LONG TERM CARE SERVICES

Chapter Fourteen of the Medical Services Manual

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

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

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

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GENERAL MEDICAID INFORMATION

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

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

- Determining all necessary regulations and guidelines for Medicaid of Louisiana program policy;
- Administering the program;
- Determining the services covered by the program and setting the reimbursement rates within federal guidelines;
- Determining the quality of care provided to recipients in LTC facilities;
- 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 audit profiles.

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***.

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.

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. When the provider completes a claim form to be submitted to the fiscal intermediary for processing, the provider **must** attach the Form 110-MNP. Payment will be made in accordance with the usual reimbursement rates set by Medicaid of Louisiana.

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.

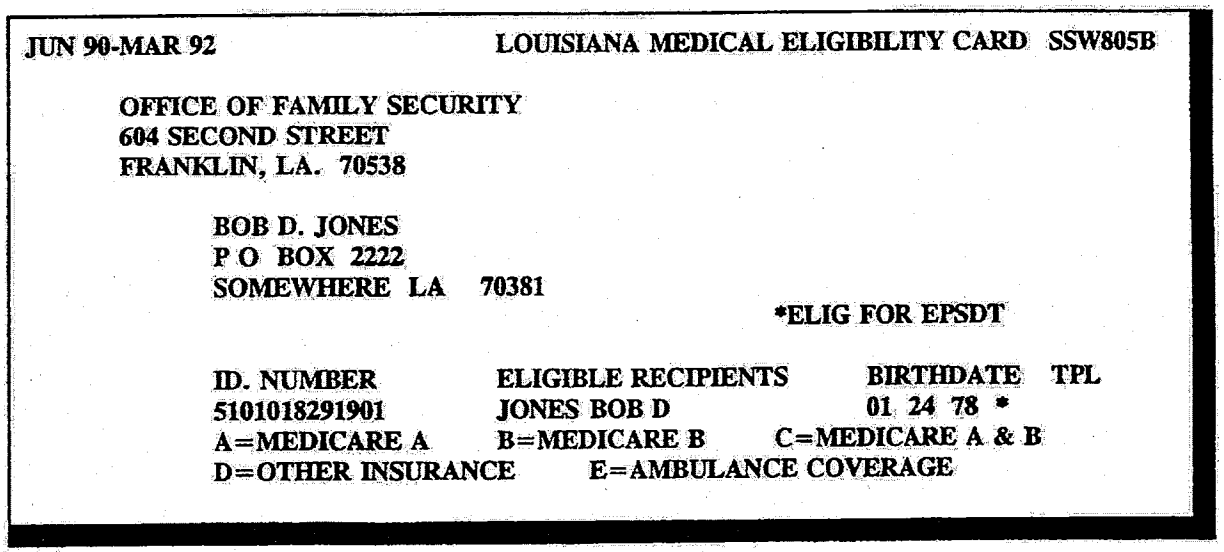
Patient Name and ID No. (include Recipient No.)	Date of Service	Provider Name and Vendor No.	Service or R_x Received On Spend-Down Date	Total Unpaid Charges for Services Received	Recipient Liability	OED Liability (Amt. and FI's actual payment may differ)
Anna M. Doar 3601012345601	07/15/90 mo/dy/yr	1312345 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. Pure QMB Medical Eligibility Card Issued by Paramax

LOCK-IN PROGRAM

The BHSF has developed a program to educate recipients who may be 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 the same size as 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.

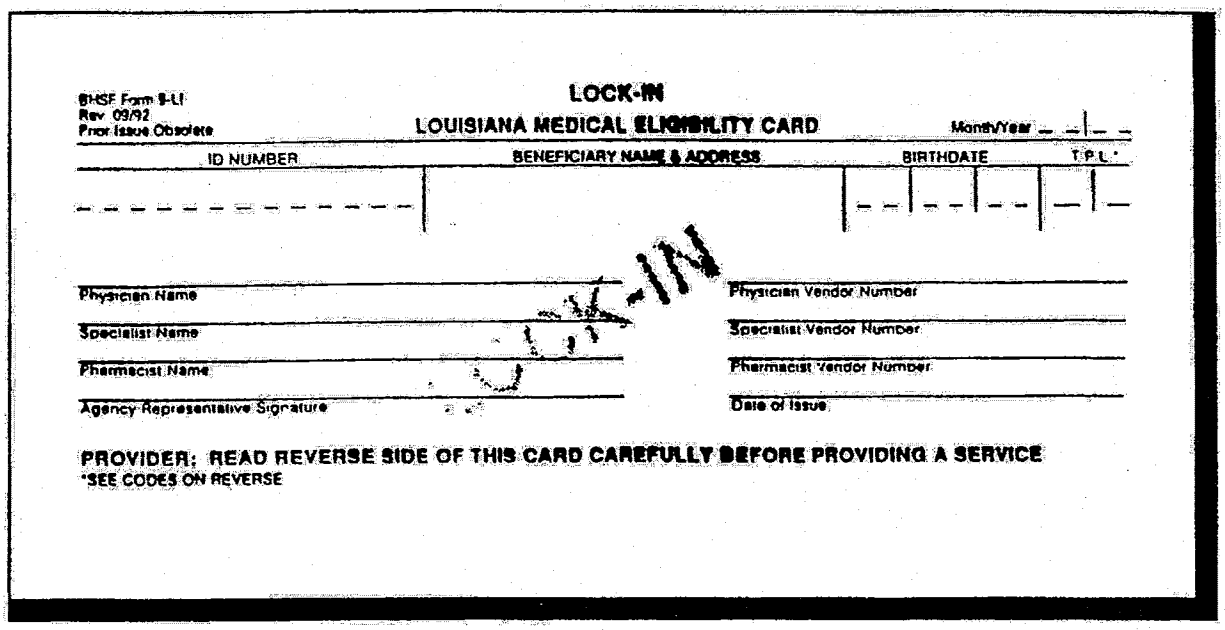
There may be circumstances under which it is necessary for a Lock-In physician to refer the Lock-In recipient for consultation on a one-time basis. The consulting physician may be reimbursed for the consultation if that consulting physician enters the name of the referring Lock-In physician in the **Referring 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 hardcopy claim forms. These hardcopy claims for emergency prescriptions should be submitted to the following address:

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

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.*
_ _ _ _ _ _ _ _ _ _ _ _		_ _ | _ _ | _ _	_ | _

LOCK-IN

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.

☞ ***CommunityCare recipients are not restricted for pharmacy services.***

LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR - MARCH 92

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

TYPE CASE 10

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

******** CAR-RT SORT ** B001
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.

The parish office of eligibility determination is responsible for determining recipient liability for LTC services. This office will send the LTC facility a **Notification of Payment Form (148-A Form)** each month to notify the facility of the amount of the bill the recipient is responsible for paying.

RECIPIENT ELIGIBILITY FOR LTC SERVICES

In order to be classified as a recipient for LTC services, an individual must be certified as ***categorically eligible***. That is, the recipient must meet the general Medicaid eligibility requirements, e.g., being classified in a certain income bracket. Also, the recipient must prove that his or her medical condition warrants placement in a LTC facility.

Generally, the eligibility determination process consists of the following steps:

- Appropriate medical and social evaluations, including a plan of care and physician certification and exploration of alternatives to institutional care, are submitted to the appropriate BHSF office for medical certification procedures. After medical eligibility requirements have been established, the BHSF office issues a **Long Term Care Notice of Medical Certification (BHSF Form 142).**

  ☛ ***A copy of the Long Term Care Notice of Medical Certification (BHSF Form 142) is provided on page 4-16 of this provider manual.***

- The parish office of eligibility determination establishes categorical eligibility and forwards notices to the provider and LTC regional office. The BHSF office issues a **Long Term Care Admission/Change Form (BHSF Form 51-NH)** to the facility after categorical eligibility and medical certification requirements have been established.

  ☛ ***A copy of the Long Term Care Admission/Change Form (BHSF Form 51-NH) is provided on page 4-17 of this provider manual. Providers must attach a recipient's 51-NH form to the TAD claim form when requesting payments for services. Providers may not bill for new recipients unless they receive a new 51-NH form for a new recipient.***

A BHSF FORM 142
Revised 08/91
Prior Issues Usable

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM (TITLE XIX)

NOTICE OF MEDICAL CERTIFICATION

Date of Birth: _____

WIS ID No _____

To: _____ SSN _____

Home Address. _____

Facility/Provider Name and Address: _____
(If Medical Assistance applicant in facility)

_____

☐ I Medical and related social information has been carefully reviewed in relation to your need for Skilled Nursing Facility or Immediate Care Facility services or for Home and Community-Based services This is to advise you of the determination made This is separate and distinct from a determination of your eligibility for Medicaid (Title XIX) based on your financial resources and income

☐ A. Approved for _____ services effective _____.

- Determination is effective for 30 days prior to admission to a facility which provides ICF services and 5 days prior to admission to a facility which provides SNF services.
- Determination will be subject to periodic review of continued need

☐ B. Not Approved – Does not meet Medicaid qualifications under Title XIX.

☐ C. Not Approved - Unable to make a determination as information requested has not been received

☐ II. Current medical and related social information has been reviewed in relation to your need to continue

_____ services. This is to advise you of the determination made

☐ A. No Longer Approved.

- Medicaid payment will continue for above type services through _____.
- This is not a notice of discharge but relates to benefits only.

☐ B. Approved for _____ services effective _____.

- These services can be provided by:
  - ☐ Continued stay in same facility.
  - ☐ Admission to an appropriate facility (Contact parish Office of Family Support if assistance with transfer is needed.)

_____ M.D.
Title

_____
Address

_____

_____
LTC Regional Office Address

_____
Date

WHITE-Recipient
BLUE- Facility/Provider
GREEN-Recipient's home parish
PINK-OFS Parish Office where facility is located
GOLDEN-LTC Regional Office

LA BHSF FORM 51-NH
Rev 1/92
III

Prior Issues Usable

ADMISSION/CHANGE FORM

1. _____ PROVIDER NAME

2. _____ PROVIDER NO

3. _____ REGION NO

4 _____ RECIPIENT NAME

5 _____ RECIPIENT I D No

6. _____ PARISH OF RESIDENCE

7 _____ CERTIFICATION/ADMISSION CODE

7A _____ ADMISSION DATE

8. _____ DATE VENDOR PAYMENTS BEGINS TO FACILITY

8A _____ RECIPIENT LIABILITY

9 _____ ASSIGNED REVIEW DATE

10 _____ EFFECTIVE CERT/ CHANGE DATE

11 CLASSIFICATION OF CARE
- ☐ Skilled (20)
- ☐ ICF I (21)
- ☐ ICF II (22)
- ☐ ICF/MR (26)
- ☐ Mental Hospital–Under 21 (23)
- ☐ Mental Hospital–65 & Over(24)
- ☐ SNF/TDC (28)
- ☐ ICF/MR Rehab. (29)
- ☐ SNF/ID (30)

12. WAIVER
- ☐ Skilled (20)
- ☐ Adult Day Health Waiver (27)
- ☐ MR/DD Waiver
  - ☐ Personal Care Attendant
  - ☐ Respite Care
  - ☐ Sub. Family Care
  - ☐ Spvr. Independent Living
  - ☐ Hab./Supported Employment

13. _____ PRIMARY DIAGNOSIS

14. _____ SECONDARY DIAGNOSIS

15. _____ SOURCE OF ADMISSION

16. _____ DATE FORM COMPLETED

_____ SIGNATURE

_____ ID#

SOURCE OF ADMISSION CODE
ITEM 15

1–OWN HOME
2–BOARDING HOME
3–HOME OF RELATIVE
4–FOSTER HOME
5–GENERAL HOSPITAL
6–MENTAL HOSPITAL
7–ICF/MR
8–ICF I/II
9–SNF
10–APPLICANT IN FACILITY
11–ADULT DAY HEALTH CARE SERVICES
12–OTHER

CERT/ADMISSION CODES
ITEM 7

1– READMISSION OF RECIPIENT TO SAME OR ANOTHER LTC FACILITY WITHIN A PERIOD OF TWO WEEKS OR LESS AFTER PRIOR DISCHARGE.
2– READMISSION OF RECIPIENT TO SAME OR ANOTHER LTC FACILITY WITHIN A PERIOD OF MORE THAN TWO WEEKS AFTER PRIOR DISCHARGE.
3– READMISSION OF A RECIPIENT TO SAME OR ANOTHER LTC FACILITY, DISREGARDING TIME LAPSE, AFTER A STAY IN A HOSPITAL OR DISCHARGE.
4– NEW ADMISSION OF RECIPIENT INTO A LTC FACILITY.
5– APPLICATION OF A PATIENT ALREADY IN A FACILITY FOR TITLE XIX CERTIFICATION.
6– USED TO INITIATE CHANGES TO AN EXISTING ACTIVE RECIPIENT RECORD.

HSSRO Copy

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
Health Standards Section
P.O. Box 3767
Baton Rouge, LA. 70815

☎ (504) 342-0113 OR (504) 342-0138

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.

REQUIREMENTS FOR PARTICIPATION

Requirements for participation applicable to skilled nursing facilities and intermediate care facilities are published in the ***Standards for Payment For Nursing Facilities.*** This document is issued by the Health Standards Section at the Bureau of Health Services Financing (BHSF) in Baton Rouge.

Provided below is a list of the three different types of LTC facilities that may enroll in Medicaid of Louisiana:

- Nursing facilities,
- ICF-H facilities, and
- Mental health hospitals.

REIMBURSEMENT FOR SERVICES

The amount of reimbursement Long Term Care facilities receive from Medicaid of Louisiana is based on an estimate of how much it costs to operate the facility and maintain adequate patient care. The estimate includes room and board costs.

The BHSF sets the reimbursement rates for nursing and mental health facilities, and a special unit of the BHSF named the Rate Administration Unit sets the rates for ICF-H facilities.

Provided in this section is a description of LTC services and the policy governing reimbursement for these services.

REIMBURSEMENT FOR THE MONTH OF ENTRY

Usually, Medicaid will not pay for the month the recipient is admitted to a nursing home. The only exceptions to this policy include the following situations:

- When the recipient is eligible for LTC services before entering the nursing home

OR

- When the recipient was institutionalized in a hospital or another nursing home during the month of admission into a Medicaid nursing home.

When a recipient is eligible during the month of entry, Medicaid payment will start from the date the vendor payment begins. Payment will be calculated at the number of days approved times the facility's daily per diem rate. Then, the recipient's daily patient liability amount times the number of approved days will be subtracted from the calculated per diem amount. This calculation will be done for those recipients who are eligible less than a full month.

REIMBURSEMENT FOR TRANSFERS

Medicaid will pay for transfers from one facility to another, but only under certain circumstances.

- **During the Month of Entry.** For those persons eligible for vendor payments during the month of entry, Medicaid payment will start from the date the vendor payment begins. Payment will be calculated at the number of days approved times the facility's daily per diem rate. Then, the recipient's daily patient liability amount times the number of approved days will be subtracted from the calculated per diem amount. This calculation will be done for those recipients who are eligible less than a full month.

- **During the Regular Month.** During a regular month, Medicaid will pay (to each facility) the applicable per diem rate, less the per diem recipient liability, times the number of days the recipient was in the facility.

REIMBURSEMENT FOR CHANGES IN LEVEL OF CARE

For the number of days the recipient was eligible for each different level of care, Medicaid will pay the facility the applicable per diem rate, less the per diem recipient liability.

REIMBURSEMENT FOR THE DATES OF ADMISSION AND DISCHARGE

Medicaid will not pay for the date of discharge. In addition, Medicaid will not pay for the date of admission unless the recipient's Medicaid eligibility has been established prior to the date of admission to the facility. Also, Medicaid will not reimburse two different facilities the per diem for the same recipient on the same date of service.

☞ ***Medicaid will pay for the date of death.***

REIMBURSEMENT FOR EVACUATIONS

When local conditions require evacuations of residents in LTC facilities, the following payment procedures apply:

- If clients are absent from the facility for less than 24 hours, the facility should charge for a service day.

- If the facility sends staff with the clients to the evacuation site, the facility should charge for a service day.

- If the clients go to a family or friend's home at the facility's request, the facility should charge neither a service day nor a leave day, and the facility should not collect patient liability.

- If the clients go home at the family's request or on their own initiative, the facility should charge a leave day.

- If a client evacuates to the hospital, the hospital should not charge Medicaid for a hospital day.

The BHSF, Health Standards Section, requires that LTC facilities have an evacuation plan approved for emergency situations, such as tornadoes, floods, etc. The plan must include decisions about sites, medications, and identification of clients.

MEDICARE/MEDICAID REIMBURSEMENT

Provided below are the payment calculation specifications for recipients who have both Medicaid and Medicare coverage:

Medicaid will compare the Medicare per diem rate, the coinsurance rate, and the provider's Medicaid Provider File per diem rate.

- ☞ When the Medicare rate is the lowest, Medicaid will multiply the Medicare rate amount times the number of coinsurance days in order to determine the Medicaid payment.

- ☞ When the Medicaid per diem rate is the lowest, Medicaid will subtract the coinsurance rate from the Medicare per diem rate and subtract the net result from the Medicaid per diem rate. The remaining amount will be multiplied by the number of coinsurance days in order to determine the Medicaid payment.

Example: Medicare per diem - $100.00
Coinsurance rate - 84.50

15.50

Medicaid per diem rate - $53.00
15.50

Medicaid payment 37.50
(x No.of coinsurance days)

☞ When the coinsurance rate is the lowest, Medicaid will multiply the coinsurance rate times the number of coinsurance days to determine the Medicaid payment.

Medicaid's per diem rates have not, thus far, exceeded the coinsurance rate.

NEW REIMBURSEMENT POLICY FOR SKILLED NURSING FACILITIES (SNF)

Effective January 1, 1990, only facilities certified to provide skilled services may bill Medicare.

In addition, the skilled nursing medical criteria remains the same for both Medicare and Medicaid. The medical criteria did not change with the repeal of catastrophic insurance.

However, the number of Medicare-covered days is now 100 days, beginning January 1, 1990.

REIMBURSEMENT FOR HOSPITALIZED NURSING HOME RESIDENTS

When a nursing home resident is admitted to a Distinct Part Psychiatric Unit of an acute care hospital, Medicaid will pay to reserve the recipient's nursing home bed for 10 days per hospitalization just as it does for an acute care admission. In the event that the hospitalization exceeds 10 days, the recipient or his family may pay the nursing home to continue to reserve a bed.

The practice of discharging the patient for 24 hours and then readmitting him in order to "protect" his nursing home bed is not an accepted practice.

REIMBURSEMENT FOR LEAVE DAYS

Provided below is Medicaid's reimbursement policy for temporary leaves. This policy applies to home visits and hospital visits. Although federal regulations do not require states to pay for any days that a recipient is absent from the facility, we have established policy under which facilities may bill for visits with family and friends and for temporary hospitalization absences.

A **leave day** is an absence from the facility for a 24 hour period or more. A leave of absence is broken only when the recipient returns to the facility for at least a 24 hour period. According to Medicaid policy, leaves of absence, excluding elopements and hospitalization, should be considered as part of the individual's treatment plan.

Hospital leave days of ten days per occurrence are permitted for recipients in Nursing facilities. Recipients in ICF-H facilities will be allowed 15 days per occurrence.

Home leave days for recipients in Nursing facilities are limited to nine days per calendar year.

Home leave days for recipients in ICF-H facilities are limited to 45 per fiscal year (July 1 of one year through June 30 of the next year), The 45 days is further limited to 14 days per occurrence and must be included in the recipient's plan of care.

Leave days are also permitted under the following circumstances:

- Special Olympics
- Roadrunner sponsored events
- Louisiana planned conferences
- Trial discharges (limited to 14 days per occurrence)

These leave days are not deducted from the 45 day leave days allowed per year. However, 13 leave days per occurrence are allowed. After 14 days, the recipient will be discharged.

☞ ***These leave days must be included in the client's plan of care.***

An individual's direct transfer from one institution to another does not change the number of home leave days he is allowed per calendar year if he is cared for in a nursing home or in an intermediate care facility for the handicapped.

In addition, the limits do not mean that other leave days will not be permitted. However, Medicaid will not pay for the extra leave days; arrangements for payment must be made with the recipient's responsible party. Such arrangements may include a charge by the facility to the family for the full Medicaid rate or for a reduced daily rate, or the facility may absorb the cost of non-covered days into its operating costs.

REIMBURSEMENT FOR SKILLED SERVICES

On July 1, 1989, new criteria were developed for the skilled service determination process for Medicaid recipients. In addition, new reimbursement procedures were developed.

Provided below is a list of the new reimbursement procedures:

- The facility should bill Medicare first if the client is Part A eligible and meets the skilled criteria.
- Under no circumstances can Medicaid certify for skilled services if Medicare denies payment.
- If the facility UR Committee makes a determination not to bill Medicare because the skilled criteria are not met. Medicaid cannot certify for skilled services.
- If the client is not eligible for Medicare Part A, but is eligible for Medicaid, only the medical determination for skilled services will be made by regional office staff.

☛ ***The revised criteria indicate that documentation must be done on a daily basis. The skilled criteria is included in the Nursing facilities standards for payment manual.***

Medicaid will determine that an individual meets the requirements for the SNF level of care in a LTC facility when the criteria listed below (based on current needs) are met. These criteria are meant to be objective, self-explanatory, and universally applicable.

- The individual requires nursing, psychosocial, or rehabilitation services, i.e., services that must be performed by or under the supervision of professional health personnel. Examples of such services include registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech pathologist, or audiologist services.

- The individual requires such services on a regular basis (7 days per week or 5 days per week for rehabilitation services).

- The daily skilled services can be provided only on an inpatient basis in a skilled nursing facility.

Provided below is a more comprehensive list of the services that require the supervision of professional personnel:

- Intravenous, intramuscular, or subcutaneous injections;

- Nasogastic tube and gastrostomy feedings;

- Insertion, sterile irrigation and replacement of catheters as adjunct to active treatment of a urinary tract disease;

- Application of dressings involving prescription medications and sterile techniques;

- Nasopharyngeal or tracheostomy aspiration;

- Treatment of decubitus ulcers (of a Grade 3 severity or worse) or of a widespread skin disorder;

- Heat treatments (moist), specifically ordered by a physician as part of active treatment done by a physical therapist;

- Initial phases of a regimen involving administration of medical gases, such as bronchodilator therapy;

- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, i.e., bowel and bladder training;

- Care of a colostomy during the early postoperative period in the presence of associated complications;
- Observation, assessment, and judgement of professional personnel in the presence of an unstable or complex medical condition to ensure the safety of the recipient and/or other residents in cases of active suicidal or assaultive behavior; and
- Physical therapy, speech therapy, or occupational therapy that occurs at least five times per week.

☞ ***Documentation must support the criteria that skilled nursing services were needed and that these services were provided on a daily basis.***

REIMBURSEMENT FOR PRIVATE ROOMS

Rooms in LTC facilities usually accommodate two or more recipients. Therefore, vendor payments due not include fees for private rooms.

REIMBURSEMENT FOR TRANSPORTATION

A facility cannot include the cost of transporting recipients in the cost report. However, even though transportation costs are not included in the vendor payment, the facility will be responsible for arranging transportation under the Transportation Program if the services are needed.

☞ ***Under no circumstances should the facility require its recipients or responsible parties to provide for or to pay for transportation services.***

The BHSF or a contracted agency will be available to assist with arranging transportation services. However, the facility should contact the BHSF or contracted agency at least two days in advance of the medical appointment to allow for arrangements to be made.

☞ ***The recipients freedom of choice in selecting a transportation provider must be respected and conveyed to the BHSF or the contracted agency when the request for transportation services is made.***

If less than two day's notice is given, transportation resources will be explored but may not be available.

When the facility cannot contact the BHSF or the contracted agency (on weekends and holidays and at night), non-emergency ambulance transportation may be arranged in an emergency situation.

On the next working day, however, the facility should notify the BHSF or the contracted agency via a MT-2 form. This form will be reviewed, and the BHSF or contracted agency will authorization to the ambulance company.

REIMBURSEMENT FOR ATTENDANT SERVICES

The facility is required to provide an attendant if the recipient or the responsible party cannot arrange for an attendant. Under no circumstances should the facility require the recipient or the responsible party to pay for an attendant.

REIMBURSEMENT FOR PHYSICAL THERAPY

The facility will be responsible for making physical therapy arrangements when the therapy is recommended by the attending physician.

REIMBURSEMENT FOR VENTILATOR EQUIPMENT

Medicaid will pay for ventilator equipment required by dually eligible Medicare/Medicaid recipients in LTC facilities. Medicaid, however, cannot provide this equipment to individuals in a skilled nursing facility until 20 days after the nursing home admissions date.

☞ ***Medicaid would like to encourage the nursing home staff to ask families to return life-saving equipment, such as ventilators, for use by other Medicaid recipients.***

REIMBURSEMENT FOR OXYGEN CONCENTRATORS

Oxygen concentrators may be requested through the Durable Medical Equipment Program.

REIMBURSEMENT FOR DENTAL SERVICES

Nursing facilities should have satisfactory arrangements for assisting recipients in obtaining routine and emergency dental care. A recipient's freedom of choice in selecting a dentist should be respected.

REIMBURSEMENT UNDER THE SWING BED PROGRAM

Effective February 1, 1985, the Swing Bed Program was implemented by Medicaid to reimburse for SNF services in enrolled rural hospitals with less than 50 beds (excluding nursery and ICU beds). In such hospitals, a certain number of beds may be designated as SNF beds or acute care beds.

Requirements for SNF services in Swing Bed facilities are the same as free-standing SNF requirements. As stated in the LTC standards for payment manual, the following will be required:

- Physician certification
- A plan of care
- SSD
- Patient activities
- Complaint investigation procedures
- Accurate record keeping

Eligibility requirements are the same as well. Any Medicaid eligible, except a Medically Needy recipient, who applies for SNF services will be eligible the month of admission and prior to the first full calendar month in the facility.

Payment for swing bed services is set at the average statewide SNF rate.

A lack of compliance with SNF standards for swing bed certification does not affect the facility's participation as a Medicaid hospital.

HOSPICE SERVICES PROVIDED IN NURSING FACILITIES

"Hospice" is a concept which extends a process of care to terminally ill patients. Hospice is a program of palliative (control of pain and symptoms) and supportive services which provides physical, psychological, social and spiritual care for dying persons and families.

Hospice care concentrates on assuring the quality of the terminal patient's remaining life rather than on trying to prolong the length of that life.

A Louisiana nursing facility (NF) resident who is eligible for both Medicare and Medicaid can elect the Medicare hospice benefit if the nursing home is being or could be reimbursed for the resident's care by Medicaid. Hospice beneficiaries receive hospice NF benefits and pharmacy benefits only. Other needed medical care is arranged for by the hospice.

HOSPICE ADMISSION CRITERIA

1. The beneficiary must be eligible for Medicare Part A.

2. The beneficiary must be Medicaid eligible or found Medicaid eligible upon entering a NF.

3. A prognosis of six months or less shall be confirmed by the attending physician. The prognosis of the terminal illness must be in terms of days, weeks or months.

4. Election of the hospice benefit must be made by the competent beneficiary or family member, in the order described by Louisiana law, for the non-competent beneficiary.

5. Care goal must be palliative and not curative.

6. Beneficiary must be under the care of an attending physician who consents to the hospice admission and who will continue to assume responsibility for medical care.

7. The beneficiary lives in a nursing facility within the hospice service area.

8. Final determination of medical eligibility for admission to hospice is made by the Health Standards Section of the Bureau of Health Services Financing.

RESPONSIBILITY OF PARTICIPATING PROVIDERS

The nursing facility and the hospice must have a contractual agreement outlining the specific responsibilities of each entity which shall include but is not limited to:

1. Eligible beneficiaries.

2. Services to be furnished by the hospice.

3. Services to be furnished by the nursing facility.

4. Cooperation in professional management.

5. Financial responsibility.

6. Provider of first choice.

7. Public relations.

8. Compliance with government regulations.

9. Terms of agreement.

10. Indemnification and limit of liability.

The Bureau of Health Services Financing has adopted the "Protocol and Agreement for the Provision of Hospice to Nursing Facility Residents" (see page 8.1-8).

MEDICAID ENROLLMENT FOR HOSPICE PROVIDERS

The provider shall request a Title XIX Medicaid enrollment packet from the following address:

Health Standards Section Provider Enrollment
P. O. Box 3767
Baton Rouge, LA 70821
☎ (504) 342-0138

The provider enrollment form (PE50) shall be returned to that office as soon as it is completed and signed by the administrator or authorized representative.

The hospice provider must be licensed and certified by the department in accordance with federal regulations and state law prior to submitting an application for Medicaid hospice enrollment.

MEDICAID REIMBURSEMENT

When a dually eligible beneficiary elects the Medicare hospice benefit and the hospice and the nursing facility (NF) have a written agreement under which the hospice is responsible for the professional management of the beneficiary's hospice care and the NF agrees to provide room and board to the beneficiary, the Medical Assistance Program will pay the hospice an amount equal to the amounts allocated under the State Plan for room and board in the NF. The hospice will reimburse the NF for room and board. Medicaid payment to the NF is discontinued when payment to the hospice begins. Transfer and Admission forms (Form 148) are filed by the NF and the hospice provider effecting the transfer.

In the context of hospice - NF care, the term "room and board" includes performance of personal care services which includes:

1. Assistance in the activities of daily living
2. Socializing activities
3. Administration of medication

4. Maintaining the cleanliness of resident's room

5. Supervision and assistance in the use of durable medical equipment and prescribed therapies.

It continues to be the responsibility of the NF to collect the beneficiary's personal liability income (PLI) to be applied to the Medicaid hospice per diem.

FEDERAL REGULATIONS AND STATE REQUIREMENTS

The NF must continue to meet all federal regulations for certification and state requirements for licensure.

The hospice must continue to meet all federal regulations for certification and state requirements for licensure.

The beneficiary who is receiving hospice in the NF will be subject to surveys for both the Long Term Care and hospice programs.

ADMISSION REVIEW PROCEDURES

The following procedures shall be followed when the hospice benefit is elected by the dually eligible beneficiary currently residing in the NF:

1. The NF must:

   a. discontinue billing Medicaid on the date that hospice is elected;

   b. notify the Health Standards Section (HSS) regional office and respective parish office by OFS Form 148 that beneficiary is being placed in the hospice category on effective date; and

   c. provide the hospice provider a copy of OFS Form 148 indicating the date of discharge from NF care.

2. The hospice must submit the following information to HSS regional office for review:

   a. the attending physician's referral confirming prognosis of less than (6) six months and to approve the hospice admission;

   b. the hospice RN assessment;

   c. the plan of care; and

   d. OFS Form 148 from the hospice to indicate the effective date of admission to hospice care, and a copy of Form 148 from the NF indicating the date of discharge for those beneficiaries who are already placed in a NF.

3. The BHSF Health Standards Regional Office must:

   a. review all documentation and determine medical eligibility;

   b. issue admissions approval Form 142 indicating the name of the hospice, the level of care and the name of the NF for approved admissions and the date of eligibility for approved hospice; and

   c. upon notification of financial eligibility, issue Form 51-NH to the hospice to authorize billing.

NOTE: When the recipient is dually eligible this action is handled according to the established transfer procedures.

4. The Parish Office must:

   a. determine eligibility for hospice care for dually Medicare-Medicaid eligible residents requesting hospice care according to the standards for NF eligibility;

   b. upon eligibility determination, issue Form 18-LTC to NF to discontinue billing; and

   c. issue Form 18-LTC notifying client and Health Standards regional office of the client's eligibility and send a copy indicating the amount of payment and PLI to both the hospice and NF.

The following procedures shall be followed when the hospice benefit is elected by an individual **prior to admission** to the NF.

1. The NF must submit the following to the Health Standards regional office for review;

   a. Forms 148, 90-L, and PASARR-1 as outlined in the Standards for Payment for Nursing facilities.

> **NOTE:** Form 148 will specify the level of care, effective date of admission, and **must include a notation at the bottom of the admission section** that the applicant is entering the hospice at the same time. Representatives of both the NF and the hospice should sign Form 148 at the bottom.

2. The hospice must submit the following information to the Health Standards regional office for review:

   a. the attending physician's referral confirming prognosis of less than six (6) months to live, including approval of the hospice admission;

   b. the hospice RN assessment; and

   c. the plan of care.

3. The BHSF Health Standards Regional Office must:

   a. review all documentation and determine eligibility;

   b. issue admissions approval Form 142 indicating the name of the hospice, the level of care and the name of the NF; and

   c. upon notification of financial eligibility, issue Form 51-NH to the hospice to authorize billing.

4. The Parish Office must:

   a. determine eligibility for hospice care for individuals requesting hospice care according to standards for NF eligibility; and

   b. upon eligibility determination, issue Form 18-LTC notifying client and HSRO of client's eligibility and send a copy indicating the amount of payment and PLI to both the hospice and the NF.

The following agreement is suggested for use by hospices and nursing facilities in order to provide hospice care to dually Medicare/Medicaid beneficiaries residing in nursing facilities.

PROTOCOL AND AGREEMENT

FOR THE PROVISION OF HOSPICE SERVICES TO

RESIDENTS OF _____
(Name of nursing facility)

WHEREAS, _____(hereinafter referred to as "The Home") is a Skilled Nursing Facility/Nursing Facility under Medicare/Medicaid or a Medicaid-only certified nursing facility which occasionally has among its residents individuals whose source of payment for nursing services is dually eligible Medicare/Medicaid beneficiaries), and who are terminally ill with a medical prognosis of six months or less, and

WHEREAS, The Home desires to assure the highest quality and level of services are provided to such individuals with respect to the care and management of their terminal illness, and

WHEREAS, The Home desires to make hospice services available to such individuals in order that such individuals may obtain the additional services covered under the Medicare Hospice Benefit while continuing to reside in the Home, and

WHEREAS, HOSPICE_____(hereinafter referred to as "The Hospice") is certified by the federal government to provide comprehensive hospice services to dually-eligible Medicare/Medicaid beneficiaries and desires to provide such services to residents of the Home in cooperation with the management and the staff of the Home.

NOW THEREFORE, The Home and The Hospice, in consideration of mutual advantages occurring to each and to eligible residents and their families, do hereby agree each with the other, as follows:

SECTION I. Eligible Residents

A. Eligible residents are persons who reside at the Home; residents may be referred by either Hospice to the Home or by the Home to Hospice.

B. Are using reimbursement other than Medicare to reimburse the Home for care and services.

C. Have made a Hospice Medicare election.

D. Are appropriate for and accepted by The Hospice in accordance with Hospice Admission Criteria which are made a part of the agreement and are appended thereto to page 8.1-18.

E. Receive Hospice Care in accordance with an individualized Hospice plan of care (hereinafter called the "Plan") developed by Hospice and approved by the attending physician.

F. Residents who are accepted by Hospice pursuant to this Agreement are hereinafter referred to as "residents".

SECTION II. Services to be Furnished by the Hospice.

A. Hospice shall develop the Plan to be provided to the Home specifying information pertinent to the resident's treatment. The Plan will be reviewed weekly and updated as necessary by Hospice.

B. Hospice services provided to residents will be the same as those provided to other Hospice patients. Services may include not only nursing assessment and intervention for symptom control but also physician, social work, counseling, aide/homemaker, chaplaincy, volunteer, physical, speech, and/or occupational therapy and other services not provided by the home nor included in the basic room and board charge. (See Hospice Routine Home Care, page 8.1-17.)

C. Hospice agrees to provide all drugs and pharmaceuticals related to management of the terminal illness specified in the Plan for a resident.

D. Additional medical equipment and medical supplies which are not ordinarily provided to the residents and included in the basic room and board charge will be supplied by Hospice for conditions relating to the terminal illness.

E. Residents are entitled to continuous care and Hospice inpatient services for conditions related to the management of the terminal illness should the needs and conditions of the resident change as determined by Hospice and attending physician.

(i) Continuous care: If a resident experiences a medical crisis, Hospice agrees to place nursing or aide services in the Home until the resident's acute problem is ameliorated.

(ii) Inpatient care: If a resident experiences chronic or acute symptoms which require hospitalization, Hospice agrees to provide such services in a contracted Hospice facility.

F. If a resident requires transportation, Hospice will provide or arrange transportation or ambulance or may request staff of the Home to do so.

G. Hospice agrees to provide counseling to family members of the resident to assist them in adjusting to the emotional stress associated with terminal illness in the family. Hospice also agrees to provide bereavement counseling to family members for as long as one year after a resident has die.

H. Hospice agrees to provide orientation and training to the Home to acquaint them with the Hospice concept and symptom control protocols.

SECTION III. Services to be Furnished by the Home.

The Home shall furnish to the resident all services normally provided to residents who are not hospice patients except when contraindicated by the Plan. Such services include room and board, medications not related to the management of the terminal illness, nursing and personal care as provided to other residents of The Home, room furnishings to include those items normally provided to residents by The Home, and The Home's normal program of therapies and activities unrelated to the resident's terminal illness.

With respect to the management of a resident's terminal illness, the Home shall:

A. Notify Hospice of changes in the resident's condition.

B. Make records of care and services to the resident available to Hospice.

SECTION IV. Cooperation in Professional Management

In respect of The Home's responsibility for services carried out within its facility, The Hospice shall provide to The Home the following:

(1) Current information documenting the appropriate licensure and credentials of all Hospice personnel visiting residents of The Home; and

(2) A Certificate of Insurance issued by any insurance company acceptable to The Home, indicating The Hospice has complete workers' compensation and liability insurance coverage, including coverage for any acts of professional malpractice, in amounts satisfactory to The Home; and

(3) Current information documenting that The Hospice is licensed by the State of Louisiana and is certified by the United States government pursuant to Public Law 97-248, for the provision of hospice services; and

(4) Subject to the patient's consent, access to all records of Hospice services rendered to the patient; and

(5) Access by representatives of The Home to attend and participate in Hospice Interdisciplinary Team Conferences for the purpose of developing and evaluating the Hospice Plan for such eligible residents.

(6) The Hospice and The Home each agree to cooperate with each other in reviewing the quality and appropriateness of Hospice services rendered in The Home. To this end, the Home and The Hospice will each appoint three individuals who will, together, constitute a liaison committee which will meet, when appropriate, to review working relationships between The Hospice and The Home, to discuss services rendered to residents who are Hospice patients, and to make recommendations for improving the contractual agreement between the parties.

SECTION V. Financial Responsibility

Subsection A. Dually Eligible Medicare/Medicaid

Residential Patients

Hospice shall bear full responsibility for hospice care and for the room and board provided by the Home to the dually eligible Medicare/Medicaid residents who have signed the Hospice Medicare election forms.

Hospice may purchase services from the Home including pharmaceuticals, supplies, oxygen and therapies in accordance with the Plan and related to the management of the terminal illness.

Hospice agrees to reimburse the Home, the room and board rate at the facility's Medicaid reimbursement rate.

The Home agrees to collect the client participation from the dually-eligible Medicare/Medicaid recipient.

The Hospice is responsible for notifying the recipient's DHH Medicaid eligibility worker to report election of hospice so the worker can arrange termination of the nursing home payment.

Subsection B. Medicare Residential Patients

Nursing Facility agrees to bill Hospice for any Purchased Hospice Services provided to a Medicare Eligible Residential Hospice Patient as set forth in the Listing of Services and Items to be Purchased (page 8.1-21). Nursing Facility will accept such payment as payment in full for Purchased Hospices Services provided under this Agreement to such Medicare Eligible Residential Hospice patient. Nursing Facility shall bill each Medicare Eligible Residential Hospice Patient or the Medicare Residential Hospice Patient's third party payor, if applicable, for Nursing Facility Room and Board Services provided such Patient and accept such payment as payment in full for Nursing Facility Room and Board Services.

Subsection C. Private Pay Residential Hospice Patients

With respect to any Private Pay Residential Hospice Patient, Nursing Facility agrees to bill Hospice for any Purchased Hospice Services provided to that Private Pay Residential Hospice Patient, as set forth in the Listing of Services and Items to be Purchased (page 8.1-21), and to accept such payment as payment in full for such Purchased Hospice Services. Nursing Facility shall bill each Private Pay Residential Hospice Patient or the Private-Pay Residential Hospice Patient's third-party payor, if applicable, for Nursing Facility Room and Board Services provided such Patient and accept such payment as payment in full for Nursing Facility Room and Board Services. Neither party shall seek reimbursement from the other in the event of default of financial obligations on the part of the Private Pay Residential Hospice Patient.

Subsection D. Health Maintenance Organization and Private Health Plan Residential Patients for whom Hospice receives Hospice Reimbursement.

Nursing Facility agrees to bill Hospice for any purchased Hospice Services provided to such patients as set forth in the Listing of Services and Items to be Purchased (page 8.1-21). Nursing Facility will accept such payment as payment in full for Purchased Hospice Services provided under this agreement. Nursing Facility agrees to bill Hospice at a fixed rate for each Residential Hospice Care Day provided to a Health Maintenance Organization and Private Health Plan Residential Hospice Patient, for whom Hospice is reimbursed by the Health Plan for Nursing Facility and Room and Board Services, at the rate set forth in the Reimbursement Agreement Between Hospice and Nursing Facility

(page 8.1-24). Nursing Facility agrees to accept such payment as payment in full for Nursing Facility Room and Board services.

Subsection E. Billing

Within thirty (30) days after the provision of Nursing Facility Room and Board Services or Purchased Hospice Services, Nursing Facility shall submit to Hospice all bills issued pursuant to Subsection A, B, C, or D on forms acceptable to Hospice that include information usually provided to third-party payors to verify the services and charges reflected in such billings.

Hospice shall pay Nursing Facility within sixty (60) days after receipt of each Nursing Facility bill or, if applicable, upon payment by Medicaid to Hospice, whichever is earlier. Payment by Hospice in respect of such bill shall be considered final, unless adjustments are requested in writing by Nursing Facility within thirty (30) days of payment.

Subsection F. Financial Record Keeping

Nursing Facility will keep accurate books of accounts and records at its principal place of business covering all transactions relating to this Agreement. Not more than once a year, Hospice may, at its expense, retain an independent public accountant or other auditor to review the Financial Records and prepare a detailed statement showing the charges made to Hospice by Nursing Facility. Hospice and its duly authorized representatives, including independent public accountant or other auditor, shall have the right during regular business hours and on reasonable written notice to Nursing Facility to examine Nursing Facility's Financial Records and to make copies thereof.

SECTION VI. Provider of First Choice

The Home agrees to exert its best efforts to promote the use of Hospice home care services by directing the personnel of The Home to refer all terminally ill patients, subject to the informed consent of the patient and the approval of the attending physician, to The Hospice.

SECTION VII. Public Relations

Both parties shall obtain the prior written approval of the other for press releases, media advertisements, or any form of publicity or marketing which concerns the arrangements between the parties.

SECTION VIII. Compliance with Governmental Regulations

Subsection A. The Home as a Place of Residence

This agreement is entered into with the understanding that the Home constitutes for the purpose of complying with the Hospice admission criteria, the eligible individual's place of residence. Because the Home provided support and services to residents which otherwise may be provided by families, the Hospice agrees to accept residency in the Home as satisfying the Hospice admission requirement that a patient live at home and have a primary caregiver. To that end, the Hospice will admit eligible residents who execute, as part of the Hospice admissions process, a "Request for the Provision of Hospice Home Care Services to a Nursing Home Resident," a copy of which is appended to this Agreement on page 8.1-22 and, by reference, is made part thereof.

Subsection B. Verification of Nature and Cost of Services

If services purchased by the Hospice from the Home under this Agreement have an aggregate value or cost of $10,000 or more over a 12-month period, the Home shall, until the expiration of four years after the furnishing of such services, make available upon written request by the Secretary's or Comptroller General's duly authorized representatives, this Agreement, the books, documents, and records of the Home that are necessary to verify the nature and extent of the cost of the services provider under this Agreement.

Section IX. Terms of the Agreement

This agreement shall commence as of the date appearing, and continue until terminated by either party by giving 30 days written notice to the other party. This Agreement may be amended at any time by mutual agreement of the Home and Hospice.

Section X. Indemnification and Limit of Liability

The Hospice shall only be liable for obligations required to be provided by it in this Agreement and not for any act or omission of the Home or the Home's officers, employees or agents. The Home agrees to indemnify and hold harmless Hospice from any and all losses, damages, costs and expenses that arise from any omission fault, negligence, or misconduct by the Home, its employees, independent contractors, or volunteers. Likewise, the Home shall not be liable under any contracts or obligations of the Hospice, for any act or omission by Hospice, hospice officers, employees or agents. Hospice agrees to hold the Home harmless for losses, damages, costs and expenses arising out of such action.

Hospice and the Home are independent contractors engaging in the operation of respective businesses. Neither is an agent of the other and neither has authority to enter into any obligations for the other. Nothing in this Agreement shall be construed to establish a relationship of co-partners or joint venture between the two parties.

Hospice	Home
Name_____	Name_____
Address_____	Address_____
_____	_____
Signature_____	Signature_____
Date_____	Date_____

HOSPICE ROUTINE HOME CARE

Based on the needs of the patient and family as determined by the Hospice and documented in the patient's Plan of Care and interdisciplinary record of care, the following services related to the management of the terminal illness will be provided to eligible residents:

1. Home visits by Registered nurses;
2. Home visits by licensed practical nurses or licensed vocational nurses;
3. Home visits by social workers;
4. Home visits by chaplains;
5. Home visits by home health aides or homemakers;
6. Home visits by volunteers;
7. Prescription drugs specifically delineated in the Plan of Care as being related to the hospice's palliative management of the patient's terminal illness;
8. Durable medical equipment;
9. Physical therapy;
10. Nutritional counseling and meal planning;
11. Speech therapy;
12. Ostomy therapy;
13. Occupational therapy;
14. Respiratory therapy;
15. Family counseling services to family members during the time the patient is receiving Hospice care; and
16. Bereavement care and counseling for family members for as long as one year following the patient's death.

HOSPICE ADMISSION CRITERIA

1. Patient has expected survival of six months or less in the opinion of the attending physician and hospice _____.

2. Patient is no longer on treatment directed at control of disease but rather, control of symptoms.
   Patients undergoing the following care are ordinarily not yet candidates for the Hospice:
   a. Receiving or expected to receive chemotherapy;
   b. Receiving radiation for control of disease or expected to do so;
   c. Undergoing surgery for control of disease or expecting to do so;
   d. Receiving hyperalimentation or expected to do so;
   e. Receiving treatments which require intensive monitoring or frequent in-hospital treatment, (e.g., respirator care, renal dialysis, frequent transfusions); or
   f. Intention to perform CPR or convert to respirator.

   Appropriate measures for symptom control may be:
   a. Radiation given for palliative reasons, (e.g., control of bone pain);
   b. Surgery performed for symptom control, (e.g., stabilization of pathological fracture);
   c. Feeding tube hydration and nutrition in patient unable to swallow due to obstruction or neuromuscular disease;
   d. Oxygen, suction and other supportive measures; or
   e. Parenteral analgesic infusion with appropriate vascular access.

3. Patient is advised of advance directives and DNR (Do Not Resuscitate).

4. Patient and family understand that patient is terminal and that hospice care is palliative, not curative. (See palliative care guidelines.)

5. Plan of care is directed toward management at place of residence, with the ability of inpatient care for symptom control if needed.

6. Conditions exist which allow an adequate standard of care at home, (e.g., a primary caregiver is available, conditions are safe enough to allow safe access to nurse/team members.

7. The patient must be under the care of an attending physician who consents to Hospice admission and who will continue to assume responsibility for medical care.

8. The patient agrees to Hospice care and is a resident of the hospice service area.

9. There is no discrimination as to age, race, religion, sex, or ability to pay.

PALLIATIVE CARE GUIDELINES

The focus of hospice care is palliation of symptoms, not control or cure of disease. While it is impossible to define all procedures, tests, medications, etc. in a definitive policy, the following are some general guidelines. In all cases the plan of care is individualized with input from the patient, family, attending physician, nursing facility interdisciplinary team and the hospice interdisciplinary team.

MEDICATIONS

Patients are medicated as needed for control of symptoms regardless of the route of medication.

RADIATION THERAPY

Radiation treatments for the alleviation of bone pain are considered palliative. Radiation treatment for other than pain control will be considered on an individual basis by the attending physician and the Hospice Medical Director.

CHEMOTHERAPY

Chemotherapy is not generally considered palliative by the hospice and is therefore not administered. Exceptions may be made with approval of the attending physician, the Hospice medical director, and the Hospice interdisciplinary team.

INTRAVENOUS INFUSION/HYPERALIMENTATION

Hydration may be done if the patient is symptomatic. Hyperalimentation is not generally considered palliative. Infusions for hydration or pain control should meet the following criteria:

1. necessary for symptom control and ordered by a physician;
2. central venous access catheter in place and available for use; and
3. nursing facility staff who are authorized and certified to administer fluids.

TUBE FEEDING

Tube feedings are considered palliative when the patient is mechanically obstructed and unable to obtain nourishment through the digestive tract. Patients with altered levels of consciousness affecting their ability to swallow may be evaluated on an individual basis.

Tube feedings may be provided with the following:

1. specific order from a physician;
2. nursing facility staff who are trained and authorized to administer feedings.

LISTING OF SERVICES AND ITEMS TO BE PURCHASED, AS NEEDED, BY THE HOSPICE FROM THE NURSING FACILITY

ITEM/SERVICE	UNIT PRICE

AUTHORIZATION FOR PURCHASES

The hospice shall provide the nursing facility a list of those individuals authorized to purchase or order items and services from the nursing facility related to the management of a patient's terminal illness.

BILLING AND PAYMENT

The nursing facility shall bill the hospice on a monthly basis for all items and services purchased from the nursing facility by the hospice. The hospice shall only be liable for those items and services specifically ordered by an authorized representative of the hospice. The hospice shall pay the nursing facility, based on an itemized billing as requested by the hospice, for all such ordered items and services within sixty (60) days after receiving such billing from the nursing facility.

REQUEST FOR THE PROVISION OF HOSPICE HOME CARE SERVICES TO A NURSING FACILITY RESIDENT

I,_____, a resident of the _____ nursing facility (the facility), in the presence of a representative of the facility, hereby request admission to the _____ _____hospice program of care based on my understanding and that of the hospice that the facility is considered to be my place of residence. Because the facility provides support and services tome which otherwise would be provided by may family, I have requested that my residency at the facility be considered by the hospice as satisfying the hospice admission criteria that I live at home and have a primary caregiver. Should the Health Care Financing Administration of the United States Department of Health and Human Services now or in the future determine that the facility is not considered my place of residence for the provision of routine hospice home care services, then I understand that I will no longer meet the hospice admission criteria of living in my home with a primary caregiver. In such circumstances, I understand and agree that I may be discharged from the hospice program of care immediately upon such a determination by the Health Care Financing Administration of the United States Department of Health and Human Services.

_____	_____
Witness	Signature of Patient
_____	_____
Date	Date
_____	_____
Witness	Signature of Nursing Facility representative
_____	_____
Date	Date
_____	_____
Witness	Signature of Hospice representative
_____	_____
Date	Date

MEDICAL EQUIPMENT PROVIDED BY THE HOSPICE TO NURSING FACILITY RESIDENTS

The following types of equipment are to be provided by the hospice to residents of nursing facilities who are in their care:

1. oxygen concentrators;
2. suction machines;
3. alternating pressure pads
4. wheelchairs (if not available from the facility); and
5. other specialized equipment as determined necessary based on an individual assessment of the patient.

REIMBURSEMENT AGREEMENT BETWEEN HOSPICE AND NURSING FACILITY

_____
HOSPICE

AND

_____
NURSING FACILITY

REIMBURSEMENT RATE AGREEMENT

Beginning _____ and continuing until _____, the following rates shall apply:
(date) (date)

DUALLY ELIGIBLE MEDICARE/MEDICAID RESIDENTIAL PATIENTS	Current nursing facility Medicaid per diem, minus the patient's liability amount which shall be collected by the nursing facility from the patient or family member.
HEALTH MAINTENANCE ORGANIZATION AND PRIVATE HEALTH PLAN RESIDENTIAL PATIENTS FOR WHOM THE HOSPICE RECEIVES ROOM AND BOARD REIMBURSEMENT	

_____ _____
Signature of hospice representative Date

_____ _____
Signature of nursing facility representative Date

LIMITATIONS FOR RECIPIENTS IN LTC FACILITIES

Long Term Care facilities are responsible for providing the following services, supplies, or equipment to Medicaid recipients for whom Medicaid nursing facility vendor payments are made:

- Room, board, and therapeutic diets
- Food supplements or food replacements, e.g., Sustagen or Nutriment, and dextrose when it is used as a food replacement
- Professional nursing services and supervision of services provided by required staff in accordance with a plan of care established by the attending physician or other personnel involved in the care of the recipient
- Professional supervision of personal care services, such as hair cuts and beauty work services performed by nursing facility employees

  ☞ ***Hair cuts, permanent waves, shampoo and sets, etc., when provided by a licensed barber or beautician, should be paid for by the patient or by personal funds from the recipient's family.***

- The following staple drugs, as prescribed by the attending physician, but not necessarily stocked by the facility:
  - Antiseptics, such as the following:
    - Hydrogen Peroxide or similar product
    - Zephiran or a similar product
    - Providyne
  - Aromatic Spirits of Ammonia
  - Aspirin, at least one brand of all dosage forms
  - Acetaminophen, at least one brand of all dosage forms
  - Epsom Salts and table salts

- Laxatives, any one brand of the following:
  - Milk of Magnesia
  - Cascara
  - Glycerin Suppositories
- Rubs, such as the following:
  - Dermassage or a similar product
  - Glycerin
  - Isopropyl Alcohol (60%)
- At least one sugar and one salt substitute
- Zinc Oxide ointment and paste

☞ ***Upon admission, facilities should advise each patient and his next of kin or sponsor of the staple drug items furnished by the facility. Listings of these items should be posted in conspicuous places, and copies should be furnished upon request. Items prescribed by the attending physician, other than those maintained and furnished by the facility, should be billed to Medicaid by the pharmacy or to the recipient's family, if Medicaid does not cover the drug.***

- An adequate number of standard wheelchairs (for general transportation or for temporary use)

☞ ***The facility should attempt to arrange the provision of customized wheelchairs as needed for a resident.***

- Adequate number of standard, adjustable walkers and crutches; over-the-bed tables; bedside commodes; lifts and restraints; sheepskins or similar decubitus prevention and treatment devices; and mechanical supports (such as Posey vest-type)
- Other items which are generally a part of nursing facility treatment

☞ ***All such durable equipment purchased through Medicaid of Louisiana becomes the property of the recipient or his family when it is no longer required by the patient.***

- Other personal care items, such as soap and shampoo

  ☞ ***Any brand of soap and/or shampoo other than that supplied by the facility will be paid for by the recipient or responsible party. Personal need items should be purchased by the patient or by his family.***

- Syringes and needles (all types)
- IV set ups
- Tubing and bags of all kinds, except those provided through other funding sources
- Gauze
- Bandages
- Thin film wound dressings (Tegraderm, Duoderm, and similar products)
- Non-adhering dressings (Telfa or similar products)
- Pads/Diapers

  ☞ ***The facility must provide some means of protection for the incontinent resident, such as pads or diapers. This cost should not be passed on to the resident or responsible party. If the resident of responsible party elects to use a special diaper, the facility is not required to furnish such items as a part of vendor payments.***

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.

TAD BILLING INSTRUCTIONS

The billing document for Long Term Care facilities is referred to as a Turnaround Document (TAD). A new LTC provider in Medicaid will receive a blank TAD and must supply Paramax with initial information concerning all recipients and with an OFS form 51-NH for each resident.

The TAD consists of an original and a carbon copy. The carbon copy should be retained by the provider upon completion, and the original should be forwarded to Paramax for processing.

During the third week of each month, Paramax will mail a preprinted TAD to each participating LTC facility. The preprinted TAD is created by Paramax from the facility's prior month's paid claims. The provider is responsible for verifying all preprinted data on the TAD prior to submitting the billing document to Paramax. If the preprinted data is not changed it is treated as an entry by the provider. The provider should attest to the validity of the entry on the signature page as if he had written the entry himself.

The facility should complete the document on or after the last day of the month and return it to Paramax as soon as possible after the first day of the next month.

Provided in this section are some general billing reminders and other general claim form information, as well as specific billing instructions for the TAD.

☞ ***Provided on the following page is a sample TAD.***

UBMIT TO U… S
PO BOX 91021
BATON ROUGE, LA 70821
(800) 737-8647
924-5040 (IN BATON ROUGE)

LONG TERM CA… FACILITY

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM

PROVIDER NO.	PAGE	DATE

F NO.	LAST NAME		I.D. NUMBER	CERT DATE	A D M	LVL OF CARE	FROM DOS			LEV-2		LEV-3		TO DAY	TOT DAYS	S T A T	A-HOME/B-HOSP ABSENT DAYS												HOME LEAVE USED
T CODE	FIRST	INT.					MM	DD	YY	LOC	DAY	LOC	DAY				TYP	FROM	TO	TYP	FROM	TO	TYP	FROM	TO	TYP	FROM	TO	

COMMENTS:

ACTION CODE
A-ADD
C-CHANGE
D-DELETE

UNISYS 112 (3-88)

GENERAL BILLING REMINDERS

Provided below is a list of billing reminders for LTC facilities:

- Providers should check the recipient's current monthly medical eligibility card at the time of admission and at the beginning of each month thereafter.

- Providers should complete the TAD according to the steps listed in the subsection entitled ***Specific Billing Instructions***. All changes to the TAD must be made in red ink.

- Providers should attach a BHSF form 51-NH to the TAD for each new admission, change in the level of care, or change in the recipient's number. Failure to attach the 51-NH will result in the denial of the claim.

  ☞ ***Attaching a 51-NH is not required when the facility is adding a recipient to correct a denial.***

- Providers should enter multiple billings for the same recipient on consecutive lines of the TAD.

- Providers should remember to sign the last page of the TAD before mailing it to Paramax for processing.

- Completed TADs should be mailed to the following address:

Paramax
P.O. Box 91021
Baton Rouge, Louisiana 70821

FULL MONTH BILLING FOR A RECIPIENT

If the status of a recipient remains the same, it is not necessary to change the any of the information in the columns on the TAD.

PARTIAL MONTH BILLING FOR A RECIPIENT

If a recipient listed on the TAD was discharged during the billing month, providers should follow the procedures listed below:

- Providers should code the appropriate discharge code in the ***Stat*** column of the detail line for the recipient.
- Providers should mark an *X* through the preprinted ***To Day*** and code the appropriate ***Tot. Days*** to be billed on the same detail line.
- When the recipient is released for home and/or hospital leave and some or all of the days need to be billed, providers should complete the ***Home LV*** and/or ***Hosp LV*** columns of the detail line, and they should total the days in the ***Tot. Days*** column.

CLAIM FORM REQUESTS

New LTC facilities receive a supply of blank TAD forms for the first billing. For subsequent billing, TAD forms are preprinted to list all the recipients reflected on the previous month's document. An additional blank billing sheet is included so that additional recipients who were admitted during the month can be added to the TAD.

Additional TAD forms may be obtained from the following address:

Paramax
8591 United Plaza Blvd., Suite 100
Baton Rouge, LA. 70809
Attention: Mail Room

SPECIFIC BILLING INSTRUCTIONS

Provided below are the instructions for completing the TAD. The instructions include an explanation of the preprinted items. Preprinted items are marked with an asterisk.

* 1. **PROVIDER NAME/ADDRESS.** Enter the provider's name and address.

* 2. **PROVIDER NUMBER.** Enter the provider number assigned to the facility. The first two letters in the name of the facility will be preprinted following the provider number.

* 3. **PAGE.** Each page number of the TAD will consist of 7 digits. Each page number will be preprinted in numeric number.

* 4. **DATE.** The date on which the TAD was preprinted will appear in this block in month, day, year format (MM/DD/YY).

* 5. **REF. NO.** The reference number is a four-digit internal reference number that is preprinted (for Paramax use only).

6. **ACT. CODE (ACTION CODE).** The action code must be coded by the provider of services (red ink only) when one of the following situations exist:

A Code A should be used when you are adding a new recipient to the TAD for the first time or when you are adding an existing recipient to the TAD to correct a denial. To bill with this code, you must add a separate detail line for each month of service and attach a 51-NH form to the TAD for the month of entry. When correcting a denial, you must note in the comments section that the 51-NH is on file. Also, each detail line must be coded separately with action code A.

C Code C should be used when a change in one or more data fields is being reported for a recipient on the current preprinted document. If preprinted data is being changed, line through the data field that needs to be changed and print the correct entry directly above the lined through entry in the same box. To report a change in the level of care and/or home or hospital leave, enter a C in the action code field and print the necessary data in the leave day fields.

D Code D should be used when you are deleting an existing recipient from the current preprinted TAD. To bill with code D, you must line through the data on the line that is being deleted.

☞ ***If a change is made to the preprinted document and item 6 is not completed, then the affected line of the TAD will be deleted and your payment will be delayed.***

* **7. PATIENT NAME.** The recipient's name will be preprinted. The last name will be printed on the top line, and the first name and middle initial will be printed on the bottom line.

* **8. ID NUMBER.** The 13-digit recipient identification number will be printed in this column. When initiating a change in the identification number of an existing recipient, enter a C in the action code block, line through the old identification number, and enter the new number above the old number.

* **9. CERT DATE.** The recipient's certification date will be taken from the 51-NH form (item 8), and it will be preprinted on the TAD.

* **10. ADM (Admission Code).** The current admission code for the recipient will be preprinted on the TAD. The code is taken from item 7 on the 51-NH. After the recipient's first month of stay, code 06 should be entered in this block.

* **11. LVL OF CARE (Level of Care).** The level of care code from item 11 of the 51-NH form should be entered in this block. If the recipient's level of care was changed in the month prior to the billing month on the preprinted TAD, initiate the change by entering a C in the action code column, line through the admit code and enter a 6 above it, and line through the old level of care and enter the new level of care above it.

☞ ***Report all other level of care changes in accordance with the instructions in item 13.***

* **12. FROM DOS MM DD YY (To and From Date of Service).** This column is preprinted with the first day of the billing month. You should not use the from date of service to attempt to reduce the vendor payment due to leave days. Report leave days in the appropriate blocks and do not alter the from date of service field. For a new admission, enter the date from item 8 on the 51-NH form.

13. LEV-2 LOC (Level of Care). This column is left blank on the preprinted TAD. Enter the first level of care **change** which occurs in the billing month.

14. LEV-2 DAY. This column is left blank on the preprinted TAD. This column is used to report the day on which the first level of care change is effective. Enter the day from item 10 on the 51-NH form that was issued to authorize the first level of care change.

15. LEV-3 LOC. This column is left blank on the preprinted TAD. Enter the second level of care code from item 11 on the 51-NH form that was issued to authorized the second level of care change.

16. LEV-3 DAY. This column is left blank on the preprinted TAD. Enter the day from the date in item 10 on the 51-NH form that was issued to authorized the second level of care change.

* 17. **TO DAY.** This column is preprinted with the last day of the billing month. This column should not be changed unless the recipient dies or is discharged prior to the last day of the billing month. Do not use this column to attempt to reduce the vendor payment due to leave days. Report leave days in the appropriate blocks and do not alter this field.

* 18. **TOT DAYS.** This column will be preprinted with the number of days billed during the month. This column should be changed only if a change is indicated in the ***To Day*** column due to a discharge or death.

☞ ***The system will automatically calculate and cut back the total days when leave days are reported.***

* 19. **STAT (Status).** This field is preprinted with a recipient status code of six, indicating that the recipient is still a resident on the last day of the month. This column should reflect a change only if the ***To Day*** and the ***Tot Days*** columns are changed because the recipient dies or is discharged. Provided below is a list of the other status codes:

1 **Discharged to somewhere other than a LTC facility.** This code should be used when a recipient is discharged from a LTC facility either for admittance to a facility other than a LTC facility or as a result of that recipient having exceeded the limitation criteria for approved hospital leave.

3 **Transferred to another LTC facility.**

4 **Discharged due to death.**

5 **Discharged to home.**

6 **Still a resident.** This code should be preprinted on the TAD when the resident is still included in the facility Medicaid census on the last day of the billing month. This code applies to residents on home or hospital leave who are not discharged on or before the last day of the month or to residents who are actually in the facility on the last day of the month.

7 **Discharged recipient exceeded hospital leave days.**

20. **TYP (Type).** This field is used to indicate the recipient's type of absence. The two codes that may be used in this block are listed below:

A Home

B Hospital

21. **FROM.** This column will indicate the first calendar day of absence for the current billing month. If the from day overlaps a home or hospital stay from the previous month's billing, then the from day should be 01, indicating that the recipient was not in the facility on the first day of the current billing month.

22. **TO.** This item represents the last day that the recipient was considered to be out of the facility.

23. **TYP.** This field indicates the recipient's type of absence. The two codes that may be used in this block are listed below:

A Home

B Hospital

24. **FROM.** This column will indicate the first calendar day of absence for period two of the current billing month.

25. **TO.** This item indicates the last day of absence for period two of the current billing month.

26. **TYP.** This field indicates the recipient's type of absence. The two codes that may be used in this block are listed below:

A Home

B Hospital

27. **FROM.** This field indicates the first calendar day that the recipient was out of the facility for period 3 of the current billing month.

28. **TO.** This field indicates the last calendar day that the recipient was out of the facility for period three of the current billing month.

29. **TYP.** This field indicates the recipient's type of absence. The two codes that may be used in this block are listed below:

A Home

B Hospital

30. **FROM.** This field indicates the first calendar day that the recipient was out of the facility for period four of the current billing month.

31. **TO.** This field indicates the last calendar day that the recipient was out of the facility for period four of the current billing month.

32. **TYP.** This field indicates the recipient's type of absence. The two codes that may be used in this block are listed below:

A Home

B Hospital

33. **FROM.** This item indicates the first calendar day that the recipient was out of the facility for period five of the current billing month.

34. **TO.** This item indicates the last calendar day that the recipient was out of the facility for period five of the current billing month.

35. **HOME LEAVE USED.** This column is used for reporting purposes only. On the monthly preprinted TAD, this column will indicate the number of home leave days paid for each individual recipient for the current period.

36. **CARRIER CODE.** This field is used to report the recipient's private insurance sources. You should enter the appropriate six-digit carrier code from the ***Third-Party Liability (TPL) Carrier Code Listing.***

37. **TPL AMT.** This field is used to indicate any payment received from a third party for the month of service currently being billed.

☞ ***The TAD should be completed on or after the last day of the month and returned to Paramax as soon as possible after the first day of the month. Be sure to sign and date the last page of the TAD before mailing it to Paramax for processing. The mailing address for Paramax is provided below:***

Paramax
P.O. Box 91021
Baton Rouge, LA. 70821

CLAIM FORM EXAMPLES

EXAMPLES REFERENCED ON TAD FORMS

Provided below is a list of the examples that are referenced on the sample TAD forms.

1. Adding a new recipient
2. Hospital leave exceeds 10 days - holding bed
3. Hospital leave exceeds 10 days - discharged to hospital
4. Discharged due to death
5. Deleting an existing recipient
6. Home leave days
7. Home leave days exceeded - discharged to home
8. Level of care change within the month
9. Change to identification number to an existing recipient
10. Signature page

SUBMIT TO **UNISYS**
PO BOX 91021
BATON ROUGE, LA 70821
(800) 737-8647
924-5040 (IN BATON ROUGE)

LONG TERM CARE FACILITY

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM

@ Heritage Manor of Yourtown
123 East Street
Anytown, LA 70000

1S12001		
PROVIDER NO.	PAGE	DATE

REF. NO. / T. CODE	LAST NAME / FIRST	INT.	I.D. NUMBER	CERT DATE	ADM	LVL OF CARE	FROM DOS MM DD YY	LEV-2 LOC	LEV-2 DAY	LEV-3 LOC	LEV-3 DAY	TO DAY	TOT DAYS	SAT	A-HOME/B-HOSP ABSENT DAYS TYP FROM TO	TYP FROM TO	TYP FROM TO	TYP FROM TO	HOME LEAVE USED
	Brinkley																		
9	Diane	C	320167777801	04 01 92	1	21	04 17 92					30	14	6					
	Brinkley																		
A	Diane	C	320167777801	04 01 92	1	21	05 01 92					31	31	6					
	Brinkley																		
A	Diane	C	320167777801	04 01 92	6	21	06 01 92					30	30	6					
	Brinkley																		
A	Diane	C	320167777801	04 01 92	6	21	07 01 92					31	31	6					

COMMENTS:

ACTION CODE
A-ADD
C-CHANGE
D-DELETE

UNISYS 112 (3-88)

SUBMIT TO **UNISYS**
PO BOX 91021
BATON ROUGE, LA 70821
(800) 737-8647
924-5040 (IN BATON ROUGE)

LONG TERM CARE FACILITY

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM

HERITAGE MANOR OF YOURTOWN
123 EAST STREET
ANYTOWN, LA 71111

1512001	00001	
PROVIDER NO	PAGE	DATE

REF NO / ACT CODE	LAST NAME / FIRST	INT	I.D. NUMBER	CERT DATE	ADM	LVL OF CARE	FROM DOS MM DD YY	LEV-2 LOC	LEV-2 DAY	LEV-3 LOC	LEV-3 DAY	TO DAY	TOT DAYS	STAT	A-HOME/B-HOSP ABSENT DAYS TYP FROM TO	TYP FROM TO	TYP FROM TO	TYP FROM TO	HOLD LEAVE USE
	Anthony																		
	Josie		2103002342101	02 01 91	1	21	07 01 92					31	31	6					
	Brown		③												B 15 29				
C	Jim		2903001002102	01 15 92	4	21	07 01 92					31	31	6					
	Davis																		
	Kaplan	R	2104003024901	12 12 91	1	21	07 01 92					31	31	6					
	Kinney		③									20	19	1	B 10 19				
C	Mary		2303002845601	10 01 91	1	21	07 01 92					~~31~~	~~31~~	6					
	Lewis																		
	George		3201047297001	09 01 90	1	21	07 01 92					31	31	6					
	Smith		④									12	12	4					
C	Hazel		2903054002001	11 10 91	4	21	07 01 92					~~31~~	~~31~~	6					
	~~Turner~~		⑤																
D	~~Margie~~		~~2901134311001~~	~~07 01 91~~	~~1~~	~~21~~	~~07 01 92~~					~~31~~	~~31~~	~~6~~					

COMMENTS:

ACTION CODE
A-ADD
C-CHANGE
D-DELETE

UNISYS 1121

SUBMIT TO UNISYS
PO BOX 91021
BATON ROUGE, LA 70821
(800) 737-8647
924-5040 (IN BATON ROUGE)

LONG TERM CARE FACILITY

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM

Heritage Manor of Yourtown
123 East Street
Anytown, LA 71111

1512001	00002	
PROVIDER NO.	PAGE	DATE

REF. NO / ACT. CODE	LAST NAME / FIRST	INT	I.D. NUMBER	CERT DATE	ADM	LVL OF CARE	FROM DOS MM DD YY	LEV-2 LOC	LEV-2 DAY	LEV-3 LOC	LEV-3 DAY	TO DAY	TOT DAYS	STAT	A-HOME/B-HOSP ABSENT DAYS TYP FROM TO	TYP FROM TO	TYP FROM TO	TYP FROM TO	HC LE US
	Brown																		
	Susan		2401002005201	01 01 90	4	22	08 01 92					31	31	6					
	Jefferson		(6)												A 06 09				
C	Roy		3202002918901	12 08 90	1	22	08 01 92					31	31	6					
	Knight																		
	Earl		3203001287701	06 11 90	1	22	08 01 92					31	31	6					
	[illegible]nton		(7)									25	24	5	A 16 24				
C	Barbara		2601001893201	09 01 89	4	22	08 01 92					~~31~~	~~31~~	6					
	Tillman																		
	Newton		3503027026001	11 01 91	1	22	08 01 92					31	31	6					
	Victor		(8)																
C	Frank		0102903012301	03 02 91	4	22	08 01 92	21	12			31	31	6					
	Williams		(9) a30304140300l																
C	George		~~2301030401001~~	04 01 92	1	22	08 01 92					31	31	6					

COMMENTS:

† ACTION CODE
A-ADD
C-CHANGE
D-DELETE

UNISYS 1121 (J 88)

SUBMIT TO **UNISYS**
PO BOX 91021
BATON ROUGE, LA 70821
(800) 737-8647
924-5040 (IN BATON ROUGE)

LONG TERM CARE FACILITY

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM

HERITAGE MANOR OF YOURTOWN
123 EAST STREET
ANYTOWN, LA 70000

1512001		
PROVIDER NO.	PAGE	DATE

REF. NO. / ACT. CODE	LAST NAME / FIRST	INT	I.D. NUMBER	CERT DATE	ADM	LVL OF CARE	FROM DOS MM DD YY	LEV-2 LOC	LEV-2 DAY	LEV-3 LOC	LEV-3 DAY	TO DAY	TOT DAYS	S/T	A-HOME/B-HOSP ABSENT DAYS TYP FROM TO	TYP FROM TO	TYP FROM TO	TYP FROM TO	HO LEA USI
				(10)															
				I HAVE READ THE REVERSE SIDES OF THE ABOVE FORMS AND DUE HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH:															
				DATE:															
				SIGNATURE:															
				# OF PAGES ____ # OF DETAILS ____															
				# OF RECIPIENTS ____															
				# OF DAYS ____															

COMMENTS:

ACTION CODE
A-ADD
C-CHANG
D-DELET

UNISYS

ADDING A RECIPIENT TO YOUR TAD FOR THE FIRST TIME

To add a recipient to your TAD for the first time you must follow the procedures listed below:

- Always use action code A.
- Fill in the name, number, and certification date from item 8 on the 51-NH form, and fill in the admission code from item 7 on the 51-NH form.
- For each sequential month of billing, change the admit code to a 6. This code will tell the system not to look for another 51-NH form.

HOME AND HOSPITAL LEAVE DAYS

To calculate home or hospital leave days, remember that the first day is the first 24 hour leave day. That is, if the recipient is not absent from the facility for 24 hours or more, then the day is not counted as a leave day.

EXAMPLE ONE: The patient Jim Brown goes to the hospital on July 14, 1992, at 8:00 A.M.. The first leave day then will be July 15, 1992, at 8:00 A.M.. The 15th is the day that should be reported as the leave day on the TAD.

EXAMPLE TWO: George Lewis goes to the hospital on January 4, 1992, at 8:00 A.M. and arrives back at the nursing home on January 5, 1992, at 7:45 A.M.. Because the patient did not leave for 24 hours or more, the absence should not be counted as a leave day.

NOTE: Home leave days are calculated the same way.

Hospital Leave Days

A recipient who is in a nursing home with Level of Care 20, 21, or 22 is allowed 10 hospital leave days per occurrence. After the tenth day, the provider must discharge the recipient. However, if the family of the recipient or the provider is willing to hold the bed until the recipient returns to the facility, the recipient does not have to be listed as discharged on the TAD.

Other recipients in a nursing home with Level of Care 23, 24, or 26 are allowed 15 hospital leave days per occurrence.

Home Leave days

Recipients in facilities with level of care 20, 21, or 22 are allowed only 9 home leave days per calendar year. Those in facilities with level of care 23 or 24 are allowed 18 home leave days per calendar year, and those in facilities with level of care 26 have 45 home leave days per fiscal year.

Within the 45 home leave day period, the providers cannot bill for more than 14 consecutive home leave days. They must discharge the recipient on the 15th day and submit a new 51-NH to readmit the recipient to their facility. If the provider fails to list the recipient as discharged from the TAD on the 15th day, the system will automatically perform the cut back and insert the code 902 (LTC leave days exceed limit).

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.

ADJUSTMENTS

Provided in this section are the instructions for completing adjustment forms. The first form reviewed in the 148 PLI form.

THE 148 PLI FORM

The 148 PLI form is used only to adjust incorrect payments due to patient liability. If a provider bills incorrectly for his days and receives incorrect payment due to the patient liability, a 21 Adjustment must be filed first to correct the number of days billed. Then, the provider must file a 148 PLI, using the 212 Adjustment control number, to correct patient liability.

☞ *A sample 148 PLI form is provided on the following page.*

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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

755 RIVERSIDE NORTH — P O BOX 44065
BATON ROUGE, LOUISIANA 70804

LONG TERM CARE
PATIENT LIABILITY ADJUSTMENT FORM

FOR OFFICE USE ONLY

TO _____

FROM _____

1 PROVIDER NO	2 RECIPIENT I D NUMBER	3 RECIPIENT LAST NAME	4 FIRST NAME

5 LEVEL OF CARE	6 INITIATED BY
	☐ FACILITY ☐ PARISH OFS

7 FROM DATE OF SERVICE	8 TO DATE OF SERVICE	9 TOTAL DAYS	10 CONTROL NUMBER	11 CORRECT PATIENT LIABILITY	12 STATUS	UNISYS OFFICE USE ONLY

AUTHORIZED SIGNATURES

13. FACILITY _____ DATE _____

14. PARISH OFS _____ DATE _____

FISCAL AGENT COPY

UNISYS-148/.
1/91

BILLING INSTRUCTIONS FOR THE 148 PLI FORM

All blocks should be completed on the form, and a separate line should be used for each month in which an incorrect LTC payment was made.

1 **PROVIDER NO.** Enter the seven-digit provider number as it appears on the RA when the claim to be adjusted/voided was originally processed for payment.

2 **RECIPIENT ID.** Enter the unique 13-digit recipient identification number as it appeared on the RA when the claim was originally processed for payment.

3/4 **RECIPIENT NAME.** Enter the last name of the recipient in block 4 and the first name of the recipient in block 5.

5 **LEVEL OF CARE.** Enter the level of care code recorded on the original RA when the incorrect payment was made. A separate line should be completed for each level of care.

6 **INITIATED BY.** Check the appropriate box.

7 **FROM DATE OF SERVICE.** Enter the month, day, and year of the beginning date of service for the month being adjusted. Two digits are required for each of the date fields.

8 **TO DATE OF SERVICE.** Enter the month, day, and year of the ending date of service for the month being adjusted. Two digits are required for each of the date fields.

9 **TOTAL DAYS.** Enter the total number of days. This number is found on the original RA under benefit days, and it is the sum of the days entered in blocks 7 and 8.

10 **CONTROL NUMBER.** Enter the internal control number assigned to the paid claim. This number is located in the last column of the RA. If the original claim was adjusted incorrectly, enter the internal control number assigned to the claim.

11 **CORRECT PATIENT LIABILITY.** Enter the correct total patient liability income of the recipient for the month being adjusted. Paramax will determine daily patient liability for partial months of service.

12 **STATUS.** Enter the status code of the recipient from block 21 on the TAD.

13 **FACILITY.** The facility administrator or authorized person should sign and date the form.

14 **PARISH OFS.** The OFS parish worker or supervisor should sign and date the form.

☞ ***This item is not required if the facility initiates the 148 PLI.***

THE 212 ADJUSTMENT/VOID FORM

A 212 Adjustment is used to adjust provider or Paramax errors, such as incorrect payment due to the number of days, level of care, and home and hospital leave days. A 212 Void is used when the provider wants Medicaid to take back all of the money that was billed to Medicaid.

Provided in the following section are the specific instructions for completing a 212 adjustment or void.

☞ ***A blank sample 212 form is provided on the following page.***

MAIL TO
INISYS
O BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
LONG TERM CARE ADJUSTMENT/VOID FORM

FOR OFFICE USE ONLY

1	2	3	4	5
☐ 1 ADJ ☐ 2 VOID	PROVIDER I.D.	RECIPIENT I.D.	RECIPIENT LAST NAME	FIRST NAME

6	7	8	9			10		11		12	13	14	15										
CERT DATE	A D M	LVL OF CARE	FROM DOS MM	DD	YY	LEV-2 LOC	DAY	LEV-3 LOC	DAY	TO DAY	TOT DAYS	STAT	A-HOME / B-HOSP ABSENT DAYS TYP	FROM	TO	TYP	FROM	TO	TYP	FROM	TO	TYP	FROM	TO

16		17	18
CONTROL NUMBER	THIS NUMBER APPEARS IN THE RIGHT HAND COLUMN ON THE REMITTANCE ADVICE LISTING THE PAID ITEM TO BE ADJUSTED OR VOIDED. BE SURE TO COPY THE NUMBER EXACTLY AS SHOWN FOR THAT ITEM.	CARRIER	TPL AMT

19 REASONS FOR ADJUSTMENTS

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

20 REASONS FOR VOID

☐	10	CLAIM PAID FOR USING WRONG RECIPIENT
☐	11	CLAIM PAID TO WRONG PROVIDER
☐	99	OTHER-PLEASE EXPLAIN

21 PROVIDER NAME AND ADDRESS

22

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

SIGNATURE OF PROVIDER DATE

UNYSIS - 212
10/91

FISCAL AGENT COPY

212 BILLING INSTRUCTIONS

The 212 form should be prepared in duplicate. Information required on the form should be obtained from the TAD, the 51-NH form, and the Remittance Advice (RA) for the month in which the claim was originally filed or processed for payment. An adjustment or void cannot be processed unless all items on the form are completed. An incomplete form will be returned to the facility. Individual items should be completed as follows:

1 **ADJ/VOID BOX.** Check the appropriate block to indicate a request to either adjust a payment or to void a payment.

BLOCK ONE. Check block one to indicate a payment adjustment if the incorrect number of days were billed or if payment was received for the incorrect level of care.

BLOCK TWO. Check block two to indicate a void if the entire payment needs to be voided and recouped by Paramax.

2 **PROVIDER ID.** Enter the seven-digit provider number as it appears on the RA when the claim to be adjusted/voided was originally processed for payment.

3 **RECIPIENT ID.** Enter the unique 13-digit recipient identification number as it appeared on the RA when the claim was originally processed for payment.

4/5 **RECIPIENT NAME.** Enter the last name of the recipient in block 4 and the first name of the recipient in block 5.

6 **CERT DATE (Certification Date).** Enter the LTC certification date of the recipient. This date may be changed on an adjustment provided that a new form 51-NH is attached to reflect the corrected date. On a void, this information should be entered the same way it was entered on the original TAD.

7 **ADM.** Enter the admission code of the recipient. This code may be changed on an adjustment provided that a new form 51-NH is attached to reflect the corrected code. On a void, this information should be entered the same way it was entered on the original TAD.

8 **LVL OF CARE (Level of Care).** Enter the level of care code of the recipient for the first day of the detail month billed. This code may be changed on an adjustment provided that a new form 51-NH is attached to reflect the corrected code. On a void, this information should be entered the same way it was entered on the original TAD.

9 **FROM DOS (MM DD YY).** Enter the beginning date of service for the service month billed. Each field in the date must contain two digits. On a void, this information should be entered the same way it was entered on the original TAD.

10 **LEV-2 - LOC DAY.** This item is used only when the level of care of a recipient changed during the billing month. The new level of care and the date the level of care changed should be entered. This information may be changed on an adjustment provided that a new 51-NH form is attached to reflect the corrected information. On a void, this information should be entered the same way it was entered on the original TAD.

11 **LEV-3 - LOC DAY.** This item is used only when the level of care of a recipient changes a second time during the billing month. This information may be changed on an adjustment provided that a new 51-NH form is attached to reflect the corrected information. On a void, this information should be entered the same way it was entered on the original TAD.

12 **TO DAY.** Enter the last day of the service month in which the recipient was a patient in the facility. On a void, this information should be entered the same way it was entered on the original TAD.

13 **TOT DAYS.** Enter the total number of days billed for the recipient for the service month. This total should reflect the sum of the number of days in blocks 9 and 12. On a void, this information should be entered the same way it was entered on the original TAD.

14 **STAT.** Enter the status code for the last day of the service month in which the recipient was a patient in the facility. On a void, this information should be entered the same way it was entered on the original TAD.

15 **ABSENT DAYS.** Enter the number of authorized home/hospital leave days used by the recipient during the service month billed. On a void, this information should be entered the same way it was entered on the original TAD.

16 **CONTROL NUMBER.** Enter the internal control number assigned to the paid claim. This number is located in the last column of the RA. If the original claim was adjusted incorrectly, enter the new internal control number assigned to the claim.

17 **CARRIER.** Enter the applicable six-digit TPL code.

18 **TPL AMOUNT.** Enter the payment received from a TPL for the month of service for which the adjustment is being requested.

19 **REASON FOR ADJUSTMENT.** Check the appropriate box and give a brief written explanation for the adjustment on the lines provided.

20 **REASONS FOR VOID.** Check the appropriate box and give a brief written explanation for the void ont he lines provided.

21 **PROVIDER NAME AND ADDRESS.** Enter the complete provider name and address, including the zip code.

22 **SIGNATURE OR PROVIDER AND DATE.** The facility administrator or authorized person should sign and date the form. An adjustment or void cannot be processed unless the form is signed or dated.

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

RETURN/REFUND CHECKS

RETURN CHECKS

All return checks should be mailed to the following address:

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

REFUND CHECKS

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

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

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

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

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

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

CHECKS SHOULD NOT BE MADE PAYABLE TO PARAMAX.

PARAMAX PROVIDER RELATIONS

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

Baton Rouge Providers **(504) 924-5040**

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

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

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

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

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

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

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

RECIPIENT ELIGIBILITY VERIFICATION SYSTEM

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

However, there is a simple solution.

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

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

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

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

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

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

MANUAL UPDATES

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

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

The information in the 1998 Long Term Care/Hospice Services Provider Training packet, Medicaid Issues for 1998, was published in September, 1998.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

Bobby P. Jindal
SECRETARY

April 24, 1997

Dear Health Professional:

I write to ask for your assistance in reducing drug waste in long-term care facilities. Reducing the incidence of destructions will help control costs in the Medicaid program, while ensuring high quality care.

The Department of Health and Hospitals appointed an Interdisciplinary Committee, composed of physicians, pharmacists, nursing facility officials, consumer advocates and DHH medical professionals, to address drug wastes in long-term care facilities. After nine months of review, the committee has recommended clarification of program policies which should reduce the medications requiring destruction.

The Medicaid Pharmacy Provider Manual currently states:

> *Providers shall dispense a one month's supply, unless the prescribing provider specifies a smaller quantity for medical reasons, to recipients in long-term care facilities. Dispensing a smaller quantity should only be done in exceptional cases.*

To fully clarify the Department's policy, prescriptions taken by long-term care patients are generally classified as either "maintenance" medications or "prn" (as needed) medications.

"Maintenance" medications are those used to treat chronic conditions or illnesses. **Initial therapy** of a "maintenance" medication may be dispensed in a small quantity (a ten-day supply) to ensure patient tolerance before dispensing a one month's supply of medication. The prospective DUR compliance module will only allow a refill on the eighth day of a ten-day therapy period. If on the eighth day of therapy the patient has progressed with no adverse effects, a one month's supply shall be dispensed unless otherwise specified by the prescriber.

For "prn" prescriptions, thirty units or a ten-day supply shall be supplied, unless otherwise specified by the prescriber. This dispensing pattern should be reviewed periodically by the nursing home pharmacy consultant to determine if the "prn" order has become a "maintenance" one. In that event, refer to the "maintenance" drug policy. Otherwise, if every six months, a quantity of the "prn" medication remains unused by the resident and is destroyed, the health care team (nursing home administration, medical, nursing and pharmacy consultant) should reevaluate the necessity of the order as well as the quantity of the prescribed medication. Should the prescriber authorize an additional "prn" medication, then the subsequent dispensed quantity shall be reduced to an amount equal to the utilization of the prior six-month period.

In order to accomplish these tasks, every member of the health care team must accept responsibility to reduce drug waste. Long-term care settings are not exempt from the circumstances which generate drug waste in other settings. Therefore, **total** elimination of drug waste cannot be achieved in spite of rather stringent prescribing practices and the control of medication dispensing in all types of settings. However, in the **very closed** setting of our long-term care facilities, we can expect the medical director, prescribing physician, consultant pharmacist, dispensing pharmacist and the medication nurses to coordinate the drug order, dispensing and administration in a manner which keeps prescription stock to a minimum.

Pharmacies are providing 24 hours coverage to the long-term care facilities. Prescription reorders should not be made until a three-day supply remains. Evidence from the drug destruction survey, which was recently undertaken by DHH, documents a ten-day supply plus a 30-day supply of the same medication for the same patient being destroyed. If this reorder had been postponed for a week, it is possible that only a three-day supply would have been wasted.

If, individually and collectively, every member of the health care team approaches drug utilization with common sense and diligent attention, drug waste can be curtailed.

We appreciate your continued efforts to control costs while ensuring the delivery of high quality health care services.

Sincerely,

Bobby P. Jindal
Secretary

BPJ/wp

J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
Bobby P. Jindal
SECRETARY

June 24, 1997

TO: NURSING HOME PROVIDERS

FROM: THOMAS D. COLLINS
DIRECTOR

An interdisciplinary committee was formed to address several issues of mutual concern to DHH and the Nursing Home industry. Based on the decisions reached by the committee, the following policies will become effective July 1, 1997.

1. OVER-THE-COUNTER (OTC) DRUGS

The nursing facility will develop its own OTC formulary. The facility must provide the OTC's in accordance with the procedures stated on page 8, Chapter 5, of the Standards for Payment. The facility can use bulk packaging for dispensing the OTC's. DHH will not provide a list of therapeutic classes of OTC's. Any problems arising from this new requirement will be addressed on an individual basis.

2. DISPOSITION OF DRUGS FOR DECEASED RESIDENTS

On May 1, 1997, an opinion was rendered by the Attorney General's office that only persons to whom drugs were prescribed have a possessory interest. Therefore, prescription drugs belonging to a deceased resident are not to be given to anyone else upon the death of the resident. The drugs should be destroyed following the appropriate destruction procedure.

3. DISPOSITION OF DISCONTINUED DRUGS

The nursing facility can keep discontinued medication(s) or medication(s) of residents admitted to the hospital for up to 60 days. The medication(s) should be destroyed by the last day of the month following the month the resident was admitted to the hospital or the medication(s) was discontinued. The medication is to be maintained in an appropriately secured storage area approved by the Director of Nursing and Consultant Pharmacist and should be readily accessible.

. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
Bobby P. Jindal
SECRETARY

JUNE 24, 1997

TO: NURSING HOME PROVIDERS

FROM: THOMAS D. COLLINS
DIRECTOR

RE: TITLE XVIII BED CHANGES

Please be advised that reporting of Skilled Nursing Facility (SNF) Medicare Title XVIII bed changes can be discontinued effective June 30, 1997. The Health Care Financing Administration (HCFA) informed us that the Fiscal Intermediaries no longer need to know the number and location (by room number) of existing SNF beds in a licensed nursing facility except at the time of the Annual Standard Survey.

Therefore, if you are a Medicare SNF provider, you may discontinue reporting SNF bed changes. A bed change is defined as an increase, a decrease, or a relocation of your existing SNF beds within your licensed facility beds. You can make these changes as often as you deem necessary. Our surveyors will be required to report the number and location of all beds by classification at the time of the Annual Standard Survey. The classification of a licensed nursing facility bed includes a SNF (Title XVIII), SNF/NF (Title XVIII/XIX), NF (Title XIX) and non-participating (private pay).

You must continue to inform this office of NF Medicaid (Title XIX) bed changes approved through Facility Need Review.

For clarification, a SNF/NF bed is dually certified. A bed change that involves changing a SNF/NF bed to a NF bed or a NF bed to a SNF/NF bed does not necessitate action on our part, therefore, a notice to this department by your facility is not required.

If you have any questions, please call Carolyn Dell at (504) 342-5771.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

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

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

April 15, 1998

To: All Nursing Facilities Administrators

From: Thomas D. Collins
Director

Re: Salary and Motor Vehicle Allowable Cost Limitations

The *Standards for Payment for Nursing Facilities*, Chapter 5, pages 5-19 and 5-20 addresses allowable costs for reimbursement to Long Term Care Facilities providing services under the Louisiana Medicaid Program and sets limitations for administrative salaries and motor vehicle purchase and lease expenditures. The Bureau of Health Services Financing's Health Standards Section hereby sets these limitations as follows:

Administrative Salaries Limitations

Effective July 1, 1997, the allowable annual salary maximums for administrative salaries are as follows:

- Administrator $79,524
- Assistant Administrator $73,440

Motor Vehicle Purchase Price Limitations

Effective July 1, 1998, the allowable purchase price of a new motor vehicle is limited to the following average sticker price amounts:

- Automobile $20,500
- Van $25,600
- Station Wagon $22,500

Motor Vehicle Interest Expense Limitations

Interest expense allowed for the purchase of motor vehicles as determined by the current prevailing interest will not exceed 8.0% over 36 months.

Motor Vehicle Lease Cost Limitations

Effective January 1, 1998, the monthly allowable lease cost of a motor vehicle, based on average lease costs, is limited to the following amounts:

- Automobile $400
- Van $460
- Station Wagon $435

If you require further information, please contact Mr. E. N. Kirkpatrick at (504) 342-3926.

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
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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.

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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

July 31,1998

TO: All Medicaid Enrolled Nursing Facilities

FROM: Thomas D. Collins
Director

RE: Clarification on Leave of Absence Days for Nursing Facilities Residents

In accordance with Act 1379 of the 1997 Regular Session of the Louisiana Legislature, the Bureau has increased the number of allowable leave of absence days for nursing facility residents for the purpose of home leave and hospitalization. Effective for July 1, 1998, leave of absence days for home leave is increased to fifteen (15) days per year and leave of absence days for hospitalization for an acute condition is increased to seven (7) days per spell of illness.

Please note that nursing facility leave of absence days will continue to be counted on a calendar year basis. Therefore, any home leave days taken prior to July 1, 1998 will be deducted from the new maximum limit of fifteen days to determine the resident's current balance of home leave days.

In regard to hospitalization of nursing facility residents, the new maximum limit of seven days shall apply to hospital admissions on or after July 1, 1998. For any resident admitted to the hospital prior to July 1, the old maximum limit of five days shall be used to compute reimbursement for the applicable month(s).

If there are any questions regarding this notice or the leave of absence days policy for nursing facility residents, you may contact Terry Cooper at (504) 342-0118. If there are any questions regarding claims payment or a resident's home leave days balance, you may contact Unisys Provider Relations staff at (800) 473-2783 or (504) 924-5040

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

UNISYS

NOVEMBER 10, 1998

TO: LONG TERM CARE PROVIDERS

Listed below is the 1999 LTC MONTHLY PROCESSING SCHEDULE. THIS SCHEDULE REPRESENTS THE ONE TO BE FOLLOWED SINCE THE IMPLEMENTATION OF DIRECT DEPOSIT OF PROVIDER PAYMENT BEGINNING WITH THE CHECK WRITE DATED 02/10/98. DIRECT DEPOSIT OF PAYMENTS MEANS FASTER ACCESS TO FUNDS.

NOTE: It is VERY IMPORTANT that you get your turnaround document (TAD) to Unisys no later than the scheduled deadline for billing (TADS RECEIVED AT UNISYS) in order to receive payment on the "check release (issue) date" shown on the schedule below. If your TAD is received at Unisys after the deadline & if the regular monthly LTC check write is missed, the TAD will be processed for payment with the next regular check write. Once a provider is on direct deposit and paid in the regular check write, the funds will be available on the work day after the normal Tuesday check write date.

MAIL TAD TO PROVIDERS	TAD RECEIVED AT UNISYS	CHECK RELEASE (ISSUE) DATE	DAY	DIRECT DEPOSIT FUNDS AVAILABLE DATE	DAY
12/21/98	01/07/99 5:00p.m.	01/11/99	Monday	01/12/99	Tuesday
01/21/99	02/04/99 5:00p.m.	02/09/99	Tuesday	02/10/99	Wednesday
02/18/99	03/04/99 5:00p.m.	03/09/99	Tuesday	03/10/99	Wednesday
03/18/99	04/08/99 5:00p.m.	04/12/99	Monday	04/13/99	Tuesday
04/20/99	05/06/99 5:00p.m.	05/10/99	Monday	05/11/99	Tuesday
05/19/99 *	06/08/99 12Noon	06/10/99	Thursday	06/11/99	Friday
06/19/99	07/08/99 5:00p.m.	07/12/99	Monday	07/13/99	Tuesday
07/20/99	08/05/99 5:00p.m.	08/10/99	Tuesday	08/11/99	Wednesday
08/19/99 *	09/07/99 5:00p.m.	09/09/99	Thursday	09/10/99	Friday
09/21/99	10/07/99 12Noon	10/11/99	Monday	10/12/99	Tuesday
10/19/99	11/04/99 5:00p.m.	11/09/99	Tuesday	11/10/99	Wednesday
11/17/99 *	12/07/99 5:00p.m.	12/09/99	Thursday	12/10/99	Friday

*** MIDWEEK CYCLE**

1999
LTC SUPPLEMENTAL BILLING SCHEDULE

TAD RECEIVED AT UNISYS	DAY	CHECK RELEASE(ISSUE) DATE	DAY	DIRECT DEPOSIT FUNDS AVAILABLE	DAY
JANUARY					
01/14/99- 12NOON	THURSDAY	01/19/99	TUESDAY	01/20/99	WEDNESDAY
01/21/99- 12NOON	THURSDAY	01/26/99	TUESDAY	01/27/99	WEDNESDAY
FEBRUARY					
02/11/99- 12NOON	THURSDAY	02/16/99	TUESDAY	02/17/99	WEDNESDAY
02/18/99- 12NOON	THURSDAY	02/25/99	TUESDAY	02/26/99	WEDNESDAY
MARCH					
03/11/99- 12NOON	THURSDAY	03/16/99	TUESDAY	03/17/99	WEDNESDAY
03/18/99- 12NOON	THURSDAY	03/23/99	TUESDAY	03/24/99	WEDNESDAY
APRIL					
04/15/99- 12NOON	THURSDAY	04/20/99	TUESDAY	04/21/99	WEDNESDAY
04/22/99- 12NOON	THURSDAY	04/27/99	TUESDAY	04/28/99	WEDNESDAY
MAY					
05/13/99- 12NOON	THURSDAY	05/13/99	TUESDAY	05/14/99	WEDNESDAY
05/20/99- 12NOON	THURSDAY	05/25/99	TUESDAY	05/26/99	WEDNESDAY
JUNE					
06/10/99- 12NOON	THURSDAY	06/15/99	TUESDAY	06/16/99	WEDNESDAY
06/17/99- 12NOON	THURSDAY	06/22/99	TUESDAY	06/23/99	WEDNESDAY
JULY					
07/15/99- 12NOON	THURSDAY	07/20/99	TUESDAY	07/21/99	WEDNESDAY
07/22/99- 12NOON	THURSDAY	07/27/99	TUESDAY	07/28/99	WEDNESDAY
AUGUST					
08/12/99- 12NOON	THURSDAY	08/17/99	TUESDAY	08/18/99	WEDNESDAY
08/19/99- 12NOON	THURSDAY	08/24/99	TUESDAY	08/25/99	WEDNESDAY
SEPTEMBER					
09/16/99- 12NOON	THURSDAY	09/21/99	TUESDAY	09/22/99	WEDNESDAY
09/23/99- 12NOON	THURSDAY	09/28/99	TUESDAY	09/29/99	WEDNESDAY
OCTOBER					
10/14/99- 12NOON	THURSDAY	10/19/99	TUESDAY	10/20/99	WEDNESDAY
10/21/99- 12NOON	THURSDAY	10/26/99	TUESDAY	10/27/99	WEDNESDAY
NOVEMBER					
11/11/99- 12NOON	THURSDAY	11/16/99	TUESDAY	11/17/99	WEDNESDAY
11/18/99- 12NOON	THURSDAY	11/23/99	TUESDAY	11/24/99	WEDNESDAY
DECEMBER					
12/16/99- 12NOON	THURSDAY	12/21/99	TUESDAY	12/22/99	WEDNESDAY
12/23/99- 12NOON	THURSDAY	12/28/99	TUESDAY	12/29/99	WEDNESDAY

ANY SUPPLEMENTAL BILLING RECEIVED AT UNISYS IN THE LAST WEEK OF EACH MONTH WILL BE PROCESSED WITH YOUR PRE-PRINTED TAD IN THE FOLLOWING MONTH.

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

David W. Hood
SECRETARY

January 22, 1999

TO: Nursing Facility Providers

FROM: Tom Collins, Director

RE: Refund of Nursing Facility Payment for Retroactive Eligibility Period

HCFA Center for Medicaid and State Operations (Baltimore) has recently become aware that some Medicaid participating nursing facilities are retaining money they are required to refund to residents when Medicaid eligibility is made retroactive. They have asked that we clarify the policy to nursing facilities and take steps to enforce compliance with the requirements.

When a person applies for admission to a nursing facility pending Medicaid eligibility or if a resident has spent most of his private funds in the nursing facility and is applying for Medicaid, the nursing facility may require a private rate payment until Medicaid eligibility is determined. When Medicaid eligibility is determined, it is most often made retroactive to a time prior to the date that the decision is made. Federal statutory, regulatory requirements mandate that the nursing facility accept Medicaid payment as payment in full when the person's Medicaid eligibility begins. Thus, NF's are required to refund any payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the resident is determined eligible for Medicaid.

The policies described above reflect the requirements of the following statutory and regulatory provisions:

- Section 1919(c)(5)(A)(I)(I) of the Social Security Act requires that a NF must not require individuals applying to reside or residing in the facility to waive their rights to benefits under Medicaid or Medicare.

- Section 1919(c)(5)(A)(iii) requires that a NF, in the case of an individual who is entitled to medical assistance for NF services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under Medicaid, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual of the individual's continued stay in the facility.

- Under 42 CFR 483.12(d), a NF:

  must not require residents or potential residents to waive their rights to Medicare or Medicaid;

  must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility; and

  in the case of a person eligible for Medicaid, a NF must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility.

- Providers must reconcile remittance advice to Form 18 LTC. If the remittance advice does not reconcile with Form 18 LTC, a Form 212 must be completed and submitted to Unisys to make corrections.

We are requesting strict adherence to these regulations; failure to do so shall result in enforcement action against the nursing home.

J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

FEBRUARY 22, 2000

MEMORANDUM

TO: **ALL DURABLE MEDICAL EQUIPMENT (DME) PROVIDERS AND ALL INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF-MR)**

FROM: **THOMAS D. COLLINS**
DIRECTOR

RE: **ELIMINATION OF COVERAGE OF MEDICAL EQUIPMENT BY THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM FOR MEDICAID RECIPIENTS RESIDING IN ICF-MR FACILITIES**

Effective for dates of service of March 1, 2000 and after, Medicaid will deny DME claims for the purchase or rental of any medical equipment and/or supplies that the ICF-MR facility is responsible for providing to its residents. The Unisys Prior Authorization Unit will also discontinue the authorization of DME requests with dates of service on or after March 1, 2000, for services rendered to ICF-MR residents. The ICF-MR facility shall be responsible for furnishing all the medical equipment and supplies listed in section 0-500 of the DME Program Provider Manual, with the exception of certain disposable supply items that will continue to be covered by the DME Program. Additionally, other non-listed medical equipment items that would normally be considered by the DME Program for EPSDT eligible recipients must be furnished by the ICF-MR facility when the interdisciplinary team identifies the recipient's need for the item.

Therefore, claims for medical equipment and supplies provided to ICF-MR residents should be billed directly to the ICF-MR facility. Please note that the ICF-MR facility is responsible for the payment of the coinsurance and deductible amounts for any medical equipment and supplies provided to Medicare/Medicaid recipients that has been approved and reimbursed by Medicare and for which the facility is required by Medicaid to furnish.

"The following supplies will continue to be reimbursed through the DME Program:

- Urinary catheters (except indwelling types covered through the Pharmacy Program) and disposable urological supply items,
- Enteral and parenteral formulas or solutions and administrative supplies (ICF-MR is responsible for providing infusion pumps and stands),
- IV therapy administrative supplies (ICF-MR is responsible for providing IV pumps and stands; IV medications and fluids are available only through the Pharmacy Program),

- Ostomy supplies,
- Surgical dressings and bandages for wound care (gauze, tape, sponges, cement, anc disposable gloves),
- Disposable tracheostomy supplies (trach tubes, trach care kits, and cannulas),
- Suction catheters, and
- Batteries for hearing aids, pacemakers, and artificial larynxes."

Facilities are required to provide all accessories (disposable and non-disposable) necessary for the use of the equipment they furnish in addition to necessary repairs and the replacement of all parts and components when needed.

If further clarification or additional information is needed concerning DME Program coverage of specific DME items, you may contact Mr. Gene King at #225-342-3930.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

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

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

June 19, 2000

MEMORANDUM

TO: ALL NURSING FACILITIES, DURABLE MEDICAL EQUIPMENT PROVIDERS AND REHABILITATION FACILITIES

FROM: BEN BEARDEN
ACTING DIRECTOR

RE: WHEELCHAIR SEATING EVALUATIONS AND TRANSPORTATION TO REHABILITATION FACILITIES FOR MEDICAID RECIPIENTS IN NURSING FACILITIES

Medicaid policy requires that Durable Medical Equipment (DME) providers submit a copy of a wheelchair seating evaluation from a rehabilitation therapist along with their requests for prior authorization of customized wheelchairs for Medicaid recipients residing in nursing facilities (ICF I, II, & SNF). Previously, Medicaid has described three basic methods by which such evaluations may be obtained in nursing facilities. These were published in the *Provider Update* newsletter of August 1999, page 4. The three basic methods described in this article that may be utilized by DME providers are: (1) have a home health agency provide a physical therapist for the evaluation in the nursing facility; (2) utilize a therapist under contract with the nursing facility to provide therapy services for the recipient for the seating evaluation; or, (3) reimburse a therapist at the DME provider's own expense to perform a seating evaluation when neither of the first two methods are available to obtain an evaluation.

Effective August 1, 2000, Medicaid is revising the third method of obtaining wheelchair evaluations, as described in the above referenced *Provider Update* newsletter article, for nursing home Medicaid recipients. Effective for August 1, 2000 and after, DME providers can no longer reimburse rehabilitation therapists at their own expense to perform wheelchair seating evaluations for Medicaid recipients in nursing facilities. Since nursing facilities are required to provide medically necessary transportation services for Medicaid recipients residing in their facilities, nursing facilities must provide transportation of their Medicaid residents to outpatient rehabilitation facilities for wheelchair seating evaluations. Nursing facilities must provide such transportation, however, only when no home health agency is available to provide a therapist to perform such an evaluation in their facility and when no facility-contracted therapist is available for an individual recipient needing a wheelchair evaluation.

DME providers may continue to reimburse rehabilitation therapists for wheelchair seating evaluations in nursing homes in accordance with the provisions described in the above referenced August 1999 newsletter article, when no other method of obtaining such evaluations in the facility is available, for therapist evaluations that are performed through July 31, 2000. All rehabilitation therapist wheelchair evaluations for Medicaid recipients residing in nursing facilities, dated August 1, 2000 and after, must be performed in an outpatient rehabilitation therapy facility if no home health agency is available to provide a physical therapist for a seating evaluation in the nursing facility, or if no facility-contracted therapist is available to provide a seating evaluation for the individual. The outpatient rehabilitation facility must bill Medicaid for the wheelchair seating evaluation performed by their therapist and must not accept reimbursement from the DME provider for the service.

If further clarification or additional information is needed concerning these regulations, you may contact Gene King at 225-342-3930.

Sincerely,

Ben A. Bearden
Acting Director

BAB:GEK:slg

DME/Rehabilitation/Nursing Facilities

Wheelchair Seating Evaluations for Medicaid Recipients in Nursing Facilities

Since Medicaid policy for the prior authorization of customized wheelchairs requires DME providers to submit a wheelchair seating evaluation from a rehabilitation therapist, several DME providers have recently requested that BHSF clarify Medicaid policy with regard to the methods by which they may obtain such evaluations in nursing facilities. Three methods that may be utilized by DME providers to obtain seating evaluations for nursing home recipients:

First, Medicaid does reimburse home health agencies for the provision of physical or occupational therapists to perfrom wheelchair seating evaluations for Medicaid recipients in nursing facilities. If therapy services are available from a home health agency for a facility resident, a DME provider may work with that home health agency to have a therapist perform a seating evaluation. (Please note, however, that Medicaid does not reimburse rehabilitation centers for the provision of therapists for wheelchair seating evaluations in nursing facilities).

Second, since nursing facilities are required to provide rehabilitation services for skilled care Medicaid recipients residing in their facilities, they often employ physical and occupational therapists on staff to render rehabilitation services to these recipients. A DME provider, therefore, may work with a therapist, who is employed by a facility to obtain a wheelchair seating evaluation for a facility resident.

Third, some DME providers, at their own expense, reimburse therapists to perform seating evaluations for nursing home recipients when no other method is available for their reimbursement. Medicaid policy does not specifically address this as an option for DME providers, but since policy does not prohibit it, and since policy does require a seating evaluation by a therapists as a prerequisite for prior authorization of a customized wheelchair, BHSF recognizes that DME provider reimbursement for a therapist's evaluation of a nursing home recipient may be necessary in those circumstances where there is no other method of reimbursement. DME providers, however, should document in their records that no facility contracted therapist, home health agency therapist, or other funding source is available for an evaluation for that individual recipient. (Please note, also, that Medicaid regulations do not permit a DME provider to pay a therapist for seating evaluation services for a recipient when that therapist is already employed by a home health agency, a nursing home, or a rehabilitation center to provide rehabilitation services for that recipient.)

Home Health

Filling Out Home Health Services Claims

When filing claims for home health services, Block 19, "Patient Status," on the Home Health Services claim form must be completed.

There must be a date in either Block A - Date of Discharge , Block B - Date of Death, or Block C - Visits Exhausted or an X must be placed in Block D - Still Receives. Failure to fill in one of these blocks will cause the claim to be denied.

Previous *Provider Update* Correction

The June/July 1999 issue of the Provider Update included an article for Home Health Agencies entitled, "*RN Qualifications for Psychiatric Home Health Visits.*"

The last paragraph of this article incorrectly stated that the services must be prior authorized. The correct wording of the paragraph is "Additionally, the services must be medically necesary and providsd only to recipents who meet Medicaid's homebound criteria."

We apologize for any inconvenience this may have caused.

Louisiana Medicaid

Provider Update

Volume 16, Issue 4 August 1999

Y2K Readiness Update

As you are aware, the Department of Health and Hospitals and Unisys have been working diligently to ensure that all Louisiana Medicaid systems are Year 2000 ready. As of June 30, 1999, the remediation and testing of code for Y2K readiness (including mirroring, bridging, and expansion of critical date fields) is complete, implemented, and currently in production. We are presently conducting the final phase of our Y2K project which involves extensive end-to-end testing of the system using future Year 2000 dates.

As part of our outreach initiative to ensure that recipients and providers are not adversely affected by our Y2K changes, we would like to provide the following information on key areas:

PERMANENT 13-DIGIT IDENTIFICATION NUMBER

The Medicaid recipient identification number previously assigned to recipients is a 13-digit "intelligent" number that houses certain pieces of information used in Medicaid billing. Use of this "intelligent" number has caused billing difficulty for the provider community. In an effort to resolve these issues, beginning July 1, 1999, a new permanent 13-digit number was assigned to each Medicaid recipient. The most current 13-digit recipient ID number was frozen and became the permanent person number for all individuals on the Unisys recipient file on June 30, 1999. Recipients added to the file as of July 1, 1999 and after are being assigned a new permanent 13-digit number, which may look somewhat different to you. Information previously obtained from the "intelligent" number is currently available and will be supplied as a part of the response given when making eligibility inquiries through MEVS or REVS. Providers must access and verify eligibility through REVS or MEVS

USE OF PREVIOUSLY ISSUED RECIPIENT IDENTIFICATION NUMBERS

This does not mean that other identification numbers previously issued to recipients may not be used to bill claims for services rendered. Any 13-digit number that was a valid number and is still on the recipient file may be used to bill claims. In situations where services were pre-certified or prior authorized using a number other than the permanent 13-digit person number, it is necessary to bill using the number under which the pre-certification or prior authorization was issued.

As of July, 1999, we encourage providers to make note of the identification number confirmed or obtained from Unisys REVS or MEVS eligibility inquiries as this number will be the PERMANENT number. For dates of service and pre-certification and prior authorization after July 1, 1999, the permanent 13-digit person number will be used by all DHH and Unisys systems. PLEASE REMEMBER THAT THIS 13-DIGIT PERSON NUMBER DOES NOT REPLACE THE 16-DIGIT CARD CONTROL NUMBER (CCN) CONTAINING LEADING DIGITS OF "777."

PLASTIC IDENTIFICATION CARD/CARD CONTROL NUMBER

Medicaid recipients now have a plastic swipe ID card which is encoded with a 16-digit Card Control Number (CCN) containing the lead digits of "777". This card number is used to access Medicaid eligibility, benefit, and service limit information. The CCN should never be used for billing with the exception of pharmacy POS. Claims submitted with this number will deny. (Pharmacy

Continued on Page 5

FOR INFORMATION OR ASSISTANCE, CALL US!

Provider Relations	**1-800-473-2783** **(225) 924-5040**
REVS Line	**1-800-776-6323** **(225) 216-REVS(7387)**
Point of Sale Help Desk	**1-800-648-0790** **(225) 237-3381**
Prior Authorization	
Home Health/EPSDT - PCS	**1-800-807-1320**
Dental	**1-504-619-8589**
DME & All Other	**1-800-488-6334** **(225) 928-5263**
Hospital Pre-Certification	**1-800-488-6334**

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

July 25, 2005

Dear Health Care Provider:

Louisiana Medicaid's Pharmacy Benefits Management staff (LMPBM) and Louisiana Medicaid's Drug Utilization Review Board are charged with assuring that prescriptions billed to Medicaid are appropriate and medically necessary. In 2005, our Drug Utilization Review program is focusing on behavioral health issues and pain disorders. The purpose of this correspondence is to notify prescribers of upcoming edits and limitations the LMPBM is implementing regarding antipsychotic agents and anti-anxiety drugs. The goal is to assure appropriate use of antipsychotic agents and anti-anxiety agents based on established clinical practice guidelines and available diagnostic information.

Procedures in the pharmacy audit program have been established to verify the provider's documentation and compliance associated with program policy. Therefore, prescribers are asked to assist pharmacists in obtaining required documentation and notations.

If you have concerns or comments regarding this correspondence, you may contact Melwyn B. Wendt at 225-342-9768 or send a fax to 225-342-1980. We appreciate your continued cooperation and support of our Drug Utilization Review (DUR) efforts to assure prescriptions paid by Medicaid are appropriate for the individual patient.

Sincerely,

Ben A. Bearden
Medicaid Director

BAB/MJT/mbw

Attachment

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LA 70821-9030
PHONE #: 225/342-5774 • FAX #: 225/342-3893

ANTIPSYCHOTIC AGENTS

Medicaid's Drug Utilization Review Board joined the Department of Health and Hospitals Office of Mental Health to establish parameters for reviewing antipsychotic agents. To help ensure the safety and well being of Medicaid patients, and to avoid duplication of benefits, effective August 10, 2005, prescriptions for antipsychotic agents:

- **will require an appropriate ICD-9 diagnosis code on all new prescriptions. The accepted diagnosis codes fall in the range from 290.0 through 319.9. The numeric code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The ICD-9 code may be transmitted to the pharmacist electronically or via telephone or facsimile;**

- **will be screened per recipient to search for two active prescriptions for antipsychotic agents. Any incoming pharmacy claim for an antipsychotic agent will deny when the recipient has two active antipsychotic prescriptions on their file. An active prescription is a prescription in which the days supply has not expired;**

- **that are classified as atypical agents, will be screened for doses exceeding the maximum recommended dose.**

(1) Pharmacy claims for new prescriptions for antipsychotic agents shall be submitted with an ICD-9 diagnosis code. Claims submitted without an appropriate diagnosis code or without any diagnosis code will deny. If the prescriber does not indicate a diagnosis code, and the pharmacist determines the patient cannot wait to receive the medication, the pharmacy provider may override the denial.

(2) Incoming pharmacy claims for antipsychotic agents billed for recipients who have two (2) active prescriptions for any antipsychotic medications (either typical or atypical agents) on file will deny with a therapeutic duplication. The pharmacist may override the denial upon consultation with the prescriber. The pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a third antipsychotic agent. Listed below are the current antipsychotic agents reviewed in the screening process. As new antipsychotic agents are made available, they will be included in the screening process.

Typical Antipsychotic Agents

Chlorpromazine	Thiothixene	Haloperidol
Perphenazine	Fluphenazine	Mesoridazine
Trifluoperazine	Prochlorperazine	Thioridazine
Loxapine	Pimozide	Molindone

Atypical Antipsychotic Agents

Generic Name	Brand Name	Maximum Dose Per Day
Aripiprazole	Abilify	30mg/day
Clozapine	Clozaril	900mg/day
Olanzapine	Zyprexa	40mg/day
Quetiapine	Seroquel	1200mg/day
Risperidone	Risperdal	16mg/day
Ziprasidone	Geodon	200mg/day

(3) Pharmacy claims for doses for **atypical antipsychotic agents** (listed above) which exceed the maximum recommended doses will deny. After consultation with the prescriber, the pharmacist may override the claim. The pharmacist must note on the hardcopy prescription, the reason the prescriber requires a dose above the maximum recommended dose.

ANTIANXIETY AGENTS

Effective **August 10, 2005** an incoming pharmacy claim for a recipient who has an **active** prescription for an anti-anxiety agent on file will deny as a therapeutic duplication. The pharmacist may override the denial upon consultation with the prescriber. The pharmacist must document on the hardcopy prescription the reason an additional anti-anxiety agent was requested by the prescriber.

Alprazolam	Halazepam
Buspirone	Hydroxyzine
Chlordiazepoxide	Lorazepam
Chlorazepate	Meprobamate
Diazepam	Oxazepam

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

MEMORANDUM

TO: Administrators of ICF/MR Facilities

FROM: Jerry Phillips
Medicaid Director

SUBJECT: Reimbursement Add on for Designated Medical Supplies

DATE: March 19, 2007

On September 20, 2006, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule (*Louisiana Register, Volume 32, Number 9*) to reimburse ICF/MR facilities for the following medical supplies when furnished to medically fragile individuals: ostomy supplies, tracheotomy supplies, and/or enteral nutrition.

Ostomy, Tracheotomy and Enteral Nutritional Supplies

Ostomy Supplies
Ostomy Bag

Enteral Nutrition (does not include supplemental feeding)
Feeding Bag
Formula
Feeding Pump
G-Tube Extension Sets

Tracheotomy Supplies
Tracheotomy Kit
Tracheotomy Tubes
Suction Catheter Kit

Approval of Requests

Effective with dates of service on or after September 20, 2006, The Inventory for Client and Agency Planning (ICAP) committee began accepting prior approval requests for these medical supplies for medically fragile recipients. Requests are based on individual need. All requests must have a physician's order specific to that recipient. When a request is approved, the money will be added to the facility's per diem for that recipient; and the facility will be subject to the direct care floor.

The provider must submit annual documentation to support the need for the adjustment to the rate. To request these supplies, send the attached medical supply request to:

ICAP Manager
Rate and Audit Section
P O Box 91030
Baton Rouge, LA 70821-9030

Reimbursement

Reimbursement is based on an average daily cost of the approved supplies. Reimbursement for enteral formula is based on the average cost of the formula, minus the per diem food costs that the facility expends as indicated on the most recent audited cost report data base.

Attachment

JP/MN

Medical Supply Request for Medically Fragile ICF/MR Individuals

Date of Request: _____ Dates of Reimbursement: _____

Recipient Name: _____ Medicaid Number: _____

Facility Name: _____ Provider Medicaid #: _____

Medicare/Private Insurance Information: _____

Enteral Nutrition**

Item Description	Frequency of Usage (times per day/week/month)
_____	_____
_____	_____
_____	_____

****If a feeding pump is required, please indicate above if you are buying or renting a pump and if you are sharing this pump among other individuals.**

Ostomy

Item Description	Frequency of Usage (times per day/week/month)
_____	_____
_____	_____

Tracheotomy

Item Description	Frequency of Usage (times per day/week/month)
_____	_____
_____	_____
_____	_____

Contact Person: _____ Phone Number: _____

A RECIPIENT SPECIFIC PHYSICIAN'S ORDER MUST BE ATTACHED.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

an Babineaux Blanco
GOVERNOR

Department of
HEALTH and
HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

MEMORANDUM

Date: March 23, 2007

To: Medicaid Enrolled Hospice, Wavier and Support Coordination Providers

From: Jerry Phillips
Medicaid Director

Hugh Eley
OAAS Assistant Secretary

Re: Waiver/Hospice Concurrent Care

In 2005 the Department of Health and Hospitals (DHH) clarified our policy regarding Hospice and Wavier services provided concurrently. At that time, DHH began to require recipients to forfeit their waiver services if they chose to elect hospice services. This decision was made because Medicaid administration was concerned about the possibility of duplication of services and payment in both programs.

DHH is pleased to announce that this policy has been reversed. Effective May 1, 2007, recipients may receive both hospice and waiver services concurrently. However, both hospice and waiver providers must work together to ensure that no services are duplicated. To ensure the integrity of both programs, Medicaid and OAAS collaborated to craft policy designed to reduce the possibility of duplication. Both Hospice and Waiver Providers must adhere to this policy when providing services to a Medicaid recipient that is receiving both services. This includes recipients who have both Medicare/Private Insurance and Medicaid.

If you have questions please contact Randy Davidson at (225) 342-4818.

Attachment

Hospice Waiver Recipients Policy

I. Medicaid Waiver Recipients and Hospice Services

Recipients who receive home and community-based services through one of the waiver programs offered by OAAS or OCDD are also eligible for Medicaid hospice services. These waiver programs are:

Adult Day Health Care (ADHC) Waiver
Elderly and Disabled Adult (EDA)Waiver
New Opportunities Waiver (NOW)
Children's Choice Waiver (CCW)
Supports Waiver (SW)
Note: Long Term Personal Care Services (LT PCS) is a Medicaid State Plan Service and not a waiver service; LT PCS recipients may not receive hospice services while receiving LT PCS.

II. Service Coordination

Medicaid expects the hospice provider to interface with other non-hospice providers depending on the need of the recipient to ensure that the recipient's overall care is met and that non-hospice providers do not compromise or duplicate the hospice plan of care. This expectation applies to Medicaid hospice recipients and Medicare/Medicaid hospice recipients. The hospice provider must ensure that a thorough interview process is completed when enrolling a Medicaid or Medicare/Medicaid recipient to identify all other Medicaid or other state and/or federally funded program providers of care.

Medicaid waiver recipients who elect the hospice benefit do not have to disenroll from the waiver program, but they must be under the direct care of the Medicaid hospice provider for those services both programs have in common. The waiver member who elects the hospice benefit can still receive waiver services **that are not related to the terminal hospice condition and are not duplicative of hospice care.** The hospice provider and the waiver support coordinator must collaborate and communicate regularly to ensure the best possible overall care to the waiver/hospice member. These collaborative sessions must be documented in both the hospice and waiver case manager/support coordinator progress notes. Failure to collaborate may result in administrative sanctions.

Guidelines for hospice and waiver providers include the following:

- The hospice provider, waiver provider and waiver case manager must meet to develop a coordinated plan of care.
    - The hospice provider must prepare the hospice plan of care to include all services that the hospice provider would have covered to treat the terminal illness and related conditions had the Medicaid recipient not been on the waiver program.

- The waiver provider must prepare the waiver plan of care to include all services that the waiver provider would have covered had the Medicaid recipient not been on the hospice program.

- The waiver providers must then modify the waiver plan of care to ensure there is no duplication of services by the waiver provider for those services held in common that would be necessary to treat the terminal illness and related conditions. For example, the waiver provider must modify or adjust hours in the waiver plan of care if the hospice agency must provide personal care, attendant care, or homemaker hours to treat the terminal condition that the waiver provider would otherwise provide if the recipient had not elected hospice services.

- Different diagnoses for the respective hospice and waiver plans of care are not sufficient to ensure that there is no duplication of services. Medical records of each provider may demonstrate that a patient's primary hospice diagnosis and patient's waiver diagnosis intermingle to such a degree that it is not possible to differentiate between the waiver diagnoses and the hospice primary diagnoses.

- The fact the hospice provider and the waiver provider are in the member's home at different times is not sufficient to ensure that there is no duplication.

- Both providers must thoroughly document the required distinction between the services provided.

- The hospice provider shall be responsible for providing those services that intermingle between diagnoses. Approved waiver services shall be reduced by the appropriate level.

The hospice provider's failure to include all necessary hospice core services in the hospice plan of care for the waiver/hospice recipient subjects the hospice provider to recoupment when overpayment or duplication is identified.

III. Inquiries

Inquiries to DHH about policy clarification for the coordination of care for waiver recipients who are dually-eligible and receive Medicare hospice benefit are handled by referring the Medicare hospice to the Medicare fiscal intermediary. While Medicaid is the payor of last resort and must not under any circumstances pay for waiver services that are duplicative of Medicare hospice care, DHH has no authority to instruct a Medicare hospice provider about Medicare hospice plan of care modifications. The hospice provider must obtain clarification from Medicare.

All inquiries to DHH from waiver providers regarding coordination of hospice and waiver services will be handled by either OAAS or OCDD. Inquiries from hospice providers about the provision of Medicaid Hospice services will be handled by Medicaid Hospice staff.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

MEMORANDUM

TO: All Nursing Facility and ICF-MR Providers

FROM: Jerry Phillips
Medicaid Director

SUBJECT: New Procedures for Optional State Supplement Checks

DATE: August 6, 2007

Effective September 1, 2007, the Department of Health and Hospitals (DHH) will assume the responsibility of issuing Optional State Supplement (OSS) checks to eligible residents of nursing facilities and intermediate care facilities. The monthly OSS checks are issued to residents who receive SSI benefits and who meet the criteria for supplemental payments.

The Department of Social Services previously handled these supplemental payments by sending paper checks to the facility or the resident's responsible representative. DHH will now issue payments to the facilities via electronic funds transfer (EFT). The funds will be transferred the first full work week of each month. **This transaction will occur prior to the monthly Long Term Care check-write.** Attached is the OSS schedule for the year. Since this entire process will be done electronically, please verify that your EFT information as correct. If you have any questions regarding EFT, please contact Provider Enrollment at 225-216-6370.

Since these funds are designated for the personal care needs of the resident, you must transfer the funds to the resident's personal funds account **within three business days of receipt** of the EFT. There will be a monthly remittance advice statement available on www.lamedicaid.com for the facility to download. Once you log into the secure provider area on the Provider Applications page, click the link called OSS Checks and click on Remittance Advice Statements. All return payments will be handled electronically through the OSS Checks link. A user manual for the OSS process will be available on this same link. If you need assistance with the secure provider area, contact the Technical Support Help Desk at 1-877-598-8753.

If you have any questions or need additional information regarding these new procedures, please contact Laurie Tichenor at 225-342-9076.

JP/SV/khb

Attachment

OSS Check-write Schedule

September 2007 through June 2008

Published 07/31/2007
Subject to Change

Month	OSS Checks Date	OSS Remits Date	EFT Date
Sep 2007	8/31/2007	8/31/2007	9/4/2007
Oct 2007	9/28/2007	9/28/2007	10/2/2007
Nov 2007	11/2/2007	11/2/2007	11/6/2007
Dec 2007	11/30/2007	11/30/2007	12/4/2007
Jan 2008	12/28/2007	12/28/2007	1/2/2008
Feb 2008	2/1/2008	2/1/2008	2/5/2008
Mar 2008	2/29/2008	2/29/2008	3/4/2008
Apr 2008	3/28/2008	3/28/2008	4/1/2008
May 2008	5/2/2008	5/2/2008	5/6/2008
Jun 2008	5/30/2008	5/30/2008	6/3/2008

Bobby Jindal
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
Alan Levine
SECRETARY

MEMORANDUM

TO: Nursing Facility Providers
Intermediate Care Facilities for the Developmentally Disabled Providers
Hospice Providers

FROM: Jerry Phillips
Medicaid Director

SUBJECT: Payment Calculation Modifications

DATE: June 19, 2008

Currently your monthly provider payments are calculated using two methods. When patient billing is for a full month, the payment amount is calculated by multiplying the daily rate by 365 days and dividing the product by 12 months. When patient billing is less than a full month, the payment amount is calculated by multiplying the daily rate by the number of days billed.

Effective for dates of service on or after July 1, 2008, the payment calculations will be modified for nursing facilities, intermediate care facilities for the developmentally disabled, and hospice providers. The full-month calculation method will no longer be used. Your payments will always be calculated by multiplying the daily rate by the number of days billed. This calculation method will be evident in the August 11, 2008 check write and all future payments.

Should you have additional questions regarding the modifications to the payment calculations, you may contact Kent Bordelon in the Rate and Audit Section at (225) 342-6116 or kbordelo@dhh.la.gov.

JP/DAY

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

DATE: September 23, 2008

TO: All Nursing Facility and ICF-MR Providers

FROM: Jerry Phillips
Medicaid Director

SUBJECT: New Contact Information for Optional State Supplement Payments and Check Write Schedule Changes

Effective September 1, 2008, the Department of Health and Hospitals (DHH), Eligibility Support Section (ESS) will assume the responsibility of assisting providers with any Optional State Supplement (OSS) payment/refund questions. Providers may contact the ESS at (225) 342-3610.

In addition, the current check-write schedule will no longer apply as OSS payments are now being processed on the first **working** day of each month and will be deposited into the providers account within approximately two to three days of that date. These funds continue to be designated for the personal care needs of the resident; therefore, you must continue to transfer these funds to the resident's personal funds account within three business days of receipt. If you experience any problems with your Electronic Funds Transfer, you may contact Provider Enrollment at (225) 216-6370.

If you have any questions or need additional information regarding these updated procedures, please contact ESS at (225) 342-3610.

JP/lt/km