DENTAL PROVIDER TRAINING

Spring 2006

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

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 with the exception of dental prior authorization; 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 Spring 2006 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 of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as third party liability. Such information is presented only in the Basic Medicaid Information Training packet. This packet may be obtained by attending the Basic Medicaid Information workshop; by requesting a copy from Unisys Provider Relations; or by downloading it from the Louisiana MEDICAID website, www.lamedicaid.com.

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES.

TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.

(See listing of numbers on attachment)

MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator 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. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.**

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED.

TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955

(or TTY 1-877-544-9544)

MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive Mental Health Rehabilitation Services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by mental health prior authorization unit.

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

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; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically 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 covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES

Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. 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. The PCS service provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES

Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For

Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. ***EARLYSTEPS*** CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve 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.

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 in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544).
IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED,
CALL 1-888-758-2220 FOR ASSISTANCE.

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.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY

METROPOLITAN HUMAN SERVICES DISTRICT
1010 Common Street, 5th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660

CAPITAL AREA HUMAN SERVICES DISTRICT
4615 Government St. - Bin #16 - 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-800-768-8824

REGION III
690 E. First Street
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

REGION IV
214 Jefferson Street - Suite 301
Lafayette, LA 70501
Phone: (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

REGION V
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Phone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

REGION VI
429 Murray Street - Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
3018 Old Minden Road
Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

REGION VIII
122 St. John St. - Room 343
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
21454 Koop Drive - Suite 2H
Mandeville, LA 70471
Phone: (985) 871-8300
FAX: (985) 871-8303
Toll Free: 1-800-866-0806

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
3101 W. Napoleon Ave – S140
Metairie, LA 70001
Phone: (504) 838-5357
FAX: (504) 838-5400

TABLE OF CONTENTS

STANDARDS FOR PARTICIPATION

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

- Provider agreement and enrollment with the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH);

- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;

- Agreement to accept as payment in full the amounts established by the BHSF and refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.

- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services;

- **NOTE: Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, or the state Attorney General's Medicaid Fraud Control Unit.**

- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1978*, and, where applicable, *Title VII of the 1964 Civil Rights Act*.

Picking and Choosing Services

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

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

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

Providers continue to have the option of picking and choosing from which patients they will accept Medicaid. Providers are not required to accept every Medicaid patient requiring treatment.

Statutorily Mandated Revisions to All Provider Agreements

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

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

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

MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive. The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

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

Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify Provider Enrollment immediately that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.

Surveillance Utilization Review

The Department of Health and Hospitals' Office of Program Integrity, in partnership with Unisys, perform the Surveillance Utilization Review function of the Louisiana Medicaid program. This function is intended to combat fraud and abuse within Louisiana Medicaid and is accomplished by a combination of computer runs, along with medical staff that review providers on a post payment basis. Providers are profiled according to billing activity and are selected for review using computer-generated reports. The Program Integrity Unit of DHH also reviews telephone and written complaints sent from various sources throughout the state, including the fraud hotline.

☞ Program Integrity and SURS would also like to remind all providers that they are bound by the conditions of their provider agreement which includes but is not limited to those things set out in Medical Assistance Program Integrity Law (MAPIL) R.S. 46:437.1 through 440.3, The Surveillance and Utilization Review Systems Regulation (SURS Rule) Louisiana Register Vol. 29, No. 4, April 20, 2003, and all other applicable federal and state laws and regulations, as well as Departmental and Medicaid policies. Failure to adhere to these could result in administrative, civil and/or criminal actions.

Providers should anticipate an audit during their association with the Louisiana Medicaid program. When audited, providers are to cooperate with the representatives of DHH, which includes Unisys, in accordance with their participation agreement signed upon enrollment. Failure to cooperate could result in administrative sanctions. The sanctions include, but are not limited to:

- Withholding of Medicaid payments
- Referral to the Attorney General's Office for investigation
- Termination of Provider Agreement

Program Integrity and the Unisys Surveillance Utilization Review area remind providers **that a service undocumented is considered a service not rendered**. Providers should ensure their documentation is accurate and complete. All undocumented services are subject to recoupment. Other services subject to recoupment are:

- Upcoding level of care
- Maximizing payments for services rendered
- Billing components of lab tests, rather than the appropriate lab panel
- Billing for medically unnecessary services
- Billing for services not rendered
- Consultations performed by the patient's primary care, treating, or attending physicians

Fraud and Abuse Hotline

The state has a hotline for reporting possible fraud and abuse in the Medicaid Program. Providers are encouraged to give this phone number/web address to any individual or provider who wants to report possible cases of fraud or abuse.

Anyone can report concerns at (800) 488-2917 or by using the web address at http://www.dhh.state.la.us/offices/fraudform.asp?id=92

IDENTIFICATION OF ELIGIBLE RECIPIENTS

All recipients enrolled in Louisiana's Medicaid Program are issued **Plastic Identification Cards**. These permanent identification cards contain a card control number (CCN) which can be used by the provider to verify Medicaid eligibility. The Department of Health and Hospitals (DHH) now offers several options to assist providers with verification of current eligibility. Use of these options will require provider verification.The following eligibility verification options are available:

1. Medicaid Eligibility Verification System (MEVS), an automated eligibility verification system using a swipe card device or PC software through vendors.
2. Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system
3. e-MEVS, a web application accessed through www.lamedicaid.com
4. Pharmacy Point of Sale (POS).

These eligibility verification systems provide confirmation of the following:

- Recipient eligibility
- Third Party (Insurance) Resources
- Service limits and restrictions
- CommunityCARE
- Lock-In

Before accessing the REVS, MEVS, and e-MEVS eligibility verification systems, providers should be aware of the following:

- In order to verify recipient eligibility, inquiring providers must supply the system and Provider Relations with two (2) identifying pieces of information about the recipient.
- Specific dates of service must be requested. A date range in the date of service field on an inquiry transaction is not acceptable, and Provider Relations will not supply eligibility information for date ranges.

Recipient Eligibility Verification System (REVS)

The Recipient Eligibility Verification System (REVS) is a toll-free telephonic eligibility hotline that is used to verify Medicaid eligibility and is provided at no additional cost to enrolled providers. REVS can be accessed through touch-tone telephone equipment using the Unisys toll-free telephone number **(800) 776-6323** or the local Baton Rouge area number **(225) 216-REVS (7387)**.

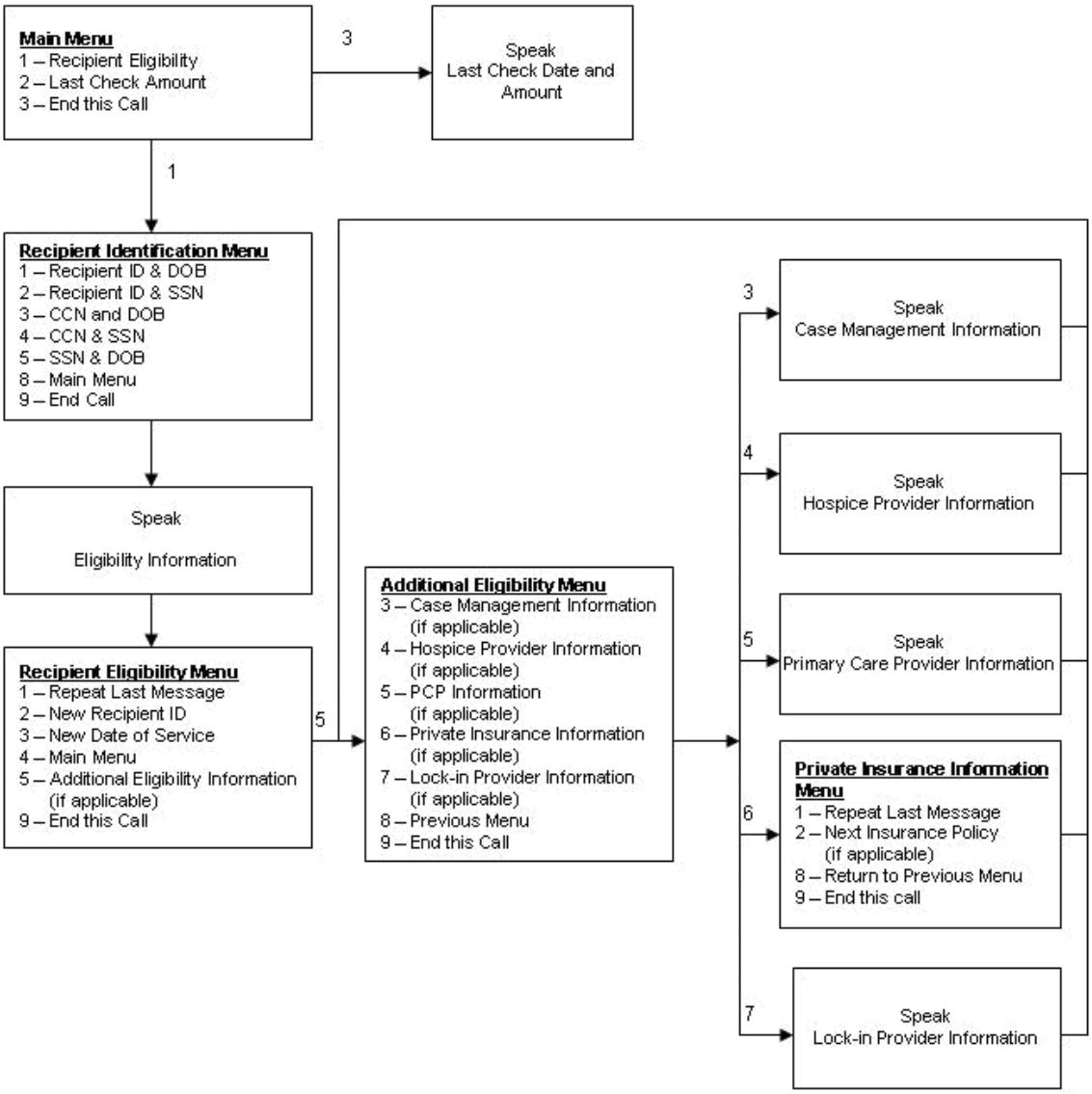
Accessing REVS

Providers may access recipient eligibility by using the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Medicaid ID number (valid during the last 12 months) and recipient birth date
- Medicaid ID number (valid during the last 12 months) and social security number
- Social Security number and recipient birth date

REVS MENU – (800) 776-6323

The 7-digit Louisiana Medicaid provider number must be entered to begin the eligibility verification process.



Medicaid Eligibility Verification System (MEVS)

The Medicaid Eligibility Verification System (MEVS) is an electronic system used to verify Medicaid eligibility. MEVS access is provided through contracts with approved "Switch Vendors" who are responsible for provision of the magnetic card reader, PC software, or computer terminal necessary to access this system. Providers are charged a fee for this service and this fee will depend on the type of service selected.

MEVS allows providers to retrieve printed verification by using one of the three following verification methods:

point of sale technology, using "swipe card devices" similar to retail credit cards
personal computer (PC) software tailored to fit the individual provider's specific needs; or
computer terminal

Providers should keep hardcopy proof of eligibility.

The following vendors are approved by DHH:

Vendor	Contact	Telephone	Website
Emdeon Business Services formerly WebMD Business Services	Inside Professional Sales	(877) 469-3263 Option 3	www.emdeon.com
Healthcare Data Exchange	Lee Ledbetter	(610) 448-4133	www.hdx.com
Passport Health Communications	Cathy Cameron	(601) 605-0338 (601) 201-4377	www.passporthealth.com
HealthNet Data Link	Lucy Joseph	(954) 331-6500 (800) 338-1079	www.ehdl.com
NEBO Systems, Inc.	NEBO Help Desk	(866) 810-0000	www.ecare.com

NOTE: Except for a short time needed each week for maintenance, MEVS is available 24 hours a day, 7 days a week to allow providers easy and immediate retrieval of current recipient eligibility information.

Accessing MEVS

Providers may access recipient eligibility by using the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Medicaid ID number (valid during the last 12 months) and recipient birth date
- Medicaid ID number (valid during the last 12 months) and social security number
- Social Security number and recipient birth date
- Recipient name and recipient birth date
- Recipient name and social security number

e-MEVS

Providers can now verify eligibility and service limits for a Medicaid recipient using a web application accessed through www.lamedicaid.com. This application was implemented to provide 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 eligibility and service limits data for that individual will be returned on a web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Providers should keep hardcopy proof of eligibility.

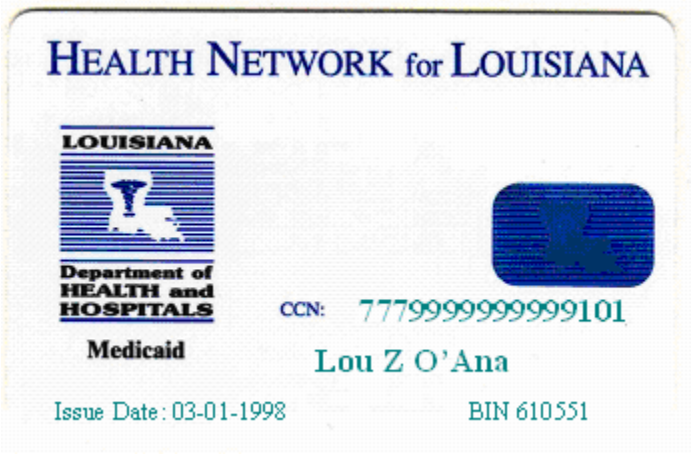
Accessing e-MEVS

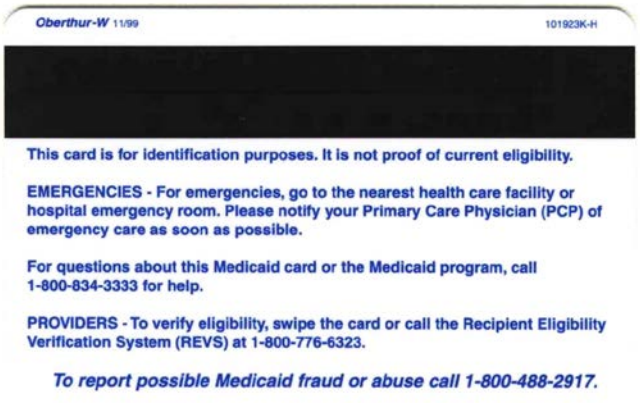
Providers may access recipient eligibility by using the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Social Security number and recipient birth date
- Recipient ID number (valid during the last 12 months) and recipient birth date
- Recipient ID number (valid during the last 12 months) and social security number
- Recipient name and social security number
- Recipient name and recipient birth date

Pharmacy Point of Sale (POS)

For pharmacy claims being submitted through the POS system, eligibility is automatically verified. Checking eligibility through REVS, MEVS, and e-MEVS is not necessary except in an instance of recipient retroactive eligibility.


HEALTH NETWORK for LOUISIANA
LOUISIANA
Department of HEALTH and HOSPITALS
Medicaid
CCN: 7779999999999101
Lou Z O'Ana
Issue Date: 03-01-1998
BIN 610551


Oberthur-W 11/99
101923K-H
This card is for identification purposes. It is not proof of current eligibility.
EMERGENCIES - For emergencies, go to the nearest health care facility or hospital emergency room. Please notify your Primary Care Physician (PCP) of emergency care as soon as possible.
For questions about this Medicaid card or the Medicaid program, call 1-800-834-3333 for help.
PROVIDERS - To verify eligibility, swipe the card or call the Recipient Eligibility Verification System (REVS) at 1-800-776-6323.
To report possible Medicaid fraud or abuse call 1-800-488-2917.

MEVS, REVS, and e-MEVS Reminders

It is important to remind you of areas that may potentially cause problem responses through MEVS, REVS and e-MEVS:

- You must listen to the menu and press the appropriate keys to obtain CommunityCARE or Lock-In information through REVS.

- When using a recipient's 13-digit Medicaid number, remember that all systems carry only recipient numbers which are valid for the last 12 months. If you are entering an old number (valid prior to the last 12 months), you will receive a response that indicates the recipient is not on file.

- An error message will be returned through the automated systems if the date is not a valid 8-digit date.

- Claims must be filed with the 13-digit Medicaid identification number.

- Providers cannot obtain KIDMED linkage through traditional forms of eligibility verification, such as REVS, MEVS, or e-MEVS. In order to obtain KIDMED linkage, providers must call Unisys or ACS. When requesting KIDMED linkage, providers must be specific as to whether they are requesting KIDMED or CommunityCARE linkage. In addition, when rendering a screening, the recipient must either be linked to the screening provider, or the screening provider must have a contractual agreement with the provider to whom the recipient is linked.

Eligibility Verification Responses

The eligibility verification systems for MEVS, REVS, and e-MEVS provide response messages that supply all information required to service the recipient. The following table is representative of the types of information received from these verification systems:

Recipient Eligibility	Response
Recipient is a CommunityCARE recipient	Message indicates that the recipient is CommunityCARE and includes the name of the recipient's PCP and the telephone number of the PCP to allow the inquiring provider to contact the PCP for a referral prior to providing services.
Recipient is eligible through a category of service that limits coverage of certain services or by certain providers	Information provided as part of eligibility response. For example: If the recipient is covered through the Medically Needy Program, which does not cover certain services, and the provider calling is a provider of a non-covered service, the response will include a message indicating that the recipient is Medically Needy and the services provided by the calling provider would not be covered.
Recipient is QMB eligible QMB Only QMB Plus Non QMB	In cases where the recipient is QMB Only, the REVS response will state: "This recipient is only eligible for Medicaid payment of deductible and co-insurance of services covered by Medicare. This recipient is not eligible for other types of Medicaid assistance." If the recipient is QMB Plus the REVS message will state "The recipient is eligible for both Medicare co-insurance and deductible and Medicaid services." Finally, if the recipient is a Non-QMB there will be no specific message, however REVS will indicate that the recipient has Medicare in the TPL segment of the response.
Recipient is presumptively eligible	Response will indicate: "This recipient may be eligible for outpatient ambulatory services only. Providers must call 1-800-834-3333 to verify current eligibility."
Recipient is a child	Message indicates that the recipient is EPSDT eligible, meaning the recipient is under 21 years of age and eligible for all services and service limits allowed for children.

All eligibility and service limitation information is related to the inquiring provider. However, it is the provider's responsibility to know and understand all policy limitations.

EXPANDED DENTAL SERVICES FOR PREGNANT WOMEN (EDSPW) PROGRAM POLICY AND POLICY REMINDERS

The following pages contain policy for the EDSPW Program. This information provides all EDSPW Program policy and includes policy revisions made since the implementation of the EDSPW Program. Several policy reminders are also included. This information has been previously published in other provider resources such as the Medicaid Remittance Advice(s) (RA), Provider Update(s), and/or the Medicaid provider website at www.lamedicaid.com (refer to page 96 of this document for further information regarding the website.) Procedure Codes marked with an asterisk (*) in the following policy revisions and in the attached EDSPW Program Fee Schedule indicate services that require prior authorization. Please take notice that in the future the dental services manual will be revised to reflect this information.

Program Information

Effective November 1, 2003, Medicaid implemented a new adult dental program for pregnant women, which is entitled the "Expanded Dental Services for Pregnant Women Program". This program provides coverage for certain designated dental services for Medicaid eligible pregnant women ages 21 through 59 years in order to address their periodontal needs during pregnancy. The services covered in this program are identified in the fee schedule which is located in Appendix C of this document.

It is the responsibility of the provider to verify recipient eligibility using the Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS) or Electronic Medicaid Eligibility Verification System (e-MEVS) which is available on the web at www.lamedicaid.com. The provider should keep hardcopy proof of eligibility from MEVS/e-MEVS.

Unisys provider relations staff can answer questions regarding claims processing. You may contact Unisys Provider Relations by calling (800) 473-2783 or (225) 924-5040. LSU Dental School, Dental Medicaid Unit can answer questions related to the Medicaid dental programs. You may contact the LSU Dental School, Dental Medicaid Unit by calling (225) 216-6470.

Eligibility Criteria

A Medicaid recipient is eligible for the Expanded Dental Services for Pregnant Women Program if she is 1) pregnant and has the original BHSF Form 9-M (Referral for Pregnancy Related Dental Services) which was completed and signed by the medical professional providing her pregnancy care; 2) Medicaid eligible; and 3) ages 21 through 59 years.

EDSPW Program services are available for recipients whose Medicaid coverage includes the full range of Medicaid benefits. Dental services are not covered for pregnant women certified in the following Medicaid categories:

Medically Needy - Pregnant women, who are certified for Medicaid in the "Medically Needy Program" (MNP), are **not** eligible for dental services. If the recipient is certified for Medicaid in the Medically Needy Program, the REVS/MEVS/e-MEVS message will specifically indicate that

she is not eligible for dental services or dentures. If you receive this message and the recipient appears to meet the other program criteria, you should refer the pregnant woman to her local parish Medicaid office for a re-determination of her Medicaid eligibility.

Qualified Medicare Beneficiary Only - Pregnant women, who are certified as "Qualified Medicare Beneficiary Only" (QMB Only), are **not** eligible for dental services. If the recipient is certified for Medicaid as a QMB Only recipient, the REVS/MEVS/e-MEVS message will indicate that she is only eligible for Medicaid payment of deductibles and co-insurance for services covered by Medicare.

Eligibility Period

The recipient must be pregnant on each date of service in order to be eligible for services covered in this program. **Eligibility for the Expanded Dental Services for Pregnant Women Program ends at the conclusion of the pregnancy.**

Referral Requirement – BHSF Form 9-M (Mandatory)

The BHSF Form 9-M is the referral form that is used to verify pregnancy for the Expanded Dental Services for Pregnant Women (EDSPW) Program. This referral form also provides additional important information.

The recipient is required to obtain the original completed BHSF Form 9-M from the medical professional providing her pregnancy care and give it to the dentist prior to receiving dental services. Prior to rendering any services, the dental provider must have the original BHSF Form 9-M with the signature of the medical professional providing the pregnancy care. Facsimile copies are not acceptable. The original form must be kept in the recipient's dental record. A copy of this form must be submitted to the Dental Medicaid Unit when requesting prior authorization for any of the EDSPW Program services that require prior authorization.

The BHSF Form 9-M was revised with an issue date of 12/03. Effective April 1, 2004, the BHSF Form 9-M with the issue date of 12/03 became the only version excepted by Medicaid. A copy of the revised BHSF Form 9-M (Referral for Pregnancy Related Dental Services) with an issue date of 12/03 can be found in Appendix D. Blank forms may be photocopied for distribution as needed. Additional copies of this form may also be obtained from the LA Medicaid website (http://www.lamedicaid.com) or from Unisys Provider Relations by calling (800) 473-2783 or (225) 924-5040.

Prior Authorization

Services that require prior authorization are identified with an asterisk (*) in the EDSPW Program fee schedule located in Appendix C of this document. Medicaid requires the use of the American Dental Association (ADA) Claim Form for all dental prior authorization requests. The 2002 American Dental Association Claim Form and the 2002, 2004 American Dental Association Claim Form are the only hardcopy dental claim forms accepted for Medicaid prior authorization of services covered in the Medicaid EDSPW Program regardless of the date of

service. Dental prior authorization requests received by LSU Dental School, Dental Medicaid Unit on the older versions of the ADA Claim Form will be returned to the provider.

When requesting prior authorization, two identical copies of the ADA form must be submitted with the appropriate mounted bitewing or periapical radiographs that support the clinical findings and justify the treatment requested.

Radiographs, unless contraindicated, should be attached to each request for authorization. If radiographs are contraindicated, the reason must be stated in the "Remarks" section of the claim forms and documented in the treatment record as well. Prior authorization requests that do not have adequate information or radiographs necessary to make the authorization determination will be returned.

When requesting prior authorization, the provider should list all services that are anticipated, even those not requiring authorization, so that the general dental health and condition of the recipient can be fully understood. Explanations or reasons for treatment, if not obvious from the radiographs, should also be entered in the "Remarks" section of the claim form. If the information required in the remarks section of the claim exceeds the space available, the provider should include a cover sheet which must include the date of the request, the recipient's name, the recipient's Medicaid ID#, the provider's name and the provider's Medicaid ID# and should outline the information required to document the requested service(s).

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the patient record and provide that information to the Dental Medicaid Unit. Additionally, it is the provider's responsibility to utilize the appropriate procedure code in a request for prior authorization.

Please remember to group services requiring authorization on a single claim form so that only one Prior Authorization Number is required to be issued per recipient. However, if a recipient requires services in two separate programs (e.g. Expanded Dental Services for Pregnant Women Program and the Adult Denture Program), a separate prior authorization request should be submitted for **each** program. If two separate requests are being submitted for a single individual, please note this in the "remarks" section of the dental claim form so that the dental consultants can review the entire treatment plan.

A copy of the BHSF Form 9-M **must** accompany each individual prior authorization request when requesting services covered under the Expanded Dental Services for Pregnant Women Program.

To ensure proper handling of the requests for prior authorization for services covered in the EDSPW Program, DHH asks that the BHSF Form 9-M be placed on <u>top</u> of the ADA claim form and other documents (i.e., radiographs) for each prior authorization request that is sent to the LSU Dental School, Dental Medicaid Unit.

All **<u>dental prior authorization requests</u>** should be sent to the following:

LSU Dental School
Dental Medicaid Unit
P.O. Box 80159
Baton Rouge, LA 70898-0159

If you have questions regarding dental prior authorization, you may contact the **LSU Dental School, Dental Medicaid Unit** by calling **225-216-6470**.

Once prior authorization has been approved for a service, a copy of the claim form and the radiographs will be returned to the provider and the other copy will be retained by the Dental Medicaid Unit. A prior authorization letter will be sent to the provider and to the recipient detailing those services that have been prior authorized. The letter will also include a 9-digit prior authorization number used when the provider submits a claim for payment of those prior authorized services.

Failure to receive the returned claim form and radiographs and/or a Prior Authorization Letter within 25 days from the date of submission should alert the provider that the documents might have been misdirected. In these instances, please contact the dental consultants at the Dental Medicaid Unit. If the claim form is returned, but the radiographs that were included with the claim are not returned, the provider must immediately contact the dental consultants at the Dental Medicaid Unit. Please document the contacts with the dental consultants in the patient's record. In general, EDSPW Program prior authorization decisions are rendered within two weeks from the date of receipt by the Dental Medicaid Unit.

To amend or request reconsideration of a prior authorization, the provider should submit a copy of the Prior Authorization Letter and copies of the original claim form and supporting documentation with a statement of what is requested. The services indicated on a single Prior Authorization Letter should match the services originally requested on a single page of the claim submitted for prior authorization. Requests for additional treatment must be submitted as a new claim for which a new prior authorization will be issued. For administrative changes only, e.g. provider number or recipient number corrections, date of service changes, etc., a copy of the Prior Authorization Letter with the requested changes noted may be sufficient.

- ☞ If the provider proceeds with treatment before receiving prior authorization, the provider should consider that the request may not be authorized for services rendered. However, providers may render and bill for services that do not require prior authorization while they are awaiting prior authorization of those services that do.

- ☞ Prior authorization of a requested service does not constitute approval of the fee indicated by the provider nor is it a guarantee of recipient Medicaid eligibility. When a recipient loses Medicaid eligibility, any authorization (approval) for services becomes void.

Notes: If a service is prior authorized and the pregnancy ends prior to receiving the service, the recipient is no longer eligible for the service.

It is the dental provider's responsibility to obtain a dental prior authorization on behalf of the patient. If a dental provider has not received a dental prior authorization decision (or other correspondence from the Dental Medicaid Unit) within 25 days from the date of submission, it is the provider's responsibility to contact the Dental Medicaid Unit at 225-216-6470. The provider should NEVER instruct the patient to contact Medicaid regarding the prior authorization request.

Refer to page 48 of this document for a prior authorization check list. This information is being provided as a tool to assist providers in avoiding common errors when requesting dental prior authorization.

Program Guidelines

Providers enrolled as a group or individual providers who are not linked to a group but are located in the same office as another provider are responsible for checking office records to assure that Medicaid established guidelines, limitations and/or policies are not exceeded.

Providers are not allowed to provide services to a Medicaid recipient beyond the intent of Medicaid guidelines, limitations and/or policies for the purpose of maximizing payments or circumventing Medicaid guidelines, limitations and/or policies. If this practice is detected, Medicaid will apply sanctions.

A Medicaid dental provider cannot limit his practice to diagnostic and preventive services only. A dental provider who only offers diagnostic and preventive services in his practice does not meet the necessary criteria for participation in the Medicaid EPSDT Dental, Adult Denture or Expanded Dental Services for Pregnant Women (EDSPW) Programs. Medicaid covered dental services requiring treatment by a specialist may be referred to another provider who can address the specific treatment; however, the recipient or guardian, as appropriate, must be advised of the referral. The reimbursement made for the examination, prophylaxis, bitewing radiographs and/or fluoride to providers who routinely refer recipients for restorative, surgical and other treatment services is subject to recoupment.

General Coding Information

A complete list of Medicaid covered services and procedure codes for the Expanded Dental Services for Pregnant Women Program can be found in the fee schedule in Appendix C of this document. These codes conform to the American Dental Association (ADA) Code on Dental Procedures and Nomenclature. Fees for all procedures include local anesthesia and routine postoperative care. Providers cannot provide a service that has a defined CDT procedure code and bill a different service that has a defined CDT procedure code in order to receive reimbursement by Medicaid.

Tooth Numbering System and Oral Cavity Designators

Please refer to sections 16.2.4 of the 2003 Dental Services Manual for information regarding the tooth numbering system and oral cavity designator. Services requiring specific tooth numbers/letters and/or oral cavity designators are identified in the fee schedule.

Claims Filing

The 2002 American Dental Association Claim Form and the 2002, 2004 American Dental Association Claim Form are the only hardcopy dental claim forms accepted for the billing of services covered in the Medicaid EDSPW Program regardless of the date of service. Dental claims for payment received by Unisys on the older versions of the ADA Claim Form will be returned to the provider. Completed **claims for payment** should be mailed to:

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

Please refer to the ADA Claim Form Information and Instructions beginning on page 50 of this document and Chapter 7 (E) of the Dental Services Manual for other information related to claims filing.

Covered Services

The program is designed to address the periodontal needs of the recipients. Covered services are divided into five categories: Diagnostic Services; Preventive Services; Restorative Services; Periodontal Services; and Oral and Maxillofacial Surgery Services. **Services requiring prior authorization are identified by an asterisk (*). Dental services should not be separated or performed on different dates of service solely to enhance reimbursement.** The guidelines and policies related to each service should be reviewed carefully prior to rendering the service.

For Medicaid purposes, local anesthesia, when applicable, is considered part of any procedure covered by Medicaid.

Dental Visit (Initial)

The initial dental visit must include the following diagnostic and preventive services:

1. Comprehensive Periodontal Examination; and

2. Bitewing radiographs (unless contraindicated); and

3. Prophylaxis, including oral hygiene instructions (unless a Full Mouth Debridement [D4355] is required)

These services are limited to one each per pregnancy.

Providers must ask new patients when they last received a Medicaid covered comprehensive periodontal examination, bitewing radiographs, and/or prophylaxis and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that these services have not been rendered during the current pregnancy.

If it is determined that the recipient has already received a comprehensive periodontal examination, bitewing radiographs and/or prophylaxis during the current pregnancy, the recipient is ineligible for these services. If the recipient seeks additional eligible services from a second dental provider, the second dental provider should request a copy of the patient's treatment record and/or radiographs from the previous provider.

Diagnostic Services

Diagnostic services include a comprehensive periodontal examination and radiographs.

D0180 Comprehensive Periodontal Examination - New or Established Patient
D0220 Intraoral – periapical first film
D0230 Intraoral – periapical each additional film (maximum of 4)
D0240* Intraoral – occlusal film
D0272 Bitewings – two films
D0330* Panoramic Film

Examination

D0180 Comprehensive Periodontal Examination - New or Established Patient

A comprehensive periodontal examination is limited to one per pregnancy.

This procedure code is indicated for patients showing signs or symptoms of periodontal disease. It includes, but is not limited to, evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history, and general health assessment. It also includes the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, and oral cancer screening.

This visit should also include preparation and/or updating of the patient's records, development of a current treatment plan, and the completion of reporting forms.

After the comprehensive examination, subsequent visits should be scheduled by the dentist to correct the dental defects that were identified.

Radiographs (X-Rays)

D0220 Intraoral – periapical first film
D0230 Intraoral – periapical each additional film (maximum of 4)
D0240* Intraoral – occlusal film
D0272 Bitewings – two films
D0330* Panoramic Film

A lead apron and thyroid shield must be used when taking any radiographs reimbursed by the Medicaid program. When taking radiographs, the use of a lead apron and thyroid shield is a generally accepted standard of care practice and is part of normal, routine, radiographic hygiene.

Radiographs taken must be of **good diagnostic quality** and, when submitted for prior authorization or post payment review, must be properly mounted. Radiographic mounts and panographic-type radiographs must indicate the date taken, the name of the recipient, and the provider. Radiographic copies must also indicate the above as well as be marked to indicate the left and right sides of the recipient's mouth. Radiographs that are not of good diagnostic quality will be rejected.

Scanned radiographic images should be of an adequate resolution to be diagnostically acceptable and must indicate right and left side. Scanned images that are not diagnostic will be returned for new images.

According to the accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis should be taken.

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the dental treatment record and in the remarks section on any claims submitted for authorization:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the oral condition's effect on the periodontal health

Any prior authorization requests, which are not accompanied by the appropriate radiographs, must be accompanied by a copy of the recipient's treatment record as created on the Comprehensive Periodontal Examination appointment. The recipient's name and Medicaid number must be indicated on the copy of the treatment records submitted for review.

If the treatment records do not adequately describe the conditions requiring treatment, the services requiring prior authorization will be denied.

Any periapical radiographs, occlusal radiographs or panoramic radiographs taken routinely at the time of a dental examination appointment for screening purposes are not covered. If a routine practice of taking such radiographs, without adequate diagnostic justification, is discovered during post payment review, all treatment records may be reviewed and recoupment of money paid for all radiographs will be initiated.

D0220 Intraoral – periapical first film
D0230 Intraoral – periapical each additional film

Payment for periapical radiographs taken in addition to bitewings is limited to a total of five and is payable when their purpose is to obtain information in regard to a specific pathological condition other than caries (e.g. periapical pathology or extensive periodontal conditions).

Periapical radiographs, unless contraindicated, must be taken prior to any tooth extraction.

For reimbursement by the Medicaid program, the radiographs must be associated with a specific unextracted Tooth Number 1 through 32 or Tooth A through T. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

D0240* Intraoral – occlusal film

A #2 size film taken in an occlusal orientation will be considered an anterior periapical radiograph for payment. The fee for an occlusal radiograph will be paid only when a true occlusal film (2" x 3") is used to evaluate the maxillary or mandibular arch. The actual occlusal radiograph must be sent with the prior authorization request for an occlusal film.

This radiograph is reimbursable for Oral Cavity designators 01 and 02. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D0272 Bitewings – two films

Bitewing radiographs are required (unless contraindicated) at the comprehensive periodontal examination and are limited to one set per pregnancy. In cases where the provider considers radiographs to be medically contraindicated, a narrative describing the contraindication must be documented in the recipient's record.

D0330* Panoramic film

Panoramic radiographs are not indicated and will be considered insufficient for diagnosis in periodontics and restorative dentistry and will not be reimbursed. Panoramic radiographs are only reimbursable in conjunction with oral and maxillofacial surgery services. The dental consultants may request the actual panoramic radiograph before a prior authorization request can be completed.

Preventive Services

Adult Prophylaxis

D1110 Adult Prophylaxis

This procedure includes removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. Qualified dental personnel must perform any prophylaxis. This service is limited to one per pregnancy.

If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid, then procedure code D4355 (Full Mouth Debridement) will not be subsequently reimbursed during this pregnancy.

Restorative Services

Restorative services include: amalgam restorations, resin-based composite restorations, stainless steel crowns and resin crowns. Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there are circumstances that would not allow restorative treatment in this manner, the contraindication(s) must be documented in the patient's dental record. All restorative services require prior authorization.

D2140* Amalgam – one surface, primary or permanent
D2150* Amalgam – two surfaces, primary or permanent
D2160* Amalgam – three surfaces, primary or permanent
D2161* Amalgam – four or more surfaces, permanent
D2330* Resin-based composite, one surface, anterior
D2331* Resin-based composite, two surfaces, anterior
D2332* Resin-based composite, three surfaces, anterior

D2335* **Resin-based composite – four or more surfaces or involving incisal angle (anterior)**
D2390* **Resin-based composite crown, anterior**
D2931* **Prefabricated stainless steel crown – permanent tooth**
D2932* **Prefabricated resin crown, primary or permanent**
D2951* **Pin retention, per tooth, in addition to restoration**

Since this program is designed to address the periodontal needs during pregnancy, the location of the caries to be restored must be in an area that would impact the gingival integrity and affect the periodontal health of the woman. Radiograph(s), unless contraindicated, that support the need for the restoration to maintain the gingival integrity (e.g. significant subgingival decay, etc.) must be taken and submitted with the request for prior authorization. Restoration of dental caries not penetrating the dentin will be denied.

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the dental treatment record and in the remarks section on any claims submitted for authorization:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the oral condition's effect on the periodontal health

Any prior authorization requests, which are not accompanied by the appropriate radiographs, must be accompanied by a copy of the recipient's treatment record as created on the Comprehensive Periodontal Examination appointment. The recipient's name and Medicaid number must be indicated on the copy of the treatment records submitted for review.

If the treatment records do not adequately describe the conditions requiring treatment; the services requiring prior authorization will be denied.

Local anesthesia is considered to be part of restorative services. Tooth and soft tissue preparation, all adhesives (including amalgam bonding agents), liners and bases, are included as part of amalgam restorations. Tooth and soft tissue preparation, all adhesives (including resin bonding agents), liners and bases and curing are included as part of resin-based composite restorations. Pins should be reported separately.

The original billing provider is responsible for the replacement of the original restoration within the first twelve months after initial placement.

Laboratory processed crowns are not covered.

Amalgam Restorations (including polishing)

D2140* **Amalgam – one surface, primary or permanent**
D2150* **Amalgam – two surfaces, primary or permanent**
D2160* **Amalgam – three surfaces, primary or permanent**
D2161* **Amalgam – four or more surfaces, permanent**

Procedure codes D2140, D2150, D2160, and D2161 represent final restorations.

Procedure code D2140 is payable only for Class V type restorations on the buccal or lingual surface in direct contact with the periodontally affected gingival tissue. **Occlusal surfaces and buccal, lingual, and occlusal pits are specifically excluded from reimbursement for code D2140.**

Procedure codes D2150, D2160, and D2161 are payable only for restorations in which at least one of the involved surfaces is in direct contact with the periodontally affected gingival tissue.

In addition to the requirement of gingival contact, amalgam restorations must be placed in a preparation in which the entire preparation extends through the enamel and into dentin, and follows established dental protocol that the preparation and restoration include all grooves and fissures on the billed surface(s). If the restoration is a mesial occlusal or distal occlusal restoration, the preparation must extend down the mesial or distal surface far enough for the restoration to contact the periodontally affected gingival tissue.

Duplicate surfaces are not payable on the same tooth in amalgam restorations in a 12-month period.

If two or more restorations are placed on the same tooth, a maximum amalgam fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.

The fee for any additional restorative service(s) on the same tooth will be cutback to the maximum fee for the combined number of non-duplicated surfaces when performed within a 12-month period.

Procedure codes D2140, D2150 and D2160 are reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through C, H through M, and R through T.

Procedure code D2161 is reimbursable for Tooth Numbers 1 through 32 only. Code D2161 is not payable for primary teeth.

The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

Resin-Based Composite Restorations

D2330* Resin-based composite, one surface, anterior
D2331* Resin-based composite, two surfaces, anterior
D2332* Resin-based composite, three surfaces, anterior
D2335* Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390* Resin-based composite crown, anterior

Posterior composite restorations are not reimbursable under the guidelines of Louisiana Medicaid.

Procedure code D2330 is payable only for Class V type restorations on the buccal or lingual surface in direct contact with the periodontally affected gingival tissue. **Occlusal surfaces and buccal, lingual, and occlusal pits are specifically excluded from reimbursement for code D2330.**

Procedure codes D2331, D2332, D2335, and D2390 are payable only for restorations in which at least one of the involved surfaces is in direct contact with the periodontally affected gingival tissue.

In addition to the requirement of gingival contact, resin-based composite restorations must be placed in a preparation in which the entire preparation extends through the enamel and into dentin, and follows established dental protocol that the preparation and restoration include all grooves and fissures on the billed surface(s).

Procedure codes D2330, D2331, D2332, D2335, and D2390 represent final restorations. If two restorations are placed on the same tooth, a maximum fee for resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum fee for the combined number of surfaces when performed within a 12-month period.

Procedure D2335 is reimbursable only once per day, same tooth, any billing provider.

To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto the claimed surface. A Class V resin-based composite restoration is a one surface restoration.

The resin-based composite – four or more surfaces or involving incisal angle (D2335) is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four surfaces of an anterior tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least 1/3 of the clinical crown of the tooth.

The resin-based composite crown, anterior (D2390) is a single anterior restoration that involves full resin-based composite coverage of a tooth. Providers may request this procedure in cases where two D2332 restorations would not adequately restore the tooth or in cases where two D2335 would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment.

Crown services require radiographs (unless contraindicated) or other documentation which depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by the Bureau or its designee upon request.

Procedure codes D2330, D2331, D2332, D2335, and D2390 are reimbursable for Tooth Numbers 6 through 11, 22 through 27 and Tooth Letters C, H, M and R. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

Non-Laboratory Crowns

D2931* Prefabricated Stainless Steel Crown – permanent tooth
D2932* Prefabricated Resin Crown – primary or permanent tooth

Procedure codes D2931 and D2932 represent final restorations. These restorations must be in direct contact with the periodontally affected gingival tissue. Non-laboratory or chair-side full coverage restorations such as stainless steel and polycarbonate crowns are available but should only be considered when other conventional chair-side types of restorations such as complex amalgams and composite resins are unsuitable.

Crown services require radiographs (unless contraindicated).

Indications such as extensive caries, extensive cervical caries, fractured teeth, replacing a missing cusp, etc. must be radiographically evident and/or documented in the recipient's treatment records if radiographs are medically contraindicated. The documentation that supports the need for crown services must be available for review by the Bureau or its designee upon request.

D2931* Prefabricated Stainless Steel Crown – permanent tooth

This procedure is reimbursable for Tooth Numbers 1 through 32. The appropriate tooth number must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D2932* Prefabricated Resin Crown – primary or permanent tooth

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M and R. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

Other Restorative Services

D2951* Pin retention - per tooth, in addition to restoration

Reimbursement for pins is limited to one per tooth, per lifetime and may only be billed in conjunction with the complex restoration codes D2160 or D2161.

This procedure is reimbursable for Tooth Numbers 2 through 5; 12 through 15; 18 through 21; and 28 through 31. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

Periodontal Services

Periodontal services include periodontal scaling and root planing and full mouth debridement. Local anesthesia is considered to be part of periodontal procedures.

Prior authorization is required for all periodontal services.

D4341* Periodontal scaling and root planing – four or more teeth per quadrant
D4355* Full mouth debridement

Unless contraindicated, radiograph(s) that support the need for the periodontal services must be taken and submitted with the request for prior authorization.

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the dental treatment record and in the remarks section on any claims submitted for authorization:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the oral condition's effect on the periodontal health

Any prior authorization requests, which are not accompanied by the appropriate radiographs, must be accompanied by a copy of the recipient's treatment record as created on the Comprehensive Periodontal Examination appointment. The recipient's name and Medicaid number must be indicated on the copy of the treatment records submitted for review.

If the treatment records do not adequately describe the conditions requiring treatment, the services requiring prior authorization will be denied.

D4341* Periodontal scaling and root planing – <u>four or more teeth per quadrant</u>

Radiographic evidence of large amounts of subgingival calculus, deep pocket formation, and bone loss must be submitted. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces as well as the removal of rough, calculus-contaminated cementum and dentin. It is therapeutic not prophylactic in nature, usually requiring local anesthesia.

This procedure requires prior authorization. Radiographic evidence of bone loss indicating a true periodontal disease state must be supplied with bitewings and/or posterior/anterior periapicals. This service is not approved for recipients who have not progressed beyond the mixed dentition stage of development.

Only two units of periodontal scaling and root planing may be reimbursed per day.

This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4355* Full Mouth Debridement

This procedure involves the gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

<u>This service must be performed at the initial visit if the service is indicated.</u>

No other dental services except an examination and/or radiographs are reimbursable on the same date of service as full mouth debridement. When an exam is performed on the same date of service as a full mouth debridement, the exam must be performed after completion of the full mouth debridement.

Only one Full Mouth Debridement is allowed per pregnancy. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) to the same billing provider or another Medicaid provider in the same office as the billing provider during this pregnancy.

This procedure requires prior or post authorization. When requesting prior or post authorization, bitewing radiographs (unless contraindicated) that supply evidence of significant posterior supra and/or subgingival calculus in at least two quadrants must be submitted. In cases where radiographs are contraindicated or in which the radiographs do not visually satisfy the two quadrant minimum, the provider must include in the request for authorization a copy of the written patient record that provides narrative documentation that describes and supports the necessity for this procedure. Although not reimbursable in the EDSPW Program, intraoral photographs that clearly depict the extent of debris and need for D4355 can be submitted.

Prior to requesting authorization for a D4355 (Full Mouth Debridement), providers must ask their new patients if they have received a Medicaid covered prophylaxis (D1110) during this pregnancy and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that a D1110 has not been reimbursed by Medicaid for this recipient during this pregnancy. If it is determined that a D1110 has been reimbursed by Medicaid for this recipient during this pregnancy, the recipient is not eligible for a D4355.

If the prior or post authorization request for D4355 is denied and it has been determined that Medicaid has not reimbursed a D1110 (Adult Prophylaxis) for the recipient during this pregnancy, the provider may render and bill Medicaid for a D1110 (Adult Prophy).

Oral and Maxillofacial Surgery Services

Note: Dental providers who are qualified to bill for services using the Current Physician's Terminology (CPT) codes, may bill for certain medical oral surgery services using the CPT codes which are covered under the Physician's Program when those services are rendered to Medicaid recipients who are eligible for services provided in the Physician's Program. Refer to the Oral and Maxillofacial Surgery Program section of the 1995 Dental Services Manual for specific details.

The prophylactic removal of an asymptomatic impacted tooth is not covered.

Due to the potential risk of complications involved in the surgical removal of teeth, including the extraction of impacted teeth, minimal standards of care require that these procedures not be attempted without radiographic evaluation.

Requests for prior authorization for surgical extractions, including the extraction of impacted teeth, will not be considered without radiographs. The radiographic findings determine the necessity of surgical extraction and the degree of impaction and correspond to the CDT

definitions of impactions. The prior authorization letter will list the tooth numbers and will correspond to the CDT definitions. Therefore, it is suggested that prior authorization be used to resolve differences in interpretation prior to the day of surgery.

Procedure codes D7240 and D7241 are not reimbursable in this program.

Extractions

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210* Surgical removal of erupted tooth
D7220* Removal of impacted tooth – soft tissue
D7230* Removal of impacted tooth - partial bony

These codes include local anesthesia, suturing (if needed), and routine post-operative care.

Procedure codes D7140, D7210, D7220, and D7230 are reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T. ADA tooth numbering codes for Supernumerary Teeth 51 through 82 or AS through TS should be used when needed. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

Non-surgical Extractions

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

This procedure includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.

Radiograph(s), unless contraindicated, must be taken prior to this procedure (D7140).

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the recipient's treatment record:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the effect of the oral condition on the periodontal health

Surgical Extractions

D7210* Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

This procedure includes the cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone, and closure.

This procedure requires prior authorization. <u>All requests for prior authorization of the surgical removal of erupted tooth require the submission of radiographs.</u>

For pre-surgical prior authorization, the radiographic evidence must clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure.

If the radiographic evidence does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, the prior authorization request will be denied. After the tooth is removed, the provider may bill Medicaid for a D7140 or resubmit the prior authorization request for reconsideration (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications and the radiographs.

In the event a planned simple extraction becomes a surgical procedure, the provider may submit a "post" authorization request (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications along with the radiographs which will be used by the dental consultants in the authorization determination.

D7220* Removal of impacted tooth - soft tissue

The occlusal surface of the tooth is covered by soft tissue and removal of the tooth requires mucoperiosteal flap elevation.

All requests for prior authorization of the removal of impacted tooth - soft tissue (D7220) require the submission of radiographs.

D7230* Removal of impacted tooth – partial bony

Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

All requests for prior authorization of the removal of impacted tooth – partial bony (D7230) require the submission of radiographs.

Non-Covered Services

Non-covered services include but are not limited to the following:

- Procedure codes not included in the fee schedule located in Appendix C of this document
- Routine post-operative services (these services are covered as part of the fee for the initial treatment provided)
- Treatment of incipient or non-carious lesions
- Routine panoramic radiographs, occlusal radiographs, upper and lower anterior, or posterior periapical radiographs (when utilized as part of an initial examination or screening without a specific diagnostic reason why the radiograph(s) is necessary)
- General anesthesia
- Administration of in-office pre-medication

EDSPW Program Reminders

- The date of service on a dental claim must reflect the actual date that the service was completed/delivered. Dental claims shall not be filed prior to the completion/delivery of the service. At a minimum, Medicaid will recover the payment for all claims billed when the date of service on the claim does not reflect the date the service was completed.

- Providers must ask their new patients when they last received a Medicaid covered periodontal examination, prophylaxis, and bitewing radiographs, and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that the specified patient has not received these services during the current pregnancy. If it is determined that these services have been rendered during the current pregnancy, the patient is not eligible for the services.

EPSDT DENTAL PROGRAM POLICY REVISIONS AND POLICY AND GENERAL PROGRAM REMINDERS

This section of the dental provider training packet does not replace the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program section of the 2003 Dental Services Manual. The following pages contain specific policy revisions, policy reminders, and general program reminders made since the printing of the 2003 Dental Services Manual. With exception to the specific revisions identified below, existing EPSDT Dental Program policy still applies. The following information should be utilized when providing these services to EPSDT recipients as it is current policy. This information has been previously published in other provider resources such as the Medicaid Remittance Advice(s) (RA), Provider Update(s), and/or the Medicaid provider website at www.lamedicaid.com (refer to page 96 of this document for further information regarding the website). Procedure codes marked with an asterisk (*) in the following policy revisions and in the attached EPSDT Fee Schedule indicate services that require prior authorization. Procedure codes marked with an underscored asterisk (*) in the following policy revisions and in the attached EPSDT Fee Schedule indicate services that require partial prior authorization. Prior authorization requirements for these procedures are based on tooth number or age of recipient. Please take notice that in the future the dental services manual will be revised to reflect this information.

Policy Revisions

For Medicaid purposes, local anesthesia, when applicable, is considered part of any procedure covered by Medicaid.

Diagnostic Services

D0150 Comprehensive Oral Evaluation (New Patient)

Medicaid recognizes this code for a new patient only. A new patient is described as a patient that has not been seen by this provider for at least three years. This procedure code is to be used by a general dentist and/or specialist when evaluating a patient comprehensively for the first time. This would include the examination and recording of the patient's dental and medical history and a general health assessment. The dental visit that includes the Comprehensive Oral Examination should include (but is not limited to) examination of the oral cavity and all of its structures, using a mirror and explorer, and periodontal probe (if required) and necessary diagnostic or vitality tests (considered part of the examination).

After the comprehensive oral examination, subsequent visits should be scheduled by the dentist to correct the dental defects that were identified. If no subsequent visit is required, the bitewing radiographs, prophylaxis, and fluoride must be provided at the time of the initial comprehensive or periodic oral examination. If subsequent treatment is required, these services must be provided at the first treatment visit if they were not provided at the initial comprehensive or periodic oral examination.

The dental provider should maintain a recall of the patient for future examinations and treatment, (if required).

This procedure should not be billed to Medicaid unless it has been at least three years since the patient was seen by the specified provider or another provider in the same office. An initial comprehensive oral examination (D0150) is limited to once per three years when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider.

D0220 Intraoral – Periapical Radiograph, First Film
D0230 Intraoral – Periapical Radiographs, Each Additional Film

Payment for periapical radiographs (D0220 and D0230) taken in addition to bitewings is limited to a total of five and is payable when their purpose is to obtain information in regard to a specific pathological condition other than caries (ex. periapical pathology or serious doubt regarding the presence of the permanent dentition).

Under the following circumstances periapical radiographs must be taken, or written documentation as to why the radiograph(s) was (were) contraindicated must be in the patient's record:

- An anterior crown or crown buildup is anticipated; or
- Posterior root canal therapy is anticipated (root canal working and final fill films are included in the fees for endodontic treatment); or
- Anterior **initial** or **retreatment** root canal therapy is anticipated (both maxillary and mandibular anterior films) (root canal working and final fill films are included in the fees for endodontic treatment); or
- Prior to any tooth extraction.

These radiographs are reimbursable for and must be associated with a specific unextracted Tooth Number 1 through 32 or Letter A through T. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

D0350 Oral / Facial Photographic Images

This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be a part of the patient's clinical record.

Oral/Facial Photographic Images are required when dental radiographs do not adequately indicate the necessity for the requested treatment in the following situations: Buccal and lingual decalcification prior to crowning; prior to gingivectomy; prior to full mouth debridement; or with the presence of a fistula prior to retreatment of previous root canal therapy, anterior.

The provider should bill Medicaid for oral/facial photographic images ONLY when the photographs are taken under these circumstances. If post payment review discovers the billing of oral/facial images not in conjunction with these specific services, recoupment will be initiated. Oral/facial photographic images must be of good diagnostic quality and must indicate the necessity for the requested treatment.

This procedure is limited to two units per same date of service.

This procedure is reimbursable for oral cavity designators 01, 02, 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA claim form when requesting prior authorization or reimbursement for this procedure.

Preventive Services

D1110 Prophylaxis – Adult

Adult prophylaxis for children 12 through 20 years of age includes removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. Qualified dental personnel must perform any prophylaxis.

This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1110 (Adult Prophylaxis).

D1120 Prophylaxis – Child

Child prophylaxis for children under 12 years of age includes removal of plaque, calculus and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irritational factors. Qualified dental personnel must perform any prophylaxis.

This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

If, at the initial visit, it is determined that the Child Prophylaxis is the appropriate treatment and code D1120 (Child Prophylaxis) is billed to and reimbursed by Medicaid, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1120 (Child Prophylaxis).

D1203 Topical Fluoride Treatment (prophylaxis not included) – Child

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

Topical fluoride treatment should be provided to children less than 12 years of age. This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

D1204 Topical Fluoride Treatment (prophylaxis not included) – Adult

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

Topical fluoride treatment should be provided to children 12 through 15 years of age. This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

D1351 Sealants – per tooth

A sealant is a mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are limited to six- and twelve-year molars only. They are further limited to one application per tooth per lifetime by the same billing provider or another Medicaid provider located in the same office as the billing provider.

Six-year molar sealants will be paid only for those recipients under 10 years of age. Twelve-year molar sealants will be paid only for those recipients under 16 years of age.

If no restorations or other treatment services are necessary, all sealants must be performed on a single date of service. If restorative or other treatment services are necessary, sealants may be performed on the same date of service as the restorative or other treatment services.

This procedure is reimbursable for tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 only. The appropriate tooth number must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

In order for a tooth to be reimbursable for sealant services, it cannot have been previously sealed or restored on any surface and is caries-free on the date of service. Sealants are not reimbursable for teeth that have any previous restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana.

Restorative Services

D2930* Prefabricated Stainless Steel Crown, Primary Tooth

Stainless steel crowns (D2930) may be placed on primary teeth that exhibit any of the following indications, when failure of other available restorative materials is likely to occur prior to the natural shedding of the tooth:

- extensive caries;
- interproximal decay that extends into the dentin;
- significant observable cervical decalcification;
- significant observable developmental defects, such as hypoplasia and hypocalcification following pulpotomy or pulpectomy;
- restoring a primary tooth that is to be used as an abutment for a space maintainer; or,
- fractured tooth.

Additionally, a stainless steel crown may be authorized to restore an abscessed primary 2nd molar, in conjunction with a pulpectomy prior to the eruption of the permanent 1st molar in order to avoid placement of an indicated distal shoe space maintainer.

Stainless steel crowns are not medically indicated and reimbursement will not be paid in the following circumstances:

- primary teeth with abscess or bone resorption; or
- primary teeth where root resorption equals or exceeds 75% of the root; or

- primary teeth with insufficient tooth structure remaining so as to have a poor prognosis of success, i.e. unrestorable; or
- incipient carious lesions.

Endodontic Services

D3310* Root Canal, Anterior (excluding restoration)
D3320* Root Canal, Bicuspid (excluding restoration)
D3330* Root Canal, Molar (excluding restoration)

Complete root canal therapy (procedures D3310, D3320 and D3330) includes treatment plan, all appointments necessary to complete treatment, clinical procedures, all intra-operative radiographs (which must include a post operative radiograph) and follow-up care.

Prior authorization is required. Requests for prior authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographs, as applicable, to judge the general oral health status of the patient. Specific treatment plans for final restoration of the tooth must be submitted. If the radiographs do not indicate the need for a root canal, the provider must include a written statement as to why the root canal is necessary. Approval of any requested root canal will depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and the past history of recipient oral care.

Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider or if the radiographs do not adequately indicate the need for the root canal requested, the request for prior authorization will be returned to the provider requesting additional information.

A lifetime maximum of six root canals is allowed in the entire mouth and will be allowed as follows:

- A lifetime maximum of <u>two posterior root canals</u> (D3320 or D3330) is allowed per recipient with a limit of one (1) posterior root canal per covered tooth. Posterior root canals will be approved only when the tooth is in occlusion and will serve to stabilize the arch. Retreatment of previous root canal therapy is not a covered benefit for posterior teeth.
- A lifetime maximum of <u>four anterior root canals</u> (D3310) is allowed per recipient.

In cases where multiple root canals are requested or when teeth are missing or in need of endodontic therapy in the same arch, a partial denture may be indicated. Third molar root canals are not reimbursable.

<u>The date of service on the payment request must reflect the final treatment date.</u> Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the root canal and must be maintained in the patient treatment record.

D3310* Root Canal, Anterior (excluding restoration)

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D3320* Root Canal, Bicuspid (excluding restoration)

This procedure is reimbursable for Tooth Numbers 4, 5, 12, 13, 20, 21, 28 and 29. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D3330* Root Canal, Molar (excluding restoration)

This procedure is reimbursable for Tooth Numbers 2, 3, 14, 15, 18, 19, 30 and 31. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D3346* Retreatment of Previous Root Canal Therapy, Anterior

Effective September 1, 2004, procedure code D3346, Retreatment of Previous Root Canal Therapy – Anterior, became payable only to a different provider or provider group than originally performed the initial root canal therapy, and is reimbursable in the amount of $212.00 (with prior authorization) for Medicaid eligible recipients under 21 years of age.

The prior authorization request of procedure code D3346 by the same provider or provider group who performed the initial root canal therapy will be denied with a new denial code (452) which will state: "An anterior root canal retreatment is not payable to the same dentist or dental group who performed the initial root canal. Recipients may seek the service from a different dentist (dental group) who will submit for a new prior authorization."

Procedure D3346 may include the removal of post, pin(s), old root canal filling material, and the procedures necessary to prepare the canal and place the canal filling. This includes complete root canal therapy. The reimbursement for this procedure includes all appointments necessary to complete treatment and all intra-operative radiographs. The date of service on the payment request must reflect the final treatment date. Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the retreatment of the root canal and must be maintained in the patient treatment record.

Approval of any requested root canal retreatment will depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and the past history of recipient oral care. Requests for prior authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographs, as applicable, to judge the general oral health status of the patient. Specific treatment plans for final restoration of the tooth must also be submitted.

If the radiographs do not indicate the need for a root canal, the provider must include a written statement as to why the root canal retreatment is necessary. If a fistula is present, a clear

oral/facial image (photograph) is required and will be reimbursable in situations where dental radiographs do not adequately indicate the necessity for the requested retreatment of previous root canal therapy.

Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider or if the radiographs do not adequately indicate the need for the retreatment of a previous root canal, the request for prior authorization will be returned to the provider requesting additional information.

If the Dental Medicaid Unit consultant determines that Medicaid has reimbursed the initial root canal provider for an incomplete root canal, the matter will be referred to the Dental SURS Unit for further review and possible recoupment of the reimbursement for the initial root canal.

A lifetime maximum of four retreatment of root canal, anterior (D3346) are allowed per recipient with a limit of one (1) retreatment per covered tooth.

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

Periodontal Services

D4210* Gingivectomy or Gingivoplasty – Four or More Contiguous Teeth or Bounded Teeth Spaces per Quadrant

This procedure involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, and to restore normal architecture when gingival enlargements or asymmetrical or unesthetic topography is evident with normal bony configuration.

This procedure requires prior authorization. A gingivectomy may be approved by Medicaid only when the tissue growth interferes with mastication as sometimes occurs from Dilantin® therapy. Explanations or reasons for treatment should be entered in the "Remarks" section of the claim form and a photograph of the affected area(s) must be included with the request for authorization.

This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4341* Periodontal Scaling and Root Planing – Four or More Teeth per Quadrant

Radiographic evidence of large amounts of subgingival calculus, deep pocket formation, and bone loss must be submitted. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces as well as the removal of rough, calculus-contaminated cementum and dentin. It is therapeutic—not prophylactic—in nature, usually requiring local anesthesia.

This procedure requires prior authorization. Radiographic evidence of bone loss indicating a true periodontal disease state must be supplied with bitewings and/or posterior/anterior periapicals. This service is not approved for recipients who have not progressed beyond the mixed dentition stage of development.

Only two units of periodontal scaling and root planing may be reimbursed per day. For patients requiring hospitalization for dental treatment, a maximum of four units of procedure code D4341 may be paid on the same date of service if prior authorized. The claim form used to request prior authorization or reimbursement must identify the "Place of Treatment" (Block 38) and "Treatment Location" (Block 56) if the service was performed at a location other than the primary office.

This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4355* Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis

This procedure involves the gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

This service must be performed at the initial visit if this service is indicated.

No other dental services except examination, radiographs or oral/facial photographic images are reimbursable on the same date of service as full mouth debridement. When an exam is performed on the same date of service as a full mouth debridement, the exam must be performed after completion of the full mouth debridement.

Only one full mouth debridement is allowed in a 12 month period. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) or Child Prophylaxis (D1120) to the same billing provider or another Medicaid provider in the same office as the billing provider within a 12 month period.

This procedure requires prior or post authorization. When requesting prior or post authorization, bitewing radiographs that supply evidence of significant posterior supra and/or subgingival calculus in at least two quadrants must be submitted. In the occasional instance where the bitewing radiographs do not supply evidence of significant calculus in at least two quadrants, Oral/Facial Photographic Images that provide evidence of significant plaque and calculus are required.

Prior to requesting authorization for a D4355 (Full Mouth Debridement), providers must ask their new patients when they last received a Medicaid covered prophylaxis (D1110 or D1120) and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that it has been over 12 months since a D1110 or D1120 was reimbursed by Medicaid for this recipient. If it is determined that it has been less than 12 months, the recipient must reschedule for a later date which exceeds the 12 month period.

If the prior or post authorization request for D4355 is denied and it has been determined that Medicaid has not reimbursed a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis) within the preceding 12 months for this recipient, the provider may render and bill Medicaid for a D1110 (Adult Prophy) or D1120 (Child Prophylaxis), whichever is applicable based on the patient's age.

Removable Prosthodontic Services

D5211* Maxillary Partial Denture – Resin Base (including any conventional clasps, rests and teeth)
D5212* Mandibular Partial Denture – Resin Base (including any conventional clasps, rests and teeth)
D5213* Maxillary Cast Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)
D5214* Mandibular Cast Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth
D5820* Interim Partial Denture (Maxillary) – Includes any necessary clasps and rests
D5821* Interim Partial Denture (Mandibular – Includes any necessary clasps and rests

Only one prosthesis (excluding interim partial dentures) per recipient per arch is allowed in a five-year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana. Once the recipient becomes 21 years of age, the rules of the Adult Denture Program apply.

To receive consideration for approval for cast partial dentures, providers must submit periapical radiographs of the abutment teeth and bitewings with the treatment plan.

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. The provider should use the following symbols in Block 34 of the ADA claim form to indicate tooth status. "X" will be used to identify missing teeth and "/" will be used to identify teeth to be extracted.

The design of the prosthesis and materials used should be as simple as possible and consistent with basic principles of prosthodontics.

Only permanent teeth are eligible for replacement by an interim partial denture or a partial denture.

Opposing partial dentures are available if each arch independently fulfills the requirements.

Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch, and must serve to increase masticatory function and stability of the entire mouth.

The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries free or have been completely restored and have sound periodontal support. On those recipients requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographs may be requested prior to approval of a partial denture.

Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition stages in the following cases:

- Missing one or two maxillary permanent anterior tooth/teeth, or
- Missing two mandibular permanent anterior teeth, or
- Missing three or more permanent teeth in the same arch (of which at least one must be anterior)

Medicaid may provide a partial denture in cases where the recipient has matured beyond the mixed dentition stage in the following cases:

- Missing three or more maxillary anterior teeth, or
- Missing two or more mandibular anterior teeth, or
- Missing at least 3 adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or
- Missing at least 2 adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one quadrant (third molars not considered for replacement), or
- Missing a combination of two or more anterior and at least one posterior tooth (excluding wisdom teeth and the second molar) in the same arch.

Cast partials (D5213 and D5214) will be considered only for those recipients who are 18 years of age or older. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining teeth will dictate whether a cast or acrylic partial is approved. Radiographs should verify that all pre-prosthetic services have been successfully completed. On those recipients requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographs may be requested prior to approval of a cast partial denture.

D5510 Repair broken complete denture base
D5520 Replace missing or broken tooth – complete denture – per tooth
D5610 Repair resin partial denture base
D5630 Repair or replace broken clasp
D5640 Replace missing or broken tooth – partial denture – per tooth
D5650 Add tooth to existing partial denture – per tooth
D5660 Add clasp to existing partial denture

Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one year has elapsed since denture insertion by the same billing provider or another Medicaid provider located in the same office as the billing provider and the repair makes the denture fully serviceable and eliminates the need for a new denture.

If the same provider/provider group (or another Medicaid-enrolled provider located in the same office as the requesting provider) requests a complete or partial denture excluding interim partial dentures) within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee. A repair is allowed in conjunction with a reline on the same recipient as long as the repair makes the denture fully serviceable.

A total of $125.00 in base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same recipient is allowed within a single one-year period for a single billing provider.

Procedure Codes D5510 and D5610 are reimbursable for Oral Cavity Designators 01 and 02. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting reimbursement for these procedures.

The request for payment for procedure codes D5510 and D5610 must include the location and description of the fracture in the “Remarks” section of the claim form.

The fee assigned for the first tooth billed using the codes D5520 or D5640 or D5650 will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. However, the fee assigned for the additional teeth will reflect the additional allowance per tooth as indicated in Appendix A.

Procedures D5520, D5640 and D5650 are reimbursable for Tooth Numbers 2 through 15 and 18 through 31. The appropriate tooth number must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

Procedure Codes D5630 and D5660 are reimbursable for Oral Cavity Designators 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting reimbursement for these procedures. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the “Remarks” section of the claim form.

Minimal procedural requirements for repair services include the following:

- The prosthesis should be processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the patient’s treatment record.

- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion.

- The prosthesis must be finished in a workmanlike manner; be clean; exhibit a high gloss; and be free of voids, scratches, abrasions, and rough spots.

- The treatment record must specifically identify the location and extent of the breakage.

Failure to provide adequate documentation of services billed as repaired when requested by DHH or its authorized representative will result in recoupment of monies paid by the program for the repair.

Oral and Maxillofacial Surgery Services

D7140 Extraction, Erupted Tooth or Exposed Root (elevation and/or forceps removal)

This procedure includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.

D7210* Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

This procedure includes the cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone, and closure.

This procedure requires prior authorization. All requests for prior authorization of the surgical removal of erupted tooth require the submission of radiographs.

For pre-surgical prior authorization, the radiographic evidence must clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure.

If the radiographic evidence does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, the prior authorization request will be denied. After the tooth is removed, the provider may bill Medicaid for a D7140 or resubmit the prior authorization request for reconsideration (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications and the radiographs.

In the event a planned simple extraction becomes a surgical procedure, the provider may submit a “post” authorization request (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications along with the radiographs which will be used by the dental consultants in the authorization determination.

D7280* Surgical Access of an Unerupted Tooth

This procedure includes an incision, the reflection of tissue, and the removal of bone as necessary to expose the crown of an impacted tooth not intended to be extracted.

This procedure no longer includes the placement of orthodontic attachment. Refer to procedure code D7283 below for information related to the orthodontic attachment.

This procedure requires prior authorization.

Procedure Code D7280 is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. The appropriate tooth number must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D7283* Placement of Device to Facilitate Eruption of Impacted Tooth

This procedure involves the placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.

This procedure is only reimbursable in conjunction with a Medicaid-approved comprehensive orthodontic treatment plan.

This procedure requires prior authorization.

Procedure Code D7283 is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. The appropriate tooth number must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D7286* Biopsy of Oral Tissue – Soft

This procedure is for the surgical removal of an architecturally intact specimen only, and is not used at the same time as codes for apicoectomy/periradicular curettage.

This procedure requires post authorization. A copy of the pathology report should be submitted to the Dental Medicaid Unit when requesting post authorization.

This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for these procedures.

Policy Reminders

Radiographs (X-rays)

In order for the Dental Medicaid Unit to be able to make necessary authorization determination, radiographs and/or oral/facial images must be of good diagnostic quality. Those requests for prior authorization that contain radiographs and oral/facial images that are not of good diagnostic quality will be rejected.

A lead apron and thyroid shield must be used when taking any radiographs reimbursed by the Medicaid program. When taking radiographs, the use of a lead apron and thyroid shield is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.

Refer to the EPSDT Program policy revision section of this manual as well as the 2003 Dental Services Manual for additional policy information related to radiographs.

Restorative and Treatment Services

Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a

second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there are circumstances that would not allow restorative treatment in this manner, the contraindication(s) must be documented in the patient's dental record.

Refer to the EPSDT Program policy revision section of this manual as well as the 2003 Dental Services Manual for additional policy information related to restorative and treatment services.

Crown Services

Crown services require radiographs, photographs, other imaging media or other documentation which depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by the Bureau or its designee upon request.
Refer to the EPSDT Program policy revision section of this manual as well as the 2003 Dental Services Manual for additional policy information related to crowns.

Extraction of Primary Teeth in the Advanced Stages of Natural Exfoliation

Post-payment reviews have shown that a number of providers are billing for the extraction of primary teeth in the advanced stages of natural exfoliation, with little or no therapeutic indication or benefit. Primary teeth that are being lost naturally should not be billed to Medicaid as an extraction. If a practice is noted during post-payment review of billing for the extraction of primary teeth that are shown radiographically to be in the advanced stages of root resorption (more than ¾ of the root resorbed), i.e., exfoliating naturally, there will be a recoupment of money paid for all such therapeutically unnecessary extractions.

If the extraction is warranted due to therapeutically indicated circumstances such as prolonged retention, blocking out of erupting permanent teeth, severe decay, abscess with bone loss, or other specifically identifiable indications, a preoperative periapical radiograph should be taken as a diagnostic aid and as means of documentation. This radiograph must be maintained in the recipient's record, and must be furnished to post-payment review if requested. Written documentation of the reason for the extraction must be noted in the dental treatment record.

Refer to the EPSDT Program policy revision section of this manual as well as the 2003 Dental Services Manual for additional policy information related to extractions.

General Program Reminders

- **Dental services should not be separated or performed on different dates of service solely to enhance reimbursement.**

- The date of service on a dental claim must reflect the actual date that the service was completed/delivered (please refer to page 16-11 of the Medicaid Dental Services Provider Manual). The Dental Surveillance and Utilization Department continues to identify dental providers who have billed and been paid for root canal therapy prior to the completion of the service. Dental claims shall not be filed prior to the completion/delivery of the service. This includes, but is not limited to, root canal therapy, a complete or partial denture and space maintainers. At a minimum, Medicaid will recover the payment for all claims billed when the date of service on the claim does not reflect the date the service was completed.

- A Medicaid dental provider cannot limit his practice to diagnostic and preventive services only. A dental provider who only offers diagnostic and preventive services in his practice does not meet the necessary criteria for participation in the Medicaid EPSDT Dental, Adult Denture or Expanded Dental Services for Pregnant Women (EDSPW) Programs. Medicaid covered dental services requiring treatment by a specialist may be referred to another provider who can address the specific treatment; however, the recipient or guardian, as appropriate, must be advised of the referral. The reimbursement made for the examination, prophylaxis, bitewing radiographs and/or fluoride to providers who routinely refer recipients for restorative, surgical and other treatment services is subject to recoupment.

- Providers must ask their new patients when they last received a Medicaid covered oral examination, prophylaxis, bitewing radiographs and fluoride and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that it has been over one year since the patient received these services. If it is determined that it has been less than one year, the recipient must schedule for a later date.

ADULT DENTURE PROGRAM POLICY AND GENERAL PROGRAM REMINDERS

The following information contains policy and general program reminders. This provider training packet does not replace the Adult Denture Program section of the 2003 Dental Services Manual. It is intended to be used in conjunction with the 2003 Dental Services Manual, Adult Denture Program section. This information has been previously published in other provider resources such as the Medicaid Remittance Advice(s) (RA), Provider Update(s), and/or the Medicaid provider website at www.lamedicaid.com (refer to page 96 of this document for further information regarding the website.) Please take notice that in the future the dental services manual will be revised to reflect this information.

Policy Reminders

For Medicaid purposes, local anesthesia, when applicable, is considered part of any procedure covered by Medicaid.

Radiographs (X-Rays)

In order for the Dental Medicaid Unit to be able to make necessary authorization determination, radiographs must be of good diagnostic quality. Prior authorization requests that contain radiographs that are not of good diagnostic quality will be rejected.

A lead apron and thyroid shield must be used when taking any radiographs reimbursed by the Medicaid program. When taking radiographs, the use of a lead apron and thyroid shield is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.

Refer to the 2003 Dental Services Manual for additional policy information related to radiographs for the Adult Denture Program.

General Program Reminders

- **Dental services should not be separated or performed on different dates of service solely to enhance reimbursement.**

- The date of service on a dental claim must reflect the actual date that the service was completed/delivered. Dental claims shall not be filed prior to the completion/delivery of the service. At a minimum, Medicaid will recover the payment for all claims billed when the date of service on the claim does not reflect the date the service was completed.

- A Medicaid dental provider cannot limit his practice to diagnostic and preventive services only. A dental provider who only offers diagnostic and preventive services in his practice does not meet the necessary criteria for participation in the Medicaid

EPSDT Dental, Adult Denture or Expanded Dental Services for Pregnant Women (EDSPW) Programs. Medicaid covered dental services requiring treatment by a specialist may be referred to another provider who can address the specific treatment; however, the recipient or guardian, as appropriate, must be advised of the referral. The reimbursement made for the examination, prophylaxis, bitewing radiographs and/or fluoride to providers who routinely refer recipients for restorative, surgical and other treatment services is subject to recoupment.

PRIOR AUTHORIZATION INFORMATION AND REMINDERS

The 2002 American Dental Association Claim Form and the 2002, 2004 American Dental Association Claim Form are the only hardcopy dental claim forms accepted for Medicaid prior authorization (PA) of services provided under the Medicaid EPSDT Dental Program, EDSPW Program or Adult Denture Program regardless of the date of service. Dental prior authorization requests received by LSU Dental School, Dental Medicaid Unit on the older versions of the ADA Claim Form will be returned to the provider.

Reminders

- If a claim is being submitted for prior authorization, you must mark "Request for Predetermination/Preauthorization" in Block 1 of the 2002 or 2002, 2004 ADA Claim Form.
- Radiographs must be submitted with request for prior authorization when required.
- Providers are reminded that **dental prior authorization requests** are to be submitted to the following address:

LSU Dental School
Dental Medicaid Unit
P. O. Box 80159
Baton Rouge, LA 70898-0159

If you have questions regarding dental prior authorization, you may contact the **LSU Dental School, Dental Medicaid Unit** by calling **225-216-6470**.

Check List for Use Prior to Mailing a Medicaid Dental Prior Authorization Request
(Print or copy this page for your convenience)

The information provided below will help you prevent errors frequently made when completing a Medicaid dental prior authorization (PA) request. For complete dental prior authorization guidelines, refer to pages 16-6 through 16-9 of the Dental Services Manual dated May 1, 2003.

- ☐ Are you using the 2002 American Dental Association (ADA) Claim Form or the 2002, 2004 ADA Claim Form when submitting a request to Medicaid for dental prior authorization? (Only these versions are accepted.)
- ☐ Have you provided two identical copies of each ADA claim form being submitted?
- ☐ Has any information been placed in the upper right-hand corner of the claim (above the box labeled "Primary Subscriber Information")? (This area is for Medicaid use only and must be left blank.)
- ☐ Are you certain that the claim form is properly completed with provider name, group, and individual provider number, current provider address and phone number, recipient name and date of birth, etc.? (Each claim form submitted for dental prior authorization should be fully completed using the ADA Claim Form instructions on page 50 of this document. If a service has not been delivered at the time of the request, leave the date of service blank. If a service has already been delivered, enter the correct date of service on the claim form.
- ☐ Have you grouped together on the first lines of the claim form all services requiring prior authorization? (Procedures that will be rendered and do not require prior authorization should be listed on the ADA claim form after those services requiring prior authorization so that the reviewer understands the full treatment plan.)
- ☐ Have you provided an explanation or reason for treatment in the remarks section of the claim form if the reason is not obvious from the radiographs? (Be certain to include the remarks on the same ADA claim form in which the treatment is being requested.)
- ☐ Have you included bitewing radiographs and any other required radiographs?
- ☐ Are the radiographs mounted so that each individual film is readily viewable and does the doctor's name, patient's name, and the date of the films appear on the mounting? (Radiographs MUST be mounted and MUST contain the identified information.)
- ☐ Are the mounted radiographs on the top of the EPSDT Dental Program the Adult Denture Program claims? (The mounted radiographs MUST be on the top of the claim for prior authorization for these programs.)
- ☐ Is a single copy of the BHSF Form 9-M on top of the request, followed by the mounted radiographs and then the claim for the Expanded Dental Services for Pregnant Women (EDSPW) Program requests? (Placing the Form 9-M as the first page of an EDSPW request will help to identify it as related to an adult pregnant woman.)
- ☐ Have you submitted the panoramic radiograph, if one has been taken, along with the request for post-authorization of the radiograph and included any additional services requiring prior authorization on the same claim form?
- ☐ Have you stapled all pages (and the mounted radiographs) for a single recipient with a SINGLE staple in the upper left-hand corner? (Using a single staple will expedite the request. Paper clips should be not used.)
- ☐ Have you separated the dental prior authorization requests by program type (EPSDT Dental Program, Expanded Dental Services for Pregnant Women (EDSPW) Program, and Adult Denture Program and placed each program type in a separate package/envelope?
- ☐ **Are you mailing to LSU Dental School, Dental Medicaid Unit, P.O. Box 80159, B.R. LA 70898-0159?**

NOTE: It is the dental provider's responsibility to obtain a dental prior authorization on behalf of the patient. If a dental provider has not received a dental prior authorization decision (or other related correspondence from the Dental Medicaid Unit) within 25 days from the date of submission, it is the provider's responsibility to contact the Dental Medicaid Unit at 225-216-6470 to inquire on the status of the prior authorization request. The provider should NEVER instruct the patient to contact Medicaid regarding the dental prior authorization request.

Dental Electronic Prior Authorization (e-PA) Web Application

The Dental Electronic Prior Authorization (e-PA) Web Application for requesting dental prior authorizations electronically is being developed and will be tested in the near future. If you are interested in becoming a dental e-PA test provider and you currently submit at least 25 Medicaid dental prior authorization requests per month, please contact Dr. Robert Barsley, Dental Medicaid Unit Director, by calling 225-216-6470. Dental providers will be notified on the Medicaid remittance advice and/or www.lamedicaid.com website as to when the Dental e-PA Web Application is ready for use by all dental providers.

At that time, dental providers will be able to access this web application on the www.lamedicaid.com website and it will provide a secure web based tool for providers to submit electronic prior authorization requests and to view the status of previously submitted electronic requests. Complete Dental e-PA Web Application instructions will be provided upon implementation of Dental e-PA.

In order to use the Dental e-PA Web Application for submission of electronic dental prior authorization requests, providers must 1) have a computer; 2) have the capability of taking digital radiographs or scanning radiographic images; and 3) obtain the services of a vendor to submit the electronic attachment information. To locate an electronic attachment vendor, providers may do an internet search or contact the Dental Medicaid Unit by calling 225-216-6470 for assistance.

Providers who do not meet the above-referenced requirements or choose not to participate in Dental e-PA may still continue to submit hardcopy dental prior authorization requests using the current dental prior authorization hard-copy submission methods.

Dental providers are urged to consider using the Dental e-PA Web Application once available. In addition to expediting the processing time and providing a method to view the status of a previously submitted electronic dental prior authorization request, it may be cost effective as well. Providers should consider that while there are costs associated with using a vendor to submit the electronic attachment information, there will be savings realized when the mailing and supply costs associated with the submission of hardcopy dental prior authorization requests are reduced or eliminated.

ADA CLAIM FORM INFORMATION/INSTRUCTIONS AND BILLING REMINDERS

Medicaid EPSDT Dental, EDSPW and Adult Denture Program Services

The 2002 American Dental Association Claim Form and the 2002, 2004 American Dental Association Claim Form are the only hardcopy dental claim forms accepted for Medicaid reimbursement of services provided under the Medicaid EPSDT Dental Program, EDSPW Program or Adult Denture Program regardless of the date of service. Dental claims received by Unisys on the older versions of the ADA Claim Form will be returned to the provider. These claim forms may be obtained by contacting the American Dental Association or your dental supply company.

Billing Reminders

- If a claim is being submitted for payment, you must mark "Statement of Actual Services" in Block 1 of the 2002 or 2002, 2004 American Dental Association (ADA) Claim Form.

- Claims for payment that are sent to Unisys should never include radiographs. Claims for payment that are submitted with radiograph attachments will cause a delay in payment.

ADA Claim Form Instructions

The numbered line-by-line billing instructions below correspond with the same numbered block of the 2002 ADA Claim Form and the 2002, 2004 ADA Dental Claim Form. Required information must be entered to ensure claims processing. Situational information may be required only in certain situations as detailed in each instruction item. Information on the claim form may be handwritten or computer generated and must be legible and completely contained in the designated area of the claim form. Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.

EPSDT Dental Program, EDSPW Program and Adult Denture Program **claims for payment** should be submitted to:

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

1. Required. Must check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization.

   Situational. Must check box marked "EPSDT / Title XIX" if patient is Medicaid eligible and under 21 years of age. **If block is not checked, the claim will be processed as an adult claim.**

2. Situational. Must enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization.

3. Situational. If completed, must enter the primary payer information.

4. Required. If yes, complete Block 9.

5-8. Situational.

9. Situational. Must enter the third party's carrier code if a third party is involved. A list of codes identifying various carriers may be obtained from Unisys. If the provider has chosen to bill the third party and Medicaid, an explanation of benefits must be attached to the claim filed with Medicaid.

10-11. Situational.

12. Required. Enter the recipient's last name, first name, and middle initial exactly as verified through REVS or MEVS. Recipient's address is situational.

13. Required. Enter the recipient's eight-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.

14. Required. Check appropriate block.

15. Required. Enter the thirteen-digit Medicaid ID number as obtained from REVS or MEVS. **Do not use the sixteen-digit Card Control Number {CCN} from the recipient's Medicaid card.**

16-22. Situational.

23. Situational. If you enter a Patient ID/Account Number (Number Assigned by Dentist), it will appear on the Remittance Advice. It may consist of letters and/or numbers, and it may be a maximum of 20 positions.

24. Required. Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero. **A service must have been performed/delivered before billing Medicaid for payment.**

25. Situational. Must indicate the oral cavity designator when the Medicaid Program requires an oral cavity designator for the specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding oral cavity designator. If an oral cavity designator is required by Medicaid, do not enter a tooth number or letter in Block 27 of the ADA Claim Form.

26. Situational.

27. Situational. Must indicate a tooth number or letter when the Medicaid Program requires a tooth number or letter for the specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding tooth number or letter. If a tooth number or letter is required by Medicaid, do not enter a oral cavity designator in Block 25 of the ADA Claim Form.

28. Situational. Must indicate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes: B = Buccal; D = Distal; F = Facial; I = Incisal; L = Lingual; M = Mesial; and O = Occlusal. Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.

29. Required. Use appropriate dental procedure code from the current version of Code on Dental Procedures and Nomenclature. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.

30. Required. Enter the description of the service performed.

31. Required. Enter the dentist's full (usual and customary) fee for the dental procedure reported.

32. Situational.

33. Required. Total of all fees listed on the claim form.

34. Situational. Must complete for the Adult Denture Program. Situational for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with a "/".

35. Situational. Must include the following information in the remarks section of the claim form: 1) If Block 9 of the claim form is completed, write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [$0] payment); and/or 2) Additional information which is required by Medicaid regarding requested services (i.e. description of the patient management techniques being utilized for which a patient management fee is being requested, reason for hospitalization request, etc.) or any additional information that the provider needs to include. For prior authorization requests, if the information required in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the recipient's name and Medicaid ID # and the provider's name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient's treatment record.

36. Situational.

37. Situational.

38. Situational. Must check applicable box if services are to be/were provided at a location other than the address entered in Block 48. If services were provided at a location other than the address entered in Block 48, completion of Block 56 is required.

39. Situational. Must complete if applicable. Enter 00 to 99 in applicable boxes. Claims submitted for prior authorization should contain the identified attachments. Claims submitted for payment should not contain any of the attachments listed in Block 39.

40. Situational. Must complete if requesting comprehensive orthodontic services. Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.

41. Situational.

42. Situational.

43. Situational. Must complete if applicable. Check appropriate box. If yes, complete Block 44, if known.

44. Situational. Must complete if date is known. Enter the appropriate eight-digit date in month, day and year (MM/DD/CCYY).

45. Situational. Must complete if applicable. Check applicable box.

46. Situational. Must complete if applicable. Enter the eight-digit date in month, day and year (MM/DD/CCYY).

47. Situational. Must complete if applicable. Enter auto accident state.

48. Required. Enter the name of the individual dentist or dental group to whom payment is being made. If payment is being made to a group, the group name must be entered. Enter the full address, including city, state and zip code, of the dentist or dental group to whom the payment is being made.

49. Required. Enter the seven-digit billing provider Medicaid ID number to whom payment is being made. If payment is being made to a group, the group Medicaid ID number must be entered.

50. Situational.

51. Situational.

52. Required. Enter the phone number for the dentist or dental group to whom payment is being made.

53. Required. Signature of treating (attending) dentist. Enter the date the claim was signed. Signature stamps and computer-generated signatures are acceptable if they are initialed. The signature may be initialed by the provider or the provider's assistant.

54. Required. Enter the Medicaid provider ID number of the treating (attending) dentist.

55. Required. Enter the license number of the treating (attending) dentist.

56. Situational. Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dentist, if different from Block 48.

57. Situational. Enter the phone number for the treating (attending) dentist, if different from Block 52.

58. Situational.

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
   - [X] Statement of Actual Services – OR – [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT/Title XIX
2. Predetermination/Preauthorization Number: 123456789

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: **Brown, Wade**

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Subscriber Identifier (SSN or ID#)
06/19/2000	[X] M [ ] F	1234567890123

16. Plan/Group Number	17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Subscriber Identifier (SSN or ID#)
	[ ] M [ ] F	

9. Plan/Group Number TPL-Carrier Code (if applicable)	10. Relationship to Primary Subscriber (Check applicable box)
	[ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Carrier Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box)	19. Student Status
[ ] Self [ ] Spouse [ ] Dependent Child [ ] Other	[ ] FTS [ ] PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Patient ID/Account Number (Assigned by Dentist)

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
	[ ] M [ ] F	

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	02/14/2006	10				D4341	Periodontal Scaling & Root Planing	75.00
2	02/14/2006			13		D2954	Post & Core	70.00
3	02/14/2006			15		D2931	Stainless Steel Crown	90.00
4								
5								
6								
7								
8								
9								
10								

SAMPLE

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s):

33. Total Fee: 235.00

35. Remarks: **If TPL involved: write the words "Carrier Paid" and enter the amount paid by TPL here**

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box): [ ] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39. Number of Enclosures (00 to 99): Radiograph(s) ____ Oral Image(s) ____ Model(s) ____

40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box): [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code:
XYZ Dental Group
123 Smiley St.
Anywhere, LA 70000

49. Provider ID	50. License Number	51. SSN or TIN
1800000		

52. Phone Number (225) 555 – 1212

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X John White, DDS — 05/04/06
Signed (Treating Dentist) — Date

54. Provider ID	55. License Number
1888888	88888

56. Address, City, State, Zip Code

57. Phone Number ( ) –

58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

EPSDT DENTAL SERVICES ADJUSTMENT/VOID (209) AND ADULT DENTAL SERVICES ADJUSTMENT/VOID (210) FORM CHANGES

The EPSDT Dental Services 209 Adjustment/Void form (revision date 10/04) must be used when submitting adjustments/voids for EPSDT Dental Program services for all dates of service.

Additionally, dental providers must use the Adult Dental Services 210 Adjustment/Void form (revision date 10/04) when submitting adjustments/voids for the Adult Denture Program or Expanded Dental Services for Pregnant Women Program regardless of the dates of service.

For both adjustment/void forms Form Locator 15 has been renamed as "Patient I.D./Account# Assigned by Dentist". If the patient's account (medical record) number is entered here, it will appear on the Medicaid Remittance Advice. It may consist of letters and/or numbers, and it may be a maximum of 20 positions. Providers can obtain these forms from Unisys or through the Louisiana Medicaid website at www.lamedicaid.com. Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

INSTRUCTIONS FOR COMPLETING 209 ADJUSTMENT/VOID FORM (EPSDT)

1	Adj/Void	Check the appropriate box.
2-4	Patient's Last Name, First Name, MI	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
5	Medical Assistance ID Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
6	Patient's Address	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
7	Date of Birth	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
8	Sex	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
9-14		Not Required
15	Patient ID/Account Number (Assigned By Dentist)	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
16	Pay to Dentist or Group	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.

17	Pay to Dentist or Group Provider No.	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
18	Are X-Rays Enclosed	Not required.
19	Treatment Necessitated By	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
20	Payment Source Other Than Title XIX	**Adjust** - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. **Void** - Enter the information exactly as it appeared on the original invoice.
21-22		Leave these spaces blank.
23	Diagram	Not required.
24	Examination and Treatment Plan	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted. **Void** - Enter the information exactly as it appeared on the original invoice.
25	Paid or Payable by Other Carrier	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0). **Void** - Enter the information exactly as it appeared on the original invoice.
26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the paid or denied the claim.
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied claim.

28 & 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.
30	Request for Authorization	Leave this space blank.
31	Request for Pre-Authorization	Enter the 9-digit PA # assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization.
32	Attending Dentist's Signature - Provider Number	All adjustment forms must be signed, and the provider number must be entered.

If a new procedure or corrected procedure is entered on the adjustment form and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Unisys for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

Patient ID/Account Number

FOR PREAUTHORIZATION MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT REMIT TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
EPSDT DENTAL SERVICES

SAMPLE

FOR OFFICE USE ONLY

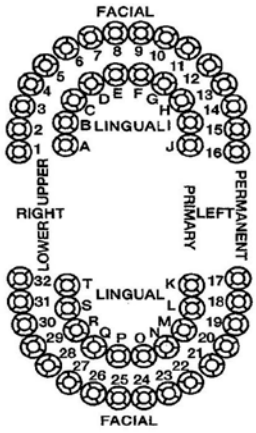
1 ADJ. [X] VOID [ ]

2 PATIENT'S LAST NAME (PRINT): Smith
3 FIRST NAME: Sally
4 MI: L
5 MEDICAL ASSISTANCE I.D. NUMBER: 1 2 3 4 5 6 7 8 9 0 1 2 3
6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)
7 DATE OF BIRTH: 02 15 1999
8 SEX: [ ] M [X] F

9 REFERRING AGENCY NO.
10 DATE OF REFERRAL
11 REFERRED FOR: [ ] EMERGENCY [ ] BASIC SCREENING
12 DENTIST OR GROUP REFERRED TO: NAME / ADDRESS / TEL. NO.
13 REFERRED BY: (SIGNATURE)
14 TELEPHONE NO.
15 PATIENT I.D. / ACCOUNT # ASSIGNED BY DENTIST

16 PAY TO DENTIST OR GROUP: NAME / ADDRESS / CITY ____ ST. ____ ZIP ____
17 PAY TO DENTIST OR GROUP PROVIDER NO.: 1800000
18 ARE X-RAYS ENCLOSED? [ ] YES [ ] NO — NUMBER OF X-RAYS
19 TREATMENT NECESSITATED BY: A. EMPLOYMENT [ ] YES [ ] NO; B. ACCIDENT/INJURY [ ] YES [ ] NO
20 PAYMENT SOURCE OTHER THAN TITLE XIX TPL CARRIER CODE: 1. 2. 3.
21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? [ ] YES [ ] NO
22 IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OFS DENTAL PROGRAM [ ]

23



A. INK IN RESTORATIONS
B. INDICATE MISSING TEETH WITH AN-X.
C. INDICATE CROWNS WITH AN-O.
D. INDICATE TEETH TO BE EXTRACTED WITH-/.

REMARKS FOR UNUSUAL SERVICE:

24 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU NO. 32 - USE CHARTING SYSTEM SHOWN.

A. TOOTH # OR LETTER	B. SURFACE	C. PROCEDURE CODE	D. DESCRIPTION OF SERVICE	UNITS	E. DATE SERVICE PERFORMED MO.	DAY	YR.	F. ADJUSTED FEE (FOR STATE USE ONLY)	G. USUAL AND CUSTOMARY FEE
16		D2931	Stainless Steel Crown		02	15	06		80 00

H. ORAL CAVITY

25 PAID OR PAYABLE BY OTHER CARRIER: $

26 CONTROL NUMBER: 5123456789012
(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.: 04/05/2006

28 REASONS FOR ADJUSTMENT

Billed wrong tooth #; Should be tooth # 16, not 15.

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

29 REASONS FOR VOID

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

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

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER — DATE

31 REQUEST FOR PRE-AUTHORIZATION (FOR STATE USE ONLY)
APPROVED - YES [ ] NO [ ] W/EXCEPTIONS [ ]
PA 123456789
AUTHORIZED SIGNATURE — DATE

32 *Dr. Joe Smiley, DDS*
ATTENDING DENTIST'S SIGNATURE
1888888 05/12/06
PROVIDER NUMBER

UNISYS 209
10/04

MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

Patient ID/Account Number

FOR PREAUTHORIZATION
MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT
REMIT TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
EPSDT DENTAL SERVICES

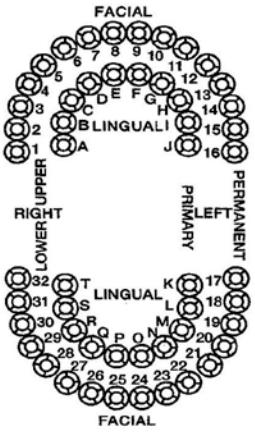
SAMPLE

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

2 PATIENT'S LAST NAME (PRINT): Smith
3 FIRST NAME: Sally
4 MI: L
5 MEDICAL ASSISTANCE I.D. NUMBER: 1 2 3 4 5 6 7 8 9 0 1 2 3
6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)
7 DATE OF BIRTH: 02 15 1999
8 SEX: [ ] M [X] F
9 REFERRING AGENCY NO.
10 DATE OF REFERRAL
11 REFERRED FOR: [ ] EMERGENCY [ ] BASIC SCREENING
12 DENTIST OR GROUP REFERRED TO: NAME / ADDRESS / TEL. NO.
13 REFERRED BY: (SIGNATURE)
14 TELEPHONE NO.
15 PATIENT I.D. / ACCOUNT # ASSIGNED BY DENTIST
16 PAY TO DENTIST OR GROUP: NAME / ADDRESS / CITY ____ ST. ____ ZIP ____
17 PAY TO DENTIST OR GROUP PROVIDER NO.: 1800000
18 ARE X-RAYS ENCLOSED? [ ] YES [ ] NO — NUMBER OF X-RAYS
19 TREATMENT NECESSITATED BY: A. EMPLOYMENT [ ] YES [ ] NO; B. ACCIDENT/INJURY [ ] YES [ ] NO
20 PAYMENT SOURCE OTHER THAN TITLE XIX TPL CARRIER CODE: 1. 2. 3.
21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? [ ] YES [ ] NO
22 IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OFS DENTAL PROGRAM [ ]

23



A. INK IN RESTORATIONS
B. INDICATE MISSING TEETH WITH AN-X.
C. INDICATE CROWNS WITH AN-O.
D. INDICATE TEETH TO BE EXTRACTED WITH-/.

REMARKS FOR UNUSUAL SERVICE:

24 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU NO. 32 - USE CHARTING SYSTEM SHOWN.

A. TOOTH # OR LETTER	B. SURFACE	C. PROCEDURE CODE	D. DESCRIPTION OF SERVICE	UNITS	E. DATE SERVICE PERFORMED MO. DAY YR.	F. ADJUSTED FEE (FOR STATE USE ONLY)	G. USUAL AND CUSTOMARY FEE
		D4210	Gingivectomy per quad		02 15 06		140 00
H. ORAL CAVITY		10				25 PAID OR PAYABLE BY OTHER CARRIER	$

26 CONTROL NUMBER: 5123456789012
(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.: 04/05/2006

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

Using new appropriate oral cavity code "10" to indicate "upper right".

29 REASONS FOR VOID

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

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

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER — DATE

31 REQUEST FOR PRE-AUTHORIZATION (FOR STATE USE ONLY)
APPROVED - YES [ ] NO [ ] W/EXCEPTIONS [ ]
PA 123456789
AUTHORIZED SIGNATURE — DATE

32
Dr. Joe Smiley, DDS
ATTENDING DENTIST'S SIGNATURE
1888888 05/12/06
PROVIDER NUMBER

UNISYS 209
10/04

MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

INSTRUCTIONS FOR COMPLETING 210 ADJUSTMENT/VOID FORM (ADULT)

1	Adj/Void	Check the appropriate box.
2-4	Patient's Last Name, First Name, MI	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
5	Medical Assistance ID Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
6	Patient's Address	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
7	Date of Birth	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
8	Sex	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
9-14		Not Required
15	Patient ID/Account Number (Assigned By Dentist)	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.

16	Pay to Dentist or Group	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
17	Pay to Dentist or Group Provider No.	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
18	Are X-Rays Enclosed	Not required.
19	Treatment Necessitated By	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
20	Payment Source Other Than Title XIX	**Adjust** - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. **Void** - Enter the information exactly as it appeared on the original invoice.
21		Not required.
22		Leave blank.
23	A - G	**Adjust** - Enter the information exactly as it appeared on the original invoice unless this information is being adjusted. **Void** - Enter the information exactly as it appeared on the original invoice.
24	Paid or Payable by Other Carrier	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0). **Void** - Enter the information exactly as it appeared on the original invoice.
25	Other Information	Leave blank.

26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the paid or denied the claim.
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied the claim.
28 & 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.
30	Request for Authorization	Leave this space blank.
31	Request for Pre-Authorization	Enter the 9-digit PA # assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization.
32	Attending Dentist's Signature - Provider Number	All adjustment forms must be signed, and the provider number must be entered.

If a new procedure or corrected procedure is entered on the adjustment form and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Unisys for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

Patient ID/Account Number

FOR PREAUTHORIZATION MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT REMIT TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
ADULT DENTAL SERVICES

SAMPLE

FOR OFFICE USE ONLY

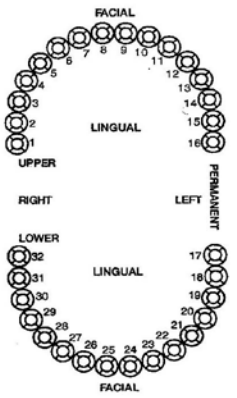
1 ADJ. [X] VOID [ ]

2 PATIENT'S LAST NAME (PRINT): Que
3 FIRST NAME: Suzie
4 MI: L
5 MEDICAL ASSISTANCE I.D. NUMBER: 1 2 3 4 5 6 7 8 9 0 1 2 3
6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)
7 DATE OF BIRTH: 06 19 1935
8 SEX: [ ] M [X] F

9 REFERRING AGENCY NO.
10 DATE OF REFERRAL
11
12 DENTIST OR GROUP REFERRED TO: NAME / ADDRESS / TEL. NO.
13 REFERRED BY: (SIGNATURE)
14 TELEPHONE NO.
15 PATIENT I.D. / ACCOUNT # ASSIGNED BY DENTIST

16 PAY TO DENTIST OR GROUP: NAME / ADDRESS / CITY ____ ST. ____ ZIP ____
17 PAY TO DENTIST OR GROUP PROVIDER NO.
18 ARE X-RAYS ENCLOSED? [ ] YES [ ] NO — NUMBER OF X-RAYS
19 TREATMENT NECESSITATED BY: A. EMPLOYMENT 1800000 [ ] YES [ ] NO; B. ACCIDENT/INJURY [ ] YES [ ] NO
20 PAYMENT SOURCE OTHER THAN TITLE XIX — TPL CARRIER CODE: 1. 2. 3.
21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? [ ] YES [ ] NO

22



INDICATE TEETH TO BE EXTRACTED WITH A/.

INDICATE MISSING TEETH WITH AN X.

SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND TEETH TO BE CLASPED.

23 A. PROCEDURE CODE	B. DESCRIPTION OF SERVICE	C. DATE SERVICE PERFORMED MO. DAY YEAR	D. ADJUSTED FEE (FOR STATE USE ONLY)	E. USUAL AND CUSTOMARY FEE
D5510	Repair Full Denture Base	03 20 06		85 00
F. ORAL CAVITY: 01	G. TOOTH #		24 PAID OR PAYABLE BY OTHER CARRIER	$

25 (1) IS THE PATIENT EDENTULOUS?
MAXILLARY: NO [ ] YES [ ] DATE OF LAST EXTRACTIONS ___/___/___
MANDIBULAR: NO [ ] YES [ ] DATE OF LAST EXTRACTIONS ___/___/___
(2) DOES PATIENT PRESENTLY WEAR A DENTURE? DATE OF PLACEMENT.
MAXILLARY: NO [ ] YES [ ] FULL [ ] PARTIAL [ ] MO. ____ YR. ____
MANDIBULAR: NO [ ] YES [ ] FULL [ ] PARTIAL [ ] MO. ____ YR. ____
COMMENTS:

INFORMATION FROM PATIENT
(1) IN WHAT MONTH AND YEAR WAS YOUR LAST DENTURE MADE? UPPER ____ LOWER ____
(2) NAME AND ADDRESS OF DENTIST
(3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES [ ] NO [ ]

26 CONTROL NUMBER: 5123456789012
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.: 04/26/2006

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 wrong charge amount. Initially billed $8.50 instead of $85.00.

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

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

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER DATE

31 REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY)
APPROVED YES [ ] NO [ ] W/EXCEPTIONS [ ]

32 *Dr. Joe Smiley, DDS*
ATTENDING DENTIST'S SIGNATURE
1888888 05/12/06
PROVIDER NUMBER

UNISYS-210
10/04

MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

Patient ID/Account Number

FOR PREAUTHORIZATION MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT REMIT TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
ADULT DENTAL SERVICES

SAMPLE

FOR OFFICE USE ONLY

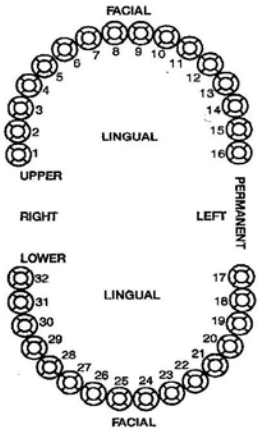
1 ADJ. [X] VOID [ ]

2 PATIENT'S LAST NAME (PRINT): **Jones**
3 FIRST NAME: **Lizzy**
4 MI: **L**
5 MEDICAID ASSISTANCE I.D. NUMBER: **1 2 3 4 5 6 7 8 9 0 1 2 3**
6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)
7 DATE OF BIRTH: **06 19 1950**
8 SEX: [ ] M [X] F

9 REFERRING AGENCY NO.
10 DATE OF REFERRAL
11
12 DENTIST OR GROUP REFERRED TO:
NAME
ADDRESS
TEL. NO.
13 REFERRED BY: (SIGNATURE)
14 TELEPHONE NO.
15 PATIENT I.D. / ACCOUNT # ASSIGNED BY DENTIST

16 PAY TO DENTIST OR GROUP
NAME
ADDRESS
CITY ST. ZIP
17 PAY TO DENTIST OR GROUP PROVIDER NO.: **1800000**
18 ARE X-RAYS ENCLOSED? [ ] YES [ ] NO
NUMBER OF X-RAYS
19 TREATMENT NECESSITATED BY:
A. EMPLOYMENT [ ] YES [ ] NO
B. ACCIDENT/INJURY [ ] YES [ ] NO
20 PAYMENT SOURCE OTHER THAN TITLE XIX
TPL CARRIER CODE:
1.
2.
3.
21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? [ ] YES [ ] NO

22



INDICATE TEETH TO BE EXTRACTED WITH A/.

INDICATE MISSING TEETH WITH AN X.

SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND TEETH TO BE CLASPED.

23 A. PROCEDURE CODE	B. DESCRIPTION OF SERVICE	C. DATE SERVICE PERFORMED MO. DAY YEAR	D. ADJUSTED FEE (FOR STATE USE ONLY)	E. USUAL AND CUSTOMARY FEE
D5520	Replace tooth on denture/partial	05 25 06		53 00

F. ORAL CAVITY	G. TOOTH #	24 PAID OR PAYABLE BY OTHER CARRIER
	13	$

25 (1) IS THE PATIENT EDENTULOUS?
MAXILLARY: NO [ ] YES [ ] DATE OF LAST EXTRACTIONS ___/___/___
MANDIBULAR: NO [ ] YES [ ] DATE OF LAST EXTRACTIONS ___/___/___
(2) DOES PATIENT PRESENTLY WEAR A DENTURE? DATE OF PLACEMENT.
MAXILLARY: NO [ ] YES [ ] FULL [ ] PARTIAL [ ] MO. ____ YR. ____
MANDIBULAR: NO [ ] YES [ ] FULL [ ] PARTIAL [ ] MO. ____ YR. ____
COMMENTS:

INFORMATION FROM PATIENT
(1) IN WHAT MONTH AND YEAR WAS YOUR LAST DENTURE MADE? UPPER ____ LOWER ____
(2) NAME AND ADDRESS OF DENTIST
(3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES [ ] NO [ ]

26 CONTROL NUMBER: **5123456789012**
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.: **06/08/2006**

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 wrong charge amount. Initially billed $5.30 instead of $53.00.

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

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

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER DATE

31 REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY)
APPROVED YES [ ] NO [ ] W/EXCEPTIONS [ ]

32 *Dr. Joe Smiley, DDS*
ATTENDING DENTIST'S SIGNATURE
1888888 06/12/06
PROVIDER NUMBER

UNISYS-210
10/04

MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

DENTAL CLAIM ERROR CODE INFORMATION

The Medicaid computer system compares information from claims against specific program requirements (i.e., reporting of tooth codes, prior authorization, service limitations, etc.) Claim error codes are used when the claim information does not match these program requirements. A discussion of the most common dental claim error codes follows. Please note that this is not a complete list of dental claim error codes. The remittance advice (RA) contains a brief description of each error code reported; however, if further explanation/information is required regarding an error code, the provider should contact Unisys Provider Relations by calling (800) 473-2783 or (225) 924-5040.

EDIT RESOLUTION		
Code	**Message**	**Resolution**
103	Invalid Tooth Code/Oral Cavity Designator	Either the data in the "Tooth # or letter" or oral cavity designator columns of the claim form is not recognized as a valid tooth code or oral cavity designator. Or The data in the "Tooth # or letter" column of the claim form is valid tooth code or oral cavity designator, but it is not valid for the service billed (e.g., billing a tooth number for a service requiring an oral cavity designator.). Or The claim does not indicate a tooth code or oral cavity designator for a procedure code that requires this information. Determine whether the procedure requires a tooth code or oral cavity designator. Correct the claim to reflect the appropriate and accurate data and resubmit the claim.
510	Only 1 of These Procs in 7 Years Per Recip/Provider	Only one of the procedures billed can be performed for the recipient, by the provider, within seven years. The system will deny the claim.
515	Override Required-Send To Dental PA Unit	The claim history for this recipient indicates this claim is the second restoration request for the same tooth within a year. The reason that the tooth requires a second or additional restoration must be well documented in the patient's record. For Medicaid to reconsider the claim, you must send the following to the LSU Dental School, Dental Medicaid Unit, P. O. Box 80159, Baton Rouge, Louisiana 70898-0159: • A cover letter requesting reconsideration of the 515 denial. • One original and one copy of the ADA claim form with the denied service(s) listed. NOTE: ADA claim form, Block 1, must be marked "Statement of Actual Services" and completed so that it is acceptable by Unisys for payment. • A copy of the Remittance Advice denying your request for payment (indicating the 515 denial). • A copy of the entire treatment record. • All pertinent radiographs taken. If radiographic copies are sent, they must be labeled right/left and be of good diagnostic quality.

EDIT RESOLUTION		
Code	**Message**	**Resolution**
598	PA Tooth/Oral Cavity Code Not Same as Claim	This claim was prior authorized. The tooth number/letter or oral cavity designator on the claim does not match the tooth number or oral cavity designator prior authorized. The system will deny the claim. Ensure that the correct prior authorization number, tooth number, and/or oral cavity designator were billed on the claim form. If not, correct the claim and resubmit.
603	Tooth Code/Oral Cavity Designator Required	The claim does not indicate a tooth code or oral cavity designator for a procedure code that requires this information. Ensure that the tooth code or oral cavity designator is on the claim form and in the correct column. Resubmit the claim.
613	Invalid Tooth Code/Oral Cavity Designator	Either the data in the "Tooth # or letter" or oral cavity designator columns of the claim form is not recognized as a valid tooth code or oral cavity designator. Or The data in the "Tooth # or letter" column of the claim form is valid tooth code or oral cavity designator, but it is not valid for the service billed (e.g., billing a tooth number for a service requiring an oral cavity designator.). Or The claim does not indicate a tooth code or oral cavity designator for a procedure code that requires this information. Determine whether the procedure requires a tooth code or oral cavity designator. Correct the claim to reflect the appropriate and accurate data and resubmit the claim.
742	Only 1 of These Procs Allowed in 5 Years Per Recip/Prov	Only one of the procedures billed can be performed for the recipient, by the provider, within five years. The system will deny the claim.
775	Payment Cutback Same Tooth	The claim history for this recipient indicates that Medicaid has already processed a claim or claims for this tooth, and the paid amounts have been applied toward the maximum amount allowed for the tooth. In payment of the current claim, only part of the billed amount could be reimbursed without exceeding the maximum allowed payment. Normally this occurs when more than one restoration is billed for the same tooth by the same provider within a certain period of time. Ensure the correct date of service and procedure code were billed on the claim form. If not, correct the claim and resubmit. Otherwise, refer to the patient's chart and billing records, including RAs that reflect payment for services for the recipient.
779	Procedure on Extracted Tooth Not Payable	The claim history for this recipient indicates that Medicaid has already paid for the extraction of this tooth. Ensure that the correct date of service, procedure code and tooth letter/number were billed on the claim form. If not, correct and resubmit. Otherwise, contact the Dental Medicaid Unit by calling 225-216-6470.

ORAL AND MAXILLOFACIAL SURGERY PROGRAM (MEDICAL SERVICES)

Covered Services

Medicaid recipients, regardless of age, who are eligible for services that are covered under the Physician's Program are eligible for coverage of essentially medically necessary oral and maxillofacial medical procedures that are covered in the Medicaid Physician's Program when required in the treatment of injury or disease related to the head and neck. Procedures performed for cosmetic purposes are not allowed.

Providers are not allowed to bill unlisted/miscellaneous Current Procedural Terminology (CPT) codes for services that have specific codes published in the Current Dental Terminology (CDT) for that service even if the CDT procedure is a non-covered Medicaid service. For example, a provider cannot bill an unlisted/miscellaneous CPT code for a tooth extraction since there are specific CDT codes for this procedure. Please note: Tooth extractions are not covered by Medicaid for adults except for those extractions covered in the Expanded Dental Services for Pregnant Women (EDSPW) Program.

Recipient Eligibility

Providers should verify the recipient's eligibility on each date of service using the Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS). Electronic Medicaid Eligibility Verification System (E-MEVS) is also available on the web at www.lamedicaid.com. The provider should keep hardcopy proof of eligibility from MEVS and/or e-MEVS in the patient's record. (Payment is made for authorized services only if the recipient is eligible on the date the service is rendered.)

Reimbursement

Reimbursement to providers is determined by federal regulations and state policy. Reimbursement to dental providers for oral and maxillofacial surgery services covered under the Physician's Program is based upon the fee for service that has been established for physician providers for the procedure code billed on the claim form.

Claims Filing

The CMS-1500 Claim Form is the only claim form that can be processed for payment of claims for medical services (CPT codes) in the Oral and Maxillofacial Surgery Program.

Procedure Codes

The CPT (Physicians Current Procedural Terminology) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by qualified

providers. The purpose of the terminology is to provide a uniform language that will accurately designate medical, surgical, and diagnostic services and that will provide an effective means for reliable, nationwide communications among providers, patients, and third parties.

Diagnosis Codes

Providers should use the appropriate diagnosis codes listed in the ICD-9-CM Diagnosis Code Book when completing the CMS-1500 claim form.

Diagnosis codes are required entries. Omission will cause the claim to be denied. The diagnosis codes appropriate for all treatment rendered should be listed in Block 21.

NOTE: A diagnosis code beginning with an E or M is not covered.

Additional Program Information

Please refer to the 2006 Basic Services Training Packet and/or the 2006 Professional Services Training Packet for additional information regarding claims filing, prior authorization, third party liability, Medicare/Medicaid reimbursement, etc.

COMMUNITYCARE

Program Description

CommunityCARE is operated as a State Plan option as published in the Louisiana Register volume 32: number 3 (March 2006). It is a system of comprehensive health care based on a primary care case management (PCCM) model. CommunityCARE links Medicaid eligibles with a primary care physician (PCP) that serves as their medical home.

Recipients

Participation in the CommunityCARE program is mandatory for most Medicaid eligibles. Currently, seventy-five to eighty percent of all Medicaid eligibles are linked to a primary care provider. Recipients not linked to a CommunityCARE PCP may continue to receive services without a referral/authorization just as they did before CommunityCARE. Those recipient types that are **EXEMPT** from participation in CommunityCARE, and will not be linked to a PCP, are listed below. (This list is subject to change):

- Residents of long term care nursing facilities, psychiatric facilities, or intermediate care facilities for the mentally retarded (ICF/MR) such as state developmental centers and group homes
- Recipients who are 65 or older
- Recipients with Medicare benefits, including dual eligibles
- Foster children or children receiving adoption assistance
- Hospice recipients
- Office of Youth Development recipients (children in State custody)
- Recipients in the Medicaid physician/pharmacy 'Lock-In' program (recipients that are pharmacy-only 'Lock-In' are not exempt)
- Recipients who have other primary insurance with physician benefits, including HMOs
- Recipients who have an eligibility period of less than 3 months
- Recipients with retroactive only eligibility (CommunityCARE does not make retroactive linkages)
- BHSF case-by-case approved "Medically High Risk" exemptions
- Native American Indians residing in parish of reservation (currently Jefferson Davis, St. Mary, LaSalle and Avoyelles parishes)
- Recipients in pregnant woman eligibility categories
- Recipients in the PACE program
- SSI recipients under the age of 19
- Recipients under the age of 19 in the NOW and Children's Choice waiver programs

CommunityCARE enrollees are identified under the CommunityCARE segment of REVS, MEVS and the online verification system through the Unisys website – www.lamedicaid.com. This segment gives the name and telephone number of the linked PCP.

Primary Care Physician

As part of the PCPs' care coordination responsibilities they are obligated to ensure that referral authorizations for medically necessary healthcare services which they can not/do not provide are furnished promptly and without compromise to quality of care. The PCP shall not unreasonably withhold or deny valid requests for referrals/authorizations that are made in accordance with CommunityCARE policy. The PCP also shall not require that the requesting provider complete the referral authorization form. The State encourages PCPs to issue appropriately requested referrals/authorizations as quickly as possible, taking into consideration the urgency of the enrollee's medical needs, not to exceed a period of 10 days. Although this time frame was designed to provide guidance for responding to requests for post-authorizations, we encourage PCPs to respond to requests sooner than 10 days if possible. Deliberately holding referral authorizations until the 10th day just because the PCP has 10 days is inappropriate.

The PCP referral/authorization requirement does not replace other Medicaid policies that are in existence. For example, if the service requires prior authorization, the provider must still obtain prior authorization **in addition to** obtaining the referrals/authorizations from the PCP.

The Medicaid covered services, which do not require authorization referrals from the CommunityCARE PCP, are "**exempt**." The current list of exempt services is as follows:

- Chiropractic service upon KIDMED referrals/authorizations, ages 0-21
- Dental services for children, ages 0-21 (billed on the ADA claim form)
- Dental Services for Pregnant Women (ages 21-59), billed on the ADA claim form
- Dentures for adults
- The three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but **do require POST authorization**. Refer to "Emergency Services" in the CommunityCARE Handbook
- Inpatient Care that has been pre-certed (this also applies to public hospitals even without pre-certification for inpatient stays): hospital, physician, and ancillary services billed with inpatient place of service.
- EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program
- Family planning services
- Prenatal/Obstetrical services
- Services provided through the Home and Community-Based Waiver programs
- Targeted case management
- Mental Health Rehabilitation(privately owned clinics)
- Mental Health Clinics(State facilities)
- Neonatology services while in the hospital
- Ophthalmologist and Optometrist services (age 0-21)
- Pharmacy
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists services
- Transportation services

- Hemodialysis
- Hospice services
- Specific outpatient laboratory/radiology services
- Immunization for children under age 21 (Office of Public Health and their affiliated providers)
- WIC services (Office of Public Health WIC Clinics)
- Services provided by School Based Health Centers to recipients age 10 and over
- Tuberculosis clinic services (Office of Public Health)
- STD clinic services (Office of Public Health)
- Specific lab and radiology codes

Non-PCP Providers and Exempt Services

Any provider other than the recipient's PCP must obtain a referral from the recipient's PCP, **prior to rendering services**, in order to receive payment from Medicaid. Any provider who provides a non-exempt, non-emergent (routine) service for a CommunityCARE enrollee, without obtaining the appropriate referral/authorization prior to the service being provided risks non-payment by Medicaid. **DHH and Unisys will not assist providers with obtaining referrals/authorizations for routine/non-urgent care not requested in accordance with CommunityCARE policy.** PCPs are not required to respond to requests for referrals/authorizations for non-emergent/routine care not made in accordance with CommunityCARE policy: i.e. requests made after the service has been rendered.
When a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the patient's PCP to obtain the appropriate referral/authorization for any follow-up services the patient may need after discharge (i.e. Durable Medical Equipment (DME) or home health). Neither the home health nor DME provider can receive reimbursement from Medicaid without the appropriate PCP referral/authorization. **The DME and home health provider must have the referral/authorization in hand prior to rendering the services.**

General Assistance – all numbers are available Mon-Fri, 8am-5pm

Providers:

Unisys - (800) 473-2783 or (225) 924-5040 - CommunityCARE Program policy, procedures, and problems, complaints concerning CommunityCARE

ACS - (800) 259-4444 PCP - assignment for CommunityCARE recipients, inquiries related to monitoring, certification

ACS - (877) 455-9955 – Specialty Care Resource Line - assistance with locating a specialist in their area who accepts Medicaid.

Enrollees:

Medicaid provides several options for enrollees to obtain assistance with their Medicaid enrollment. Providers should make note of these numbers and share them with recipients.

- CommunityCARE Enrollee Hotline (800) 259-4444: Provides assistance with questions or complaints about CommunityCARE or their PCP. It is also the number recipients call to select or change their PCP.

- Specialty Care Resource Line (877) 455-9955: Provides assistance with locating a specialist in their area who accepts Medicaid.

- CommunityCARE Nurse Helpline (866) 529-1681: Is a resource for recipients to speak with a nurse 24/7 to obtain assistance and information on a wide array of health-related topics.

- www.la-communitycare.com

- www.lamedicaid.com

PHARMACY SERVICES

Prior Authorization

The prescribing provider must request prior authorization for non-preferred drugs from the University of Louisiana – Monroe. Prior authorizations requests can be obtained by phone, fax, or mail, as listed below.

Contact information for the Pharmacy Prior Authorization department:

Phone: (866) 730-4357 (8 a.m. to 6 p.m., Monday through Saturday)
FAX: (866) 797-2329

University of Louisiana – Monroe
School of Pharmacy
1401 Royal Avenue
Monroe, LA 71201

The following page includes a copy of the "Request for Prescription Prior Authorization" form, as can be found on the LAMedicaid.com website under "Rx PA Fax Form".

Preferred Drug List (PDL)

The most current PDL can be found on the LAMedicaid.com website.

Monthly Prescription Service Limit

An eight-prescription limit per recipient per calendar month has been implemented in the LA Medicaid Pharmacy Program.

The following federally mandated recipient groups are exempt from the eight-prescription monthly limitation:

- Persons under the age of twenty-one (21) years
- Persons living in long term care facilities such as nursing homes and ICF-MR facilities
- Pregnant women

If it is deemed medically necessary for the recipient to receive more than eight prescriptions in any given month, the provider must write "medically necessary override" and the ICD-9-CM diagnosis code that directly relates to each drug prescribed on the prescription.

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).

Date of Request:*	Number of Fax Pages (including cover page):*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth:*
Call-Back Phone Number (include area code):*	
Fax Number (include area code):	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO
2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:
3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interaction(s) in the box below:
4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:*

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

CONFIDENTIALITY NOTICE
The documents accompanying this facsimile transmission may contain confidential information which is legally privileged. The information is intended only for the use of the individual or entity to which it is addressed. If you are not the intended recipient, you are hereby notified that any review, disclosure/redisclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy this information.

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

Any submitter - individual providers, clearinghouse, billing agents, etc. - that submits at least one claim electronically in a given year is required to submit an Annual EDI Certification Form. This form is then kept on file to cover all submissions within the calendar year. It must be signed by an authorized representative of the provider and must have an original signature (no stamps or initials.)

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 EDI Certification Notices and Forms HIPAA Information Center link. The required forms are also available in both the General EDI Companion Guide and the EMC Enrollment Packet.

Failure to submit the Annual Certification Form will result in deactivation of the submitter number. Once the Cert is received, the number will be reactivated. There will be a delay if the number is deactivated thus preventing timely payment to your providers. Failure to correctly complete the Certification Form will result in the form being returned for correction.

To contact the EMC Department at Unisys, call (225) 216-6000 and select option 2. Providers may write to Unisys EMC Department, P.O. Box 91025, Baton Rouge, LA 70821.

Electronic Data Interchange (EDI) General Information

Please review the entire General EDI Companion Guide before completing any forms or calling the EMC 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

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.

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 MEDIA SUBMISSION OF CLAIMS** (EMC Contract).

- **Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse** – complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS** (EMC 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 EMC Contract and a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Enrollment Requirements For 835 Electronic Remittance Advices

- All EMC billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EMC 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 EMC Department at (225) 216-6000 ext. 2.

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, 11/21/06
KIDMED Submissions	4:30 P.M. Tuesday, 11/21/06
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/22/06

Important Reminders For EMC 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.**

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
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
Timely filing - letter/other proof i.e., RA page	Continue hardcopy billing

PLEASE NOTE: When a provider submits a claim, which has more than one page of procedures and charges, each claim page must be totaled and attachments must be submitted with each page of the claim.

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 form 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.

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.

Rejected Claims

Unisys currently returns claims that are illegible or incomplete. These claims are not processed and are returned along with a cover letter stating why the claim(s) is/are rejected. During 2005, Unisys returned 273,291 rejected claims to providers. The most common reasons for rejection are listed as follows:

- A signature or handwritten initials were missing
- The recipient number was invalid or missing
- The provider # was missing or incomplete

The criteria for legible claims are:

- All claim forms are clear and in good condition
- All information is readable to the normal eye
- All information is centered in the appropriate block
- All essential information is complete

IMPORTANT UNISYS ADDRESSES

Please be aware that **different post office boxes** are used for the various Medicaid programs. If you are submitting an original "clean" hard copy claim for payment or adjustments/voids, please utilize the following post office boxes and zip codes.

Type of Claim	P.O. Box	Zip Code
Pharmacy	91019	70821
CMS-1500 Claims Case Management Chiropractic Durable Medical Equipment EPSDT Health Services FQHC Hemodialysis Professional Services Independent Lab Mental Health Rehabilitation PCS Professional Rural Health Clinic Substance Abuse and Mental Health Clinic Waiver	91020	70821
Inpatient & Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long Term Care	91021	70821
Dental, Home Health, Rehabilitation, Transportation (Ambulance and Non-ambulance)	91022	70821
ALL Medicare Crossovers and All Medicare Adjustments and Voids	91023	70821
KIDMED	14849	70898

Unisys also has different post office boxes for various departments. They are as follows:

Department	P.O. Box	Zip Code
EMC, Unisys business & Miscellaneous Correspondence	91025	70898
Prior Authorization*	14919	70898
Provider Enrollment	80159	70898
Provider Relations	91024	70821

*Dental prior authorization requests must be sent to the following:

LSU Dental School
Dental Medicaid Unit
P.O. Box 80159
Baton Rouge, LA 70898-0159

TIMELY FILING GUIDELINES

In order to be reimbursed for services rendered, all providers must comply with the following filing limits set by Medicaid of Louisiana:

- Straight Medicaid claims must be filed within 12 months of the date of service.
- KIDMED screening claims (KM-3 forms or 837P with K-3 segment) must be filed within 60 days from the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations.
- Claims which fail to cross over via tape and have to be filed hard copy MUST be adjudicated within six months from the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.
- Claims with third-party payment must be filed to Medicaid within 12 months of the date of service.

Dates of Service Past Initial Filing Limit

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

A Claims Status Inquiry (e-CSI) screen print indicating that the claim was processed within the specified time frame.

OR

A Remittance Advice indicating that the claim was processed within the specified time frame.

OR

Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the recipient.

NOTE 1: All proof of timely filing documentation must reference the individual recipient and date of service. RA pages and e-CSI screen prints must contain the specific recipient information, provider information, and date of service to be considered as proof of timely filing.

NOTE 2: At this time Louisiana Medicaid **does not** accept printouts of Medicaid Electronic Remittance Advice (ERA) screens as proof of timely filing. Reject letters are not considered proof of timely filing as they do not reference a specific individual

recipient or date of service. Postal "certified" receipts and receipts from other delivery carriers are not acceptable proof of timely filing.

To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible.

Submitting Claims for Two-Year Override Consideration

Providers requesting two-year overrides for claims with dates of service over two years old must provide proof of timely filing and must assure that each claim meets at least one of the three criteria listed below:

- The recipient was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted.
- The recipient won a Medicare or SSI appeal in which he or she was granted retroactive Medicaid Benefits.
- The failure of the claim to pay was the fault of the Louisiana Medicaid Program rather than the provider's each time the claim was adjudicated.

All provider requests for two-year overrides must be mailed directly to:

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

The provider must submit the claim with a cover letter describing the criteria that has been met for consideration along with all supporting documentation. Supporting documentation includes but is not limited to proof of timely filing and evidence of the criteria met for consideration.

Claims submitted without a cover letter, proof of timely filing, and/or supporting documentation will be returned to the provider without consideration. Any request submitted directly to DHH staff will be routed to Unisys Provider Relations.

PROVIDER ASSISTANCE

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

LSU DENTAL SCHOOL, DENTAL MEDICAID UNIT

The LSU Dental School, Dental Medicaid Unit, can assist providers with inquiries related to the Medicaid dental programs and may be reached by calling 225-216-6470.

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) 216-6334**

*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 Louisiana Medicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

Provider Relations cannot assist recipients. The telephone listing in the "Recipient Assistance" section found on page 95 should be used to direct Medicaid recipient inquiries appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number bay be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

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 Third Party Liability (TPL) should be directed to:

DHH-Third Party 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 is available in this training packet under "Unisys Claims Filing Addresses".

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, since Field Analysts routinely work in the field, they 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	
Kellie Conforto (225) 216-6269	Assumption Calcasieu Cameron Jeff Davis Lafourche	St. Mary St. Martin (**below Iberia**) Terrebonne Vermillion
Martha Craft (225) 216-6306	Jefferson Orleans Plaquemines St. Bernard	St. Charles St. James St. John the Baptist St. Tammany (**Slidell only**)
Sharon Harless (225) 216-6267	East Baton Rouge (**Baker & Zachary only**) West Baton rouge Iberville Pointe Coupee	St. Helena East Feliciana West Feliciana Woodville (MS) Centerville (MS)
Erin McAlister (225) 216-6201	Ascension East Baton Rouge (**excluding Baker & Zachary**) Livingston	St. Tammany (**excluding Slidell**) Tangipahoa Washington McComb (MS)
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin (**above Iberia**) Beaumont (TX)
Kathy Robertson (225) 216-6260	Avoyelles Beauregard Caldwell Catahoula Concordia Franklin Grant LaSalle	Natchitoches Rapides Sabine Tensas Vernon Winn Natchez (MS) Jasper (TX)
Anna Sanders (225) 216-6273	Bienville Bossier Caddo Claiborne DeSoto East Carroll Jackson Lincoln Madison	Morehouse Ouachita Red River Richland Union Webster West Carroll Marshall (TX) Vicksburg (MS)

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) 216-6334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 216-6381	(225) 216-6334
Electronic Media Claims (EMC) - Unisys		(225) 216-6000 option 2	(225) 216-6335
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 216-6342
Dental P.A. - LSU School of Dentistry		**(225) 216-6470**	**(225) 216-6476**
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 216-6370	
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) 342-9808	Providers may request verification of eligibility for presumptively eligible recipients; recipients may request a new card or discuss eligibility issues.
Eligibility Operations – **BHSF**	(888) 342-6207	Recipients may address eligibility questions and concerns
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - **Vaccines for Children Program**	(504) 838-5300	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Specialty Care Resource Line - **ACS**	(877) 455-9955	Providers and recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED. Providers may inquire about PCP assignment for CommunityCARE recipients and CommunityCARE monitoring/certification, and obtain information on KIDMED linkage, referrals, monitoring, and certification.
CommunityCARE Nurse Helpline – **ACS**	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - **OPH**	(866) 327-5978	Providers and recipients may obtain information on EarlySteps Program and services offered
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4153	Providers may request termination as a recipient's lock-in provider.
Division of Long Term Supports and Services (DLTSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding waiver services to waiver 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 specific program:

Program Manager - (i.e. Dental, DME, Hospital, etc.)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

The telephone listing below should be used to direct **recipient** inquiries appropriately.

Department	Phone	Purpose
Fraud and Abuse Hotline	(800) 488-2917	Recipients may anonymously report any suspected fraud and/or abuse.
Regional Office – DHH	(800) 834-3333 (225) 342-9808	Recipients may request a new card or discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns
LaCHIP Program	(877) 252-2447	Recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Specialty Care Resource Line - ACS	(877) 455-9955	Recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED.
CommunityCARE Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - OPH	(866) 327-5978	Recipients may obtain information on EarlySteps Program and services offered
LINKS	(504) 838-5300	Recipients may obtain immunization information.
Division of Long Term Supports and Services (DLTSS)	(225) 219-0200 (800) 660-0488	Recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 219-0200 (800) 660-0488	Recipients may request assistance regarding waiver services.

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; and
- 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; and
- Prior Authorization (e-PA) for requesting prior authorizations electronically.

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 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 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 statuses to have access to remittance advices for this purpose. A 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.

e-PA:

Dental electronic Prior Authorization (e-PA) is currently being developed and will be tested in the near future. Refer to page 49 for further information regarding dental electronic Prior Authorization.

Additional DHH Available Websites

www.lamedicaid.com: Louisiana Medicaid Information Center which includes field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, fee schedules, and program training packets

www.lamedicaid.com/provweb1/HIPAA/HIPAAindex.htm: Louisiana Medicaid HIPAA Information Center

www.dhh.louisiana.gov: DHH website – LINKS (includes a link entitled "Find a doctor or dentist in Medicaid")

www.dhh.state.la.us: Louisiana Department of Health and Hospitals (DHH)

www.la-kidmed.com: KIDMED – program information, Frequently Asked Questions, outreach material ordering

www.la-communitycare.com: CommunityCARE – program information, PCP listings, Frequently Asked Questions, outreach material ordering

https://linksweb.oph.dhh.louisiana.gov: Louisiana Immunization Network for Kids Statewide (LINKS)

www.ltss.dhh.louisiana.gov: Division of Long Term Community Supports and Services (DLTSS)

www.dhh.louisiana.gov/offices/?ID=77: Office of Citizens with Developmental Disabilities (OCDD)

www.dhh.louisiana.gov/offices/?ID=257: EarlySteps Program

www.dhh.state.la.us/offices/?ID=111: DHH Rate and Audit Review (nursing home updates and cost report information, Outpatient Surgery Fee Schedule, Updates to Ambulatory Surgery Groups, contacts, FAQ)

www.doa.louisiana.gov/employ_holiday.htm: State of Louisiana Division of Administration site for Official State Holidays

Appendix A

EPSDT Dental Program Fee Schedule

EFFECTIVE NOVEMBER 1, 2005

APPENDIX A: EPSDT DENTAL PROGRAM FEE SCHEDULE

Effective November 1, 2005

All procedures listed in the EPSDT Dental Program Fee Schedule are subject to the guidelines, policies and limitations of the Louisiana Medicaid EPSDT Dental Program. Please refer to the EPSDT Dental Program section of the Dental Services Manual for complete guidelines, policies and limitations for each procedure.

All services marked with an asterisk (*) in the code column require prior authorization.

All services marked with an underscored asterisk (*) in the code column requires partial prior authorization. Prior authorization requirements for these procedures are based on tooth number or age of recipient.

All services marked with a number sign (#) in the code column for the EPSDT Dental Program require a tooth number or letter to be specified on the claim form for payment requests and prior authorization requests if required.

All services marked with a plus sign (+) in the code column for the EPSDT Dental Program require an oral cavity designator to be specified on the claim form for payment requests and prior authorization requests if required.

Fees marked with a check mark (√) in the fee column denotes fee for permanent tooth.

All fees marked with 5 asterisks (*****) in the fee column will be priced manually by the dental consultant.

EPSDT DENTAL PROGRAM FEE SCHEDULE

EPSDT DENTAL PROGRAM DIAGNOSTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
D0120	Periodic Oral Examination – Patient of Record	18.00
D0150	Comprehensive Oral Examination – New Patient Note: Medicaid requires use of this code to report new patients (patients not seen by the billing provider within 3 years) only.	20.00
*D0210	Radiographs – Complete Series (including bitewings)	35.00
#D0220	Radiograph – Periapical, First Film This procedure is reimbursable for Tooth Numbers 1 through 32; and Tooth Letter A through T.	6.00
#D0230	Radiograph – Periapical, Each Additional Film This procedure is reimbursable for Tooth Numbers 1 through 32; and Tooth Letter A through T.	5.00
+*D0240	Radiograph – Occlusal Film This procedure is reimbursable for Oral Cavity Designator 01 and 02.	10.00
D0272	Radiograph – Bitewings, Two Films	13.00
*D0330	Radiograph – Panoramic Film	35.00
+D0350	Oral/Facial Images This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	4.00
*D0470	Diagnostic Casts	25.00
*D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report	80.00
*D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical Margins for Presence of Disease, Preparation and Transmission of Written Report	80.00

EPSDT DENTAL PROGRAM PREVENTIVE PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
D1110	Prophylaxis – Adult (12 through 20 years of age)	29.00
D1120	Prophylaxis – Child (under 12 years of age)	15.00
D1203	Topical Application of Fluoride (prophylaxis not included) – Child (under 12 years of age)	11.00
D1204	Topical Application of Fluoride (prophylaxis not included) – Adult (12 through 15 years of age)	11.00
#D1351	Sealant, Per Tooth (6-year molar sealant – under 10 years of age; 12-year molar sealant – 10 through 15 years of age.) This procedure is reimbursable for Tooth Numbers 2, 3, 14, 15, 18, 19, 30, and 31.	19.00
+*D1510	Space Maintainer, Fixed, Unilateral This procedure is reimbursable for Oral Cavity Designator 10, 20, 30, and 40.	95.00
+*D1515	Space Maintainer, Fixed, Bilateral This procedure is reimbursable for Oral Cavity Designator 01 and 02.	177.00
+D1550	Recementation of Space Maintainer This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30, and 40.	20.00

EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#D2140	Amalgam, One Surface, Primary or Permanent This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T. However, this Procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	40.00/47.00√

EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#D2150	Amalgam, Two Surfaces, Primary or Permanent This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T. However, this Procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	55.00/58.00√
#D2160	Amalgam, Three Surfaces, Primary or Permanent This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T. However, this Procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	70.00/74.00√
#D2161	Amalgam, Four or More Surfaces, Permanent This procedure is reimbursable for Tooth Numbers 1 through 32.	108.00
#D2330	Resin-based Composite, One Surface, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letter C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	65.00
#D2331	Resin-based Composite, Two Surfaces, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	75.00
#D2332	Resin-based Composite, Three Surfaces, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	85.00

EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#*D2335	Resin-based Composite, Four or More Surfaces, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	108.00
#*D2390	Resin-based Composite Crown, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27; and Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	104.00
#D2920	Recement Crown This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T.	20.00
#*D2930	Prefabricated Stainless Steel Crown, Primary Tooth This procedure is reimbursable for Tooth Letters A through T. However, this procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. Prior Authorization is required only for Tooth Letters B, I, L, and S for recipients 8 years of age and older; and for Tooth Letters A, C, H, J, K, M, R and T for recipients 9 years of age and older.	108.00
#*D2931	Prefabricated Stainless Steel Crown, Permanent Tooth This procedure is reimbursable for Tooth Numbers 1 through 32.	108.00
#*D2932	Prefabricated Resin Crown This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27; and Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	104.00
#*D2950	Core Buildup, Including Any Pins This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31	55.00

EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#D2951	Pin Retention, Per Tooth, In Addition To Restoration This procedure is reimbursable for Tooth Numbers 2 through 5; 12 through 15; 18 through 21; and 28 through 31.	15.00
#*D2954	Prefabricated Post And Core In Addition To Crown This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31	75.00
#*D2999	Unspecified Restorative Procedure, By Report	*****

EPSDT DENTAL PROGRAM ENDODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#D3110	Pulp Cap – Direct (excluding final restoration) This procedure is reimbursable for Tooth Numbers 1 through 32.	15.00
#*D3220	Therapeutic Pulpotomy (excluding final restoration) This procedure is reimbursable for Tooth Numbers 1 through 32; and Tooth Letters A through T. However, this procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. Prior authorization required for Tooth Numbers 1 through 32 only.	40.00
#*D3240	Pulpal Therapy (Resorbable Filling), Posterior, Primary Tooth This procedure is reimbursable for Tooth Letters A, J, K, and T.	50.00
#*D3310	Root Canal Therapy, Anterior (excluding final restoration) This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27.	212.00
#*D3320	Root Canal Therapy, Bicuspid (excluding final restoration) This procedure is reimbursable for Tooth Numbers 4, 5, 12, 13, 20, 21, 28 and 29.	241.00
#*D3330	Root Canal Therapy, Molar (excluding final restoration) This procedure is reimbursable for Tooth Numbers 2, 3, 14, 15, 18, 19, 30 and 31.	306.00

EPSDT DENTAL PROGRAM ENDODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#*D3346	Retreatment of Previous Root Canal Therapy, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27.	212.00
#*D3352	Apexification/Recalcification, Interim Medication Replacement This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	50.00
#*D3410	Apicoectomy/Periradicular Surgery, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27.	100.00
#*D3430	Retrograde Filling, Per Root This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27.	56.00
#*D3999	Unspecified Endodontic Procedure, By Report	*****

EPSDT DENTAL PROGRAM PERIODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
+*D4210	Gingivectomy or Gingivoplasty, Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	125.00
+*D4341	Periodontal scaling and root planing – four or more teeth per quadrant This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	81.00
*D4355	Full Mouth Debridement To Enable Comprehensive Evaluation and Diagnosis	61.00
*D4999	Unspecified Periodontal Procedure, By Report	*****

EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
*D5110	Complete Denture, Maxillary	495.00

EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
*D5120	Complete Denture, Mandibular	495.00
*D5130	Immediate Denture, Maxillary	495.00
*D5140	Immediate Denture, Mandibular	495.00
*D5211	Maxillary Partial Denture, Resin Base (including clasps)	470.00
*D5212	Mandibular Partial Denture, Resin Base (including clasps)	470.00
*D5213	Maxillary Partial Denture, Cast Metal (including clasps)	550.00
*D5214	Mandibular Partial Denture, Cast Metal (including clasps)	550.00
+D5510	Repair Broken Complete Denture Base This procedure is reimbursable for Oral Cavity Designator 01 and 02.	100.00
#D5520	Replace Missing or Broken Tooth, Complete Denture, Per Tooth 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	52.00/26.00
+D5610	Repair Resin Denture Base, Partial Denture This procedure is reimbursable for Oral Cavity Designator 01 and 02.	100.00
+D5630	Repair or Replace Broken Clasp, Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	95.00
#D5640	Replace Broken Teeth, Partial Denture, Per Tooth 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	52.00/26.00
#D5650	Add Tooth to Existing Partial Denture 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	52.00/26.00
+D5660	Add Clasp to Existing Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	95.00
*D5750	Reline Complete Maxillary Denture (Laboratory)	238.00
*D5751	Reline Complete Mandibular Denture (Laboratory)	238.00

EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
*D5760	Reline Maxillary Partial Denture (Laboratory)	208.00
*D5761	Reline Mandibular Partial Denture (Laboratory)	208.00
*D5820	Interim Partial Denture (Maxillary), Includes Clasps	300.00
*D5821	Interim Partial Denture (Mandibular), Includes Clasps	300.00
*D5899	Unspecified Removable Prosthodontic Procedure, By Report	*****

EPSDT DENTAL PROGRAM MAXILLOFACIAL PROSTHETIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
+*D5986	Fluoride Gel Carrier This procedure is reimbursable for Oral Cavity Designators 01 and 02.	30.00

EPSDT DENTAL PROGRAM FIXED PROSTHODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#*D6241	Pontic - Porcelain Fused to Predominantly Base Metal This procedure is reimbursable for Tooth Numbers 7, 8, 9, and 10.	300.00
#*D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis This procedure is reimbursable for Tooth Numbers 6, 7, 8, 9, 10 and 11.	150.00
*D6999	Unspecified, Fixed Prosthodontic procedure, By Report	*****

EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#D7140	Extraction, Erupted Tooth or Exposed Root This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	46.00
#*D7210	Surgical Removal of Erupted Tooth This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	57.00

EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#*D7220	Removal of Impacted Tooth – Soft Tissue This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	86.00
#*D7230	Removal of Impacted Tooth – Partially Bony This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	136.00
#*D7240	Removal of Impacted Tooth – Completely Bony This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	161.00
#*D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	186.00
#*D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure) This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	57.00
+*D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth This procedure is reimbursable for Oral Cavity Designators 01 and 02.	***** Maximum Fee 150.00
#*D7280	Surgical Access of an Unerupted Tooth This procedure is reimbursable for Tooth Numbers 2 through 15; and 18 through 31.	50.00
#*D7283	Placement of Device to Facilitate Eruption of Impacted Tooth This procedure is reimbursable for Tooth Numbers 2 through 15; and 18 through 31 <u>for Medicaid approved comprehensive orthodontic cases only.</u>	$250.00

EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
+*D7285	Biopsy of Oral Tissue – Hard (bone, tooth) This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 or 40.	***** Maximum Fee 200.00
+*D7286	Biopsy of Oral Tissue - Soft (all others) This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40.	50.00
+*D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report This procedure is reimbursable for Oral Cavity Designators 01 and 02 for Medicaid approved comprehensive orthodontic cases only.	60.00
+*D7310	Alveoloplasty in Conjunction with Extractions – Per Quadrant This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40.	54.00
#D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue This procedure is reimbursable for Tooth Numbers 1 through 32.	38.00
+*D7880	Occlusal Orthotic Device, By Report This procedure is reimbursable for Oral Cavity Designators 01 and 02.	250.00
D7910	Suture of Recent Small Wounds up to 5 cm	50.00
+*D7960	Frenulectomy (Frenectomy or Frenotomy) – Separate Procedure This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40.	90.00
*D7999	Unspecified Oral Surgery Procedure, By Report	*****

EPSDT DENTAL PROGRAM ORTHODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
+*D8050	Interceptive Orthodontic Treatment of the Primary Dentition This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40.	***** Maximum Fee 350.00
+*D8060	Interceptive Orthodontic Treatment of the Transitional Dentition This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40.	***** Maximum Fee 350.00
*D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition	***** Maximum Fee 4,050.00
*D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	***** Maximum Fee 4,050.00
*D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	***** Maximum Fee 4,050.00
*D8220	Fixed Appliance Therapy	150.00
*D8999	Unspecified Orthodontic Procedure, By Report	*****

EPSDT DENTAL PROGRAM ADJUNCTIVE GENERAL SERVICES		
CODE	**DESCRIPTION**	**FEE**
D9110	Palliative (Emergency) Treatment of Dental Pain	25.00
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	7.00
*D9241	Intravenous Conscious Sedation/Analgesia – First 30 Minutes	94.00
*D9242	Intravenous Conscious Sedation/Analgesia – Each Additional 15 Minutes	31.00
*D9248	Non-intravenous Conscious Sedation	50.00
*D9420	Hospital Call	125.00
*D9440	Office Visit – After Regularly Scheduled Hours	75.00
*D9920	Behavior Management, By Report	30.00

EPSDT DENTAL PROGRAM ADJUNCTIVE GENERAL SERVICES		
CODE	**DESCRIPTION**	**FEE**
+*D9940	Occlusal Guard, By Report This procedure reimbursable for Oral Cavity Designators 01 and 02.	50.00
*D9951	Occlusal Adjustment – Limited	68.00
*D9999	Unspecified Adjunctive Procedure, By Report	*****

Note: Dental prior authorization requests and dental claims for payment must indicate tooth surface(s) when the procedure code directly involves one or more tooth surfaces.

Appendix B

ADULT Denture Program Fee Schedule

EFFECTIVE AUGUST 1, 2003

APPENDIX B: ADULT DENTURE PROGRAM FEE SCHEDULE

Effective August 1, 2003

Provided in the table on the following pages are the reimbursable dental procedure codes and fees for the Medicaid of Louisiana, Adult Denture Program.

All procedures listed in the Adult Denture Program Fee Schedule are subject to the guidelines, policies and limitations of the Medicaid of Louisiana, Adult Denture Program. Please refer to the Adult Denture Program section of the Dental Services Manual for complete guidelines, policies and limitations for each procedure.

All services marked with an asterisk (*) in the code column require prior authorization.

All services marked with a number sign (#) in the code column require a tooth number to be specified on the claim form for payment requests and prior authorization requests if required.

All services marked with a plus sign (+) in the code column require an oral cavity designator to be specified on the claim form for payment requests and prior authorization requests if required.

All fees marked with 5 asterisks (*****) in the fee column will be priced manually by the dental consultant.

ADULT DENTURE PROGRAM FEE SCHEDULE

ADULT DENTURE PROGRAM DIAGNOSTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
*D0150	Comprehensive Oral Examination (Adult Oral Examination)	20.00
*D0210	Intraoral Radiographs, Complete Series	35.00

ADULT DENTURE PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
*D5110	Complete Denture, Maxillary	495.00
*D5120	Complete Denture, Mandibular	495.00
*D5130	Immediate Denture, Maxillary	495.00
*D5140	Immediate Denture, Mandibular	495.00
*D5211	Maxillary Partial Denture, Resin Base (including clasps)	470.00
*D5212	Mandibular Partial Denture, Resin Base (including clasps)	470.00
+D5510	Repair Broken Complete Denture Base This procedure is reimbursable for Oral Cavity Designators 01 and 02.	100.00
#D5520	Replace Missing or Broken Tooth, Complete Denture, Per Tooth 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	52.00/26.00
+D5610	Repair Resin Denture Base, Partial Denture This procedure is reimbursable for Oral Cavity Designators 01 and 02.	100.00
+D5630	Repair or Replace Broken Clasp, Partial Denture This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40.	95.00
#D5640	Replace Broken Teeth, Partial Denture, Per Tooth 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	52.00/26.00

ADULT DENTURE PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
#D5650	Add Tooth to Existing Partial Denture 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	52.00/26.00
+D5660	Add Clasp to Existing Partial Denture This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40.	95.00
*D5750	Reline Complete Maxillary Denture (Laboratory)	238.00
*D5751	Reline Complete Mandibular Denture (Laboratory)	238.00
*D5760	Reline Maxillary Partial Denture (Laboratory)	208.00
*D5761	Reline Mandibular Partial Denture (Laboratory)	208.00
*D5899	Unspecified Removable Prosthodontic Procedure, By Report	*****

Appendix C

Expanded Dental Services for Pregnant Women (EDSPW) Program Fee Schedule

EFFECTIVE NOVEMBER 1, 2005

APPENDIX C: EXPANDED DENTAL SERVICES FOR PREGNANT WOMEN (EDSPW) PROGRAM FEE SCHEDULE

Effective November 1, 2005

Provided in the table on the following pages are the reimbursable dental procedure codes and fees for the Medicaid of Louisiana, Expanded Dental Services for Pregnant Women (EDSPW) Program.

All procedures listed in the EDSPW Program Fee Schedule are subject to the guidelines, policies and limitations of the Medicaid of Louisiana, EDSPW Program. Please refer to page 12 of this document for further guidelines, policies and limitations of each procedure.

All services marked with an asterisk (*) in the code column require prior authorization.

All services marked with a number sign (#) in the code column require a tooth number or letter to be specified on the claim form for payment requests and prior authorization requests if required.

All services marked with a plus sign (+) in the code column require an oral cavity designator to be specified on the claim form for payment requests and prior authorization requests if required.

EXPANDED DENTAL SERVICES FOR PREGNANT WOMEN (EDSPW) PROGRAM FEE SCHEDULE

CODE	DESCRIPTION	FEE
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	20.00
#D0220	Intraoral - Periapical First Film This procedure is reimbursable for Tooth Numbers 1 through 32; and Tooth Letters A through T.	6.00
#D0230	Intraoral – Periapical Each Additional Film This procedure is reimbursable for Tooth Numbers 1 through 32; and Tooth Letters A through T.	5.00
+*D0240	Intraoral - Occlusal Film This procedure is reimbursable for Oral Cavity Designators 01 and 02.	10.00
D0272	Bitewings, Two Films	13.00
*D0330	Panoramic Film	35.00
D1110	Prophylaxis – Adult	29.00
#*D2140	Amalgam, One Surface, Primary or Permanent This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through C, H through M, and R through T.	40.00/47.00√
#*D2150	Amalgam, Two Surfaces, Primary or Permanent This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through C, H through M, and R through T.	55.00/58.00√
#*D2160	Amalgam, Three Surfaces, Permanent This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through C, H through M, and R through T.	70.00/74.00√
#*D2161	Amalgam, Four or More Surfaces, Permanent This procedure is reimbursable for Tooth Numbers 1 through 32.	108.00
#*D2330	Resin-based Composite, One Surface, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M and R.	65.00
#*D2331	Resin-based Composite, Two Surfaces, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M and R.	75.00
#*D2332	Resin-based Composite, Three Surfaces, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M and R.	85.00
#*D2335	Resin-based Composite, Four or More Surfaces or Involving Incisal Angle, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M and R.	108.00

CODE	DESCRIPTION	FEE
#*D2390	Resin-based Composite Crown, Anterior This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M and R.	104.00
#*D2931	Prefabricated Stainless Steel Crown, Permanent Tooth This procedure is reimbursable for Tooth Numbers 1 through 32.	108.00
#*D2932	Prefabricated Resin Crown This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M and R.	104.00
#*D2951	Pin Retention, Per Tooth, In Addition To Restoration This procedure is reimbursable for Tooth Numbers 2 through 5; 12 through 15; 18 through 21; and 28 through 31.	15.00
+*D4341	Periodontal scaling and root planing – four or more teeth per quadrant This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40.	81.00
*D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	61.00
#D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal) This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T; and for Supernumerary Teeth 51 through 82 or AS through TS.	46.00
#*D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T; and for Supernumerary Teeth 51 through 82 or AS through TS.	57.00
#*D7220	Removal of Impacted Tooth, Soft Tissue This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T; and for Supernumerary Teeth 51 through 82 or AS through TS.	86.00
#*D7230	Removal of Impacted Tooth, Partially Bony This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T; and for Supernumerary Teeth 51 through 82 or AS through TS.	136.00

√ Indicates Reimbursement Fee for Permanent Teeth

Note: Dental prior authorization requests and dental claims for payment must indicate tooth surface(s) when the procedure code directly involves one or more tooth surfaces.

Appendix D

Referral for Pregnancy Related Dental Services (Form 9-M)

REVISION DATE: DECEMBER 2003

BHSF Form 9-M
Issued 12/03

Medicaid Program

Referral for Pregnancy Related Dental Services

(Must Be Completed By the Medical Professional Providing Pregnancy Care)

Part I: All Items Must Be Complete

Name of Patient: _____

Street Address:_____ City:_____ Zip Code:_____

Medicaid Recipient ID #: _____

Estimated Date of Delivery (MM/DD/YYYY):_____

Part II: Check (☑) All Conditions That Apply

- ❑ Bleeding Gums
- ❑ Swollen, puffy gums
- ❑ Loose teeth
- ❑ Teeth with obvious decay
- ❑ Teeth that appear longer
- ❑ Pain associated with teeth or gums
- ❑ Bad breath odor that does not go away with normal brushing
- ❑ Spaces between the teeth that were not there before
- ❑ Inability to chew or swallow properly
- ❑ Tender gums that bleed when brushing

Are there any medical or perinatal complications that the dentist should be aware of prior to the delivery of dental services? ❑ YES ❑ NO If yes, please describe below:

_____
_____

Is pre-medication or other medication required prior to dental treatment? ❑ YES ❑ NO
(If yes, please attach a photocopy of the prescription.)

Part III: Check (☑) Any Services That Are Contraindicated

- ❑ Local Anesthetic
- ❑ Radiograph(s)
- ❑ Teeth Cleaning
- ❑ Restoration(s)
- ❑ Gum Treatment – Ultrasonic Cleaning and/or Scaling Below the Gum Line
- ❑ Extraction(s)

Part IV: Please include other comments and/or recommendations below:

_____
_____

I have confirmed the pregnancy with diagnostic testing for the above-named patient.

_____	_____	(___)_____	_____
Medical Professional Signature **(Required)**	Provider Type & License #	Office Telephone #	Date

To locate a Medicaid enrolled dentist, you may contact the Medicaid Referral Assistance Hotline toll-free at 1-877-455-9955.

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					
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS REPRESENTATIVES					
The speakers were thorough and knowledgeable	1	2	3	4	5
Topics were well organized and presented	1	2	3	4	5
Reps provided effective response to question	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION: Dental					

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