RHC/FQHC PROVIDER TRAINING

Medicaid Issues for 2004
(Fall Issue)

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

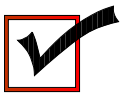
UNISYS

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 THESE 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.**

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Services Available to Medicaid Eligible Children Under 21

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

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

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

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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.

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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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MEDICAID PROSPECTIVE PAYMENT SYSTEM

In accordance with Section 1902(aa)/the provisions of the Benefits Improvement Act (BIPA) of 2000, effective January 1, 2001, payments to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Medicaid services will be made under a Prospective Payment System (PPS) and paid on a per visit basis.

The PPS per visit rate is provider specific. To establish the interim baseline rate for 2001, each RHC/FQHC's 1999 and 2000 allowable costs as taken from the RHC/FQHC's filed 1999 and 2000 Medicaid cost reports were totaled and divided by the total number of Medicaid patient visits for 1999 and 2000. The baseline calculation includes all Medicaid coverable services provided by the RHC/FQHC regardless of existing methods of reimbursement for said services. This includes, but is not to be limited to ambulatory, transportation, laboratory (where applicable), KidMed and dental services previously reimbursed on a fee-for-service or other non-encounter basis. **The per visit rate is all-inclusive. RHC/FQHC's are not eligible to bill separately for any Medicaid covered services**. The final PPS rate will be based on audited final cost reports for 1999 and 2000.

For an RHC/FQHC which enrolls and receives approval to operate on or after January 1, 2001, the facility's initial PPS per visit rate will be determined first through comparison to other RHCs/FQHCs in the same town/city/parish. Scope of services will be considered in determining which proximate provider most closely approximates the new provider.

REIMBURSEMENT ADJUSTMENTS

The PPS per visit rate for each facility will be increased annually by percentage increase in the published Medicare Economic Index (MEI) for primary care services. The MEI will be applied on July 1 of each year.

NOTE: Please direct all cost reporting concerns to Carolyn Jones at (225) 342-2495.

REMINDER: RHCs/FQHCs must submit an annual cost report. The cost report must be sent to Trispan at the following address:

Trispan Health Services
5420 Corporate Boulevard, Suite 201
Baton Rouge, LA 70808

Phone: 225/925-8115

RHC/FQHC PROGRAM OVERVIEW

There are 3 components that may be provided under the RHC/FQHC Program: Encounter Visits, KIDMED Screening Services, and EPSDT Dental, Adult Denture Services and Expanded Dental Services for Pregnant Women (EDSPW)

RHC/FQHC Encounter Visits

Encounter visits must be billed using procedure code T1015. **Beginning with January 1, 2005 dates of service (DOS) in addition to the encounter code it is necessary to indicate the specific services provided by entering the individual procedure code, description, and total charges for each service rendered on subsequent lines. If the encounter detail is not included the claim will deny.**

For obstetrical (OB) services the RHC/FQHC providers must bill the encounter code T1015 with modifier TH and all services performed on that DOS.

RHC/FQHC KIDMED Screening Services

RHC/FQHC KIDMED screening services must be billed on the revised KM3 form using encounter code T1015 along with modifier EP. It will be necessary for providers to indicate the specific screening services provided by entering the individual procedure code for each service rendered on the appropriate line. If a registered nurse performs the screening, providers must enter the appropriate procedure code followed by the modifier TD next to 'Screening Completed by a Nurse'. If immunizations are given at the time of the screening, then those codes continue to be billed on the CMS1500, along with encounter code T1015 and modifier EP. All claims billed using the T1015 and EP modifier **must include** supporting detail procedures.

RHC/FQHC EPSDT Dental, Adult Denture Services and Expanded Dental Services for Pregnant Women (EDSPW)

Dental services must be billed on the 2002 or 2002,2004 ADA claim form using the encounter code D0999. It will be necessary for providers to indicate the specific dental services provided by entering the individual procedure code for each service rendered on subsequent lines. All claims billed using D0999 **must include** supporting detail procedures.

NOTE: The dental encounter, D0999, may be billed on the same date of service as the encounter codes T1015(RHC/FQHC), T1015 TH(OB encounter), and/or T1015 EP(KIDMED screening).

RHC/FQHC ENCOUNTER VISIT

RHC/FQHC Medical Encounter

A medical encounter is defined as receipt of services from a licensed practitioner and includes physicians, nurse practitioners and physicians' assistants.

- Upon presentation at the clinic, a full mental, physical and dental assessment shall be done and any health problems identified must be addressed to the highest degree possible **at that encounter.**
- Encounter must include an assessment and written plan for each identified problem noted in the history and physical exam.
- Encounters for those recipients under the age of 21 must include all the aspects of a well-child screening visit.
- The documented Medical Encounter* level of service, **at a minimum**, is to include
    - An expanded, problem-focused history (chief complaint, brief history of present illness, problem pertinent system review)
    - An expanded, problem-focused exam (limited exam of the affected body area or organ system and other symptomatic or related organ systems)
    - This would be low level complexity of medical decision making (limited number of diagnoses, limited complexity of data to review, the risk of complications and management options- low)

- A new patient medical encounter level of service is to include the following:
    - A detailed history (chief complaint, history of present illness, problem pertinent system review, pertinent past, family, social history)
    - A detailed exam with low-to moderate complexity decision making

RHC/FQHC Clinical Social Worker Encounter

A clinical social worker encounter is defined as receipt of services from a clinical social worker.

- Problems identified at an encounter must be addressed to the highest degree possible *at that encounter.*
- The documented initial face-to-face clinical social worker encounter is to include, **at a minimum;**
    - The collection of current demographic data
    - Assessment/identification of current needs and make appropriate referrals with written contact information
    - Record any observable or reported deficits in function

- The documented subsequent face-to-face clinical social worker encounter should include, **at a minimum:**
    - The identification and coordination of referrals as indicated or requested
    - Discussion of services with the patient
    - Assessment of patient understanding of information discussed

- Coordinate with facilities, physician, and others the completion of appropriate medical information as required to assist the patient

* These definitions are modeled after those found in the Current Procedural Terminology Manual – 2004 (CPT) currently used by the medical provider community to determine the level of medical care provided. These are minimal requirements from the Louisiana Department of Health and Hospitals, however providers are still required to comply with additional requirements outlined in the CPT book.

RHC/FQHC visits may be generated by the following licensed health care practitioners:

- Physicians
- Nurse Midwives (under a physician's direction)
- Clinical Psychologists (under a physician's direction)
- Physician Assistants (under a physician's supervision)
- Specialized Nurse Practitioners (in accordance with an approved protocol and under a physician's direction)
- Clinical Social Workers (under a physician's direction)
- Nurse Practitioners (in accordance with an approved protocol and under a physician's direction)
- Dentists

NOTE: Providers must obtain a Professional manual and training packet as a reference for policy regarding Professional services.

RHC/FQHC VISIT CODES

RHC/FQHC encounter visits are billed using code T1015. Each visit counts as 1 of the 12 allowable physician outpatient visits per state fiscal year for recipients who are 21 years of age or older. Only one encounter visit should be billed per recipient per day. **All services performed at the visit should be included on the claim form, beginning with DOS 01/01/2005.**

- Providers who bill their claims electronically should list all services performed in addition to encounter code T1015.
- Providers who bill their claims hardcopy should list the top 5 services performed in addition to encounter code T1015.
- The attending provider number **MUST BE** included in block 24K to indicate the individual provider performing services if the physician, nurse practitioner or psychiatrist provides the service. If a physician assistant, MSW, or psychologist provides the services, the number entered must be the RHC/FQHC group number.

OBSTETRICAL CARE BILLING

Code **T1015, along with the modifier of TH,** is used by RHCs/FQHCs to bill for obstetrical (OB) services. This code is also reimbursable at the clinic's encounter rate. All services performed at the encounter should be listed on the claim form along with the encounter code.

> **NOTE**: The code T1015 when used with modifier TH is not counted in the 12 "office (regular) and other outpatient visits" for recipients 21 years and older.

RHC/FQHC
CMS 1500 CLAIMS FILING

BILLING ENCOUNTERS ON THE CMS 1500

- **The encounter should be billed using T1015**. If the encounter is obstetrical, the modifier TH should be appended.

- **All detailed service procedure codes** provided to the patient on a DOS should be listed on the claim form following encounter code T1015, T1015 –TH or T1015 –EP, beginning with DOS 01/01/2005.

- For KIDMED providers: If immunizations are given at the time of the medical screening, the specific immunization codes are listed on the CMS 1500, along with encounter T1015 and modifier EP. The EP modifier signifies a screening of a recipient under age 21. All claims billed using the T1015 with modifier EP must include one or more supporting detail procedures.

REMINDER: Only 1 T1015 procedure code will be paid per DOS.

Below are instructions for completing the claim form. A completed example is shown following the instructions for completion.

Certain items on the CMS-1500 are mandatory, as indicated below by an asterisk (*).

Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. Such claims cannot be processed until corrected and resubmitted by the provider.

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

*1A. **Insured's ID Number -** enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid swipe card (MEVS) or through REVS.

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

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

*2. **Patient's Name -** Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through MEVS or REVS.

*3. **Patient's Birth Date and Sex -** Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS or REVS, 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. **Insured's Name -** Complete correctly if appropriate or leave this space blank.

5. **Patient's Address -** Print the recipient's permanent address.

6. **Patient Relationship to Insured -** Complete if appropriate or leave this space blank.

7. **Insured's Address -** Complete if appropriate or leave this space blank.

8. **Patient Status -** Leave this space blank.

9. **Other Insured's Name -** Complete if appropriate or leave this space blank.

9A. **Other Insured's Policy or Population Number -** Complete using the recipient's 6-digit TPL carrier code if the recipient has other insurance and the claim has been processed by the third party insurer. (If this is the case, the EOB from the other insurance should be attached to the claim.) If the recipient does not have other coverage, leave this space blank.

9B. **Other Insured's Date of Birth -** Complete if appropriate or leave this space blank.

9C. **Employer's Name or School Name -** Complete if appropriate or leave this space blank.

9D. **Insurance Plan Name or Program Name -** Complete if appropriate or leave this space blank.

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

11. **Insured Policy Population or FECA Number -** Complete if appropriate or leave this space blank.

11A. **Insured's Date of Birth -** Complete if appropriate or leave this space blank.

11B. **Employer's Name or School Name -** Complete if appropriate or leave this space blank.

11C. **Insurance Plan Name or Program Name -** Complete if appropriate or leave this space blank.

12. **Patient's or Authorized Person's Signature -** Complete if appropriate or leave this space blank.

13. **Insured's or Authorized Person's Signature -** Obtain signature if appropriate or leave this space blank.

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

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

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

*17. **Name of Referring Physician or Other Source -** If services are performed by a CRNA, the name of the directing physician must be entered here. If services are performed by an independent laboratory, the name of the referring physician must be entered in this field. If services are performed by a nurse practitioner or clinical nurse specialist, the name of the directing physician must be entered in this field. If the recipient is a lock-in recipient and has been referred to the billing provider for services, the lock-in physician's name must be entered here.

17A. **ID Number of Referring Physician -** Enter the referring physician's Medicaid ID number, if known. If the recipient is a Community Care recipient, the Primary Care Physician referral authorization number must be entered here.

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

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

20. **Outside Lab -** Leave this space blank.

*21. **Diagnosis or Nature of Illness or Injury -** Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.

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

23. **Prior Authorization -** Complete if required or leave space blank.

*24A. **Date of Service -** Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.

*24B. **Place of Service -** Enter the appropriate code from the approved Medicaid place of service code list.

24C. **Type of Service –** Enter the appropriate code from the approved Place of Service listing.

*24D. **Procedure Code -** Enter the appropriate encounter procedure code on the first line.

Encounter codes:
RHC/FQHC encounter visit: T1015
RHC/FQHC obstetrical services: T1015 with modifier TH
RHC/FQHC KIDMED services: T1015 with modifier EP

<u>In addition to the encounter code it is necessary to indicate the specific services provided by entering the individual procedure code, description, and total charges for each service rendered on subsequent lines.</u>

*24E. **Diagnosis Code -** Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a "1", "2", "3",

or “4”. More than one diagnosis may be related to a procedure. Do not enter an ICD-9-CM diagnosis code in this item.

*24F. **Charges -** Enter your encounter rate for the encounter code and your usual and customary charges for the service procedure codes.

*24G. **Days or Units -** Enter the number of units billed for the procedure code entered on the same line in 24D.

24H. **EPSDT -** Leave blank or Enter a “Y” if services were performed as a result of an EPSDT referral.

24I. **EMG -** Leave this space blank.

24J. **COB -** Leave this space blank.

*24K. **Attending Provider Number -** The attending provider number **MUST BE** included in block 24K to indicate the individual provider performing services if the physician, nurse practitioner or psychiatrist provides the service. If a physician assistant, MSW, or psychologist provides the services, the number entered must be the RHC/FQHC group number.

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

26. **Your Patient’s Account Number -** (Optional) Enter the recipient’s medical record number or other individual provider-assigned number to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.

27. **Accepts Assignment -** Leave this space blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.

*28. **Total Charge -** Total of all charges listed on the claim.

29. **Amount Paid -** Leave this space blank unless payment has been made by a third party insurer. If such payment has been made, indicate the amount paid.

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

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

Date - Enter the date of the signature.

32. **Name and Address Where Services Were Rendered** – Complete as appropriate or leave this space blank.

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

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

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

3. PATIENT'S BIRTH DATE (MM DD YY): **03 04 50** SEX: M | F X

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **6 Digit carrier code if applicable**

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN **CommunityCARE referral number If applicable**

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. **149.0** 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	1 06 05	1 06 05	72		T1015		1	95.00	1				1234567
2	1 06 05	1 06 05	72		99213		1	65.00	1				1234567
3	1 06 05	1 06 05	72		85025		1	15.00	1				1234567
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 $ **175.00**

29. AMOUNT PAID $ **Amt pd by TPL**

30. BALANCE DUE $ **175.00**

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 *Ted Johnson* DATE **1/07/2005**

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

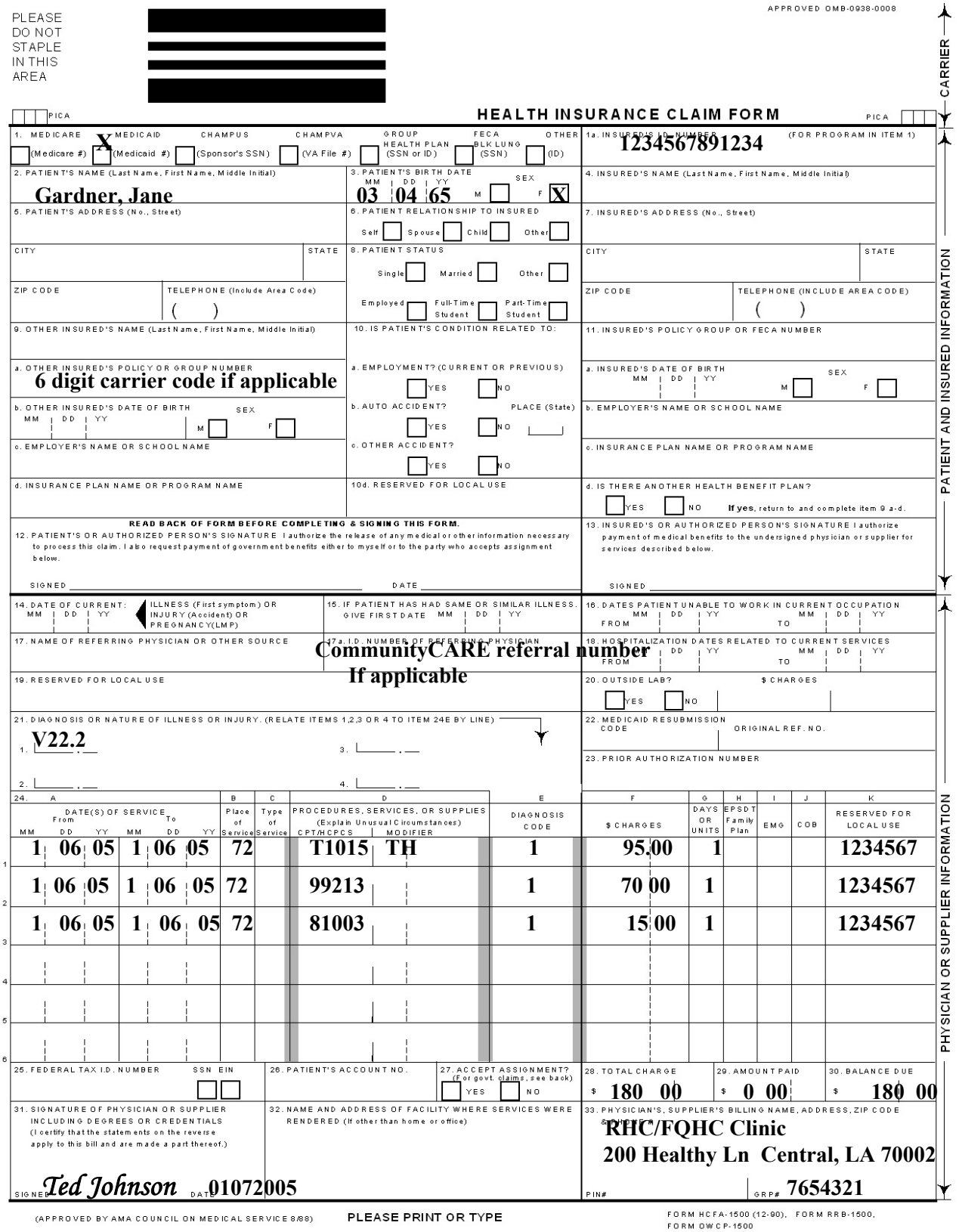
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

RHC/FQHC Clinic
200 Anywhere St Central, La 70002

PIN# GRP# **7654321**

(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

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APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

X

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

1234567891234

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

Gardner, Jane

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

03 04 65 — X

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

6 digit carrier code if applicable

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

CommunityCARE referral number If applicable

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

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

1. V22.2 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 06 05	1 06 05	72		T1015	TH	1	95 00	1				1234567
1 06 05	1 06 05	72		99213		1	70 00	1				1234567
1 06 05	1 06 05	72		81003		1	15 00	1				1234567

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 $ 180 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 180 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 *Ted Johnson* DATE 01072005

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

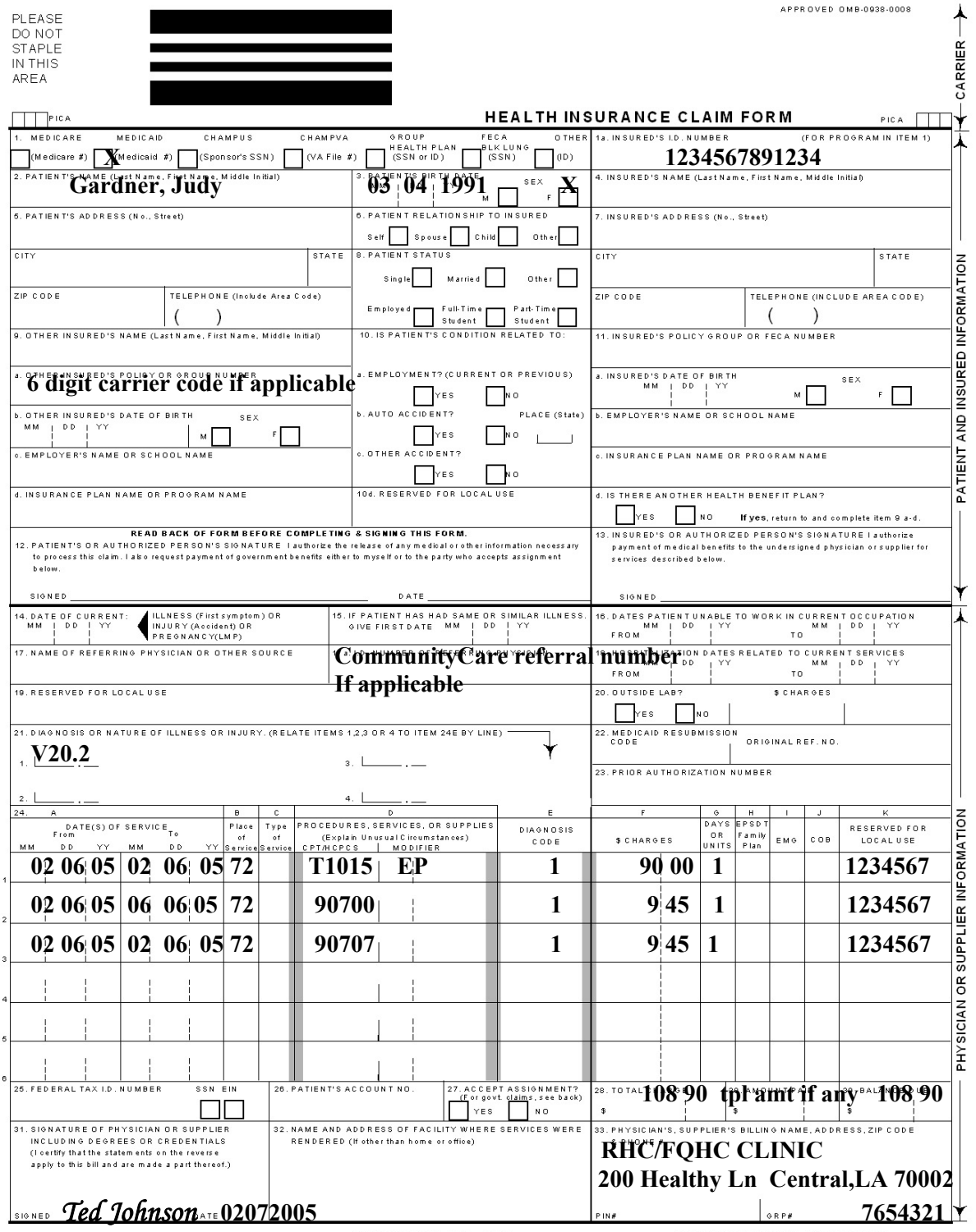
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

RHC/FQHC Clinic
200 Healthy Ln Central, LA 70002

PIN# GRP# 7654321

(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

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APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

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

3. PATIENT'S BIRTH DATE: 05 04 1991 SEX: M | F X

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 6 digit carrier code if applicable

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN (NPI)

CommunityCare referral number If applicable

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. V20.2 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	02 06 05 | 02 06 05	72		T1015	EP	1	90 00	1				1234567
2	02 06 05 | 06 06 05	72		90700		1	9 45	1				1234567
3	02 06 05 | 02 06 05	72		90707		1	9 45	1				1234567
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 $ 108 90

29. AMOUNT PAID $

30. BALANCE DUE $ 108 90

tpl amt if any

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 Ted Johnson DATE 02072005

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#

RHC/FQHC CLINIC
200 Healthy Ln Central,LA 70002

PIN# GRP# 7654321

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

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

UNISYS 213 ADJUSTMENT/VOID FORM

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

FORM COMPLETION

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

Only an **approved claim** can be adjusted or voided.

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

1. A claim is approved and paid on the R.A. dated 11/02/2004, ICN 4123567890123.

2. The claim is adjusted on the R.A. dated 11/16/2004, ICN 4139890123456.

3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (4139890123456) and R.A. date (11/16/2004) must be used.

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

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

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

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

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

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

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ 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

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

ADJUSTMENT

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

UNISYS - 213
5/97

FISCAL AGENT COPY

213 ADJUSTMENT/VOID INSTRUCTIONS

***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 this space blank.

8. Patient's Relationship to Insured—Leave this space blank.

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

10. Other Health Insurance Coverage—Leave this space blank.

11. Was Condition Related to:—Leave this space blank.

12. Insured's Address—Leave this space blank.

13. Date of:—Leave this space blank.

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

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

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

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

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

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

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

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

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

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

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

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

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

***25. A through F**

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

b. **To 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—(Optional) Enter the patient's correct provider-assigned account number.

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

RHC/FQHC
KIDMED SCREENING POLICY

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is a Medicaid program that was established by the Federal government in 1967. The purpose of the program is to provide low-income children with comprehensive health care. Louisiana began EPSDT services in 1972. The screening component of EPSDT is called KIDMED and includes medical, vision, and hearing screening services.

KIDMED providers have the responsibility for coordinating medical, vision, and hearing screenings. Medical, vision, and hearing screenings should be performed on the same day to prevent the child from having to return at a later date. The following pages discuss the elements of KIDMED screenings. Additional information, including a description of each component and who may conduct each component, is found in the KIDMED provider manual.

MEDICAL SCREENING

Billing may not be submitted for a medical screening unless **all** of the following components are administered:

COMPONENTS OF THE MEDICAL SCREENING
1. Comprehensive health and developmental history (including assessment of both physical and mental health and development)
2. Comprehensive unclothed physical exam or assessment
3. Appropriate immunizations according to age and health history (unless medically contraindicated or parents or guardians refuse at the time)
4. Laboratory tests (including appropriate neonatal, iron deficiency anemia, urine, and blood lead screenings)
5. Health education (including anticipatory guidance)

All components, including specimen collection, must be provided on-site during the same medical screening visit.

VISION SCREENING

The purpose of the vision screening is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malfunctions, eye diseases, strabismus, amblyopia, refractive errors, and color blindness.

SUBJECTIVE VISION SCREENING

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of

- any eye disorders of the child or his family
- any systemic diseases of the child or his family which involve the eyes or affect vision
- behavior on the part of the child that may indicate the presence or risk of eye problems
- medical treatment for any eye conditions

OBJECTIVE VISION SCREENING

Effective immediately, the KIDMED objective vision screenings may be performed by trained office staff under the supervision of a LICENSED Medicaid physician, physician assistant, registered nurse, or optometrist. The interpretive conference to discuss findings from the screenings must still be performed by a licensed physician, physician assistant, or registered nurse, as is currently the stated policy in the KIDMED manual.

Objective vision screenings begin at age 4. The objective vision screening must include the following tests:

- visual acuity (Snellen Test or Allen Cards for preschoolers and equivalent tests such as Titmus, HOTV or Good Light, or Keystone Telebinocular for older children);
- color perception (must be performed at least once after the child reaches the age of 6 using polychromatic plates by Ishihara, Stilling, or Hardy-Rand-Ritter); and
- muscle balance (including convergence, eye alignment, tracking, and a cover-uncover test).

HEARING SCREENING

The purpose of the hearing screening is to detect central auditory problems, sensorineural hearing loss, conductive hearing impairments, congenital abnormalities, or a history of conditions which may increase the risk of potential hearing loss.

SUBJECTIVE HEARING SCREENING

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of

- the child's response to voices and other auditory stimuli
- delayed speech development
- chronic or current otitis media
- other health problems that place the child at risk for hearing loss or impairment

OBJECTIVE HEARING SCREENING

Effective immediately, the KIDMED objective hearing screenings may be performed by trained office staff under the supervision of a LICENSED Medicaid audiologist or speech pathologist, physician, physician assistant, or registered nurse. The interpretive conference to discuss findings from the screenings must still be performed by a licensed physician, physician assistant, or registered nurse, as is currently the stated policy in the KIDMED manual.

Objective hearing screenings begin at age 4. The objective hearing screening must test at 1000, 2000, and 4000 Hz at 20 decibels for each ear using the puretone audiometer, Welsh Allyn audioscope, or other approved instrument.

> **NOTE: Age appropriate hearing and vision screening should be performed in conjunction with an RHC/FQHC KIDMED medical screening. These services are not payable separately. If a hearing and/or vision screening is done separately from the KIDMED medical screening, an encounter may not be billed, and the services will not be paid.**

IMMUNIZATIONS

Appropriate immunizations (unless medically contraindicated or the parents or guardians refuse at the time) are a federally required medical screening component. Failure to comply with or properly document the immunization requirement constitutes an incomplete screening and is subject to recoupment of the total medical screening fee.

- **The immunization administration fee is included in the KIDMED encounter reimbursement. Immunizations may not be reimbursed separately. If a recipient is too ill to receive immunizations at the time of a KIDMED medical screening the reason should be documented in the chart and they should be scheduled to return at a later date for immunization administration. An encounter visit cannot be charged for the return visit, because immunization administration was reimbursed in the original visit payment.**

KIDMED follows the current Childhood Immunization Schedule recommended by ACIP, AAP, and AAFP which is updated yearly. Providers are responsible for obtaining current copies of the schedule.

LABORATORY

Age-appropriate laboratory tests are required at selected age intervals. Specimen collection must be performed in-house at the medical screening visit. A child cannot be sent to an outside laboratory to have blood drawn. Documented laboratory procedures provided less than six months prior to the medical screening should not be repeated unless medically necessary. **Iron deficiency anemia screening and urine screening when required are included in the KIDMED medical screening fee and CANNOT be billed separately.**

Providers should not bill Medicaid for lab services not performed in their own office.

NOTE: Providers must obtain a KIDMED manual and training packet as a reference for policy regarding KIDMED services.

RHC/FQHC KIDMED CODES

Code	Descripiton
	Initial comprehensive preventative medicine by a physician
99381	Infant (age under 1 year)
99382	Early Childhood (ages 1-4)
99383	Late Childhood (age 5-11)
99384	Adolescent (ages 12-17)
99385	Adult (ages 18-20)
	Periodic comprehensive preventative medicine by a physician
99391	Infant (age under 1 year)
99392	Early Childhood(age1-4)
99393	Late Childhood(age 5-11)
99394	Adolescent(ages 12-17)
99395	Adult(ages 18-20)
	Initial comprehensive preventative medicine by a nurse
99381 -TD	Infant (age under 1 year)
99382 -TD	Early Childhood (ages 1-4)
99383 -TD	Late Childhood (age 5-11)
99384 -TD	Adolescent (ages 12-17)
99385 -TD	Adult (ages 18-20)
	Periodic comprehensive preventative medicine by a nurse
99391 -TD	Infant (age under 1 year)
99392 -TD	Early Childhood (age1-4)
99393 -TD	Late Childhood (age 5-11)
99394 -TD	Adolescent (ages 12-17)
99395 -TD	Adult (ages 18-20)
99173	Screening test of visual acuity, quantitative and bilateral
92551	Audiologic Screening Test

The following list of codes are to be used on the CMS 1500 to report immunizations administered. These will be listed along with encounter code T1015 and modifier EP.

BILLABLE VACCINE CODES	
Vaccine Code	**Description**
90476^	Adenovirus vaccine, type 4, live, for oral use
90477^	Adenovirus vaccine, type 7, live, for oral use
90581^	Anthrax vaccine, for subcutaneous use
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633*	Hepatitis A vaccine pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
90634*	Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HEPA-HEPB), adult dosage, for intramuscular use
90645*	Hemophilus Influenza B vaccine (HIB), HBOC conjugate, 4-dose schedule, for intramuscular use
90646*	Hemophilus Influenza B vaccine (HIB), PRP-D conjugate, for booster use only, intramuscular use
90647*	Hemophilus Influenza B vaccine (HIB) PRP-OMP conjugate, 3-dose schedule, for intramuscular use
90648*	Hemophilus Influenza B vaccine (HIB), PRP-T conjugate, 4-dose schedule, for intramuscular use
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90657*	Influenza Virus vaccine, split virus, 6-35 months dosage, for intramuscular use
90658*	Influenza Virus vaccine, split virus, 3 years and above dosage, for intramuscular use
90660^	Influenza Virus vaccine live, for intranasal use
90665^	Lyme Disease vaccine, adult dosage, for intramuscular use
90669*	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
90675^	Rabies vaccine, for intramuscular use
90676^	Rabies vaccine, for intradermal use
90680	Rotavirus vaccine, tetravalent, live, for oral use
90690^	Typhoid vaccine, live, oral use
90691^	Typhoid vaccine, VI capsular polysaccharide (VICPS), for intramuscular use
90692^	Typhoid vaccine, heat-and phenol-inactivated (H-P) for subcutaneous or intradermal use
90693	Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (US Military)
90698	Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Haemophilus influenza Type B, and Poliovirus vaccine, inactivated, (DT-aP-Hib-IPV) for intramuscular use
90700 *	Diphtheria, Tetanus Toxoids, and Acellular Pertussis vaccine (DTAP) for intramuscular use
90701	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine (DTP), for intramuscular use
90702*	Diphtheria and Tetanus Toxoids (DT) absorbed for use in individuals younger than 7 years, for intramuscular use
90703	Tetanus Toxoids for trauma, for intramuscular use
90704	Mumps Virus vaccine, live, for subcutaneous use
90705	Measles Virus vaccine, live, for subcutaneous use
90706	Rubella Virus vaccine, live, for subcutaneous use

BILLABLE VACCINE CODES	
Vaccine Code	**Description**
90707*	Measles, Mumps and Rubella Virus vaccine (MMR), live, for subcutaneous
90708	Measles and Rubella Virus vaccine, live, for subcutaneous use
90710	Measles, Mumps, Rubella, and Varicella vaccine (MMRV), live, for subcutaneous use
90712	Poliovirus vaccine, any type(s), (OPV), live, for oral use
90713*	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use
90715	Tetanus, Diphtheria Toxoids and Acellular Pertusis vaccine (TdaP), for use in individuals 7 years or older, for intramuscular use
90716*	Varicella Virus vaccine, live, for subcutaneous use
90717	Yellow Fever vaccine, live, for subcutaneous use
90718*	Tetanus and Diphtheria Toxoids (TD) adsorbed for use in individuals 7 years or older, for intramuscular use
90719	Diphtheria Toxoid, for intramuscular use
90720	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine and Hemophilus Influenza B vaccine (DTP-HIB), for intramuscular use
90721*	Diphtheria, Tetanus Toxoids, and Acellular Pertussis vaccine and Hemophilus Influenza B vaccine (DTAP-HIB), for intramuscular use
90723*	Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Hepatitis B, and Poliovirus vaccine, inactivated (DTAP-HEPB-IPV), for intramuscular use
90725	Cholera vaccine for injectable use
90727	Plague vaccine, for intramuscular or jet injection use
90732*	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735	Japanese Encephalitis Virus vaccine, for subcutaneous use
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 3-dose schedule, for intramuscular use
90743	Hepatitis B vaccine, adolescent, 2-dose schedule, for intramuscular use
90744*	Hepatitis B vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90746*	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 4-dose schedule, for intramuscular use
90748*	Hepatitis B and Hemophilus Influenza B vaccine (HEP-HIB), for intramuscular use

* indicates the vaccine is available from the Vaccines For Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

VACCINES FOR CHILDREN & LOUISIANA IMMUNIZATION NETWORK FOR KIDS STATEWIDE

VACCINES FOR CHILDREN (VFC)

VFC is covered under Section 1928 of the Social Security Act. Implemented on October 1, 1994, it was an "unprecedented approach to improving vaccine availability nationwide by providing vaccines free of charge to VFC-eligible children through public and private providers."

The goal of VFC is to ensure that no VFC-eligible child contracts a vaccine preventable disease because of his/her parent's inability to pay for the vaccine or its administration.

Persons eligible for VFC vaccines are between the ages of birth through 18 who meet the following criteria:

- Eligible for Medicaid
- No insurance
- Have health insurance, but it does not offer immunization coverage and they receive their immunizations through a Federally Qualified Health Center
- Native American or Alaska native

Providers can obtain an enrollment packet by contacting the Office of Public Health's (OPH) Immunization Section at (504) 483-1900.

LOUISIANA IMMUNIZATION NETWORK FOR KIDS STATEWIDE (LINKS)

LINKS is a computer-based system designed to keep track of immunization records for providers and their patients.

The purpose of LINKS is to consolidate immunization information among health care providers to assure adequate immunization levels and to avoid unnecessary immunizations.

LINKS can be accessed through the OPH website: WWW.OPH.DHH.STATE.LA.US.

LINKS will assist providers within their medical practice by offering:

- Immediate records for new patients
- Decrease staff time spent retrieving immunization records
- Avoid missed opportunities to administer needed vaccines
- Fewer missed appointments (if the "reminder cards and letter" option is used)

LINKS will assist patients by offering:

- Easy access to records needed for school and child care
- Automatic reminders to help in keeping children's immunizations on schedule
- Reduced cost (and discomfort to child) of unnecessary immunizations

Providers can obtain an enrollment packet, or learn more about LINKS by calling the Louisiana Department of Health and Hospitals, Office of Public Health Immunization Program at (504) 483-1900.

RHC/FQHC
KM-3 CLAIMS FILING INSTRUCTIONS

- KIDMED screening services are billed on the **revised** KM3 form. **It is necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on appropriate lines.**
- Providers **must** also indicate encounter code T1015, with modifier EP, on the KM3 form
- If immunizations are given at the time of the screening, then those codes are listed on the CMS 1500, along with encounter T1015 and modifier EP. All claims billed with encounter T1015 and modifier EP **must include** all supporting detail procedures. Claims without an encounter code AND detail procedure will deny.
- If, on the same date of service, a recipient is referred in-house for treatment of a problem identified during the screening, encounter code T1015 is billed on the CMS1500 along with the appropriate CPT code indicating the level of care.
- When encounter code T1015 is billed on a CMS 1500, along with supporting detail, on the same date of service that a KIDMED screening is billed on the KM3, one encounter rate will pay and the other will deny with error code 715.
- Only **1** encounter code (T1015) will be paid per day.
- If the encounter code is missing, the detail line item(s) will deny.
- If the encounter code is denied, the detail line item(s) will deny.
- If the encounter code is present and passes all edits but the detail line item(s) is/are missing, the encounter code will deny.
- If the encounter code is present and passes all edits, it will deny if all detail line items deny.
- If the encounter code and detail line items are present, correct, and pass all edits, the encounter code will pay at the provider's encounter rate and the detail line item(s) will be approved at zero ($0).
- KIDMED screenings performed by a registered nurse should be billed using encounter code T1015 with modifier EP **and** the appropriate KIDMED medical screening code and the modifier TD to signify a registered nurse.
- Only a physician doing a screening should bill with no modifier.

KM-3 claim forms should be mailed to the following address for processing:

Unisys
P.O. Box 14849
Baton Rouge, LA 70821

NOTE: When a provider bills an encounter code, supporting detail and modifier on one claim form the claims processing sub-system keeps all lines together for processing purposes.

Following are instructions for completing the items of the KM-3 claim form:

Item No. **Description and details**

1. **Type of claim -** There are three choices in this box. You may choose only one, entering a checkmark as appropriate.

   Check "original" if this is the original screening claim for this beneficiary for the service date indicated later in item 25. If you check "original," skip directly to item 4.

   Check "adjustment" if this claim adjusts a previously paid claim for this beneficiary for the service date indicated later in item 25.

   Check "void" if you are voiding a claim already submitted for this beneficiary for the service date indicated later in item 25.

   If there is no checkmark in this block, it is considered to be an original claim

2. **Reason** If you checked "adjustment" or "void" in item 1, you must complete item 2 by entering the applicable two-digit code:

	Code	Explanation
Adjustments	02	Adjustment due to provider error
	03	Adjustment not due to provider error
Voids	10	Void due to claim paid for wrong beneficiary
	11	Void due to claim paid to the wrong provider

3. **Adjustment ICN -** Complete this item only if you completed item 2. Enter the 13-digit Internal Control Number (ICN) as listed on the remittance advice for the original claim being adjusted or voided.

4. **Billing Provider No. -** Enter your valid seven-digit Medicaid Provider ID Number.

5. **Billing Provider Name -** Enter up to 17 letters of the billing provider's name, starting with the last name first and leaving a space between the last and first names. For example, William Sutherland, M.D., would be entered as "Sutherland (space) Willia." If the billing provider is a facility or agency (such as a school board, health unit, or clinic) rather than an individual, enter the name of the facility or agency.

6. **Site Number -** This item applies only to providers who have more than one screening site. If you have only one site, skip to item 7. If you have more than one screening site, enter the valid three-digit site code at which the screening was conducted. If the site code has less than three digits, fill the empty spaces to the left with zeros. For example, if the site code is 1, enter "001."

7. **Attend Provider No. –** Leave blank

8. **Attend Provider Name –** Leave blank

9. **Refer Provider No**. - Complete this item if the recipient is not linked to you but you are screening the recipient under a contractual agreement with the recipient's CommunityCARE PCP. If you have contracted with a CommunityCARE physician to conduct some of his KIDMED screenings, enter that CommunityCARE PCP's 7-digit Medicaid provider ID number here.

10. **Medicaid No**. - Enter the beneficiary's 13-digit Medicaid number as verified through the REVS, MEVS or e=MEVS eligibility systems. This should also be the 13-digit Medicaid number that appears on the RS-0-07 for that month.

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

11. **Patient Last Name -** Enter the first 17 letters of the beneficiary's last name, starting at the left of the block, as verified through the REVS, MEVS or e-MEVS eligibility systems. If the name has less than 17 letters, leave the remaining spaces blank.

12. **Patient First Name -** Enter up to 12 letters of the beneficiary's first name, starting at the left of the block, as verified through the REVS, MEVS or e-MEVS eligibility systems. If the name has less than 12 letters, leave the remaining spaces blank.

13. **Date of Birth -** Enter the six-digit date of birth for the beneficiary, using the MMDDYY format so that you fill up all the spaces. The beneficiary must be under age 21 on the date of the screening. Do not leave any of the spaces blank.

14. **Sex -** Optional. Enter "M" for male or "F" for female.

15. **Race -** Optional. Enter one of the following codes:

Unknown	0
White	1
Black or African American	2
American Indian or Alaskan Native	3
Asian	4
Hispanic or Latino	5
Native Hawaiian or Other Pacific Islander	6
Hispanic or Latino and one or more races	7
More than one race(Hispanic or Latino not indicated)	8
Unknown	9

16. **Medical Record No**. - Optional. This number may be used to cross-reference your patient's medical record number. Enter up to 18 alphabetical and/or numerical characters assigned by your office as the patient's medical record number.

17. **Patient Address -** Optional. Enter the beneficiary's street address or P.O. box number, starting at the left of the block. Leave any unused spaces blank.

18. **City -** Optional. Enter up to nine letters of the city in which the beneficiary lives, starting at the left of the block. Leave any unused spaces blank.

19. **State -** Optional. Enter the commonly accepted postal abbreviation for the state ("LA" for Louisiana).

20. **Zip Code -** Optional. Enter the zip code for the beneficiary's address. If you do not know the full nine-digit zip code, enter the first five digits, and leave the remaining four spaces blank.

21. **Patient Home Phone -** If the beneficiary has a home phone number or a contact phone number, you must complete this item, including the area code. Enter the three-digit area code and seven-digit home or contact phone number.

22. **Patient Work Phone -** If the beneficiary has a work phone number, you must complete this item, including the area code. Enter the three-digit area code and seven-digit work phone number.

23. **Parent/Guardian Last Name -** This item must be completed for all beneficiaries living with a parent or guardian. A foster parent or adoptive parent is considered a guardian. Enter up to 17 letters of the parent or guardian's last name, starting at the left of the block. Leave any unused spaces blank. If the beneficiary is not living with a parent or guardian, leave this item blank and skip to item 25.

24. **Parent/Guardian First Name -** If you complete item 23, you must complete item 24 also, entering up to 12 letters of the parent or guardian's first name, starting at the left of the block. Leave any unused spaces blank.

The next part of the claim form documents the “all inclusive” encounter, as well as the screening services performed which are being submitted on the claim. It also documents the encounter rate and screening fees. In addition, it records information about future screenings scheduled.

NOTE: You must bill the RHC/FQHC encounter procedure code T1015 with modifier EP on the appropriate claim line.

In addition to the encounter code it is necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on appropriate lines.

Listed below are the four types of screenings to be indicated on the KM3:

- **Medical Screening Nurse (99381-99385 and 99391-99395 plus modifier TD)-** This is a medical screening where a registered nurse, nurse practitioner, or certified physician assistant conducted the **complete unclothed physical assessment** and other required age-appropriate medical screening components, including age-appropriate immunizations.

- **Medical Screening Physician (99381-99385 and 99391-99395 with no modifier) -** This is a medical screening where a licensed physician conducted the **complete unclothed physical exam** and other required age appropriate medical screening components, including age appropriate immunizations.

  ☞ You must enter one or the other for a single medical screening, but not both. If both a physician and a registered nurse conduct the screening, **the procedure code must be entered in the field by the person performing the physical exam or assessment**.

- **Vision (99173) -** This is an objective vision screening conducted by a licensed physician, certified physician assistant, registered nurse, licensed optometrist or a trained office staff member. (The interpretive conference with the family or recipient concerning the results of the test must be done by the RN, PA, or physician.) **No claim will be paid on a child under age four.**

- **Hearing (92551) -** This is an objective hearing screening conducted by a licensed physician, certified physician assistant, registered nurse, licensed and ASHA-certified audiologist, licensed and ASHA-certified speech pathologist, or a trained office staff member. (The interpretive conference with the family or recipient concerning the results of the test must be done by the RN, PA, or physician.) **No claim will be paid on a child under age four.**

  ☞ A vision and/or hearing screening will be approved only if there is an age appropriate medical screening listed.

25. **Date of Screening -** For **each** applicable line, enter the date of each service (Including the encounter and the screening(s)). For proper reimbursement, you must date **each** service line for which you are billing.

26. **Billed Charge -** For **each** line you completed in item 25, enter the appropriate charge for services rendered, using up to five digits for dollars and cents.

27. **Next Screening Appointment Date -** If a future screening appointment has been scheduled, enter the six-digit appointment date for each applicable screening line. If no future appointments have been made at the time you submit the claim, leave this item blank and skip to item 29.

28. **Time -** If a future screening appointment has been scheduled, enter the appointment time.

29. **Immunization Status -** This item is required and should be completed for **medical screenings only**. You must certify with each claim whether or not the beneficiary's immunizations are complete and current for his or her age. Check "Yes" if immunizations are complete and current for this age beneficiary. Check "No" if they are not. If you check "Yes," skip to item 31.

30. **Reason -** If you indicate in item 29 that immunizations are not current and complete, you must check the appropriate box explaining why. Check "A" in the case of medical contraindication. Check "B" if the parents or guardians refuse to permit the immunization. Check "C" if immunizations are off schedule. For example, check "C" if the beneficiary received an immunization at this visit but is still due one for his or her age. Do not check "C" if immunizations are off schedule and you did not immunize.

31. **Presence or absence of suspected conditions -** This item relates to screening findings. If you find no suspected conditions, check "no" and skip to item 36. If you do find one or more suspected conditions, check "yes" and proceed to item 32.

32. **Nature of suspected conditions and referral strategy -** This item documents the general types of suspected conditions identified during the screening and whether or not a referral was made in-house (includes self-referrals) or offsite. Complete it by checking the appropriate boxes. For example, if you found a suspected medical condition for which the beneficiary is already under care by you or any other provider, check the far left box on the first line. If you found a suspected nutritional condition and you have self-referred, check the far right column on the fifth line (E). If you found a suspected psychological/social condition and have made a referral outside your practice, check the middle column on the eighth line (H). Be sure to enter information about all suspected conditions found. Do not make any entries on lines J through L.

☞ Note that each of these items may require you to enter up to eight different kinds of information in the spaces marked A, B, C, D, E, F, G, H, and I.

33-35. **Referrals for Suspected Conditions -** You must complete at least one of these items if any suspected conditions are listed in item 32 as being referred in-house or offsite. The number of items you complete will depend on how many conditions you found in the screening and on the referrals made. As you will see below If more than four suspected conditions are found, you must fill out at least items 33 and 34. If more than eight suspected conditions are found, you must fill out items 33 through 35. Also, you must complete one item for each referral made. If there are more referrals than blocks 33-35 will accommodate, such referrals should be documented in the recipient's chart and would not be listed on the claim form.

33A. **Suspected Condition -** Referring back to item 32, enter in item 33A up to four letters (A through I), identifying the type of condition(s) identified. Remember, the referral may cover up to four conditions, but only one referral provider. Start at the left of the block, and leave any unused spaces blank. **DO NOT enter an ICD-9 diagnosis code or diagnosis abbreviation (e.g., "URI") here—that information should be entered in 33E.**

33B. Referral Assist Needed - Check “no,” if there is a referral. If assistance is needed from the Louisiana KIDMED office on finding a referral resource, contact ACS at (877) 455-9955

33C. Appointment Date - If you referred the beneficiary either in-house or offsite, enter the date of the appointment. The appointment date should be estimated if it is not known at the time the claim form is completed.

33D. Appointment Time - If you referred the beneficiary either in-house or offsite, enter the time of the appointment. The appointment time should be estimated if it is not known at the time the claim form is completed.

33E. Reason for Referral - Enter the reason for the referral, using up to 40 letters and/or the ICD-9 diagnostic codes. In addition, if referral assistance is needed because the referred-to provider requires direct contact with the beneficiary, indicate so here.

33F. Referred To - If you made your own in-house or offsite referral, enter up to 20 letters of the name of the specific provider to whom the beneficiary was referred, starting with the last name first. Be as specific as possible. For example, if the beneficiary was referred to a large facility, give the name and department onsite. If you self-referred, enter "self" for this item. Skip to item 36 if you have no other referral information to report.

33G. (Blank) - Do not enter any data here. This item is reserved for future use by KIDMED.

33H. Phone No. - If you made your own in-house or offsite referral, enter the area code and six-digit phone number of the referred-to provider. If you self-referred, leave this item blank.

33I. Transportation Assistance Needed - Check “no,” as this block is no longer used to obtain transportation assistance. The recipient (or the recipient’s parent) should contact the Medical Dispatch Office at 1-866-272-5501.

34. Follow the instructions above for item 33.

35. Follow the instructions above for item 33.

36. Providers must read and sign the certification statement at the bottom of the screening claim form in order to be paid. Providers may use a signature stamp if it is initialed by the individual completing the form. A signature certifies that the provider has provided all components of the screening, including appropriate immunizations when the medical screening is billed. The claim form will be returned unprocessed if no signature is present.

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED

MEDICAID OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. ☐ ORIGINAL ☐ ADJUSTMENT ☐ VOID

2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
( ) –	( ) –		

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE				$		
MEDICAL SCREENING PHYSICIAN				$		
VISION				$		
HEARING				$		
ENCOUNTER (RHC/FQHC)				$		
TOTAL BILLED AMOUNT				$		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT?
☐ YES ☐ NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. ☐ MEDICALLY CONTRAINDICTED
B. ☐ PARENTAL REFUSAL
C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☐ YES ☐ NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE
REFERRAL OFFSITE
REFERRAL IN-HOUSE

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:
- **A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;**
- **A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;**
- **APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICTED OR PARENT REFUSED AT THE TIME);**
- **LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND**
- **HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).**

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

2/03 | 36. SIGNATURE OF PROVIDER | 37. DATE

KM-3

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. X ORIGINAL ☐ ADJUSTMENT ☐ VOID
2. REASON 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1444440	Kids R Us				

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Susie	09011999	F	

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE
SmitthS	123 Oak Lane	Sunny	LA	70000–

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 – 1212	( ) –		

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99383	TD	01 06 2005	$ 51.00		
MEDICAL SCREENING PHYSICIAN				$		
VISION	99173		01 06 2005	$ 4.00		
HEARING	92551		01 06 2005	$ 3.60		
ENCOUNTER (RHC/FQHC)	T1015	EP	01 06 2005	$ 95.00		
TOTAL BILLED AMOUNT				$ 153.60		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT?
X YES ☐ NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. ☐ MEDICALLY CONTRAINDICTED
B. ☐ PARENTAL REFUSAL
C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☐ YES X NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE
REFERRAL OFFSITE
REFERRAL IN-HOUSE

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

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- **A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;**
- **APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICTED OR PARENT REFUSED AT THE TIME);**
- **LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND**
- **HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).**

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

IMA BILLER — 36. SIGNATURE OF PROVIDER
01072005 — 37. DATE

2/03
KM-3

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. X ORIGINAL ☐ ADJUSTMENT ☐ VOID
2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1444440	Kids R Us				

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Susie	09011999	F	

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE
SmithS	123 Daylight Way	Sunny	LA	70000

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 – 1212	( ) –	Smith	Jonathon

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE				$		
MEDICAL SCREENING PHYSICIAN	99383		02062005	$ 51.00		
VISION				$		
HEARING				$		
ENCOUNTER (RHC/FQHC)	T1015	EP	02062005	$ 95.00		
TOTAL BILLED AMOUNT				$ 146.00		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? ☐ YES X ☐ NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
X
A. ☐ MEDICALLY CONTRAINDICTED
B. ☐ PARENTAL REFUSAL
C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? X YES ☐ NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
		X	A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
A	X ☐ YES ☐ NO	02072005	9:45

E. REASON FOR REFERRAL: UTI

F. REFERRED TO: Dr Brown | G.

H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	☐ YES ☐ NO		

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	☐ YES ☐ NO		

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

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- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICTED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

IMA BILLER — 36. SIGNATURE OF PROVIDER

02072005 — 37. DATE

2/03

KM-3

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED

MEDICAID OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. X ORIGINAL
☐ ADJUSTMENT
☐ VOID

2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1444440	Kids R Us	012			1111111

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	James	09011999	M	

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE
SmithJ	123 Oak Lane	Sunny	LA	70000–

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 – 1212	( ) –	Smith	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99383	TD	02012005	$ 51.00		
MEDICAL SCREENING PHYSICIAN				$		
VISION				$		
HEARING				$		
ENCOUNTER (RHC/FQHC)	T1015	EP	02012005	$ 91.00		
TOTAL BILLED AMOUNT				$ 142.00		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT?
X YES ☐ NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. ☐ MEDICALLY CONTRAINDICTED
B. ☐ PARENTAL REFUSAL
C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☐ YES X NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

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- **A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;**
- **APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICTED OR PARENT REFUSED AT THE TIME);**
- **LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND**
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I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

IMA BILLER — 36. SIGNATURE OF PROVIDER
02022005 — 37. DATE

2/03
KM-3

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED

MEDICAID OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. ☐ ORIGINAL
X ADJUSTMENT
☐ VOID

2. REASON: 02
3. ADJUSTMENT ICN: 9876543213216

PRINT OR TYPE ONLY - USE BLACK INK

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1444440	Kids R Us	012			

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Jones	Johnny	01012000	M	

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE
JonesJo	134 Oak Park	Sunny	LA	70000 –

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 – 1212	( ) –	Jones	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE				$		
MEDICAL SCREENING PHYSICIAN	99382		02212005	$ 51.00		
VISION				$		
HEARING				$		
ENCOUNTER (RHC/FQHC)	T1015	EP	02212005	$95.00		
TOTAL BILLED AMOUNT				$146.00		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT?
X YES ☐ NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. ☐ MEDICALLY CONTRAINDICTED
B. ☐ PARENTAL REFUSAL
C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☐ YES X NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

33.
A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? ☐ YES ☐ NO | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

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- **APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICTED OR PARENT REFUSED AT THE TIME);**
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- **HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).**

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

IMA BILLER — 36. SIGNATURE OF PROVIDER
02222005 — 37. DATE

2/03
KM-3

RHC/FQHC and KIDMED ERROR CODES

Error Code	Message	Reason for Denial
092	Invalid procedure modifier	When procedure T1015 is billed without the EP modifier on the KM3 claim form
136	No eligible service paid, encounter denied	Several different types of errors can cause this denial: • When encounter code T1015, mod. EP, is billed without an approved corresponding detail line item(s) • When line item detail is billed without the corresponding encounter code T1015 with modifier EP • When immunizations, vision and/or hearing screenings are billed without a physician or nurse screening
210	Provider/Procedure Conflict	Billing a code after May 1, 2003 that has been put in a non payable, non billable status will trigger this denial
715	Duplicate edit	In situations where a medical screening is billed with T1015 EP on the KM3 and immunizations are listed on the CMS 1500 with T1015 EP for the same day of service one of the encounters will pay at the providers established rate and the others will deny

REMINDER: An encounter code, modifier(if necessary) and supporting detail (beginning with DOS 01/01/2005) must be entered on <u>each claim form</u> to get the correct error code.

RHC/FQHC EPSDT DENTAL, ADULT DENTURE SERVICES and EXPANDED DENTAL SERVICES FOR PREGNANT WOMEN(EDSPW)

Dental Encounter Code Usage

The all inclusive dental encounter code (D0999) is required for billing RHC/FQHC dental services. When billing for EPSDT Dental, Adult Dental services or EDSPW, this code must appear on the first line of the 'Record of Services Provided' section of the claim form. The encounter code and other required information (date of service, procedure code, procedure description, and fee) must also be entered on the 1st line of the claim form. In addition to the encounter code (D0999), it is necessary to indicate on subsequent lines of the claim form the specific dental services provided and other required information for each service rendered.

Claims must pass all processing edits for payment to be approved.

- If the encounter code is missing, the detail line item(s) will deny.
- If the encounter code is denied, the detail line item(s) will deny.
- If the encounter code is present and passes all edits but the detail line item(s) is/are missing, the encounter code will deny.
- If the encounter code is present and passes all edits, it will deny if all detail line items deny.
- If the encounter code and detail line items are present, correct, and pass all edits, the encounter code will pay at the provider's encounter rate and the detail line item(s) will be approved at zero ($0).

REMINDER: Dental services should not be separated or performed on different dates of service solely to enhance reimbursement. If no restorative or other treatment services are necessary, all sealants must be performed on a single date of service. If restorative or other treatment services are necessary, sealants may be performed on the same day of service as the restorative or other treatment services. Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there are circumstances that would not allow restorative treatment in this manner, the contraindication (s) must be documented in the patient's dental record. A lead apron and thyroid shield must be used when taking any radiographs reimbursed by the Medicaid program. When taking radiographs, the use of a lead apron and thyroid shield is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene. Should you have any questions regarding this information, you may contact the Dental Medicaid Unit by calling 504-619-8589.

NOTE: Providers must obtain the 2003 Dental Provider Manual and training packet as a reference for policy regarding Dental services.

EPSDT DENTAL POLICY UPDATES/REMINDERS

The following pages contain policy updates and/or reminders made since the printing of the 2003 Dental Services Manual. Providers should adopt this information as policy. Most of this information has been previously published in other provider resources such as the Medicaid Remittance Advice(s) (RA), Provider Update(s), and/or the Medicaid provider website at www.lamedicaid.com. Please take notice that in the future the dental services manual will be revised to reflect this information.

POLICY UPDATES

ADDITIONAL PROCEDURE CODE MADE PAYABLE EFFECTIVE SEPTEMBER 1, 2004

Retreatment Of Previous Root Canal Therapy, Anterior (D3346)

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

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

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

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

If the radiographs do not indicate the need for a root canal, the provider must include a written statement as to why the root canal retreatment is necessary. If a fistula is present, a clear oral/facial image (photograph) is required and will be reimbursable in situations where dental radiographs do not adequately indicate the necessity for the requested retreatment of previous root canal therapy.

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

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

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

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

ROOT CANAL THERAPY (including treatment plan, clinical procedures and follow-up care) (D3310, D3320 AND D3330)

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

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

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

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

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

- A lifetime limit of one posterior root canal therapy can be reimbursed per side of the mouth (right or left). Posterior root canals will be approved only when the occlusion of that half of the arch is stable and extraction would result in destabilization.

- A lifetime maximum of four anterior root canal therapies limited to a maximum of three in either arch can be reimbursed.

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

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

Procedure code D3310, Root canal, anterior (excluding restoration),is reimbursable for Tooth Number 6 through 11 and 22 through 27. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

Procedure code D3320, Root canal, bicuspid (excluding restoration) is reimbursable for Tooth Number 4, 5, 12, 13, 20, 21, 28 and 29. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

Procedure code D3330, Root canal, molar (excluding restoration) is reimbursable for Tooth Number 2, 3, 14, 15, 18, 19, 30 and 31. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

RADIOGRAPHS (X-RAYS) - GENERAL INFORMATION

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

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

PERIAPICAL RADIOGRAPHS (D0220 AND D0230)

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

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

- An anterior crown or crown buildup is anticipated; or

- Posterior root canal therapy is anticipated (root canal working and final fill films are included in the fees for endodontic treatment); or

- Anterior **initial or retreatment** root canal therapy is anticipated (both maxillary and mandibular anterior films) (root canal working and final fill films are included in the fees for endodontic treatment); or

- Prior to any tooth extraction.

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

ORAL/FACIAL IMAGES (D0350)

Procedure Code D0350, Oral / Facial images (photographs), are required when dental radiographs do not adequately indicate the necessity for the requested treatment in the following situations:

- Buccal and lingual decalcification prior to crowning; or

- Soft tissue biopsy; or

- Prior to Gingivectomy; **or**

- **Presence of a fistula prior to retreatment of previous root canal therapy, anterior**.

Acrylic Interim Partial Dentures (D5820 AND D5821)

Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition stages in the following cases: 1) Missing one or two maxillary permanent anterior tooth/teeth; or 2) Missing two mandibular permanent anterior teeth; or 3) Missing three or more permanent teeth in the same arch (of which at least one must be anterior).

CROWN SERVICES – GENERAL INFORMATION

Crown services require radiographs, photographs, other imaging media or other documentation which depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by the Bureau or its designee upon request.

PREFABRICATED STAINLESS STEEL CROWN, PRIMARY TOOTH (D2930)

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

extensive caries;
interproximal decay that extends into the dentin;

significant observable cervical decalcification;
significant observable developmental defects, such as hypoplasia and hypocalcification.
following pulpotomy or pulpectomy;
restoring a primary tooth that is to be used as an abutment for a space maintainer; or,
fractured tooth.

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

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

primary teeth with abscess or bone resorption; or
primary teeth where root resorption equals or exceeds 75% of the root; or
primary teeth with insufficient tooth structure remaining so as to have a poor prognosis of success, i.e. unrestorable; or
incipient carious lesions

SEALANT (D1351)

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

RESTORATIVE AND TREATMENT SERVICES

Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there are circumstances that would not allow restorative treatment in this manner, the contraindication(s) must be documented in the patient's dental record.

EXTRACTION OF PRIMARY TEETH IN THE ADVANCED STAGES OF NATURAL EXFOLIATION

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

If the extraction is warranted due to therapeutically indicated circumstances such as prolonged retention, blocking out of erupting permanent teeth, severe decay, abscess with bone loss, or other specifically identifiable indications, a preoperative periapical radiograph should be taken as a diagnostic aid and as means of documentation. This radiograph must be maintained in the

recipient's record, and must be furnished to post-payment review if requested. Written documentation of the reason for the extraction must be noted in the dental treatment record.

POLICY REMINDERS

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

☞ Effective May 1, 2003, oral cavity designators replaced the arch designator codes (X and Y) and quadrant designator codes (UR, UL, LL, AND LR). However, some providers are still filing claims using the arch and quadrant designators. Providers should be using the ADA oral cavity designators as identified in the Dental Services Manual (Issue Date May 1, 2003), pages 16-15 and 16-16, regardless of the date of service, when reporting services that require an oral cavity designator. Services that require an oral cavity designator are identified in the 2003 Dental Services Manual and EPSDT Dental Program Fee Schedule. Below is an oral cavity designator conversion chart for your assistance:

Arch/Quadrant Codes Effective Prior to 05/01/03	New Oral Cavity Codes Effective 05/01/03
X – Upper Arch	01
Y – Lower Arch	02
UR – Upper Right	10
UL – Upper Left	20
LL – Lower Left	30
LR – Lower Right	40

ADULT DENTURE PROGRAM POLICY UPDATES/REMINDERS

The following pages contain policy updates and/or reminders made since the printing of the 2003 Dental Services Manual. Providers should adopt this information as policy. Most of this information has been previously published in other provider resources such as the Medicaid Remittance Advice(s) (RA), Provider Update(s), and/or the Medicaid provider website at www.lamedicaid.com. Please take notice that in the future the dental services manual will be revised to reflect this information.

POLICY UPDATES

RADIOGRAPHS (X-RAYS) - GENERAL INFORMATION

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

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

POLICY REMINDERS

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

- Effective May 1, 2003, oral cavity designators replaced the arch designator codes (X and Y) and quadrant designator codes (UR, UL, LL, AND LR). However, some providers are still filing claims using the arch and quadrant designators. Providers should be using the ADA oral cavity designators as identified in the Dental Services Manual (Issue Date May 1, 2003), pages 16-15 and 16-16, regardless of the date of service, when reporting services that require an oral cavity designator. Services that require an oral cavity designator are identified in the 2003 Dental Services Manual and Adult Denture Program Fee Schedule. Below is an oral cavity designator conversion chart for your assistance:

Arch/Quadrant Codes Effective Prior to 05/01/03	New Oral Cavity Codes Effective 05/01/03
X – Upper Arch	01
Y – Lower Arch	02
UR – Upper Right	10
UL – Upper Left	20
LL – Lower Left	30
LR – Lower Right	40

NOTE: Providers must obtain the 2003 Dental Provider Manual and training packet as a reference for policy regarding Dental services.

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

Program Information

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

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

Eligibility Criteria

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

Dental services are not covered for pregnant women certified in the following Medicaid categories:

Medically Needy - Pregnant women, who are certified for Medicaid in the "Medically Needy Program" (MNP), are **not** eligible for dental services. If the recipient is certified for Medicaid in the Medically Needy Program, the REVS/MEVS message will specifically indicate that she is not eligible for dental services or dentures. If you receive this message and the recipient appears to meet the other program criteria, you should refer the pregnant woman to her local parish Medicaid office for a re-determination of her Medicaid eligibility.

Qualified Medicare Beneficiary Only - Pregnant women, who are certified as "Qualified Medicare Beneficiary Only" (QMB Only), are **not** eligible for dental services. If the recipient is certified for Medicaid as a QMB Only recipient, the REVS/MEVS message will indicate that she is eligible for co-payments and co-insurance for Medicare covered services and coverage of part A and B premiums.

Eligibility Period

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

Referral Requirement – BHSF Form 9-M (Mandatory)

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

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

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

Prior Authorization

Services that require prior authorization are identified with an asterisk (*) in the EDSPW Program fee schedule located in Appendix C of this document. Medicaid requires the use of the American Dental Association (ADA) Claim Form for all prior authorization requests. Effective January 1, 2005, the 2002 American Dental Association Claim Form and the 2002, 2004 American Dental Association (ADA) Claim Form will become the only hardcopy dental claim forms accepted for Medicaid prior authorization of services provided under the Medicaid EDSPW Program regardless of the date of service.

All prior authorization requests received by LSU Dental School prior to January 1, 2005 on the older versions of the ADA Claim Form will be processed. In-house and pending PA requests received on the older versions of the dental claim form will be processed. However, on or after January 1, 2005 any dental prior authorization requests received by Unisys on the older versions of the ADA Claim Form will be returned to the provider.

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

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

When requesting prior authorization, the provider should list all services that are anticipated, even those not requiring authorization, so that the general dental health and condition of the

recipient can be fully understood. Explanations or reasons for treatment, if not obvious from the radiographs, should also be entered in the "Remarks" section of the claim form. If the information required in the remarks section of the claim exceeds the space available, the provider should include a cover sheet which must include the date of the request, the recipient's name, the recipient's Medicaid ID#, the provider's name and the provider's Medicaid ID# and should outline the information required to document the requested service(s).

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

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

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

All dental prior authorization requests should be sent to the following:

LSU Dental School
Dental Medicaid Unit
1100 Florida Ave, Box F5-510
New Orleans, LA 70119

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

Failure to receive the returned claim form and radiographs and/or a Prior Authorization Letter within two weeks time should alert the provider that the claim form might have been misdirected. In these instances, please contact the dental consultants at the LSU School of Dentistry. If the claim form is returned, but the radiographs that were included with the claim are not returned, the provider must immediately contact the dental consultants at the LSU School of Dentistry. Please document the contacts with the dental consultants in the patient's record.

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

provider number or recipient number corrections, date of service changes, etc., a copy of the PA Letter with the requested changes noted, may be sufficient.

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

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

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

Program Guidelines

The fiscal intermediary provider relations staff can answer questions regarding claims processing. LSU School of Dentistry, under contract to the Bureau, provides dental prior authorization services and consultation on dental policy. They can answer questions related to dental prior authorization and dental policy.

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

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

General Coding Information

A complete list of Medicaid covered services and procedure codes for the Expanded Dental Services for Pregnant Women Program, can be found in the fee schedule in Appendix C of this document. These codes conform to the American Dental Association (ADA) Code on Dental Procedures and Nomenclature. Fees for all procedures include local anesthesia and routine postoperative care.

Tooth Numbering System and Oral Cavity Designators

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

Claims Filing

The American Dental Association (ADA) Claim Form is to be used and completed forms for payment should be mailed to:

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

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

COVERED SERVICES

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

DENTAL VISIT (INITIAL)

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

1) Comprehensive Periodontal Examination; and

2) Bitewing radiographs (unless contraindicated); and

3) Prophylaxis, including oral hygiene instructions (unless a Periodontal Scaling and Root Planing [D4341] or a Full Mouth Debridement [D4355] is required)

These services are limited to one of each of these services per pregnancy.

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

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

DIAGNOSTIC SERVICES

Diagnostic services include a comprehensive periodontal examination and radiographs.

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

Examination

D0180 Comprehensive Periodontal Examination - New or Established Patient

A comprehensive periodontal examination is limited to one per pregnancy.

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

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

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

Radiographs (X-Rays)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D0240* Intraoral – occlusal film

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

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

D0272 Bitewings – two films

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

D0330* Panoramic film

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

PREVENTIVE SERVICES

Adult Prophylaxis

D1110 Adult Prophylaxis

Adult prophylaxis includes removal of calculus on the teeth, removal of acquired stains, and polishing of the teeth. Qualified dental personnel must perform the prophylaxis. This service is limited to one per pregnancy.

If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 is billed, then further periodontal treatment (codes D4341 and/or D4355) will not be subsequently reimbursed.

RESTORATIVE SERVICES

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

D2140* Amalgam – one surface, primary or permanent
D2150* Amalgam – two surfaces, primary or permanent
D2160* Amalgam – three surfaces, primary or permanent
D2161* Amalgam – four or more surfaces, permanent
D2330* Resin-based composite, one surface, anterior
D2331* Resin-based composite, two surfaces, anterior
D2332* Resin-based composite, three surfaces, anterior
D2335* Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390* Resin-based composite crown, anterior
D2931* Prefabricated stainless steel crown – permanent tooth
D2932* Prefabricated resin crown, primary or permanent
D2951* Pin retention, per tooth, in addition to restoration

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

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

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

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

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

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

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

Laboratory processed crowns are not covered.

Amalgam Restorations (including polishing)

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

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

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

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

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

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

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

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

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

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

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

Resin-Based Composite Restorations

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

D2390* Resin-based composite crown, anterior

Posterior composite restorations are not reimbursable under the guidelines of Louisiana. Providers cannot provide a service that has a defined CDT procedure code and bill a different service that has a defined CDT procedure code in order to receive reimbursement by Medicaid.

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

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

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

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

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

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

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

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

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

Procedure codes D2330, D2331, D2332, D2335, and D2390 are reimbursable for Tooth Number 6 through 11, 22 through 27 and Tooth Letter C, H, M and R. The appropriate tooth

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

Non-Laboratory Crowns

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

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

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

D2931* Prefabricated Stainless Steel Crown – permanent tooth
This procedure is reimbursable for Tooth Number 1 through 32. The appropriate tooth number must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D2932* Prefabricated Resin Crown – primary or permanent
This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 and Tooth Letter C, H, M and R. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

Other Restorative Services

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

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

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

PERIODONTAL SERVICES

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

Prior authorization is required for all periodontal services.

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

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

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

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

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

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

D4341* Periodontal scaling and root planing, – four or more contiguous teeth or bounded teeth spaces per quadrant

This service should be requested when large amounts of supra and/or subgingival calculus, deep pocket formation, and bone loss are present. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces as well as the removal of rough, calculus-contaminated cementum and dentin. It is therapeutic, not prophylactic in nature, usually requiring local anesthesia.

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

This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) during this pregnancy.
This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4355* Full Mouth Debridement

This service should be requested when an adult prophylaxis (D1110) is not sufficient to reestablish good gingival health and should be performed at the initial visit if indicated.

Bitewing radiographs (unless contraindicated) that show posterior subgingival calculus in two or more quadrants must be submitted when requesting authorization.

Only one Full Mouth Debridement is allowed per pregnancy and it cannot be performed on the same date of service as an adult prophylaxis (D1110) or as a periodontal scaling and root planning (D4341).

This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) during this pregnancy.

ORAL AND MAXILLOFACIAL SURGERY SERVICES

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

The prophylactic removal of an asymptomatic impacted tooth is not covered. Due to the potential risk of complications involved in the removal of impacted teeth, minimal standards of care require that these procedures not be attempted without radiographic evaluation.

Requests for prior authorization for surgical extractions, including the extraction of impacted teeth, will not be considered without radiographs. The radiographic findings determine the necessity of surgical extraction and the degree of impaction and correspond to the CDT definitions of impactions. The prior authorization number will list the tooth numbers and will correspond to the CDT definitions. Therefore, it is suggested that prior authorization be used to resolve differences in interpretation prior to the day of surgery.

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

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

Extractions

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

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

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

Non-surgical Extractions

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

This procedure includes the routine removal of tooth structure and closure, as necessary. This code should be used for all routine extractions as well as uncomplicated root tip removal.

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

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

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

Surgical Extractions

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

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

All requests for prior authorization of the surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth (D7210) require the submission of radiographs.

In the event a planned simple extraction becomes a surgical procedure, the provider may submit a "post" authorization request (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications. Radiographs are required and must clearly demonstrate the need for the cutting of gingiva and removal of bone or tooth structure.

D7220* Removal of impacted tooth - soft tissue

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

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

D7230* Removal of impacted tooth – partial bony

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

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

NON-COVERED SERVICES

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

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

PRIOR AUTHORIZATION UPDATE

Effective January 1, 2005, the 2002 American Dental Association Claim Form and 2004 American Dental Association Claim Form will become the only hardcopy dental claim forms accepted for Medicaid prior authorization (PA) of services provided under the Medicaid EPSDT Dental Program, EDSPW Program or Adult Denture Program regardless of the date of service.

All prior authorization requests received by LSU Dental School prior to January 1, 2005 on the older versions of the ADA Claim Form will be processed. In-house and pending PA requests received on the older versions of the dental claim form will be processed. However, on or after January 1, 2005 any dental prior authorization requests received by LSU Dental School on the older versions of the ADA Claim Form will be returned to the provider.

EPSDT Dental Services Adjustment/Void (209) and Adult Denture Program Adjustment/Void (210) Form Changes

Effective October 1, 2004, when submitting adjustments/voids for EPSDT services for any and all dates of service, dental providers must use the newly revised EPSDT Dental Services 209 Adjustment/Void form (revision date 10/04). Additionally, when submitting adjustments/voids for Adult Denture services, dental provider must use the newly revised Adult Denture Program 210 Adjustment/Void form (revision date 10/04). For both adjustment/void forms Form Locator 15 has been renamed as "Patient I.D./Account# Assigned by Dentist". If the patient's account (medical record) number is entered here, it will appear on the Medicaid Remittance Advice. It may consist of letters and/or numbers, and it may be a maximum of 20 positions. Providers can obtain these forms from Unisys or through the Louisiana Medicaid website at www.lamedicaid.com. Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

INSTRUCTIONS FOR COMPLETING 209 ADJUSTMENT/VOID FORM (EPSDT)

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

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

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

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

Patient ID/Account Number

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

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

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

SAMPLE

FOR OFFICE USE ONLY

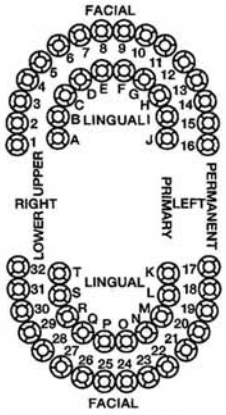
1 ADJ. [X] VOID [ ]

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

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

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

23



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

REMARKS FOR UNUSUAL SERVICE:

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

A. TOOTH # OR LETTER	B. SURFACE	C. PROCEDURE CODE	D. DESCRIPTION OF SERVICE	UNITS	E. DATE SERVICE PERFORMED MO. DAY YR.	F. ADJUSTED FEE (FOR STATE USE ONLY)	G. USUAL AND CUSTOMARY FEE
16		D2931	Stainless Steel Crown		10 15 04	80 00	
H. ORAL CAVITY						25 PAID OR PAYABLE BY OTHER CARRIER	$

26 CONTROL NUMBER: 4123456789012
(THIS IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.: 04/06/2004

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

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

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

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

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

32 Dr. Joe Smiley, DDS
ATTENDING DENTIST'S SIGNATURE
1888888 11/12/04
PROVIDER NUMBER

UNISYS 209
10/04

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

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

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

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

INSTRUCTIONS FOR COMPLETING 210 ADJUSTMENT/VOID FORM (ADULT)

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

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

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

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

Patient ID/Account Number

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

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

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

SAMPLE

FOR OFFICE USE ONLY

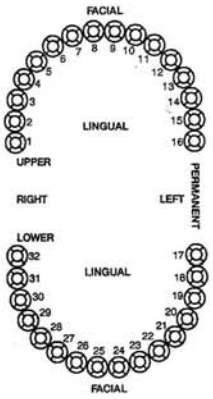
1 ADJ. [X] VOID [ ]

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

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

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

22



INDICATE TEETH TO BE EXTRACTED WITH A/.

INDICATE MISSING TEETH WITH AN X.

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

23 A. PROCEDURE CODE	B. DESCRIPTION OF SERVICE	C. DATE SERVICE PERFORMED MO. DAY YEAR	D. ADJUSTED FEE (FOR STATE USE ONLY)	E. USUAL AND CUSTOMARY FEE
D5510	Repair Full Denture Base	01 20 04		85 00

F. ORAL CAVITY	G. TOOTH #	24 PAID OR PAYABLE BY OTHER CARRIER
01		$

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

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

26 CONTROL NUMBER: 4123456789012
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.: 04/27/2004

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

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

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

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

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

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

32 Dr. Joe Smiley DDS
ATTENDING DENTIST'S SIGNATURE
1888888 02/12/05
PROVIDER NUMBER

UNISYS-210
10/04

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

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

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

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

RHC/FQHC 2002 ADA CLAIM FORM INSTRUCTIONS FOR BILLING MEDICAID EPSDT DENTAL AND ADULT DENTURE SERVICES

MEDICAID EPSDT DENTAL, EDSPW AND ADULT DENTURE PROGRAM SERVICES

Effective January 1, 2005, the 2002 American Dental Association Claim Form and the 2002, 2004 American Dental Association Claim Form will become the only hardcopy dental claim forms accepted for Medicaid reimbursement of services provided under the Medicaid EPSDT Dental Program, EDSPW Program or Adult Denture Program regardless of the date of service.

All dental claims received by Unisys prior to January 1, 2005 on the older versions of the ADA Claim Form will be processed. In-house and pending claims received on the older versions of the dental claim form will be processed. However, on or after January 1, 2005 any dental claims received by Unisys on the older versions of the ADA Claim Form will be returned to the provider.

In order to be compliant with this requirement by January 1, 2005, hardcopy billing providers who are currently using older versions of the ADA Claim Form should:

- request the 2002 ADA Claim Form or the 2002, 2004 ADA Claim Form from the ADA as soon as possible in order to utilize the claim form on January 1, 2005.

In order to be compliant with this requirement by January 1, 2005, providers who are currently using older versions of dental software to print hardcopy dental claims should:

- contact their software vendor as soon as possible for updated software in order to begin using the updated software on January 1, 2005.

REMINDER: The all inclusive encounter code (D0999) and other required information regarding this code must be entered on the 1st line of the claim form; tooth number/letter, surface or oral cavity designator is not required for this line. In addition to the encounter information, it is necessary to indicate on subsequent lines of the claim form, the specific dental services provided by entering the individual procedures, including all appropriate line item information for each service rendered.

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

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

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

   Situational. Must check box marked "EPSDT / Title XIX" if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment program for persons under age 21. **If block is not checked, the claim will be processed as an adult claim.**

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

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

4. Required. If yes, complete Block 9.

5-8. Situational.

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

10-11. Situational.

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

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

14. Required. Check appropriate block.

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

16-23. Situational.

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

25. Situational. Must indicate the oral cavity designator when the Medicaid Program requires an oral cavity designator for the specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding oral cavity designator.

26. Situational.

27. Situational. Must indicate a tooth number or letter when the Medicaid Program requires a tooth number or letter for the specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding tooth number or letter.

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

*29. Required. **Enter the encounter code D0999 on the first line**. Enter the specific services provided by entering the appropriate dental procedure code from the current version of *Code on Dental Procedures and Nomenclature* on subsequent lines.. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.

*30. Required. Enter "ENCOUNTER ALL INCLUSIVE" on the first line. Enter the description of the specific services on subsequent lines.

*31. Required. Enter your encounter rate on the 1st line to correspond with the encounter code and enter the dentist's full (usual and customary) fee for the **specific** dental procedure reported.

32. Situational.

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

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

35. Situational. Must include the following information in the remarks section of the claim form: 1) If Block 9 of the claim form is completed, write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [$0] payment); and/or 2) Additional information which is required by Medicaid regarding requested services (i.e. description of the patient management techniques being utilized for which a patient management

fee is being requested, reason for hospitalization request, etc.) or any additional information that the provider needs to include. For prior authorization requests, if the information required in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the recipient's name and Medicaid ID # and the provider's name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient's treatment record.

36. Situational.

37. Situational.

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

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

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

41. Situational.

42. Situational.

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

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

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

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

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

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

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

50. Situational.

51. Situational.

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

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

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

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

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

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

58. Situational.

SAMPLE

ADA Dental Claim Form

HEADER INFORMATION

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

PRIMARY PAYER INFORMATION

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

PRIMARY SUBSCRIBER INFORMATION

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

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

16. Plan/Group Number	17. Employer Name

OTHER COVERAGE

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

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

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

9. Relationship to Primary Subscriber (Check applicable box): [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Carrier Name, Address, City, State, Zip Code: TPL Carrier Code – if applicable

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box): [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other

19. Student Status: [ ] FTS [ ] PTS

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

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

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	02/14/2005					D0999	Encounter All Inclusive	125.00
2	02/14/2005			15		D2931	Stainless Steel Crown	90.00
3								
4	02/14/2005			13		D2954	Post & Care	70.00
5								
6								
7								
8								
9								
10								

SAMPLE

MISSING TEETH INFORMATION

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

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	285.00

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

AUTHORIZATIONS

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

X _____ Patient/Guardian signature Date

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

X _____ Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

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

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

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

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

42. Months of Treatment Remaining

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

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

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

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

47. Auto Accident State

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

48. Name, Address, City, State, Zip Code:
RHC/FQHC Clinic1
23 Smiley St.
Anywhere, LA 70000

49. Provider ID	50. License Number	51. SSN or TIN
1234567		

52. Phone Number (225) 555 - 1212

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X *John White, DDS* Signed (Treating Dentist) 05/24/05 Date

54. Provider ID	55. License Number
1888888	88888

56. Address, City, State, Zip Code

57. Phone Number ( ) -

58. Treating Provider Specialty

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

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

DENTAL CLAIM ERROR CODE INFORMATION

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

EDIT RESOLUTION			
Code	**Message**	**Action**	**Resolution**
103	Invalid Tooth Code/Oral Cavity Designator	Changed	Either the data in the "Tooth # or letter or oral cavity designator" columns of the claim form is not recognized as a valid tooth code or oral cavity designator. Or The data in the "Tooth # or letter" column of the claim form is valid tooth code or oral cavity designator, but it is not valid for the service billed (e.g., billing a tooth number for a service requiring an oral cavity designator.). Or The claim does not indicate a tooth code or oral cavity designator for a procedure code that requires this information. Determine whether the procedure requires a tooth code or oral cavity designator. Correct the claim to reflect the appropriate and accurate data and resubmit the claim.
136	No eligible service paid, encounter denied	New	Several different types of errors can cause this denial: • When encounter code T1015, mod. EP, is billed without an approved corresponding detail line item(s) • When line item detail is billed without the corresponding encounter code T1015 with modifier EP • When immunizations, vision and/or hearing screenings are billed without a physician or nurse screening
510	Only 1 of these procedures in 7 years per recipient/ provider	Changed	Only one of the procedures billed can be performed for the recipient, by the provider, within seven years. The system will deny the claim.
598	PA Tooth/	New	This claim was prior authorized. The tooth number/letter or oral

EDIT RESOLUTION			
Code	**Message**	**Action**	**Resolution**
	Oral Cavity Code Not Same as Claim		cavity designator on the claim does not match the tooth number or oral cavity designator prior authorized. The system will deny the claim. Ensure that the correct prior authorization number, tooth number, and/or oral cavity designator were billed on the claim form. If not, correct the claim and resubmit.
603	Tooth Code/ Oral Cavity Designator Required	Changed	The claim does not indicate a tooth code or oral cavity designator for a procedure code that requires this information. Ensure that the tooth code or oral cavity designator is on the claim form and in the correct column. Resubmit the claim.
613	Invalid Tooth Code/Oral Cavity Code Designator	Changed	Either the data in the "Tooth # or letter or oral cavity designator" columns of the claim form is not recognized as a valid tooth code or oral cavity designator. Or The data in the "Tooth # or letter" column of the claim form is valid tooth code or oral cavity designator, but it is not valid for the service billed (e.g., billing a tooth number for a service requiring an oral cavity designator.). Or The claim does not indicate a tooth code or oral cavity designator for a procedure code that requires this information. Determine whether the procedure requires a tooth code or oral cavity designator. Correct the claim to reflect the appropriate and accurate data and resubmit the claim.
742	Only 1 of these procedures allowed in 5 years per recipient/ provider	Changed	Only one of the procedures billed can be performed for the recipient, by the provider, within five years. The system will deny the claim.
775	Payment Cutback same Tooth	Changed	The claim history for this recipient indicates that Medicaid has already processed a claim or claims for this tooth, and the paid amounts have been applied toward the maximum amount allowed for the tooth. In payment of the current claim, only part of the billed amount could be reimbursed without exceeding the maximum allowed payment. Normally this occurs when more than one restoration is billed for the same tooth by the same provider within a certain period of time. Ensure the correct date of service and procedure code were billed on the claim form. If not, correct the claim and resubmit.

EDIT RESOLUTION			
Code	**Message**	**Action**	**Resolution**
			Otherwise, refer to the patient's chart and billing records, including RAs that reflect payment for services for the recipient.

ELECTRONIC DATA INTERCHANGE (EDI)

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

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

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

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

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

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

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

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

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

HIPAA DESK TESTING SERVICE ENROLLMENT

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

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

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

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

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

HIPAA-COMPLIANT 837 TRANSACTION TESTING SERVICE

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

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

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

MMIS PARALLEL TESTING

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

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

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

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

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 the required Certification forms are included in the 2004 Basic Training packet and may also be obtained from lamedicaid.com under the HIPAA Information Center link. The required forms are available in both the General EDI Companion Guide and the EDI Enrollment Packet.

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

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

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

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

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

Electronic Adjustments/Voids

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

Submission Deadlines
Regular Business Weeks

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

Thanksgiving Week

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

Important Reminders For EDI Submission

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

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

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

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

ELECTRONIC DATA INTERCHANGE (EDI) GENERAL INFORMATION

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

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

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

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

    - Case Management services
    - Non-Ambulance Transportation

Enrollment Requirements For EDI Submission

- **Submitters wishing to submit EDI 837 transactions without using a Third Party Biller -** complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC 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.

CLAIMS PROCESSING REMINDERS

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

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

- Submit an original claim for whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.
- Enter information within the appropriate boxes and align forms in 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 have been 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.

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, 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

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
Office Visits over limit - Form 158A for extension of office visits	Continue hardcopy billing
Norplant if earlier than 5 years - 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.**

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

PHARMACY PRIOR AUTHORIZATION

The established process for requesting pharmacy prior authorization (PA) has not changed since its implementation on June 10, 2002.

Who Can Obtain Prior Authorization

The prescribing practitioner is responsible for obtaining prior authorization. (Pharmacist or recipient calls/request will not be accepted). The prescribing practitioner must have and provide his/her valid individual LA Medicaid prescribing provider number to obtain prior authorization. (Only individual provider numbers will be accepted.) The prescribing practitioner may obtain the PA by (1) phone, (2) fax, or (3) mail.

Phone:	1-866-730-4357
Fax:	1-866-797-2329 – Do not send a cover sheet with the FAX.
Mail:	ULM College of Pharmacy – Rx PA Program 1401 Royal Avenue Monroe, LA 71201

The hours of operation for the ULM Prior Authorization Unit are 8am to 6pm Central Time, Monday through Saturday.

Contacts

University of Louisiana at Monroe Prior Authorization Unit 1401 Royal Avenue Monroe, LA 71201	1-866-730-4357
Unisys POS Help Desk P.O.Box 91024 Baton Rouge, LA 70821	1-800-648-0790 1-225-237-3381
Unisys Provider Relations P.O. Box 91024 Baton Rouge, LA 70821	1-800-473-2783 1-225-924-5040
Unisys Provider Enrollment P.O. Box 80159 Baton Rouge, LA 70898-0159	1-225-237-3370

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

FIELD ANALYST	PARISHES SERVED		
Martha Craft **(225) 237-3306**	Jefferson Orleans	St. Charles Plaquemines St. Bernard	
Open	Bienville Bossier Caddo 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 Beaumont, TX
Sharon Harless **(225) 237-3267**	Avoyelles Iberville West Baton Rouge	East Feliciana West Feliciana Woodville/Centerville (MS) Pointe Coupee	
Erin McAlister **(225) 237-3201**	Ascension Assumption Livingston St. Helena St. James	St. John the Baptist St. Tammany Tangipahoa Washington McComb (MS)	
Courtney Patterson **(225) 237-3269**	East Baton Rouge		
Kathy Robertson **(225) 237-3260**	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 Media Claims (EDI) - Unisys		(225) 237-3200 option 2	(225) 237-3331
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 237-3342 / (225) 929-6803
Home Health P.A. - Unisys EPSDT PCS P.A. - Unisys	(800) 807-1320		(225) 237-3342 / (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:

Department of Health and Hospitals
RHC/FQHC Program Manager
P.O. Box 91030
Baton Rouge, LA 70821

Appendix A

EPSDT Dental Program Fee Schedule

EFFECTIVE September 1, 2004

APPENDIX A: EPSDT DENTAL PROGRAM FEE SCHEDULE

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

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

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

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

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

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

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

EPSDT DENTAL PROGRAM FEE SCHEDULE

EPSDT DENTAL PROGRAM DIAGNOSTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
D0120	Periodic Oral Examination – Patient of Record	18.00
D0150	Comprehensive Oral Examination – New Patient Note: Medicaid requires use of this code to report new patients (patients not seen by the billing provider within 2 years) only.	20.00
*D0210	Radiographs – Complete Series (including bitewings)	35.00
#D0220	Radiograph – Periapical, First Film This procedure is reimbursable for Tooth Number 1 through 32; and Tooth Letter A through T.	6.00
#D0230	Radiograph – Periapical, Each Additional Film This procedure is reimbursable for Tooth Number 1 through 32; and Tooth Letter A through T.	5.00
+*D0240	Radiograph – Occlusal Film This procedure is reimbursable for Oral Cavity Designator 01 and 02.	10.00
D0272	Radiograph – Bitewings, Two Films	13.00
*D0330	Radiograph – Panoramic Film	35.00
+D0350	Oral/Facial Images This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	4.00
*D0470	Diagnostic Casts	25.00
*D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report	80.00
*D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical Margins for Presence of Disease, Preparation and Transmission of Written Report	80.00

EPSDT DENTAL PROGRAM PREVENTIVE PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**

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

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

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

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

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

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

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

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

EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
***D5110**	Complete Denture, Maxillary	495.00
*D5120	Complete Denture, Mandibular	495.00
*D5130	Immediate Denture, Maxillary	495.00
*D5140	Immediate Denture, Mandibular	495.00
*D5211	Maxillary Partial Denture, Resin Base (including clasps)	470.00
*D5212	Mandibular Partial Denture, Resin Base (including clasps)	470.00
*D5213	Maxillary Partial Denture, Cast Metal (including clasps)	550.00
*D5214	Mandibular Partial Denture, Cast Metal (including clasps)	550.00
+D5510	Repair Broken Complete Denture Base This procedure is reimbursable for Oral Cavity Designator 01 and 02.	100.00
#D5520	Replace Missing or Broken Tooth, Complete Denture, Per Tooth 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	52.00/26.00
+D5610	Repair Resin Denture Base, Partial Denture This procedure is reimbursable for Oral Cavity Designator 01 and 02.	100.00
+D5630	Repair or Replace Broken Clasp, Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	95.00
#D5640	Replace Broken Teeth, Partial Denture, Per Tooth 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	52.00/26.00
+D5660	Add Clasp to Existing Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	95.00
*D5750	Reline Complete Maxillary Denture (Laboratory)	238.00

EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	**DESCRIPTION**	**FEE**
*D5751	Reline Complete Mandibular Denture (Laboratory)	238.00
*D5760	Reline Maxillary Partial Denture (Laboratory)	208.00
*D5761	Reline Mandibular Partial Denture (Laboratory)	208.00
*D5820	Interim Partial Denture (Maxillary), Includes Clasps	300.00
*D5821	Interim Partial Denture (Mandibular), Includes Clasps	300.00
*D5899	Unspecified Removable Prosthodontic Procedure, By Report	*****

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

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

EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	***DESCRIPTION***	**FEE**
#D7140	Extraction, Erupted Tooth or Exposed Root This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	46.00
#*D7210	Surgical Removal of Erupted Tooth This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	57.00
#*D7220	Removal of Impacted Tooth – Soft Tissue This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	86.00
#*D7230	Removal of Impacted Tooth – Partially Bony This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	136.00
#*D7240	Removal of Impacted Tooth – Completely Bony This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	161.00
#*D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	186.00
#*D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure) This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	57.00

EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	***DESCRIPTION***	**FEE**
+*D7270	**Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth** This procedure is reimbursable for Oral Cavity Designator 01 and 02.	***** Maximum Fee 150.00
#*D7280	Surgical Access of an Unerupted Tooth This procedure is reimbursable for Tooth Number 2 through 15; and 18 through 31 for Medicaid approved comprehensive orthodontic cases only.	***** Maximum Fee 300.00
#*D7281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption This procedure is reimbursable for Tooth Number 2 through 15; and 18 through 31.	50.00
+*D7285	Biopsy of Oral Tissue – Hard (bone, tooth) This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 or 40.	***** Maximum Fee 200.00
+*D7286	Biopsy of Oral Tissue - Soft (all others) This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	50.00
+*D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report This procedure is reimbursable for Oral Cavity Designator 01 and 02 for Medicaid approved comprehensive orthodontic cases only.	60.00
+*D7310	Alveoloplasty in Conjunction with Extractions – Per Quadrant This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	54.00
#D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue This procedure is reimbursable for Tooth Number 1 through 32.	38.00

EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	***DESCRIPTION***	**FEE**
+*D7880	Occlusal Orthotic Device, By Report This procedure is reimbursable for Oral Cavity Designator 01 and 02.	250.00
D7910	Suture of Recent Small Wounds up to 5 cm	50.00
+*D7960	Frenulectomy (Frenectomy or Frenotomy) – Separate Procedure This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	90.00
*D7999	Unspecified Oral Surgery Procedure, By Report	*****

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

EPSDT DENTAL PROGRAM ADJUNCTIVE GENERAL SERVICES		
CODE	***DESCRIPTION***	**FEE**
D9110	Palliative (Emergency) Treatment of Dental Pain	25.00
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	7.00
*D9241	Intravenous Conscious Sedation/Analgesia – First 30 Minutes	94.00
*D9242	Intravenous Conscious Sedation/Analgesia – Each Additional 15 Minutes	31.00
*D9248	Non-intravenous Conscious Sedation	50.00
*D9420	Hospital Call	125.00
*D9440	Office Visit – After Regularly Scheduled Hours	75.00
*D9920	Behavior Management, By Report	30.00
+*D9940	Occlusal Guard, By Report This procedure reimbursable for Oral Cavity Designator 01 and 02.	50.00
*D9951	Occlusal Adjustment – Limited	68.00
*D9999	Unspecified Adjunctive Procedure, By Report	*****

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

Appendix B

ADULT Denture Program Fee Schedule

EFFECTIVE AUGUST 1, 2003

ADULT DENTURE PROGRAM FEE SCHEDULE

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

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

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

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

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

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

ADULT DENTURE PROGRAM FEE SCHEDULE

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

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

ADULT DENTURE PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	***DESCRIPTION***	**FEE**
+D5630	Repair or Replace Broken Clasp, Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	95.00
#D5640	Replace Broken Teeth, Partial Denture, Per Tooth 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	52.00/26.00
#D5650	Add Tooth to Existing Partial Denture 1st Tooth = $52.00; Each Additional Tooth = $26.00 This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	52.00/26.00
+D5660	Add Clasp to Existing Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	95.00
*D5750	Reline Complete Maxillary Denture (Laboratory)	238.00
*D5751	Reline Complete Mandibular Denture (Laboratory)	238.00
*D5760	Reline Maxillary Partial Denture (Laboratory)	208.00
*D5761	Reline Mandibular Partial Denture (Laboratory)	208.00
*D5899	Unspecified Removable Prosthodontic Procedure, By Report	*****

Appendix C

Expanded Dental Services for Pregnant Women (EDSPW) Fee Schedule

EFFECTIVE SEPTEMBER 1, 2004

Expanded Dental Services for Pregnant Women Program
Covered Services Fee Schedule

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

CODE	DESCRIPTION	FEE
*D2335	Resin-based Composite, Four or More Surfaces or Involving Incisal Angle, Anterior *This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 and Tooth Letter C, H, M and R.*	108.00
*D2390	Resin-based Composite Crown, Anterior *This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 and Tooth Letter C, H, M and R.*	104.00
*D2931	Prefabricated Stainless Steel Crown, Permanent Tooth *This procedure is reimbursable for Tooth Number 1 through 32.*	108.00
*D2932	Prefabricated Resin Crown *This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 and Tooth Letter C, H, M and R.*	104.00
*D2951	Pin Retention, Per Tooth, In Addition To Restoration *This procedure is reimbursable for Tooth Number 2 through 5; 12 through 15; 18 through 21; and 28 through 31.*	15.00
*D4341	Periodontal Scaling and Root Planing - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant *This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.*	81.00
*D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	61.00
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal) *This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T; and for Supernumerary Teeth 51 through 82 or AS through TS.*	46.00
*D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth *This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T; and for Supernumerary Teeth 51 through 82 or AS through TS.*	57.00
*D7220	Removal of Impacted Tooth, Soft Tissue *This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T; and for Supernumerary Teeth 51 through 82 or AS through TS.*	86.00

*D7230	Removal of Impacted Tooth, Partially Bony *This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T; and for Supernumerary Teeth 51 through 82 or AS through TS.*	136.00

* Prior Authorization is **required**
√ Indicates Reimbursement Fee for Permanent Teeth

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

Appendix D

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

REVISION DATE: DECEMBER, 2003

BHSF Form 9-M
Issued 12/03

Medicaid Program

Referral For Pregnancy Related Dental Services

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

Part I: All Items Must Be Complete

Name of Patient: _____

Street Address: _____ City: _____ Zip Code: _____

Medicaid Recipient ID #: _____

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

Part II: Check (☑) All Conditions That Apply

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

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

_____

_____

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

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

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

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

_____

_____

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

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

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

HOW DID WE DO?

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

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

Provider Subspecialty (if applicable):_____

FACILITY	**Poor**				**Excellent**
The seminar location was satisfactory	1	2	3	4	5
Facility provided a comfortable learning environment	1	2	3	4	5
SEMINAR CONTENT	**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: RHC/FQHC					

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.**