HEMODIALYSIS PROVIDER 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.

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

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

EPSDT/KIDMED EXAMS AND CHECKUPS

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

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

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

PERSONAL CARE SERVICES

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

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

EXTENDED HOME HEALTH SERVICES

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

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

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

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

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

SERVICES IN SCHOOLS OR EARLY INTERVENTION CENTERS

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

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

MEDICAL EQUIPMENT AND SUPPLIES

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

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

MENTAL HEALTH REHABILITATION SERVICES

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

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

TRANSPORTATION

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

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

OTHER MEDICAID COVERED SERVICES

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

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

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

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

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.**

***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.

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.

***

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.

***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.

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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HEMODIALYSIS CODES AND CLAIMS

HIPAA LOCAL CODE CHANGES

As of May 1, 2003, local Hemodialysis codes were replaced by new HIPAA standard procedure codes. These changes are as follows:

Local Code	Type of Service	Rate	HIPAA Standard Procedure Code	Type of Service	Rate
J0940 Deca-Durabolin 200MG	03	$16.70	J2322 Nandrolone Deconate, Ut To 200MG	03	$16.70
Z1638 Calcijex (Calcitriol)	**NON-PAYABLE**				
Z6138 Calcijex (Calcitriol)	03	$19.40	J0636 Calcitriol .1MCG	03	$ 1.13
J0960 Delatestryl Injection	03	$6.58	J3120 Testosterone Enanthate Injection Up to 100 MG	03	$10.67

HARD COPY CLAIM FORM CHANGES

All hemodialysis facility services are to be billed on the UB92. There are no hard copy claim form changes.

ELECTRONIC DATA INTERCHANGE (EDI) CHANGES

The HIPAA EDI 837I format, which was implemented April 7, 2003, is used for electronic billing of hemodialysis claims.

EPOGEN

REIMBURSEMENT OF EPOGEN

Effective with date of service July 1, 2001, Medicaid of Louisiana has changed the payment methodology for reimbursement of the drug Epogen (EPO). The new reimbursement will be paid per 1,000 units (rounded to the nearest 100 units) administered, not to exceed the Medicare rate of June 30, 2001.

For Medicaid only recipients requiring 10,000 units or more of EPO per administration, special documentation is no longer required with the claim; however, this information should be maintained with the recipients' records for five years.

INCORRECT REIMBURSEMENT

When claims for Epogen services are billed with HR634 or HR635, payment is indicated on the first line and all other lines are paid at zero (0). This type of payment methodology does not allow providers to submit adjustments if the claims are paid incorrectly. Therefore, providers must submit a void and resubmit a corrected claim in order to receive correct reimbursement. Be sure to submit the void one week prior to submitting the corrected claim. Keep in mind that to void more than one claim line, a separate UB92 form is required for each claim line (since each line has a different Internal Control Number).

READING THE REMITTANCE ADVICE FOR EPO PAYMENTS

For centers that bill the Epogen treatments individually, the payment is based on the total units of EPO as indicated in value code 40A. The total payment for EPO is indicated on the first treatment claim line for the first service date, and the remainder of the EPO treatment dates will appear on the RA with zero (0 dollar) payments and edit code 978 (payment adjusted to zero, call help desk). An example of this as it appears on the remittance advice is on the following page.

TO: MEDICAL

P O BOX
NEW ORLEANS LA

OUTPATIENT FACILITY REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 05/14/2002 PAGE: 1

REMITTANCE NO:

M M D D Y Y

MEDIA: 3

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
APPROVED ORIGINAL CLAIMS										
0 2001 (102900	ANDERSON)/(102900C92050003	042302	042302	1	635 EPOIETIN OVER 10000 U	62400	62400	00	62400	2123 36500
0 2001 (102900	ANDERSON)/(102900C92050003	042502	042502	1	635 978 EPOIETIN OVER 10000 U	15600	00	00	00	2123 36501
0 2001 (102900	ANDERSON)/(102900C92050003	042702	042702	1	635 978 EPOIETIN OVER 10000 U	15600	00	00	00	212 5502
0 2001 (102900	ANDERSON)/(102900C92050003	043002	043002	1	635 978 EPOIETIN OVER 10000 U	15600	00	00	00	212 026503
0 2001 (102900	ANDERSON)/(102900C92050003	042502	042502	1	636 DRUGS REQUIRING DETAI J1760	3496	3496	00	3496	212 26504
0 2001 (102900	ANDERSON)/(102900C92050003	042302	042302	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	212 26505
0 2001 (102900	ANDERSON)/(102900C92050003	042502	042502	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	212 26506
0 2001 (102900	ANDERSON)/(102900C92050003	042702	042702	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	212 6507
0 2001 (102900	ANDERSON)/(102900C92050003	043002	043002	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	212 6508
0 901 (102891	DOYLE)/(102891C92050002	042202	042202	1	635 EPOIETIN OVER 10000 U	45600	45600	00	45600	21 6400
0 901 (102891	DOYLE)/(102891C92050002	042402	042402	1	635 978 EPOIETIN OVER 10000 U	15600	00	00	00	21 401
0 901 (102891	DOYLE)/(102891C92050002	042702	042702	1	635 978 EPOIETIN OVER 10000 U	15600	00	00	00	212 7402
0 901 (102891	DOYLE)/(102891C92050002	042202	042202	1	636 116 DRUGS REQUIRING DETAI J3370	1807	643	00	643	21 3403
0 901 (102891	DOYLE)/(102891C92050002	042402	042402	1	636 116 DRUGS REQUIRING DETAI J3370	1807	643	00	643	21 3404
0 901 (102891	DOYLE)/(102891C92050002	042702	042702	1	636 116 DRUGS REQUIRING DETAI J3370	1807	643	00	643	2 3405
0 901 (102891	DOYLE)/(102891C92050002	042202	042202	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	21 7406
0 901 (102891	DOYLE)/(102891C92050002	042402	042402	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	21 .407
0 901 (102891	DOYLE)/(102891C92050002	042702	042702	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	21 3408
0 201 (102670	STEPHENS)/(102670C92050001	042202	042202	1	635 EPOIETIN OVER 10000 U	60800	60800	00	60800	21 3300
0 201 (102670	STEPHENS)/(102670C92050001	042402	042402	1	635 978 EPOIETIN OVER 10000 U	15200	00	00	00	21 3301
0 201 (102670	STEPHENS)/(102670C92050001	042602	042602	1	635 978 EPOIETIN OVER 10000 U	15200	00	00	00	21 302
0 201 (102670	STEPHENS)/(102670C92050001	042902	042902	1	635 978 EPOIETIN OVER 10000 U	15200	00	00	00	21 03
0 201 (102670	STEPHENS)/(102670C92050001	042202	042202	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	21 26304
0 201 (102670	STEPHENS)/(102670C92050001	042402	042402	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	21 3305
0 201	STEPHENS	042602	042602	1	821 HEMODIALYSIS/COMPOSIT 90935	12719	12719	00	12719	2 306

HEMODIALYSIS CLAIMS FILING REMINDERS

- ***Outpatient*** hemodialysis services are covered for free standing hemodialysis centers only.

- When a patient has both Medicare and Medicaid, and Medicare adds a drug to their file, Medicaid will consider payment on the claim using the Medicare/Medicaid reimbursement methodology. However, before Medicaid payment is considered, the new code must be loaded on the Medicaid system.

- When new drugs are introduced, Medicaid does not automatically cover these drugs. If Medicare adds a drug to their file, Medicaid will consider payment of the Medicaid portion of the claim.

- There are limits placed on the number of line items that are allowed when filing claims. **ALL** claims are limited to 23 total lines, which includes the line for the total charges.

- Always enter "1" for service units in block 46 when billing for Epogen services.

- Always enter the Hematocrit level in block 39A (amount field). Be sure to use "49" in the code field.

- Always enter the total Epogen units in block 40A (amount field). Be sure to use "68" in the code field.

MEDICARE/MEDICAID REIMBURSEMENT METHODOLOGY

In determining the Medicaid payment, a "cost comparison" is conducted. This means that Medicaid will review the amount Medicare paid and compare that dollar amount to Medicaid's reimbursement. If the amount Medicare paid is less than Medicaid's reimbursement, Medicaid will pay the difference between the Medicaid allowable and what Medicare paid (up to the co-insurance and deductible amount). If the amount Medicare paid is greater than Medicaid's allowable amount, the claim will be approved and paid at $0 (zero) dollars and the edit 996 (deductible and/or co-insurance reduced to max allowable) will be applied.

Please be aware that a patient eligible with both Medicare and Medicaid is placed in one of three Medicare/Medicaid eligibility categories. The recipient's eligibility category determines what services Medicaid will consider for reimbursement.

- **QMB Only:** Eligible for Medicaid payment of deductibles and coinsurance for **MEDICARE COVERED** services ONLY

- **QMB Plus: (Formerly Dual QMB):** Eligible for Medicaid payment of deductibles and coinsurance for all **MEDICARE COVERED** services as well as for **MEDICAID COVERED** services

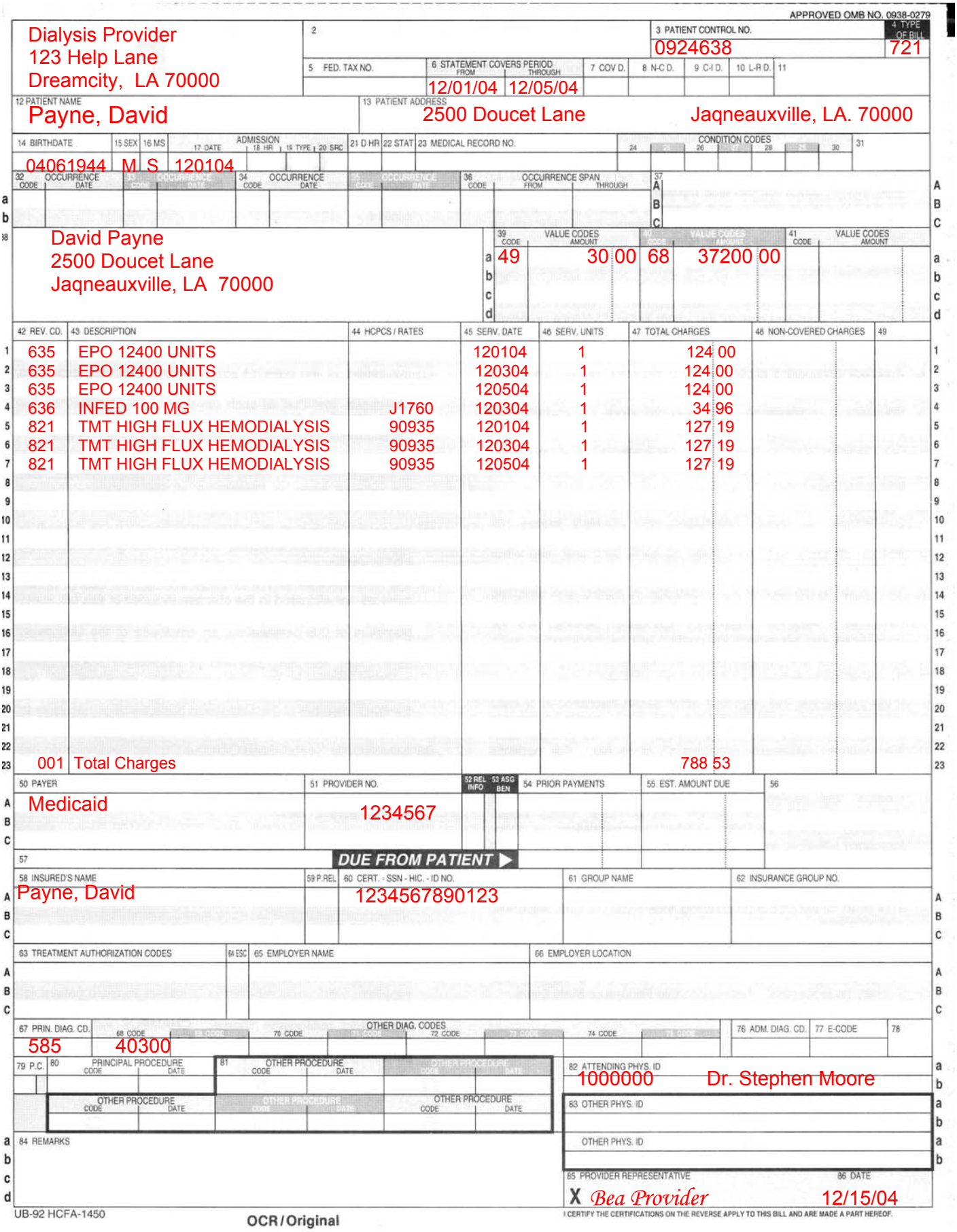
- **Non QMB:** Eligible for Medicaid payment of deductibles and coinsurance for **MEDICAID COVERED** services ONLY

HEMODIALYSIS UB92 FORM INSTRUCTIONS

Locator #	Description	Instructions
*1	Provider Name, Address, Telephone #	**Required –** Enter the name and address of the facility
2	Unlabeled Field (State)	Leave blank
*3	Patient Control No.	**Required –** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 16 characters**.**
*4	Type of Bill	**Required –** Enter Code **721** for claims. Enter Code **727** for adjustments. Enter Code **728** for voids.
5	Federal Tax No.	Not required
*6	Statement Covers Period (From and Through Dates)	**Required –** Enter the beginning and ending service dates of the period covered by this bill.
*12	Patient's Name	**Required** – Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial**.**
13	Patient's Address (City, State, Zip)	Enter the patient's permanent address
14	Patient's Birthdate	Enter the patient's date of birth using 8 digits (MMDDYYYY). If only one digit appears in a field, enter a leading zero.
15	Patient's Sex	Enter the patient as: M = Male F = Female U = Unknown
16	Patient's Marital Status	Not required
*17	Admission Date	**Required** – Enter 6 digits for the date of admission (MMDDYY). If there is only one digit in a field, enter a leading zero.
23	Medical Record No.	**Situational** – Enter the patient's medical record number (up to 16 characters)
*39 - 41	Value Codes and Amounts	**Required** for benefit determination. Value codes used to file hemodialysis claims follow: **49 =** Hematocrit Reading – Enter the patient's hematocrit reading to justify administering more than 10,000 units of EPO. Enter 49 in the "Code" field. Enter the hematocrit reading in the "Amount" field, right justified to the left of the dollar/cents delimiter. **68 =** EPO Drug – Enter the total number of units of EPO administered and/or supplied relating to the billing period. Enter 68 in the "Code" field. Enter the total number of EPO units administered in the "Amount" field. Report amount in whole units right-justified to the left of the dollar/cents delimiter**.**
*42	Revenue Code	**Required –** Enter the appropriate Revenue Code.
*43	Revenue Description	**Required -** Enter the narrative description of the revenue code.

*44	HCPCS/Rates	**Required –** Enter the 5 digit HCPC or procedure code.
*45	Date of Service	**Required** -Enter the date of service for outpatient services in the last six digits of the revenue description. The date must be a valid date in the (MMDDYY) format.
*46	Units of Service	**Required** - Enter one **(1)** as the quantity for Epogen service line. Enter the appropriate unit amount for all other services.
*47	Total Charges	**Required –** Enter the total charges pertaining to the related revenue codes. Must be numeric. Revenue Code "**001**" represents the total amount charged for this bill, and should be the last entry.
*50 – A, B, C	Payer ID	**Required** - Enter Medicaid on Line "A" and other payers on Lines "B" and "C." If another insurance company is primary payer, enter name of insurer.
*51 – A, B, C	Provider Number	**Required** - Enter the 7-digit numeric provider identification number assigned by the Medicaid Program.
52 – A, B, C	Release of Information	Not required
53 – A, B, C	Assignment of Benefits Cert., Ind.	Not required
54 – A, B, C	Prior Payments	**Situational -** Leave blank unless payment has been made by a third party insurer (TPL) - Commercial Insurance only. Enter the TPL payment amount here even if payment is zero. **DO NOT** indicate Medicare payment here.
*58 – A, B, C	Insured's Name	**Required –** Enter the recipient's name as it appears on the Medicaid identification card. Enter the last name first, first name, middle initial. If there is insurance coverage carried by someone other than the patient, enter the name of that individual to correspond with 50 B or C.
*60 – A, B, C	Insured's ID. No.	**Required** - Enter the recipient's 13-digit Medicaid number as it appears on the Medicaid ID card in 60-A. If there are other payers, enter the recipient's identification number as assigned by the other payers in block 50 B or C.
61-A, B, C	Insured's Group Name (Medicaid not Primary)	**Situational -** If there is third party insurance, enter carrier code of the insurance company indicated in 50, on the corresponding line.
*67	Principle Diagnosis Code	**Required –** Enter the ICD-9-CM code for principle diagnosis. **Codes beginning with "E" or "M" are not acceptable for any diagnosis code.**
68-75	Secondary Diagnosis Code	**Situational** – Enter the ICD-9-CM code for secondary diagnosis. **Codes beginning with "E" or "M" are not acceptable for any diagnosis code**
82	Attending Physician ID.	Enter the name and/or number which identifies the physician. This can be the Medicaid ID No., Louisiana Licensing No., or the UPIN.

84	Remarks	**Situational -** If adjustment or void (Form Locator 4, third digit equal "7"(for adjustment) or "8" (for void)) enter the ICN of the paid Medicaid claim and an "A" or "V" to indicate whether adjustment or void. Also enter a reason code: **Adj** — **Void** 01 TPL Recovery — 10 Claim paid for wrong recipient 02 Provider correction — 11 Claim paid to wrong provider 03 Fiscal Agency error — 00 Other 99 Other
*85	Provider Rep. Signature	**Required** - Enter the signature and title of the appropriate person at the facility who is authorized to submit Medicaid billing (Stamped and computer generated signatures must be initialed).
*86	Date Bill Submitted	**Required -** Enter the date the bill was signed and submitted for payment. Must be a valid date (MMDDYY) format. Must be greater than the through date in Form Locator 6.
***Required Fields** – If not completed, the claim will be denied.		



APPROVED OMB NO. 0938-0279

Dialysis Provider
123 Help Lane
Dreamcity, LA 70000

3 PATIENT CONTROL NO.: 0924638
4 TYPE OF BILL: 721
6 STATEMENT COVERS PERIOD FROM: 12/01/04 THROUGH: 12/05/04

12 PATIENT NAME: Payne, David
13 PATIENT ADDRESS: 2500 Doucet Lane Jaqneauxville, LA. 70000

14 BIRTHDATE: 04061944 | 15 SEX: M | 16 MS: S | 17 ADMISSION DATE: 120104

David Payne
2500 Doucet Lane
Jaqneauxville, LA 70000

39 VALUE CODES: a 49 30 00 | 40 VALUE CODES: 68 37200 00

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	635	EPO 12400 UNITS		120104	1	124 00	
2	635	EPO 12400 UNITS		120304	1	124 00	
3	635	EPO 12400 UNITS		120504	1	124 00	
4	636	INFED 100 MG	J1760	120304	1	34 96	
5	821	TMT HIGH FLUX HEMODIALYSIS	90935	120104	1	127 19	
6	821	TMT HIGH FLUX HEMODIALYSIS	90935	120304	1	127 19	
7	821	TMT HIGH FLUX HEMODIALYSIS	90935	120504	1	127 19	
23	001	Total Charges				788 53	

50 PAYER: Medicaid
51 PROVIDER NO.: 1234567

58 INSURED'S NAME: Payne, David
60 CERT. - SSN - HIC. - ID NO.: 1234567890123

67 PRIN. DIAG. CD.: 585
68 OTHER DIAG. CODES: 40300

82 ATTENDING PHYS. ID: 1000000 Dr. Stephen Moore

85 PROVIDER REPRESENTATIVE: X Bea Provider
86 DATE: 12/15/04

UB-92 HCFA-1450 OCR / Original

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

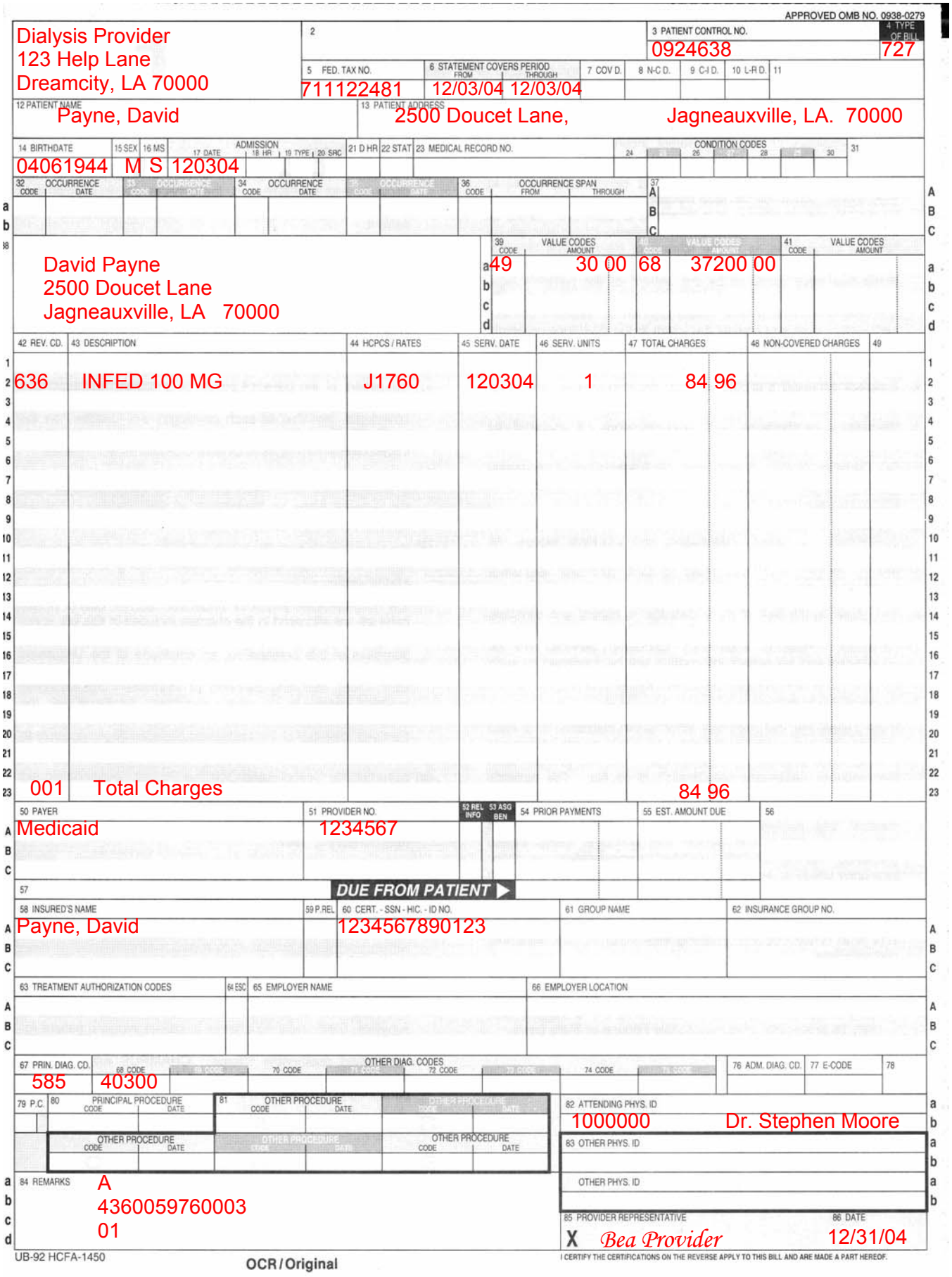
ADJUSTMENTS/VOIDS FOR HEMODIALYSIS

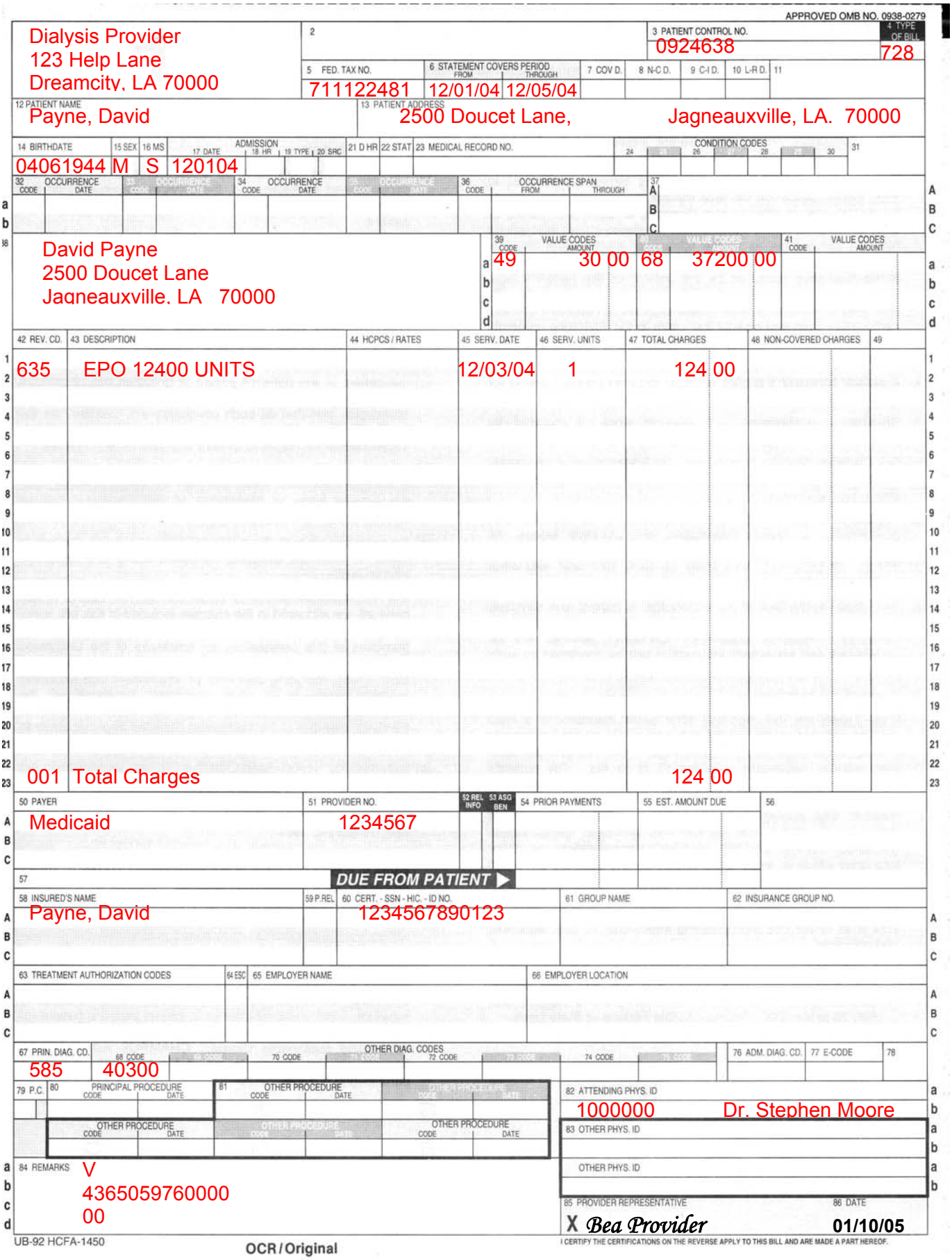
Below are billing reminders when completing the UB92 for adjustments or voids:

- Only **paid** claims can be adjusted or voided
- Only one previously paid claim line can be adjusted or voided per UB92
- Enter bill type 727 for an adjustment or bill type 728 for a void
- In block 84 three items are required:

Adjustment	Void
1. Enter A for adjustment	1. Enter V for void
2. Enter the previously paid Internal Control Number (ICN) - The ICN is found on the paid RA for the line item	2. Enter the previously paid Internal Control Number (ICN) - The ICN is found on the paid RA for the line item
3. Enter one of the following reason codes: 01 TPL Recovery 02 Provider correction 03 Fiscal Agency error 99 Other	1. Enter one of the following reason codes: 10 Claim paid for wrong recipient 11 Claim paid to wrong provider 00 Other

NOTE: For a Medicare adjustment/void, there will be only one Internal Control Number (ICN). Only one adjustment/void claim form will be completed. For straight Medicaid claims, please continue to file adjustment/void claims by line item.


APPROVED OMB NO. 0938-0279
Dialysis Provider
123 Help Lane
Dreamcity, LA 70000
3 PATIENT CONTROL NO.
0924638
4 TYPE OF BILL
727
5 FED. TAX NO.
711122481
6 STATEMENT COVERS PERIOD FROM THROUGH
12/03/04 12/03/04
12 PATIENT NAME
Payne, David
13 PATIENT ADDRESS
2500 Doucet Lane, Jagneauxville, LA. 70000
14 BIRTHDATE
04061944
15 SEX
M
16 MS
S
17 DATE
120304
David Payne
2500 Doucet Lane
Jagneauxville, LA 70000
39 CODE
49
VALUE CODES AMOUNT
30 00
40 CODE
68
37200 00
41 CODE
VALUE CODES AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
636
INFED 100 MG
J1760
120304
1
84 96
001
Total Charges
84 96
50 PAYER
Medicaid
51 PROVIDER NO.
1234567
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56
57
DUE FROM PATIENT
58 INSURED'S NAME
Payne, David
59 P.REL
60 CERT. - SSN - HIC. - ID NO.
1234567890123
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.
585
68 CODE
OTHER DIAG. CODES
70 CODE
72 CODE
74 CODE
76 ADM. DIAG. CD.
77 E-CODE
78
79 P.C.
80 PRINCIPAL PROCEDURE CODE DATE
40300
81 OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
82 ATTENDING PHYS. ID
1000000
Dr. Stephen Moore
83 OTHER PHYS. ID
OTHER PHYS. ID
84 REMARKS
A
4360059760003
01
85 PROVIDER REPRESENTATIVE
X Bea Provider
86 DATE
12/31/04
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
UB-92 HCFA-1450
OCR / Original


APPROVED OMB NO. 0938-0279
Dialysis Provider
123 Help Lane
Dreamcity, LA 70000
3 PATIENT CONTROL NO.
0924638
4 TYPE OF BILL
728
5 FED. TAX NO.
711122481
6 STATEMENT COVERS PERIOD
12/01/04 12/05/04
12 PATIENT NAME
Payne, David
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2500 Doucet Lane, Jagneauxville, LA. 70000
14 BIRTHDATE
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David Payne
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12/03/04
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124 00
001
Total Charges
124 00
50 PAYER
Medicaid
51 PROVIDER NO.
1234567
DUE FROM PATIENT
58 INSURED'S NAME
Payne, David
60 CERT. - SSN - HIC. - ID NO.
1234567890123
67 PRIN. DIAG. CD.
585
68 CODE
40300
82 ATTENDING PHYS. ID
1000000
Dr. Stephen Moore
84 REMARKS
V
4365059760000
00
85 PROVIDER REPRESENTATIVE
X Bea Provider
86 DATE
01/10/05
UB-92 HCFA-1450
OCR / Original

HARD COPY REQUIREMENTS

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

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	BILLING REQUIREMENTS
Spend Down Recipient - 110MNP Spend Down Form	Continue hardcopy billing
Third Party/Medicare Payment - EOBs. (Includes Medicare adjustment claims)	Continue hardcopy billing
Failed Crossover Claims - Medicare EOB	Continue hardcopy billing
Retroactive Eligibility - copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing
Recipient Eligibility Issues - copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing - letter/other proof i.e., RA page	Continue hardcopy billing
All unlisted procedures - medical documentation	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.

CommunityCARE

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.**

NOTE TO HEMODIALYSIS PROVIDERS: Beginning with the date of service of November 15, 2001, services provided at hemodialysis centers became exempt from the CommunityCARE referral process. However, hemodialysis centers may often prescribe supplies or services for their patients which are not exempt from the CommunityCARE referral process. In such cases, the hemodialysis center is responsible for contacting the patient's CommunityCARE primary care provider to obtain a referral which may be passed on to the providers of other non-exempt services. In order to simplify this process, a referral may be given to the hemodialysis center, for a period not to exceed one year, to cover non-exempt 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

LOUISIANA MEDICAID WEBSITE APPLICATIONS

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

www.lamedicaid.com

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

Provider Login And Password

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

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

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

WEB APPLICATIONS

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

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

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

e-MEVS:

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

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

e-CSI:

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

www.dhh.state.la.us - DHH website – LINKS

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 Vicksburg, MS	Ouachita Richland Union Webster West Carroll Marshall, TX	
Mona Doucet (225) 237-3249	Acadia Evangeline Iberia Lafayette	St. Landry St. Martin St. Mary Vermillion	
Open	Allen Beauregard Calcasieu Cameron	Jeff Davis Lafourche Terrebonne Vernon	Jasper, TX
Sharon Harless (225) 237-3267	Avoyelles Iberville West Baton Rouge	East Feliciana West Feliciana Woodville/Centerville (MS) Pointe Coupee	
Erin McAlister (225) 237-3201	Ascension Assumption Livingston St. Helena St. James	St. John the Baptist St. Tammany Tangipahoa Washington McComb (MS)	
Courtney Patterson (225) 237-3269	East Baton Rouge		
Kathy Robertson (225) 237-3260	Caldwell Catahoula Concordia DeSoto Franklin Grant Jackson LaSalle	Natchitoches Rapides Red River Sabine Tensas Winn Natchez (MS)	

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

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

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

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

DHH PROGRAM MANAGER REQUESTS

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

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

ELECTRONIC DATA INTERCHANGE TRANSITION

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

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

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

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

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

If you are not currently submitting the HIPAA compliant 837 transaction, Louisiana Medicaid strongly recommends that you contact your VBC to determine if they can meet your needs as a

Louisiana Medicaid provider. If your VBC has not started testing, you may go to www.lamedicaid.com/hipaa to view the VBC list and select a VBC that is **approved for your** program. This list is updated monthly by the EDI group**. YOU MUST BE TRANSITIONED TO THE 837 HIPAA COMPLIANT FORMAT BY THE APPLICABLE DATES IN ORDER TO CONTINUE TO SUBMIT CLAIMS ELECTRONICALLY.**

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

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

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

HIPAA DESK TESTING SERVICE ENROLLMENT

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

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

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

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

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

HIPAA-COMPLIANT 837 TRANSACTION TESTING SERVICE

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

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

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

MMIS PARALLEL TESTING

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

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

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

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

ELECTRONIC DATA INTERCHANGE (EDI)

CLAIMS SUBMISSION

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

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

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

CERTIFICATION FORMS

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

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

Required Certification forms may be obtained from lamedicaid.com under the HIPAA Information Center link. The required forms are 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 Media Claims (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 Data)	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 DATA SUBMISSION OF CLAIMS** (EDI Contract **) and** a Limited Power of Attorney**.**

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

Enrollment Requirements For 835 Electronic Remittance Advices

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

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

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

General Information

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

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

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

UNISYS CLAIMS FILING ADDRESSES

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

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

CLAIMS PROCESSING REMINDERS

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

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

- Submit an original claim form whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.
- Enter information within the appropriate boxes and align forms in you printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.
- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. **DO NOT use a highlighter to draw attention to specific information.**
- Paper claims must be legible and in good condition for scanning into our document imaging system.
- **Don't forget to sign and date your claim form. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.**
- Continuous feed forms must be torn apart before submission.
- Use high quality printer ribbons or cartridges-black ink only.
- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.
- Do not use italic, bold, or underline features.
- Do not submit two-sided documents.
- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

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

REJECTED CLAIMS

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

The criteria for legible claims are:

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

ATTACHMENTS

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

CHANGES TO CLAIM FORMS

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

DATA ENTRY

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

APPENDIX A

HEMODIALYSIS REVENUE CODES

October 2004

HR270	Medical/Surgical Supplies/Device
HR634	Epoetin Alfa (also referred to as Epoetin, Epogen or EPO) under 10,000 units. This code pays $10.00 per 1,000 units.
HR635	Epoetin Alfa (also referred to as Epoetin, Epogen, or EPO) over 10,000 units.
HR636	Drugs Requiring Detailed Coding
HR821	Hemodialysis/Composite or Other Rate
HR841	Self-Administered EPO in the home utilizing CAPD (Continuous Ambulatory Peritoneal Dialysis) Method/Composite Rate/Per Diem
HR851	Self-Administered EPO in the home utilizing CCPD (Continuous Cycling Peritoneal Dialysis) Method/Composite Rate/Per Diem

HOW DID WE DO?

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

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

Provider Subspecialty (if applicable):_____

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

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.