VISION (EYE WEAR) SERVICES TRAINING

Medicaid Issues for 2004
(Fall Issue)

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

UNISYS

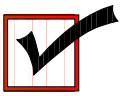
ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the 2004 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis in the workshops is on policy and procedures, which affect Medicaid billing.

This packet does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability. Such information is presented only in the Basic Medicaid Information Training session. The Basic Medicaid Information Training packet may be obtained by attending the Basic Medicaid Information workshop or by requesting a copy from Unisys Provider Relations or by download from the LAMEDICAID website.

Providers should use this packet in conjunction with the Physician Services Medicaid Provider Manual.



FOR YOUR INFORMATION! SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

I. MR/DD WAIVER WAITING LIST

The MR/DD Waiver Program provides services in the home, instead of institutional care, to persons who are mentally retarded or have other developmental disabilities. Each person admitted to the Waiver Program occupies a "slot." Slots are filled on a first-come, first-served basis. Services provided under the MR/DD Waiver are different from those provided to Medicaid recipients who do not have a Waiver slot. Some of the services that are only available through the Waiver are: *Respite Services; Substitute Family Care Services; Supervised Independent Living and Habilitation/Supported Employment*. There is currently a Waiting List for waiver slots.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

II. BENEFITS FOR CHILDREN AND YOUTH ON THE MR/DD WAIVER WAITING LIST

CASE MANAGEMENT

If you are a Medicaid recipient under the age of 21 and have been on the MR/DD Waiver Waiting list at any time since October 20, 1997, you may be eligible to receive case management *NOW*.

YOU NO LONGER NEED TO WAIT FOR THIS SERVICE. A case manager works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services), then assists you in obtaining them.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

Notice P-17
Revised November 1, 2000
*****DISCLAIMER: This information is currently being updated and some content may be incorrect or incomplete. If you are unable to get assistance using the telephone numbers listed under the specific programs, you may contact Medicaid Program Operations at 225-342-5774.**

III. BENEFITS AVAILABLE TO ALL CHILDREN AND YOUTH UNDER THE AGE OF 21

THE FOLLOWING SERVICES ARE AVAILABLE NOW. YOU DO NOT NEED TO WAIT FOR A WAIVER SLOT TO OBTAIN THEM.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history, physical exam, immunizations, vision and hearing checks, and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed.

TO OBTAIN AN EPSDT SCREEN OR DENTAL SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

EPSDT screens may help to find problems which need other health treatment or additional services. **Children under 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.** Some of these additional services are very similar to services provided under the MR/DD Waiver Program. There is no waiting list for these Medicaid services.

PERSONAL CARE SERVICES

Personal care services are provided by attendants to persons who are unable to care for themselves. These services assist in bathing, dressing, feeding, and other non-medical activities of daily living. PCS services *do not* include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. Once ordered by a physician, the PCS service provider must request approval for the service from Medicaid.
FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A PCS SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

EXTENDED HOME HEALTH SERVICES

Children and youth may be eligible to receive *Skilled Nursing Services* and *Aide Visits* in the home. These can exceed the normal hours of service and types of service available for adults. These services are provided by a Home Health Agency and must be provided in the home. This service must also be ordered by a physician. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.
FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A HOME HEALTH SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY , AND AUDIOLOGY SERVICES

If a child or youth wants *Rehabilitation Services* such as *Physical, Occupational, or Speech Therapy, or Audiology Services* outside of or in addition to those being provided in the school, these services can be provided by Medicaid at hospitals on an outpatient basis, or, in the home from Rehabilitation Centers or under the *Home Health* program. These services must also be ordered by a physician. Once ordered by a physician, the service provider must request approval for the service from Medicaid.

FOR ASSISTANCE IN APPLYING FOR THESES SERVICES AND LOCATING A SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

SERVICES IN SCHOOLS OR EARLY INTERVENTION CENTERS

Children and youth can also obtain *Physical, Occupational, and Speech Therapy, Audiology Services, and Psychological Evaluations and Treatment* through early intervention centers (for ages 0-2) or through their schools (For ages 3-21). Medicaid covers these services if the services are a part of the IFSP or IEP. These services may also be provided in the home.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR EARLY INTERVENTION CENTER OR SCHOOL OR CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions. *Medical Equipment and Supplies* must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

FOR ASSISTANCE IN APPLYING FOR MEDICAL EQUIPMENT AND SUPPLIES AND LOCATING MEDICAL EQUIPMENT PROVIDERS CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

MENTAL HEALTH REHABILITATION SERVICES

Children or youth with mental illness may receive *Mental Health Rehabilitation Services*. These services include: clinical and medical management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. *MENTAL HEALTH REHABILITATION SERVICES MUST BE APPROVED BY THE LOCAL OFFICE OF MENTAL HEALTH*.

FOR ASSISTANCE IN APPLYING FOR MENTAL HEALTH REHABILITATION SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

TRANSPORTATION

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment.

TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

Notice P-17
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OTHER MEDICAID COVERED SERVICES

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

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NOTICE TO ALL PROVIDERS

Pursuant to Chisholm v. Cerise DHH is required to inform both recipients and providers of certain services covered by Medicaid. The following two pages contain notices that are sent by DHH to some Medicaid recipients notifying them of the availability of services for EPSDT recipients (recipients under age 21). These notices are being included in this training packet so that providers will be informed and can help outreach and educate the Medicaid population. Please keep this information readily available so that you may provide it to recipients when necessary.

DHH reminds providers of the following services available for all recipients under age 21:

- Children under age 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. **This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.**

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

- Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment. **TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).**

Recipients may also CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544) for referral assistance with all services, not just transportation.

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Services Available to Medicaid Eligible Children Under 21

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

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

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

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD waiver, you may be eligible for case management services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office.

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

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

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

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

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ELECTRONIC DATA INTERCHANGE TRANSITION

It is very important for providers billing electronically to take the necessary steps to ensure that their claims are submitted using the HIPAA mandated 837 specifications. The following information will assist your Software Vendor, Billing Agent or Clearinghouse (VBC) to submit HIPAA approved 837 transactions to Louisiana Medicaid.

The following table contains the current DHH implementation schedule for transition to HIPAA compliant electronic submissions by the applicable Medicaid Programs. Affected providers will be required to bill Louisiana Medicaid using the compliant 837 format by the implementation date stated below. **Additionally, in the near future claims submitted using the proprietary specifications will be held for 21 days. Please watch for further information that will be forthcoming about this change.**

PROGRAM	IMPLEMENTATION DATE
Ambulance Transportation	January 1, 2005
DME	January 1, 2005
Dental	January 1, 2005
Hemodialysis	November 1, 2004
Hospice	November 1, 2004
Hospital Inpatient/Outpatient	November 1, 2004
KIDMED	TBD
Personal Care Services (PCS)	TBD
Professional: Ambulatory Surgical Centers EPSDT Health Services Independent Lab & X-ray Mental Health Clinics Mental Health Rehabilitation Centers Physician Services (including physicians, optometrists, podiatrists, audiologists, psychologists, chiropractors, APRNs) Rehabilitation Centers Vision	To Be Phased In Beginning April 1, 2005 (Further information concerning dates of phases and programs will be forthcoming.)
Rural Health Clinics/Federally Qualified Health Centers	TBD
Waiver (all)	TBD

NOTE 1: Long Term Care/LTC (Nursing Facilities, ICF-MR Facilities, Hospice Room and Board, Adult Day Health Care Facilities) MUST ultimately transition to either 837 electronic billing or UB-92 paper billing. The final implementation date for this transition is to be determined.

NOTE 2: Non-Emergency Medical Transportation and Case Management Providers are excluded from HIPAA and will continue to submit electronic claims with the Louisiana Medicaid Proprietary Transactions.

If you are not currently submitting the HIPAA compliant 837 transaction, Louisiana Medicaid strongly recommends that you contact your VBC to determine if they can meet your needs as a Louisiana Medicaid provider. If your VBC has not started testing, you may go to www.lamedicaid.com/hipaa to view the VBC list and select a VBC that is approved for your program. This list is updated monthly by the EDI group. **YOU MUST BE TRANSITIONED TO THE 837 HIPAA COMPLIANT FORMAT BY THE APPLICABLE DATES IN ORDER TO CONTINUE TO SUBMIT CLAIMS ELECTRONICALLY.**

The list includes contact information, the types of X12N HIPAA 837 transactions supported, and a status of "Enrolled", "Testing", "Parallel", or "Approved". The final "Approved" status means a provider can submit HIPAA EDI 837 transactions THROUGH the approved VBC to Louisiana Medicaid.

Louisiana Medicaid encourages all providers to use the VBC list to shop for a VBC that best suits their needs and budget. The features, functions, and costs vary significantly between VBCs. *Find the one that is right for you.*

Providers can also monitor the list to see how their VBC is progressing toward production approval.

HIPAA Desk Testing Service Enrollment

The first step towards HIPAA readiness is to have the VBC complete the HIPAA Testing Enrollment Form located at www.lamedicaid.com/hipaa. All VBCs MUST complete the required testing before any electronic claims may be submitted for providers. Therefore, the VBC must contact the LA Medicaid HIPAA EDI Group to enroll. (Providers who develop their own electronic means of submitting claims to LA Medicaid are considered the VBC).

VBCs can also get an enrollment form by e-mailing the HIPAA EDI group at *hipaaedi@unisys.com or by calling (225) 237-3318. The VBC must complete the form and return it by e-mail to Louisiana Medicaid. A HIPAA EDI representative will issue the VBC login information for our testing service.

Throughout the implementation of HIPAA requirements, Louisiana Medicaid has offered intense support. One of the support systems offered to the VBCs is HIPAADesk.com, which is a completely automated testing site for validation of X12 syntax. While the HIPAADesk.com is available for any VBC's use to validate X12 transactions, Louisiana Medicaid has furnished additional resources within this site. **The enhanced Louisiana-specific service will be offered through January 31, 2005 only.** After that, it will be the responsibility of the VBC to validate X12 syntax before testing with Louisiana Medicaid. Validation of X12 syntax does not validate 837 transactions for submission to Louisiana Medicaid. Additional testing is required.

With the exception of Long Term Care providers, individual providers using software that has been approved for a VBC do not need to test individually. Once a VBC is approved for production, this approval is also applied to those providers using the approved software.

In the Louisiana-specific section of HIPAADesk.com all Companion Guides for the 837I, 837P, 837D, and 278 transactions are available for download. **Our testing service through HIPAADesk.com is available 24 hours a day, 7 days a week and will maintain those hours through the end of January 2005.**

HIPAA-Compliant 837 Transaction Testing Service

Testing of 837 transactions involves two levels: validation of 837 transaction syntax and parallel testing of claims submitted in proprietary and HIPAA-compliant formats. Once the VBC has contacted Louisiana Medicaid and the enrollment process is complete, login information will be furnished to the identified testers on the enrollment form.

The testing service is a secure web based application that requires an internet connection and a web browser. The testing service contains all necessary information for a VBC to test for compliance with Louisiana Medicaid. Companion Guides for the 837I, 837P, 837D, and 278 transactions and other necessary and useful documentation are available for download from within the HIPAADesk.com testing service.

Each 837 testing program includes several tasks that must be performed successfully to complete EDI Desk.com testing. Upon completion of EDI testing, the VBC will begin MMIS Parallel Testing. The testing service is comprehensive and evaluates SNIP 1-7 types of testing.

MMIS Parallel Testing

Please refer to the section on Connectivity with the Payer/Communications in the Louisiana Medicaid General Companion Guide for instructions on how to gain access to our test Bulletin Board System (BBS). This guide is also available for download from within HIPAADesk.com.

Parallel testing will compare a current proprietary electronic claim file with a parallel HIPAA EDI file both utilizing the same source data. Generally, the current proprietary and HIPAA EDI file should adjudicate the same.

NOTE: For those submitters who did not previously send proprietary electronic Medicaid claims, such as TAD billers, the parallel testing process will be slightly different. Instead of sending a copy of an EDI file to the BBS, you will e-mail 25 Internal Control Numbers (ICNs) from paper-billed claims from your last remittance advice to your HIPAA EDI QA parallel testing support person. If there weren't 25 ICNs on your last remittance advice, e-mail all the ICNs on your most recent weeks remittance advice and that is acceptable. If a tester does not have an assigned support person, contact the HIPAA EDI Test Team at *hipaaedi@unisys.com or call (225) 237-3318.

These claims will be compared to the HIPAA file sent to the test BBS, which was generated from the same data.

PROCEDURE CODE CHANGES

Claims Submission

For dates of service prior to March 1, 2004, claims for payment of eye wear must contain the local procedure codes that began with an ”X”. Any claim submissions for dates of service March 1, 2004 and after must contain the new standard codes. Refer to the **LOUISIANA MEDICAID EYE WEAR CODE CONVERSION CHART & FEE SCHEDULE** which is located in Appendix B of this document for the specific LA Medicaid approved eye wear codes.

All claims for payment for dates of service on or after March 1, 2004 should be submitted with the procedure code(s) that are identified in Appendix B of this document for lens and frames and the appropriate number of units (quantity) for each item.

Reimbursement Fee

Effective for dates of service March 1, 2004 and after, a flat fee has been established for each code listed in the **LOUISIANA MEDICAID EYE WEAR CODE CONVERSION CHART & FEE SCHEDULE** with the exception of the “non-specific” codes as listed below:

V2199 V2299 V2399 V2499 V2599 V2799

These non-specific codes require prior authorization and the reimbursement fee will be determined at the time of prior authorization based on invoice cost. A copy of the invoice must be submitted with the prior authorization request in order to determine the amount of reimbursement. Use of these codes should be limited to the instance when there is no established code available to describe the service being rendered.

The fees listed in the **LOUISIANA MEDICAID EYE WEAR CODE CONVERSION CHART & FEE SCHEDULE** are effective for March 1, 2004 and after dates of service.

Modifier Required

The following modifiers should be used for prior authorization and claims for payment *ONLY* in conjunction with procedure code V2102 when the lens is over 12.00D sphere:

1) RT-indicates right eye; and 2) LT-indicates left eye.

These modifiers should not be used when billing procedure code V2102 when the lens is plus or minus 7.12 to plus or minus 12.00D sphere or with any other procedure code.

PRIOR AUTHORIZATION

Prior authorization for eye wear will be considered only when the item is considered medically necessary.

Providers should submit a **PA-01 Form, a copy of the prescription, and a letter which documents medical necessity** for all prior authorization requests. The letter of medical necessity must be obtained from the prescribing provider and must be specific to each individual recipient.

The PA-01 Form sample and instructions are located on pages 7-11 of this document. The PA-01 Form must include information regarding all eye wear items that will be delivered on the same date of service to the recipient, **including those items that do not require prior authorization.**

The items which require prior authorization must be listed on the first line(s) of the PA-01 Form under the "Description of Services" section and must include the following: Procedure Code (Field # 11), Modifier- when applicable (Field # 11A), Description (Field # 11B), Requested Units (Field # 11C), and Requested Amount (Field # 11D).

The items that do not require prior authorization must be listed below those that require prior authorization on the PA-01 Form. Only the Description (Field # 11B) should be completed on the PA-01 Form for items that do not require prior authorization. **Do not enter a procedure code for items that do not require prior authorization.**

In addition to the above requirements, a copy of the invoice as well as a detailed description of the item(s) must be submitted with a prior authorization request for codes V2199, V2299, V2399, V2499, V2599 and V2799.

Prior authorization requests related to eye wear will be granted for a three-month authorization period. The provider should indicate the appropriate three-month span in the "Dates of Service" sections of the Form PA-01. The "Begin Date of Service" (Field # 7) must be the date of initial contact with the recipient. The "End Date of Service" must be three months from the begin date of service specified in Field # 7.

Upon prior authorization approval, the provider should deliver the services as soon as possible within the authorized period. In order for a claim to be paid by Medicaid for services that require prior authorization, the request must have been approved and the dates of service must fall between the dates listed on the prior authorization. **The actual date that the service was delivered should be used as the date of service when filing a claim for payment.** Providers who are enrolled as a group must indicate the individual provider's Medicaid provider number on the Form PA-01 (Field 6) when requesting prior authorization. This provider number must match the attending provider number in item 24K of the CMS-1500 when services are billed.

A prior authorization request that contains all of the required documentation should not take longer than 25 days to process. Should the provider fail to receive a prior authorization decision within a timely manner, the provider should contact the Prior Authorization Unit by calling (800) 488-6334 or (225) 928-5263.

After prior authorization approval is received and the eye wear is delivered to the patient, the provider should bill for all of the services rendered. All eye wear services, regardless of whether prior authorization is required, may be billed on the same claim form.

If the service requires prior authorization, the provider should not fill the prescription or dispense the eye wear until an approval letter is obtained from Medicaid.

Prior authorization for code V2102 is required ONLY for lenses over 12.00D sphere. The following modifiers must be used for prior authorization and claims for payment *ONLY* in /conjunction with procedure code V2102 when the lens is over 12.00D sphere: 1) RT-indicates right eye; and 2) LT-indicates left eye.

A blank and completed sample PA-01 form can be found on the following pages, along with instructions on how to complete the form.

Providers can obtain blank PA-01 forms by accessing the www.lamedicaid.com web-site, by photocopying the blank form in this document, or by requesting the forms from the Prior Authorization Unit.

Completed requests with all required documentation should be mailed to the following address:

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

Once the review process has been completed, providers are notified via letter whether or not the service has been approved or denied. If the procedure is not approved, a denial reason is indicated in this letter. The letter also indicates the 9-digit prior authorization number assigned to the request. When billing for an approved service, this 9-digit number must be entered in item 23 of the CMS 1500 form.

Post authorization may be obtained for a procedure that normally requires prior authorization if a recipient becomes retroactively eligible for Medicaid. However, such requests must be submitted within six months from the date of Medicaid certification of retroactive eligibility.

A system for requesting prior authorization electronically is being developed. However, this system is not yet in place and providers will be notified when this is complete.

Instructions For Completing Prior Authorization Form (PA-01)

NOTE: Only the fields listed below are to be completed by the provider of service. All other fields are to be used by the Prior Authorization department at Unisys.

FIELD NO. 1 Check the appropriate block to indicate the type of prior authorization requested**.**

FIELD NO. 2 Enter recipient's 13-digit Medicaid ID number or the 16-digit CCN number.

FIELD NO. 3 Enter the recipient's Social Security number.

FIELD NO. 4 Enter the recipient's last name, first name and middle initial as it appears on their Medicaid card**.**

FIELD NO. 5 Enter the recipient's date of birth in MM/DD/YYY format (MM=month, DD=day, YYYY=year).

FIELD NO. 6 Enter the provider's 7-digit Medicaid number. If associated with a group, enter the attending provider number only.

FIELD NO. 7 Enter the beginning and ending dates of service in MM/DD/YYY format (MM=month, DD=day, YYYY=year).

FIELD NO. 8 Enter the numeric ICD9-diagnosis code (primary & secondary) and the corresponding description.

FIELD NO. 9 Enter the day the prescription, doctor's orders was written in MM/DD/YYY format (MM=month, DD=day, YYYY=year).

FIELD NO. 10 Enter the name of the recipient's attending physician prescribing the services.

FIELD NO. 11 Enter the HCPCS/procedure code.

FIELD NO. 11A Enter the corresponding modifiers (when appropriate).

FIELD NO. 11B Enter the HCPCS/procedure code's corresponding description for each procedure requested.

FIELD NO. 11C Enter the number of units requested for each individual HCPCS/procedure.

FIELD NO. 11D Enter the requested charges for each individual HCPCS/procedure when it is appropriate for the requested HCPCS/procedure.

FIELD NO. 12 Enter the location for all services rendered.

FIELD NO. 13 Enter the name, mailing address and telephone number for the provider of service.

FIELD NO. 14 Enter the name, mailing address and telephone number of the recipient's case manager, if available.

FIELD NO. 15 Provider/authorized signature is required. Your request will not be accepted if not signed. If using a stamped signature, it must be initialed by authorized personnel.

FIELD NO. 16 Date is required. Your request will not be accepted if field is not dated.

If you have any questions concerning the prior authorization process, please contact the Prior Authorization department at Unisys:

Toll-free number	**800-488-6334**
Local	**225-928-5263**
Fax	**225-929-6803**

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

FAX TO: (225) 929-6803

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

CONTINUATION OF SERVICES ____YES ____ NO

P.A. NUMBER

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

x

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2): 1 2 3 4 5 6 7 8 9 1 2 3 4

Social Security No. (3): 444 11 4444

RECIPIENT LAST NAME: Henderson | FIRST: Ruth | MI (4):

DATE OF BIRTH (5): 01 18 1997

MEDICAID PROVIDER NUMBER (7- DIGIT) (6): 1 1 1 1 1 1 1

BEGIN DATE OF SERVICE (MMDDYYYY) (7): 09 01 2004

END DATE OF SERVICE (MMDDYYYY): 12 01 2004

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION: 367.1 Myopia
SECONDARY CODE & DESCRIPTION:

PRESCRIPTION DATE (9) (MMDDYYYY): 09 01 2004

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10) Dr. I. Lasik

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S
V2025					Deluxe Frame	1	75.00				

(12) PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY X OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: #1 Optical Shoppe
ADDRESS: 45 Oak St.
CITY: Sunny STATE: LA ZIPCODE 70000
TELEPHONE: (504) 555 1212 FAX NUMBER: (504) 555 1234

(14) CASE MANAGER INFORMATION:
NAME:
ADDRESS:
CITY: STATE: ZIPCODE
TELEPHONE (____) ____ FAX NUMBER: (____) ____

(15) PROVIDER SIGNATURE: *Claire Bell*

(16) DATE OF REQUEST: 9/01/2004

PA-01 FORM

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

FAX TO: (225) 929-6803

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

P.A. NUMBER

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
x 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2): 1 2 3 4 5 6 7 8 9 1 2 3 4

Social Security No. (3): 444 11 4444

RECIPIENT LAST NAME: Henderson | FIRST: Ruth | MI (4):

DATE OF BIRTH (5): 01 18 1997

MEDICAID PROVIDER NUMBER (7- DIGIT) (6): 1 1 1 1 1 1 1

BEGIN DATE OF SERVICE (7) (MMDDYYYY): 09 01 2004

END DATE OF SERVICE (MMDDYYYY): 12 01 2004

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION: 367.1 Myopia
SECONDARY CODE & DESCRIPTION:

PRESCRIPTION DATE (9) (MMDDYYYY): 09 01 2004

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)
Dr. I. Lasik

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S
V2102	**RT**	**LT**			Lenses **+18.00d** Frames	2	72.00				

(12) PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY **X** OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: #1 Optical Shoppe
ADDRESS: 45 Oak St.
CITY: Sunny STATE: LA ZIPCODE 70000
TELEPHONE: (504) 555 1212 FAX NUMBER: (504) 555 1234

(14) CASE MANAGER INFORMATION:
NAME:
ADDRESS:
CITY: STATE: ZIPCODE
TELEPHONE (____) ____ FAX NUMBER: (____) ____

(15) PROVIDER SIGNATURE: *Claire Bell*

(16) DATE OF REQUEST: *9/01/2004*

PA-01 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
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES _____YES _____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S

(12)
PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY ___ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE: (___) _____ _____ FAX NUMBER: (___) ___ _____

(14) CASE MANAGER INFORMATION:
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE (___) _____ _____ FAX NUMBER: (___) _____ _____

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-01 FORM

PRIOR AUTHORIZATION ERROR CODES

The prior authorization (PA) error codes identified below are generated by PA denials from the Unisys PA Unit and reflect the most common PA error codes. Please note that this is not a complete list of PA error codes. The PA letter contains a brief description of each error code; however, if further explanation/information is required regarding a PA error code, the provider should contact Unisys Prior Authorization by calling (800) 488-6334 or (225) 928-5263.

Providers must bill services exactly as they are authorized.

Please note that the following PA error codes are **NOT** claim error codes. The most common claim error codes are located on page 14 of this document.

PRIOR AUTHORIZATION ERROR CODES

ERROR CODE 025- PROCEDURE CODE GIVEN DOES NOT REQUIRE PA
Cause: A PA-01 was submitted for a procedure code that does not need PA.
Resolution: No PA required for procedure. Submit claim for payment.

ERROR CODE 041- PROCEDURE CODE IS MISSING OR THERE IS A DESCRIPTION CONFLICT
Cause: The information on the PA-01 form is not the same information found on the prescription or the procedure code was omitted on the PA01 form.
Resolution: Verify information on the PA-01 form with the claim information; correct if necessary and resubmit.

ERROR CODE 071- RESUBMIT WITH DETAILED EXPLANATION WHY RECENTLY PURCHASED EQUIPMENT NEEDS TO BE REPLACED
Cause: Request for PA has been received within a narrow time line.
Resolution: Resubmit with necessary documentation to substantiate the need for replacement of eyewear.

ERROR CODE 101- PRESCRIPTION AND REQUESTED SERVICES/SUPPLIES CONFLICT
Cause: Information on the PA-01 does not match the information submitted on the prescription and/or on the letter of medical necessity.
Resolution Complete PA-01 to correspond with prescription and/or letter of medical necessity.

ERROR CODE 125- MISCELLANEOUS PROCEDURE CODE IS INAPPROPRIATE; HCPCS CODE IS AVAILABLE
Cause: PA-01 request was submitted with an unlisted procedure code when an appropriate HCPC code was available for the service requested.
Resolution: Resubmit PA-01 with appropriate HCPCS. Refer to the list of codes located in Appendix B.

ERROR CODE 126- RESUBMIT WITH DOCUMENTATION TO WARRANT MEDICAL NECESSITY OF PRESCRIBED LENSES AND/OR METAL FRAME
Cause: PA-01 was submitted without documentation.
Resolution: Resubmit with all necessary attachments.

ERROR CODE 187- PLEASE SUBMIT A LETTER OF MEDICAL NECESSITY FROM THE PHYSICIAN TO JUSTIFY THE REQUESTED EQUIPMENT AND/OR SERVICES
Cause: PA-01 was submitted without all necessary documentation attached.
Resolution: Resubmit with all necessary attachments.

ERROR CODE 231- EQUIPMENT/SUPPLIES NOT CONSIDERED MEDICALLY NECESSARY. JUSTIFICATION LETTER MUST BE PATIENT SPECIFIC
Cause: The documentation attached to the PA-01 did not reference the recipient.
Resolution: All letters of medical necessity must be recipient specific.

ERROR CODE 344- NEED DOCUMENTATION WHY LESS COSTLY LENSES WOULD NOT BE APPROPIATE
Cause: Documentation did not support HCPCS request.
Resolution: Resubmit request with justification of HCPCS requested.

ERROR CODE 689- PLEASE SUBMIT A LETTER OF MEDICAL NECESSITY FROM THE PHYSICIAN TO JUSTIFY THE REQUEST
Cause: Letter of medical necessity was not sent with the PA-01.
Resolution: Resubmit with letter of medical necessity and other necessary attachments.

ERROR CODE 702- DOCUMENTATION SUBMITTED DOES NOT JUSTIFY BIFOCAL LENSES. PLEASE DOCUMENT THE MEDICAL NECESSITY FOR BIFOCAL LENSES
Cause: PA-01 request and letter of medical necessity do not correspond.
Resolution: Review documentation and resubmit accordingly.

ERROR CODE 711- DIAGNOSIS CODE GIVEN DOES NOT JUSTIFY MEDICAL NEED FOR REQUESTED EYEGLASSES
Cause: Diagnosis code does not justify the need for eyeglasses.
Resolution: Verify diagnosis from recipients chart and resubmit if warranted.

CLAIM ERROR CODES RELATED TO PA

Providers must bill services exactly as they are authorized. The Medicaid computer system compares several items which must be the same on both the claim form and the prior authorization record, for example: PA number, Medicaid recipient ID number, provider number, procedure code, and date of service.

The remittance advice (RA) reflects the PA number entered on each processed claim on the left-hand side of the document, just below the recipient name.

Several claim error codes pertain to the process the computer uses in matching items on the claim to items on the prior authorization record. A discussion of these claim error codes follows. Please note that this is not a complete list of claim error codes. The remittance advice (RA) contains a brief description of each error code reported; however, if further explanation/information is required regarding a PA error code, the provider should contact Unisys Provider Relations by calling (800) 473-2783 or (225) 924-5040.

CLAIM ERROR CODES RELATED TO PA

ERROR CODE 190 - PA NUMBER NOT ON FILE
Cause: The number entered in block 23 of the CMS-1500 claim form is not a recognized number.
Resolution: Review the PA letter, paying special attention to the Prior Authorization number. Make sure the number listed on the PA letter is the same as the number entered in block 23. Make any necessary changes and resubmit.

ERROR CODE 191 – PROCEDURE REQUIRES PRIOR AUTHORIZATION
Cause: No PA number entered in block 23, or the service billed was not covered by the PA number entered in block 23.
Resolution: 1. Review recipient records to ascertain whether or not authorization has been given. If the PA letter shows an approval for that service, be sure to indicate that specific PA number in block 23. 2. If no record is found, complete a PA-01 and submit to the Prior Authorization Department. If criteria is met and the PA is approved, enter the PA number in block 23.

ERROR CODE 193 - DATE ON CLAIM NOT COVERED BY PA
Cause: The date of service on the claim does not match the covered dates for the PA number on the claim.
Resolution: 1. review recipient records to ascertain whether the date entered on the claim is correct. 2. Review the PA letter to ensure that the correct PA number is given.

ERROR CODE 194 - CLAIM EXCEEDS PRIOR AUTHORIZED LIMITS
Cause: The service indicated by the PA number on the claim has already been paid by Unisys or the number of units being billed exceeds units prior authorized.
Resolution: 1. Refer to remittance advices for previous payment. 2. Compare units billed to units prior authorized and correct claim for resubmission.

ERROR CODE 196 - CLAIM RECIPIENT ID DOES NOT MATCH ID ON PRIOR AUTH FILE
Cause: The Medicaid recipient number on the claim does not match the Medicaid recipient number on the prior authorization record.
Resolution: Review the PA letter, paying special attention to the recipient ID number make sure that you have submitted the claim with the proper recipient number and the proper PA number.

ERROR CODE 197 – PA PROVIDER ID NOT SAME AS CLAIM PROVIDER ID
Cause: The provider number on the claim is not the provider on the PA file at Unisys.
Resolution: Resolution: Verify that the provider number on the claim and the provider number on the approved PA match.

ERROR CODE 597- PA MODIFIER DOES NOT MATCH CLAIM MODIFIER
Cause: The procedure code modifier on the claim was not the same as the procedure code modifier on the prior authorization record.
Resolution: Verify that the number on the PA letter matches the PA number on the claim: if not, correct and resubmit.

HARD COPY REQUIREMENTS

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

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	BILLING REQUIREMENTS
Spend Down Recipient – 110MNP Spend Down Form	Continue hardcopy billing
Third Party/Medicare Payment - EOBs (Includes Medicare adjustment claims)	Continue hardcopy billing
Failed Crossover Claims - Medicare EOB	Continue hardcopy billing
Retroactive Eligibility - copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing
Recipient Eligibility Issues - copy of MEVS printout, cover letter	Continue hardcopy billing
Emergency Services for Lock-In Recipient	Allow EDI Billing Place “3” in field (Service Authorization Exception) segment
Timely filing - letter/other proof (i.e., RA page)	Continue hardcopy billing

BILLING INSTRUCTIONS AND CLAIMS FILING

Unisys now accepts standardized professional 837P electronic transactions if the VBC used by the provider has tested and been approved by Unisys. Providers billing hard copy claims will continue to bill on the CMS-1500 (formerly known as HCFA-1500). All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

When Filing Claims On or After the March 1, 2004 HIPAA Implementation Date

- **Billing for dates of service prior to March 1, 2004**

  If billing for dates of service prior to March 1, 2004, providers will indicate the local procedure code that was in effect on the date of service.

- **Billing for dates of service March 1, 2004 and after**

  If billing for dates of service March 1, 2004 and after, the provider will use the new standard procedure codes found in this document.

CMS-1500 Claim Form Instructions

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

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

1. REQUIRED Enter an "X" in the box marked Medicaid **(Medicaid #)**.

***1A. REQUIRED** Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid swipe card (MEVS), REVS or e-MEVS.

NOTE: The recipients' 13-digit Medicaid ID number **must** be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable.

NOTE: If the 13-digit Medicaid ID number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.

***2.**	**REQUIRED**	Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through MEVS , REVS or e-MEVS.
3.	**SITUATIONAL**	Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, REVS or e-MEVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.
4.	**SITUATIONAL**	Complete correctly if appropriate or leave blank.
5.	**SITUATIONAL**	Print the recipient's permanent address.
6.	**SITUATIONAL**	Complete if appropriate or leave blank.
7.	**SITUATIONAL**	Complete if appropriate or leave blank.
8.	**SITUATIONAL**	Leave blank.
9.	**SITUATIONAL**	Complete if appropriate or leave blank.
9A.	**SITUATIONAL**	If recipient has no other coverage, leave blank. If there is other coverage, put the state assigned 6-digit TPL carrier code in this block-make sure the EOB is attached to the claim.
9B.	**SITUATIONAL**	Complete if appropriate or leave blank.
9C.	**SITUATIONAL**	Complete if appropriate or leave blank.
9D.	**SITUATIONAL**	Complete if appropriate or leave blank.
10.	**SITUATIONAL**	Leave blank.
11.	**SITUATIONAL**	Complete if appropriate or leave blank.
11A.	**SITUATIONAL**	Complete if appropriate or leave blank.
11B.	**SITUATIONAL**	Complete if appropriate or leave blank.
11C.	**SITUATIONAL**	Complete if appropriate or leave blank.
12.	**SITUATIONAL**	Complete if appropriate or leave blank.
13.	**SITUATIONAL**	Obtain signature if appropriate or leave blank.
14.	**SITUATIONAL**	Leave blank.
15.	**SITUATIONAL**	Leave blank.
16.	**SITUATIONAL**	Leave blank.
17.	**SITUATIONAL**	If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.

17A.	**SITUATIONAL**	Leave blank.
18.	**SITUATIONAL**	Leave blank.
19.	**SITUATIONAL**	Leave blank.
20.	**SITUATIONAL**	Leave blank.
***21.**	**REQUIRED** -	Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.
22.	**SITUATIONAL**	Leave blank.
23.	**SITUATIONAL**	Complete if required or leave blank.
***24A.**	**REQUIRED**	Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.
***24B.**	**REQUIRED**	Enter the appropriate code from the approved Medicaid place of service code list.
24C.	**SITUATIONAL**	Leave blank.
***24D.**	**REQUIRED**	Enter the procedure code(s) for services rendered.
***24E.**	**REQUIRED**	Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a “1”, “2”, etc. More than one diagnosis may be related to a procedure. Do not enter ICD-9-CM diagnosis code.
***24F.**	**REQUIRED**	Enter usual and customary charges for the service rendered.
***24G.**	**REQUIRED**	Enter the number of units billed for the procedure code entered on the same line in 24D.
24H.	**SITUATIONAL**	Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.
24I.	**SITUATIONAL**	Leave blank.
24J.	**SITUATIONAL**	Leave blank.
24K.	**SITUATIONAL**	Enter the attending provider number if group number is indicated in block 33.
25.	**SITUATIONAL**	Leave blank.
26.	**SITUATIONAL**	Enter the provider specific information assigned to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.

27. SITUATIONAL Leave blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.

***28. REQUIRED** Total of all charges listed on the claim.

29. SITUATIONAL If block 9A is completed, indicate the amount paid; if no TPL, leave blank.

30. SITUATIONAL If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from the billed charges.

***31. REQUIRED** The claim form **MUST** be signed. The practitioner is not required to sign the claim form. However, the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. **If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned unprocessed.**

Date Enter the date of the signature.

32. SITUATIONAL Complete as appropriate or leave blank

***33. REQUIRED** Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid billing provider number must be entered in the space next to "Group (Grp) #."

Note: If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567891234

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

3. PATIENT'S BIRTH DATE: 01 18 97 | SEX: M X F

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 367 1 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 123456789

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	09 03 04 09 03 04	11		V2102	RT LT	1	72 00	2				
2	09 03 04 09 03 04	11		V2020		1	15 53	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 87 53

29. AMOUNT PAID (TPL Amt)

30. BALANCE DUE $ 87 53

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

IMA BILLER 09/15/04

SIGNED DATE

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

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

#1 Optical Illusion Shop

45 Oak St Sunny, La 70000

PIN# GRP# 1111111

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

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0123456789123

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

3. PATIENT'S BIRTH DATE: 05 17 93 SEX: M [ ] F [X]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

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

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

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 367 1

2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 012345678

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 23 04 09 23 04	11		V2025		1	75 00	1				
2 09 23 04 09 23 04	11		V2104		1	20 04	2				
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 95 04

29. AMOUNT PAID $ (TPL Amt)

30. BALANCE DUE $ 95 04

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

IMA BILLER 10/15/04

SIGNED DATE

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

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

#1 Optical Illusion Shop
45 Oak St Sunny, La 70000

PIN# GRP# 1111111

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

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

ADJUSTMENT/VOID CLAIMS

Claims paid on the CMS-1500 form are adjusted or voided using the Unisys 213 adjustment/void form. These may be ordered from Unisys at no cost. Denied claims must be corrected and resubmitted—not adjusted or voided.

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

Only a paid claim can be adjusted or voided. Adjustments and or voids can be denied, the denial code is indicated on the Remittance Advice on which the adjustment appears as a denied claim.

Electronic submitters may electronically submit adjustment/void claims.

Only the paid claim's most recently approved control number can be adjusted or voided. For example:

1. A claim is paid on the RA dated 7-15-04, ICN 4170567890123.
2. The claim is adjusted on the RA dated 8-19-04, ICN 4200590123456.
3. If the claim requires further adjustment or needs to be voided, only ICN 4200590123456 may be used.

Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column. An example of a completed adjustment form appears on page 28.

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

Filing Adjustments For a Medicare/Medicaid Claim

When a provider has filed a claim with Medicare, Medicare pays, then the claim becomes a “crossover” to Medicaid for consideration of payment of the Medicare deductible or co-payment.

If, at a later date, it is determined that Medicare has overpaid or underpaid, the provider should rebill Medicare for a corrected payment. These claims may “crossover” from Blue Cross to Medicaid, but cannot be automatically processed by Medicaid (as the claim will appear to be a duplicate claim, and therefore must be denied by Medicaid).

In order for the provider to receive an adjustment, it is necessary for the provider to file a hard copy claim (Unisys Form 213) with Medicaid. A copy of both the most recent Medicare

explanation of benefits and the original explanation of benefits must be attached to the adjustment form and should be mailed to the following address:

Unisys
Attention: Crossover Adjustments
P.O. Box 91023
Baton Rouge, LA 70821

In addition, the provider should write “2X7” at the top of the adjustment/void form to indicate the adjustment is for a Medicare/Medicaid claim.

INSTRUCTIONS FOR FILING UNISYS 213 ADJUSTMENT/VOID CLAIMS

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

*2. Patient's Name

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

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

3. Patient's Date of Birth

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

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

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

5. Patient's Address and Telephone Number

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

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

6. Patient's Sex

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

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

7. Insured's Name— Leave blank

8. Patient's Relationship to Insured—Leave blank

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

10. Other Health Insurance Coverage—Leave blank

11. Was Condition Related to—Leave blank

12. Insured's Address—Leave blank

13. Date of—Leave blank

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

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

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

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

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

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

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

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

*22. Diagnosis of Nature of Illness

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

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

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

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

*25. A through F

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

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

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

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

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

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

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

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

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

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

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION

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

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

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

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

ADJUSTMENT

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

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

UNISYS - 213
5/97

FISCAL AGENT COPY

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

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

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Smith, Johnny
3 PATIENT'S DATE OF BIRTH: 01/18/97
4 MEDICAID ID NUMBER: 1234567891234
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO
B. AN AUTO ACCIDENT YES [ ] NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 367.1
2
3
23 ATTENDING NUMBER
24 PRIOR AUTHORIZATION NO. 123456789

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
09	03	04	09	03	04	11	V2025		1	75 00	1		

26 CONTROL NUMBER: 4123456789012
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 10/28/04

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

Billed for wrong frame – Should have billed V2025 instead of V2020

ADJUSTMENT

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Ima Biller 10/03/04
32 YOUR PATIENT'S ACCOUNT NUMBER
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
#1 Optical Illusion Shop
45 Oak St Sunny, La 70000
1111111

UNISYS - 213
5/97

FISCAL AGENT COPY

GENERAL MEDICAID EYE WEAR POLICY

Recipient Eligibility

Medicaid covered eye wear services are available to Medicaid eligible recipients who are under the age of 21.

No eye wear services are available for recipients aged 21 and older unless the recipient receives both Medicare and Medicaid and Medicare covers the required eye wear. In this instance, Medicaid may pick up a calculated portion of the payment as a Medicare cross-over claim.

It is the responsibility of the provider to verify recipient Medicaid eligibility. The Recipient Verification System (REVS), the Medicaid Eligibility System (MEVS) or the Medicaid Electronic Eligibility System (e-MEVS) should be used to obtain recipient eligibility information. e-MEVS is available on the web at www.lamedicaid.com. The recipient must be eligible for each date of service. It is advisable that providers keep on file hardcopy proof of eligibility from MEVS and/or e-MEVS.

Additional Information

Lenses

Lenses must be of good quality and untinted, conforming to the Z 80.1 hardened glass or plastic lens standards of the American National Standards Institute, Federal Food and Drug Administration regulations, and federal law.

In order to receive Medicaid reimbursement for single vision lenses, at least one lens must exceed +1.00 sphere, -0.50 sphere, or +/-0.50 plano cylinder.

If a complete eyeglass (frames and lenses) is delivered to a Medicaid recipient on the same date of service, the provider must bill for all components of the eyeglass. Providers may not bill Medicaid for lenses only and let the patient pay for the frames.

Providers may dispense replacement lenses to a complete eyeglass in which a recipient already owns.

Contact lenses will only be considered when medically necessary and no other means can restore vision.

Bifocal/Trifocal lenses will only be considered when medically necessary. Bifocal/Trifocal lenses requested for convenience will not be authorized.

Polycarbonate lens - add-on, per lens (S0580) will only be considered when medically necessary, i.e. for a child who has seizures and may be prone to fall, a child who is blind in one eye, etc.

Frames

Medicaid recipients must be offered a choice between metal or plastic frames. The frames must be sturdy and nonflammable. Both the metal and non-metal frames must carry at least a one-year manufacturer's warranty.

Providers may dispense a replacement frame to a complete eyeglass in which a recipient already owns. Replacement frames should not be billed to Medicaid if the frame is covered by the one-year manufacturer's warranty.

If a complete eyeglass (frames and lenses) is delivered to a Medicaid recipient on the same date of service, the provider must bill for all components of the eyeglass. Providers may not bill Medicaid for frames only and let the patient pay for the lenses.

Deluxe frames (V2025) require prior authorization and will only be considered when medically necessary, i.e. child has a wide nose bridge due to a medical syndrome; or child has a small head and regular frames would not fit, etc.

Same-Day Or Subsequent Day Follow-Up Office Visit Policy

A separate same-day or subsequent day follow-up **Optometrist** or **Ophthalmologist** office visit is allowed for the purpose of the delivery, and final adjustment to the visual axis and anatomical topography of Medicaid-covered eye wear. Presence of the physician is not required. If the visit meets these criteria, procedure code 99211 should be used when billing for this service. Documentation in the patient's record should reflect that the patient returned for a separate visit on the same day or subsequent day for the purpose of the delivery and final adjustment of the eye wear, and must include a description of the services provided. If the patient returns on the same day or subsequent day simply to pick up their eye wear, and no final adjustments to the visual axes and anatomical topography are performed, the provider must not bill for this service.

Miscellaneous Eye Wear Policy

Eye wear is limited to three pair per calendar year without review. Billing for the fourth and subsequent pairs must have documentation attached justifying the need for more than three pair of eye wear per year. Acceptable documentation includes, but is not limited to:

1) Documentation which shows the necessity of changing the prescription for the eye wear more than three times in the calendar year;

Or

2) Copies of the different prescriptions for eyeglasses which were written within the calendar year.

For services that do not require prior authorization, providers should fill the prescription and dispense the glasses to the recipient prior to filing for payment. Providers should not hold the eye wear until payment is received.

Date of delivery of eye wear is the date of service on the claim form.

Providers may not require a payment/deposit for eye wear pending payment from Medicaid. Payment from the Louisiana Medicaid Program must be accepted as payment in full.

Eye wear may not be upgraded for cosmetic purposes and the recipient allowed to pay the difference.

Medicaid covers medically necessary eye wear. Medicaid does not cover any eye wear, initial or replacement, that is to be used as “spare” or “back-up” eye wear. The recipient may choose to purchase (out of pocket) duplicate eye wear that is to be used as “spare or “back-up” eye wear.

LOUISIANA MEDICAID WEBSITE APPLICATIONS

The newest way to obtain general and specific Medicaid information is on our Louisiana Medicaid Provider Website:

www.lamedicaid.com

This website has several applications that should be used by Louisiana Medicaid providers. These applications require that providers establish an online account for the site.

Provider Login And Password

To ensure appropriate security of recipient's patient health information (PHI) and provider's personal information, the secure area of the web site is available to providers only. It is the responsibility of each provider to become "Web Enrolled" by obtaining a login and password for this area of the site to be used with his/her provider number. Once the login and password are obtained by the provider who "owns" the provider number, that provider may permit multiple users to login using the provider number. This system allows multiple individuals to login using the same login and password OR a provider may have up to 500 individual logins and passwords established for a single provider number. The administrative account rights are established when a provider initially obtains a login and password, and should remain with the provider or designated office staff employed by the provider.

A login and password may be obtained by using the link, Provider Web Account Registration Instructions. Should you need assistance with obtaining a login and password or have questions about the technical use of the application, please contact the Unisys Technical Support Desk at 877-598-8753.

☞ Unisys has received inquiries from billing agents/vendors attempting to access this web application. DHH and CMS Security Policy restrictions will not permit Unisys to allow access of this secure application to anyone except the owner of the provider number being used for accessing the site. In cases where an outside billing agent/vendor is contracted to submit claims on behalf of a provider, any existing business partner agreement is between the provider and the billing agent/vendor. Unisys may not permit anyone except the provider to receive or ask for information related to a login and password to access secured information.

Web Applications

There are a number of web applications available on the Medicaid website, however, the following applications are the most commonly used:

- Medicaid Eligibility Verification System (e-MEVS) for recipient eligibility inquiries;
- Claims Status Inquiry (e-CSI) for inquiring on claims status; and
- Clinical Data Inquiry (e-CDI) for inquiring on recipient pharmacy prescriptions as well as other medical claims data

These applications are available to providers 24 hours a day, 7 days a week at no cost.

e-MEVS:

Providers can now verify eligibility, primary insurance information, and service limits for a Medicaid recipient using this web application accessed through www.lamedicaid.com. This application provides eligibility verification capability in addition to MEVS swipe card transactions and REVS. An eligibility request can be entered via the web for a single recipient and the data for that individual will be returned on a printable web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Since its release, the application has undergone some cosmetic and informational changes to make it more user-friendly and allow presentation of more complete, understandable information.

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on e-CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the e-CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims status to have access to remittance advices for this purpose. An LA Medicaid/HIPAA Error Code Crosswalk is available on this website by accessing the link, Forms/Files.

Once enrolled in the website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

e-CDI:

The e-CDI application provides a Medicaid recipient's essential clinical history information at the authorized practitioner's finger tips at any practice location.

The nine (9) clinical services information components are:

1. Clinical Drug Inquiry
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a six-month period. These updates are based on Medicaid claims history. A print-friendly version of the information on each of the web pages will be accessible and suitable for the recipient's clinical chart.

The major benefits of the use of e-CDI by the practitioner will include:

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by all providers that have provided services to each individual recipient.
2. Provides the practitioner rapid access to current clinical data to help him/her evaluate the need for "modifications" of an individual Medicaid recipient's health care treatment.
3. Promotes the deliberate evaluation by a practitioner to help prevent duplicate drug therapy and decreases the ordering of duplicate laboratory tests, x-ray procedures, and other services.
4. Supplies a list of all practitioner types providing health care services to each Medicaid recipient.
5. Assists the practitioner in improving therapeutic outcomes and decreasing health care costs.

Additional DHH Available Websites

www.lamedicaid.com/HIPAA: Louisiana Medicaid HIPAA Information Center

www.la-communitycare.com: DHH website – CommunityCARE (program information, provider listings, Frequently Asked Questions (FAQ)

www.la-kidmed.com: DHH website - KIDMED – (program information, provider listings, FAQ)

www.dhh.la.gov/BCSS: DHH website - Bureau of Community Supports and Services

www.oph.dhh.state.la.us: DHH website - EarlySteps Program

www.oph.dhh.state.la.us: DHH website - LINKS

www.dhh.state.la.us/RAR: DHH Rate and Audit Review (nursing home updates and cost report information, contacts, FAQ)

PROVIDER ASSISTANCE

Many of the most commonly requested items from providers including, but not limited to, Field Analyst listing, RA messages, Provider Updates, preferred drug listings, general information, program packets, etc. are available online

Unisys Provider Relations Telephone Inquiry Unit

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure/ information/clarification, ordering printed material, requesting a Field Analyst visit, etc., and may be reached by calling:

(800) 473-2783 or (225) 924-5040*
FAX: (225) 237-3334**

* Please listen to the menu options and press the appropriate key for assistance.

NOTE: Providers should access eligibility information via the Medicaid Eligibility Verification System (MEVS), or the automated Recipient Eligibility Verification System (REVS) at (800) 776-6323 or (225) 216-7387. Providers may also check eligibility by accessing the web-based application (e-MEVS) now available on the LAMedicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

NOTE: UNISYS cannot assist recipients. If recipients have problems, please direct them to the Parish Office or the number on their card:

RECIPIENT HELPLINE (800) 834-3333

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

Unisys Provider Relations Correspondence Group

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

All requests to the Correspondence Unit should be submitted to the following address:

Unisys Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge, LA 70821

NOTE: All correspondence sent to Provider Relations, including recipient file updates, must include a separate cover letter explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). **A COPY OF THE CLAIM FORM ALONG WITH APPLICABLE CORRECTIONS AND/OR ATTACHMENTS MUST ACCOMPANY ALL RESUBMISSIONS.**

Provider Relations staff does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

Requests to update TPL third party liability should be directed to:

DHH – Third Part Liability
Medicaid Recovery Unit
P.O. Box 91030
Baton Rouge, LA 70821

"Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box. A complete list of claims filing addresses is available on page 42 of this training packet.

NOTE: CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.

Unisys Provider Relations Field Analysts

Upon request, Provider Relations Field Analysts are available to visit and train new providers and their office staff on site. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However, Field Analysts ARE NOT available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

FIELD ANALYST	PARISHES SERVED		
Martha Craft **(225) 237-3306**	Jefferson Orleans	St. Charles Plaquemines St. Bernard	
OPEN	Bienville Bossier Caddo Caldwell Claiborne East Carroll Franklin Lincoln Vicksburg, MS	Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Marshall, TX	
Mona Doucet **(225) 237-3249**	Acadia Evangeline Iberia Lafayette	St. Landry St. Martin St. Mary Vermillion	
OPEN	Allen Beauregard Calcasieu	Cameron Jeff Davis Lafourche Terrebonne	Jasper, TX Beaumont, TX
Sharon Harless **(225) 237-3267**	Avoyelles Iberville West Baton Rouge	East Feliciana West Feliciana Woodville/Centerville (MS) Pointe Coupee	
Erin McAlister **(225) 237-3201**	Ascension Assumption Livingston St. Helena St. James	St. John the Baptist St. Tammany Tangipahoa Washington McComb (MS)	
Courtney Patterson **(225) 237-3269**	East Baton Rouge		
Kathy Robertson **(225) 237-3260**	Catahoula Concordia DeSoto Grant Jackson LaSalle Natchitoches	Rapides Red River Sabine Vernon Winn Natchez (MS)	

ELECTRONIC DATA INTERCHANGE (EDI)

CLAIMS SUBMISSION

Electronic data interchange submission is the preferred method of submitting Medicaid claims to Unisys. With electronic data, a provider or a third party contractor (billing agent) submits Medicaid claims to Unisys on a computer encoded magnetic tape, diskette or via telecommunications.

Each claim undergoes the editing common to all claims, e.g., verification of dates and balancing. Each type of claim has unique edits consistent with the requirements outlined in the provider manuals. All claims received via electronic data must satisfy the criteria listed in the manual for that type of claim.

Advantages of submitting claims electronically include increased cash flow, improved claim control, decrease in time for receipt of payment, automation of receivables information, improved claim reporting by observation of errors and reduction of errors through pre-editing claims information.

Certification Forms

Each reel of tape, diskette or telecommunicated file submitted for processing must be accompanied by a submission certification form signed by the authorized Medicaid provider or billing agent for each provider whose claims are billed using electronic data. The certification must be included in each tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.

Third Party Billers are required to submit a Certification Form including a list of provider(s) name(s) and Medicaid Provider numbers. Additionally, all Third Party Billers **MUST** obtain a “Professional, Pharmacy, Hospital or KIDMED Services Certification" form on which the provider has attested to the truth, accuracy and completeness of the claim information. These forms **MUST** be maintained for a period of five years. This information must be furnished to the agency, the DHH Secretary, or the Medicaid Fraud Control Unit upon request.

Required Certification forms may be obtained from LAMedicaid.com under the HIPAA Information Center link. The required forms are also available in both the General EDI Companion Guide and the EDI Enrollment Packet.

For telecommunication file, the required Certification Form must be mailed to the Unisys EDI Unit within 48 hours. The form must be completed in its entirety including the following fields:

- Provider Name
- Provider Number
- Submitter Number
- Claim Count
- Total Charges of submission
- Submission Date
- Original Signature
- For **Third Party Billers/Clearinghouses** – a list of Provider Names and Numbers contained in the submission must be attached.

Failure to correctly complete the Certification Form will result in the form being returned for correction.

To contact the EDI Department at Unisys, call (225) 237-3200 and select option 2. Providers may write to Unisys EDI Department, P.O. Box 91025, Baton Rouge, LA 70821.

Electronic Data Interchange (EDI) may be submitted by magnetic tape, 5 1/4" diskette, 3 1/2" diskette, or telecommunication (modem).

Electronic Adjustments/Voids

Adjustments and voids can be submitted electronically. If your present software installation does not offer this option, please contact your software vendor to discuss adding this capability to your software.

Submission Deadlines

Regular Business Weeks

Magnetic Tape and Diskettes	4:30 P.M. each Wednesday
KIDMED Submissions (All Media)	4:30 P.M. each Wednesday
Telecommunications (Modem)	10:00 A.M. each Thursday

Thanksgiving Week

Magnetic Tape and Diskettes	4:30 P.M. Tuesday, 11/23/04
KIDMED Submissions	4:30 P.M. Tuesday, 11/23/04
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/24/04

Important Reminders for EDI Submission

- Denied claims may be resubmitted electronically unless the denial code states otherwise. This includes claims that have produced a denied claim turnaround document (DTA). Claims with attachments must be submitted hardcopy.

- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.

- The total amount of the submitted file must equal the amount indicated on the Unisys response file.

- **All claims submitted must meet timely filing guidelines.**

Electronic Data Interchange (EDI) General Information

- Please review the entire General EDI Companion Guide before completing any forms or calling the EDI Department.

- The following claim types may be submitted as approved HIPAA compliant 837 transactions:

    - Pharmacy
    - Hospital Outpatient/Inpatient
    - Physician/Professional
    - Home Health
    - Emergency Transportation
    - Adult Dental
    - Dental Screening
    - Rehabilitation
    - Crossover A/B

- The following claims types may be submitted under proprietary specifications (not as HIPAA-compliant 837 transactions):

    - Case Management services
    - Non-Ambulance Transportation

Enrollment Requirements For EDI Submission

- **Submitters wishing to submit EDI 837 transactions without using a Third Party Biller -** complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA SUBMISSION OF CLAIMS** (EDI Contract).

- **Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse –** complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA SUBMISSION OF CLAIMS** (EDI Contract) **and** a Limited Power of Attorney.

- **Third Party Billers or Clearinghouses** (billers for multiple providers) are required to submit a completed HCFA 1513 – Disclosure of Ownership form and return it with a completed EDI Contract and a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Enrollment Requirements for 835 Electronic Remittance Advices

- All EDI billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EDI billers to download their remittance advices weekly.

- 835 Transactions may not contain all information printed on the hardcopy RA, ex. blood deductible, patient account number, etc.

- To request 835 Transactions – Electronic Remittance Advice, contact Unisys EDI Department at (225) 237-3200 ext. 2.

General Information

- Any number of claims can be included in production file submissions. There is no minimum number.

- EDI Testing is required for all submitters (including KIDMED) before they are approved to submit claims for production unless the testing requirement has been completed by the Vendor. LTC providers must test prior to submission to production.

- Case Management Services and Non-Ambulance Transportation submitters who file via modem MUST wait 24 hours, excluding weekends, between file submissions to allow time for processing.

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

Department	Toll Free Phone	Phone	Fax
REVS - Automated Eligibility Verification	(800) 776-6323	(225) 216-7387	
Provider Relations	(800) 473-2783	(225) 924-5040	(225) 237-3334
POS (Pharmacy) – Unisys	(800) 648-0790	(225) 237-3381	(225) 237-3334
Electronic Data Interchange (EDI) - Unisys		(225) 237-3200 option 2	(225) 237-3331
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 237-3342 or (225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A**. - Unisys	(800) 807-1320		(225) 237-3342 or (225) 929-6803
Dental P.A. - LSU School of Dentistry		(504) 619-8589	(504) 619-8560
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 237-3370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline - Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – DHH	(800) 834-3333 (225) 925-7948	Providers may request verification of eligibility for presumptively eligible recipients; recipients should contact to request a new card or to discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address questions concerning eligibility issues.
LaCHIP Program	(877) 252-2447	Providers and recipients may obtain information regarding the LaCHIP program, which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - Vaccines for Children Program	(504) 483-1900	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Referral Assistance - ACS	(877) 455-9955	Providers or recipients may use this phone number for referral assistance.
KIDMED Provider Hotline – ACS	(800) 259-8000	Providers may obtain information on KIDMED linkage, referrals, monitoring, certification, and names of agencies that provide PCS services.
KIDMED Recipient Hotline – ACS	(800 259)-4444	Recipients request enrollment in KIDMED program and obtain information on KIDMED linkage.
CommunityCARE Provider Hotline – ACS	(800) 609-3888	Providers inquire about PCP assignment for CommunityCARE recipients and about CommunityCARE monitoring/certification.
CommunityCARE Recipient Hotline – ACS	(800) 359-2122	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, and express complaints concerning the CommunityCARE program.
Bureau of Community Support and Services – BCSS	**(**800) 660-0488 (225) 219-0200	Providers and recipients may request assistance regarding waiver services provided to waiver recipients **(does not include claim or billing problems or questions)**
EarlySteps Program - OPH	(866) 327-5978	Providers and recipients may information on the EarlySteps Program and services offered
LINKS	(504) 483-1900	Providers may obtain immunization information on recipients.

DHH Program Manager Requests

Questions regarding the rationale for Medicaid policy, procedure coverage and reimbursement, medical justification, written clarification of policy that is not documented, etc. should be directed in writing to the manager of your program:

Program Manager (Eye Wear Services)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

UNISYS CLAIMS FILING ADDRESSES

To expedite payment, providers should send "clean" claims directly to the appropriate Post Office Box as listed below. All Post Office Boxes are for Unisys Corporation, Baton Rouge, LA.

Type of Claim or Department	Post Office Box
The zip code for the following P.O. Boxes is <u>70821</u>:	
Pharmacy (original claims and adjustment/voids).....	91019
CMS-1500, including services such as Professional, Independent Lab, Substance Abuse and Mental Health Clinic, Hemodialysis, **Professional Services**, Chiropractic, Durable Medical Equipment, Mental Health Rehabilitation, EPSDT Health Services, Case Management, FQHC, and Rural Health Clinic (original claims and adjustment/voids)	91020
Inpatient and Outpatient Hospitals, Long Term Care, Hospice, Hemodialysis Facility, Freestanding Psychiatric Hospitals (original claims and adjustment/voids).....	91021
Dental, Transportation (Ambulance and Non-ambulance), Rehabilitation, Home Health (original claims and adjustment/voids).....	91022
All Medicare Crossovers and All Medicare Adjustments and Voids.....	91023
Provider Relations.....	91024
EMC/EDI, Unisys Business, and Miscellaneous Correspondence.....	91025
The zip code for the following P.O. Boxes is <u>70898</u>:	
Provider Enrollment…….	80159
Prior Authorization.....	14919
KIDMED.....	14849

CLAIMS PROCESSING REMINDERS

Unisys Louisiana Medicaid images and stores all Louisiana Medicaid paper claims on-line. This process allows the Unisys Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

If claims cannot be submitted electronically, prepare paper claim forms according to the following instructions to ensure appropriate and timely processing:

- Submit an original claim for whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.

- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.

- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. **DO NOT use a highlighter to draw attention to specific information.**

- Paper claims must be legible and in good condition for scanning into our document imaging system.

- **Don't forget to sign and date your claim form. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.**

- Continuous feed forms must be torn apart before submission.

- Use high quality printer ribbons or cartridges - black ink only.

- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.

- Do not use italic, bold, or underline features.

- Do not submit two-sided documents.

- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

- **The recipient's 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic card is NOT acceptable**.

Rejected Claims

Unisys currently returns illegible claims. These claims have not been processed and are returned along with a cover letter stating what is incorrect.
The criteria for legible claims are:

(1) claim forms are clear and in good condition,
(2) all information is readable to the normal eye,
(3) information is centered in the appropriate block, and
(4) essential information is complete.

Attachments

All claim attachments should be standard 81/2 x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper. If it is necessary to attach documentation to a claim, the documents must be placed directly behind each claim that requires this documentation. Therefore, it may be necessary to make multiple copies of the documents if they must be placed with multiple claims.

Changes To Claim Forms

Louisiana Medicaid policy prohibits Unisys staff from changing any information on a provider's claim form. Any claims requiring changes must be made prior to submission. Please do not ask Unisys staff to make any changes on your behalf.

Data Entry

Data entry clerks do not interpret information on claim forms - data is keyed as it appears on the claim form. If the data is incorrect, or **IS NOT IN THE CORRECT LOCATION**, the claim will not process correctly.

Appendix A
Summary of Vision (Eye Wear) Services Changes
Effective March 1, 2004

Attention: Vision (Eye Wear) Service Providers			
Category	**Sub-Category**	**Prior to 03/01/04**	**Effective 03/01/04**
Vision (Eye Wear) Services	**Billing**	Use the local procedure code(s)	• **When billing for dates of service prior to March 1, 2004:** Providers will indicate the local procedure code that was in effect on the date of service. • **When billing for dates of service March 1, 2004 and after:** Providers will use the new standard procedure code(s) found in the 2004 Vision (Eye Wear) Services Provider Training packet.
	Billing for services which require prior authorization		• **When billing for dates of service prior to March 1, 2004:** **Providers should bill Medicaid on the CMS-1500 form using the discontinued local "X" procedure code and the prior authorization number granted for the discontinued local "X" procedure code.** • **For dates of service on or after March 1, 2004:** **Providers should bill Medicaid on the CMS-1500 form using the new standard procedure code and the prior authorization number granted for the new standard procedure code.** **Note:** For dates of service effective March 1, 2004, code V2102 is to be used to bill Sphere, Single Vision, Over Plus or Minus 12.00 to Plus or Minus 20.00D sphere, per lens. **Prior authorization and the use of the RT/LT Modifier is required if the sphere is over Plus or Minus 12.00D.**

Category	Sub-Category	Prior to 02/16/04	Effective 02/16/04
Prior Authorization	**Requesting authorization for vision (eye wear) services that require prior authorization**	Providers should complete the PA01 form using the appropriate local code(s)	**Providers should complete the PA01 form using the new standard procedure code(s**). However, all vision (eye wear) services which require prior authorization that were delivered prior to March 1, 2004 must be billed with and have a prior authorization number issued for the local code X0089. If the provider delivered the eye wear prior to March 1, 2004 and did not request a prior authorization approval for this service prior to February 16, 2004, please contact the Unisys Prior Authorization Unit by calling 1-800-488-6334 or 1-225-928-5263. **Note:** For dates of service effective March 1, 2004, code V2102 is to be used to bill Sphere, Single Vision, Over Plus or Minus 12.00 to Plus or Minus 20.00D sphere, per lens. **Prior authorization and the use of the RT/LT Modifier is required if the sphere is over Plus or Minus 12.00D.**
	PA 01 Form	PA 01	Use revised PA01 Form (regardless of date of service)

General Eye Wear Information			
Category		**Prior to 03/01/04**	**Effective 03/01/04**
Hardcopy Claim Form		CMS-1500	No change
Adjustment/Void Form		Unisys 213	No change
Electronic Data Interchange (EDI)		Unisys proprietary electronic specifications	837P (is accepted regardless of the date of service)

Category	Prior to 6/28/03	Effective 6/28/03
MEVS (Medicaid Eligibility Verification System) Inquiry Responses	DHH approved inquiry responses	Federally required standardized inquiry responses (Responses are more general than the former DHH approved inquiry responses). **NOTE:** A MEVS web application (e-MEVS) is also available to providers by accessing the LA Medicaid web site at www.lamedicaid.com.

Visit us on the web for up-to-date Medicaid information:
www.lamedicaid.com

Appendix B

Louisiana Medicaid Eye Wear Code Conversion Chart & Fee Schedule

Effective March 1, 2004

Reimbursement Fee

A flat fee has been established for each code listed in the fee schedule with the exception of the "non-specific" codes. These codes include V2199, V2299, V2399, V2499, V2599 and V2799. These codes require prior authorization and the reimbursement fee will be determined at the time of prior authorization approval based on invoice cost. A copy of the invoice must be submitted with the prior authorization request in order to determine the amount of reimbursement. Use of these codes should be limited to the instance when there is no established code available to describe the service being rendered.

Reminders:

- In order to receive Medicaid reimbursement for single vision lenses, at least one lens must exceed +1.00 sphere, -0.50 sphere, or +/-0.50 plano cylinder.
- Bifocal/Trifocal lenses will only be considered when medically necessary. Bifocal/Trifocal lenses requested for convenience will not be authorized.

LOUISIANA MEDICAID EYE WEAR CODE CONVERSION CHART & FEE SCHEDULE
EFFECTIVE 03/01/2004

LOCAL CODE	HIPAA CODE	MOD REQ	DESCRIPTION	FEE	PA REQUIRED
X0089	S0580		POLYCARBONATE LENS -ADD ON, PER LENS	35.00	YES
X6373	V2020		FRAMES, PURCHASES	15.53	
X0089	V2025		DELUXE FRAME	75.00	YES
X9066	V2100		SPHERE, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00, PER LENS	10.02	
X9067	V2101		SPHERE, SINGLE VISION, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D, PER LENS	11.50	
X9068	V2102		SPHERE, SINGLE VISION, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D, PER LENS **Note:** Effective with dates of service March 1, 2004, code V2102 is to be used to bill Sphere, Single Vision, Plus or Minus 7.12 to Plus or Minus 12.00D sphere, per lens. No prior authorization or modifier is required if the sphere is equal to or less than Plus or Minus 12.00 sphere. **Note:** For dates of service prior to March 1, 2004, code X9068 is used to bill Sphere, Single Vision, Plus or Minus 7.12 to Plus or Minus 12.00D sphere, per lens. No prior authorization or modifier is required.	13.91	
X0089	V2102	RT or LT	SPHERE, SINGLE VISION, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D, PER LENS **Note:** For dates of service effective March 1, 2004, code V2102 is to be used to bill Sphere, Single Vision, Over Plus or Minus 12.00 to Plus or Minus 20.00D sphere, per lens. Prior authorization and the use of the RT/LT Modifier is required if the sphere is over Plus or Minus 12.00D. **Note:** For dates of service prior to March 1, 2004, code X0089 is used to bill a variety of services including Sphere, Single Vision, Over Plus or Minus 12.00 to Plus or Minus 20.00D sphere, per lens. Prior authorization is required, however, the RT/LT modifier is not required.	36.00^	YES*
X9066	V2103		SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D SPHERE, .12 TO 2.00 D CYLINDER, PER LENS	10.02	
X9066	V2104		SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS	10.02	
X9066	V2105		SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS	10.02	

LOUISIANA MEDICAID EYE WEAR CODE CONVERSION CHART & FEE SCHEDULE
EFFECTIVE 03/01/2004

LOCAL CODE	HIPAA CODE	MOD REQ	DESCRIPTION	FEE	PA REQUIRED
X0089	V2106		SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D, SPHERE, OVER 6.00D CYLINDER, PER LENS	35.15	YES
X9067	V2107		SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, .12 TO 2.00D CYLINDER, PER LENS	11.50	
X9067	V2108		SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS	11.50	
X9067	V2109		SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS	11.50	
X0089	V2110		SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO 7.00D SPHERE, OVER 6.00D CYLINDER, PER LENS	37.05	YES
X9068	V2111		SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, .25 TO 2.25D CYLINDER, PER LENS	13.91	
X9068	V2112		SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 2.25 TO 4.00D CYLINDER, PER LENS	13.91	
X9068	V2113		SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS	13.91	
X0089	V2114		SPHEROCYLINDER, SINGLE VISION, SPHERE OVER PLUS OR MINUS 12.00D, PER LENS	41.80	YES
X0089	V2115		LENTICULAR, (MYODISC), PER LENS, SINGLE VISION	45.00	YES
X0089	V2118		ANISEIKONIC LENS, SINGLE VISION, PER LENS	49.35	YES
X0089	V2121		LENTICULAR LENS, PER LENS, SINGLE	46.67	YES
X0089	V2199		NOT OTHERWISE CLASSIFIED, SINGLE VISION LENS	Manually Priced	YES
X0089	V2200		SPHERE, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D, PER LENS	33.05	YES
X0089	V2201		SPHERE, BIFOCAL, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D, PER LENS	35.60	YES
X0089	V2202		SPHERE, BIFOCAL, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D,PER LENS	39.00	YES
X0089	V2203		SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, .12 TO 2.00D CYLINDER, PER LENS	35.40	YES
X0089	V2204		SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS	36.45	YES

LOUISIANA MEDICAID EYE WEAR CODE CONVERSION CHART & FEE SCHEDULE
EFFECTIVE 03/01/2004

LOCAL CODE	HIPAA CODE	MOD REQ	DESCRIPTION	FEE	PA REQUIRED
X0089	V2205		SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS	37.50	YES
X0089	V2206		SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, OVER 6.00D CYLINDER, PER LENS	38.90	YES
X0089	V2207		SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, .12 TO 2.00D CYLINDER, PER LENS	37.35	YES
X0089	V2208		SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS	37.90	YES
X0089	V2209		SPHEROCYLINDER,BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 4.25 TO 6.00 CYLINDER, PER LENS	38.80	YES
X0089	V2210		SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, OVER 6.00 CYLINDER, PER LENS	40.80	YES
X0089	V2211		SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, .25 TO 2.25D CYLINDER, PER LENS	37.40	YES
X0089	V2212		SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 2.25 TO 4.00D CYLINDER, PER LENS	40.75	YES
X0089	V2213		SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS	41.90	YES
X0089	V2214		SPHEROCYLINDER, BIFOCAL, SPHERE OVER PLUS OR MINUS 12.00D, PER LENS	43.80	YES
X0089	V2215		LENTICULAR (MYODISC), PER LENS, BIFOCAL	47.60	YES
X0089	V2218		ANISEIKONIC, PER LENS, BIFOCAL	51.95	YES
X0089	V2219		BIFOCAL SEG WIDTH OVER 28MM - ADD-ON, PER LENS	20.00	YES
X0089	V2220		BIFOCAL ADD OVER 3.25D - ADD-ON, PER LENS	19.00	YES
X0089	V2221		LENTICULAR LENS, PER LENS, BIFOCAL	49.27	YES
X0089	V2299		SPECIALTY BIFOCAL (BY REPORT)	Manually Priced	YES
X0089	V2300		SPHERE, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D, PER LENS	$37.30	YES
X0089	V2301		SPHERE, TRIFOCAL, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D PER LENS	$40.40	YES
X0089	V2302		SPHERE, TRIFOCAL, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D, PER LENS	$42.00	YES

LOUISIANA MEDICAID EYE WEAR CODE CONVERSION CHART & FEE SCHEDULE
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LOCAL CODE	HIPAA CODE	MOD REQ	DESCRIPTION	FEE	PA REQUIRED
X0089	V2303		SPHEROCYLINDER, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, .12 TO 2.00D CYLINDER, PER LENS	$38.45	YES
X0089	V2304		SPHEROCYLINDER, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, 2.25 TO 4.00D CYLINDER, PER LENS	$39.35	YES
X0089	V2305		SPHEROCYLINDER, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS	$40.65	YES
X0089	V2306		SPHEROCYLINDER, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, OVER 6.00D CYLINDER, PER LENS	$41.75	YES
X0089	V2307		SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, .12 TO 2.00D CYLINDER, PER LENS	$40.05	YES
X0089	V2308		SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS	$40.95	YES
X0089	V2309		SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS	$42.50	YES
X0089	V2310		SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, OVER 6.00D CYLINDER, PER LENS	$44.75	YES
X0089	V2311		SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, .25 TO 2.25D CYLINDER, PER LENS	$42.70	YES
X0089	V2312		SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 2.25 TO 4.00D CYLINDER, PER LENS	$43.15	YES
X0089	V2313		SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS	$44.50	YES
X0089	V2314		SPHEROCYLINDER, TRIFOCAL, SPHERE OVER PLUS OR MINUS 12 .00D, PER LENS	$45.80	YES
X0089	V2315		LENTICULAR, (MYODISC), PER LENS, TRIFOCAL	$49.60	YES
X0089	V2318		ANISEIKONIC LENS, TRIFOCAL, PER LENS	$53.95	YES
X0089	V2319		TRIFOCAL SEG WIDTH OVER 28 MM - ADD-ON, PER LENS	$30.00	YES
X0089	V2320		TRIFOCAL ADD OVER 3.25D - ADD-ON, PER LENS	$29.00	YES
X0089	V2321		LENTICULAR LENS, PER LENS, TRIFOCAL	$51.27	YES
X0089	V2399		SPECIALTY TRIFOCAL (BY REPORT)	Manually Priced	YES
X0089	V2410		VARIABLE ASPHERICITY LENS, SINGLE VISION, FULL FIELD, GLASS OR PLASTIC, PER LENS	50.70	YES

LOUISIANA MEDICAID EYE WEAR CODE CONVERSION CHART & FEE SCHEDULE
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LOCAL CODE	HIPAA CODE	MOD REQ	DESCRIPTION	FEE	PA REQUIRED
X0089	V2430		VARIABLE ASPHERICITY LENS, BIFOCAL, FULL FIELD, GLASS OR PLASTIC, PER LENS	55.70	YES
X0089	V2499		VARIABLE ASPHERICITY LENS, OTHER TYPE	Manually Priced	YES
X0089	V2500		CONTACT LENS, PMMA, SPHERICAL, PER LENS	125.00	YES
X0089	V2501		CONTACT LENS, PMMA, TORIC OR PRISM BALLAST, PER LENS	150.00	YES
X0089	V2502		CONTACT LENS, PMMA, BIFOCAL, PER LENS	150.00	YES
X0089	V2503		CONTACT LENS, PMMA, COLOR VISION DEFICIENCY, PER LENS	150.00	YES
X0089	V2510		CONTACT LENS, GAS PERMEABLE, SPHERICAL, PER LENS	125.00	YES
X0089	V2511		CONTACT LENS, GAS PERMEABLE, TORIC, PRISM BALLAST, PER LENS	150.00	YES
X0089	V2512		CONTACT LENS, GAS PERMEABLE, BIFOCAL, PER LENS	150.00	YES
X0089	V2513		CONTACT LENS, GAS PERMEABLE, EXTENDED WEAR, PER LENS	150.00	YES
X0089	V2520		CONTACT LENS, HYDROPHILIC, SPHERICAL, PER LENS	125.00	YES
X0089	V2521		CONTACT LENS, HYDROPHILIC, TORIC, OR PRISM BALLAST, PER LENS	150.00	YES
X0089	V2522		CONTACT LENS, HYDROPHILLIC, BIFOCAL, PER LENS	150.00	YES
X0089	V2523		CONTACT LENS, HYDROPHILIC, EXTENDED WEAR, PER LENS	150.00	YES
X0089	V2530		CONTACT LENS, SCLERAL, GAS IMPERMEABLE, PER LENS	175.00	YES
X0089	V2531		CONTACT LENS, SCLERAL, GAS PERMEABLE, PER LENS	175.00	YES
X0089	V2599		CONTACT LENS, OTHER TYPE	Manually Priced	YES
X0089	V2710		SLAB OFF PRISM, GLASS OR PLASTIC. PER LENS - ADD-ON	35.00	YES
X0089	V2715		PRISM, PER LENS - ADD-ON	6.00	YES
X0089	V2730		SPECIAL BASE CURVE, GLASS OR PLASTIC, PER LENS - ADD-ON	12.00	YES
X0089	V2744		TINT, PHOTOCHROMATIC, PER LENS - ADD-ON	7.00	YES
X0089	V2745		ADDITION TO LENS, TINT, ANY COLOR, SOLID, GRADIENT OR EQUAL, EXCLUDES PHOTOCHROMATIC, ANY LENS MATERIAL, PER LENS	5.00	YES
X0089	V2760		SCRATCH RESISTANT COATING, PER LENS - ADD-ON	9.00	YES

LOUISIANA MEDICAID EYE WEAR CODE CONVERSION CHART & FEE SCHEDULE
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LOCAL CODE	HIPAA CODE	MOD REQ	DESCRIPTION	FEE	PA REQUIRED
X0089	V2781		PROGRESSIVE LENS, PER LENS - ADD-ON	70.00	YES
X0089	V2799		VISION SERVICE, MISCELLANEOUS	Manually Priced	YES

^ Code V2102 - Over 12.00D Sphere will be reimbursed at $36.00 per lens.
* Code V2102 - PA required only if over 12.00D Sphere

HOW DID WE DO?

In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a Unisys representative or leave it on your table. **Your opinion is important to us**.

Seminar Date:_____ Location of Seminar (City):_____

Provider Subspecialty (if applicable):_____

FACILITY	**Poor**				**Excellent**
The seminar location was satisfactory	1	2	3	4	5
Facility provided a comfortable learning environment	1	2	3	4	5
SEMINAR CONTENT	**Poor**				**Excellent**
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS	**Poor**				**Excellent**
The speakers were thorough and knowledgeable	1	2	3	4	5
Topics were well organized and presented	1	2	3	4	5
Unisys provided effective response to questions	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION: Vision Services					

What topic was most beneficial to you?_____

Please provide constructive comments and suggestions:_____

To order written materials provided by Unisys, please call Unisys Provider Relations Telephone Inquiry Unit at **(800) 473-2783 or (225) 924-5040.**