTIFY THAT THE STATEMENTS ON THE REVERSE
PPLY TO THIS BILL AND ARE MADE A PART HEREOF)

31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, AND TELEPHONE

32 YOUR PATIENT S ACCOUNT NUMBER

UNISYS-213
7/91

FISCAL AGENT COPY

SPECIFIC INSTRUCTIONS FOR COMPLETION OF THE 213

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

***BLOCK 1 ADJ/VOID**	Check the appropriate box.
***BLOCK 2 PATIENT'S NAME**	**Adjust:** Enter the name exactly as it appears on the original invoice. **Void:** Enter the name exactly as it appears on the original invoice.
BLOCK 3 PATIENT'S DATE OF BIRTH	**Adjust:** Enter the date exactly as it appears on the original invoice. **Void:** Enter the date exactly as it appears on the original invoice.
BLOCK 4 INSURED'S NAME	**Adjust:** Enter the name exactly as it appears on the original invoice. **Void:** Enter the name exactly as it appears on the original invoice.
BLOCK 5 PATIENT'S ADDRESS AND TELEPHONE NUMBER	**Adjust:** Enter the address and telephone number exactly as they appear on the original invoice. **Void:** Enter the information exactly as it appears on the original invoice.

BLOCK 6	**PATIENT'S SEX**	**Adjust:** Enter the patient's sex exactly as it appears on the original invoice. **Void:** Enter this information exactly as it appears on the original invoice.
***BLOCK 7**	**INSURED'S ID, MEDICAID NUMBER**	**Adjust:** The ID number cannot be changed. If the number was entered incorrectly on the original claim form, the claim form must be voided. **Void:** Enter the number exactly as it appears on the original invoice.
BLOCK 8	**PATIENT'S RELATIONSHIP TO INSURED**	Leave this space blank.
BLOCK 9	**INSURED'S GROUP NUMBER**	Leave this space blank.
BLOCK 10	**OTHER HEALTH INSURANCE COVERAGE**	**Adjust:** If this information is not being adjusted, enter the information exactly as it appears on the original invoice. **Void:** Enter the information exactly as it appears on the original invoice.

BLOCK 11 WAS CONDITION RELATED TO:

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

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

BLOCK 12 INSURED'S ADDRESS

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

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

BLOCK 13 DATE OF ILLNESS:

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

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

BLOCK 14 DATE FIRST CONSULTED YOU FOR THIS CONDITION

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

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

BLOCK 15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?

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

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

BLOCK 16 DATE PATIENT ABLE TO WORK

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

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

BLOCK 17 DATE OF TOTAL DISABILITY/ DATE OF PARTIAL DISABILITY

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

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

BLOCK 18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

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

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

BLOCK 19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES

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

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

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

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

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

BLOCK 21 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?

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

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

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

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

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

BLOCK 23 EPSDT REFERRAL

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

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

***BLOCK 24 ATTENDING PHYSICIAN**

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

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

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

***BLOCK 25 A THROUGH F**	**Adjust:** If you are not adjusting the information, enter the information exactly as it appears on the original invoice. **Void:** Enter the information exactly as it appears on the original invoice.
***BLOCK 26 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS APPROVED**	Enter the correct Control Number shown on the Remittance Advice.
***BLOCK 27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID**	Enter the date of the Remittance Advice.
***BLOCK 28 REASONS FOR ADJUSTMENT**	Check the appropriate box and write a brief narrative to describe why this adjustment is necessary.
***BLOCK 29 REASONS FOR VOID**	Check the appropriate box and write a brief narrative to describe why this void is necessary.
***BLOCK 30 SIGNATURE OF PHYSICIAN OR SUPPLIER**	You must sign the form.
***BLOCK 31 PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.**	Enter the requested information. Enter the provider number. If you are billing for a group, enter the group number in this block and the individual provider number in Block 24.

BLOCK 32 YOUR PATIENT'S ACCOUNT NO.

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

* **Providers must complete these marked items.**

FRAUD AND ABUSE

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

GENERAL

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

FRAUD

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

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

Provider Fraud

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

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

Recipient Fraud

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

- The misrepresentation of facts in order to become or to remain eligible to receive benefits under Medicaid of Louisiana or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;

- The transferring (by a recipient) of a Medicaid Eligibility Card to a person not eligible to receive services under Medicaid of Louisiana or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits; and

- The unauthorized use of a Medical Eligibility Card by persons not eligible to receive medical benefits under Medicaid.

ABUSE

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

Provider Abuse

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

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

Recipient Abuse

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

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

FRAUD AND ABUSE DETECTION

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

Referrals

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

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

Recipient Verification Notices (REOMBs)

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

The REOMB contains the following information:

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

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

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

Computer Profiling

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

Profile reports include the following information:

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

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

ADMINISTRATIVE SANCTIONS

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

Levels of Administrative Sanctions

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

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

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

- Suspending the provider or withholding payments from the provider;

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

- Recovering money from the provider by deducting from future payments or by requiring direct payment for money improperly or erroneously paid;

- Referring a provider to the appropriate state licensing authority for investigation;

- Referring a provider for review by the appropriate professional organizations;

- Referring a provider to the Attorney General's Medicaid Fraud Control Unit for fraud investigation;

- Suspending a provider from participating in Medicaid of Louisiana; and

- Refusing to allow a provider to participate in Medicaid of Louisiana.

Grounds for Sanctioning Providers

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

- A provider is not complying with Medicaid of Louisiana's policy, rules, and regulations or with the terms and conditions prescribed by Medicaid of Louisiana in its provider agreement and signed claim that set the terms and conditions applicable to each provider group's participation in the program.

- A provider has submitted a false or fraudulent application for provider status.

- Such a provider is not properly licensed or qualified, or such a provider's professional license, certificate, or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated.

- Such a provider has engaged in a course or conduct; has performed an act for which official sanction has been applied by the licensing authority, professional peer group, or peer review board or organization; or has continued the poor conduct after having received notification by a licensing or reviewing, indication that his conduct should cease.

- Such a provider has failed to correct deficiencies in his delivery of services or his billing practices after having received written notice of these deficiencies from Medicaid of Louisiana.

- Such a provider has been excluded from participation in Medicare because of fraudulent of abusive practices pursuant to Public Law 95-142, or **such a provider has been convicted of Medicaid fraud (Louisiana R.S. 14:70.1).**

- Such a provider has been convicted of a criminal offense relating to performance of a provider agreement with the state, to fraudulent billing practices, or to negligent practice, resulting in death or injury to the provider's patient.

- Such a provider has presented false or fraudulent claims for services or merchandise for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

- Such a provider has engaged in a practice of charging and accepting payment (in whole or in part) from recipients for services for which a charge was already made to Medicaid of Louisiana and for which payment was already made.

- Such a provider has rebated or accepted a fee or a portion of a fee for a patient referral.

- Such a provider has failed to repay or make arrangements to repay an identified overpayment or otherwise erroneous payment.

- Such a provider has failed, after having received a written request from Medicaid of Louisiana, to keep or to make available for inspection, audit, or copying, records regarding payments claimed for providing services.

- Such a provider has failed to furnish any information requested by Medicaid of Louisiana regarding payments for providing goods and services.

- Such a provider has made, or caused to be made, a false statement or a misrepresentation of a material fact in connection with the administration of Medicaid of Louisiana.

- Such a provider has furnished goods or services to a recipient which are in excess of the recipient's needs, harmful to the recipient, or of grossly inadequate or inferior quality (This determination would be based upon competent medical judgement and evaluation.).

- The provider, a person with management responsibility for a provider, an officer or person owning (either directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate provider, an owner of a sole proprietorship which is a provider, or a partner in a partnership which is a provider is found to fall into one or more of the following categories:

    - Was previously barred from participation in Medicaid of Louisiana;

- Was a person with management responsibility for a previously terminated provider during the time of conduct which was the basis for that provider's termination from participation in Medicaid of Louisiana;

- Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a previously terminated corporate provider during the time of conduct which was the basis for that provider's termination from participation in Medicaid of Louisiana;

- Was an owner of a sole proprietorship or a partner of a partnership which was previously terminated during the time of conduct which was the basis for that provider's termination from participation in the program;

- Was engaged in practices prohibited by federal or state law or regulation;

- Was a person with management responsibility for a provider at the time that such a provider engaged in practices prohibited by state or federal law or regulation;

- Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a provider at the time such a provider engaged in practices prohibited by federal or state law or regulation;

- Was an owner or a sole proprietorship or partner or a partnership which was a provider at the time such a provider engaged in practices prohibited by federal or state law or regulation;

- Was convicted of Medicaid fraud under federal or state law or regulation;

- Was a person with management responsibility for a provider at the time that such a provider was convicted of Medicaid fraud under federal or state law or regulation;

- Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a provider at the time such a provider was convicted of Medicaid fraud under federal or state law or regulation; or

- Was an owner or a sole proprietorship or partner or a partnership which was a provider at the time such a provider was convicted of Medicaid fraud under federal or state law or regulation;

APPEALS

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

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

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

ORDERING INFORMATION

ICD-9-CM CODE BOOK ORDER INFORMATION

ICD-9-CM Code Books are to be used to obtain diagnosis codes. Volume 1 is a numeric listing of diagnosis codes, and Volume 2 is an alphabetical listing (Volume 3 is a listing of ICD-9-CM procedure codes that are used by hospitals only.). These books may be obtained from the following address:

ICD-9-CM
P.O. Box 971
Ann Arbor, MI. 48106

Current prices for ICD-9-CM books may be obtained by phoning the publisher's office. Providers may obtain that number by calling Operator Assistance in the appropriate city. Also, Home Medical School bookstores stock these books.

RETURN/REFUND CHECKS

RETURN CHECKS

All return checks should be mailed to the following address:

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

REFUND CHECKS

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

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

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

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

- Whenever a duplicate payment is made, the full amount of the second payment must be refunded.

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

CHECKS SHOULD NOT BE MADE PAYABLE TO PARAMAX.

THE PRIOR AUTHORIZATION UNIT

On January 1, 1991, the Prior Authorization Unit (PAU) was moved from the BHSF to Paramax. Paramax now handles prior authorization for DME, rehabilitation services, hospital extensions, outpatient visit extensions, eyeglass exceptions, air ambulance services, 158-C procedures, and out-of-state care.

Providers should make all requests for prior authorization to Paramax. Most requests for prior authorization must be made by mail, but there are a few exceptions which may be authorized over the telephone in an emergency (for DME services only).

Once the request for authorization has been made, the provider will be issued a prior authorization number. This number must be entered on all claim forms that are submitted for processing. If this number is not entered on a claim, the claim will be denied.

The address and the telephone numbers for the new Prior Authorization Unit at Paramax are listed below:

Address:	**Attention: Prior Authorization** **Paramax** **P.O. Box 14919** **Baton Rouge, LA. 70898-4919**
Telephone Numbers:	**1-800-488-6334** **(504) 928-5263**

PARAMAX PROVIDER RELATIONS

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

Baton Rouge Providers	**(504) 924-5040**
Providers Outside of Baton Rouge (Louisiana Providers only)	**1-800-473-2783**

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

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

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

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

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

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

RECIPIENT ELIGIBILITY VERIFICATION SYSTEM

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

However, there is a simple solution.

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

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

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

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

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

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

MANUAL UPDATES

It is very important to read all the following documentation, as it contains information in addition to that found in the Hemodialysis Services Manual issued May 1, 1993.

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

The information in the 1997 Hospital/ Dialysis Centers Training packet, Medicaid Issues for 1997, was published in September, 1997.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

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

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

May 20, 1998

To: **All Medicaid Enrolled Providers**

From: Thomas D. Collins

Re: Statutorily Mandated Revisions to all Provider Agreements

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

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

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

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
(504) 342-3956 OR (504) 342-5774 • FAX (504) 342-3893

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

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

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

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

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

David W. Hood
SECRETARY

August 18, 1998

MEMORANDUM

TO: All Enrolled Medicaid Providers

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

RE: Office for Civil Rights Policy Memorandum

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

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

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

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

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

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

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

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

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

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

Nancy-Ann Min DeParle

The attached pages are from the 1997 Louisiana Medicaid Provider Training packet for Hemodialysis providers. These pages contain important information about billing for hemodialysis services.

POLICY REMINDERS - HEMODIALYSIS

Description of Services

Louisiana Medicaid Program will reimburse Medicaid enrolled free-standing End Stage Renal Disease (ESRD) facilities for the services outlined in this section. To become enrolled in Louisiana Medicaid Program, however, these facilities must be Medicare certified.

Once the facility is enrolled in Louisiana Medicaid Program, reimbursement to the facility will be determined by the facility's charge for the service(s) rendered. These charges, however, should not exceed Medicare allowable charges for comparable services.

Reimbursement is made to free-standing hemodialysis facilities for the following services:

- Dialysis treatment (including routine laboratory services);
- Medically necessary non-routine lab services; and
- Medically necessary injections.

Dialysis Services

Dialysis services will be reimbursed by Louisiana Medicaid Program. Providers billing for dialysis treatment (**technical component**) should use revenue code 821 and bill on the UB-92 claim form. To bill for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) services, providers should use revenue codes 841 and 851, respectively.

Providers billing for physician supervision of dialysis (**professional component**) should bill on the HCFA-1500 claim form.

Reimbursement for some laboratory tests required monthly for CAPD and CCPD patients is also included in the composite rate. These laboratory tests include the following:

- Bun
- Creatinine
- Sodium
- Dialysate Protein
- Albumin Hgb
- Carbon Dioxide
- LDH
- Phosphate
- SGOT
- Magnesium Alkaline Phosphates
- Calcium
- Total Protein
- Potassium
- HCT

Epoetin Alfa (EPO)

Epoetin Alfa (EPO); also referred to as Epoetin or Epogen, is covered under Louisiana Medicaid Program when it is used to treat anemia associated with chronic renal failure. Patients with this condition include those who require renal dialysis and are eligible for Medicare under the end-stage renal disease (ESRD) provisions of the law. EPO may be administered either intravenously or subcutaneously for the treatment of anemia associated with chronic renal failure. Coverage can be made for facility-dialyzed recipients, as well as for recipients who dialyze at home and are competent to use the drug without medical or other supervision. The facility is required to limit the "on-hand" supply to home dialysis recipients up to a two-month's supply. Initially, the facility may bill for up to a two-month's supply. Subsequently, however, the facility must bill for only a one-month's supply at a time.

Billing for EPO Services

This service must be billed under revenue code 634 for the administration of any units under 10,000 units and revenue code 635 for the administration of 10,000 units or more. The reimbursement for HR634 is $40.00. If it is necessary for the provider to bill HR635 for 10,000 units or more, an additional $30.00 is paid under code 635.

Providers must bill both codes 634 and 635 if billing for 10,000 units or more. When billing revenue code HR635, providers must complete and submit the ***Epoetin Alpha (EPO) Required Documentation*** form with the claim. Providers should address the following in their medical documentation:

- Iron deficiency (Most patients will need supplemental iron therapy while being treated, even if they do not start out iron deficient.);
- Concomitant conditions such as infection, inflammation, or malignancy (These conditions should be addressed insofar as possible for EPO to have maximum effect.);
- Unrecognized blood loss [Patients with kidney disease and anemia may have chronic blood loss (usually gastrointestinal) as a reason for the anemia; as a result, the effectiveness of EPO will be limited.];
- Concomitant hemolysis, bone marrow dysplasia, or refractory anemia for a reason other than renal disease, such as aluminum toxicity;
- Folic acid or vitamin B_{12};
- Circumstances in which the bone marrow is replaced with other tissue, such as malignancy or osteitis fibrosa cystica; and
- Patient's weight, the current dose required, a historical record of the amount that has been given, and the hematocrit response to date.

APPROVED OMS NO. 0938-027

Renal Center Of LA.
708 SUNDAY DR.
HOPE, LA. 790943

2	3 PATIENT CONTROL NO	4 TYPE OF BILL
		721

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/03/97	01/31/97					

12 PATIENT NAME: George Kimberly

13 PATIENT ADDRESS

14	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	26	28	30	31
										CONDITION CODES				

32 CODE	32 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
							A
							B
							C

	39 CODE	39 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a				
b				
c				
d				

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	821	Hemo/Composit	90935	01/03/97	1	120 00		
2	821	Hemo/Composit	90935	01/05/97	1	120 00		
3	821	Hemo/Composit	90935	01/10/97	1	120 00		
4	821	Hemo/Composit	90935	01/13/97	1	120 00		
5	821	Hemo/Composit	90935	01/16/97	1	120 00		
6	821	Hemo/Composit	90935	01/19/97	1	120 00		
7	821	Hemo/Composit	90935	01/22/97	1	120 00		
8	821	Hemo/Composit	90935	01/25/97	1	120 00		
9	821	Hemo/Composit	90935	01/28/97	1	120 00		
10								
11								
12								
13	001				9	1080 00		
14								

HEMODIALYSIS CENTER

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	1799999					

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Kimberly George		2600000000020		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	OTHER DIAG. CODES 70 CODE	72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
585							

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE		
OTHER PROCEDURE CODE	DATE		OTHER PROCEDURE CODE	DATE		

82 ATTENDING PHYS. ID: 72-6584992

83 OTHER PHYS. ID

OTHER PHYS. ID

REMARKS

85 PROVIDER REPRESENTATIVE: X

86 DATE: 02/12/97

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

OCR / Original

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

July 13, 1999

TO: Administrators of Title XIX Hemodialysis Centers

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

RE: Verification of Medical Transportation (Form MT-3)

It has come to our attention that some hemodialysis centers maintain all of the MT-3 forms in a single stack during the recipients' treatment, making it necessary for the driver to go through every form in the stack in order to find his own. In order to expedite the process for the drivers and to protect the recipients' confidentiality, we are requesting that you separate the MT-3 forms by transportation provider and place each provider's forms in a folder labeled with the name of the company.

We appreciate your cooperation in this matter. If you have any questions, please contact Ms. Willene Mire at (225) 342-0127.

cc: Medical Dispatch, Inc.
Baton Rouge Dispatch
New Orleans Dispatch
Ruth Kennedy

OFFICE OF MANAGEMENT & FINANCE
1201 CAPITOL ACCESS ROAD • P. O. BOX 629 • BATON ROUGE, LOUISIANA 70821-0629
PHONE #: 225/342-6726 • FAX #: 225/342-5568