HOME AND COMMUNITY BASED WAIVER SERVICES TRAINING

Medicaid Issues for 2004
(Fall Issue)

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

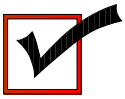
UNISYS

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.



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.

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

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

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

EPSDT/KIDMED EXAMS AND CHECKUPS

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

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

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

PERSONAL CARE SERVICES

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

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

EXTENDED HOME HEALTH SERVICES

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

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

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

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

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

SERVICES IN SCHOOLS OR EARLY INTERVENTION CENTERS

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

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

MEDICAL EQUIPMENT AND SUPPLIES

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

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

MENTAL HEALTH REHABILITATION SERVICES

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

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

TRANSPORTATION

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

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

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OTHER MEDICAID COVERED SERVICES

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

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

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

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

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NOTICE TO ALL PROVIDERS

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

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

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

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

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

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

Services Available to Medicaid Eligible Children Under 21

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

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

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

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

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

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 the 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.

RECORD KEEPING/DOCUMENTATION

Documentation And Progress Notes

It is the responsibility of the support coordinator agency and service provider to provide adequate documentation of services offered to waiver recipients for the purpose of continuity of care and support for the individual, and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of activities undertaken on behalf of the recipient. Progress notes must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be drawn from the content of the note (general terms such as “called the recipient” or “supported recipient” or “assisted recipient” is not sufficient and does not reflect adequate content). Check lists alone are not adequate documentation.

BCSS does not prescribe a format for documentation, but must find all components outlined below. The schedule for documentation differs based on each waiver/service system. Please see the table for documentation schedule.

Support Coordinators

Support Coordinator providers will document progress as follows:

Service Logs-Chronology of events and contacts, which support justification of critical case management elements for Prior Authorization of services in the CMIS system. Each service contact is to be briefly defined (i.e., telephone call, face to face visit) with narrative in the form of a progress note.

Progress Note-Narrative that reflects each entry into the service log and elaborates on the substance of the contact.

Progress Summary-Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress/lack of progress toward desired outcomes and changes to the social history. This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other support coordinators or their supervisors, and allows for evaluation of activities by program monitors.

Service Providers

Service providers will document progress as follows:

Service Logs/Payroll Sheets – Chronology of events and contacts, which support justification for Prior Authorization or payment of services

Progress Notes – Narrative that reflects each entry into the service log/payroll sheet and elaborates on the activity of the contact.

Progress Summary – Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress or lack of progress toward desired outcomes and changes that may impact the CPOC and the needs of the individual. This summary should be sufficient in detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other direct support staff or their supervisors, and allows for evaluation of activities by program monitors.

Documentation Of Progress

All notes and summaries of entries in a participant's record should include:

Name of author/person making entry
Signature of author/person making entry
Functional title of person making entry
Full date of documentation
Review by supervisor, if required
Written legibly, in ink
Narrative that follows definition for the type of documentation used

Discharge Summary For All Waivers

All transfers or closures will require a summary of progress prior to final closure.

Recipient Records

A provider must have a separate written record for each recipient served by the agency. It is the responsibility of the support coordinator agency and service provider to have the required documentation of services offered to waiver recipients for the purposes of continuity of care and support for the individuals and the need for ongoing monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of activities undertaken on behalf of the recipient

Table Of Documentation Schedule

Service Providers				
Waiver	**Service Log/ Payroll Sheet**	**Progress Notes**	**Progress Summary**	**Case Closure/ Transfer**
Children's Choice	At Time Of Activity	At Time Of Activity	Between The 6th And 9th Month Or More Frequently, If Indicated	Within 14 Days Of Discharge
Elderly And Disabled Adult	At Time Of Activity	At Time Of Activity	At Least Every 90 Days	Within 14 Days Of Discharge
New Opportunities Waiver	At Time Of Activity	At Time Of Activity	At Least Every 90 Days	Within 14 Days Of Discharge
Targeted Population	At Time Of Activity	At Time Of Activity	At Least Every 90 Days	Within 14 Days Of Discharge

ELDERLY AND DISABLED ADULT (EDA) WAIVER

The following procedure codes represent current information. Any claims submitted with dates of service prior to April 1, 2004 should be billed with the procedure code applicable at that time.

Provider Type	Proc Code	Modifier	Description	Unit Size
82	S5125		Attendant Care Services	15 Min
82	S5130		Homemaker	15 Min
82	S5135	**U1**	Companion Care (Adult)	15 Min
82	S5135	**UJ**	Companion Care (Adult)	15 Min
15	Z0060		Environmental Modifications – Ramp	$3,000.00 Lifetime Limit (Based on Comprehensive Plan of Care)
15	Z0061		Environmental Modifications - Lift	
15	Z0062		Environmental Modifications - Bathroom	
15	Z0063		Environmental Modifications-Adaptations	
16	Z0058		Personal Emergency Response Installation	Once Per Life
16	Z0059		Personal Emergency Response System – Monthly Fee	Monthly

Modifier definition

U1 = Day
UJ = Night

ELDERLY AND DISABLED ADULT WAIVER FACT SHEET

Description	This waiver was implemented on July 1, 1993. Home and Community-Based Services Waiver programs are based on federal criteria, which allow services to be provided in a home or community-based setting for the recipient who would otherwise require institutional care. On April 1, 1997 changes in the admission criteria and the target population resulted in the waiver name being changed to the Elderly and Disabled Adult Waiver (EDA). Due to the demand for these services, there is a Request for Services Registry (RFSR) that lists individuals and their request date. This waiver is offered on a first-come first-served basis. Persons interested in being added to the RFSR for this waiver should contact the Louisiana Options in Long Term Care Statewide toll free Help-Line at 1-877-456-1146 (TDD Line: 1-877-465-1172). The application process does not begin until a slot is available. At that time medical and financial determinations are done simultaneously and are the same as those for long term nursing facility care. Requestors have freedom of choice for providers. There are nine (9) services provided under this waiver: Support Coordination Transition Intensive Support Coordination Personal Care Attendant Household Supports Personal Supervision (day) Personal Supervision (night) Environmental Modifications Personal Emergency Response System Transitional Service (lifetime maximum assistance for individuals transitioning from a nursing home to the community). **At the present time, the approved Cost Cap is an average of $60.00 a day.**
Level of Care	Requestors **must meet** the level of care criteria for admission to a long term nursing facility. Medical and social information must be submitted to support this determination.
Population	Age 65 or older, and 21 or older who are disabled according to Medicaid standards or SSI disability criteria.
Financial	* Income - For 2004, the income limits are $1,692 (up to 3 times the SSI amount) for an individual, and $3,312 for a couple when one spouse needs long-term care. * Resources - For 2004, countable resources cannot be worth more than $2,000 for an individual, or $3,000 for a couple when one spouse needs long-term care. For 2004, under Spousal Impoverishment rules, a couple can have up to $92,760 in countable resources, as long as there is a spouse at home who does not get long-term care. *** These income and resources limits are subject to change each year.**

**** All requests for ANY Home and Community-Based Services Waivers should be directed to the Louisiana Options and Long Term Care toll-free Help Line at 1 (877) 456-1146.**

CHILDREN'S CHOICE WAIVER

The following procedure codes represent current information. Any claims submitted with dates of service prior to April 1, 2004 should be billed with the procedure code applicable at that time.

Procedure Code	Modifier	Description	Units
9E001		Children's Choice Support Coordinator	Monthly
H2011		Crisis Intervention	15 minutes
S5125		Attendant Care Services	15 minutes
T1005	**HQ**	Respite Care	15 minutes
S5111		Home Care Training-Family	Based on CPOC
T2028		Specialized Supplies	
S5165	**U4**	Home Modifications	
S5165	**U5**	Home Modifications	
S5165		Home Modifications	
T2039		Vehicle Modifications	
H2011	**UN**	Crisis Intervention	15 minutes
S5125	**UN**	Attendant Care Services	15 minutes
H2011	**HQ**	Crisis Intervention	15 minutes

Modifier definition

HQ = Group Setting
UN = 2 people
U4 = ramp
U5 = bathroom

CHILDREN'S CHOICE WAIVER FACT SHEET

Description	The Children's Choice Waiver began February 21, 2001 to offer supplemental support to children with developmental disabilities who currently live at home with their families, or who will leave an institution to return home. The Children's Choice Waiver is an option offered to children on the MR/DD Request for Services Registry as funding permits. Families choose to either apply for the Children's Choice Waiver or remain on the MR/DD Request for Services Registry. Participants are eligible for all medically necessary Medicaid services, and will also receive up to $15,000 per year in Children's Choice services (including required support coordinator). The service package is designed for maximum flexibility. A family that chooses Children's Choice may later experience a crisis that increases the need for paid supports to a level that would be more than the $15,000 cap on Children's Choice expenditures. During an initial one-year trial period, special provisions have been made to provide additional supports during the crisis period until other arrangements can be made. When recipients of Children's Choice reach their 19th birthday they transfer with their slots to an appropriate MR/DD waiver as long as they remain eligible for waiver services. The following services are provided under this waiver: **Support Coordination** – to assist families in life planning for the child, including gaining access to needed waiver and state plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Home visits are required. **Family Support** – provided directly to the child to enable a family to keep the child at home and that enhance family functioning. **Center Based Respite Care** – services provided on a short-term basis to children unable to care for themselves due to the absence or need for relief of the parents or to others who normally provide care and supervision. **Family Training** – training and education services for the families of recipients that is provided by professional organizations or practitioners appropriate to the needs of the child and approved by BCSS. **Environmental Accessibility Modifications** – physical adaptations to the home or vehicle necessary to ensure health, welfare, and safety of the child, or which enable the child to function with greater independence in the home, and without which additional supports, institutionalization would be required. Excluded are adaptations of general use or those that add to the total square footage of the home. Excluded are fire alarms, smoke detectors, and fire extinguishers. **Specialized Supplies** - diapers for ages three and older
Level of Care	Recipients must meet ICF/MR level of care for medical and/or psychological criteria. The procedure and requirements for admission to the waiver are the same as for ICF/MR determination.
Population	**Age-**Birth through age 18. **Disability**- Meets the federal definition for mental retardation or a developmental disability.
Financial	**Income-**Up to 3 times SSI amount. Income of other family members is not considered. **Needs Allowance**-Three times the SSI amount. **Resources**-Less than $2,000 **Non-financial**-meets all Medicaid non-financial requirements (citizenship, residence, Social Security number, etc.) **Financial**-Same resource, parental income counted, etc. as for ICF/MR.

NEW OPPORTUNITIES WAIVER SERVICES

The following procedure codes represent current information. Any claims submitted with dates of service prior to April 1, 2004 should be billed with the procedure code applicable at that time.

Provider Type	Procedure Code	Modifier	Description	Unit Size
89	S5136		Companion Care	Day
84	S5140		Foster Care, adult	Day
16	S5160		PER (Install & Test)	Initial installation
	S5161		PER (Maintenance)	Monthly
ONLY HOME HEALTH AGENCIES CAN PERFORM SKILLED NURSING SERVICES (T1002, T1003)				
44	T1002		RN Services	15 min
	T1002	**UN**	RN Services, 2 persons	15 min
	T1002	**UP**	RN Services 3 persons	15 min
	T1003		LPN/LVN Services	15 min
	T1003	**UN**	LPN/LVN Services	15 min
	T1003	**UP**	LPN/LVN Services	15 min
82	S5125	**U1**	Attendant Care Services	15 min
	S5125	**UJ**	Attendant Care Services	15 min
	S5125	**U1 & UN**	Attendant Care Services	15 min
	S5125	**U1 & UP**	Attendant Care Services	15 min
	S5125	**UN & UJ**	Attendant Care Services	15 min
	S5125	**UP & UJ**	Attendant Care Services	15 min
ONLY HOME HEALTH AGENCIES, PCA, AND SIL PROVIDERS MAY PERFORM THE FOLLOWING SERVICES. THESE SERVICES MUST HAVE AN INDIVIDUAL NUMBER INDICATED IN BLOCK 24K OF THE CLAIM FORM IN ORDER FOR PAYMENT TO BE MADE. THE INDIVIDUAL PROVIDER NUMBER MUST BE LINKED TO THE WAIVER OR HOME HEALTH AGENCY PROVIDER NUMBER. THE WAIVER OR HOME HEALTH AGENCY PROVIDER IS RESPONSIBLE FOR OBTAINING THE ENROLLMENT PACKET FOR THE INDIVIDUAL PROVIDER (PHYSCHOLOGIST, SOCIAL WORKER, RN, OR LPN) AND ENSURING THAT THE PACKET IS COMPLETED AND RETURNED TO UNISYS.				
44 82 89	**H2011**	**U7**	Crisis Intervention Services	15 min
	H2011	**TD**	Crisis Intervention Services	15 min
	H2011	**TE**	Crisis Intervention Services	15 min
44 82 89	H2017	**U7**	Psychosocial Rehabilitation Services	15 min
	H2017	**TD**	Psychosocial Rehabilitation Services	15 min
	H2017	**TE**	Psychosocial Rehabilitation Services	15 min
	H2017	**AJ**	Psychosocial Rehabilitation Services	15 min
44 82 89	H2014	**U7**	Skilled Training and Development	15 min
	H2014	**AJ**	Skilled Training and Development	15 min
	H2014	**TD**	Skilled Training and Development	15 min
82	T2025		Waiver Services	15 min
89	T2025	**UN**	Waiver Services	15 min
ONLY OCDD IS ABLE TO PERFORM THIS SERVICE				
02	T2038		Community Transition, Waiver	Lifetime
83	T1005	**HQ**	Respite Care	15 min
15	Z0616		Environmental Access. (Ramp)	$4,000.00 per recipient; once the recipient reaches 90% or greater of the cap and the account has been dormant for 3 years, the recipient will receive another allotment of funds so that they have access to another $4,000.00
	Z0617		Environmental Access. (Lift)	
	Z0618		Environmental Access. (Bathroom)	
	Z0620		Environmental Access. (Other)	
16	Z0621		Medical Equip. & Supplies (lifts)	$4,000.00 per recipient; once the recipient reaches 90% or greater of the cap and the account has been dormant for 3 years, the recipient will receive another allotment of funds so that they have access to another $4,000.00
	Z0622		Medical Equip. & Supplies (switches)	
	Z0623		Medical Equip. & Supplies (controls)	
	Z0624		Medical Equip. & Supplies (other)	
98	H2023		Supported Employment	15 min
	H2026		Ongoing Support to Maintain Employment	Day
	H2025	**TT**	Ongoing Support to Maintain Employment	15 min
14	T2002		Non-Emergency Transportation	Day (Roundtrip)
98	A0130		Non-Emergency Transportation (wheelchair)	Day (Roundtrip)
13	T2019		Habilitation, Supported Employment	15 min
14	T2021		Day Habilitation Waiver	15 min
14	T2002	**U6**	Non-Emergency Transportation	Day (Roundtrip)
98	A0130	**U6**	Non-Emergency Transportation wheelchair	Day (Roundtrip)

Modifier definition

AJ = Licensed Social Worker
HQ = Group Setting
TD = Registered Nurse (RN)
TE = Licensed Practical Nurse (LPN)
U7 = Psychologist
TT = Individual Service Provided to More than One Person
UJ = Night
U1 = Day
UN = 2 people
UP = 3 people
U6 = Day Habilitation

NEW OPPORTUNITIES WAIVER (NOW) FACT SHEET

Description	Home and Community-Based Services Waiver programs are based on federal criteria, which allow services to be provided in a home or community-based setting for recipients who would otherwise require institutional care. Due to the demand for these services, there is an MR/DD Request for Services Registry that lists individuals who meet the Louisiana MR/DD definition, and their request date. This waiver is offered on a first-come, first-served basis. Persons interested in being added to the Request for Services Registry for this waiver should contact the Bureau of Community Supports and Services (BCSS) at (800) 660-0488. The application process does not begin until a slot is available. At that time medical and financial determinations are done simultaneously to validate that the individual has mental retardation or a developmental disability, and meets the financial and medical/psychological requirements for institutional care in an ICF/MR. Through freedom of choice, requestors choose their support coordinators and direct service providers. NOW is only appropriate for those individuals whose health and welfare can be assured via the Comprehensive Plan of Care and for whom home and community-based waiver services represent a least restrictive treatment alternative. NOW is intended to provide specific, activity focused services rather than continuous custodial care. The following services are provided under the NOW program: Individualized and Family Support (IFS) Service, both Day and Night Shared Supports for some services Substitute Family Care Center-Based Respite Community Integration Development Residential Habilitation Supervised Independent Living Day Habilitation Day Habilitation - Transportation Supported Employment Supported Employment – Transportation Facility-Based Employment Professional Services Professional Consultation Transitional Professional Support Services Skilled Nursing Services Transitional Expenses Personal Emergency Response System Environmental Accessibility Modification Specialized Medical Equipment and Supplies
Level of Care	Requestors must meet ICF/MR level of care for medical and/or psychological criteria. Procedure and requirements are the same as ICF/MR facility determination for MR/DD.
Population	**Age – Three (3) years and older and Mentally Retarded or Developmentally Disabled (MR/DD which manifested** prior to age 22. Must meet the Louisiana definition for MR/DD.
Financial	**Income**: For 2004, the income limit is $1,692 (up to 3 times the SSI amount). For children, income of other family members is not considered if the child receives SSI. Parental income is counted toward minor children for the month of admission only. The income of the minor and the parent(s) with whom the child lived during that month is counted together. **Resources –** For 2004, countable resources cannot be worth more than $2,000.00 for an individual or $3,000.00 for a couple who needs ICF/MR level of care. For 2004, under Spousal Impoverishment rules, a couple can have up to $92,760 in countable resources, as long as there is a spouse still living at home**.**

BILLING REMINDERS

- ✓ Staff at SRI can only prior authorize information that is submitted – they cannot make changes to the CPOC or Revision Plan. It is the provider's responsibility to ensure that the information contained on these forms is correct prior to submission to SRI.

- ✓ BCSS contractor forwards all MR/DD-14 forms to the direct service providers. Services are not authorized until an **approved** authorization form has been released from SRI thru the Louisiana Service Tracking Software System (LAST).

- ✓ SRI releases the Prior Authorization number to Unisys three (3) working days after the provider has notified SRI of the service being completed. If the provider files the claim before Unisys' computer system is updated with this information, the claim will deny.

- ✓ SRI will release the unit or dollar amount that corresponds with the provider's records (as transmitted through Louisiana Service Tracking Software System (LAST)), not the amount actually authorized.

- ✓ SRI authorizes direct services on a quarterly basis. Services can be billed in any increment as long as the services have been provided and the billed dates and unit amounts fall within the span time allotted.

- ✓ SRI authorizes diapers on a monthly basis. Services cannot be billed until the services have been provided and the span date has passed.

- ✓ Providers cannot bill for dates of services not yet performed-make sure the span date **does not** include future dates of service.

- ✓ Providers should only enter the first nine (9) digits of the Prior Authorization number in block 23 of the claim form.

- ✓ Providers must write **"WAIVER"** at the top of the claim form.

- ✓ The thirteen (13) digit Medicaid ID number **must** be used to bill all claims. This number is indicated on the authorization form. Never use the sixteen (16) digit number located on the plastic Medicaid card.

- ✓ When entering the diagnosis code in block 21, be sure to write it exactly as shown. This code will always be between three and five digits. Do not indicate a decimal point or add zeros. If this information cannot be located on the participant's paperwork, contact the support coordinator. It is not necessary to purchase an ICD-9-CM book in order to obtain this information.

- ✓ Enter the appropriate Medicaid provider number for service type being performed.

- ✓ To resolve denied claims, please review the Remittance Advice (RA) thoroughly.

    - ❖ Denials between **190-198** should be directed to **SRI** at (225) 767-0501
    - ❖ Denial code **105, 109** should be directed to **BCSS** at (225) 219-0200
    - ❖ All other denial codes should be directed to **Unisys** at (800) 473-2783

- ✓ Providers should be sure to always read the first two pages of their RA; changes to policy or new information that is critical to billing is disseminated through the Remittance Advice.

PRIOR AUTHORIZATION

All Waiver services require prior authorization, which is transmitted through Statistical Resources, Incorporated (SRI). In order to obtain and process prior authorization, all providers must use the Louisiana Service Tracking System (LAST) for data tracking purposes.

Louisiana Service Tracking Software (LAST) System

All service events, modifications completion logs, and distribution of diapers logs must be entered in the LAST system.

Information files must be sent to SRI prior to billing. Units of service are released based upon the data entered and received from the agency.

LAST software, training, and technical support is provided by BCSS to direct service providers.

LAST software has incorporated numerous reports to assist you with the service management, including remaining balances, for a recipient.

Computer Minimum Requirements:

The provider must maintain computer equipment, internet accessibility, and software compatible with those needed to conduct business with the BCSS.

Issuance of Prior Authorized waiver services:

Quarterly for direct services
Monthly for diapers (issued amount is based on CPOC)
Based on job for modifications (issued amount is based on CPOC)

Direct services may be billed anytime within the PA cycle.

Diapers may be billed anytime after the PA cycle ends.

Modifications are initially issued for the CPOC year. The PA is then updated to reflect the actual completion date (once the completion form is received, indicating acceptance by the family).

CPOC Balance Report must be sent to the Support Coordinator whenever there is a revision to the Plan of Care or recipient is transferred to another provider.

SUPPORT COORDINATION SERVICES

Medical Assistance Program Integrity Law (MAPIL)

It is the provider's responsibility to be knowledgeable of all these terms and conditions in MAPIL and in the provider agreement. MAPIL became effective August 15, 1997, and is cited as LSARS 46:437.1-46: 440.3. It statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into the agreement.

The Bureau's Provider Enrollment section may terminate a provider's enrollment for failure to comply with MAPIL terms or other Medicaid policies. Additionally, on September 20, 1999, new regulations were promulgated related to provider conduct and sanctioning. These new regulations should be reviewed by all providers. The new regulations can be reviewed in the *Louisiana Register*, Vol.25, No. 9, September 20, 1999, pages 1630-1650.

Enrollment To Serve Additional Populations

An enrolled and contracted support coordinator agency must request a separate enrollment and Medicaid provider number for each additional target or waiver group before providing services. Approval of enrollment is subject to each of the provider enrollment requirements and procedures to provide support coordinator services for the additional target or waiver groups.

Note: Services cannot be provided nor billed on the new number until the new provider has met all requirements for enrollment as a Support Coordinator provider.

Change Of Address/Enrollment Status

Providers who have changes in enrollment information should notify in writing:

Bureau of Community Supports and Services (BCSS)
Support coordinator Administrator
446 North 12th Street
Baton Rouge, Louisiana 70802

AND

DHH Provider Enrollment
Post Office Box 91030, Bin 24
Baton Rouge, LA 70821-9030

Additional Enrollment Requirements for DHH Support Coordinator Providers

An applicant or currently enrolled agency must meet each of the enrollment requirements to be approved for enrollment as a Medicaid or other DHH-funded support coordinator provider. The applicant must:

A. Have demonstrated direct experience in successfully serving the target population or waiver group and demonstrated knowledge of available community services and methods for accessing them.

B. Possess a current license to provide service coordination in Louisiana **or** written proof of application for BCSS licensure.

C. Demonstrate administrative capacity to provide all core elements of support coordination and ensure effective support coordination of all services to the target population or waiver group in accordance with BCSS requirements.

D. Assure that each support coordinator is directly employed by the support coordinator agency in accordance with federal Internal Revenue Service (IRS) regulations requiring that a W-2 form be submitted on each employee. Each support coordinator and supervisor must be employed (not contracted) at least forty (40) hours per week.

E. Assure that each support coordinator, support coordinator trainee and support coordinator supervisor complies with each of the following:

1. Satisfactorily completes an orientation and training program in the first ninety (90) days of employment.

2. Satisfactorily completes support coordinator related training on an annual basis to meet at least minimum BCSS training requirements described in Section 6 of the *Support Coordinator Services Provider Manual* issued March 1, 1999 and then revised on July 1, 2002.

3. Satisfactorily completes any support coordinator training mandated by DHH.

4. Possess adequate support coordination abilities, skills and knowledge to adequately perform each core element of support coordination.

Note: The provision of, arranging for, and payment for such training is the responsibility of the support coordinator agency.

F. Have a written plan to determine the effectiveness of the program including a Quality Improvement Plan (QIP) approved by BCSS.

G. Maintain a separate record on each recipient as described in Section 5 of the *Support Coordinator Services Provider Manual* issued March 1, 1999 and then reissued on July 1, 2002.

H. Agree to safeguard the confidentiality of the participant's records in accordance with DHH regulations and federal and state laws and regulations governing confidentiality.

I. Assure each eligible participant's right to: freedom of choice for support coordination and direct service provider.

J. Assure that the agency and support coordinators will not provide support coordination and Medicaid reimbursed direct services to the same recipient(s).

K. Have adequate financial resources, establish a system of business management and staffing, and demonstrate fiscal accountability to assure maintenance of complete and accurate accounts, books, and records in keeping with generally accepted accounting principles.

L. Maintain a written non-discriminatory policy for intake screening, including referral criteria, transition, and closure including a plan for maintenance of needed services after case closure when applicable.

M. Assure that services will be provided in a culturally sensitive manner.

N. With the participant's permission, agree to maintain regular contact with, share information and coordinate medical services with the participant's primary care or attending physician or clinic.

O. Fully comply with the *Code of Governmental Ethics*.

P. Demonstrate the capacity to participate and agree to participate in a data-base program and provide up-to-date data to the Regional Office and/or Program Office on a weekly basis via electronic mail (applicable to infants and toddlers with special needs and MR/DD waiver). A database program will be provided without charge to the provider. All participants' information must be entered prior to billing each month.

The computer system must meet the following criteria:

- IBM compatible PC with a Pentium III MHZ processor
- 128 MB of RAM (minimum)
- 25 MB free hard drive space
- Color monitor capable of 800X600 resolution
- Printer compatible with hardware and software required
- Modem (56K or faster)
- CD ROM
- Windows 98 Operating System (minimum)
- An Internet account with E-mail and Web-browser software
- Corel Word Perfect 8 or above

Agency Must Maintain Hardware Compatible with Currently Required Software

Q. An enrolled support coordination provider must request a separate enrollment and Medicaid provider number for each additional target or waiver group before providing services.

Applicants will be subject to review by BCSS to determine ability and capacity to serve the target population and a site visit to verify compliance with all provider enrollment requirements prior to a decision by the Medicaid Program on enrollment as a support coordinator provider or at any time subsequent to enrollment.

Enrolled support coordination providers will be subject to review by BCSS and the U.S. Department of Health and Human Services to verify compliance with all Provider Enrollment requirements at any time subsequent to enrollment.

OVERVIEW OF SUPPORT COORDINATION SERVICES

Definition

Targeted Support Coordination

This definition is adapted from Public Law 100-203 (g)(2) and Section 4302A of the State Medicaid Manual. DHH defines support coordination as ***services provided to eligible participants to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services*.**

Philosophy

Support coordination is a ***professional service*** involving a set of logical steps and a process of interaction within the community service network which assures that participants receive services and supports in a manner that responsively, effectively and efficiently leads to the personal outcomes. Participants requiring support coordinator have multiple service needs and require a variety of community resources.

Goals of Support Coordination

The goals of support coordination are to foster independence and self-sufficiency, and ensure the participants' health, safety, and well being in the least restrictive environment. The ultimate goal is achieving and maintaining the participants' desired personal outcomes. This is accomplished through the coordination of paid and generic community services, and other natural support systems.

These goals are often achieved by preventing inappropriate institutionalization or reducing periods of institutionalization in acute and long-term care settings.

The Department of Health and Hospitals utilizes a "service broker" model of support coordination. The support coordinator is a gate opener, helper, enabler, and advocate for the participant, and functions in a manner that is person-centered and person empowering.

Support Coordination Values and Principles

The underlying values and principles listed here are the foundation upon which licensed support coordinator services are provided.

A. The focus of support coordinator services must be on:

- identifying and utilizing the participant's strengths to cope with their condition or disabilities;
- understanding the participant's defined and prioritized personal outcomes; and
- assisting the participant to implement strategies to attain or maintain these personal outcomes.

B. The principle of informed decision-making is central to support coordination. Decisions and choices are meaningful when three dimensions are present: experience, support and creativity. Personal outcomes are achieved when the following occurs:

- Participants are given a range of experiences from which to make choice.
- Participants are provided with ongoing support while learning from experiences.
- Professionals, providers and guardians are as creative as possible when developing the array of choices.

C. The relationship between the support coordinator and the participant is primary and essential to service provision.

D. Support coordinator must be accessible to the participant and guardian. Contacts with participants receiving support coordination services must take place in settings and at times most helpful to them during, as well as outside, normal business hours.

E. The community must be viewed as a potential resource, not as an obstacle.

F. Support coordination services must be participant driven.

G. The participant's self-determination must be maximized to the fullest extent possible.

H. Support Coordination services must be culturally sensitive.

I. Participants with severe developmental disabilities can learn, grow, and change.

J. When serving children, the family unit is included in the process of developing outcomes.

Philosophy of Personal Outcomes

Personal outcomes form the core of person centered support coordination. According to the Council on Quality and Leadership in Support of People with Disabilities, personal outcomes relate to the principle expectations in a person's life and what they require from the services and supports they receive to meet these expectations. These outcomes are based on gathering information from all relevant sources such as the participant, support network, and providers and are the basis for planning, developing, and implementing the Comprehensive Plan of Care (CPOC).

Training regarding personal outcomes will be provided by BCSS.

Elements Of Support Coordination

- Intake
- Assessment (Initial and Ongoing)
- Development of a person centered Comprehensive Plan of Care (CPOC) or Individualized Family Service Plan (IFSP).
- Securing approval of the CPOC - All targeted and waiver populations are subject to prior authorization requirements.
- Building/Implementing Supports
- Face-to-face visits between the support coordinator and participant as required by the waiver or target population criteria
- Monitoring Support Strategies (Monitoring of Service Providers)
- Self-Evaluation
- Transition/Closure
- Training of Staff
- Collection of data in a database to be provided by DHH and provider will generate reports as requested
- Internal Support Coordination agency Grievance Process
- 24-hour toll-free phone line for participants to access support coordinators. This must be a person not an answering machine
- Effective Support Coordination is the connecting link between all services and should enhance the cost containment aspect of the continuum of services.
- The components of Support Coordination as well as the relevant policies and procedures are explained in the *Support Coordinator Services Provider Manual* issued March 1, 1999 and then reissued on July 1, 2002.
- For Support Coordinator services provided as a waiver service, additional requirements apply. These are outlined in the Waiver Services Provider Manual. See Louisiana Children's Choice Support Coordination and Direct Services Manual and Elderly and Disabled Adult Waiver Manuals.

ELIGIBILITY REQUIREMENTS FOR SUPPORT COORDINATION FOR TARGET AND WAIVER POPULATIONS

Participants of DHH Support Coordination services must meet the specific eligibility requirements applicable to the specific target or waiver populations. Participants receiving Medicaid funded Support Coordination services must be Medicaid eligible in the months that services are provided. The provider is responsible for verifying eligibility prior to providing services. The eligibility requirements for each population are identified in program Fact Sheets and the *Support Coordinator Services Provider Manual* issued March 1, 1999 and then reissued on July 1, 2002.

Covered Services

Intake

Intake is the entry point into Support Coordination. The purpose of intake is to determine the participant's eligibility, need, appropriateness, and desire for Support Coordination services as an alternative to institutionalization.

These general Support Coordination intake procedures are applicable for all targeted and waiver populations. Referrals for Support Coordination services are from the point of entry and the Support Coordination agency. The required procedures of intake screening are as follows:

A. Interview the recipient within three (3) working days of receipt of the Freedom of Choice (FOC), preferably face-to-face, and obtain demographic information as required by DHH.

Note: Intake activities performed solely to determine eligibility and need for targeted Support Coordination are not billable to Medicaid.

Assessment

A. The initial assessment must begin within seven (7) calendar days and be completed within 30 calendar days of the referral.

B. A reassessment must be completed within 7 days of notice of a change in the participant's status.

C. Quarterly review of the CPOC, with the support coordinator and participant to determine if the participant's needs continue to be addressed.

D. Completed annually

E. Re-certifications - Completed total package to BCSS Regional Office no later than 35 calendar days but as early as 60 days prior to expiration of the CPOC. Incomplete packages will not be accepted. Support coordinators will be responsible for retrieving incomplete packages from the regional office. Sanctions will be applied to any agencies that do not meet these time lines.

Assessment Process

The person-centered supports assessment must be conducted by the support coordinator and consists of the following:

- face to face home interviews with the recipient
- direct observation of the recipient
- direct contact with family and other natural supports
- other professionals and support/service providers as indicated by the situation and the desires of the recipient
- freedom of choice, the availability of all services and with option of support coordination as an alternative to institutionalization.

Comprehensive Plan of Care

The Comprehensive Plan of Care (CPOC) refers to the analysis of information from the formal evaluations and the person-centered supports assessment and is based on the unique personal outcomes envisioned, defined and prioritized by the recipient.

The CPOC must be a face to face visit with the participant and members of the support network, which may include family members, service providers, appropriate professionals, and others who are well acquainted with the recipient. **It must be held at a time that is convenient for the participant.**

The CPOC must be outcome-oriented, individualized and time limited.

The CPOC must incorporate steps which empower and help the recipient to develop independence, growth, and self-management. The CPOC must not be completed prior to the CPOC meeting.

The participant, support coordinator, members of the support system, direct service providers, and appropriate professional personnel *must be directly involved in the development of the CPOC.*

The CPOC must be written in language that is understandable to all parties involved. Specific problems due to a diagnosis or situation that causes a problem for the recipient must be clearly explained.

All participants present at the CPOC meeting must sign the CPOC.

The CPOC must be completed and approved as per CPOC instructions in Appendix A of the *Support Coordination Services Provider Manual* issued March 1, 1999, and then re-issued July 1, 2002.

The participant must be informed of his or her right to refuse a CPOC after carefully reviewing it.

Required CPOC Time Frames

The completed CPOC and financial eligibility must be completed and received by BCSS Regional Office within thirty-five (35) calendar days from the date of the referral. All incomplete packages will be returned.

- The CPOC must be revised annually or as necessary to meet the needs of the participant and must be reflected in the approved revised CPOC and submitted to the BCSS regional office no later than 35 calendar days prior to expiration as required in Section 5 of the *Support Coordination Services Provider Manual* issued March 1, 1999, and re-issued July 1, 2002.

Note: The 90-L may be completed 90 days prior to the expiration of the CPOC, but it must be received by BCSS Regional Office no later than 35 days prior to the expiration of the CPOC.

- The CPOC, for NOW, EDA and EPSDT participants, must be reviewed at least quarterly to ensure that the personal outcomes and support strategies are consistent with the needs of the recipient.
- The CPOC for Children's Choice participants must be reviewed at least 6 to 9 months after implementation to ensure that the personal outcomes and support strategies are consistent with the needs of the recipient.

- Routine changes must be submitted 15 working days prior to the change (vacations, family, and school out of session).

- Emergency changes must be submitted within 24 hours or the next working day.

- Annual CPOCs are due 35 calendar days, not 35 working days, prior to the expiration date of the previous CPOC.

Initiating Changes in the CPOC

If there are significant changes in the way the recipient defines or prioritizes the personal outcomes, and/or if there are significant changes in the support strategies or service providers, the support coordinator must revise the CPOC to reflect these changes and submit the request to the BCSS regional office for approval.

A comprehensive review of the CPOC must be completed at a minimum of every quarter to ensure that the personal outcomes and support strategies contained in the CPOC are consistent with the needs of the recipient.

Note: Changes in waiver service provider(s) can only be requested by the participant; any request for a change requires a completion of a FOC form.

Documentation

The CPOC must include the frequency and location of the support coordinator's face to face contacts with the participant, service providers, and others in the support network.

- A copy of the approved CPOC must be kept in the participant's home, in their case record at the Support Coordination agency, and in the service provider's files.

- A copy of the CPOC must be made available to all staff directly involved with the recipient.

Note: **After the initial CPOC is completed, all billable ongoing Support Coordination services must be provided according to the approved written CPOC.**

Note: ***The EPSDT-Targeted population is eligible for all Medicaid and EPSDT services, which may be implemented as soon as the need is identified. The CPOC does not have to be approved to implement services.***

Building and Implementing Supports

The implementation of the CPOC involves arranging for, building and implementing a continuum of both informal supports and formal/professional services that will contribute to the achievement of the desired personal outcomes.

The support coordinator is responsible for building and implementing the supports and services as described in the CPOC. The support coordinator is responsible for, but not limited to the following:

- Assisting the participant to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the approved CPOC.

- Being knowledgeable of potential community resources, including formal resources (Food Stamps, SSI, housing, etc.)

- Being knowledgeable of all Medicaid services and informal/natural resources, that may be useful in developing strategies to support the recipient in attaining his/her desired personal outcomes.

- Communicating, as often as necessary, coordinating and problem solving with support and service providers.

- A comprehensive review of the current approved CPOC must be completed at a minimum of every quarter to ensure that the personal outcomes and support strategies contained in the CPOC are consistent with the needs of the participant.

- The case manager must notify the direct service provider(s) regarding the time and place of the quarterly review and encourage their participation.

- Assisting the participant to initiate, develop and maintain a natural support network and to obtain the services identified in the approved CPOC assuring that they meet the

participant's individual needs.

- Training and supporting the participant to become an independent self advocate to select providers and utilize community resources to achieve and maintain his/her desired outcomes.

- Advocate on behalf of the participant to help establish, expand, maintain and strengthen the natural support network, and obtain appropriate services. This may involve calling and/or visiting recipients, community groups, organizations or agencies with or on behalf of the participant.

- Requesting services compliant with all Medicaid rules and regulations.

- Oversight of the service providers to ensure that the participant receives appropriate services and outcomes as designated in the approved CPOC. CPOC approval must be received prior to initiating and delivery of services. No service will be prior authorized or delivered until all eligibility is met. The PA for direct service providers will begin on the date BCSS issues the 51-NH.

- Providing a copy of the approved CPOC and any subsequent revisions for the home record book and all direct waiver service providers for their files.

- Assuring a copy of the approved CPOC is made available to all staff directly involved with the participant.

- Assisting the participant to overcome obstacles, recognizing potential opportunities, and developing creative opportunities.

- Meeting with the participant in a face-to-face home visit, at least once per quarter or more often if necessary to meet the individual's needs. This should be documented in the CPOC.

- When preparing quarterly summary, support coordinator must indicate the dates of services being reviewed and commented on. (Actual time period being reviewed (ex. April 27, 2002 to July 27, 2002)

Note: **Advocacy is defined as assuring that the participant receives appropriate services of high quality and locating additional services not readily available in the community**

Monitoring Support Strategies

The Support Coordinator and the participant develop an action plan to monitor and evaluate strategies to ensure continued progress toward the participant's personal outcomes.

- The support coordinator must contact the recipient within 10 working days after services begin to assure the appropriateness and adequacy of the service delivery for participants receiving NOW, EDA and CC services.

- Monitor the service provider(s) quarterly which includes:

  Note: For the purposes of monitoring, quarterly is defined the same as the DHH fiscal/calendar year: July through September, October through December, January through March, and April through June.

- Observation of Services (NOW, EDA)

  The Support Coordinator must observe the delivery of services (preferably in the home) by the formal service provider. This part of the monitoring may be incorporated into the required quarterly home visit if the service provider is present and providing services to the recipient.

- Review of the service provider's current log. Check to see if it is correct and current. Make note of where it is kept.

- Attending meetings with educational, residential and other service providers

- The Support Coordinator shall have progress notes that reflect the discussion in these meetings and the progress towards the outcomes.

- Telephone call

  - The Support Coordinator should do periodic phone monitoring and maintain a log in the participant's case record to monitor and verify that the service provider is in the home by speaking to the provider. Include recipient name, provider name, time, date and activity. Deficiencies found shall be noted in the monitoring file. (NOW, EDA)
  - Monthly telephone call to participant in months that a face-to-face (home) visit was not completed

- Inform the recipient as to the necessity to contact the Support Coordinator of significant changes in his status or if problems arise with his service providers. A major change in status requires a reassessment.

- Inform the participant of the BCSS toll free 1-800-660-0488 Helpline

- Notify service providers within 24 hours of receipt of written approval of changes in the CPOC. Changes in services shall not occur until such notification.

- Monitor compliance of the Waiver standards for waiver providers and report non-compliance to the BCSS Regional Office.

Note: If the participant refuses to comply with Support Coordination requirements, the support coordinator must document all instances appropriately and contact BCSS Regional Office immediately.

Support Coordination Transition/Closure

The transition or closure of Support Coordination services must occur in response to the request of the recipient, or if the recipient is no longer eligible for services. The closure process must ease the transition to other services or care systems.

Closure Criteria

Criteria for closure of Support Coordination services include, but are not limited to, the following:

- Recipient request for termination of services.
- Death.
- Permanent relocation of the recipient out of the service area.
- Long term admission to a hospital, institution or nursing facility.
- Does not meet the criteria for the Support Coordination established by the funding source (Medicaid or the Program Office).
- The recipient requires a level of care beyond that which can safely be provided through Support Coordination. This level of care is distinctive to each recipient and each specific waiver.
- The safety of the Support Coordinator is in question.
- 30-day hospitalization/institutional rule.
- Recipient refuses to comply with Support Coordinator.
- The Support Coordination agency closes (see transfer procedures).
- For Support Coordination that is a waiver service, the recipient no longer meets all eligibility requirements for waiver participation.
- The client does not receive any services.
- Completion of 148.

NOTE: **Providers are reminded that they should report to the BCSS Regional Office when participants (1) are arrested (convicted or not convicted); (2) are convicted of crimes (house arrest or incarcerated); or (3) are not receiving waiver services. These instances should at least be classified as an incident. Due to the 30-day rule of continuity of care, notification should be as soon as the incident occurs, but prior to 30 days non-compliance.**

Procedures for Changing Providers

A recipient may change support coordination agencies once after a six month period and for Good Cause, provided that the new agency has not met maximum number of participants.

Good Cause is defined as:

- The recipient moves to a new region; or
- The recipient and Support Coordination agency have unresolved difficulties and mutually agree to a transfer. This transfer must be approved by the BCSS Support Coordinator Administrator, prior to transfer.

Once the recipient has selected a new Support Coordination provider and SRI has linked them to a contract provider, the new provider must complete the FOC file transfer. Also, the receiving agency must obtain the case record and authorized signature, and inform the transferring Support Coordination agency.

Upon receipt of the completed form, the previous provider must have provided copies of the following information:

- Most current CPOC
- Current assessments on which CPOC is based
- Number of services used in the calendar year (NOW, CC, EDA)
- Current and previous quarter's progress notes
- Form MR/DD-14 (Electronic Prior Authorization)
- Form 90-L (NOW, CC, EDA)
- Complete a 148 that reflects the date the records were given to the receiving agency

The new provider must bear the cost of copying which cannot exceed the community's competitive copying rate. If the information is not received by the new provider in a timely fashion, the appropriate Program Office should be contacted for assistance.

All populations shall be prior authorized, see the procedures for prior authorization in Section 7 of the *Support Coordination Services Provider Manual* issued March 1, 1999, and re-issued July 1, 2002.

Infant and Toddlers with Special Needs

In addition to Medicaid eligibility, the Office of Public Health, through the EarlySteps program, determines eligibility for this optional targeted group. The referral from the Systems Point of Entry (SPOE) must be in each recipient's case record.

The SPOE completes the intake and assessment process and then begins the process of developing the initial Individual Family Service Plan (IFSP). The IFSP is a written plan for providing early intervention services for EarlySteps eligible infants and toddlers and their families. The Family Support Coordinator is invited to attend and participate in the development of the initial IFSP. The initial IFSP is to be completed within 45 days of receipt of referral by the SPOE.

When the initial IFSP is completed the Family Support Coordinator is then responsible for:

1) Coordinating all services included in the IFSP across agency and provider lines;

2) Assisting infants and toddlers and their families in accessing early intervention services which are adequate to meet the infant or toddler's needs;

3) Serving as the single point of contact for helping the family obtain the services and assistance they need as these services impact the developmental needs of the infant or toddler.

Training on the IFSP will be provided by the Office of Public Health in conjunction with the Regional Infant/Toddler Coordinators.

A review of the IFSP must be conducted at least every six (6) months, or more often if conditions warrant, or if the family requests a review to determine the following:

- The degree to which progress is being made toward achieving the outcomes;
  and
- Whether modifications or revisions of the outcomes or services are necessary.
- Inform participants of rights to change providers.

Annual IFSP Meeting

- An annual meeting must be conducted to evaluate the IFSP and to revise the IFSP.

- Conducting, at a minimum, a quarterly face-to-face home visit with the participant present. More frequent home visits must occur if they are required to insure the participant meets the identified outcomes.

Transition and Closure

Transition is the process of the child moving from early intervention services to preschool services under Part B of IDEA toddler services or otherwise terminating early intervention services.

A. A referral on a child must be made to the Office for Citizen's with Developmental Disabilities no more than six (6) months prior to the child's third birthday to initiate the transition process.

   1. For those children who begin receiving family service coordination after 24 months of age, transition planning must be addressed at the initial IFSP meeting.

   2. 120 days prior to the child's third birthday, the FSC must convene a meeting with the family to discuss the transition to the preschool program.

   3. The FSC must develop and coordinate the transition process that prepares the child and family and all involved agencies.

B. All Medicaid-funded family service coordination services must be terminated no later than the child's third birthday.

C. All cases which do not have an active IFSP and necessary linkage or monitoring activities must be closed.

STAFFING REQUIREMENTS

Education and Experience

On-Site Project Manager

- Responsible for the overall operation of the agency and are responsible to, BCSS for Quality Assurance and Self-Evaluation. The education and experience required of the On-Site Project Manager shall be identified by the agency. Each agency in each DHH region must have an On-Site Project Manager.

Support Coordinator

- All support coordinators must meet the minimum qualifications for education and experience as identified in the Service Coordination Services Provider Manual issued March 1, 1999 and re-issued July 1, 2002.
- Experience gained while employed in a position in which ***minimum qualifications were not initially met*** cannot be counted toward the required experience
- Experience as a teacher does not qualify as direct services.

Support Coordinator Trainee

All requests for this position must be submitted in writing to the BCSS Support Coordination Administrator from the Onsite Project Manager and must state the following:

- That the employee meets the educational requirements;
- The name of the supervisor;
- That the supervisor's caseload has been adjusted to include this position as one of the (eight) 8 supervisees allowed and that only (one) 1 trainee will be assigned to any (one) 1 supervisor;
- A statement ensuring that the trainee will receive the required supervision and training;
- A copy of the Individual Employee Supervision Plan;
- A prospective date of hire, and
- A copy of the written approval letter from the BCSS Support Coordination Program Manager must be maintained in the personnel file. No Exceptions

NOTE: There will be no retroactive approval nor payment made for any Support Coordination activity performed by the support coordinator trainee prior to the written date of approval from BCSS.

Qualifications

The support coordinator trainee must meet all of the educational requirements of a support coordinator.

The experience will be waived with the addition of increased supervision and a limited caseload.

Caseload

A support coordinator trainee's caseload may never exceed 20 participants.

The population makeup of the caseload may include the following populations:

- Infants and Toddlers
- HIV
- MR/DD Waiver
- Elderly and Disabled Adults
- EPSDT
- Children's Choice

The trainee must sign all documents as "Support coordinator Trainee".

NOTE: The Support coordinator Trainee shall not perform duties that are clerical in nature to support other Support Coordination staff.

Supervision

The trainee position counts as one (1) of the eight (8) Support Coordinators under a supervisor's direction. There shall only be one (1) Support Coordinator trainee position per supervisor.

The supervisor is accountable for the training, experience and activities of the Support Coordinator trainee and will be responsible to develop and implement an Individual Employee Supervision Plan (IESP) that will designate the training, field experience, and peer relationships for the trainee for a period of no less than (1) year. The supervision is more intense for these positions and includes the following:

- Supervise the trainee on a daily basis for a period of three months.

- After the three months, an assessment shall be completed to identify areas on which to focus training and supervision. If all areas are covered in the first 3-month period, supervision may begin occurring less frequently, but no less than 3 times per week for the remainder of the year of training.

- The Support Coordination supervisor shall conduct regular field visits with the trainee to view the trainee's application of Support Coordination knowledge and skills. The number of visits the supervisor attends shall be no less than 1/3 of the trainee's caseload. A veteran Support Coordinator may attend the other visits, but in no instance shall the trainee make visits alone.

- The supervisor shall sign all case record documentation and CPOC's for the trainee.

- At the end of the year, the Support Coordinator supervisor must submit a letter to the BCSS Support Coordinator Administrator requesting change of status from support coordinator trainee to support coordinator. The support coordinator supervisor must verify completion and outcome of the IESP.

Training

In addition to the training for support coordinators (initial and annual) outlined in this manual, the trainee is required to have at least an additional 40 hours of training (general supervision excluded). The trainee must attend a basic Support Coordinator Training within 45 days of hire which will be counted toward the additional 40 hours. The request for the training shall come from the agency/supervisor to the BCSS Support Coordinator Administrator no later than 5 days after the hire date.

Support Coordination Supervisor or Any Other Individual Supervising Support Coordinators

All Support Coordination supervisors must meet the qualifications for education and experience as identified in the Service Coordination Services Provider Manual issued March 1, 1999 and re-issued July 1, 2002.. This includes supervisors for NOW, Elderly and Disabled Adult, EPSDT, Children's Choice, Infants and Toddlers and HIV.

Nurse Consultant

Support Coordination agencies must employ or contract a nurse to provide consultation on health related issues and education and training to the agency's staff and supervisors. He/she employed or contracted for a minimum of 4 hour per week and is to be on-site at the agency.

The agency is to have a written job description and consultation plan describing how the nurse will participate in developing the CPOC for medically complex individuals and others with high risks indicators.

All nurse consultants must meet the following minimum qualifications for education and experience:

- A Louisiana registered nurse with a bachelor's degree in nursing and one year of paid experience as a registered nurse in a public health or human service field providing direct recipient services or Support Coordination. No substitutions for the bachelor's degree in nursing will be allowed.

Training for Employees

Support Coordinators need ongoing training to maintain and improve their performance. Such training must be provided by or arranged by the Support Coordinator's employer at the *employer's expense*.

The required orientation and training for Support Coordinators and supervisors described in this section must be documented in the employee's personnel record including: dates and hours of specific training, trainer or presenter's name, title, agency affiliation or qualification, other sources of training and the orientation/training agenda.

All training mandated by DHH is required in addition to the following:

Orientation and Training for New Employees

A. New Staff Orientation

1. Orientation of at least sixteen (16) hours must be provided to all staff, volunteers, and students within five (5) working days of employment.

2. A minimum of eight (8) hours of the orientation training must cover orientation to the target population including, but not limited to, specific service needs and resources. This orientation must include, at a minimum:

- Provider policies and procedures
- Medicaid and other applicable DHH policies and procedures
- Confidentiality
- Documentation in case records
- Recipient rights protection and reporting of violations
- Recipient abuse and neglect reporting policies and procedures
- Recognizing and defining abuse and neglect
- Emergency and safety procedures
- Data management and record keeping
- Infection control and universal precautions
- Working with the target or waiver populations
- Professional ethics
- Outcome measures

B. Training for New Staff

In addition to the required sixteen (16) hours of orientation, all new employees with no documented training must receive an additional minimum sixteen (16) hours of training during the first ninety (90) calendar days of employment.

This training must be related to the target or waiver populations to be served and specific knowledge, skills, and techniques necessary to provide Support Coordination to the target or waiver populations. It must be provided by an individual with demonstrated knowledge of both the training topics and the target or waiver populations.

This training must include the following at a minimum:

- assessment techniques
- service planning
- resource identification
- interviewing and interpersonal skills
- data management and record keeping
- communication skills
- cultural awareness
- outcome measures

A new employee ***shall not be given*** Support Coordination responsibility until the orientation is satisfactorily completed.

Note: Routine supervision shall not be considered training

Annual Training

It is important for Support Coordinators to receive continuing training to maintain and improve skills. Each Support Coordinator must satisfactorily complete forty (40) hours of case-management related training annually, which may include training updates on subjects covered in orientation and initial training.

A. The sixteen (16) hours of training for new staff required in the first ninety (90) days of employment may be part of the forty (40) hour minimum annual training requirement.

B. Appropriate updates of topics covered in orientation and training for a new Support Coordinator must be included in the required forty (40) hours of annual training.

Training for Supervisors

Each Support Coordinator supervisor must complete a minimum of forty (40) hours of training a year.

Training-Infants and Toddlers with Special Needs

Ongoing annual training is the responsibility of the family service coordination agency and is defined by the Office of Public Health Early Steps Program.

A. Family Service Coordination Staff

The family Service Coordinator must complete the required EarlySteps training within two (2) years of enrollment

Mandatory DHH Support Coordination Training

Support Coordination agencies must ensure that support coordinator staff attend and satisfactorily complete mandated DHH training on support coordination policies and procedures. Certificates will be given for attendees and will indicate the hours and training category.

Staff Coverage

The support coordination agency must ensure that support coordination services are available 24 hours a day, 7 days a week, through the toll free number.

Hours

A. Each support coordinator and supervisor must be employed 40 hours per week and work at least 50% of the time during normal business hours (8:00 a.m. to 5:00 p.m., Monday through Friday).

B. There must be one full time Support Coordination supervisor for every eight (8) support coordinators.

1. A supervisor must maintain on-site office hours at least 50% of the time during normal business hours.

2. A supervisor must also be continuously available to support coordinators by telephone or beeper at all times when not on site.

Sharing Onsite Project Managers

Agencies having more than one contract and request that project managers share administrative responsibilities must submit a plan to the BCSS Service Coordination Program Administrator. This plan must be approved prior to its implementation. The plan's approval is completely at the discretion of the Service Coordination Program Administrator and may be terminated at anytime it is determined that the administrative needs of any region are not being met.

Caseload Size and Mix

Each support coordination supervisor must not supervise more than eight (8) full-time support coordinators or other professional-level human service staff.

- A supervisor may carry 1/8 of a caseload (35 participants) for each support coordinator supervised fewer than eight (8) (refer to chart below). But never more than 50% of their time can be used for caseloads (i.e.: No caseload size over 17 if only supervises four Support coordinators).

SUPERVISE	CASELOAD
7 = 35 / 8	4.37 **= 4**
6 = 70 / 8	8.74 **= 9**
5 = 105 / 8	13.11 **= 13**
1-4 = 140 / 8	17.48 **= 17**

- A supervisor carrying a caseload must be supervised by an individual who meets the supervisory qualification in Section 6 of the of the *Service Coordination Services Provider Manual* issued March 1, 1999, and re-issued July 1, 2002.

- A plan must be approved by the BCSS Administrator prior to it being implemented.

Each full-time support coordinator can have a caseload of no more thirty-five (35) participants.

Part Time Support Coordinators

A part-time support coordinator may be used for specific period of time to cover a temporary increase in the number of participants such as additional waiver slots. In no case can a part-time support coordinator be employed for more than three months. Part-time case mangers must meet all qualification for a support coordinator. All requests must be prior approved by the BCSS Program Administrator. Requests for approval will be monitored for frequency of requests.

Prior Authorization Procedure

New Service Coordination Participants:

- Freedom of Choice (FOC) forms for service coordination are provided to the recipient only by BCSS or designee. BCSS or designee receives the FOC form from the recipient.

- For participants receiving service coordination from a contracted service coordination agency (NOW, CC, EPSDT), BCSS or designee will link participants to their first choice, if the service coordination agency has not reached their capacity. In the event that capacity is reached, participants will be assigned to their second choice in a three-agency region and to the second agency in a two-agency region. Participants will be assigned on a first received, first assigned basis.

- For participants receiving service coordination for the Children's Choice program, BCSS or designee links the recipient to their choice of Support Coordination agency, depending on availability. If the recipient is an EPSDT target population recipient currently linked as receiving EPSDT target population (ETP) Support Coordination and wishes to remain with the same agency, they may remain with the same agency and will be dually linked with a target type of CC. If the recipient is not currently linked as target type-ETP, BCSS or designee will link the recipient for EPSDT target population Support Coordination with a target type-CCTR (Children's Choice Transition Recipient).

- For participants receiving service coordination from a non-contracted service coordination agency (EDA, NFP), BCSS or designee will link participants to their first choice.

- BCSS or designee notifies the linked service coordination agency of a new recipient by mailing the service coordination agency the FOC form with a workday journal. BCSS or designee also notifies the recipient of the assigned agency. Only linkages from BCSS or designee are valid.

NOW, EPSDT Participants

The procedures for issuing PA numbers for the NOW, EPSDT Target Population participants are as follows:

- The PA number is issued with an effective starting date no earlier than the later of the following:

  - The PA period will start 35 days prior to the BCSS Regional Office packet receipt date as indicated/stamped on the CPOC approval page but not before the CPOC signature date, or the Freedom of Choice Date.

  - No more than 60 days prior to the BCSS or designee packet receipt date requesting a PA number.

Children's Choice Participants

The procedures for issuing PA numbers for Children's Choice Support Coordination participants are as follows:

- The PA number is issued with an effective starting date no earlier than the later of the following: The BCSS Regional office will mail or fax the demographic cover page, approval page of the CPOC, budget page and the 51 NH to BCSS or designee. The PA for Support Coordination providers will begin on the date BCSS issues the 51NH.

- For an existing ETP recipient (target-ETP), the ETP PA will be canceled on the last day of the following month. The Children's Choice PA number (target type-CC) is issued with an effective starting date of the first day of the month after the CPOC approval date and will not overlap with the ETP PA number.

- For a recipient who is linked as Target-CCTR, a PA number is issued starting on the linkage date until the last day of the month.

    - The PA period will start 35 days prior to the BCSS Regional Office packet receipt date as indicated/stamped on the CPOC approval page but not before the CPOC signature date, or the Freedom of Choice Date.
    - No more than 60 days prior to the BCSS or designee packet receipt date requesting a PA number**.**

Elderly and Disabled Adult Waiver Participants

Procedures for issuing PA numbers for the Elderly and Disabled Adult Waiver participants are as follows:

- BCSS Regional office will mail or fax the demographic cover page, approval page of the CPOC, budget page, and the 51 NH to BCSS or designee.

- The PA number is issued with an effective starting date on the 51NH. The PA period will end one month after the end of a fiscal quarter, either, January 31, April 30, July 31, or October 31.

For participants transferring to a new support coordination agency, a new PA number will be issued with an effective starting date of the first day of the first month after the date of transfer of records, but in no case will BCSS or designee backdate the PA period prior to the first day of the month in which the FOC form/Transfer of Records Section is received by BCSS or designee. The transferring agency's PA number will expire on the date of transfer of records.

Case Closure

The Support Coordination agency is required to submit the Form 148 with the reason for closure noted. The PA time period will be modified to end on the date of closure. BCSS or designee will send the modified PA on the workday journal. Support Coordination agencies must edit/modify the PA record in the CMIS software to reflect the modified PA.

Recipient Re-Entering Support Coordination Program

If a recipient reenters the Support Coordination program within 6-months of the original linkage date and the case has been closed, the agency will submit the participant Re-entering Support Coordination Program form. The PA period will begin on the date the recipient re-enters the program but no earlier than 60 days prior to receipt of form by BCSS or designee.

PA numbers for support coordination services will be released for billing when billing requirements are met as determined by data submitted by the Support Coordination agency in CMIS.

HIV-Target Population Participants

The procedures for issuing PA numbers for the HIV-Target Population participants are as follows:

- The PA number is issued with an effective starting date as the approval date listed on the Signature Page with the following exception:
- If the PA Packet is received by BCSS or designee more than 60 days from the CPOC meeting date, the PA number will be issued with an effective starting date of 60 days prior to the receipt date.

Infant And Toddler With Special Needs Support Coordination

Authorization for reimbursement is issued by the Office of Public Health or designee.

Nurse Home Visits for First Time Mothers

The procedures for issuing PA numbers for Nurse Home Visits for First Time Mothers participants are as follows:

- Prior authorization numbers will be issued on a monthly basis. BCSS or designee will run reports from the CMIS Data System on the 15th of the month for the previous month. PA numbers will be issued based on all service requirements being met. PA numbers will be mailed to the Support Coordination agency's office.

Data System

All agencies must submit current data into the BCSS approved statewide database maintained by the data contractor. Data must be sent at least weekly to SRI via E-mail. All recipient files must be current prior to billing. Agencies that fail to enter all data will be assessed sanctions. At the end of each quarter a review will be done of all data collected to determine what services have been provided. Failure to comply with data requirements shall result in sanctions and/or recoupment. All data reflecting services provided must be entered into the computer system no later than the 14th day following the end of the quarter.

Note: SRI process files daily. Files received by 3:00 p.m. will be processed that day.

Note: A replacement PA due to an incorrect or replaced Medicaid number will be issued for the exact date range of the original PA number. A request for a replacement PA must be submitted in writing to Statistical Resources Inc (SRI). Requests cannot be made over the telephone or E-mail.

Reimbursement

General Requirements

Candidates for Support Coordination services must be Medicaid eligible. Medicaid eligibles must be certified as a member of the targeted populations by the Medicaid agency or its designee. Payment for targeted or waiver Support Coordination services is dictated by the nature of the activity and the purpose for which the activity is performed. These activities must be related to and obtain the outcomes identified in the CPOC. All Support Coordination services billed must be provided by qualified support coordinators and meet the DHH definition of Support Coordination services provided by qualified staff to the targeted or waiver population to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services.

For waiver participants who are institutionalized (enter a hospital, nursing facility, or ICF/MR), Support Coordination that is a waiver service cannot be billed during the time the recipient is institutionalized.

Federal Regulations

Federal regulations require that the Medicaid Program ensure that payments made to providers do not duplicate payments for the same or similar services furnished by other providers or under other authority such as an administrative function or as an integral part of a covered service. Therefore, Support Coordination providers must not bill Medicaid for Support Coordination services at the same time they bill another funding source for the same service.

General Provisions For Reimbursement

The reimbursement rate for optional targeted and waiver Support Coordination services is a monthly rate as defined by negotiated amount in the contract for contracted agencies, or the amount specified by the Bureau, which is associated with intake, ongoing assessment, planning (development of the CPOC), building/implementing supports, monitoring support strategies and transition closure. These fees are established based on the cost of providing these services to an eligible recipient of a target or waiver group.

All Support Coordination activities must lead to the presence of the personal outcomes defined and prioritized by the recipient during the person centered planning process, and/or be associated with organizational processes which lead to the presence of personal outcomes for the individuals served. All Support Coordination activities must be appropriately documented as specified in the Record Keeping Documentation section and Services section of the *Support Coordination Services Provider Manual* issued March 1, 1999, and re-issued July 1, 2002.

- Documentation in the required data system must be current prior to billing for service. Sanctions will be assessed to non-compliant agencies.

Cost Reviews And Audits

Cost reviews and/or audits will be conducted based on allowable cost in accordance with the guidelines prescribed by the ***Provider Reimbursement Manual*** not to exceed limitations established by the Medicaid Program.

All agencies are required to submit a yearly external audit. Agencies shall not have outstanding or unresolved audit disclaimers with DHH.

RECORD KEEPING/DOCUMENTATION

General Record Keeping

Failure to comply may result in one or more of the following: recoupments, sanctions, loss of enrollment, or referral to Surveillance and Utilization Review Systems (SURS).

Components Of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at the DHH regional enrolled office site. The Support Coordination agency must have sufficient space, facilities, and supplies to ensure effective record keeping.

The provider must keep sufficient records to document compliance with DHH Support Coordination requirements for the target or waiver populations served and the provision of Support Coordination services.

A separate Support Coordination record must be maintained on each recipient that fully documents services for which payments have been made. The provider must maintain sufficient documentation to enable DHH to verify that each charge is due and proper prior to payment.

The provider must make available all records that DHH finds necessary to determine compliance with any federal or state law, rule, or regulation promulgated by DHH.

Retention Of Records

The Support Coordination agency must retain records for whichever of the following time frames is longer:

Until records are audited and all audit questions are answered

OR

Five (5) years from the date of the last payment

Note: **Upon agency closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements.**

Supervisory Record Keeping

- Each supervisor must maintain a file on each support coordinator supervised and hold supervisory sessions on at least a weekly basis.

Confidentiality And Protection Of Records

Records, including administrative and recipient, must be the property of the Support Coordination agency and the agency, as custodian, must secure the records against loss, tampering, destruction or unauthorized use throughout the retention period whether the agency is in operation or closed.

A. Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the participants or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information from which participants or their families might be identified. Conditions for release of information are identified in the Support Coordination Services Provider Manual

Note: Under no circumstances should providers allow Support Coordination staff to take case records on participants out of the office.

Review By State And Federal Agencies

Providers must make all administrative, personnel and recipient records available to DHH and appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of recipient information.

Recipient Records

A provider must have a separate written record for each recipient served by the Support Coordination agency.

Support Coordinator providers will document progress as follows:

Service Logs-Chronology of events and contacts, which support justification of critical case management elements for Prior Authorization of services in the CMIS system. Each service contact is to be briefly defined (i.e., telephone call, face to face visit) with narrative in the form of a progress note.

Progress Note-Narrative that reflects each entry into the service log and elaborates on the substance of the contact.

Progress Summary-Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress/lack of progress toward desired outcomes and changes to the social history. This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other support coordinators or their supervisors, and allows for evaluation of activities by program monitors.

Availability Of Recipient Records

Providers must make all necessary recipient records available to appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of recipient information. Under no circumstances should providers allow Support Coordination staff to take records home. The Support Coordination agency can release confidential information only under the following conditions:

- By court order; or
- By the participant's written informed consent for release of information. In cases where the recipient has been declared legally incompetent, the individual to whom the participant's rights have devolved must provide informed written consent.

Storage Of Recipient Records

Providers must provide reasonable protection of recipient records against loss, damage, destruction, and unauthorized use. Administrative, personnel and recipient records must be retained until records are audited and all audit questions are answered or five (5) years from the date of the last payment, whichever is longer.

PROGRAM MONITORING

QA/QI Plan

An agency's QA/QI plan must be submitted within 60 days following licensure. An agency's QA/QI plan must be submitted to the BCSS QA/QI manager.

Support Coordination Agency Self-Evaluation

Six (6) months after the beginning of the Support Coordination contract, or after licensure, and annually thereafter, the Support Coordination agency is required to conduct an agency self-evaluation and to submit a report on the findings of the self-evaluation to the BCSS QA/QI manager. The findings of the report are subject to the approval of BCSS. More frequent self-evaluation by the Support Coordination agency may be required as part of a corrective action plan.

Report Of Self-Evaluation Findings

The Support Coordination agency must submit two (2) copies of a report of the findings of the self-evaluation to:

Bureau of Community Supports and Services
Attn: Barbara Chustz
446 North 12th Street
Baton Rouge, LA 70802-4613

The initial self-evaluation is due 6 months after approval of the QA/QI plan, and then once a year after the first report.

If the findings of the Support Coordination agency self-evaluation indicate that the agency is not working toward personal outcome requirements and/or case record documentation requirements, the self-evaluation report must also include a QIP describing:

- how the agency will address issues with individual support coordinators and/or implement changes in organizational processes, and
- otherwise make systematic efforts to meet the personal outcome and case record documentation requirements.

IMPORTANT REMINDERS

Comprehensive Plan Of Care

All CPOC planning must be person centered.

Progress Notes

Progress Notes should be a "snapshot in time" documenting what is happening, what is observed, outcomes of the meeting, and follow-up required. They should contain at least the following information:

- the name of all participants (it must be clear if the recipient is present)
- the place of the contact
- the date/time of the contact
- the reason for contact, support coordinator's observation of the meeting, and outcome of the contact
- the signature of the person writing the notes and the date they were written.

Quarterly meetings should address all personal outcomes on the CPOC and the progress toward each.

Progress notes should be legible. Corrections shall be made by drawing a line through the erroneous information, writing "error" by the correction, and initialing the correction. Correction fluid shall not be used in recipient records.

CPOC Implementation Dates

A. **EPSDT Target Population** – Support coordinators may begin linking the recipient with services immediately. PCS and other services do require prior authorization, and each individual service provider is responsible for obtaining his own prior authorization. Support Coordination agencies are fiscally liable for any services they authorize providers to perform due to misinformation.

B. **Elderly and Disabled Adult Waiver Participants Population** – Services cannot begin until the BCSS Regional Office approves the CPOC. This includes initial certifications and any subsequent revisions to the CPOC. Support Coordination agencies are fiscally liable for any services they authorize providers to perform due to misinformation. All approvals should be in writing.

C. **NOW Waiver Population** – Services cannot begin until the BCSS Regional Office approves the CPOC. This includes initial certifications and any subsequent revisions to the CPOC. Support Coordination agencies are fiscally liable for any services they authorize providers to perform due to misinformation. All approvals should be in writing.

Medicaid Eligibility

A. EPSDT Targeted Population must be Medicaid eligible at the time of referral. It is the responsibility of the support coordinator to check the participant's continuing eligibility. Eligibility for this may change frequently. BCSS suggests that support coordinators check eligibility upon notification of linkage and at the first of each month.

B. Waiver population participants are not normally subject to change in eligibility as frequently as the above populations. Nevertheless, it is the support coordinator's responsibility for verifying eligibility.

Medicaid Waiver And Support Coordination Services Policy And Reimbursement

The BCSS Regional Office, the BCSS Support Coordination, or the Waiver Management Section should be contacted for interpretation of all Medicaid policies and reimbursement issues.

Freedom Of Choice

A. Support Coordination – only BCSS data contractor may offer freedom of choice to a recipient

- OCDD is the point of entry for NOW Waiver, Children's Choice, and EPSDT Target Population
- OPH Systems Point of Entry is the point of entry for Infants and Toddlers.
- LA Options on Long Term Care is the point of entry for the Elderly and Disabled Adults Waiver
- OPH is the point of entry for Nurse Family Partnership Targeted population
- Licensed HIV agencies are the point of entry for HIV Targeted population

B. Service Providers – only the Support Coordination agency may offer freedom of choice of service providers

C. No one is to solicit a recipient to choose any provider.

D. Any knowledge of violations of this policy should be reported to the BCSS Helpline immediately.

BILLING FOR SERVICES

Billing Schedule

In an effort to reduce the number of Support Coordination claim denials, Statistical Resources, Inc. suggests the following procedures:

1. Enter data daily.

2. Create and send an information file daily before 2:30 p.m. (Note: Statistical Resources, Inc. has a 3:00 p.m. deadline for receipt for files. If a file is received after 3:00 p.m., it will not be processed until the next business day and PA releases will be delayed.)

Following the above procedures will insure that PA numbers will be released to Unisys and the statewide data/monitoring information is updated on a timely basis.

For questions regarding:	Contact:
Support Coordination policy and procedures	Bureau of Community Supports and Services at (225) 219-0200
Support Coordination software and data entry	Statistical Resources at (225) 767-0501
Verification of receipt of files	Statistical Resources at (225) 767-0501 (Statistical Resources will be able to verify the last file received and processed as of the prior business day.)
Prior authorization numbers (denial error codes 190 and 191)	Statistical Resources at (225) 767-0501
Denied claims or billing issues	Unisys Provider Relations at (800) 473-2783 or (225) 924-5040

CommunityCARE Program

Program Description

CommunityCARE is operated in Louisiana under a freedom of choice waiver granted by the Centers for Medicare and Medicaid Services (CMS). It is a system of comprehensive health care based on a primary care case management (PCCM) model. CommunityCARE links Medicaid eligibles with a primary care physician (PCP) that serves as their medical home.

Recipients

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

- Residents of long term care nursing facilities, psychiatric facilities, or intermediate care facilities for the mentally retarded (ICF/MR) such as state developmental centers and group homes
- Recipients who are 65 years or older
- Recipients with Medicare benefits, including dual eligibles
- Foster children or children receiving adoption assistance
- Office of Youth Development recipients (children in State custody)
- Recipients in the Medicaid 'Lock In' program
- Recipients who have other primary insurance with physician benefits, including HMO's
- Recipients who have an eligibility period of less than 3 months
- Recipients with retroactive eligibility (for the retroactive eligibility period only as CommunityCARE linkages may not be retroactive)
- BHSF case-by-case approved "Medically High Risk" exemptions
- Recipients enrolled in Hospice
- Native American Indians residing in parish of reservation (currently Jefferson Davis, St. Mary, LaSalle, and Avoyelles Parishes)

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

Primary Care Physician

As part of the case management responsibility, the PCP is obligated to ensure that referrals/authorizations for medically necessary healthcare services which they can not/do not provide are furnished promptly and without compromise to quality of care. The PCP cannot unreasonably withhold them **OR** require that the requesting provider complete them. **Any referral/authorization requests must be responded to, either approved or denied, within 10 business days.** The need for a PCP referral/authorization does not replace other Medicaid policies that are in existence. For example, if the service requires prior authorization, the provider must still obtain prior authorization **in addition to** obtaining the referral/authorization from the PCP.

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

- Chiropractic service upon KIDMED referral (ages 0-21)
- Dental services for children, ages 0-21 (billed on the ADA claim form)
- Dental Services for Pregnant Women (ages 21-59), billed on the ADA claim form
- Dentures for adults
- The three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services. (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but do require POST authorization). Refer to "Emergency Services" in the CommunityCARE Handbook.
- Inpatient Care that has been precerted (this also applies to public hospitals even though they aren't required to obtain precertification for inpatient stays) and related hospital, physician and ancillary services
- EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program

  Note: A REFERRAL/AUTHORIZATION from the PCP IS REQUIRED for "Children's Special Health Services" clinics (Handicapped Children's Services) operated by The Office of Public Health.
- Family planning services
- Prenatal/Obstetrical Services
- Services provided through the Home and Community Based Waiver programs
- Targeted case management
- Mental Health Clinic services (State facilities)
- Mental Health Rehabilitation services
- Neonatology services while in the hospital
- Ophthalmologist and Optometrist services
- Pharmacy
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists Services
- Transportation services
- Hemodialysis
- Hospice services
- Specific lab and radiology codes

Non-PCP Providers and Exempt Services

Any provider, other than the recipient's PCP, must obtain a referral/authorization from the recipient's PCP in order to receive payment for services rendered. Any provider who provides a non-exempt, non-emergent (routine) service for a CommunityCARE enrollee, without obtaining the appropriate referral/authorization prior to the service being provided risks non-payment by Medicaid.

When a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the patient's PCP to obtain the appropriate referral/authorization for any follow-up services the patient may need after discharge (i.e. Durable Medical Equipment (DME) or home health). Neither the home health nor DME provider can receive reimbursement from Medicaid without the appropriate PCP referral/authorization. **The DME and home health provider must have the referral/authorization in hand prior to rendering the services.**

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

Providers:

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

ACS - (800) 609-3888 - PCP assignment for CommunityCARE recipients, inquiries related to monitoring, certification

ACS - (877) 455-9955 - referral assistance

Recipients:

ACS - (800) 259-4444

NOTE: It is the **waiver or support coordinator service** that is exempt from the CommunityCARE program, **NOT** the recipient. In most cases the recipient **is** linked to a PCP. If the waiver or support coordinator provider is assisting in the coordination of medical services for a waiver recipient, keep in mind that the recipient will need to obtain a PCP referral for those services that are not listed in this section.

PERSONAL CARE SERVICES

Personal Care Services are available to ***all*** Medicaid-eligible recipients, as long as the recipient meets the appropriate criteria. **Personal Care Services are *not* waiver services**. Although waiver recipients may receive personal care services, it is a distinctly separate program and has different guidelines than those set by BCSS.

There are two programs within Personal Care Services:

1. **Early Periodic Screening, Diagnosis, and Treatment - Personal Care Services (EPSDT-PCS)**

2. **Long Term – Personal Care Services (LT-PCS)**

Providers must obtain a provider type 24 provider number in order to provide personal care services. The 2004 Personal Care Services Training Packet can offer more detailed information on this program.

CLAIMS FILING

Waiver services are billed on the CMS-1500 (formerly known as HCFA-1500) claim form. Items to be completed are either **required** or **situational. Required** information ***must*** be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. **Situational** information may be required (but only in certain circumstances as detailed in the instructions below). Claims should be submitted to:

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

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

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

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

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

***2. REQUIRED** Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through REVS, MEVS, or e-MEVS

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

4. SITUATIONAL Leave blank

5. SITUATIONAL Leave blank

6. SITUATIONAL Leave blank

7. SITUATIONAL Leave blank

8. SITUATIONAL Leave blank

9. SITUATIONAL Leave blank

9A. SITUATIONAL Leave blank

9B. SITUATIONAL Leave blank

9C. SITUATIONAL Leave blank

9D. SITUATIONAL Leave blank

10.	**SITUATIONAL**	Leave blank
11.	**SITUATIONAL**	Leave blank
11A.	**SITUATIONAL**	Leave blank
11B.	**SITUATIONAL**	Leave blank
11C.	**SITUATIONAL**	Leave blank
12.	**SITUATIONAL**	Leave blank
13.	**SITUATIONAL**	Leave blank
14.	**SITUATIONAL**	Leave blank
15.	**SITUATIONAL**	Leave blank
16.	**SITUATIONAL**	Leave blank
17.	**SITUATIONAL**	Leave blank
17A.	**SITUATIONAL**	Leave blank
18.	**SITUATIONAL**	Leave blank
19.	**SITUATIONAL**	Leave blank
20.	**SITUATIONAL**	Leave blank
***21.**	**REQUIRED**	Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions is **not** mandatory, but can be accepted**.**
22.	**SITUATIONAL**	Leave blank
23.	**REQUIRED**	Enter the Prior Authorization number
***24A.**	**REQUIRED**	Enter the date of service for each procedure code. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.
***24B.**	**REQUIRED**	Enter either 12 (home) or 99 (other) for Place of Service
24C.	**SITUATIONAL**	Leave blank
***24D.**	**REQUIRED**	Enter the procedure code(s) for services rendered
***24E.**	**REQUIRED**	Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each service by entering either a “1”, “2”, etc. Do not enter ICD-9-CM diagnosis code
***24F.**	**REQUIRED**	Enter usual and customary charges for the service rendered
***24G.**	**REQUIRED**	Enter the number of units billed for the procedure code entered on the same line in 24D
24H.	**SITUATIONAL**	Leave blank

24I. SITUATIONAL Leave blank

24J. SITUATIONAL Leave blank

24K. SITUATIONAL Leave blank, unless providing **Professional Support Services**. If providing Professional Support services, enter individual provider number. This number must be linked to direct service provider number indicated in block 33.

25. SITUATIONAL Leave blank

26. SITUATIONAL Enter the provider specific information assigned to identify the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be up to 16 characters**.**

27. SITUATIONAL Leave blank

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

29. SITUATIONAL Leave blank

30. SITUATIONAL Carry total over from block 28

***31. REQUIRED** The claim form **MUST** be signed. It is acceptable for an authorized representative (of the facility) to sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by an authorized representative. **If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned unprocessed.**

Date Enter the date of the signature

32. SITUATIONAL Leave blank

***33. REQUIRED** Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number.

MAKE SURE "WAIVER" IS WRITTEN IN BOLD, LEGIBLE LETTERS ON THE TOP OF THE CLAIM FORM

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)

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

3. PATIENT'S BIRTH DATE MM | DD | YY 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 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

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

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

b. AUTO ACCIDENT? YES PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

DATE SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) MM | DD | YY INJURY (Accident) MM | DD | YY 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 PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. ____.__ 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

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 #

PIN# GRP#

EXAMPLE CMS-1500 FORM

(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

WAIVER

APPROVED OMB-0938-0008

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): **6955231546013**

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

3. PATIENT'S BIRTH DATE: **07 31 1972** 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 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 [ ]

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. 351.0
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: **417365219**

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 11 01 04	11 30 04	12		S5125 U1		1	39200	112				
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 $ **39200**

29. AMOUNT PAID $

30. BALANCE DUE $ **392 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.)

SIGNED **Mary Lou** DATE **December 12,**

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 #

Waiver Provider #1
Carlton, LA

PIN# GRP# **1418230**

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

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

WAIVER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 6955231546013

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JAYCO, TRAVIS

3. PATIENT'S BIRTH DATE: 07 31 1972 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 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 [ ]

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. 351.0
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 417365220

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 04	11 30 04	12		H2017	U7	1	294 24	48				1718199
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 $ 294 24

29. AMOUNT PAID $

30. BALANCE DUE $ 294 24

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.)

Mary Lou SIGNED December 12, 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 #

Waiver Provider #1
Carlton, LA

PIN# GRP# 1418230

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

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

FILING ADJUSTMENTS AND VOIDS

Claims paid on the CMS-1500 form are adjusted or voided using the Unisys 213 adjustment/void form. These may be ordered from Unisys at no cost.

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

Only a **paid** claim can be adjusted or voided. Denied claims must be corrected and resubmitted - not adjusted or voided.

Electronic submitters may electronically submit adjustment/void claims.

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

1. A claim is paid on the RA dated 7-15-03, ICN 3170567890123.
2. The claim is adjusted on the RA dated 8-19-03, ICN 3200590123456.
3. If the claim requires further adjustment or needs to be voided, only ICN 3200590123456 may be used.

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

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

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).

INSTRUCTIONS FOR FILING ADJUSTMENT/VOID CLAIMS

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

*2. **Patient's Name**

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

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

3. **Patient's Date of Birth**

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

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

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

5. **Patient's Address and Telephone Number**

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

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

6. **Patient's Sex**

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

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

7. **Insured's Name**— Leave blank

8. **Patient's Relationship to Insured**—Leave blank

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

10. **Other Health Insurance Coverage**—Leave blank

11. **Was Condition Related to**—Leave blank

12. **Insured's Address**—Leave blank

13. **Date of**—Leave blank

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

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

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

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

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

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

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

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

*22. **Diagnosis of Nature of Illness**

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

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

23. **Attending Number**—If service is a Professional Support Service, enter the individual attending provider number; otherwise, leave blank.

*24. **Prior Authorization #—**Enter the PA number.

*25. **A through F**

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

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

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

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

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

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

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

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

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

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

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

3 PATIENT'S DATE OF BIRTH

4 MEDICAID ID NUMBER

5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

6 PATIENT'S SEX
MALE ☐ ☐ FEMALE

7 INSURED'S NAME

8 PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

9 INSURED'S GROUP NO. (OR GROUP NAME)

10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.

11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES ☐ ☐ NO
B. AN AUTO ACCIDENT
YES ☐ ☐ NO

12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

14 DATE FIRST CONSULTED YOU FOR THIS CONDITION

15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES ☐ ☐ NO

16 DATE PATIENT ABLE TO RETURN TO WORK

17 DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18A REFERRING ID NUMBER

19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE?
YES ☐ ☐ NO CHARGES

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

23 ATTENDING NUMBER

24 PRIOR AUTHORIZATION NO.

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

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT

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

ADJUSTMENT

29 REASONS FOR VOID

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

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

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

32 YOUR PATIENT'S ACCOUNT NUMBER

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

WAIVER

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): JAYCO, TRAVIS
3 PATIENT'S DATE OF BIRTH: 07/31/1972
4 MEDICAID ID NUMBER: 6955231546013
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 3510
2
3
23 ATTENDING NUMBER
24 PRIOR AUTHORIZATION NO. 417365219

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 $
05	01	04	05	31	04	12	S5125	U1	1	38500	110		

28 CONTROL NUMBER: 4162023462400
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: 6/29/04

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

BILLED INCORRECT UNIT AMOUNT

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.)
Mary Lou July 12, 2004
32 YOUR PATIENT'S ACCOUNT NUMBER
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Waiver Provider #1
Carlton, LA
1418230

UNISYS - 213
5/97

FISCAL AGENT COPY

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
Recipient Eligibility Issues - copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing - letter/other proof i.e., RA page	Continue hardcopy billing
Third Party/Medicare Payment - EOBs. (Includes Medicare adjustment claims)	Continue hardcopy billing
Retroactive Eligibility - copy of ID card or letter from parish office, BHSF staff	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.

WEBSITE APPLICATIONS

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

www.lamedicaid.com

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

Provider Login And Password

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

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

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

WEB APPLICATIONS

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

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

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

e-MEVS:

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

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

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on 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 Caldwell 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 Interchanges (EDI) - Unisys		(225) 237-3200 option 2	(225) 237-3331
Prior Authorization (DME, Rehab) **-** Unisys	(800) 488-6334	(225) 928-5263	(225) 237-3342 **or** (225) 929-6803
Home Health P.A. **-** Unisys **EPSDT PCS P.A. -** Unisys	(800) 807-1320		(225) 237-3342 **or** (225) 929-6803
Dental P.A. - LSU School of Dentistry		(504) 619-8589	(504) 619-8560
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 237-3370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline-Unisys	(877) 598-8753		

Additional Numbers For Provider Assistance

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

EDI CLAIMS SUBMISSION

Electronic Data Interchange 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 the 2004 Basic training packet and may also be obtained from http://www.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 Interchanges (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 70821:	
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, **Waiver**, 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 70898:	
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.

B

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 Medicaid representative or leave it on your table. **Your opinion is important to us.**

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

Provider Subspecialty (if applicable):_____

FACILITY	Poor				Excellent
The seminar location was satisfactory	1	2	3	4	5
Facility provided a comfortable learning environment	1	2	3	4	5
SEMINAR CONTENT	Poor				Excellent
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
MEDICAID 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: WAIVER/CASE MANAGEMENT					

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**.