REHABILITATION SERVICES

Chapter Seventeen 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 rehabilitation 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 rehabilitation 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 rehabilitation 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 eligibility of recipients, maintaining the recipient eligibility file, and issuing identification cards to certain categories of recipients; and
- Enrolling providers who wish to participate in the program.

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

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

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

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

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

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

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

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

UNDERSTANDING MEDICAID OF LOUISIANA

WHAT IS MEDICAID?

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

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

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

HOW DOES MEDICAID WORK?

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

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

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

ADMINISTRATION OF THE PROGRAM

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

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

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

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

STANDARDS FOR PARTICIPATION

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

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

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

PICKING AND CHOOSING SERVICES

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

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

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

INDICATION OF AGREEMENT

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

OUT-OF-STATE MEDICAL CARE

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

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

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

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

RECIPIENT ELIGIBILITY

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

CLASSIFICATIONS OF ELIGIBLE RECIPIENTS

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

Categorically Needy

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

Medically Needy

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

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

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

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

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

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

La. OFS Form 110-MNP
Revised 1/89

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

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

3601012345601 — ID NO.

Anna M. Doar — CASE NAME

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

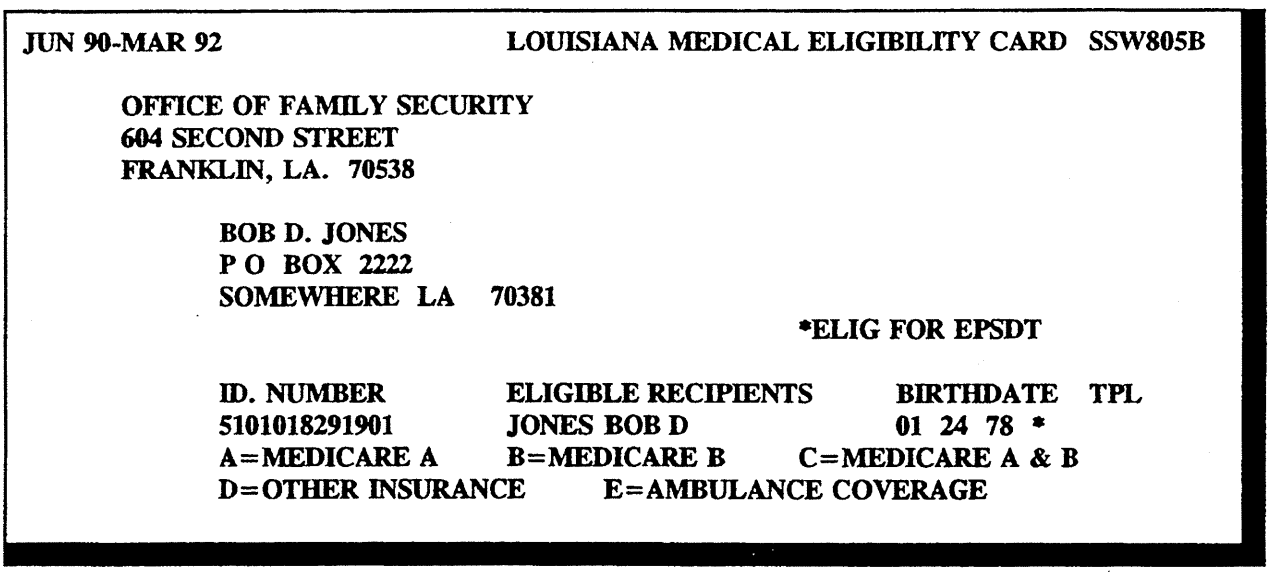
Patient Name and ID No. (include Recipient No.)	Date of Service	Provider Name and Vendor No.	Service or R_x Received On Spend-Down Date	Total Unpaid Charges for Services Received	Recipient Liability	OED Liability (Amt. and FI's actual payment may differ)
Anna M. Doar 3601012345601	07/15/90 mo/dy/yr	1312345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

Figure 4-1. Spend-Down Medically Needy Notice

IDENTIFICATION OF ELIGIBLE RECIPIENTS

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

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



JUN 90-MAR 92 LOUISIANA MEDICAL ELIGIBILITY CARD SSW805B

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

BOB D. JONES
P O BOX 2222
SOMEWHERE LA 70381

*ELIG FOR EPSDT

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

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

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

9PE LOUISIANA MEDICAL ELIGIBILITY CARD PAD163
PRESUMPTIVE ELIGIBILITY

P.O. BOX 2343
BATON ROUGE LA 70896

ERMA SMITH
555 BROWN STREET
ANYTOWN, LA 70000

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

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

Figure 4-3. Sample Presumptive Eligibility Card

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

LOUISIANA MEDICAL ELIGIBILITY CARD PAD973

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

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

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

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

NEIL BUSH
4000 LOAN STREET
NEW ORLEANS, LA 70126

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

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

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

BHSF Form 9
REV. 03/92
Prior Issue Usable

Eligible From
Through

LOUISIANA MEDICAL ELIGIBILITY CARD

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

Agency Representative Signature | Date of Issue

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

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

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

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

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

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

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

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

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

LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-SEPT. 92
OFFICE OF FAMILY SUPPORT 26
ST. CHARLES * KIDMED/EPSDT
P.O. BOX 453
HAHNVILLE LA 70057

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

DORA FRAN
200 WEST ST.
DESTREHAN LA 70047

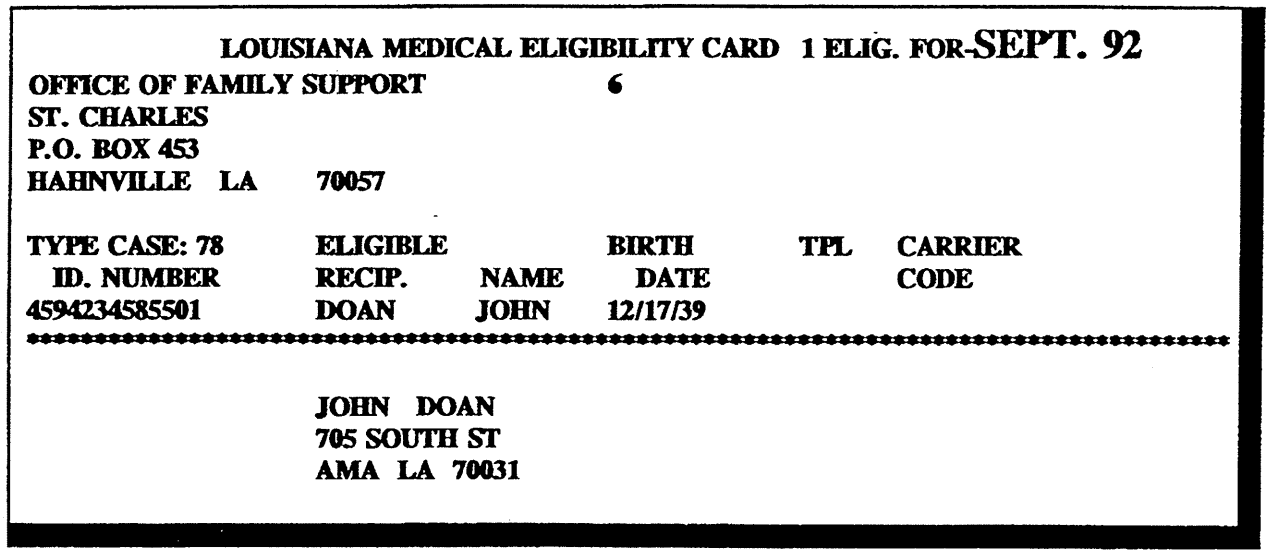
Figure 4-7. Sample One Medical Eligibility Card Issued by Paramax

LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-SEPT. 92
OFFICE OF FAMILY SUPPORT 18
ST. CHARLES #MEDICARE / MEDICAID SERVICES
P.O. BOX 453
HAHNVILLE LA 70057

TYPE CASE: 78 ID. NUMBER	ELIGIBLE RECIP.	NAME	BIRTH DATE	TPL	CARRIER CODE
45010020112014	SMITH	JOHN	10/15/26	C	

JOHN SMITH
700 SOUTH ST
DESTREHAN LA 70047

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

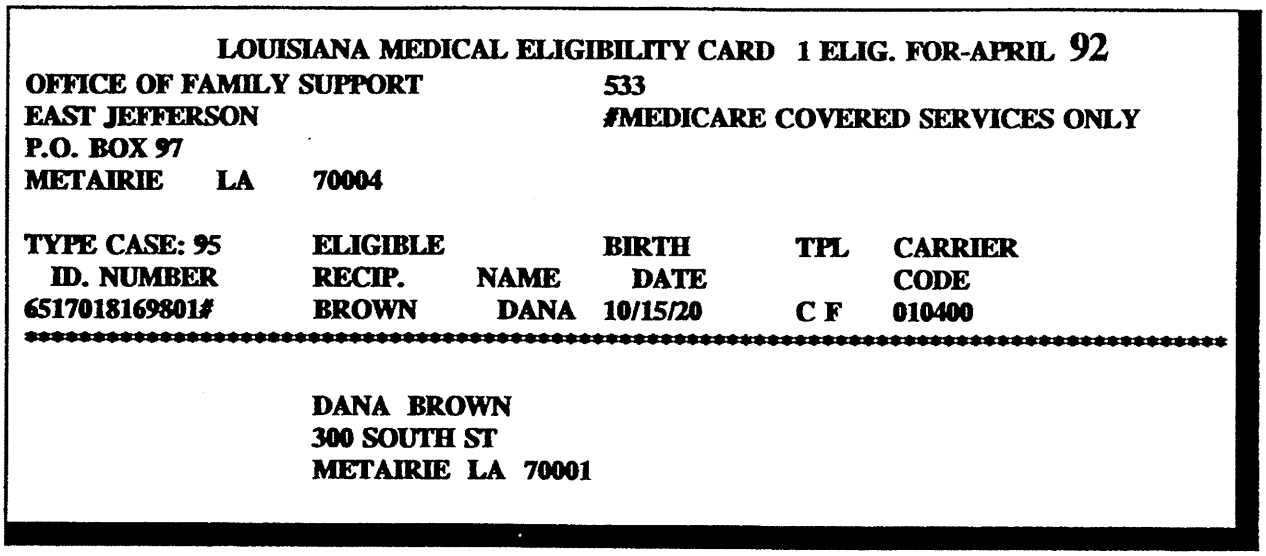


LOUISIANA MEDICAL ELIGIBILITY CARD 1 ELIG. FOR-SEPT. 92
OFFICE OF FAMILY SUPPORT 6
ST. CHARLES
P.O. BOX 453
HAHNVILLE LA 70057

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

JOHN DOAN
705 SOUTH ST
AMA LA 70031

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



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

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

DANA BROWN
300 SOUTH ST
METAIRIE LA 70001

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

LOCK-IN PROGRAM

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

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

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

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

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

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

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

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

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

LOCK-IN

LOUISIANA MEDICAL ELIGIBILITY CARD

Month/Year __ __ | __ __

ID NUMBER	BENEFICIARY NAME & ADDRESS	BIRTHDATE	TPL*
_ _ _ _ _ _ _ _ _ _ _ _ _ _		__ __ | __ __ | __ __	__ | __

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

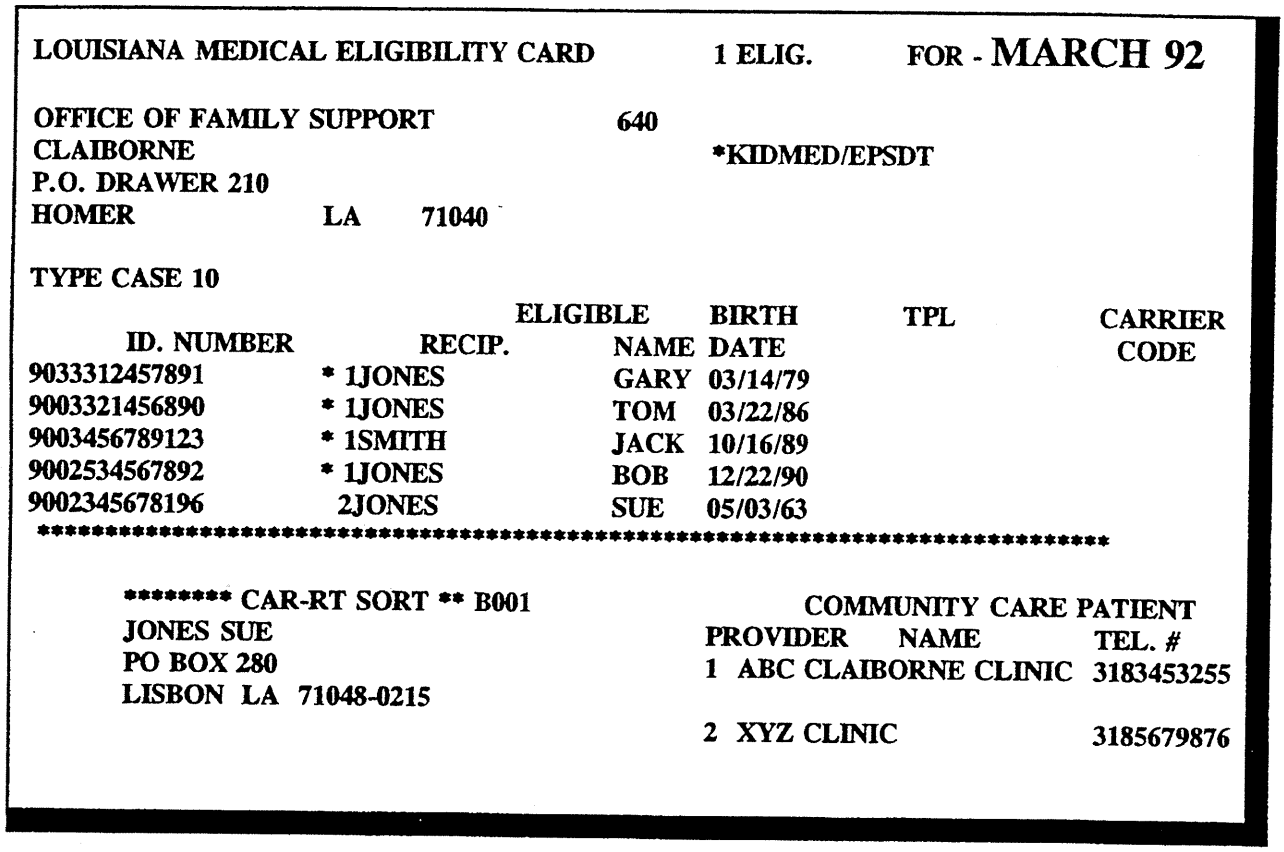
COLUMN 1
D=Private Health Insurance - Drug Coverage; E=Ambulance Insurance; F=Private Health Insurance - No Drug Coverage; G=Private Health Insurance (IV-D) - Pay & Chase
COLUMN 2
A=Medicare, Part A; B=Medicare, Part B; C=Medicare, Parts A & B

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.



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.

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

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

PROVIDER ENROLLMENT

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

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

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

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

☎ (504) 924-5040

Completed forms should be submitted to the following address:

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

☎ (504) 342-9454

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

CHANGE OF ADDRESS/ENROLLMENT STATUS

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

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

DEFINITION OF REHABILITATION SERVICES

Rehabilitation center services are services provided by both public and private rehabilitation centers to help physically disabled individuals learn to adapt to their disabilities and to help themselves. General rehabilitation services include the following:

- Occupational Therapy
- Physical Therapy
- Speech, Language, and Hearing Therapy

These services may not be provided in private homes, skilled nursing facilities, mental retardation facilities, or group homes.

PRIOR AUTHORIZATION

Rehabilitation is defined as a program to prevent further impairment or physical deformity and malfunction and to enable a significant increase in the capacity of the individual, requiring less care by others.

All rehabilitation services provided to Medicaid recipients, including physical, occupational, or speech and hearing therapy performed on an outpatient basis, must be prior authorized by the Prior Authorization Unit at Paramax.

To obtain rehabilitation services, patients must be referred by a licensed physician to a rehabilitation center. Referrals must include the patient's diagnosis, the date of the accident or the onset of the illness, the address of the referring physician and his specialty (if known), and the date of the referral.

☞ ***The rehabilitation center must retain a copy of the physician's recommendation on file. The recommendation must include the results of the evaluation which necessitates therapy.***

After the rehabilitation center receives the referral, the center must evaluate the patient and submit a proposed plan of service, including PA-01 and PA-02 forms (Initial Therapy and Extended Therapy Plan), to the Paramax Prior Authorization Unit at the following address:

Paramax Prior Authorization Unit
P.O. Box 14919
Baton Rouge, LA 70898-4919

☞ ***Providers may begin rendering treatment before the plan is approved. However, if the plan is not approved, the provider may not be reimbursed for the treatment services.***

In those cases where a delay in therapy would result in a deterioration of the patient's medical condition; e.g., burn cases, accidents, or surgery; the center may begin treatment without obtaining prior authorization, but the treatment will be subject to approval at a later date. In such instances, the request for therapy must be submitted for approval within the first week of treatment.

The Medical Review Team will recommend approval for therapy plans for individuals who are likely to realize substantial gains in self-care, self-help, or rehabilitation. ***Self-care*** and ***Self-help*** are defined as the ability of the individual to take care of personal needs; e.g., eating, dressing, walking, talking, or using devices unassisted.

☞ ***The BHSF does not have a program for long term therapy or maintenance therapy. In such cases, other resources, such as Handicapped Children's Services, school therapy programs, and community resources should be considered.***

In addition, the BHSF will not pay for vocational or developmental evaluations or voice evaluations and/or therapy, nor will it pay for instruction in the use and hygiene of the voice as treatment for vocal cord nodules or hoarseness and related conditions, unless the problem is serious enough to interfere with the patient's normal speech.

OBTAINING PRIOR AUTHORIZATION

To request prior authorization for rehabilitation services, providers must complete the PA-01 and PA-02 prior authorization request forms. These forms replace forms RC-1 and 146. In addition, providers must attach an evaluation and a physician's referral (signed by the physician) to the forms when submitting a request to substantiate the need for services.

Providers should follow the instructions provided below when completing the PA-01 form.

☞ ***A sample PA-01 form is provided after the instructions. The required items have been starred.***

1. In the block entitled **Prior Authorization Type**, check the second square entitled **05 Rehabilitation.**

2. Enter the recipient's Medicaid identification number in the block entitled **Recipient ID Number** exactly as the number appears on the recipient's Medicaid identification card.

3. Enter the recipient's last name, first name, and middle initial in the block entitled **Recipient Last Name First MI** exactly as the name appears on the recipient's Medicaid identification card.

4. Enter the seven-digit Medicaid provider number in the block entitled **Provider Number**.

5. In the block entitled **Dates of Service**, enter the anticipated **From** and **Thru** dates of the rehabilitation services.

6. Leave the block entitled **Inpatient Ext.** blank.

7. In the block entitled **Diagnosis**, enter the ICD-9-CM diagnosis code for the primary diagnosis in the square entitled **Primary Code** and **Description**. If applicable, enter the ICD-9-CM diagnosis code for the secondary diagnosis in the square entitled **Secondary Code and Description**. In addition, be sure to include a narrative description of each code listed.

8. In the block entitled **Prescribing Physician Name/Number**, enter the name of the referring physician.

9. In the space provided under the block entitled **Procedure Code**, enter the current procedure code for the procedure that is to be performed. In the space provided under the block entitled **Description**, enter the appropriate narrative description of the procedure code you entered. The **Units** block should also be completed.

10. In the block entitled **Provider Name, Address, Telephone**, enter the provider's name, address, and telephone number.

11. In the block entitled **Date of Request**, enter the date the request is being made.

12. On the line entitled **Provider Signature** at the bottom of the PA-01 form, please ensure that the request is signed by the provider of service or another authorized representative.

☞ ***We will accept stamped or computer-generated signatures if they are initialed by the provider or the provider representative.***

MAIL TO:
UNISYS / LA MEDICAID
P.O. BOX 14919
Baton Rouge, LA 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

ICN

PRIOR AUTHORIZATION TYPE:
- ☐ 01 INPATIENT
- ☐ 05 REHABILITATION
- ☐ 07 AIR AMBULANCE
- ☐ 09 DME
- ☐ 99 OTHER

RECIPIENT ID NUMBER

SOCIAL SECURITY NUMBER

LAST NAME FIRST MI

DATE OF BIRTH

PROVIDER NUMBER

DATES OF SERVICE FROM THRU

INPATIENT EXT: ☐ YES ☐ NO

TOTAL DAYS: ____

DIAGNOSIS
PRIMARY CODE AND DESCRIPTION

SECONDARY CODE AND DESCRIPTION

P.A. REVIEWER SIGNATURE

STATUS CODES:
2 = APPROVED
3 = DENY
4 = PEND

PRESCRIBING PHYSICIANS NAME \ NUMBER

PRESCRIPTION DATE

PRIOR AUTHORIZATION NUMBER

DESCRIPTION OF SERVICES

SHADED FOR OFFICE USE ONLY

PROCEDURE CODE	DESCRIPTION	BILLED UNITS	BILLED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT	DATE	STATUS

PROVIDER NAME, ADDRESS, TELEPHONE

DATE OF REQUEST

PLACE OF RESIDENCE \ TREATMENT
HOME ☐ LTC ☐ INPATIENT ☐ OUTPATIENT ☐

COMMENTS:

PROVIDER SIGNATURE: _____

P.A.01
ISSUED 1/91

Providers should follow the instructions listed below when completing the PA-02 form. Providers must attach the PA-02 form to the PA-01 form when submitting a request for services.

☞ ***A sample PA-02 form is provided after the instructions. The required items have been starred.***

1. On the line entitled **Patient Name, Age, Provider Name**, enter the patient's name exactly as it appears on the Medicaid identification card. Then enter the patient's age and the provider's name.

2. On the line entitled **Date of Accident or Surgery**, enter the appropriate date.

3. Next to the headings **Limitations** and **Aids Needed**, check off the appropriate boxes.

4. Next to the heading **Plan of Service**, check either **Initial** or **Extension**.

5. In the space provided under the heading **Requested Services**, enter the appropriate procedure code, the narrative description of the procedure code, the frequency, the time, and the total units.

6. In the block entitled **Length of Plan of Service**, enter the **From** and **To** dates, including the initial evaluation date.

7. In the space provided next to the heading **Date of Re-evaluation**, enter the appropriate date.

8. In the spaces provided next to the heading **Proposed Goals/Comments**, enter any additional information not included in the evaluation section that will assist the Prior Authorization Unit in determining authorization for the services requested.

9. In the space provided next to the heading **Requested By, Date**, please ensure that the provider or the authorized representative signs and dates the form.

NOTE: When requesting an extension for rehabilitation services, providers must submit a PA-01 form, a PA-02 form, progress notes, and a copy of the re-evaluation after six months of therapy.

Providers can only request extensions for six-month time periods. The only exception to this rule is for children under 21 years of age with long term disabilities, e.g., cerebral palsy or muscular dystrophy. In these instances, extensions will be approved for one-year time periods.

Once the review process has been completed and the request has been approved or denied, the provider of services and the recipient will receive written notification informing them of the results.

If the request is approved providers should bill Medicaid of Louisiana for the services on the appropriate claim form and enter the nine-digit prior authorization number that was assigned by Paramax in item 16A of the claim form.

MAIL TO:
UNISYS / LA MEDICAID
P.O. BOX 14919
Baton Rouge, LA 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
Medical Assistance Program
REHABILITATION SERVICES REQUEST

PATIENT NAME:_____ AGE:____ PROVIDER NAME: _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY:_____

LIMITATIONS: ☐ AMBULATORY ☐ NON-AMBULATORY TRANSPORTATION AVAILABLE ☐ YES ☐ NO

AIDS NEEDED: ☐ WALKER ☐ CANE ☐ WHEELCHAIR ☐ LIMBS OR BRACE ☐ OTHER:_____

REHABILITATION PLAN

PLAN OF SERVICE: ☐ INITIAL ☐ EXTENSION

IF INITIAL, INITIAL EVALUATION DATA AND MD REFERRAL MUST BE ATTACHED.

IF EXTENSION, PRIOR ATTENDANCE: ☐ REGULAR ☐ NON-REGULAR

REQUESTED SERVICES:	PROCEDURE CODE	DESCRIPTION	FREQUENCY	TIME/ VISIT	TOTAL UNITS
PHYSICAL THERAPY:					
SPEECH THERAPY:					
OCCUPATIONAL THERAPY:					

LENGTH OF PLAN SERVICE: FROM:_____ TO:_____
MONTH DAY YEAR MONTH DAY YEAR

DATE OF RE-EVALUATION:_____
MONTH DAY YEAR

PROPOSED GOALS/COMMENTS:_____

REQUESTED BY:_____ DATE:_____

P A 02
ISSUED 1/91

Completed requests should be mailed to the following address:

Paramax
P.O. Box 14919
Baton Rouge, LA. 70898-4919
Attention: Prior Authorization

Once a request is received by Paramax, it will be assigned a unique nine-digit prior authorization number.

After the request is assigned a number, it will be entered into the prior authorization file at Paramax. Upon entry, the system will perform a series of front-end edits. It will check for a valid seven-digit Medicaid provider identification number, a valid 13-digit recipient identification number, recipient eligibility, a valid diagnosis code and a valid procedure code (ICD-9-CM or CPT), age restrictions, etc. If any of the above do not clear the editing process, the system will deny the request automatically, and a letter of denial will be generated and sent to the provider and the recipient.

If the request clears the above editing process, it will pend to a "review status." The Medicaid consultants will then review the request to determined medical necessity.

If the request is denied by the consultant(s), a letter of denial will be generated with the appropriate denial message(s) and sent to the provider and the recipient.

If a request is denied, a provider may submit a reconsideration. To submit a reconsideration, providers should follow the instructions outlined below:

Instructions for Submitting a Reconsideration

1. Write the word ***Reconsideration*** across the top of the denial letter, and write the reason for the request for the reconsideration at the bottom of the letter.

2. Attach all of the original documentation, as well as any additional documentation or information which supports medical necessity, to the letter.

3. Mail the letter and all documentation to the Prior Authorization Unit at Paramax.

If a request is approved on the first submission or after a reconsideration is submitted, the medical consultant(s) will determine the authorized payment amount, and that information will be entered into the prior authorization file. In addition, a letter of approval will be generated and sent to the provider and the recipient.

Once the provider receives notification of approval, he/she may render the service.

When submitting a claim for the service, the provider must enter the nine-digit prior authorization number in the appropriate block on the claim form. Providers may also bill these claims electronically to expedite payments.

RECORD KEEPING

All documentation concerning cases for Medicaid recipients must be maintained in the provider's office for a period of three years from the initial date of service.

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.

FORM 102 BILLING INSTRUCTIONS

To bill for rehabilitation services provided to Medicaid only recipients (those recipients without Medicare coverage), providers should complete the 102 billing form. Instructions for completing this form are provided below.

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

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
REHABILITATION SERVICES

FOR OFFICE USE ONLY

1 PATIENT'S LAST NAME | 2 FIRST NAME | 3 M.I | 4 MEDICAL ASSISTANCE ID NUMBER

PATIENT S ADDRESS (STREET NUMBER, CITY, STATE & ZIP CODE)

6 DATE OF BIRTH | 7 SEX ☐ M ☐ F

8 PROVIDER NAME AND ADDRESS (CITY AND STATE)

9 PROVIDER NUMBER

10 ATTENDING PHYSICIAN NAME
PROVIDER NO

11 MEDICAL RECORD NUMBER

14 PAYMENT SOURCE OTHER THAN TITLE XIX TPL CARRIER CODE
1. _____
2. _____
3. _____

12 REFERRING PHYSICIAN NAME
PROVIDER NO

13 WAS CONDITION RELATED TO
A PATIENT'S EMPLOYMENT YES ☐ NO ☐
B ACCIDENT/INJURY YES ☐ NO ☐

15 DIAGNOSIS - NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES
A PRIMARY CODE AND DESCRIPTION
B SECONDARY CODE AND DESCRIPTION

16 EPSDT PROGRAM REFERRAL
YES ☐
NO ☐

16A PRIOR AUTHORIZATION NO

PLACE OF SERVICE CODES
1 INPATIENT HOSPITAL
2 OUTPATIENT HOSPITAL
3 OFFICE
4 PATIENT'S HOME
5 EMERGENCY ROOM
6. NOT USED
7. INTERMEDIATE CARE FACILITY
8 SKILLED NURSING FACILITY
9. OTHER

17	A DATE OF EACH SERVICE	B PLACE OF SERVICE (USE CODES ABOVE)	C PROCEDURE CODE	D FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	E QTY /TIME	F CHARGE	G THIRD PARTY PAYMENT
10							
2							
3							
4							
5							
6							
7							
8							
9							
				TOTALS		$	$

18 LABORATORY WORK PERFORMED IN PHYSICIAN'S OFFICE?
☐ NO (IF NO, ENTER NAME AND ADDRESS OF LAB)
☐ YES

19 SHOW NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PERFORMED (IF OTHER THAN HOME OR OFFICE VISITS)

REMARKS

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

20 SIGNATURE OF PHYSICIAN OR SUPPLIER (SEE REVERSE SIDE BEFORE SIGNING) | 21 APPROVAL DATE | 22 DATE SIGNED

FISCAL AGENT COPY

UNISYS - 102
1/91

SPECIFIC BILLING INSTRUCTIONS

Provider below are the instructions for completing the form 102.

*1-3. **PATIENT'S LAST NAME, FIRST NAME, MI.** Enter the patient's name exactly as it appears on the patient's Medicaid identification card. Enter the last name, the first name, and the middle initial.

*4. **MEDICAID ASSISTANCE I.D. NUMBER.** Enter the patient's 13-digit Medicaid identification number exactly as it appears on the patient's Medicaid identification card. When multiple persons are listed on the card, make sure you enter the correct number for actual family member who is being treated.

5. **PATIENT'S ADDRESS.** Enter the recipient's current address.

6. **DATE OF BIRTH.** Enter the recipient's date of birth using six digits (MM/DD/YY format). If only one digit appears in a field, precede that digit with a zero.

7. **SEX.** Check the appropriate box to indicate the sex of the patient.

8. **PROVIDER NAME AND ADDRESS (CITY AND STATE).** Enter the name and address of the rehabilitation center billing for the service(s).

*9. **PROVIDER NUMBER.** Enter the seven-digit provider identification number assigned to the rehabilitation center by Medicaid of Louisiana.

10. **ATTENDING PHYSICIAN NAME, PROVIDER NO.** Leave this space blank.

11. **MEDICAID RECORD NUMBER.** This item is not required. However, if you enter your patient's account (Medical Record) number, it will appear on the Remittance Advice. If you do enter the number, it may consist of 16 numbers and/or letters.

12. **REFERRING PHYSICIAN NAME.** Enter the name and, if available, the provider number of the physician who ordered the rehabilitation center services.

13A. **WAS CONDITION RELATED TO EMPLOYMENT?** Check the appropriate box. If the answer is yes, there might be the potential for obtaining coverage under Workman's Compensation.

B. **WAS THE CONDITION RELATED TO ACCIDENT/INJURY?** Check the appropriate box.

Definition of *accident*: where there is potential for insurance coverage or compensation as a result of a legal accident.

14. **PAYMENT SOURCE OTHER THAN TITLE XIX (TPL CARRIER CODE).** Enter the carrier code and the policy number of the other insurance.

NOTE: The carrier code should be listed on the ***Third-Party Liability Listing*** published by Paramax.

*15. **DIAGNOSIS - NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES.**

A. **PRIMARY CODE AND DESCRIPTION.** In the box provided enter the appropriate ICD-9-CM diagnosis code which best describes the reason for treatment. Enter the narrative description for the code next to the box.

B. **SECONDARY CODE AND DESCRIPTION.** If the patient is treated for more than one diagnosis, enter the appropriate ICD-9-CM diagnosis which best describes the secondary reason for treatment. Enter the narrative description for the secondary diagnosis code next to the second box. Leave the space blank if there is no secondary diagnosis.

*16A. **PRIOR AUTHORIZATION NUMBER.** Enter the prior authorization number that was assigned to you by the Paramax Prior Authorization Unit. This number is noted on the approval letter.

***17. SERVICE(S) INFORMATION.**

***A. DATE OF EACH SERVICE.** Enter the date each service was rendered using six digits (MM/DD/YY format). If a field contains only one digit, enter a leading zero.

***B. PLACE OF SERVICE.** Enter the appropriate place of service code from the list of codes on the claim form that best describes where the service was performed.

***C. PROCEDURE CODE(S).** Enter the CPT-4 or state assigned procedure code that best describes the procedure performed. The services listed on the claim form must be the same services that were listed originally on the PA-01 form.

***D. DESCRIPTION.** Fully describe (give a narrative description) the surgical or medical procedures or other services or supplies furnished (procedures listed in 17C) on each date of service listed.

☞ ***A list of procedure codes for rehabilitation services is provided in the next section of this manual entitled*** Rehabilitation Services Procedure Codes.

***E. QTY./TIME.** Enter the time or quantity or units for each procedure listed in 17C.

***F. CHARGE.** Enter your usual and customary charge for each of the procedures listed in item 17C.

G. **THIRD-PARTY PAYMENT.** If the recipient has health insurance or other coverage in addition to Medicaid, you must bill the other insurance carrier first. When the other insurance carrier has sent payment or denial to you, you may bill Medicaid. In this block, enter the amount paid by the other insurance. Once you have entered all of the amounts paid, total the column and enter the total in the last space of the column.

☞ ***Attach proof of payment or denial of payment from the other insurance to the claim form.***

*18. **LAB WORK PERFORMED IN PHYSICIAN'S OFFICE.** Check the appropriate box. If the answer is **No**, write in the name and address of the lab where the lab work was performed.

*19. **SHOW NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PERFORMED.** Enter the name and address of the facility.

*20. **SIGNATURE OF PHYSICIAN OR SUPPLIER.** Please ensure that the provider or a provider representative signs the claim form. Federal regulations mandate that providers or their representatives sign all claims submitted for payment. Stamped or computer-generated signatures will be accepted only if they are initialed.

21. **APPROVAL DATE.** Leave this space blank.

*22. **DATE SIGNED.** Enter the date the claim form was signed.

All completed claims should be submitted to the following address for processing:

Paramax
P.O. Box 91022
Baton Rouge, LA 70821

REHABILITATION SERVICES PROCEDURE CODES

Only the codes listed below should be used on rehabilitation center claims.

REHABILITATION SERVICES PROCEDURE CODES	
CODE	DESCRIPTION
	EVALUATION SERVICES
Y2602	Initial Rehab Center Speech and Language Evaluation
Y2612	Initial Rehab Center Hearing Evaluation
Y7702	Initial Rehab Center Physical Therapy Evaluation
Y7812	Initial Rehab Center Occupational Therapy Evaluation
Y7902	Wheelchair Seating Evaluation
	OCCUPATIONAL THERAPY
Y7810	Occupational Therapy - 15 minutes (describe proc.)
Y7811	Occupational Therapy - 20 minutes (describe proc.)
Y7813	Occupational Therapy - 30 minutes (describe proc.)
Y7814	Occupational Therapy - 45 minutes (describe proc.)
Y7815	Occupational Therapy - 60 minutes (describe proc.)
	SPEECH, LANGUAGE, AND HEARING THERAPY
Y2609	Speech, Language or Hearing Therapy - 15 minutes (describe procedure)
Y2611	Speech, Language or Hearing Therapy - 20 minutes (describe procedure)
Y2613	Speech, Language or Hearing Therapy - 30 minutes (describe procedure)
Y2614	Speech Language or Hearing Therapy - 45 minutes (describe procedure)
Y2615	Speech, Language or Hearing Therapy - 60 minutes (describe procedure)
Y2509	Group Treatment for Speech and Hearing Therapy - 1/2 Hour

REHABILITATION SERVICES PROCEDURE CODES
TABLE TWO

CODE	DESCRIPTION
	SPEECH, LANGUAGE AND HEARING THERAPY (CONTINUED)
Y2510	Group Speech Therapy, 20 minutes
Y2511	Group Speech Therapy, additional 15 minutes
Y2512	Group Speech Language and Hearing Therapy, 1 hour
	PHYSICAL THERAPY
Y7106	Center Visit With One or More Modality and/or Procedure - 15 minutes (list procedure and/or modality) • Hot or cold pack • Traction, mechanical • Electrical stimulation • Vasopneumatic devices • Paraffin batch • Ultrviolet • Paraffin batch • Microwave • Whirlpool • Diathermy (Hubbard Tank) • Infrared
Y7000	Physical Therapy, 1 Modality (list modality)
Y7050	Physical Therapy, 2 or More Modalities (list mod.)
Y7051	Center Visit With One or More Modalities - 60 min. (list modalities)
Y7100	Center Visit With One or More of the Following Procedures (initial 30 minutes) - list procedures: • Therapeutic exercises • Neuromuscular re-education • Functional activities • Electrical stimulation • Iontophoresis • Traction, manual • Massage • Contrast baths • Ultrasound • Gait training

REHABILITATION SERVICES PROCEDURE CODES TABLE THREE		
CODE	DESCRIPTION	
	PHYSICAL THERAPY (CONTINUED)	
Y7103	Center Visit With One or More Procedures - 75 Minutes (list procedure)	
Y7104	Center Visit With One or More Procedures - 90 Minutes (list procedure)	
Y7105	Center Visit With One or More Procedures - 20 Minutes (list procedure)	
Y7101	Center Visit With One or More Procedures - 45 Minutes (list procedure)	
Y7102	Center Visit With One or More Procedures - 60 Minutes (list procedure)	
Y7200	Procedures and Modalities, 30 Minutes	**(Revised June of 1993)**
Y7201	Procedures and Modalities, 45 Minutes	**(Revised June of 1993)**
Y7202	Procedures and Modalities, 60 Minutes	**(Revised June of 1993)**
97500	Orthotics Training Upper (splinting), 30 Minutes	**(Revised June of 1993)**
97520	Prosthetic Training, Initial 30 Minutes	**(Revised June of 1993)**
97530	Kinetic Activities, One Area, 30 Minutes	**(Revised June of 1993)**
97531	Kinetic Activities, Additional 15 Minutes	**(Revised June of 1993)**
97540	Daily Living Activities, 30 Minutes	**(Revised June of 1993)**
97541	Daily Living Activities, Additional 15 Minutes	**(Revised June of 1993)**

MEDICARE/MEDICAID CROSSOVERS

If a particular recipient is eligible for both Medicaid and Medicare services, the rehabilitation services provider rendering services to the recipient must be willing to accept Medicare assignment in order for Medicaid to make payment on the claim. Once Medicare has made its payment on the claim, the claim will automatically crossover to Medicaid, and Medicaid will pay the Medicare Part B deductible and co-insurance amounts. Medicaid will allow payment for Medicare/Medicaid claims up until the time the maximum number of recipient visits allowed have been used.

Rehabilitation providers must bill for Medicare/Medicaid crossovers on the UB-82 claim form and file the claim with Medicare first, ensuring that they have entered the recipient's Medicaid identification number on the claim form. Once Medicare has processed the Medicare portion of the claim, the claim payment information will be sent to Paramax via electronic tape for Medicaid payment. Paramax will process the claim and make payment to the provider.

Providers should receive Medicaid payment within six weeks after they receive payment from Medicare. If payment is not received from Medicaid, providers should submit the UB-82 claim form, along with the Medicare Remittance Notice, to Paramax for processing.

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

1	2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL

5 BC/BS PROV NO	6 FEDERAL TAX NO	7 MEDICARE NO	8 MEDICAID NO	9

10 PATIENT S LAST NAME	FIRST NAME	INITIAL	11 PATIENT S ADDRESS	CITY	STATE	ZIP

12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR	17 TYPE	18 SRC	19 A H	20 D H	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV D	24 N-C D	25 C-I D	26 L-R D	27

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

34	CONDITION CODES 35	36	37	38	39	BLOOD RECORD (PINTS) 40 FURN	41 REP.	42 NOT RP	43 DED	44 SP PROG	45

a b	46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT

50 DESCRIPTION	51 R CODE	52 S UNITS	53 TOTAL CHARGES	54	55	56

57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST AMOUNT DUE
A							
B							
C							
DUE FROM PATIENT ▶							

65 INSURED S NAME	66 SEX	67 P REL	68 CERT -SSN-HIC -ID NO	69 GROUP NAME	70 INSURANCE GROUP NO
A					
B					
C					

71 EID	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID	75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS	77 PRIN CODE	OTHER DIAGNOSES CODES 78	79	80	81

82 P C	83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS	84 PRINCIPAL PROCEDURE CD	DATE	85 OTHER PROCEDURE CD	DATE	86 OTHER PROCEDURE CD	DATE

PSRO UR DATA 87 CD	88 APP FROM	89 APP THROUGH	90 GRC	91 TREATMENT AUTH	92 ATTENDING PHYSICIAN ID	93 OTHER PHYSICIAN ID

94 REMARKS

VERIFIED N-C STAY DATES FROM	THROUGH	PR PSC D	FOR INTERMEDIARY USE ONLY	

AMT REIMBURSED	N PYM CD			APPROV BY	DATE APPROV

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

PROVIDER REPRESENTATIVE X _____ 95 DATE _____

UB-82 HCFA-1450

INSTITUTION COPY

INSTRUCTIONS

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

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

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

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

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

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

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

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

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

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

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

01 Military service related

02 Condition is employment related

03 Patient is covered by insurance note reflected here

04 HMO enrolled

05 Lien has been filed

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

17 Patient is 100 years old

38 Semi private room is not available

39 Private room medically necessary

40 Same day transfer

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

01 EPSDT/CHAMP

02 Physically Handicapped Children's Program

04 Family Planning

07 Induced abortion - danger to life

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

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

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

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

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

M Medicaid

Z Medicare

4 All other TPL carriers (specify)

60. DEDUCTIBLE. Leave this space blank.

61. COINSURANCE. Leave this space blank.

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

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

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

01 Patient is insured

02 Spouse

03 National child/insured has financial responsibility

04 Natural child/insured does not have financial responsibility

05 Step child

06 Foster child

07 Ward of the court

08 Employee

09 Unknown

10 Handicapped dependent

11 Organ donor

13 Grandchild

14 Niece/nephew

15 Injured plaintiff

16 Sponsored dependent

17 Minor dependent of minor dependent

18 Parent

19 Grandparent

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

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

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

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

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

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

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

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

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.

FORM 202 ADJUSTMENT/VOID INSTRUCTIONS

Provided below are the instructions for completing the 202 Adjustment/Void form. This form is used by rehabilitation providers to adjust or void claims billed on the 102 claim form. Providers may adjust/void only those claims which have been paid incorrectly.

☞ *A sample 202 form is provided after the instructions.*

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

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
REHABILITATION SERVICES

FOR OFFICE USE ONLY

ADJ ☐ VOID ☐

1 PATIENT'S LAST NAME | 3 FIRST NAME | 4 MI | 5 MEDICAL ASSISTANCE I D NUMBER

6 PATIENT S ADDRESS (STREET NUMBER, CITY STATE & ZIP CODE) | 7 DATE OF BIRTH | 8 SEX ☐ M ☐ F

9 PROVIDER NAME AND ADDRESS (CITY AND STATE) | 10 PROVIDER NUMBER | 11 ATTENDING PHYSICIAN NAME / PROVIDER NO

12 MEDICAL RECORD NUMBER | 13 PAYMENT SOURCE OTHER THAN TITLE XIX ☐ YES TPL CARRIER CODES 1 _____ 2. _____ 3. _____

14 REFERRING PHYSICIAN NAME / PROVIDER NO

15 WAS CONDITION RELATED TO
A PATIENT'S EMPLOYMENT YES ☐ NO ☐
B. ACCIDENT/INJURY YES ☐ NO ☐

16 DIAGNOSIS - NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES

A. PRIMARY CODE AND DESCRIPTION

B. SECONDARY CODE AND DESCRIPTION

17 EPSDT PROGRAM REFERRAL
YES ☐
NO ☐

17A PRIOR AUTHORIZATION NO

PLACE OF SERVICE CODES
1 INPATIENT HOSPITAL
2 OUTPATIENT HOSPITAL
3 OFFICE
4 PATIENT'S HOME
5 EMERGENCY ROOM
6 NOT USED
7 INTERMEDIATE CARE FACILITY
8 SKILLED NURSING FACILITY
9 OTHER

18 A DATE OF EACH SERVICE	B PLACE OF SERVICE (USE CODES ABOVE)	C PROCEDURE CODE	D FULLY DESCRIBED SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	E QTY /TIME	F CHARGE	G THIRD PARTY PAYMENT

ORATORY WORK PERFORMED IN PHYSICIAN'S OFFICE?

20 SHOW NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PERFORMED (IF OTHER THAN HOME OR OFFICE VISITS)

21 REMARKS:

22 CONTROL NUMBER

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

24 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

24 REASONS FOR ADJUSTMENT

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

25 REASONS FOR VOID

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

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

JATURE OF PROVIDER | 27 DATE

UNISYS - 202
1/91

FISCAL AGENT COPY

1. ADJ/VOID.

Check the appropriate box.

2-4. PATIENT'S LAST NAME, FIRST NAME, MI.

Adjust. If you do not wish to correct this information, enter the name exactly as it appeared on the original claim form.

Void. Enter the name exactly as it appeared on the original claim form.

5. MEDICAL ASSISTANCE ID. NUMBER.

Adjust. You may not change this number. If you wish to correct this information, you must void the original claim and resubmit.

Void. Enter the number exactly as it appeared on the original claim form.

6. PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE & ZIP CODE).

Adjust. If you do not wish to correct this information, enter the address exactly as it appeared on the original claim form.

Void. Enter the number exactly as it appeared on the original claim form.

7. DATE OF BIRTH.

Adjust. If you do not wish to correct this information, enter the date exactly as it appeared on the original claim form.

Void. Enter the date exactly as it appeared on the original claim form.

8. SEX.

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

Void. Enter the information exactly as it appeared on the original claim form.

9. PROVIDER NAME AND ADDRESS (CITY AND STATE).

Adjust. If you do not wish to correct this information, enter the name and address exactly as they appeared on the original claim form.

Void. Enter the information exactly as it appeared on the original claim form.

10. PROVIDER NUMBER.

Adjust. You may not change this number. If you wish to correct the number, you must void the original claim and resubmit.

Void. Enter the number exactly as it appeared on the original claim form.

11. ATTENDING PHYSICIAN NAME, PROVIDER NUMBER.

Adjust. If you do not wish to correct this information, enter the name and number exactly as they appeared on the original claim form.

Void. Enter the name and number exactly as they appeared on the original claim form.

12. MEDICAL RECORD NUMBER.

Adjust. If you are not correcting this number, enter the number exactly as it appeared on the original claim form.

Void. Enter the number exactly as it appeared on the original claim form.

13. PAYMENT SOURCE OTHER THAN TITLE XIX.

Adjust. If you are not correcting this information, enter the information exactly as it appeared on the original claim form.

Void. Enter the information exactly as it appeared on the original claim form.

14. REFERRING PHYSICIAN NAME, PROVIDER NUMBER.

Adjust. If you do not wish to correct this information, enter the information exactly as it appeared on the original claim form.

Void. Enter the information exactly as it appeared on the original claim form.

15. WAS CONDITION RELATED TO.

Adjust. If you do not wish to correct this information, enter the information exactly as it appeared on the original claim form.

Void. Enter the information exactly as it appeared on the original claim form.

16. DIAGNOSIS - NATURE OF ILLNESS REQUIRING SERVICE OR SUPPLIES.

Adjust. If you do not wish to correct this information, enter the information exactly as it appeared on the original claim form.

Void. Enter the information exactly as it appeared on the original claim form.

17. EPSDT PROGRAM REFERRAL.

Adjust. If you do not wish to correct this information, enter the information exactly as it appeared on the original claim form.

Void. Enter the information exactly as it appeared on the original claim form.

18. A THROUGH G.

Adjust. If you do not wish to correct any of this information, enter the information exactly as it appeared on the original claim form.

Void. Enter the information exactly as it appeared on the original claim form.

19. LABORATORY WORK PERFORMED IN PHYSICIAN'S OFFICE?

Adjust. If you do not wish to correct this information, enter the information exactly as it appeared on the original claim form.

Void. Enter the information exactly as it appeared on the original claim form.

20. SHOW NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PERFORMED (IF OTHER THAN HOME OR OFFICE).

Adjust. If you do not wish to correct this information, enter the information exactly as it appeared on the original claim form.

Void. Enter the information exactly as it appeared on the original claim form.

21. REMARKS.

Enter any information you consider to be pertinent to this claim.

22. INTERNAL CONTROL NUMBER FOR THE PAID CLAIM.

For an adjustment or a void, enter the internal control number that was assigned to the original claim submitted for processing. This number is listed on your Remittance Advice for the particular claim you are adjusting or voiding.

23. DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.

Enter the correct date.

24. REASON FOR ADJUSTMENT.

Check the appropriate box and provide a written explanation (when applicable).

25. REASON FOR VOID.

Check the appropriate box and provide a written explanation (when applicable).

26. SIGNATURE OF PROVIDER.

Please ensure that the provider or an authorized representative signs the form.

27. DATE SIGNED.

Enter the date the claim form is signed.

FRAUD AND ABUSE

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

GENERAL

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

FRAUD

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

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

Provider Fraud

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

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

Recipient Fraud

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

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

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

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

ABUSE

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

Provider Abuse

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

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

Recipient Abuse

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

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

FRAUD AND ABUSE DETECTION

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

Referrals

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

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

Recipient Verification Notices (REOMBs)

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

The REOMB contains the following information:

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

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

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

Computer Profiling

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

Profile reports include the following information:

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

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

ADMINISTRATIVE SANCTIONS

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

Levels of Administrative Sanctions

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

- Issuing a warning to a provider through written notice or consultation;

- Requiring that the provider receive education in policies and billing procedures;

- Requiring that the provider receive prior authorization for services;

- Placing the provider's claims on manual review status before payment is made;

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

- Suspending the provider or withholding payments from the provider;

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

- Recovering money from the provider by deducting from future payments or by requiring direct payment for money improperly or erroneously paid;
- Referring a provider to the appropriate state licensing authority for investigation;
- Referring a provider for review by the appropriate professional organizations;
- Referring a provider to the Attorney General's Medicaid Fraud Control Unit for fraud investigation;
- Suspending a provider from participating in Medicaid of Louisiana; and
- Refusing to allow a provider to participate in Medicaid of Louisiana.

Grounds for Sanctioning Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    - Was previously barred from participation in Medicaid of Louisiana;

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

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

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

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

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

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

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

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

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

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

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

APPEALS

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

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

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

ORDERING INFORMATION

ICD-9-CM CODE BOOK ORDER INFORMATION

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

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

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

RETURN/REFUND CHECKS

RETURN CHECKS

All return checks should be mailed to the following address:

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

REFUND CHECKS

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

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

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

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

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

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

CHECKS SHOULD NOT BE MADE PAYABLE TO PARAMAX.

THE PRIOR AUTHORIZATION UNIT

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

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

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

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

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

PARAMAX PROVIDER RELATIONS

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

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

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

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

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

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

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

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

RECIPIENT ELIGIBILITY VERIFICATION SYSTEM

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

However, there is a simple solution.

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

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

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

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

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

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

MANUAL UPDATES

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

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

The information in the 1997 Home Health/Rehab Provider Training packet, Medicaid Issues for 1997, was published in September, 1997.

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
June 27, 1997

Bobby P. Jindal
SECRETARY

MEMORANDUM

TO: ALL DURABLE MEDICAL EQUIPMENT PROVIDERS, OUTPATIENT REHABILITATION SERVICE PROVIDERS, AND EXTENDED HOME HEALTH SERVICE PROVIDERS

FROM: THOMAS D. COLLINS, DIRECTOR
BUREAU OF HEALTH SERVICES FINANCING

RE: CONTINUATION OF DENIED SERVICES FOR PRIOR AUTHORIZATION REQUESTS SUBMITTED FOR DME, OUTPATIENT REHABILITATION, AND EXTENDED HOME HEALTH SERVICES PENDING APPEAL DECISION

Beginning July 21, 1997, DHH will implement on a trial basis the continuation of services, in certain instances, for Medicaid recipients who have been receiving DME, outpatient rehabilitation, or extended home health services and whose requests for continued prior authorization of those services have been denied. Recipients will be able to receive continued services in those instances until an administrative appeal decision is rendered. This does not apply, however, to instances that are excepted from advance notices by federal regulations (42 C.F.R. 431.213).

For a recipient to qualify to receive continued services, pending an appeal decision for the denial of a prior authorization request, the following conditions must be met: (1) the services must be the type that are subject to continuation, (2) the service provider must file a prior authorization request for continuation of approved services at least 25 days before the end of the current approval period, and, (3) the recipient must file an appeal request within the first ten days from the date of the denial notice.

If a service provider is providing services to at least five recipients whose prior authorization requests for continued services have been denied and whose benefits are continuing, pending an appeal decision, any future appeal filed by a Medicaid recipient receiving services from that provider may be subject to a local evidentiary hearing prior to the appeal. Local evidentiary hearings will be conducted by a medical doctor with experience in prior authorization reviews for the Louisiana Medicaid Program and with authority to reconsider the prior approval at issue. The affected Medicaid recipient and the service provider will be

notified in advance that the local evidentiary hearing offers a final chance for the agency to reconsider the denial of the prior authorization request for continuation of services before those services are stopped. Each will be offered the opportunity to participate in the hearing by telephone. Further, both the affected service provider and the recipient will be notified in advance that if the local evidentiary hearing is adverse, Louisiana Medicaid will discontinue the services at issue, unless the agency's adverse decision is reversed on appeal or by an approval of a new application.

These local evidentiary hearings are intended to be conducted informally and to take place expeditiously. After a date and time have been set for a local evidentiary hearing, the parties, their representatives, or their service providers may be granted an extension of one or two days by DHH, upon request, to accommodate their schedules. The parties, however, shall not have the right to long postponements and shall not have any right to control the date and the time of the proceeding. Any papers submitted in connection with a local evidentiary hearing shall become part of the record for any later agency appeal hearing.

TDC:GEK:slw

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

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

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

May 20, 1998

To: **All Medicaid Enrolled Providers**

From: Thomas D. Collins

Re: Statutorily Mandated Revisions to all Provider Agreements

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

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

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

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

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

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

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

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

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

David W. Hood
SECRETARY

August 6, 1998

To: All Physicians, Audiologist and EPSDT Service Providers

From: Thomas D. Collins
Director

Re: Cochlear Device Implantation Policy

The Bureau of Health Services Financing is pleased to announce that effective for the dates of service on or after August 1, 1998, reimbursement is available for the cochlear implant device for Medicaid recipients with profound-to-total bilateral hearing loss.

Only recipients two years of age through twenty years of age who meet the medical and social criteria listed below shall qualify for implantation.

Only one device per lifetime per eligible recipient shall be reimbursed unless the device fails or is damaged beyond repair, in which case reimbursement for another device and reimplantation will be considered.

RECIPIENT MEDICAL AND SOCIAL CRITERIA

The following criteria apply to all candidates for Cochlear Device Implantation. The recipient must:

1. have a profound bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;

2. be a profoundly deaf child age two years or older or be a post linguistically deafened adult through the age of twenty years;

3. receive no significant benefit from hearing aids as validated by the cochlear implant team;

4. have high motivation to be part of the hearing community as validated by the cochlear implant team;

5. have appropriate expectations;

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6. have had radiologic studies that demonstrate no intracranial anomalies or malformations which would contraindicate implantation of the receiver-stimulator or the electrode array;

7. have no medical contraindications for undergoing implant surgery or post-implant rehabilitation; and

8. show that the candidate and his family are well-motivated, possess appropriate post-implant expectations and are prepared and willing to participate in and cooperate with pre and post implant assessment and rehabilitation programs as recommended by the implant team and in conjunction with Federal Drug Administration (FDA) guidelines.

Specific criteria:

A. Children Two Years Through Nine Years

In addition to documentation that candidates meet general criteria the requestor shall provide documentation:

1. that profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;

2. that appropriate tests were administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age appropriate speech perception materials; and

3. that no responses were obtained to Auditory Brainstem Response, Otacoustic Emission testing or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation.

B. Children 10 Years Through 17 Years

In additional to documentation that candidates meet general criteria, the requestor shall provide documentation:

1. that profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;

2. that appropriate tests were administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age and language appropriate speech perception materials;

3. that no responses were obtained to Auditory Brainstem Evoked Response, Otacoustic Emission Test or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;

4. the candidate has received consistent exposure to effective auditory or phonological stimulation in conjunction with oral method of education and auditory training;

5. that candidate utilizes spoken language as his primary mode of communication through one of the following: an oral/aural (re)habilitation program, or total communications educational program with significant oral/aural; and

6. that the individual has at least six months' experience with a hearing aid or vibrotactile device except in the case of meningitis (in which case the 6 month period will be reduced to 3 months).

C. Adults—8 Years through 20 Years

In addition to documentation that candidates meet general criteria, the requestor shall provide documentation:

1. that the candidates for implant is post linguistically deafened with severe to profound bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;

2. that no significant benefit from a hearing aid was obtained in the best aided condition for speech/sentence recognition material;

3. that no responses were obtained to Auditory Brainstem Response, Otacoustic Emission testing or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;

4. that the candidate has received consistent exposure to effective auditory or phonological stimulation or auditory communication;

5. that the candidate utilizes spoken language as his primary mode of communication through one of the following:

   - an oral/aural (re)habilitation program, or
   - total communications educational program with significant oral/aural training; and

6. that the candidate has had at least six months experience with hearing aids or vibrotactile device except in the case of meningitis (in which case the 6 month period will be reduced to 3 months).

D. Multi-Handicapped Children

Criteria appropriate for the child's age group are applied.

NON-COVERED EXPENSES

The following expenses related to the maintenance of the cochlear device are the responsibility of either the recipient or his family or care giver(s):

1. All costs for service contracts and/or extended warranties;
2. All costs for insurance to protect against loss and theft.

PRIOR AUTHORIZATION

All aspects of this procedure (preoperative speech and language evaluation, implantation, device, repairs, supplies, therapy) must be prior authorized. The request to perform surgery must come from the multidisciplinary team which assessed the recipient's disability and determined him/her to be a possible candidate for implantation.

The multidisciplinary team shall consist of:

- a surgeon/otologist;
- an audiologist;
- a speech/language pathologist;
- a psychiatrist; and,
- an educator of the deaf with experience in oral/auditory instruction.

A Form PA-01 must be completed for the device and submitted to the Prior Authorization Unit as part of the multidisciplinary team's packet. A PA-01 form requesting approval to perform the surgery must be submitted to Prior Authorization by the surgeon as part of the multidisciplinary team's packet. The team's written decision regarding the recipient's candidacy for the implant and the results of all pre-operative testing (audiogram, tympanogram, speech and language evaluation, social evaluation, etc.) shall be included in the packet sent to Unisys. Post-operative speech and language evaluation services must be prior authorized, as well. The audiologist shall submit a PA-01 form requesting approval to Prior Authorization as part of the multidisciplinary team's packet.

The single packet requesting a Cochlear implant shall be submitted for review to Unisys labeled **Unisys Prior Authorization Unit—Request for Cochlear Implant** to:

Unisys
Prior Authorization Unit
Post Office Box 14919
Baton Rouge, LA 70898-4919

Requests for reimbursement for speech processor and/or microphone repairs, headset cords, headset replacements and batteries must be prior authorized and may be made on Form PA01 to the Prior Authorization Unit at the address given previously.

HOSPITAL BILLING FOR PROCEDURE

The hospital shall be reimbursed for the cochlear device and the hospital stay for the surgery. The hospital shall bill for the device on a HCFA 1500 claim form using HCPCS code L8614 (Cochlear Device System). The letters DME must be written in red on the top of the form, and the PA number must be written in Item 23. The device will be reimbursed at a fee of $11,496.

Note: Reimbursement for the device will not be authorized until the surgical procedure has been approved.

PHYSICIAN BILLING PROCEDURE

The surgeon shall bill for the implantation on a HCFA 1500 claim form using CPT-4 procedure code 69930 (Cochlear device implantation, with or without mastoidectomy). The assistant surgeon shall bill using the same CPT procedure code with a modifier 80. **This procedure shall not be billed as either a team surgery or co-surgery (modifiers 62 and 66 respectively).**

The surgeon's fee for CPT code 69930 will be $1319.24, and the assistant surgeon's fee will be $263.85. The anesthesiologist's fee will be eight base units of anesthesia plus the actual number of time units (1 = 15 minutes) multiplied by the co-efficient of $13.50. The surgeon's claim form must have the PA number written in Item 23. The assistant surgeon and anesthesiologist's claims may be submitted without a prior authorization number. These claim forms will pend to the Medical Review Unit for review and will be paid only if the surgeon's request for implantation has been approved.

AUDIOLOGIST BILLING PROCEDURES

The audiologist shall bill CPT procedure code 92506 (Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status) on a HCFA 1500 claim form to receive reimbursement for the pre-operative speech and language evaluation.

This service will be reimbursed for prospective cochlear implant candidates even if the candidate does not subsequently receive an implant.

Procedure code 92506 is reimbursed at a fee of $300. It is limited to only once per candidate per

lifetime and is restricted to the specialty of Audiology. The PA number must be printed on the claim form in Item 23 in order for payment to be obtained.

Post-Operative Rehabilitative Services

Only the audiologist will be reimbursed for the aural rehabilitation of the cochlear implant recipient after implantation of the device. Procedure code 92510, payable at $94.90, shall be billed on the HCFA 1500 for this service. This code does not require prior authorization.

Post-Operative Speech, Language and Hearing Therapy Services

Subsequent speech, language and hearing therapy services for cochlear implant recipients must be prior authorized like all other rehabilitation services. The request for prior authorization should be submitted to the Prior Authorization Unit on Forms PA-01 and PA-02 at the address previously given.

Billing for Speech Processor Repairs, Batteries, Headset Cords, etc.

The locally-assigned codes to use to request approval and reimbursement for these items and their fees are as follows:

L8700 Speech Processor Repair - $255
L8701 Headset Replacement - $360
L8702 Microphone Repair - $240
L8703 Speech Processor Battery - $6
L8704 Headset Cord - $12

Statistics show that, on the average, processors need repairing every 2.5 years and that headset cords need to be replaced from 2-4 times per year. Batteries require replacement every 10-12 months.

Requests for reimbursement for the items above should be made conservatively. The Prior Authorization Unit reserves the right to refuse reimbursement for these maintenance costs when/if it feels requests are being made too frequently due to patient negligence.

The procedure for obtaining reimbursement for the items above is the same as that for obtaining reimbursement for the device, i.e.,the provider shall submit the applicable HCPCS code on a HCFA 1500 claim form with the letters DME written in red on the top of the form. The PA number must be written in Item 23.

REPLACEMENT OF THE EXTERNAL SPEECH PROCESSOR

The Louisiana Medicaid Program will consider replacing the external speech processor only if one of the following occurs:

1. The recipient loses his processor
2. The processor is stolen OR
3. The processor is irreparably damaged

An upgrade to the speech processor because of cosmetic or technological advances in the hardware shall not qualify as a reason for replacement.

Prior authorization for replacement of the external speech processor (HCPCS code L8619) must be obtained when/if replacement becomes necessary.

The multidisciplinary team shall initiate a new request for approval and shall submit the following information with its request for replacement:

1. A copy of Prior Authorization's initial approval letter for the implant
2. Documentation explaining the reason a new processor is needed

Billing for Replacement of the External Speech Processor

Hospitals or professional services billers shall bill for this component by submitting HCPCS code L8619 on a HCFA 1500 claim form with the letters DME written in red on the top. The PA number must be written in Item 23.

Replacement of the external speech processor shall be reimbursed at a fee of $4,936.

BILLING FOR RE-PERFORMANCE OF THE IMPLANTATION SURGERY

Re-performance of the implantation surgery (CPT code 69930) because of infection, extrusion or other reasons must be prior authorized.

Documentation explaining the reason the initial implant surgery has to be repeated and the request for re-performance should be submitted simultaneously to the Prior Authorization Unit for review.

The PA number approving the re-performance must be on the claim form for reimbursement to be received.

If you have any questions, please contact Kandis McDaniel at (504) 342-9490. Your cooperation is greatly appreciated.

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

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

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

"Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

SEPTEMBER 22, 2000

M E M O R A N D U M

TO: HOME HEALTH PROVIDERS

FROM: BEN A. BEARDEN
DIRECTOR

RE: REIMBURSEMENT FOR SPEECH THERAPY AND OCCUPATIONAL THERAPY, IN ADDITION TO PHYSICAL THERAPY THROUGH THE HOME HEALTH PROGRAM

Louisiana Medicaid currently provides reimbursement through the Home Health Program for physical therapy. Effective with date of service September 21 , 2000, Louisiana Medicaid will provide coverage for speech therapy and occupational therapy, as well as physical therapy, through the Home Health Program.

Also, effective September 21, 2000, these home health rehabilitation services will require prior authorization. Rehabilitation services are excluded from the service limit of 50 home health visits per calendar year for Medicaid recipients 21 years of age and older.

Procedure codes and reimbursement rates for these home health rehabilitation services are the same as those for outpatient hospital rehabilitation services.

PRIOR AUTHORIZATION OF REHABILITATION SERVICES:

To request prior authorization for home health rehabilitation services, providers must complete the PA-01 and PA-02 prior authorization request forms. All initial requests for approval must have attached a copy of the physician's referral and the results of the evaluation of the patient, that document the need for therapy. All extension requests for approval must have attached a copy of the physician's referral and progress notes that document the need for the continuation of therapy. The procedure codes used to request prior authorization of these services are the same "Y" codes used for the outpatient hospital rehabilitation services.

Completed requests should be mailed to the following address:

Unisys
P. O. Box 14919
Baton Rouge, LA 70821-4919
Attention: Prior Authorization

Once the review process has been completed and the request has been approved or denied, the home health agency and the recipient will receive written notification informing them of the determination. Upon receipt of the approval, the provider may render the service.

BILLING INSTRUCTIONS FOR REHABILITATION SERVICES:

Providers may bill hard copy claims using the Unisys 101 Home Health claim form. The service codes used in billing as well as the corresponding procedure codes and their fees are listed on the attached page. The nine-digit prior authorization number that is assigned by Unisys should be entered in Item 15 under the section labeled "Supplies". Reimbursement will be made at a flat fee for service.

Please note that the service codes are now Alpha/Numeric. When entering the alpha codes, it is necessary to use capital letters.

Please remember to contact your software vendor to make any necessary updates for billing electronically.

The following procedure codes are being placed in non-pay status effective with this policy.

X9926 - Home Health Physical Therapy
X9936 - Home Health Physical Therapy - PT Assistant
X9905 - Home Health Physical Therapy Visit after Initial Visit
X9915 - Home Health Physical Therapy Visit after Initial Visit - PT Assistant

NOTE: Billing procedures and reimbursement rates for home health services other than rehabilitation services have not changed.

If additional assistance is required, you may call Unisys Provider Relations at 1-800-473-2783 or (225) 924-5040.

Attachment

COVERED HOME HEALTH REHABILITATION SERVICES

DESCRIPTION OF PROCEDURE	SERVICE CODE	PROCEDURE CODE	FEE
Physical therapy, evaluation	P	Y7702	$59.40
Occupational therapy evaluation	E	Y7812	$56.10
Speech evaluation	J	Y2602	$49.50
Hearing evaluation	L	Y2612	$49.50
Wheelchair seating evaluation	N	Y7902	$56.10
Physical therapy, one modality	O	Y7000	$22.00
Physical therapy, 2 or more modalities	Q	Y7050	$33.00
P.T. - 1 or more procedure, and/or mod., 15 min.	R	Y7106	$11.00
P.T. - with procedures, 20 minutes	S	Y7105	$14.85
P.T. - with procedures, 30 minutes	T	Y7100	$22.00
P.T. - with procedures, 45 minutes	U	Y7101	$33.00
P.T. - with procedures, 60 minutes	V	Y7102	$44.00
P.T. - with procedures and mod., 60 minutes	W	Y7202	$44.00
P.T. - with procedures, 75 minutes	X	Y7103	$55.00
P.T. - with procedures, 90 minutes	Y	Y7104	$66.00
Occupational therapy, 15 minutes	Z	Y7810	$ 8.80
Occupational therapy, 20 minutes	1	Y7811	$12.10
Occupational therapy, 30 minutes	2	Y7813	$17.60
Occupational therapy, 45 minutes	3	Y7814	$26.40
Occupational therapy, 60 minutes	4	Y7815	$35.20
Speech and hearing therapy, 15 minutes	5	Y2609	$ 8.25
Speech and hearing therapy, 20 minutes	6	Y2611	$11.00
Speech and hearing therapy, 30 minutes	7	Y2613	$16.50
Speech and hearing therapy, 45 minutes	8	Y2614	$24.75
Speech and hearing therapy, 60 minutes	9	Y2615	$33.00

All services must be approved in advance by the Prior Authorization Unit except initial evaluations and wheelchair seating evaluations, which are restricted to one evaluation per recipient every 180 days. For wheelchair seating evaluations, providers must have M.D. prescriptions.

Note: Cardiac and Pulmonary/Respiratory therapy are not covered under Louisiana Medicaid. These services should not be prior authorized or billed using covered rehabilitation codes.

Billing procedures and reimbursement rates for home health services other than rehabilitation services have not changed. Listed below are these service codes and corresponding procedure codes.

A=X9900	Initial Skilled Nursing Visit
B=X9902	Skilled Nurse Visit (Hourly Rate)
C=X9903	Nurse Visit(s) After Initial Visit (Limit 3 Per Day)
D=X9904	Aide Visits After Initial Visit (Limit 1 Per Day)
F=X9901	Initial Aide Visit
G=X9910	Initial Skilled Nursing Visit)LPN)
H=X9907	Skilled Nurse (Hourly Rate) for Multiple Recipients
I=X9913	Skilled Nursing Visit After Initial Visit
K=X9916	Skilled Nursing Visit for Multiple Recipients (LPN)
M=X9906	Skilled Nurse Visit for Multiple Recipients (RN)