PERSONAL CARE SERVICES TRAINING

Medicaid Issues for 2004
(Fall Issue)

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

UNISYS

ABOUT THIS DOCUMENT

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

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

This packet does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability. Such information is presented only in the Basic Medicaid Information Training 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.

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

NOTICE TO ALL PROVIDERS

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

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

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

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

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

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

FOR YOUR INFORMATION! SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

I. MR/DD WAIVER WAITING LIST

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

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

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

CASE MANAGEMENT
If you are a Medicaid recipient under the age of 21 and have been on the MR/DD Waiver Waiting list at any time since October 20, 1997, you may be eligible to receive case management *NOW*.
YOU NO LONGER NEED TO WAIT FOR THIS SERVICE. A case manager works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services), then assists you in obtaining them.

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

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

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

EPSDT/KIDMED EXAMS AND CHECKUPS

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

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

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

PERSONAL CARE SERVICES

Personal care services are provided by attendants to persons who are unable to care for themselves. These services assist in bathing, dressing, feeding, and other non-medical activities of daily living. PCS services *do not* include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. Once ordered by a physician, the PCS service provider must request approval for the service from Medicaid.

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

EXTENDED HOME HEALTH SERVICES

Children and youth may be eligible to receive *Skilled Nursing Services* and *Aide Visits* in the home. These can exceed the normal hours of service and types of service available for adults. These services are provided by a Home Health Agency and must be provided in the home. This service must also be ordered by a physician. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

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

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

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

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

SERVICES IN SCHOOLS OR EARLY INTERVENTION CENTERS

Children and youth can also obtain *Physical, Occupational, and Speech Therapy, Audiology Services, and Psychological Evaluations and Treatment* through early intervention centers (for ages 0-2) or through their schools (For ages 3-21). Medicaid covers these services if the services are a part of the IFSP or IEP. These services may also be provided in the home. FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR EARLY INTERVENTION CENTER OR SCHOOL OR CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

MEDICAL EQUIPMENT AND SUPPLIES

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

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

MENTAL HEALTH REHABILITATION SERVICES

Children or youth with mental illness may receive *Mental Health Rehabilitation Services*. These services include: clinical and medical management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. *MENTAL HEALTH REHABILITATION SERVICES MUST BE APPROVED BY THE LOCAL OFFICE OF MENTAL HEALTH*. FOR ASSISTANCE IN APPLYING FOR MENTAL HEALTH REHABILITATION SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

TRANSPORTATION

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

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

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.

Services Available to Medicaid Eligible Children Under 21

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

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

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

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

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

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

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

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

If you live in a CommunityCARE parish, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

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ELECTRONIC DATA INTERCHANGE

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

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

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

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

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

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

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

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

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

HIPAA DESK TESTING SERVICE ENROLLMENT

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

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

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

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

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

HIPAA-COMPLIANT 837 TRANSACTION TESTING SERVICE

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

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

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

MMIS PARALLEL TESTING

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

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

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

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

EPSDT - PERSONAL CARE SERVICES

EPSDT Personal Care Services are available to EPSDT eligibles (recipients up to age 21 years) that meet the medical necessity criteria for these services. Effective August 15, 2004, providers must obtain a Personal Care Services provider number (provider type 24) in order to provide these services.

These services are not intended to provide respite. In addition, EPSDT PCS may not be provided to an EPSDT eligible receiving Individual and Family Support services through the New Opportunities Waiver (NOW) program until the waiver limit has been exhausted.

EPSDT Personal Care Services are defined as:

- Tasks that are medically necessary as they pertain to an EPSDT eligible's physical requirements when physical limitations are due to illness or injury and necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements.

- Those services which prevent institutionalization and enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.

As part of establishing medical necessity**, the recipient must be of an age at which the tasks to be performed by the recipient would ordinarily be performed by the individual, if he/she was not disabled due to illness or injury.**

EPSDT PCS does not include medical tasks, such as medication administration, tracheostomy care, feeding tubes, or catheters. The Home Health program covers these services.

EPSDT PCS providers may also provide Children's Choice services on the same date to the same recipient; however, it may not be performed at the same time. Only recipients in Children's Choice can receive these services on the same day.

If the recipient is receiving Home Health, Respite, and/or any other related services, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider.

PCS vs. PCA

Medicaid distinguishes between Personal Care Services (PCS) offered through the EPSDT Program and Personal Care Attendant (PCA) services offered through the Waiver Program by services covered, scope of service, and reimbursement rates. It is important that the provider clearly identify which service is being requested for Prior Authorization. When submitting requests for Prior Authorization of PCS, the provider must insure that the request is worded properly on all paperwork. This includes the PA-14 form, the Plan of Care and the physician's prescription. While many of our PCS providers refer to their workers as Personal Care Attendants, requests for PCS prior authorization phrases as "PCA" will be denied.

EPSDT Personal Care Services include:

- Basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with dressing

- Assistance with bladder and/or bowel requirements or problems, including helping the client to and from the bathroom or assisting the client with bedpan routines, but excluding catheterization

- Assistance with eating and food, nutrition and diet activities, including preparation of meals--for the recipient only

- Performance of **incidental** household services, for the recipient only, not the entire household, which are essential to the recipient's health and comfort in his/her home. Examples are:

    - Changing and washing the recipient's bed linens

    - Rearranging furniture to enable the client to move about more easily in his/her own room

    - Clean up of meal preparation--for the recipient only

- Accompanying, not transporting, the recipient to and from his/her physician and/or medical facility for necessary medical services.

Conditions for Provisions of EPSDT PCS:

- EPSDT PCS is not to be provided to meet childcare needs nor as a substitute for the parent/guardian when the parent/guardian is not present.

- If an EPSDT eligible is fourteen years of age or younger, childcare arrangements must be specified when requesting approval for EPSDT PCS.

- A parent or other caregiver must be in the home with an EPSDT eligible fourteen years of age or younger. Recipients over 14 years of age must be mentally and intellectually competent to direct his/her own care if they are to be left with the PCS worker without the presence of a parent or other caregiver.

- EPSDT PCS is not allowable for the purpose of providing respite care for the primary care giver. Respite services are only available through some of the waiver programs.

- EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or must be provided by the Department of Education.

- The recipient must be under 21 years of age.

- The recipient must meet medical criteria to be eligible for at least an Intermediate Care Facility 1 and be impaired in at least 2 daily living tasks, as determined by BHSF.

- The recipient must have a new prescription every 180 days, and when changes to the Plan of Care occur.

- The PCS provider must maintain a Plan of Care.

- PCS services must be prior authorized.

- PCS services cannot be provided to a recipient who resides in an institution.

- PCS services must be provided through a licensed PCA Medicaid provider. Staff assigned to provide personal care services shall not be a member of the recipient's immediate family. Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the recipient.

A physician must sign all referrals. Signatures by nurse practitioners or registered nurses are not acceptable.

Physician's Responsibilities Regarding the Authorization of PCS

Medical necessity for personal care services must be certified by the ordering physician, who must complete and sign the following:

- Form 90-L
- Plan of Care
- Prescription (signed by the physician and specifies the health/medical condition which necessitates EPSDT Personal Care Services and the number of hours requested)

In signing these documents, the physician certifies that:

1. The recipient is under his/her care;
2. The recipient requires/would require institutional level of care equal to an Intermediate Care Facility 1;
3. A face-to-face medical assessment was done on the recipient within the last 90 days;
4. These Personal Care Services are medically necessary;
5. There is a written plan for care that is approved by him/her; and
6. The plan will be reviewed periodically (at least every 180 days) by him/her.

Penalties, which may be imposed on physicians for inappropriate certification, include:

1. Referral to the Office of the Inspector General;
2. Criminal penalties in the U.S. District Court, resulting in fines and/or a jail sentence;
3. Civil prosecution in a U.S. District Court, resulting in fines and/or settlements;
4. Civil monetary penalties with an administrative law judge resulting in fines ($2,000 per line item);
5. If fraud is proven under the False Claims Act, tripling of damages and fines;
6. Simple sanction (barred from Medicare and Medicaid programs) by the Washington Office of the Inspector General.

CHRONIC NEEDS CASES

BHSF has enacted minor changes to the Prior Authorization process for those programs that require prior authorization, including EPSDT PCS. The Prior Authorization staff has begun designating some recipients as Chronic Needs Cases. Based on the recipient's medical condition, services are expected to be continuous and remain at the level currently approved. The Prior Authorization staff will notify both the provider and the recipient on the approval letter of this designation.

Once a recipient is deemed to be a Chronic Needs Case, providers shall only be required to submit a PA-14 form accompanied by a current statement from a physician verifying the recipient's condition has not improved and the services currently approved must be continued at the approved level. The provider must indicate "Chronic Needs Case" on the top of PA-14 form. This determination only applies to the services approved where requested services remain at the approved level. **Requests for an increase in these services will be treated as a traditional PA request and is subject to full review.**

PRIOR AUTHORIZATION FOR EPSDT-PCS SERVICES

EPSDT-Personal Care Services require Prior Authorization (PA), which is obtained by completing the PA14 form. Requests for authorization are forwarded to the Prior Authorization Unit, and are submitted along with the following documents:

- Form 90-L
- Prescription, Physician's Orders, or Physician's referral that specifies the medical condition that necessitates EPSDT PCS
- Plan of Care
- Social Assessment
- Any supporting documentation to support medical necessity
- Daily Time Schedule Form

COPIES OF THESE FORMS ARE AVAILABLE IN THE APPENDIX

REMINDER: **PCS prior authorization requests phrased as PCA will be denied**

NOTE: The PA-14 form may be obtained on the www.lamedicaid.com website, or from the Prior Authorization Unit at (800) 488-6334. Instructions for completing the PA-14 form and an example of the form are included on pages 11-12. A blank PA-14 form is available on page 13.

The completed PA-14 Form, along with all necessary documentation to substantiate the medical necessity of the requested services, must be submitted to the Unisys Prior Authorization Unit (PAU) at the following address:

Unisys
P.O. Box 14919
Baton Rouge, LA 70898-4919
Attn: Prior Authorization (PCS Services)

The PA request may also be faxed to (225) 237-3342.

Once the PA-14 form is received at Unisys, it will be screened for pertinent information prior to entry into the PA system. If the PA-14 form is incomplete, or the required documentation is missing/incomplete, the form will be returned to the provider with a cover letter indicating what is needed.

After the PA-14 form is screened and entered into the PA system, a unique nine-digit prior authorization number is assigned. The system will perform a series of front-end edits. It will check for a valid seven-digit Medicaid provider number, a valid thirteen-digit recipient number, recipient eligibility, a valid ICD-9 diagnosis code, age restrictions, etc. If any of the submitted information does not clear the editing process, the system will deny the request automatically and generate a letter of denial to be sent to the provider **and** the recipient.

If the PA-14 form passes the above editing process, it will be reviewed by the Unisys review nurse and/or physician consultant(s) to determine medical necessity. Once the decision is made, the status of the review is entered into the prior authorization system and an approval or denial letter is sent to the provider and the recipient within the next two days. Once the notification of approval is received, the provider may begin to render services. Approvals may be authorized for a period not to exceed **six** months.

Provider Number Transition

On September 10, 2003, providers of EPSDT PCS were notified that BHSF was changing the provider type code for providers serving recipients under the EPSDT PCS program. Providers were asked to complete a Personal Care Services enrollment packet to obtain a new Medicaid provider number.

On January 8, 2004, providers were notified to begin using their new provider number for EPSDT PCS prior authorization requests with dates of service beginning August 15, 2004. Likewise, all EPSDT PCS authorized and provided for beginning August 15, 2004 should be billed using the new provider number.

Providers who submit prior authorization requests with their Provider Type 82 provider number for dates of service beginning on or after August 15, 2004, the prior authorization unit will deny the request with denial code 997 (**All PCS Requests For Dates Of Service 8-15-2004 Or Later Must Be Requested Under Your New PCS Provider Number**).

If a provider submits a request that spans across the August 15, 2004 date, there must be 2 separate prior authorization requests. Services being requested through August 14, 2004 must be on one request using the Provider Type 82 provider number. The remaining services for the 6-month period must be made on a separate request using the Provider Type 24 provider number. It is not necessary for providers to obtain a separate prescription, 90-L or Plan of Care; however, this information must be included in both requests.

INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION FORM (PA-14)

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

FIELD 2 - Enter the recipient's 13-digit Medicaid ID number or the 16-digit CCN number.

FIELD 3 – Enter the Social Security Number of the recipient.

FIELD 4 - Enter the recipient's last and first name as it appears on his/her Medicaid ID card.

FIELD 5 - Enter the recipient's date of birth in month, day, year format (MMDDYYYY).

FIELD 6 - Enter the 7-digit Medicaid provider number.

FIELD 7 - Enter in the "Begin" date of service block the first day the service is requested to start. Enter in the "End" date of service block, the last day of service for that recipient's Treatment Plan.

FIELD 8 – Indicate whether the recipient is currently receiving PCS services.

FIELD 9 - Enter the numeric ICD-9 diagnosis code, both primary and secondary (if there is more than one diagnosis).

FIELD 10 - Enter the day the prescription was written.

FIELD 11 - Enter the name of the physician prescribing the services.

FIELD 12C - Enter the number of units needed in order to fulfill the doctor's order during the Treatment Plan.

Calculate the total units requested (1 unit=15 minutes) by multiplying the number of units per day times the number of days per week times the number of weeks covered in the Treatment Plan. This will give the total units requested. For example:

> If the physician requests five hours of service per day for seven days a week for six months, the provider should determine that twenty units of service would be needed per day, multiply that number (20) by seven (number of days per week receiving service), and multiply that number (140) by twenty-six (number of weeks in six months). This would equal 3,640 units.

FIELD 13 - Enter the name, mailing address, and telephone number of the service provider.

FIELD 14 & 15 - Provider/Authorized Signature required. The request will not be accepted if it is not signed ***and*** dated.

IF USING A STAMPED SIGNATURE, AUTHORIZED PERSONNEL MUST INITIAL IT

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

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

P.A. NUMBER

FAX TO: (225) 237-3342 CONTINUATION OF SERVICES YES NO

(1) PRIOR AUTHORIZATION TYPE:	(2) RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY
14 – EPSDT PERSONAL CARE SERVICES	0 0 0 1 0 0 1 2 3 5 1 0 1	
	(4) RECIPIENT LAST NAME: FRAN; FIRST NAME: LIONEL; MI:	(5) DATE OF BIRTH: 05 18 88

(6) MEDICAID PROVIDER NUMBER (7- DIGIT)	(7) SERVICE TREATMENT PLAN BEGIN DATE (MMDDYYY)	END DATE (MMDDYYY)	(8) IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE
1 1 2 2 3 3 4	10 04 2004	04 03 2005	x YES ____ NO	

(9) DIAGNOSIS:
PRIMARY CODE & DESCRIPTION: 343.1
SECONDARY CODE & DESCRIPTION:

(10) PRESCRIPTION DATE (MMDDYYYY): 09 20 2004

STATUS CODES:
2 = APPROVED
3 = DENIED

(11) PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: Dr. Walter Dogood

DESCRIPTION OF SERVICES — FOR INTERNAL USE ONLY

(12) PROCEDURE CODE	(12A) MODIFER	(12B) DESCRIPTION PERSONAL CARE SERVICE EACH 15 MINUTES	(12C) REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	
T1019	EP	EPSDT-Personal Care Service, each 15 minutes	3640				

(13)
PROVIDER NAME: A-1 PCS Agency
ADDRESS: 112 Main Street
CITY: Baton Rouge STATE: LA ZIPCODE 70800
TELEPHONE: (225) 555 5555 FAX NUMBER: (____) ____ ____

(14) CASE MANAGER INFORMATION
NAME:
ADDRESS:
CITY: STATE: ZIPCODE:
TELEPHONE: (___) ____ ____ FAXNUMBER: (___) ____ ____

(15)
PROVIDER SIGNATURE: Sharyn Smith

(16)
DATE OF REQUEST: 9/22/2004

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

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

P.A. NUMBER

FAX TO: (225) 237-3342

CONTINUATION OF SERVICES ____YES ____ NO

(1) PRIOR AUTHORIZATION TYPE:	(2) RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY #
14 – EPSDT PERSONAL CARE SERVICES	(4) RECIPIENT LAST NAME FIRST NAME MI	(5) DATE OF BIRTH
(6) MEDICAID PROVIDER NUMBER (7- DIGIT)	(7) SERVICE TREATMENT PLAN BEGIN DATE (MMDDYYY) / END DATE (MMDDYYY)	(8) IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES ____ YES ____ NO
(9) DIAGNOSIS: PRIMARY CODE & DESCRIPTION / SECONDARY CODE & DESCRIPTION	(10) PRESCRIPTION DATE (MMDDYYYY)	(11) PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER:

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

STATUS CODES:
2 = APPROVED
3 = DENIED

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

(12) PROCEDURE CODE	(12A) MODIFER	(12B) DESCRIPTION PERSONAL CARE SERVICE EACH 15 MINUTES	(12C) REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	
T1019	EP	EPSDT-Personal Care Service, each 15 minutes					

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

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

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA- 14 FORM

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 09/03/2004 RECIPIENT NAME
PRIOR AUTH. NBR RECIPIENT NUMBER

PROVIDER NUMBER

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
T1019/EP/ -PERSONAL CARE SERVICE, EA	176	08/15/2004-09/05/2004	APPROVED -654
T1019 -PERSONAL CARE SERVICE, EA	176	08/15/2004-09/05/2004	DENIED -278

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW,
654 - THIS REQUEST IS APPROVED FOR 2 HOURS PER DAY 7 DAYS A WEEK.
278 - THE TOTAL NUMBER OF HOURS REQUESTED / OR AN INCREASE IN PCS / OR HOME HEALTH SERVICES ARE NOT MEDICALLY NECESSARY.

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY. PAYMENT ON A CLAIM WILL ONLY BE MADE WHEN THE CLAIM IS BILLED CORRECTLY AND ALL CONDITIONS FOR PAYMENT ARE MET.

ALL CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE APPROPRIATE REFERRALS TO BE PAID.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 09/03/2004 RECIPIENT NAME
PRIOR AUTH. NBR RECIPIENT NUMBER

PROVIDER NUMBER

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
T1019/EP/ -PERSONAL CARE SERVICE, EA		06/28/2004-12/28/2004	DENIED -992

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW,
992 - PROVIDER NUMBER IS INVALID FOR REQUESTED DATES OF SERVICE

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

Reconsideration Requests

If the request is denied, a notification letter with the PA number is generated giving the reason(s) for denial and is sent to the provider and the recipient. The recipient's letter will have a notice regarding his/her rights to appeal. A provider may then submit a reconsideration request to the Unisys Prior Authorization Unit and the physician consultant(s) will review the reconsideration request. To request a Reconsideration (RECON), providers should submit the following:

- A copy of the denial letter, with the word **RECON** written across the top of the denial letter, and the reason for requesting the reconsideration written at the bottom of the letter.

- Attach **all of the original documentation**, as well as any additional information or documentation, which supports medical necessity.

Mail the reconsideration letter and all documentation to the Prior Authorization Unit at Unisys.

Unisys physician consultant(s) will review the reconsideration request for medical necessity. When the reconsideration request is approved or denied, another notification letter (with the same prior authorization number) will be generated and mailed to the provider and the recipient.

Switching PCS Providers

If a recipient is switching PCS providers, the first agency must send a letter to the Unisys Prior Authorization Unit notifying them of the recipient's discharge so that a new PA can be issued to the current PCS provider.

The new provider must submit an initial request for PA to the PA Unit using current documentation and must submit all required documentation necessary for an initial PA request.

Units approved for one provider cannot be transferred to another provider.

RECON

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 09/03/2004
PRIOR AUTH. NBR

RECIPIENT NAME
RECIPIENT NUMBER

PROVIDER NUMBER

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
T1019/EP/ -PERSONAL CARE SERVICE, EA		08/09/2004-08/14/2004	DENIED -237

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW,
237 - PROCEDURE IS SPECIALTY RESTRICTED

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

PROVIDER FILE HAS BEEN CORRECTED- PLEASE PROCESS IN ACCORDANCE WITH POLICY

LONG TERM - PERSONAL CARE SERVICES (LT-PCS)

The LT-PCS program began on January 19, 2004. It was developed to enable Medicaid recipients who require a nursing facility level of care to remain in their own home.

The purpose of personal care services is to provide limited assistance with the activities of daily living and instrumental activities of daily living. It is not intended to be a substitute for available family or community supports.

These services must be prescribed by a physician and prior authorized. Physician delegation of medical tasks or complex medical procedures is not a component of personal care services.

Recipients interested in receiving LT-PCS services must contact ACS at 1-866-229-5222. If the recipient is unable to contact them directly, his/her family may make the contact. However, **under no circumstance may the provider contact ACS to initiate services on behalf of the recipient.**

Recipient Criteria

In order to qualify for LT-PCS services, a Medicaid recipient must have the following conditions met:

- Be age 65 or older, or 21 years of age or older with a disability. Disabled is defined as criteria established by the Social Security Administration;
- Qualify for admission to a nursing facility, including all Preadmission Screening and Annual Resident Review (PASARR) requirements;
- Be able to participate in his/her care and self-direct the services of the personal care worker independently, or through a responsible representative;
- Faces a substantial possibility of deterioration in mental or physical condition if either home and community based services, or nursing facility services, were not provided within the next 120 days. This criterion is considered met if:
    - The recipient is in a nursing facility and could be discharged if community-based services were available
    - Is likely to require nursing facility admission within the next 120 days
    - Has a primary caregiver who has a disability or is over 70 years old

Covered Services

In order to qualify for LT-PCS services, the recipient must need assistance with both ADL's (Activities of Daily Living), and IADL's (Instrumental Activities of Daily Living). Assistance may be either the actual performance of the personal care task for the recipient, or supervising and prompting so the recipient performs the task.

ADL's are personal, functional activities required by an individual for continued well-being, health, and safety. These activities are usually performed on a daily basis and include:

- Bathing
- Grooming
- Dressing
- Ambulation
- Eating
- Transferring
- Toileting

IADLs are routine tasks that are essential for sustaining the individual's health and safety, but these tasks may not need to be performed every day. These tasks include:

- Laundry
- Meal preparation and storage
- Grocery Shopping
- Light Housekeeping tasks
- Assistance with scheduling medical appointments, if necessary
- Accompaniment to medical appointments, if necessary
- Assistance with accessing transportation, if necessary
- Medication *reminders*

Medication Reminders:

The personal care worker may only verbally remind the recipient to take his/her medicine, assist with opening the bottle or bubble pack, reading the directions from the label, checking the dosage chart from the label directions, and assist in ordering the medicine from the store.

The personal care worker cannot give the medicine to the recipient or set up pill organizers.

Physician delegation of medical tasks is not covered under personal care services.

Transportation:

- Medicaid does offer reimbursement for both emergency (ambulance) and non-emergency medical transportation if the recipient has no other means in which to obtain transportation to a Medicaid-covered service provider.
- Transportation is not a required component of personal care services
- If a provider opts to provide transportation services to their recipients, they must accept all liability for their employee transporting the recipient and ensure that the personal care worker has a current, valid driver's license as well as minimum liability coverage as designed by state law.

Excluded Services

Long-Term Personal Care Services do not include:

- Insertion and sterile irrigation of catheters (although changing and emptying the catheter bag is allowed)
- Irrigation of any body cavity, which requires sterile procedures
- Application of dressing, which involves prescription medication and aseptic techniques
- Skilled nursing services as defined in the State Nurse Practices Act, which include medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks
- Teaching a family member or other caregiver how to care for a recipient who requires frequent changes of clothing or linen due to partial/total incontinence for which no bowel or bladder training program is possible
- Teaching of signs/symptoms of disease process, diet and medications of any new or exacerbated disease process
- Specialized aide procedures, such as: rehabilitation of the recipient, measuring or recording of vital signs, measuring or recording of intake or output of fluids, specimen collection, special procedures such as non-sterile dressings, special skin care of decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight management, enemas
- Administration of medications
- Rehabilitative services, such as those performed by a licensed therapist
- Laundry, other than those incidental to the care of the recipient
- Food preparation or shopping for groceries or household items other than items required specifically for the health and maintenance of the recipient
- Housekeeping tasks in areas not used solely by the recipient
- Companionship
- Supervision
- Respite of primary caregiver

Delegation Of Medical Tasks

The performance of complex, and non-complex, medical procedures are not a component of personal care services. If the recipient's physician delegates the performance of medical tasks and the agency agrees to provide these tasks, the agency accepts all liability for their employee's performance of the task. The agency must have a current, signed and dated statement from the recipient's physician stating what medical procedures are being delegated. It is recommended that the statement is updated annually or whenever the recipient changes physician.

Service Location

LT-PCS services may be provided in the recipient's home or in another location, outside of the home, if the provision of these services allows the recipient to participate in normal life activities as they pertain to the IADLs as cited in the Plan of Care.

A recipient's home is defined as:

- Recipient's place of residence, including his/her own house or apartment
- Boarding house
- House or apartment of a family member or unpaid primary caregiver

The place of service must be documented in the service plan **and** service log.

Services performed outside of the recipient's home do not include travel outside of the state of Louisiana, unless the recipient lives in an area adjacent to the state's border and it is customary to seek medical and other services in the neighboring state.

These services cannot be performed in the personal care worker's home unless it can be satisfactorily assured that:

- The place of service is consistent with the recipient's choice
- The recipient's health and safety can be maintained when services are provided in the worker's home
- Services do not substitute for otherwise available family and community supports

NOTE: PCS services cannot be provided in a hospital, an institution for mental disease, a nursing facility, or an intermediate care facility for the mentally retarded (ICF/MR)

Service Limitations

Approved hours are determined by the recipient's assessment, Plan of Care, and supporting documentation, and done on an individual basis.

Changing Service Providers

A recipient may change providers without cause once after every 3 (three) month service authorization period. A recipient may change providers with good cause at any time during the service authorization period. Good cause is defined as the failure of the provider to furnish services in compliance with the service plan. DHH, or its designee, shall determine good cause. All requests for change in provider shall be submitted in writing to the contractor. Providers will receive written notification when approval has been given for the recipient to change providers.

PRIOR AUTHORIZATION FOR LT-PCS SERVICES

All recipients receiving LT-PCS services must have an assessment, and authorization must be approved prior to services being performed.

If a waiver recipient requests LT-PCS services, ACS staff will complete the recipient intake form and forward it to the Bureau of Community Supports and Services (BCSS). The recipients support coordinator (formerly known as the case manager) is responsible for contacting the recipient, scheduling and completing the in-home assessment and developing the Plan of Care. The support coordinator will then forward the information to BCSS for approval, and the prior authorization will be transmitted to the provider through Statistical Resources, Inc (SRI). An example of a Prior Authorization letter from SRI is located on page 24.

Recipients that meet LT-PCS guidelines, and are not waiver recipients, will be sent a 90PCS form for the physician to complete. Once it is completed and signed by the physician and sent back to ACS, an ACS representative will schedule an assessment. The ACS staff will be responsible for completing the Plan of Care. This information will then be forwarded to DHH for a final decision as to how many hours of services the recipient may receive. This information will be relayed through a notice that is sent to the recipient. The recipient will receive 2 copies of the Plan of Care and a list of enrolled Medicaid LT-PCS agencies in his/her region. The recipient will contact his/her preferred agency. If the agency chooses to accept the recipient as his/her client, the agency will retain a copy of the Plan of Care for their records. The provider will need to forward the following documents to ACS within 14 days so that a Prior Authorization Number can be established for these services:

- Signed service plan (based on the Plan of Care)
- Signed Agreement to Provide Services
- Date the provider agrees to begin services

The information must be mailed or faxed to ACS:

Affiliated Computer Services
5700 Florida Boulevard, 13th floor
Baton Rouge, LA 70806
Attn: Long Term-Personal Care Services

The information can be faxed to (225) 231-8151.

An example of a Prior Authorization letter from ACS is located on page 25.

The recipient or his/her responsible representative must initiate all requests for changes in services and/or hours. An interim assessment will be performed for all requests for changes in services and/or service hours.

Reassessments

Reassessments are conducted annually to determine on-going qualification for services.

Recipients Currently in Nursing Homes

If a recipient residing in a long-term care facility requests LT-PCS, a provisional assessment must be performed to determine qualification for services. If the recipient is approved for services, a provisional approval notice will be issued for a 2-month certification period. A provisional prior authorization notice will be issued to the selected provider for a 2-month service authorization period. A provisional service plan must be developed prior to the recipient leaving the facility.

Services will not begin until the recipient leaves the facility.

Once the recipient has left the nursing facility, an in-home assessment will be completed. Based on the results of the assessment, a new Plan of Care will be developed and the certification period will be issued for 12 months. A second prior authorization notice will be issued to the provider for the new service authorization period.

C-LINK DATA SYSTEM: REPORT=WORKDAY.SAS 08:17 Thursday, July 15, 2004

RECORDS ADDED OR MODIFIED IN THE C-LINK SYSTEM BETWEEN 07/14/04 AND 07/14/04
FOR CLIENTS LINKED IN REGION ' TO INC.

ISSUANCE OF A PRIOR AUTHORIZATION NUMBER TO YOUR AGENCY DOES NOT GUARANTEE PAYMENT. IT IS YOUR RESPONSIBILITY T(VERIFY MEDICAID ID NUMBERS AND ELIGIBILITY FOR EACH OF THE RECIPIENTS LISTED. STATISTICAL RESOURCES, INC. DOES NOT VERIFY MEDICAID NUMBERS, ELIGIBILITY INFORMATION, LIFETIME LIMITS, OR OTHER MEDICAID-IMPOSED LIMITS.

NAME: SSN: DOB:

CPOC CAP	PA BEGIN	PA END	PROC CODE	MODIFERS	MEDICAID NUMBER	UNITS	FEE	PA NUMBER

TARGET POPULATION = ELDR ASSIGNED MEDICAID PROVIDER NUMBER =

07/09/04	09/30/04	T1019	UB
10/01/04	12/31/04	T1019	UB
01/01/05	03/31/05	T1019	UB
04/01/05	05/26/05	T1019	UB

DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

A-1 PCS Agency
Baton Rouge, Louisiana

August 16, 2004
Date

Tullier, Jackson
Recipient Name

1002345891230
Recipient Number

This letter is to notify your agency of the following regarding Medicaid Long Term-Personal Care Services (LT-PCS):

[X] The above named recipient is authorized to receive services from 7/9/2004 to 6/30/2005. You will receive a prior authorization number every three months until 6/30/2005 unless there is a provider change. Listed below are authorization numbers, approved units of service, and authorized dates of service for this authorization period.

Authorization Numbers	Units of Service	Begin Date	End Date
446829007	368	7/9/2004	7/31/2004
446829008	496	8/1/2004	8/31/2004
446829009	480	9/1/2004	9/30/2004
446829010	496	10/1/2004	10/31/2004

[ ] The above named recipient is authorized to receive an increase in services. The recipient is authorized to receive _____ units of service a month from _____ to _____. This update has been made under your current authorization number(s). For the current month of _____ the recipient is authorized to receive _____ additional units of service.

[ ] The above named recipient has moved from a long-term care facility to reside in the community. A provisional authorization has been issued from _____ to _____. The recipient will be reassessed prior to the termination date, and a new authorization will be issued at that time. Listed below are authorization numbers, approved units of service, and authorized dates of service.

Authorization Numbers	Units of Service	Begin Date	End Date

[ ] We have been notified that the above named recipient wishes to change LT-PCS providers. Effective _____ your authorization to provide these services to this recipient will end.

_____
Agency Representative

_____
Phone Number

LT-PCS 4 Provider Authorization
Issued 02/17/04
Reissued 06/15/04
Prior issues obsolete

BILLING FOR EPSDT-PCS SERVICES

There have been several changes to the billing procedure for EPSDT-PCS in the past year. Please be sure to note the date of service and provider number indicated on the claim form when performing billing tasks.

PCA providers must use their PCA provider number (provider type 82) to bill for services until August 14, 2004.

To receive reimbursement for dates of service August 15, 2004 and thereafter, providers must bill with their provider type 24 provider number.

Providers can bill in any time increment desired, as long as the date span and unit amount are within the scope of the prior authorization number.

Dates of Service Prior To October 1, 2003:

Provider Type	Procedure Code	Description	Unit Size	Reimbursement Rate
82	Z0200	EPSDT – Personal Care Services	30 min	$4.05

Dates of Service October 1, 2003 – August 14, 2004:

Provider Type	Procedure Code	Modifier	Description	Unit Size	Reimbursement Rate
82	T1019	EP	EPSDT – Personal Care Services	15 min	$2.03

Dates of Service August 15, 2004 and Thereafter:

Provider Type	Procedure Code	Modifier	Description	Unit Size	Reimbursement Rate
24	T1019	EP	EPSDT – Personal Care Services	15 min	$2.03

BILLING FOR LT-PCS SERVICES

All LT-PCS services are prior authorized and billed with the provider number associated with their provider type 24 provider number.

Providers must be sure to bill within the date span indicated on the PA letter.

ALL SERVICES BILLED AS FOLLOWS:

Procedure Code	Modifier	Description	Unit Size	Reimbursement Rate
T1019	UB	LT – Personal Care Services	15 min	$3.00

Providers should contact Provider Relations Inquiry Unit for assistance with all denied claims. For claims denied relative to the prior authorization number, the provider may be referred to the agency that issued the prior authorization for further assistance.

CLAIMS FILING

Personal Care Services are billed to Medicaid on the CMS-1500 claim form. The following pages explain the proper completion of the claim form.

Certain items on the CMS-1500 are mandatory, as indicated below by an asterisk (*). Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. Such claims cannot be processed until corrected and resubmitted by the provider.

Completed claim forms should be mailed to:

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

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

*1A. **Insured's ID Number** - Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using REVS, MEVS or e-MEVS at www.lamedicaid.com website.

*2. **Patient's Name** - Print the name of the recipient: last name, first name, and middle initial. Spell the name exactly as indicated through eligibility verification.

3. **Patient's Birth Date and Sex** - Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS or REVS, or e-MEVS using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the recipient's sex.

4. **Insured's Name** - Leave blank

5. **Patient's Address** – Leave blank

6. **Patient Relationship to Insured** - Leave blank

7. **Insured's Address** - Leave blank

8. **Patient Status** - Leave blank

9. **Other Insured's Name** - Leave blank

9A. **Other Insured's Policy or Population Number** – Leave blank

9B. **Other Insured's Date of Birth** - Leave blank

9C. **Employer's Name or School Name** - Leave blank

9D. **Insurance Plan Name or Program Name** - Leave blank

10. **Was Condition Related To** - Leave blank

11. **Insured Policy Population or FECA Number** - Leave blank

11A. **Insured's Date of Birth** - Leave blank

11B. **Employer's Name or School Name** - Leave blank

11C. **Insurance Plan Name or Program Name** - Leave blank

12. **Patient's or Authorized Person's Signature** - Leave blank

13. **Insured's or Authorized Person's Signature** - Leave blank

14. **Date of Current Illness** - Leave blank

15. **Date of Same or Similar Illness** - Leave blank

16. **Dates Patient Unable to Work** - Leave blank

17. **Name of Referring Physician or Other Source** – Leave blank

17A. **ID Number of Referring Physician** – Leave blank

18. **Hospitalization Dates Related to Current Services** - Leave blank

19. **Reserved for Local Use** - Leave blank

20. **Outside Lab** - Leave blank

*21. **Diagnosis or Nature of Illness or Injury** – **EPSDT-PCS**: Enter the ICD-9-CM diagnosis code and, if desired, narrative description of the diagnosis. This information is required for EPSDT-PCS claims; **LT-PCS**: Leave blank

22. **Medical Resubmission Code** - Leave blank

*23. **Prior Authorization** – Enter the 9 digit Prior Authorization number indicated from the PA letter

*24A. **Date of Service** - Enter the date range for the service. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable. Make sure to enter the correct number of units in block 24G.

*24B. **Place of Service** - Enter either 12 (Home) or 99 (Other)

24C. **Type of Service** - Leave blank

*24D. **Procedure Code** – Enter appropriate procedure code based on date of service; make sure to apply the correct modifier if it is applicable on that date of service.

24E. **Diagnosis Code** – **EPSDT-PCS**: Reference which ICD-9-CM diagnosis indicated in block 21 is related to the procedure code in block 24D. **LT-PCS**: Leave blank

*24F. **Charges** - Enter usual and customary charges for this procedure

*24G. **Days or Units** - Enter the number of units of provided service for date range indicated

*24H. **EPSDT** - Leave blank

24I. **EMG** - Leave blank

24J. **COB** - Leave blank

24K. **Reserved for Local Use** – Leave blank

25. **Federal Tax ID Number** - Leave blank

26. **Your Patient's Account Number** - (Optional) Enter the recipient's medical record number or other individual provider-assigned number to identify the patient. This number will appear on the Remittance Advice (RA).

27. **Accepts Assignment** - Leave blank

*28. **Total Charge** – Enter the same dollar amount indicated in block 24F.

29. **Amount Paid** - Leave blank

30. **Balance Due** – Enter the same dollar amount indicated in block 24F.

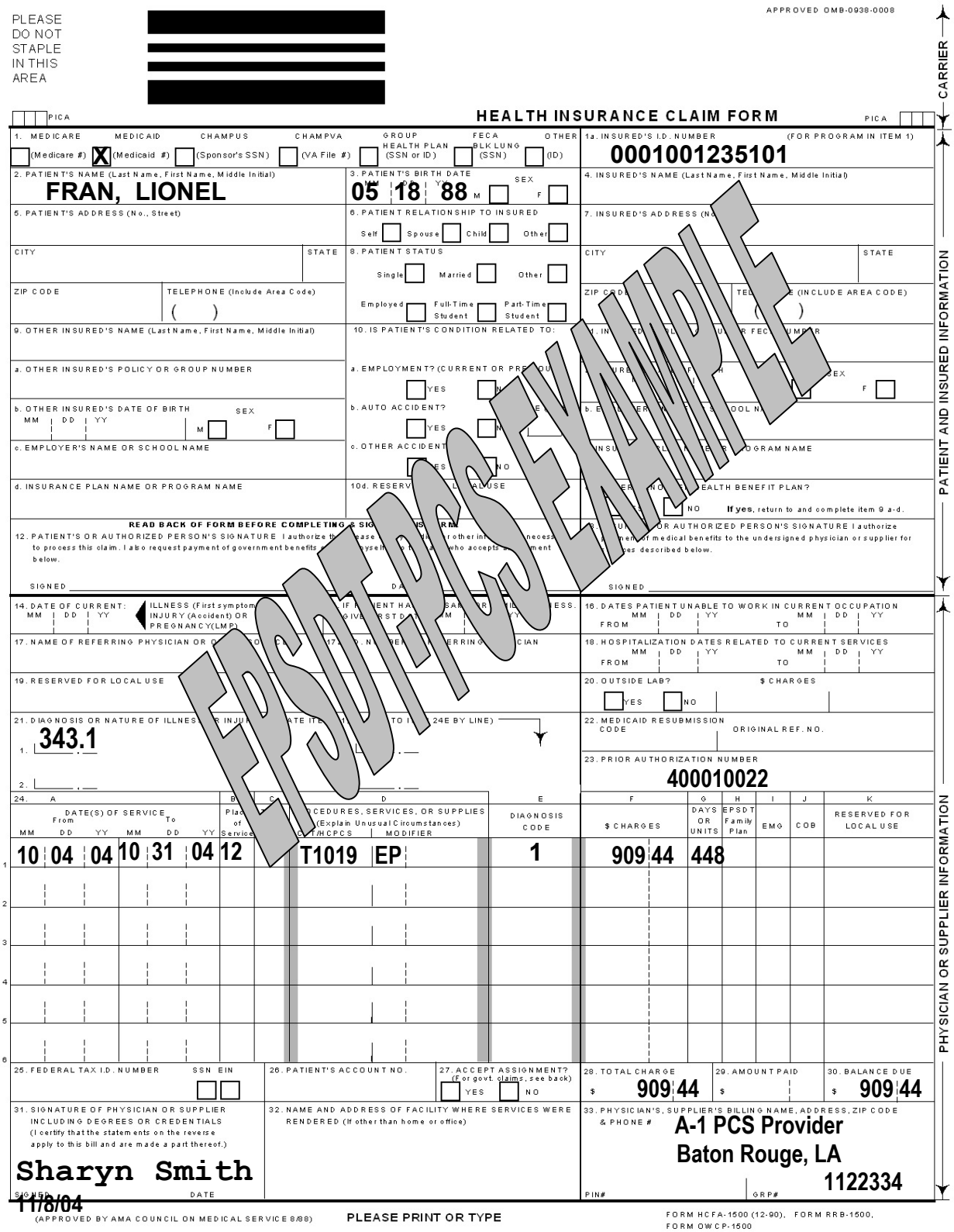
*31. **Signature of Physician/Supplier** - The claim form **MUST** be signed. Although the provider does not have to sign the form, an authorized representative from that office must sign the claim. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the provider or authorized representative. **If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned.**

Date - Enter the date of the signature

32. **Name and Address Where Services Were Rendered** - Leave blank

*33. **Physician's or Medical Assistance Supplier's Name, Address, Zip Code and Telephone Number and PIN** - Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid provider number must be entered in the space next to "GRP #."

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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0001001235101

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

3. PATIENT'S BIRTH DATE: 05 18 88 SEX: M ☐ F ☐

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

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

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

7. INSURED'S ADDRESS (No.

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. AUTO ACCIDENT? YES ☐ NO ☐

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

SIGNED

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

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

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. NPI OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

1. 343.1

2.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 400010022

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 04 04	10 31 04	12		T1019	EP	1	909 44	448				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐☐

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 909 44

29. AMOUNT PAID $

30. BALANCE DUE $ 909 44

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

Sharyn Smith

SIGNED 11/8/04 DATE

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

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

A-1 PCS Provider
Baton Rouge, LA
1122334

PIN# GRP#

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

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **1002345891230**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **TULLIER, JACKSON**

3. PATIENT'S BIRTH DATE MM DD YY: **05 18 68** SEX M [ ] F [ ]

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP | PHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO: | GROUP | FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

SEX M [ ] F [ ]

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

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

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER INSURANCE? YES [ ] NO [ ]

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

SIGNED

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. 2. 3. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: **437985629**

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 2004 10 14 2004	12		T1019	UB		480 00	160				
2											
3											
4											
5											
6											

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 480 00

29. AMOUNT PAID $

30. BALANCE DUE $ 480 00

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

Cathryn Jester 10/18/04

SIGNED DATE

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

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

A-1 PCS Agency
Baton Rouge, LA

PIN# GRP# **1122334**

LT-PCS EXAMPLE

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

UNISYS 213 ADJUSTMENT/VOID FORM

The Unisys 213 adjustment/void is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Unisys by calling Provider Relations at (800) 473-2783. Electronic submitters may electronically submit adjustment/void claims.

FORM COMPLETION

Only one (1) control number can be adjusted or voided on each 213 form.

Only an approved claim can be adjusted or voided.

Blocks 26 and 27 must contain the claim's most recently approved control number and R.A. date. For example:

1. A claim is approved on the RA dated 11/23/2004, ICN 4295067890123.

2. The claim is adjusted on the RA dated 12/28/2004, ICN 4352090123456.

3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (4352090123456) and RA date (12/28/2004) must be used.

Provider numbers and recipient Medicaid ID numbers cannot be adjusted. They must be voided and then resubmitted.

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

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

Only one (1) claim line can be adjusted or voided on each adjustment/void form.

213 Adjustment/void forms should be mailed to the following address for processing:

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

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

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

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	3 PATIENT'S DATE OF BIRTH	4 MEDICAID ID NUMBER
TULLIER, JACKSON	05/15/68	1002345891230

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

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	14 DATE FIRST CONSULTED YOU FOR THIS CONDITION	15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO
16 DATE PATIENT ABLE TO RETURN TO WORK	17 DATES OF TOTAL DISABILITY FROM / THROUGH	DATES OF PARTIAL DISABILITY FROM / THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE / 18A REFERRING ID NUMBER		19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED / DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO [ ] CHARGES

22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1
2
3

23 ATTENDING NUMBER

24 PRIOR AUTHORIZATION NO. 437985629

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
10	01	2004	10	14	2004	12	T1019	UB	1	432 00	144		

26 CONTROL NUMBER
4197064949600

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
11/23/2004

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

PAID FOR DATE OF SERVICE 10/07/2004 IN ERROR, WORKER CALLED OUT AND COULD NOT FIND REPLACEMENT

ADJUSTMENT

29 REASONS FOR VOID

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Cathryn Jester

32 YOUR PATIENT'S ACCOUNT NUMBER
1179879nn4

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
A-1 PCS AGENCY
Baton Rouge, LA
1122334

FISCAL AGENT COPY

UNISYS - 213
5/97

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION

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

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

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT

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

ADJUSTMENT

29 REASONS FOR VOID

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

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

32 YOUR PATIENT'S ACCOUNT NUMBER

UNISYS - 213
5/97

FISCAL AGENT COPY

CLAIM DENIAL RESOLUTION

This section is designed to assist providers in resolving claim denials. The most frequently encountered error codes are listed, along with an explanation of each denial and how to correct it.

HARDCOPY CLAIM DENIAL RESOLUTION

The following explanations assume that, if the claim was filed hardcopy, no data entry errors occurred. If the information on the Remittance Advice does not match the data on the claim (recipient ID number, date of service, procedure code, recipient name, charges, etc.), then a data entry error occurred. Providers may call Unisys Provider Relations department (see p. 44) to report the problem and request that the claim be reprocessed.

FOR FURTHER INFORMATION

The topics of recipient eligibility verification (using REVS, MEVS, and e-MEVS), spend-down medically needy eligibility, third party liability, timely filing guidelines, SURS, and others are discussed in detail in the 2004 Basic Medicaid Provider Training packet. Providers may obtain a copy of this document by attending a 2004 Basic Medicaid Provider Training workshop or by requesting the packet from Provider Relations.

GENERAL CLAIM FORM COMPLETION ERROR CODES

ERROR CODE 003–RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS	
Cause:	The recipient ID number on the claim form was less than 13 digits in length or included letters or other non-numeric characters.
Resolution:	Verify the correct 13-digit recipient ID number using REVS or MEVS and enter this number where required on the claim form.

ERROR CODE 009-SERVICE THRU DATE GREATER THAN DATE OF ENTRY	
Cause:	The claim was received by Unisys prior to one or more dates of service billed.
Resolution:	Correct the date span on the claim and rebill **OR** wait until all dates of service on the claim have passed and rebill.

DUPLICATE CLAIM ERROR CODES

ERROR CODE 813 - EXACT DUPLICATE ERROR: IDENTICAL CLAIMS	
Cause:	The claim is a duplicate of one that has already been paid by Unisys.
Resolution:	1. On the Remittance Advice, the denial refers the provider to the conflicting control number and adjudication date of the previously paid claim. Refer to that Remittance Advice date indicated to find the paid claim. Do not resubmit the claim if it has already been paid.
	2. If the wrong number of units were paid for that date range, submit an adjustment (see page 33) in order to receive correct payment.

RECIPIENT ELIGIBILITY ERROR CODES

ERROR CODE 215-RECIPIENT NOT ON FILE	
Cause:	The recipient ID number on the claim form is not in the Unisys eligibility files.
Resolution:	Verify the correct 13-digit recipient ID number using REVS, MEVS, or e-MEVS and enter this number where required on the claim form. If there is a MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit (address on p. 45) with a cover letter stating the problem.

ERROR CODE 216-RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE	
Cause:	The recipient ID number on the claim is in the Unisys eligibility files, but the recipient's eligibility does not cover the date of service filed on the claim.
Resolution:	Verify the recipient's eligibility using REVS or MEVS for all dates of service on the claim. If there is a MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter explaining the problem.

ERROR CODE 217-NAME AND OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD	
Cause:	1. The name on the claim form does not match the recipient ID number as recorded in the Unisys eligibility files. This is sometimes caused when a recipient marries and changes her surname, or if several family members have similar ID numbers, **OR**
	2. The first and last names have been entered in reverse order on the claim form.
Resolution:	Verify the correct spelling of the name via REVS or MEVS using the 13-digit recipient ID number. Ensure that the first and last names are entered in the correct order on the claim. Make corrections if necessary and resubmit.
NOTE:	Occasionally a recipient's name may be changed on the Unisys eligibility files after PA is issued but before billing can occur. In such cases, the provider should contact Unisys Prior Authorization Unit to request that the name on the prior authorization record be changed to reflect the new name.

ERROR CODE 222 – RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE (S)	
Cause:	The recipient ID number on the claim is in the Unisys eligibility files, but the recipient's eligibility does not cover all dates of service filed on the claim.
Resolution:	Verify the recipient's eligibility using REVS, MEVS, or e-MEVS for all dates of service on the claim. If there is a MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 295-RECIPIENT INELIGIBLE RECYCLED THREE TIMES	
Cause:	The Medicaid ID number entered on the claim form does not match a Medicaid number in the state files.
Resolution:	Review the claim submitted. The Medicaid ID number will always be a 13-digit number. If the number entered on the claim form seems appropriate, check the recipient eligibility by accessing REVS or MEVS. If the ID number given differs from the Medicaid ID number on the claim form, correct and resubmit the claim. Otherwise, this person is not covered through the Medicaid program and is responsible for their charges.

TIMELY FILING ERROR CODES

ERROR CODE 272-CLAIM EXCEEDS 1 YEAR FILING LIMIT	
Cause:	The date of service on the claim form is more than 1 year prior to the date the claim was received by Unisys. All such claims must be accompanied by proof of timely filing in order to be paid.
Resolution:	Resubmit the claim with proof of timely filing attached. Proof of timely filing is usually a copy of a RA page that shows the claim was processed by Unisys within one year from the date of service. Such claims may be mailed with a cover letter requesting an override for proof of timely filing to the Unisys Correspondence Unit.
NOTE:	When refiling claims over one year old, it is not enough for the provider to know or to believe that he has filed the claim to Unisys within one year from the date of service. He must attach proof of timely filing to the claim, or the claim will deny. A history can be ordered to assist in determining if payment has been made or if a claim has been filed timely. This may be done by calling the Provider Relations Telephone Inquiry Unit. The Field Analyst for your territory may also assist in placing such an order.

ERROR CODE 030-SERVICE "THRU" DATE MORE THAN TWO YEARS OLD	
Cause:	The date of service on the claim form is more than two years prior to the date the claim was received by Unisys.
Resolution:	Timely filing guidelines dictate that, in general, claims with dates of service over two years old are not payable. Unisys staff does not have the authority to override such claims. In the case of retroactive eligibility, DHH must review the claim and approve any overrides for timely filing.

PRIOR AUTHORIZATION ERROR CODES

Providers must bill services exactly as they are authorized via the PA letter. The Medicaid computer system compares several items which must be the same on both the claim form and the prior authorization record: PA number, Medicaid recipient ID number, provider number, procedure code, and date of service. The Remittance Advice (RA) reflects the PA number entered on each processed claim. This is found on the left-hand side of the RA page, just below the recipient name.

Several error codes pertain to the process the computer uses in matching items on the claim to items on the prior authorization record:

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

ERROR CODE 191-PROCEDURE REQUIRES PRIOR AUTHORIZATION	
Cause:	No PA number entered in block 23.
Resolution:	1. Review recipient records to ascertain whether or not authorization had been given. If the prior authorization letter shows an approval for that service, be sure to indicate that specific PA number in block 23.

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

ERROR CODE 196-CLAIM RECIPIENT ID DOES NOT MATCH ID ON PA FILE	
Cause:	Recipient ID on PA file is not the same as the one entered on the claim.
Resolution:	Review the PA letter, being sure to pay special attention to the recipient ID. When submitting the claim, all information on the PA must match the claim. Therefore, if a recipient has a different ID number on date of service than the PA record shows, the claim will deny.

ERROR CODE 197-PA PROVIDER ID NOT SAME AS CLAIM PROVIDER ID	
Cause:	The provider information on the PA file does not match the information on the claim form.
Resolution:	**EPSDT-PCS Claims only**: Review the PA letter, paying special attention to the Provider ID number. If there was a keying error or the provider did not indicate the correct ID number, a **Reconsideration** will need to be done in order for payment to be made. See page 16 for further information on how to submit a reconsideration. **LT-PCS Claims only**: Review the PA letter, paying special attention to the Provider ID number. If the provider number indicated on the PA letter is not correct, contact Provider Relations for follow up. If the provider number indicated on the claim form is incorrect, resubmit the claim with the correct provider number.

HARD COPY REQUIREMENTS

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

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	BILLING REQUIREMENTS
Spend Down Recipient - 110MNP Spend Down Form	Continue hardcopy billing
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.

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

WEB APPLICATIONS

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

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

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

e-MEVS:

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

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

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on 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.

ADDITIONAL DHH AVAILABLE WEBSITES

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

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

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

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

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

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

PROVIDER ASSISTANCE

Many of the most commonly requested items from providers including, but not limited to, 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.

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

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

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

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

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

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

RECIPIENT HELPLINE (800) 834-3333

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

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

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

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

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

NOTE: All correspondence sent to Provider Relations, including recipient file updates, must include a separate cover letter explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). **A copy of the claim form along with applicable corrections and/or attachments must accompany all resubmissions.**

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

Requests to update 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 <u>are not</u> available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

FIELD ANALYST	PARISHES SERVED	
Martha Craft (225) 237-3306	Jefferson Orleans	St. Charles Plaquemines St. Bernard
Open	Bienville Bossier Caddo Claiborne East Carroll Lincoln Madison Morehouse	Ouachita Richland Union Webster West Carroll Marshall, TX Vicksburg, MS
Mona Doucet (225) 237-3249	Acadia Evangeline Iberia Lafayette	St. Landry St. Martin St. Mary Vermillion
Open	Allen Beauregard Calcasieu Cameron Vernon	Jeff Davis Lafourche Terrebonne Beaumont, TX Jasper, TX
Sharon Harless (225) 237-3267	Avoyelles Iberville West Baton Rouge Pointe Coupee	East Feliciana West Feliciana Woodville/Centerville (MS)
Erin McAlister (225) 237-3201	Ascension Assumption Livingston St. Helena St. James	St. John the Baptist St. Tammany Tangipahoa Washington McComb (MS)
Courtney Patterson (225) 237-3269	East Baton Rouge	
Kathy Robertson (225) 237-3260	Caldwell Catahoula Concordia DeSoto Franklin Grant Jackson LaSalle	Natchitoches Rapides Red River Sabine Tensas Winn Natchez (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) 237-3334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 237-3381	(225) 237-3334
Electronic Data Interchange (EDI) - Unisys	(225) 237-3200 option 2		(225) 237-3331
Prior Authorization (DME, Rehab) **-** Unisys	(800) 488-6334	(225) 928-5263	(225) 237-3342 or (225) 929-6803
Home Health P.A. **-** Unisys **EPSDT PCS P.A. -** Unisys	(800) 807-1320		
Dental P.A. - LSU School of Dentistry		(504) 619-8589	(504) 619-8560
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 237-3370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline-Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

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

DHH PROGRAM MANAGER REQUESTS

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

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

EDI CLAIMS SUBMISSION

Electronic media claim submission is the preferred method of submitting Medicaid claims to Unisys. With electronic media, 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 media must satisfy the criteria listed in the manual for that type of claim.

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

Certification Forms

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

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

Copies of required Certification forms are included in this packet and may also be obtained from lamedicaid.com under the HIPAA Information Center link. The required forms are available in both the General EDI Companion Guide and the EDI Enrollment Packet.

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

- Provider Name
- Provider Number
- Submitter Number
- Claim Count
- Total Charges of submission
- Submission Date
- Original Signature
- For **THIRD PARTY BILLERS / CLEARINGHOUSES** - a list of Provider Names and Numbers contained in the submission must be attached.

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

for correction.

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

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

Electronic Adjustments/Voids

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

SUBMISSION DEADLINES

Regular Business Weeks

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

Thanksgiving Week

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

Important Reminders For EDI Submission

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

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

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

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

ELECTRONIC DATA INTERCHANGE (EDI) GENERAL INFORMATION

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

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

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

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

    - Case Management services
    - Non-Ambulance Transportation

Enrollment Requirements For EDI Submission

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

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

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

Enrollment Requirements For 835 Electronic Remittance Advices

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

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

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

EDI General Information

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

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

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

UNISYS CLAIMS FILING ADDRESSES

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

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

CLAIMS PROCESSING REMINDERS

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

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

- Submit an original claim 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 you printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.

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

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

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

- Continuous feed forms must be torn apart before submission.

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

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

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

- Do not submit two-sided documents.

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

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

REJECTED CLAIMS

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

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

ATTACHMENTS

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

CHANGES TO CLAIM FORMS

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

DATA ENTRY

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

APPENDIX

BHSF Form 90-L
Rev. 02/95
07/94 Issue Usable

Medicaid Program
Request for Level of Care Determination
Part I - Identifying Information

1) Please provide the following information about yourself or other person needing residential facility or home/community-based waiver services:

Name:	Home Address (include City, State, Zip Code & Parish):
SS #:	
Date of Birth: / Sex:	
Medicaid ID #:	Medicare Eligible: ❑ Yes ❑ No
Marital Status:	Spouse's Name:
Responsible Relative/Curator:	Address (include City, State, & Zip Code):
Relationship:	

2) Please provide the following information about this person's spouse, family or friends who maintain contact and/or provide care:

Name	Relationship	Address	Telephone

3) What are the current living arrangements or were they prior to residential facility admission?
   a. Lives(d) in: ❑ Own home; ❑ Relative's home; ❑ Boarding home; ❑ Other (_____)
   b. Lives(d) with: ❑ Spouse; ❑ Child(ren); ❑ Alone; ❑ Other (_____)

4) a. What previous institutional care (including nursing facilities) has this person received?

Facility Name	Dates of Admission

   b. What home/community-based services have been used/considered: ❑ Adult Day Health Care ❑ MR/DD ❑ Home Care for the Elderly ❑ Personal Care Attendant ❑ Head Injury Maintenance
   c. Why are (were) services not suitable? _____
   _____.

5) a. Services are needed at this time because: _____
   _____.
   b. This service is needed: ❑ Temporarily ❑ Permanently

Applicant's Signature _____ Date _____

Part II - Medical Information

MENTAL STATUS AND BEHAVIOR: (Check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always.)

Oriented ❑ Yes (1, 2, 3) ❑ No
Forgetful ❑ Yes (1, 2, 3) ❑ No
Depressed ❑ Yes (1, 2, 3) ❑ No
Comatose ❑ Yes (1, 2, 3) ❑ No
Confused ❑ Yes (1, 2, 3) ❑ No
Wanders ❑ Yes (1, 2, 3) ❑ No
Hostile ❑ Yes (1, 2, 3) ❑ No
Combative ❑ Yes (1, 2, 3) ❑ No

COMMUNICATION: (Check Yes or No. Please comment on patient's functional level.)

Verbal ❑ Yes ❑ No _____
Non-Verbal ❑ Yes ❑ No _____
Blind ❑ Yes ❑ No _____
Glasses ❑ Yes ❑ No _____
Deaf ❑ Yes ❑ No _____
Hearing Aid ❑ Yes ❑ No _____

ACTIVITIES OF DAILY LIVING: (Check appropriate responses.)

	Self	Min. Asst.	Max. Asst.
Eating	❑	❑	❑
Bathing	❑	❑	❑
Personal Grooming	❑	❑	❑
Oral Hygiene	❑	❑	❑
Dressing	❑	❑	❑

Ambulation
By self ❑
With walker ❑
With assistance ❑
Uses cane ❑
Mobile per wheelchair ❑
Chair bound ❑
Bed bound ❑

Appetite
Good ❑
Fair ❑
Poor ❑
Dentures ❑

Part II - Medical Information (continued)

PRESENT ILLNESS: _____

_____

_____

RECENT HOSPITALIZATIONS: (Include Psychiatric) _____

_____

_____

PHYSICAL EXAMINATION:

General _____
Head and CNS _____
Mouth and EENT _____
Chest _____
Heart and Circulation _____
Abdomen _____
Genitalia _____
Extremities _____
Skin _____
Lab Results ❑ HCT ____ ❑ HGB ____ ❑ UA ____
❑ Radiology _____
Height _____ Weight _____
Pulse _____ Resp. _____
Temp. _____ Blood Pressure ____

SPECIAL CARE/PROCEDURES: (Check all required.)

❑ Bladder/bowel incontinence _____
❑ Ostomy _____
❑ Urinary Catheter (Specify type) _____
_____
❑ Glucose Monitoring _____
❑ Restraints (Specify type) _____
❑ Decubitus care (Include stage, site, size) _____
_____
❑ IVs _____
❑ Suctioning _____
❑ Specialized Rehab. (Specify type & frequency)
_____
❑ Other (Specify) _____
❑ Diet/Tube Feeding _____

DIAGNOSIS: _____

_____

_____

PROGNOSIS/REHABILITATION POTENTIAL: _____

_____

_____

MEDICATION: (Specify dosage, frequency, and route.)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

LEVEL OF CARE RECOMMENDATION: Institutional care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as the amount of time required to render the necessary care and services. The attending physician **must** designate the required level of care by selecting the appropriate level below. This requirement also applies to applicants requesting home or community-based waiver services to allow for a determination of the level of institutional care that would otherwise be required.

❑**Minimum Care** (IC II) - Includes some aid in activities of daily living, diversionary activities, protection from hazards and/or a minimum amount of licensed nursing care.

❑**Medium Care** (IC I) - Includes need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization.

❑**Maximum Care** (SN) (Indicate special level, if appropriate: ❑ TDC; ❑ ID; ❑ NRTP {❑ Complex, ❑ Rehab}) - Includes professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

❑**IC MR** - Requires active treatment of mental retardation or a developmental disability under supervision of a qualified mental retardation or developmental disability professional.

Is this patient likely to need services in a medical facility (hospital, nursing facility, etc.) for at least thirty (30) consecutive days? ❑ Yes ❑ No

Home/community based services ❑ are ❑ are not adequate to meet the needs of this patient.

Physician's Signature _____ Date _____
Physician's Name (Please type or print clearly) _____ Phone _____
Address _____
_____

EPSDT Personal Care Services—Social Assessment
Must Be Submitted In Addition to Form 90-L

RECIPIENT NAME:_____ MEDICAID #_____

1. HOUSEHOLD COMPOSITION:

Name	Age	Relationship	School/Work?

2. PRIMARY CAREGIVER ASSESSMENT:

Name: _____ Age_____ Relationship_____ Phone_____

Does Primary Caregiver have physical or mental limitations which would affect his/her ability to care for the recipient?
☐Yes ☐No If yes, explain and attach medical documentation of limitations:

_____

_____

Will the primary caregiver supervise the PCS worker? ☐Yes ☐No

3. CHILDCARE ARRANGEMENTS:

Age of the recipient: _____ If fourteen years or younger, explain childcare arrangements when the parent is gone from the home. (ie., when parent is at work, before/after school when parent works, or when parent is away on errands).

_____

_____

4. RECIPIENT ASSESSMENT:

Does recipient attend school or work? ☐Yes ☐No If yes, specify hours attended and name of school or work:_____

Is recipient ☐ Verbal ☐ Nonverbal?
Does recipient utilize adaptive equipment? ☐Yes ☐No
If yes, specify what type equipment:_____

_____

Can recipient direct his/her own care? ☐Yes ☐No
If no, is primary caregiver or other caregiver in home? ☐Yes ☐No

Is recipient on medication: ( ) Yes ( ) No
If yes, who gives medication?_____

5. DIETARY FACTORS:

Who prepares meals?_____

Type of meals and number per day:_____
Assistive devices for eating (feeding tube, other): ( ) Yes ( ) No
If yes, specify:_____

6. HOME ENVIRONMENT:

Access (describe stairs, doors, walks, etc): _____

_____

Living Space:_____

_____

Location (rural, urban, on bus line, etc.):_____

_____

7. **Family Interpersonal Relationships:** Which family members assume major responsibilities for caring for recipient and what tasks do they perform?

_____

_____

8. SOCIAL SUPPORT SYSTEM: Are there other friends or relatives that assist in caring for the recipient or in giving relief to the primary caregiver?

_____

_____

9. OTHER SERVICES: What other services is the recipient receiving at this time (home health, respite, etc.)?

_____

_____

10. PCS SERVICES: What is the name of the agency that will provide PCS services?

_____

Signature(s) of person(s) completing assessment:

_____ Date:_____

_____ Date:_____

EPSDT PCS DAILY SCHEDULE

Client Name_____ Medicaid #_____

Specify hours of all services recieved by recipient. This includes EPSDT PCS as well as other services such as home health aide or nurse, respite or PCA from waiver or contract, physical therapy, etc. Be certain to show times the recipient is in school.

TIME	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
NOON							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							
12:00 PM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
Comments							

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):_____**EPSDT**_____**LT**

FACILITY	**Poor**				**Excellent**
The seminar location was satisfactory	1	2	3	4	5
Facility provided a comfortable learning environment	1	2	3	4	5
SEMINAR CONTENT	**Poor**				**Excellent**
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS REPRESENTATIVES	**Poor**				**Excellent**
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 questions	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION: PERSONAL CARE SERVICES					

What topic was most beneficial to you?_____

Please provide constructive comments and suggestions:_____

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