



UNISYS

KIDMED PROVIDER TRAINING

Spring 2006

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

ABOUT THIS DOCUMENT

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

This training packet has been developed for presentation at the Spring 2006 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as 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

**THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH
DEVELOPMENTAL DISABILITIES.
TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
(OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.
(See listing of numbers on attachment)**

MR/DD MEDICAID WAIVER SERVICES

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

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

SUPPORT COORDINATION

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.**

**THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE
AGE OF 21 WHO HAVE A MEDICAL NEED.
TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955
(or TTY 1-877-544-9544)**

MENTAL HEALTH REHABILITATION SERVICES

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

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

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

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES

Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. PCS services do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. The PCS service provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES

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

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

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

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

MEDICAL EQUIPMENT AND SUPPLIES

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

TRANSPORTATION

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

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

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

OTHER MEDICAID COVERED SERVICES

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

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

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

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

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

METROPOLITAN HUMAN SERVICES DISTRICT

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

REGION VI

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

CAPITAL AREA HUMAN SERVICES DISTRICT

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

REGION VII

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

REGION III

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

REGION VIII

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

REGION IV

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

FLORIDA PARISHES HUMAN SERVICES AUTHORITY

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

REGION V

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

JEFFERSON PARISH HUMAN SERVICES AUTHORITY

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

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STANDARDS FOR PARTICIPATION

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

- Provider agreement and enrollment with the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH);
- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;
- Agreement to accept as payment in full the amounts established by the BHSF and refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.
- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services;
- **NOTE: Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, or the state Attorney General's Medicaid Fraud Control Unit.**
- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1978*, and, where applicable, *Title VII of the 1964 Civil Rights Act*.

Picking and Choosing Services

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

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

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

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

Statutorily Mandated Revisions to All Provider Agreements

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

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

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

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

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

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

Surveillance Utilization Review

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

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

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

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

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

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

Fraud and Abuse Hotline

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

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

KIDMED SCREENINGS

The Early and Periodic Screening, Diagnosis, 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.

KIDMED Linkage

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

Medical Screening

Billing for these screenings should be completed hard copy on the KM-3 Form or electronically with the 837P claim transaction including the K3 segment. 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 screening)
5.	Health education (including anticipatory guidance)

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

Louisiana Medicaid reimbursement for a completed medical screening is \$51.00. **

The following procedure codes are used to bill for the medical screening:

99381*	Initial comprehensive preventive medicine; Infant (age under 1 year)
99382*	Initial comprehensive preventive medicine; Early Childhood (ages 1-4)
99383*	Initial comprehensive preventive medicine; Late Childhood (ages 5-11)
99384*	Initial comprehensive preventive medicine; Adolescent (ages 12-17)
99385*	Initial comprehensive preventive medicine; Adult (ages 18-20)
99391*	Periodic comprehensive preventive medicine; Infant (age under 1 year)
99392*	Periodic comprehensive preventive medicine; Early Childhood (ages 1-4)
99393*	Periodic comprehensive preventive medicine; Late Childhood (ages 5-11)
99394*	Periodic comprehensive preventive medicine; Adolescent (ages 12-17)
99395*	Periodic comprehensive preventive medicine; Adult (ages 18-20)

***Providers should use the TD Modifier in conjunction with the appropriate CPT code to report a screening that was performed by a registered nurse.**

Note: Providers must use the age appropriate code in order to avoid claim denial.

**** Note:** Reimbursement fees as of March 9, 2006 are current and subject to change.

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 condition

Objective Vision Screening

KIDMED objective vision screenings (99173 -EP) 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 tests of:

- 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).

Louisiana Medicaid reimbursement for a completed objective vision screening is \$4.00. **

The following procedure code is used to bill for vision screening:

99173 with EP modifier	Vision Screening
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** Note: Reimbursement fees as of March 9, 2006 are current and subject to change.

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

KIDMED objective hearing screenings (92551) 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.

Louisiana Medicaid reimbursement for a completed objective hearing screening is \$3.60. **

The following procedure code is used to bill for hearing screening:

92551	Hearing Screening
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** Note: Reimbursement fees as of March 9, 2006 are current and subject to change.

Immunizations

Appropriate immunizations (unless medically contraindicated or the parents/guardians refuse) are a federally required medical screening component, and 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. KIDMED follows the current Childhood Immunization Schedule recommended by Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (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.

Neonatal Screenings

The initial or repeat neonatal screening results for PKU, hypothyroidism, and sickle cell disease must be documented in the medical record for all children less than 6 months of age. Children over 6 months of age do not need to be screened for these conditions unless it is medically indicated.

Billing Information

Only KIDMED medical, vision, and hearing screenings should be billed on the KM-3 hard copy KIDMED claim form. If billing electronically, KIDMED medical, vision, and hearing screenings must be billed on the 837P with the K-3 (KIDMED) segment completed (see pages 31-33 for further details).

Immunizations, laboratory tests, interperiodic screenings, consultations, and low level office visits in conjunction with a KIDMED screening are billed electronically on the 837P or hard copy on the CMS 1500 claim form.

SCREENING PERIODICITY POLICY

One important obligation of the KIDMED provider is to provide services according to the periodicity schedule (a copy of which may be found on the following page and in the Appendix of this training packet). **KIDMED providers should also follow the most current copy of the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices(ACIP), and American Academy of Family Physicians (AAFP) Recommended Childhood Immunization Schedule. This schedule should be replaced by KIDMED providers each year as revisions are published.**

Initial Screening

Initial screenings must be scheduled within the time limits given below upon notification by the Louisiana KIDMED office:

Newborns - immediately

Children one month to three years of age - within 45 days

Children three to six years of age - within 60 days

Children six to 21 years of age - within 120 days

Periodicity Restrictions

Screenings must be performed on time at the ages shown on the periodicity schedule. For example, the screening due when the child is six months old must be performed after he or she has reached the age of six months, but before the seven-month birthday. The screening scheduled for three years of age must be performed between the child's third and fourth birthdays. In addition, the periodic screenings performed on children under two must be performed at least 30 days apart. Screenings performed after the child's second birthday must be at least six months apart. Claims submitted for KIDMED periodic screenings performed at an inappropriate time will not be paid.

Off-Schedule Screenings

If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring him or her up to date at the earliest possible time. **However, all screenings on children under two years of age must be at least 30 days apart, and those on children age two through six years of age must be at least six months apart.**

REQUIRED KIDMED MEDICAL, VISION, AND HEARING SCREENING COMPONENTS BY AGE OF RECIPIENT (EFFECTIVE APRIL 1, 1994)¹

AGE	BIRTH ²	BY 1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	2 YR	3 YR	4 YR	5 YR	6 YR	8 YR	10 YR	12 YR	14 YR	16 YR	18 YR	20 YR
MEDICAL SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
INITIAL/INTERVAL HISTORY	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS																					
Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X	X	X											
Blood Pressure											X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL ASSESSMENT	S	S	SO	S	S	S	SO	S	S	SO	SO	SO	SO	S	S	S	S	S	S	S	S
UNCLOTHED PHYSICAL EXAM/ASSESSMENT³	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PROCEDURES																					
Immunization ⁴	X		X	X	X		X	X				---	X	---				X	---		
Neonatal Screening ⁵	---	X																			
Anemia Screening ⁶						---	X	(X	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Urine Screening ⁷							(X	---	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Lead Risk Assessment ⁸					X	X	X	X	X	X	X	X	X								
Blood Lead Screening ⁹							X			X											
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEALTH EDUCATION¹⁰	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
VISION SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO
HEARING SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO

X = Required at visit for this age S = Subjective by history O = Objective by Medicaid – approved standard testing method
 --- = One test must be administered during this time frame

¹ Baseline lab and developmental screening must be done at the initial medical screening on all children under age six.

² The newborn screening examination at birth must occur prior to hospital discharge.

³ The physical examination/assessment must be unclothed or undraped and include all body systems.

⁴ The state health department immunization schedule must be followed per AAP recommendations.

⁵ If done less than 48 hours after birth, neonatal screening must be repeated.

⁶ Anemia screening is to be done once between 9 and 12 months or earlier if medically indicated, one year to four years, five years to 12 years, and between 13 and 20 years.

⁷ Urine testing (dipstick) is to be done once between one and four years, (as soon as toilet trained), five to 12 years, and between 13 and 20 years.

⁸ Anticipatory guidance and verbal risk assessment for lead must be done at every medical screening.

⁹ Screening beginning at six months corresponds to CDC guidelines. The frequency of screening using the blood lead test depends on the result of the verbal risk assessment.

¹⁰ Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 through 20, must receive more intensive health education which addresses psychological issues, emotional issues, substance usage, and reproductive health issues at each screening visit.

INTERPERIODIC SCREENINGS

Interperiodic screenings may be performed if medically necessary. Any parent, medical provider or qualified health, developmental, or educational professional that comes into contact with the child outside the formal health care system may request the interperiodic screening.

An interperiodic screening can only be billed if the recipient has received an age-appropriate medical screening. If their medical screening has not been performed, the provider should bill an age-appropriate medical screening. It is not acceptable to bill for an interperiodic screening if the age-appropriate medical screening had not been performed.

An interperiodic screening by a KIDMED provider must include all of the components required in the periodic screening. This includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education, and other age-appropriate procedures.

An Interperiodic screening may be performed and billed for a required Headstart physical or school sports physical but must include all of the components required in the periodic screening.

Providers should document in the recipient's records who requested the interperiodic screening, why it was requested, and the outcome of the screening. The concern, symptoms or condition that led to the request must be documented, as well as any diagnosis and/or referral resulting from the screening. Documentation must indicate that all components of the screening were completed.

There is no limit on the number or frequency of medically necessary interperiodic screenings, or on their proximity to other screenings. Therefore, documenting who requested the interperiodic screening, why it was requested, and the outcome of the screening is essential.

Medically necessary laboratory, radiology, or other procedures may also be performed and should be billed separately. **A well diagnosis is not required.**

These codes are billed hard copy on the CMS-1500 form or electronically using the 837P claim transaction and are listed on the following page. Completed hard copy examples are on pages 47 and 48.

Louisiana Medicaid reimbursement for a completed interperiodic medical screen is \$51.00. **

** Note: Reimbursement fees as of March 9, 2006 are current and subject to change.

Registered Nurse interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TD plus TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TD plus TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TD plus TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TD plus TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TD plus TS	Interperiodic Re-evaluation and Management (ages 18-21)

TD: To be used to report services provided by RN

TS: To be used to report interperiodic screenings

Physician interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TS	Interperiodic Re-evaluation and Management (ages 18-21)

TS: To be used to report interperiodic screening

DIAGNOSIS AND TREATMENT

One of the purposes of KIDMED screening services is to assure that health problems are found, diagnosed, and treated early before they become more serious and treatment more costly. KIDMED providers are responsible for identifying any general suspected conditions and reporting the presence, nature, and status of the suspected conditions. **Any referrals made for these conditions must also be reported and documented.**

Diagnosis

When a medical, vision, or hearing screening indicates the need for further diagnosis or evaluation of a child's health, the child must receive a complete diagnostic evaluation within 60 days of the screening.

An infant or toddler who meets or may meet the medical or biological eligibility criteria for EarlySteps (infant and toddler early intervention services) must be referred to the local System Point of Entry (SPOE) **within two working days of the screening.**

- ☞ EarlySteps is the responsibility of DHH/Office of Public Health. For further information on EarlySteps refer to the Appendix.

Initial Treatment

Medically necessary health care, initial treatment, or other measures needed to correct or ameliorate physical or mental illnesses or conditions discovered in a medical, vision, or hearing screening must be initiated **within 60 days of the screening.**

Providing or Referring Recipients for Services

KIDMED providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the patient for care without delay. Necessary referrals should be made at the time of screening if possible.

KIDMED providers performing diagnostic and/or initial treatment services should do so at the screening appointment when possible. Otherwise, KIDMED providers must ensure that recipients receive the necessary services within 60 days of the screening.

It is the provider's responsibility to discuss referral options with parents or guardians. You must forward necessary medical information to the 'referred-to' provider, and request from that provider a report of the results of the exam or services provided. This information should be maintained in the recipient's record.

You must follow up and verify that the child keeps the appointment and receives the services. This must be documented in the medical record. If the child missed the appointment, you must make at least two good faith efforts to re-schedule and have a process in place to document these efforts.

A sample referral follow up form (providers may develop their own) has been included in the Appendix for provider use.

Providers and recipients may contact ACS to obtain the names of participating Medicaid providers for referrals to any additional medical services:

KIDMED Hotlines:

CommunityCARE/KIDMED Hotline – ACS (800) 259-4444
Specialty Care Resource Line – (877) 455-9955
TTY Hotline for Hearing Impaired - (877) 544-9544

Referrals should not be limited to those services covered by Medicaid. For services Medicaid does not cover, KIDMED providers should attempt to locate other providers who furnish the services at little or no cost. Parents or guardians should be made aware of costs associated with services that Medicaid does not cover.

In-House Referral

If a suspected condition is identified and referred in-house (when a suspected condition is identified during the screening and is diagnosed/treated by the screening provider during the same visit), no office visit higher than 99212 is billable and payable to the same provider on the same date of service.

If any other level of office visit is billed by the same attending provider on the same day, the claim processed first (either the screening or the office visit) will pay, and the second claim will deny.

If an office visit higher than 99212 is billed in error on the same date of a screening (same recipient, same attending provider) and is paid, it will cause the screening claim to deny. The provider may adjust the office visit claim to procedure code 99211 or 99212 and then re-bill the screening claim.

Consultation Codes

Medical, vision, or hearing screening findings may indicate the need for counseling, consultation, or other intervention by ancillary personnel, including registered nurses, physician assistants, licensed social workers, and registered dietitians, beyond the basic health education and anticipatory guidance components of the medical screening. Services provided by these professionals are to be billed by an enrolled KIDMED provider certified to bill medical screenings. These services may be reimbursed by Medicaid if provided to prevent a specific health or mental health problem or condition, or to treat or alleviate an actual medical or mental health problem or condition.

- ☞ The child must have received an age-appropriate KIDMED screening in order for these services to be reimbursable.

Consultation codes are short term codes not designed with episodic or continuous therapy in mind. These codes allow payment for a service identified through the KIDMED screener, who continues to see and have access to the patient in an environment which is conducive to rendering the service, such as in a school, early intervention setting or in a physician's office where the physician serves as a continuing care provider.

KIDMED consult codes are to be specific to an individual child's needs. Documentation should be present justifying the need for the consult for that particular child. **Consult codes are not to be used for ongoing treatment.** Outcomes for the consults are to be documented as well as referrals to appropriate resources for those conditions that might require further attention.

- ☞ Consults are to be face-to-face contact in one-on-one sessions. Group sessions are not allowed. Multiple units may not be billed for the same contact.

KIDMED clinics which assume the role primarily as a screener should bill these codes infrequently. One screening provider should never refer to another screening provider for the provision of these services.

The following table identifies consultation procedure codes:

Procedure Code	Description	Fee
T1001	Nursing Assessment/Evaluation	\$13.71**
S9470	Nutritional Counseling, Dietitian Visit	\$13.71**
99211-AJ	Office or other Outpatient Visit for Evaluation and Management of an Established Patient, Minimal Problem(s)	\$13.71**

AJ = Social Worker

**** Note: Reimbursement fees as of March 9, 2006 are current and subject to change.**

Consultation Policy Reminders

- Procedure codes T1001, S9470, 99211-AJ **may not** be billed for preventive counseling, anticipatory guidance, or health education provided on the date of the medical screening by the same provider since these services are a component of the screening.
- Procedure codes T1001, S9470, 99211-AJ **may not** be billed on the same date that the same provider bills a physician's evaluation and management visit.
- The social worker (LCSW) consult code (99211-AJ) is not for treatment of mental illness or emotional disturbances. Ongoing therapy is payable by Louisiana Medicaid under the Mental Health Rehabilitation Program and appropriate referrals should be made.
- The KIDMED consultation codes are billed on the CMS 1500/837P.

WIC REFERRALS

WIC referrals and forms completion are a part of the KIDMED program. This is a federal requirement. Recipients should never be billed for these services. WIC referrals and forms completion occurring within 60 days of a KIDMED screening are considered part of the medical screening and should not be billed separately.

WIC referrals and forms completion occurring more than 60 days after a KIDMED screening may be billed as a nurse consult (T1001). This is because medical information to complete the form must be determined again since the information on the WIC referral form cannot be over 60 days old.

KM-3 INFORMATION

KM3 Form

The KM-3 form should be used when filing for Medicaid reimbursement of screening services provided under the Medicaid EPSDT KIDMED Program. **The screening services include the medical, vision, and hearing screening only.** KM-3 claim forms undergo preliminary processing before the adjudication cycle that results in claim denial or approval on the remittance advice. Once the claims have been entered into the KIDMED system, they are processed to check for errors and missing information. Certain claim errors cause a Resubmittal Turnaround Document (RTD) to be generated to the provider so that corrections may be made directly to the RTD and mailed back to Unisys. More information regarding RTDs can be found on pages 67-71.

Form Completion Reminders

- CPT codes 99381 – 99385 or 99391 – 99395 should be used for medical screenings. Please use the appropriate code to reflect the age of the child and whether or not the screening is an initial or periodic screening.
- Modifier TD should be used in conjunction with the appropriate CPT code to report that a screening was performed by a registered nurse.
- Vision screenings should be billed with CPT code 99173, with modifier -EP.
- Hearing screenings should be billed with CPT code 92551.
- The “Date of Screening” and the amount of the “Billed Charge” must be completed.
- **ONLY** Rural Health Clinics/Federally Qualified Health Centers should complete the “Encounter” block on the KM3 form.
- Item 29 (completeness of immunizations) must always be completed. If the answer is “no”, then item 30 must also be completed (please see claim example on page 26).
- Item 31 (suspected conditions) must always be completed. If the answer is “yes”, then item 32 must also be completed. If item 32 indicates anything other than undercare, then item 33 must be completed. There must be a referral for each suspected condition which is not undercare (see claim examples on pages 26 and 27).
- If the recipient is linked to a CommunityCARE PCP that is not the KIDMED provider performing the screening, it will be necessary to indicate the CommunityCARE provider that the recipient is linked to in item 9. This should only happen if the KIDMED provider performing the screening has a contractual arrangement with the CommunityCARE PCP. An example is shown on page 27.

If the KIDMED provider that the recipient is linked to for KIDMED services is unable to perform the screening and requests that another KIDMED provider perform the screening services for them, the KIDMED provider that has the recipient’s KIDMED linkage must forward a referral to the screening KIDMED provider.

REMINDER: Information on the claim form may be handwritten or computer generated. All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

KM3 Form Completion Instructions

Item No.	Description and Details
----------	-------------------------

- | | |
|----|--|
| 1. | <p>Type of claim - There are three choices in this box. Providers may choose only one, entering a checkmark as appropriate.</p> <ul style="list-style-type: none">• Check "original" if this is the original screening claim for this recipient for the service date indicated in item 25. If submitting an "original," skip directly to item 4.• Check "adjustment" if this claim adjusts a previously submitted claim for this recipient for the service date indicated in item 25.• Check "void" if this claim voids a claim already submitted for this recipient for the service date indicated in item 25. |
|----|--|

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

- | | |
|----|--|
| 2. | <p>Reason - If "adjustment" or "void" is indicated in item 1, providers must complete item 2 by entering the applicable two-digit code:</p> |
|----|--|

	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 recipient
	11	Void due to claim paid to the wrong provider

- | | |
|----|--|
| 3. | <p>Adjustment ICN - Complete this item only if Item 2 was completed. Enter the 13-digit Internal Control Number (ICN) as listed on the remittance advice for the original claim being adjusted or voided.</p> |
| 4. | <p>Billing Provider No. - Enter the provider's seven-digit KIDMED Medicaid Provider Number.</p> |
| 5. | <p>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, enter the name of the facility or agency.</p> |
| 6. | <p>Site Number – 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". Please communicate these requirements to your VBC (Software Vendor, Billing Agent or Clearing House) for updating billing software in preparation for future Medicaid program requirements.</p> |
| 7. | <p>Attend Provider No. – Complete this item only when the screening is provided by someone other than the billing provider. Enter the seven-digit Medicaid Provider I.D. Number of the provider who conducted the screening.</p> |

8. **Attend Provider Name – Complete** this item only if you completed item 7, entering up to 17 letters of the attending provider's name, starting with the last name first and using the same format that you used in item 5 above.
9. **Refer Provider No.** – Complete this item only if the recipient is linked to another KIDMED provider. Enter the CommunityCARE PCP's, or the KIDMED provider's, 7-digit Medicaid provider number.
10. **Medicaid No.** - Enter the recipient'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.
11. **Patient Last Name** - Enter the first 17 letters of the recipient'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 recipient'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 recipient, using the MMDDYY format so that all spaces are filled. The recipient must be under age 21 on the date of the screening. Do not leave any of the spaces blank.
14. **Sex** - This item is optional. Enter "M" for male or "F" for female.
15. **Race** - This item is optional. Enter one of the following codes:

Unknown	0	Hispanic or Latino	5
White	1	Native Hawaiian/ Pacific Islander	6
Black or African American	2	Hispanic/Latino and one or more	7
American Indian or Alaskan Native	3	More than one race (Hispanic or Latino not indicated)	8
Asian	4		
16. **Medical Record No.** - This item is optional. It may be used to cross-reference a patient's medical record number. Enter up to 18 alphabetical and/or numerical characters that have been assigned as the patient's medical record number.
17. **Patient Address** - This item is optional. Enter the recipient's street address or P.O. Box number, starting at the left of the block. Leave any unused spaces blank.
18. **City** - This item is optional. Enter up to nine letters of the city in which the recipient lives, starting at the left of the block. Leave any unused spaces blank.
19. **State** - This item is optional. Enter the commonly accepted postal abbreviation for the state ("LA" for Louisiana).
20. **Zip Code**- This item is optional. Enter the zip code for the recipient's address.

21. **Patient Home Phone** – Complete this item if the recipient has a home phone number or a contact phone number. Enter the three-digit area code and seven-digit home or contact phone number.
22. **Patient Work Phone** – Complete this item if the recipient has a work phone number. Enter the three-digit area code and seven-digit work phone number.
23. **Parent/Guardian Last Name** - This item must be completed for all recipients 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 recipient is not living with a parent or guardian, leave this item blank and skip to item 25.
24. **Parent/Guardian First Name** – Complete only if item 23 is completed. Enter 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 what type of provider performed the screening. It also documents the screening fee. In addition, it records information about future screenings scheduled.

Providers may bill for four types of screenings:

- **Medical Screening Nurse (99381-99385 and 99391-99395)** This is a medical screening where a registered nurse conducted the **complete unclothed physical exam** and other required age-appropriate medical screening components, including age-appropriate immunizations.

REMINDER: The above codes **MUST BE** billed with **modifier TD**, indicating that a registered nurse performed the screening.

- **Medical Screening Physician (99381-99385 and 99391-99395)** - 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.

☞ Providers must enter one or the other for a single medical screening, but not both. If both a physician and a registered nurse conducted the screening, the individual performing the physical exam or assessment should be entered.

- **Vision (99173-EP)** - This is an objective vision screening conducted by a licensed physician, physician assistant, registered nurse, licensed optometrist, or trained office staff under the supervision of one of the above listed licensed professionals. **No claim will be paid on a child under age four.**
- **Hearing (92551)** - This is an objective hearing screening conducted by a licensed physician, physician assistant, registered nurse, licensed and ASHA-certified audiologist, licensed and ASHA-certified speech pathologist, or trained office staff

under the supervision of one of the above listed licensed professionals. **No claim will be paid on a child under age four.**


*** Only Rural Health Clinics and Federally Qualified Health Centers should complete the block marked "Encounter". ALL other KIDMED providers should leave blank.**

Providers may bill for appropriately performed medical, objective vision, and/or objective hearing screenings on the same screening claim form in any combination.

- 25. Date of Screening** - For **each** applicable line, enter the date of the screening. For proper reimbursement, providers must date **each** screening type for which they are billing.
- 26. Billed Charge** - For **each** line completed in item 25, enter the appropriate charge for services rendered, using four digits for dollars and cents. For example, \$51.00 would be entered as "5100".
- 27. Next Screening Appointment Date** - If a future screening appointment has been scheduled, enter the six-digit appointment date for each applicable line. If no future appointments have been made at the time the claim form is completed, leave 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 must be completed for **medical screenings only**. Providers must certify whether the recipient's immunizations are complete and current for his or her age. Check "Yes" if immunizations are complete and current for this recipient. Check "No" if they are not. If "Yes" is indicated, skip to item 31.
- 30. Reason** - If providers indicate in item 29 that immunizations are not current and complete, they 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 recipient 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 immunizations were not given.
- 31. Presence or absence of suspected conditions** - This item is required and relates to screening findings. If no suspected conditions are found, check "no" and skip to item 36. If one or more suspected conditions are found, 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:
 - the recipient is already receiving care for the identified condition from any provider (**undercare**);
 - a referral was made **in-house** (when a suspected condition is identified during the screening and is diagnosed/treated by the screening provider during the same visit if possible or at a follow-up scheduled appointment to the screening provider for this suspected condition; includes self-referrals); or

- a referral was made **offsite** (to a provider other than the screening provider).

Complete this item by checking the appropriate boxes. For example, if a suspected medical condition was found for which the recipient is already under care by any provider, check the far left box on the first line. If a suspected nutritional condition is found and has been referred in-house/self-referred, check the far right column on the fifth line (E). If a suspected psychological/social condition is found and an outside referral is made, 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 that up to eight different kinds of information are entered in the spaces marked A, B, C, D, E, F, H, and I.

33-35. Referrals for Suspected Conditions - Providers 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 completed will depend on how many conditions were found in the screening and on the referrals made. If more than four suspected conditions are found, providers must fill out at least items 33 and 34. If more than eight suspected conditions are found, providers must fill out items 33 through 35. Also, one item must be completed 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," as this block is no longer used to obtain referral assistance. If assistance is needed from the Louisiana KIDMED office on finding a referral resource, contact ACS at (877) 455-9955.

33C. Appointment Date - If the recipient is referred 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 the recipient is referred 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 recipient, indicate so here.

33F. Referred To - If an in-house or offsite referral is made, enter up to 20 letters of the name of the specific provider to whom the recipient was referred, starting with the last name first. Be as specific as possible. For example, if the recipient was referred to a large facility, give the

name and department onsite. If self-referred, enter "self" for this item. Skip to item 36 if there is 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 an in-house or offsite referral has been made, enter the area code and seven-digit phone number of the referred-to provider. If a self-referral has been made, 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 in his region. These telephone numbers are listed in the Medicaid Services Chart.

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. If a claim form is received without a signature on it the claim form will not be processed and will be returned to the billing provider. A signature certifies that all components of the screening have been provided.

KM-3 claim forms should be mailed to:

**Unisys
P.O. Box 14849
Baton Rouge, LA 70898**

Completed KM-3 Examples

Example of a 6 year old child receiving medical screening by a nurse, vision, and hearing screening. Immunizations are current and no suspected conditions identified.

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. <input checked="" type="checkbox"/> ORIGINAL <input type="checkbox"/> ADJUSTMENT <input type="checkbox"/> VOID	2. REASON	3. ADJUSTMENT ICD
PRINT OR TYPE ONLY - USE BLACK INK		

ENCOUNTER

4. BILLING PROVIDER NO. 1234567	5. BILLING PROVIDER NAME Kids R Us	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
10. MEDICAID NO. 1234567891234	11. PATIENT LAST NAME Smith	12. PATIENT FIRST NAME Susie	13. DATE OF BIRTH 02 01 2000	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 Smith	24. FIRST NAME 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	IMMUNIZATIONS
MEDICAL SCREENING NURSE	99383	TD	4 14 06	51.00			29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
MEDICAL SCREENING PHYSICIAN							30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON: A. <input type="checkbox"/> MEDICALLY CONTRAINDICATED B. <input type="checkbox"/> PARENTAL REFUSAL C. <input type="checkbox"/> OFF SCHEDULE
VISION	99173	EP	4 14 06	4.00			
HEARING	92551		4 14 06	3.60			
ENCOUNTER (RHC/FQHC)							
TOTAL BILLED AMOUNT				58.60			

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

	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
E. REASON FOR REFERRAL			
F. REFERRED TO			
H. PHONE NO.		I. TRANSPORTATION ASSISTANCE NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

34. A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
E. REASON FOR REFERRAL			
F. REFERRED TO			
H. PHONE NO.		I. TRANSPORTATION ASSISTANCE NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

35. A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
E. REASON FOR REFERRAL			
F. REFERRED TO			
H. PHONE NO.		I. TRANSPORTATION ASSISTANCE NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENT'S 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 CONTRAINDICATED 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 THEREWITH.

Ima Biffer
36. SIGNATURE OF PROVIDER

04/16/06
37. DATE

02/03
KM-3

FISCAL AGENT COPY

Example of 6 year old child receiving medical screening by a nurse, vision and hearing screenings. Immunizations are not current (indicating reason why). Suspected medical condition and referral information included.

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. <input checked="" type="checkbox"/> ORIGINAL <input type="checkbox"/> ADJUSTMENT <input type="checkbox"/> VOID	2. REASON	3. ADJUSTMENT ICD
---	-----------	-------------------

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO. 1234567	5. BILLING PROVIDER NAME Kids R Us	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
10. MEDICAID NO. 1234567891234	11. PATIENT LAST NAME Smith	12. PATIENT FIRST NAME Susie	13. DATE OF BIRTH 02 01 2000	14. SEX F	15. RACE
16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE	
21. PATIENT HOME PHONE (225) 555 - 1212	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME Smith	24. FIRST NAME 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	99382	TD	4 14 06	51.00		
MEDICAL SCREENING PHYSICIAN						
VISION	99173	EP	4 14 06	4.00		
HEARING	92551		4 14 06	3.60		
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				58.60		

IMMUNIZATIONS 29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON: A. <input checked="" type="checkbox"/> MEDICALLY CONTRAINDICATED B. <input type="checkbox"/> PARENTAL REFUSAL C. <input type="checkbox"/> 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	
<input checked="" type="checkbox"/>	A. MEDICAL
<input type="checkbox"/>	B. VISION
<input type="checkbox"/>	C. HEARING
<input type="checkbox"/>	D. DENTAL
<input type="checkbox"/>	E. NUTRITIONAL
<input type="checkbox"/>	F. DEVELOPMENTAL
<input type="checkbox"/>	G. ABUSE/NEGLECT
<input type="checkbox"/>	H. PSYCHOLOGICAL/SOCIAL
<input type="checkbox"/>	I. SPEECH/LANGUAGE
<input type="checkbox"/>	J.
<input type="checkbox"/>	K.
<input type="checkbox"/>	L.

REFERRALS FOR SUSPECTED CONDITIONS

33. A. SUSPECTED COND. A	B. REFERRAL ASSIST NEEDED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	C. APPOINTMENT DATE (MONTH/DAY/YEAR) 4 20 06	D. TIME (HR:MIN) 9 00
E. REASON FOR REFERRAL GERD			
F. REFERRED TO Dr. Tim Smith		G.	
H. PHONE NO. 225 555 2111		I. TRANSPORTATION ASSISTANCE NEEDED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	

34. A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	

35. A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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 CONTRAINDICATED 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 THEREWITH.

02/03

KM-3

Ima Buller
36. SIGNATURE OF PROVIDER

04/16/06

37. DATE

FISCAL AGENT COPY

Example of a 2 year old child receiving medical screening by a physician. Immunizations are current. Suspected developmental condition identified and offsite referral information included.

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. <input checked="" type="checkbox"/> ORIGINAL <input type="checkbox"/> ADJUSTMENT <input type="checkbox"/> VOID	2. REASON	3. ADJUSTMENT ICD
---	-----------	-------------------

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO. 1234567	5. BILLING PROVIDER NAME Kids R Us	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO. 1111111
10. MEDICAID NO. 1234567891234	11. PATIENT LAST NAME Smith	12. PATIENT FIRST NAME Tara	13. DATE OF BIRTH 09 01 2003	14. SEX	15. RACE
16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE	
21. PATIENT HOME PHONE (225) 555 - 1212	22. PATIENT WORK PHONE () () () - () () ()	23. PARENT/GUARDIAN LAST NAME Smith	24. FIRST NAME Mary		
SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR
MEDICAL SCREENING NURSE					
MEDICAL SCREENING PHYSICIAN	99392		02 14 06	51.00	
VISION					
HEARING					
ENCOUNTER (RHC/FQHC)					
TOTAL BILLED AMOUNT				51.00	

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 CONTRAINDICATED
- 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

	A. MEDICAL
	B. VISION
	C. HEARING
	D. DENTAL
	E. NUTRITIONAL
<input checked="" type="checkbox"/>	F. DEVELOPMENTAL
	G. ABUSE/NEGLECT
	H. PSYCHOLOGICAL/SOCIAL
	I. SPEECH/LANGUAGE
	J.
	K.
	L.

REFERRALS FOR SUSPECTED CONDITIONS

33. A. SUSPECTED COND. F	B. REFERRAL ASSIST NEEDED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	C. APPOINTMENT DATE (MONTH/DAY/YEAR) 02 21 06	D. TIME (HR:MIN) 10 00
E. REASON FOR REFERRAL Speech delay			
F. REFERRED TO ABC Therapy		G.	
H. PHONE NO. (225) 555 - 8255		I. TRANSPORTATION ASSISTANCE NEEDED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
34. A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
35. A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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 CONTRAINDICATED 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 THEREWITH.

Tina Biffer
36. SIGNATURE OF PROVIDER

02/16/06
37. DATE

02/03
KM-3

FISCAL AGENT COPY

ADJUSTMENTS AND VOIDS ON THE KM-3 FORM

The KM-3 form can be used to adjust or void incorrect payments made on medical, vision or hearing screenings. Electronic submitters may electronically submit adjustment/void claims. An example of a correctly completed adjustment is shown on the following page.

ADJUSTING/VOIDING CLAIMS

The appropriate block for **adjustment** or **void** must be checked at the top of the KM-3. One of the following reason codes must be listed in Block 2 of the KM-3:

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

The most recently approved control number must be listed in Block 3 of the KM-3 form.

Only **one** (1) control number can be adjusted or voided on each KM-3 form.

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

Block 3 must contain the claim's most recently approved control number. For example:

1. A claim is approved on the remittance advice dated 10/04/2005, ICN 5266156789000.
2. The claim is adjusted on the remittance advice dated 02/07/2006, ICN 6035126742100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number, 6035126742100, must be used.

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 remittance advice. The original payment will be taken back on the same remittance advice. 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 remittance advice and a corrected claim may be submitted (if applicable).

KM-3 adjustment/voids should be mailed to the following address for processing:

**Unisys
P.O. Box 14849
Baton Rouge, LA 70898**

Completed KM-3 Example: Adjustment

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. <input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> ADJUSTMENT <input type="checkbox"/> VOID
2. REASON 02
3. ADJUSTMENT ICN 4000198765432
PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO. 1234567	5. BILLING PROVIDER NAME Kids R Us	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO. 1111111
10. MEDICAID NO. 1234567891234	11. PATIENT LAST NAME Smith	12. PATIENT FIRST NAME Tara	13. DATE OF BIRTH 09 01 2003	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
MEDICAL SCREENING NURSE	99392	TD	02 14 06	51.00	
MEDICAL SCREENING PHYSICIAN					
VISION					
HEARING					
ENCOUNTER (RHC/FQHC)					
TOTAL BILLED AMOUNT				51.00	

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	
<input type="checkbox"/>	A. MEDICAL
<input type="checkbox"/>	B. VISION
<input type="checkbox"/>	C. HEARING
<input type="checkbox"/>	D. DENTAL
<input type="checkbox"/>	E. NUTRITIONAL
<input checked="" type="checkbox"/>	F. DEVELOPMENTAL
<input type="checkbox"/>	G. ABUSE/NEGLECT
<input type="checkbox"/>	H. PSYCHOLOGICAL/SOCIAL
<input type="checkbox"/>	I. SPEECH/LANGUAGE
<input type="checkbox"/>	J.
<input type="checkbox"/>	K.
<input type="checkbox"/>	L.

REFERRALS FOR SUSPECTED CONDITIONS

33. A. SUSPECTED COND. **F** B. REFERRAL ASSIST NEEDED? ☐ Yes ☒ No C. APPOINTMENT DATE (MONTH/DAY/YEAR) **02 21 06** D. TIME (HR:MIN) **10 00**

E. REASON FOR REFERRAL
Speech delay

F. REFERRED TO **ABC Therapy** G.

H. PHONE NO. **(225) 555-8255** I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☒ NO

34. 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

35. 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 CONTRAINDICATED 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 THEREWITH.

02/03
KM-3

Ima Buller
36. SIGNATURE OF PROVIDER

04/16/06
37. DATE

FISCAL AGENT COPY

KM-3 FORM TIMELY FILING GUIDELINES

Unisys must receive initial KM-3 claim forms for screening services within 60 days from the date of service. Resubmissions must be received within 1 year and 60 days from the date of service and must be accompanied by proof of timely filing.

Proof Of Timely Filing

Acceptable forms of proof of timely filing are limited to the following:

- A remittance advice or a Claim Status Inquiry (CSI) screen print indicating that the claim was processed within 60 days from the date of service.

The following reports can suffice as proof of timely filing only if **detailed** information is indicated on the report. Refer to page 61 for additional information.

- KIDMED report CP-0-115 (Recycled Claims Listing)
- KIDMED report CP-0-50 (Denied Claims List)
- KIDMED report CP-0-50 (Resubmittal Turnaround Document)
- KIDMED report CP-0-51 (Electronic Media Claim Proof List)
- Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the recipient.

KIDMED/PREVENTIVE MEDICINE ELECTRONIC DATA INTERCHANGE (EDI) CLAIMS

HIPAA COMPLIANT TRANSACTIONS

HIPAA mandates that providers billing electronically utilize HIPAA standardized EDI specifications. The electronic HIPAA transaction accepted for billing KIDMED/preventive medicine claims is the 837P Professional format, including the K3 (KIDMED) segment.

Please communicate these requirements to your Vendor, Billing Agent, Clearinghouse (VBC), and let them know that the “file extension” on the electronic file MUST be KID, not PHY.

DHH Rule Requirements Regarding KIDMED Claims

As stated in the promulgated rule published in the *Louisiana Register*, Volume 30, No. 8, August 20, 2004;

- “All providers of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) preventative screening services shall be required to submit information to the Medicaid Program regarding recipient immunizations, referrals and health status.”

The information submitted on the KIDMED/preventative medicine claim, including the information regarding recipient immunization services provided, immunization status, suspected conditions and referral information related to suspected conditions is a federal reporting requirement.

Accurate data submission on KIDMED/preventative medicine claims, whether it is submitted by paper claim on the KM-3 or electronically using the 837P with the K-3 segment is imperative. The services provided during a KIDMED/preventative medical screen should be reflected on the claim. It is a misrepresentation of services provided when immunizations are provided, referrals are made and health status information is obtained, recorded in the patient record and not communicated on the KM-3 or K3 segment. **Misrepresentation of the services provided, specifically, immunizations, referrals for suspected conditions and health status, is considered a direct violation of the promulgated rule. All Medicaid claims are subject to post-payment review.**

KIDMED denial edit 517 (KIDMED Format Required – Claim must be submitted in KIDMED format) will be set if the KIDMED service provided was not billed hard copy on a KM-3 claim form or submitted electronically on the 837P with the K-3 segment and the KID file extension.

KIDMED denial edit 518 (KIDMED information missing – immunization and suspected condition information required) will be set if the required KIDMED claim detail information (including immunization status, suspected conditions, and referral information) is NOT provided on the claim.

KIDMED DETAIL INFORMATION WITHIN THE 837P TRANSACTION

The following information may be helpful in communicating these new requirements to your VBC.

Within the 837P transaction is the K3 claim segment which contains detailed information specifically related to the KIDMED screening services provided. Louisiana Medicaid uses the K3 segment to collect the information related to immunization status, suspected conditions and referral information. This segment mirrors what is currently collected on the KM-3 paper claim. As with previous electronic and paper submissions, providers must certify with each claim whether or not the recipient's immunizations are complete and current for his/her age.

The following information is required for each KIDMED claim and appears in the K3 segment once the claim is submitted to Louisiana Medicaid:

Immunization Status (Required Information)

Values in this segment are answered with Y (Yes) or N (No). If the status is N (No) then the following information is also required:

- A - if the immunizations are not complete due to medical contraindication;
- B - if the parent(s) or guardian(s) refuse to permit the immunization;
- C - if the patient is off schedule, having received an immunization at this visit but is still due one.

Screening Finding (Required Information) - Screening results must be reported as follows:

Field qualifier SC (Suspected Conditions)

Initially, this segment is answered with Y (Yes) or N (No). If the value is Y (Yes), additional information or type of suspected condition is required as follows:

A=Medical	D= Dental	G=Abuse/Neglect
B=Vision	E=Nutritional	H=Psychological/Social
C=Hearing	F=Developmental	I=Speech/Language

After each suspected condition is identified, the referral type is also required:

- U (if already under care)
- O (if referred offsite)
- I (if being treated in-house.)

At least one referral type must be entered. Up to three types of referrals may be entered for each condition if applicable.

NOTE 1: No more than four (4) suspected conditions may be entered. If more than four apply, enter the most significant based on medical judgment.

NOTE 2: Any of the nine (9) types of suspected conditions may be entered.

Referral Information (Suspected Conditions)

If a referral is indicated, referral information must be provided using appropriate values and data including:

Referral Number (R1)
Appointment Date
Referral Reason
Provider name
Referral Phone Number

If additional referrals have been given, give the required information for each additional referral, identifying the second referral with a qualifier R2 and the third referral with R3 if needed.

If the referral was made as a result of the EPSDT screening service, a Y (Yes) indicator is also required in the loop. If no suspected health conditions were identified and no referral resulted from the EPSDT screening service, enter N (No).

The referral outcome should be indicated as follows:

AV	Patient refused the referral.
S2	Patient is currently under care for the referred condition
ST	Patient was referred to another provider as a result of at least one suspected condition identified during the screening. (If several conditions apply as a result of a screening service, this value should take precedence.)

ELECTRONIC DATA INTERCHANGE (EDI)

Claims Submission

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

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

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

Certification Forms

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

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

Required Certification forms may be obtained from lamedicaid.com under the EDI Certification Notices and Forms HIPAA Information Center link. The required forms are also available in both the General EDI Companion Guide and the EMC Enrollment Packet.

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

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

Electronic Data Interchange (EDI) General Information

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

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

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

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

- Case Management services
- Non-Ambulance Transportation

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

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

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

Enrollment Requirements For EDI Submission

- **Submitters wishing to submit EDI 837 transactions without using a Third Party Biller** - complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS** (EMC Contract).
- **Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse** – complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS** (EMC Contract) **and** a Limited Power of Attorney.
- **Third Party Billers or Clearinghouses** (billers for multiple providers) are required to submit a completed HCFA 1513 – Disclosure of Ownership form and return it with a completed EMC Contract and a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Enrollment Requirements For 835 Electronic Remittance Advices

- All EMC billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EMC billers to download their remittance advices weekly.
- 835 Transactions may not contain all information printed on the hardcopy RA, ex. blood deductible, patient account number, etc.
- To request 835 Transactions – Electronic Remittance Advice, contact Unisys EMC Department at (225) 216-6000 ext. 2.

Electronic Adjustments/Voids

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

SUBMISSION DEADLINES

Regular Business Weeks

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

Thanksgiving Week

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

Important Reminders For EMC Submission

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

- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.
- The total amount of the submitted file must equal the amount indicated on the Unisys response file.
- **All claims submitted must meet timely filing guidelines.**

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) 838-5300.

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: <https://linksweb.oph.dhh.louisiana.gov>.

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) 838-5300.

IMMUNIZATIONS

- ☞ **COMBINATION VACCINES ARE ENCOURAGED IN ORDER TO MAXIMIZE THE OPPORTUNITY TO IMMUNIZE AND TO REDUCE THE NUMBER OF INJECTIONS A CHILD RECEIVES IN ONE DAY.**

A rule published in the Louisiana Register states: The Bureau of Health Services Financing does not reimburse providers for a single-antigen vaccine and its administration if a combined-antigen vaccine is medically appropriate and the combined vaccine is approved by the secretary of the United States Department of Health and Human Services. (*Louisiana Register, Volume 20, Number 3*)

Reimbursement

In order for providers to receive reimbursement for the administration of immunizations, providers must indicate the CPT code for the specific vaccine in addition to the appropriate administration CPT code(s). All vaccine CPT codes will be paid at zero (\$0) because the provider obtains the vaccine from the Vaccines for Children Program at no cost. The listing of the vaccine on the claim form is required for federal reporting purposes.

Billing For a Single Administration

Providers should bill CPT code 90471 (Immunization administration...one vaccine) when administering one immunization. The next line on the claim form must contain the specific CPT code for the vaccine, with \$0.00 in the “billed charges” column (see p. 49 for an example).

Billing For Multiple Administrations*

When administering more than one immunization, providers should bill as described above for the single administration. Procedure code 90472 (Immunization administration...each additional vaccine) should then be listed with the appropriate number of units for the additional vaccines placed in the “units” column. The specific vaccines should then be listed on subsequent lines. The number of specific vaccines listed after CPT code 90472 should match the number of units associated with CPT code 90472. An example of this scenario is on page 50.

*Hard Copy Claim Filing for Greater Than Four Administrations

When billing hard copy claims for more than four immunizations and the six-line claim form limit is exceeded, providers should bill on two CMS-1500 claim forms. The first claim should follow the instructions above for billing the single administration. A second CMS-1500 claim form should be used to bill the remaining immunizations as described above for billing multiple administrations. An example is shown on pages 51 and 52.

- ☞ **As of the date of this publication, Medicaid is in the process of updating the procedure files and claims processing programming to accommodate additional vaccine administration codes. Providers will be notified when these changes have been implemented.**

Pediatric Flu Vaccine: Special Situations

In the event a Medicaid provider does not have VFC pediatric influenza vaccine on hand to vaccinate a high priority VFC eligible Medicaid enrolled child, the provider should use pediatric influenza vaccine from private stock, if available. If a provider does use vaccine from private stock for a high priority VFC eligible Medicaid enrolled child, the provider would then replace dose(s) used from private stock with replacement dose(s) from VFC stock when VFC vaccine becomes available. The provider should not turn away, refer or reschedule a high priority VFC eligible Medicaid enrolled child for a later date if vaccine is available. Louisiana Medicaid will update Medicaid enrolled providers through Remittance Advices and Provider Updates regarding availability of vaccine through the VFC program and any billing issues. Please contact the Louisiana VFC Program office at (504)838-5300 for vaccine availability information.

The following chart lists vaccines for immunization services.

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
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, 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, (DTaP-Hib-IPV) for intramuscular use
90700 *	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP) for use in individuals younger than 7 years, 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

Billable Vaccine Codes	
Vaccine Code	Description
	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
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 or intramuscular use
90714*	Tetanus and diphtheria toxoids, (Td) absorbed, preservative free, for use in individuals seven years or older, for intramuscular use
90715*	Tetanus, diphtheria toxoids and acellular pertussis 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 (HepB-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

REMINDERS:

- Procedure code 90703 (Tetanus Toxoid for Trauma) will be payable at the rate of \$2.42, and it is not available through the VFC program.
- If the units for 90472 are greater than the actual vaccines reported for procedure code 90472, the units will be cutback to reflect the number of vaccines codes being reported.
- If the units for 90472 are less than the actual vaccines reported for procedure code 90472, the entire claim will be approved and paid appropriately (based on the information given on the claim form).

CMS-1500 FORM

- ☞ **Immunizations, laboratory tests, interperiodic screenings, consultations, and low level visits in conjunction with a KIDMED screening are billed on the CMS-1500 claim form.**

CMS-1500 claim forms should be mailed to the following address for processing:

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

- ☞ **Certain items on the CMS-1500 are mandatory, as indicated 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.

**Item
No.**

Description and details

1. Enter an "X" in the box marked Medicaid (Medicaid #).
 - 1a. ***Insured's ID Number** - Enter the recipient'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: If the 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 the REVS, MEVS, or e-MEVS eligibility systems.
3. **Patient's Birth Date and Sex** - Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, REVS, or e-MEVS using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.
4. **Insured's Name** - Leave blank.
5. **Patient's Address** - Leave blank.
6. **Patient Relationship to Insured** - Leave blank.
7. **Insured's Address** - Leave blank.

8. **Patient Status** - Leave blank.
9. **Other Insured's Name** - Leave blank.
 - 9a. **Other Insured's Policy or Population Number** - Leave Blank; unless the recipient has private insurance. In that case, indicate the 6-digit TPL carrier code assigned by Medicaid to that insurance company. Be sure to attach the EOB from the third party carrier to the claim.
 - 9b. **Other Insured's Date of Birth** - Leave blank.
 - 9c. **Employer's Name or School Name** - Leave blank.
 - 9d. **Insurance Plan Name or Program Name** - Leave blank.
10. **Was Condition Related To** - Leave blank.
11. **Insured Policy Population or FECA Number** - Leave blank.
 - 11a. **Insured's Date of Birth** - Leave blank.
 - 11b. **Employer's Name or School Name** - Leave blank.
 - 11c. **Insurance Plan Name or Program Name** - Leave blank.
12. **Patient's or Authorized Person's Signature** - Leave blank.
13. **Insured's or Authorized Person's Signature** - Leave blank.
14. **Date of Current Illness** - Leave blank.
15. **Date of Same or Similar Illness** - Leave blank.
16. **Dates Patient Unable to Work** - Leave blank.
17. **Name of Referring Physician or Other Source** - If services are performed by a nurse practitioner, 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** - If the recipient is linked to a PCP, the Primary Care Physician referral authorization number must be entered here. This information should be identical to item 9 on the KM3 form.
18. **Hospitalization Dates Related to Current Services** - Leave blank.
19. **Reserved for Local Use** - Leave blank.
20. **Outside Lab** - Leave blank.

21. ***Diagnosis or Nature of Illness or Injury** - 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 blank.
23. **Prior Authorization** - Leave blank.
- 24.
- 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 place of service code. Only 2 digit POS service codes are acceptable.
- 24C. **Type of Service** - Leave blank.
- 24D. ***Procedure Code** - Enter the procedures performed using the appropriate CPT code.
- 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 usual and customary charges for this service.
- 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.
- 24I. **EMG** - Leave blank.
- 24J. **COB** - Leave blank.
- 24K. **Reserved for Local Use** – Enter the attending provider number if group number is indicated in block 33.
25. **Federal Tax ID Number** - Leave blank.
26. **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 blank.
28. ***Total Charge** - Total 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. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the physician, therapist or authorized representative. **If this item is left blank, or if the stamped or computer-generated signature does has not been initialed in handwriting, 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 provider number must be entered in the space next to "GRP #." **If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.**

Example of: Interperiodic Screening Performed by a Nurse on a 7 year old child

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567891234				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Johnny					3. PATIENT'S BIRTH DATE MM DD YY 01 18 98		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street) CITY: _____ STATE: _____ ZIP CODE: _____ TELEPHONE (Include Area Code): _____					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY: _____ STATE: _____ ZIP CODE: _____ TELEPHONE (INCLUDE AREA CODE): _____		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER (TPL info here if applicable)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE		c. INSURANCE PLAN NAME OR PROGRAM NAME		
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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN PCP Auth# if applicable		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 314.0					22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.		
2. _____					23. PRIOR AUTHORIZATION NUMBER		24. A B C D E F G H I J K DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMO COB RESERVED FOR LOCAL USE		
3. _____					4. _____		5. _____		
6. _____					7. _____		8. _____		
9. _____					10. _____		11. _____		
12. _____					13. _____		14. _____		
15. _____					16. _____		17. _____		
18. _____					19. _____		20. _____		
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$
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.) Ima Biller 3/15/06					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 # Kids R Us 45 Oak St. Sunny, LA 70000 PIN# _____ GRP# 1111111		

(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

APPROVED OMB-0938-0008

PICA										HEALTH INSURANCE CLAIM FORM										PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567891234																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Johnny										3. PATIENT'S BIRTH DATE 01 18 98 SEX <input type="checkbox"/> M <input type="checkbox"/> F										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) CITY <input type="text"/> STATE <input type="text"/>										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) CITY <input type="text"/> STATE <input type="text"/>																			
ZIP CODE <input type="text"/> TELEPHONE (Include Area Code) <input type="text"/>										8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/>										ZIP CODE <input type="text"/> TELEPHONE (INCLUDE AREA CODE) <input type="text"/>																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL carrier code, if applicable										a. INSURED'S DATE OF BIRTH MM <input type="text"/> DD <input type="text"/> YY <input type="text"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYEE'S NAME OR SCHOOL NAME																			
b. WHEN INSURED'S DATE OF BIRTH MM <input type="text"/> DD <input type="text"/> YY <input type="text"/> M <input type="checkbox"/> F <input type="checkbox"/>										c. EMPLOYER'S NAME OR SCHOOL NAME										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? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
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: <input type="text"/> MM <input type="text"/> DD <input type="text"/> YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE <input type="text"/> MM <input type="text"/> DD <input type="text"/> YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <input type="text"/> MM <input type="text"/> DD <input type="text"/> YY TO <input type="text"/> MM <input type="text"/> DD <input type="text"/> YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN PCP Authorization #, if applicable										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <input type="text"/> MM <input type="text"/> DD <input type="text"/> YY TO <input type="text"/> MM <input type="text"/> DD <input type="text"/> YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES <input type="text"/>										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 3140 3. <input type="text"/> 4. <input type="text"/>																			
22. MEDICAID RESUBMISSION CODE <input type="text"/>										23. PRIOR AUTHORIZATION NUMBER <input type="text"/>										24. A B C D E F G H I J K DATE(S) OF SERVICE To Place of Type of PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMO COB RESERVED FOR LOCAL USE 1 3 03 06 3 03 06 11 99393 TS 1 51.00 1 1234567																			
25. FEDERAL TAX I.D. NUMBER <input type="text"/>										26. PATIENT'S ACCOUNT NO. <input type="text"/>										27. ACCEPT ASSIGNMENT? (for govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																			
28. TOTAL CHARGE \$ 51.00										29. AMOUNT PAID \$ <input type="text"/>										30. BALANCE DUE \$ 51.00																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Ima Biller										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 Kids' R Us 45 Oak St. Sunny, LA 70000 111111																			
SIGNED Ima Biller DATE 3/15/06										PIN# <input type="text"/>										GRP# <input type="text"/>																			

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWC-P-1500

Example of One Immunization Given

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APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM																																																																																																																						
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Henry, John					3. PATIENT'S BIRTH DATE 08 18 05 M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																	
5. PATIENT'S ADDRESS (No., Street) CITY _____ STATE _____ ZIP CODE _____ TELEPHONE (Include Area Code) _____					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>																																																																																																																	
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. V20.2 3. _____ 4. _____					22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____																																																																																																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="4">A. DATE(S) OF SERVICE</th> <th rowspan="2">B. Place of Service</th> <th rowspan="2">C. Type of Service</th> <th rowspan="2">D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/ICD-9-CM MODIFIER</th> <th rowspan="2">E. DIAGNOSIS CODE</th> <th rowspan="2">F. \$ CHARGES</th> <th rowspan="2">G. DAYS SPST OR UNITS</th> <th rowspan="2">H. Family Plan</th> <th rowspan="2">I. EMO</th> <th rowspan="2">J. COB</th> <th rowspan="2">K. RESERVED FOR LOCAL USE</th> </tr> <tr> <th>From MM DD YY</th> <th>To MM DD YY</th> <th>MM DD YY</th> <th>MM DD YY</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>3 07 06</td> <td>3 07 06</td> <td>11</td> <td></td> <td></td> <td>90471</td> <td>1</td> <td>9 45</td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td>1122334</td> </tr> <tr> <td>2</td> <td>3 07 06</td> <td>3 07 06</td> <td>11</td> <td></td> <td></td> <td>90707</td> <td>1</td> <td>0 00</td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td>1122334</td> </tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>											A. DATE(S) OF SERVICE				B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/ICD-9-CM MODIFIER	E. DIAGNOSIS CODE	F. \$ CHARGES	G. DAYS SPST OR UNITS	H. Family Plan	I. EMO	J. COB	K. RESERVED FOR LOCAL USE	From MM DD YY	To MM DD YY	MM DD YY	MM DD YY	1	3 07 06	3 07 06	11			90471	1	9 45	1					1122334	2	3 07 06	3 07 06	11			90707	1	0 00	1					1122334	3															4															5															6														
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(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/8/8)

PLEASE PRINT OR TYPE

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

Example of Four Immunizations Given

PLEASE
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APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM																																																																																																														
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 9752432916523																																																																																																									
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. V202					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																																																																																																									
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FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

Example of Five Immunizations Given (Page 1 of 2)

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HEALTH INSURANCE CLAIM FORM																			
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <div style="font-size: 1.2em;">Henry, John</div>					3. PATIENT'S BIRTH DATE <div style="font-size: 1.2em;">08/28/03</div>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
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ZIP CODE 					TELEPHONE (Include Area Code) () - () - ()					ZIP 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 <div style="font-size: 1.2em;">TPL carrier code, if applicable</div>					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M SEX F									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M SEX F					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>									
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN <div style="font-size: 1.2em;">PCP Authorization #, if applicable</div>									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> 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										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
2. _____										23. PRIOR AUTHORIZATION NUMBER									
3. _____										4. _____									
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 OF SERVICE OR UNITS										H DAYS OF SERVICE OR UNITS									
I Family Plan										J EMO									
K COB										L RESERVED FOR LOCAL USE									
1 03 07 06 03 07 06 11 90471 1 9 45 1 1122334										2 03 07 06 03 07 06 11 90713 1 0 00 1 1122334									
3										4									
5										6									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 9 45									
29. AMOUNT PAID \$										30. BALANCE DUE \$ 9 45									
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.) <div style="font-size: 1.2em;">Ima Biller</div>										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) <div style="font-size: 1.2em;">ABC Physician Clinic</div>									
DATE 3/15/06										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <div style="font-size: 1.2em;">New Hope, LA 70709</div>									
PIN#										GRP# 1111111									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/8/8)

PLEASE PRINT OR TYPE

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

Example of Five Immunizations Given (Page 2 of 2)

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM																																																																																																														
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 9752632916523																																																																																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Henry, John					3. PATIENT'S BIRTH DATE 08 28 03 M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																									
5. PATIENT'S ADDRESS (No., Street) CITY _____ STATE _____ ZIP CODE _____ TELEPHONE (Include Area Code) () _____					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL carrier code, if applicable					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																																									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME _____ d. INSURANCE PLAN NAME OR PROGRAM NAME _____					11. INSURED'S POLICY GROUP OR FECA NUMBER _____ a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME _____ c. INSURANCE PLAN NAME OR PROGRAM NAME _____																																																																																																									
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19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																																																																																																									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. V20.2					22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____																																																																																																									
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(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

213 ADJUSTMENT/VOID FORM

The 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 or at www.lamedicaid.com using the Forms/Files/User Guides link. An example of a correctly completed void form is shown on the following page.

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 of the Unisys 213 form must be completed with the claim's most recently approved control number and RA date. For example:

1. A claim is approved on the RA dated 01/03/2005, ICN 5000061223401.
2. The claim is adjusted on the RA dated 02/14/2005, ICN 5000367890100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (5000367890100) and RA date (02/14/2005) must be used.

Claims paid to the wrong provider or for the wrong recipient cannot be adjusted. They must be voided and the correct claims submitted.

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

Voids: To file a void, the provider must enter all the information from the original claim **exactly as it appeared on the original claim**. When the void claim is approved, it will be listed under the "void" column of the 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**

Example of Void

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. <input type="checkbox"/> VOID <input checked="" type="checkbox"/>	
PATIENT AND INSURED (SUBSCRIBER) INFORMATION	
2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) Jeffers, Kelly	3 PATIENT'S DATE OF BIRTH 06/11/89
4 MEDICAID ID NUMBER 1234567891234	5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
6 PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	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. TPL Carrier Code, if applicable	11 WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>	16 DATES OF PARTIAL DISABILITY FROM <input type="checkbox"/> THROUGH <input type="checkbox"/>
17 DATE PATIENT ABLE TO RETURN TO WORK 	18 DATES OF TOTAL DISABILITY FROM <input type="checkbox"/> THROUGH <input type="checkbox"/>
19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE CommunityCARE	20 REFERRING ID NUMBER Authorization # (if needed)
21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE) 	22 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED <input type="checkbox"/> DISCHARGED <input type="checkbox"/>
23 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE. V202	24 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES
25 A. DATE(S) OF SERVICE From <input type="checkbox"/> To <input type="checkbox"/> MM DD YY MM DD YY 03 09 06 03 09 06	26 ATTENDING NUMBER Attending provider number, if necessary
27 B. PLACE OF SERVICE 11	28 PRIOR AUTHORIZATION NO.
29 C. PROCEDURE 90471	30 D. DIAGNOSIS CODE 1
31 E. CHARGES 9 45	32 F. DAYS OR UNITS 1
33 G. EPSDT FAMILY PLAN 	34 TPL \$ TPL amt if any

35 CONTROL NUMBER 6076156789501	36 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID 3/29/06
37 REASONS FOR ADJUSTMENT <input type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY <input type="checkbox"/> 02 PROVIDER CORRECTIONS <input type="checkbox"/> 03 FISCAL AGENT ERROR <input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN	
38 REASONS FOR VOID <input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT <input checked="" type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN Billed claim in error	

39 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.) Ima Biller	40 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE Kids R Us 23456 Laurel Dr. Sunny, LA 71333 Provider #111111
41 YOUR PATIENT'S ACCOUNT NUMBER 	

FISCAL AGENT COPY

UNISYS - 213
5/97

CMS 1500 TIMELY FILING GUIDELINES

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

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

Dates of Service Past Initial Filing Limit

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

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

OR

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

OR

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

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

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

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

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

Submitting Claims for Two-Year Override Consideration

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

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

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

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

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

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

KIDMED REPORTS

Linkage And Screening Reports

EP-0-10 - New Recipient And Missed Screen List

- Lists newly linked recipients and the last day on which an initial screening may be scheduled
- Indicates missed appointment dates (based on lack of paid claim for the appointment date)
- Allows providers to request that KIDMED remind recipients of screening appointments, if desired
- Provided weekly by Unisys Corporation

EP-0-21 - Provider Schedule List

- Lists recipients who have appointments in the coming week and appointment date and time
- Allows providers to report whether screenings were actually performed, the reason why they were not kept, and the new appointment date and time if one has been rescheduled
- Provided weekly by Unisys Corporation (based on information given by the provider)

RS-0-07 - Screening And Provider Beneficiary Report

- Lists all recipients linked to the provider along with the effective date of linkage
- Indicates last screening date for recipients based on paid screening claims on file
- Shows the next screening period, during which next screening should be scheduled, as well as recipients requiring initial screening
- Allows providers to request that KIDMED remind recipients of screening appointments, if desired
- Located on the website www.lamedicaid.com
 - **RS-0-07 reports are loaded monthly on the www.lamedicaid.com website. These reports remain on the site for 2 months to allow providers to access the current and the previous months' reports. Effective March 1, 2005, requests for reports to be reprinted hardcopy will not be honored. Please ensure that you have procedures in place to retrieve these reports as needed.**

If any of these reports are used as a turnaround document for scheduling appointments, they should be returned to the KIDMED office at:

**ACS
5700 Florida Blvd., 13th Floor
Baton Rouge, LA 70806**

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
NEW RECIPIENT AND MISSED SCREEN LIST

EPW010
RUN: 08/07/05 03:12:04
CYCLE: 08/07/05

PROVIDER ID NO.	PROVIDER SITE NO.	PROVIDER NAME	MAILING ADDRESS	SEX	D.O.B. MM/DD/YY	TELEPHONE NUMBER(S)	LOCN	T Y	NEW BENEFICIARY OR MISSED APPOINTMENT	INITIAL SCREENING DUE/MISSED APPT DATE MM/DD/YY	APPT. DATE AND TIME GIVEN BENEFICIARY DATE / TIME
62	001	NEW IBERIA LA 70563-0000		M	05/23/89	337 276- 337 338- 337 276-	H R T	P E H	NEW BENEF	12/01/05	± ± ±
70											

TOTAL RECIPIENTS FOR ABOVE PROVIDER: 1

EPW021
 RUN: 08/07/05 03:02:49
 CYCLE: 08/06/05

MEDICAID COMMUNITYCARE/KIDMED SUBSYSTEM
 DEPARTMENT OF HEALTH AND HOSPITALS
 PROVIDER SCHEDULE LIST

REPORT NO: EP-0-21
 PAGE NO: 1

PROVIDER ID NO.	PROVIDER SITE NO.	PROVIDER	MEDICAID ID	BENEFICIARY NAME	MAILING ADDRESS	SEX	D.O.B. MM/DD/YY	TELEPHONE NUMBER(S)	LOCN	T	P	APPOINTMENT DATE & TIME MM/DD/YY	SCREENING PERFORMED YES/NO IF NO, REASON	RESCHEDULED APPT. DATE AND TIME GIVEN BENEFICIARY DATE / TIME
SHREVEPORT LA 71118-0000			44-	1-80		M	10/05/01			M		08/15/05 09:15	Y N R	± ± ±
DETHANY LA 71007-0000			92-	-62		F	10/05/01	318 773	T	M		08/15/05 09:15	Y N R	± ± ±
JULIANT LA 71007-0000			39-	-35		F	09/17/03	318 872	H	M		08/15/05 10:00	Y N R	± ± ±
LA 71419-0000			85-	3-35		F	03/18/92			M		08/15/05 14:30	Y N R	± ± ±
NEW ORLEANS LA 70126-0000			68-	3-48		F	10/12/86	504 241	T	M		08/15/05 15:00	Y N R	± ± ±
SHREVEPORT LA 71118-0000			61-	-29		M	12/12/87	318 671	T	M		08/15/05 15:30	Y N R	± ± ±
SHREVEPORT LA 71118-0000								318 671	T	M				± ± ±

REASON CODES: F=FORGOT APPT, R=REFUSED SERVICE, S=SICK, T=NO TRANSPORTATION, U=UNABLE TO FIND, X=FAILED TO SHOW, K=KEPT, Q=MISSED OTHER

REPORT NO: RS-0-07
PAGE NO: 2

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
SCREENING PROVIDER BENEFICIARY REPORT
BASED ON SCREENING CLAIMS PAID

RSMO18
RUN: 07/26/05 20:44:28
MONTH: AUGUST, 2005

PROVIDER ID NO. PROVIDER SITE NO.
001

MEDICAID ID/ LINKAGE BEGIN DATE MM/DD/YY	BENEFICIARY NAME	PROVIDER	SEX	D.O.B. MM/DD/YY	TELEPHONE NUMBER(S)	LOCN	LAST DATE SCREENED MM/DD/YY	NEXT SCREENING PERIOD MM/DD/YY	APPOINTMENT DATE AND TIME GIVEN BENEFICIARY DATE / TIME
			F				H M 01/04/05 R V - INITIAL SCREEN REQUIRED -	(07/04/05-06/26/06)	± / ± / ±
			M				H M 06/04/97 V 10/01/04 H 10/01/04	(08/28/97-11/27/97) (08/28/06-08/27/08) (08/28/06-08/27/08)	± / ± / ±
							H M 10/02/02 V - INITIAL SCREEN REQUIRED -	(10/02/03-10/01/04)	± / ± / ±
			M				H M 06/17/05 X V H	(07/17/05-08/16/05) (06/01/09-05/31/10) (06/01/09-05/31/10)	± / ± / ±
			M				H M 11/24/04 R V H	(05/24/05-05/08/06) (05/09/06-05/08/07) (05/09/06-05/08/07)	± / ± / ±
			M 1C				H M 11/23/04 R V H	(04/22/05-10/21/05) (10/22/07-10/21/08) (10/22/07-10/21/08)	± / ± / ±
			F				H M 05/12/03 R V 05/12/03 H 05/12/03	(03/25/05-03/24/07) (03/25/05-03/24/07) (03/25/05-03/24/07)	± / ± / ±
			M				H M 11/17/03 V 10/21/04 H 10/21/04	(11/17/05-11/16/07) (11/17/05-11/16/07) (11/17/05-11/16/07)	± / ± / ±

* SIGNIFIES THAT THIS RECIPIENT IS ON THE REPORT FOR THE FIRST TIME THIS MONTH.
** SIGNIFIES THAT THIS RECIPIENT IS ON THE REPORT FOR THE LAST TIME THIS MONTH.

CLAIM RELATED REPORTS

CNTL-D010 - Direct Biller Process Summary

- Informs electronic biller whether or not input was accepted (in which case the range of CCNs assigned to individual claims will be displayed) or rejected (which requires the biller to resubmit input).
- **Cannot serve as proof of timely filing, as no specific claim data is displayed.**

CP-0-51 - Electronic Media Claim Proof List

- Displays in summary the CCN range assigned to individual claims which were accepted through electronic transmission.
- Displays in detail the CCN and specific claim data transmitted within each claim line of the transmission.
- **Can serve as proof of timely filing.**

CP-0-115 - Recycled Claims Listing

- Informs provider that certain claims have “pended” for errors encountered within the processing cycle and are being recycled in case recipient eligibility files are updated.
- **Can serve as proof of timely filing.**

CP-0-50 - Resubmittal Turnaround Document (RTD)

- Informs provider of errors encountered in processing KM-3 claim form.
- Allows provider to correct errors and return RTD by specified date.
- **Can serve as proof of timely filing if provider number, recipient name or number, procedure, and date of service are present and correct.**
- Instructions on proper completion of RTD are found on pages 67 - 69.

CP-0-50 - Denied Claims List

- Informs provider of KM-3 claim denial and errors encountered in processing.
- If errors are correctable, serves as prompt to resubmit corrected KM-3.
- **Can be used as proof of timely filing.**

Examples of the above reports are shown on the following pages.

CPD010
RUN: 08/05/05 15:52:51
CYCLE: 08/05/05

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
DIRECT BILLER PROCESS SUMMARY

REPORT NO: CNTL-D010
PAGE NO: 1

SUBMITTER NAME: DATE OF DATA: 08/01/2005 MODEM-TO-MODEM 000001 5217

BILLER ID:	FROM CCN: 52	01	THRU CCN: 52	701	BILLED CHARGES:	\$7,309.08
PROVIDER ID:	FROM CCN: 52	01	THRU CCN: 52	01	BILLED CHARGES:	\$7,309.08

RECORDS READ: 662
RECORDS WRITTEN: 212
DOCUMENTS WRITTEN: 138

***** END - OF - REPORT *****

CPO010
RUN: 08/05/05 15:52:51
CYCLE: 08/05/05

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
ELECTRONIC MEDIA CLAIM PROOF LIST

REPORT NO: CP-0-51
PAGE NO: 1

SUBMITTER NAME :

DATE OF DATA: 08/01/2005

MODEM-TO-MODEM 000001 5217

CCN	PROVIDER NUMBER	SITE NO	RECIPIENT MEDICAID ID	RECIP NAME	MEDICAL RECORD NUMBER	SCREENING TYPE	SCREEN DATE	BILLED CHARGE	NEXT APPT DATE	NEXT APPT TIME	IMMUN CURR	SUSP COND
						MED - PHYS	07/20/2005	51.00	00/00/0000	00:00	Y	N
						MED - PHYS	07/18/2005	51.00	00/00/0000	00:00	Y	N
						MED - PHYS	07/19/2005	51.00	00/00/0000	00:00	Y	N
						MED - PHYS	06/07/2005	51.00	00/00/0000	00:00	Y	N
						MED - PHYS	07/21/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/21/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/21/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/18/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/18/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/18/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/22/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/22/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/22/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/20/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/20/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/20/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/20/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/20/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/20/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/20/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/21/2005	51.00	00/00/0000	00:00	Y	N
						HEARING	07/21/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	08/01/2005	51.00	00/00/0000	00:00	Y	N
						VISION	08/01/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	08/01/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/19/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/19/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/19/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/20/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/20/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/20/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/21/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/21/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/21/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	08/01/2005	51.00	00/00/0000	00:00	Y	N
						VISION	08/01/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	08/01/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/19/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/19/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/19/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/20/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/20/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/20/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/21/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/21/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/21/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	08/01/2005	51.00	00/00/0000	00:00	Y	N
						VISION	08/01/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	08/01/2005	3.60	00/00/0000	00:00	Y	N
						MED - PHYS	07/22/2005	51.00	00/00/0000	00:00	Y	N
						VISION	07/22/2005	3.72	00/00/0000	00:00	Y	N
						HEARING	07/22/2005	3.60	00/00/0000	00:00	Y	N

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
RECYCLED CLAIMS LISTING

RUN: 08/05/05
CYCLE: 08/05/05

014 * MEDICAID NUMBER NOT ON FILE
015 * RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE
017 * PATIENT LAST NAME/MEDICAID NUMBER MISMATCH
019 * PATIENT FIRST NAME/MEDICAID NUMBER MISMATCH

BILLING PROV NO	SITE NO	CCN	MEDICAID NO	PATIENT NAME	DATE OF SCREENING	ERROR 1	ERROR 2	ERROR 3	ERROR 4	ERROR 5	FIRST PEND DATE	TOTAL
001	001	5217	01 67	3073 WILLA A	08/03/2005	017					08/05/2005	1
												1

REPORT NO: CP-0-50
RPT PAGE NO: 2
PAGE NO: 2

RECIPIENT MEDICAID ID	RECIPIENT LAST NAME	RECIPIENT FIRST NAME	MEDICAL RECORD NUMBER	SITE NO	CCN	CLAIM TYPE MODIFIER	SCREENING TYPE	SCREEN DATE	STATUS	ERROR CODE
				001		ORIGINAL	MED - PHYS	07/21/2005	DENIED	068

ERROR CODE	DESCRIPTION
0000	NO ERROR
0001	INVALID COMMAND
0002	INVALID PARAMETER
0003	INVALID FILE NAME
0004	INVALID DIRECTORY NAME
0005	INVALID MODE
0006	INVALID OPERATION
0007	INVALID PERMISSION
0008	INVALID USER
0009	INVALID GROUP
0010	INVALID PATH
0011	INVALID SIZE
0012	INVALID TYPE
0013	INVALID VALUE
0014	INVALID FORMAT
0015	INVALID LANGUAGE
0016	INVALID COUNTRY
0017	INVALID TIMEZONE
0018	INVALID DATE
0019	INVALID TIME
0020	INVALID WEEKDAY
0021	INVALID MONTH
0022	INVALID YEAR
0023	INVALID DAY
0024	INVALID HOUR
0025	INVALID MINUTE
0026	INVALID SECOND
0027	INVALID MILLISECOND
0028	INVALID MICROSECOND
0029	INVALID NANSECOND
0030	INVALID PICOSECOND
0031	INVALID FEMTOSECOND
0032	INVALID ATTOSECOND
0033	INVALID ZEPTOSECOND
0034	INVALID YOKTOSECOND
0035	INVALID XENONSECOND
0036	INVALID UNKOWNSECOND
0037	INVALID UNIT
0038	INVALID PREFIX
0039	INVALID SUFFIX
0040	INVALID SYMBOL
0041	INVALID CHARACTER
0042	INVALID STRING
0043	INVALID NUMBER
0044	INVALID EXPONENT
0045	INVALID BASE
0046	INVALID OPERATOR
0047	INVALID PRECEDENCE
0048	INVALID PRIORITY
0049	INVALID ASSOCIATIVITY
0050	INVALID IDENTITY
0051	INVALID INVERSE
0052	INVALID NEUTRAL
0053	INVALID ABSORBTION
0054	INVALID IDEMPOTENCY
0055	INVALID COMMUTATIVITY
0056	INVALID ASSOCIATIVITY
0057	INVALID DISTRIBUTIVITY
0058	INVALID DECOMPOSITION
0059	INVALID REDUCTION
0060	INVALID SIMPLIFICATION
0061	INVALID TRANSFORMATION
0062	INVALID SUBSTITUTION
0063	INVALID EVALUATION
0064	INVALID COMPUTATION
0065	INVALID EXECUTION
0066	INVALID OPERATION
0067	INVALID ACTION
0068	INVALID EVENT
0069	INVALID STATE
0070	INVALID TRANSITION
0071	INVALID BEHAVIOR
0072	INVALID PROPERTY
0073	INVALID INvariant
0074	INVALID SAFETY
0075	INVALID Liveness
0076	INVALID Reachability
0077	INVALID Connectivity
0078	INVALID Accessibility
0079	INVALID Visibility
0080	INVALID Audibility
0081	INVALID Detectability
0082	INVALID Identifiability
0083	INVALID Recognizability
0084	INVALID Understandability
0085	INVALID Interpretability
0086	INVALID Communicability
0087	INVALID Interactability
0088	INVALID Relatability
0089	INVALID Associability
0090	INVALID Comparability
0091	INVALID Measurability
0092	INVALID Quantifiability
0093	INVALID Estimability
0094	INVALID Calculability
0095	INVALID Computability
0096	INVALID Executability
0097	INVALID Operability
0098	INVALID Usability
0099	INVALID Feasibility
0100	INVALID Viability
0101	INVALID Habitability
0102	INVALID Inhabitability
0103	INVALID Occupiability
0104	INVALID Resideability
0105	INVALID Liveability
0106	INVALID Thrivability
0107	INVALID Flourishability
0108	INVALID Prosperability
0109	INVALID Wellbeing
0110	INVALID Welfare
0111	INVALID Happiness
0112	INVALID Joy
0113	INVALID Pleasure
0114	INVALID Delight
0115	INVALID Ecstasy
0116	INVALID Bliss
0117	INVALID Euphoria
0118	INVALID Ecstacy
0119	INVALID Rapture
0120	INVALID Trance
0121	INVALID Zen
0122	INVALID Enlightenment
0123	INVALID Awakening
0124	INVALID Realization
0125	INVALID Understanding
0126	INVALID Knowledge
0127	INVALID Wisdom
0128	INVALID Insight
0129	INVALID Intuition
0130	INVALID Instinct
0131	INVALID Feeling
0132	INVALID Emotion
0133	INVALID Sentiment
0134	INVALID Mood
0135	INVALID Temperament
0136	INVALID Personality
0137	INVALID Character
0138	INVALID Nature
0139	INVALID Essence
0140	INVALID Core
0141	INVALID Heart
0142	INVALID Soul
0143	INVALID Spirit
0144	INVALID Mind
0145	INVALID Intellect
0146	INVALID Reason
0147	INVALID Logic
0148	INVALID Philosophy
0149	INVALID Ideology
0150	INVALID Belief
0151	INVALID Faith
0152	INVALID Trust
0153	INVALID Confidence
0154	INVALID Assurance
0155	INVALID Certainty
0156	INVALID

BILLING PROVIDER IS NOT THE DESIGNATED PROVIDER OF RECORD

REPORT NO: CP-Q-50
RPT PAGE NO: 6
PAGE NO: 2

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
DENIED CLAIMS LIST

CPW400
RUN: 07/18/01 15:51:38
CYCLE: 07/18/01

PROVIDER: 9127
SITE: 001

RECIPIENT MEDICAID ID	RECIPIENT LAST NAME	RECIPIENT FIRST NAME	MEDICAL RECORD NUMBER	SITE NO	CCN	CLAIM TYPE MODIFIER	SCREENING TYPE	SCREEN DATE	STATUS	ERROR CODE
21 1204 701	LIN	E	454	001	11 100 0401	ORIGINAL	MED - NURSE	07/11/2001	DENIED	068
33 0023 401	ALI	N	116	001	11 100 1801	ORIGINAL	MED - NURSE	07/09/2001	DENIED	043
33 0023 401	ALI	N	116	001	11 100 1901	ORIGINAL	VISION	07/09/2001	DENIED	030
33 0023 401	ALI	N	116	001	11 100 2001	ORIGINAL	HEARING	07/09/2001	DENIED	030
36 2780 701	ORG	J	725	001	11 100 3501	ORIGINAL	MED - NURSE	07/11/2001	DENIED	068
65 0362 301	ART	G	113	001	11 100 3901	ORIGINAL	MED - NURSE	07/16/2001	DENIED	068
65 2355 102	ITT	M	145	001	11 100 2901	ORIGINAL	MED - NURSE	07/11/2001	DENIED	068

ERROR CODE	ERROR CODE DESCRIPTION	NUMBER OF OCCURRENCES
030	SUSPECTED CONDITIONS ARE MISSING AND REQUIRED	2
043	SUSPECTED CONDITION MISSING AND REQUIRED FOR REFERRAL #1	1
068	BILLING PROVIDER IS NOT THE DESIGNATED PROVIDER OF RECORD	4

CP-0-50 RESUBMITTAL TURNAROUND DOCUMENTS

When KM-3 claim forms are processed, errors that are detected may result in the claim denying. However, certain errors do not cause denial but rather cause the claim to pend, enabling the provider to correct it without having to resubmit a new KM-3. Generally in these cases the erroneous claim causes a resubmittal turnaround document (RTD) to be generated and mailed by Unisys to the provider. (see example on pages 70 and 71)

The RTD can be used to correct certain errors made in completing the KM-3 form. For providers who submit their claims hardcopy, it is normally much easier to make needed corrections on the RTDs and return them, as opposed to completing entirely new KM-3 claim forms containing the correct information. Providers who submit KIDMED claims electronically may either submit corrected RTDs or they may resubmit the corrected claim electronically. There is an expiration date shown on the RTD by which the RTD must be corrected and returned to Unisys. If the RTD is not returned by the deadline, the claim will be denied and would have to be resubmitted as a corrected claim.

Each RTD lists specific information regarding the error(s) made on the KM-3 submission. The information on the original KM-3 is reflected on the RTD, and the fields on the RTD correspond to those on the KM-3 claim form. Completion requirements for the RTD parallel those of the KM-3 (e.g., a particular response in one item may require that the next item must be completed). The RTD indicates the error or omission so that it can be corrected.

Most of the errors that result in RTDs are easily understood and corrected. If needed information is missing, it can be written in on the RTD. If information shown on the RTD is incorrect, it can be lined through to delete it, or it can be lined through and the correct information written below it to make the correction. Following are instructions for correcting the RTD for the errors that seem to be most common. In addition, this information can be used to determine the cause of denials and the steps to correcting them.

Eligibility Errors – Denial Codes 013 – 019

Items 10 – 12 of the KM-3 and the RTD must be completed and must match the information on the Medicaid recipient eligibility files. Normally the Medicaid recipient eligibility files match the information you receive on the RS-0-07 report. Occasionally providers will receive eligibility denials because they are using an old Medicaid number on their files instead of the recipient ID number on the RS-0-07. In addition, errors can be caused by incomplete Medicaid ID numbers, transposing numbers within the Medicaid ID number, using part of the card control number from the Medicaid ID card rather than the 13-digit Medicaid ID number, and using the ID number for one sibling with the name of another.

Items to look for on the RTD:

- 10. Medicaid No.** - Enter the recipient'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.

11. Patient Last Name - Enter the first 17 letters of the recipient's last name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility system. The name should also appear on the recipient's current Medicaid eligibility card. If the name has less than 17 letters, leave the remaining spaces blank.

12. Patient First Name - Enter up to 12 letters of the recipient's first name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility system. The name should also appear on the recipient's current Medicaid eligibility card. If the name has less than 12 letters, leave the remaining spaces blank.

Screening Date And Billed Charges – Denial Codes 023 – 024

Items 25 and 26 should reflect the date of the screening and the charge for it. If these items are inadvertently omitted or are only partially completed, the claim will deny. These items can easily be completed or corrected on the RTD.

Items to look for on the RTD:

25. Date of Screening - For **each** applicable line, enter the date of the screening. For proper reimbursement, the provider must date each screening type that is being billed.

26. Billed Charge - For **each** line completed in item 25, enter the appropriate charge for services rendered, using four digits for dollars and cents. For example, \$51.00 would be entered as "5100."

Immunization Status – Denial Codes 025 – 027

Item 29 must contain a response. If the response is that immunizations are not complete and up-to-date, item 30 must be completed.

Items to look for on the RTD:

29. Immunization Status - Enter "Y" if immunizations are complete (items 30A – 30C should contain neither "Y" nor "N"). Enter "N" if they are not and enter Y in one of 30A – 30C (whichever is appropriate) to indicate why immunizations are not complete.

Suspected Conditions And Referrals – Denial Codes 028 – 066

Item 31 must contain a response. If the response is that there are suspected conditions, item 32 must be completed. If item 32 indicates any condition other than undercare, at least one referral must be entered in items 33-35.

Items to look for on the RTD:

31. Suspected Conditions - Enter N if there are no suspected conditions (make sure there are no suspected conditions indicated in 32). Enter "Y" if there are suspected conditions and specify them in 32. In item 32, suspected conditions are noted with "U" (undercare), "O" (off-site referral), or "I" (in-house referral). Mark an "X" in the corresponding blank to indicate the type of condition suspected.

- 32. Referrals** - If there are no suspected conditions, or if the conditions are all undercare, this section should have no information entered. Otherwise, items 33A, 34A, and 35A may be completed only with letters A – I signifying which suspected condition the referral is for. **DO NOT enter an ICD-9 diagnosis code or diagnosis abbreviation (e.g., “URI”) here, that information should be entered in 33E, 34E, and 35E.** The other items in this section are self-explanatory.

CPH400
 RUN: 07/18/01 16:51:38
 CYCLE: 07/18/01

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
 DEPARTMENT OF HEALTH AND HOSPITALS
 RESUBMITTAL TURNAROUND DOCUMENT

REPORT NO: CP-0-50
 RPT PAGE NO: 9
 PAGE NO: 3

PROVIDER: 9 20

CCN: 1043000602801

1. CLAIM TYPE: ORIGINAL		2. REASON:		3. ADJUSTMENT ICH: 00000000000000	
4. BILLING PROVIDER NO: 94 20	6. SITE NO: 001	7. ATTENDING PROVIDER NO: 0000000	9. REFERRING PROVIDER NO: 0000000		
10. MEDICAID NO: 2 40 145 3	11. PAT LAST NAME: WASHI	12. PAT FIRST NAME: D	13. DOB: 02 /2000		
16. MED REC NO:	RECIPIENT NAME ON FILE: HAS NG SHA S				
21. PAT HOME #: (504) 868-1875	22. PAT WORK #: (000) 000-0000	23. PARENT/GUARDIAN LAST NAME: HIN TON	24. FIRST NAME: TO KA		

SCRN TYPE	25. DATE OF SCREEN: 02/07/2001	26. BILLED CHG: 51.00	27. NEXT APPT DATE: 00/00/0000	28. TIME: 00:00	29. ARE IMMUNIZATION COMPLETE AND CURRENT FOR THIS AGE PATIENT: N
MED/PHYS					30A. MEDICALLY CONTRAINDICATED: Y
					30B. PARENTAL REFUSAL:
					30C. OFF SCHEDULE:

RETURN REASON *** ERROR CODE: 030 MESSAGE: SUSPECTED CONDITIONS ARE MISSING AND REQUIRED

***** ATTENTION: THIS IS TO REMIND YOU THAT THIS RESUBMITTAL TURNAROUND DOCUMENT IS STILL OUTSTANDING *****

CONTINUED NEXT PAGE

CP440C
RUN: 07/18/01 16:51:30
CYCLE: 07/18/01

LOUISIANA KIDMED FSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS-C
RESUBMITTAL TURNAROUND DOCUMENT

REPORT NO: CP 0-50
RPT PAGE NO: 10
PAGE NO: 4

CCN: 1049000502001

PROVIDER: 1104620

31. ARE THERE SUSP COND:		333. REF ASST NEED:	330. APPT DATE:	330. TIME:
			00/00/0000	00 00
332. SUSPECTED CONDITIONS:				
U O I	DESCRIPTION			
-	A. MEDICAL	330.		
-	B. VISION			
-	C. HEARING	33. TRANSPORTATION ASSISTANCE NEEDED:		
-	D. DENTAL			
-	E. NUTRITIONAL			
-	F. DEVELOPMENTAL			
-	G. ABUSE/NEGLECT	340. APPT DATE: 040. TIME: 00/00/0000 00:00		
-	H. PSYCHOLOGICAL			
-	I. SPEECH/LANGUAGE			
-	J.			
-	K.			
-	L.			
343. REASON FOR REFERRAL:				
345. REFERRED TO: 346.				
344. PHONE NO: (000) 000-0000		341. TRANSPORTATION ASSISTANCE NEEDED:		
354. SUSP COND:		358. REF ASST NEED:	350. APPT DATE:	350. TIME:
			00/00/0000	00:00
359. REASON FOR REFERRAL:				
357. REFERRED TO: 358.				
354. PHONE NO: (000) 000-0000		351. TRANSPORTATION ASSISTANCE NEEDED:		

CORRECT AND RESUBMIT IF IS DUPT

THIS CORRECTED COPY MUST BE RECEIVED BEFORE 09/18/2001 OR THIS CLAIM WILL BE DENIED.

I HEREBY ATTEST/CORRECT, AS INDICATED ABOVE, THE MEDICAL CLAIM IDENTIFIED ON THIS SHEET AND REQUEST THE REFUND/RECESS NG OF THE SAID CLAIM BE MADE WITH THE INFORMATION PROVIDED ON THIS DOCUMENT. ALL INFORMATION ON THE CLAIM IDENTIFIED ABOVE AND NOT AMENDED SHALL REMAIN AS IS. I HEREBY CERTIFY THAT THE CLAIM FOR SERVICES AND INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS

PROVIDER SIGNATURE: DATE OF SIGNATURE

PLEASE RETURN TO: UNISYS-KIDMED
P.O. BOX 14549

BATON ROUGE, LA 70808-4549

COMMUNITYCARE

Program Description

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

Recipients

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

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

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

Primary Care Physician

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

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

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

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

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

Non-PCP Providers and Exempt Services

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

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

Providers:

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

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

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

Enrollees:

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

- CommunityCARE Enrollee Hotline (800) 259-4444: Provides assistance with questions or complaints about CommunityCARE or their PCP. It is also the number recipients call to select or change their PCP.
- Specialty Care Resource Line (877) 455-9955: Provides assistance with locating a specialist in their area who accepts Medicaid.
- CommunityCARE Nurse Helpline (866) 529-1681: Is a resource for recipients to speak with a nurse 24/7 to obtain assistance and information on a wide array of health-related topics.
- www.la-communitycare.com
- www.lamedicaid.com

HARD COPY REQUIREMENTS

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

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	BILLING REQUIREMENTS
Spend Down Recipient - 110MNP Spend Down Form	Continue hardcopy billing
Retroactive Eligibility - copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing
Recipient Eligibility Issues - copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing - letter/other proof i.e., RA page	Continue hardcopy billing

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

LOUISIANA MEDICAID WEBSITE APPLICATIONS

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

www.lamedicaid.com

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

Provider Login And Password

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

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

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

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

e-MEVS:

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

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

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to remittance advices for this purpose. A LA Medicaid/HIPAA Error Code Crosswalk is available on this website by accessing the link, Forms/Files.

Once enrolled in the website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

e-CDI:

The e-CDI application provides a Medicaid recipient's essential clinical history information at the authorized practitioner's finger tips at any practice location.

The nine (9) clinical services information components are:

- | | |
|-------------------------------|----------------------------|
| 1. Clinical Drug Inquiry | 5. Ancillary Services |
| 2. Physician/EPSTD Encounters | 6. Lab & X-Ray Services |
| 3. Outpatient Procedures | 7. Emergency Room Services |
| 4. Specialist Services | 8. Inpatient Services |
| | 9. Clinical Notes Page |

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a six-month period. These updates are based on Medicaid claims history. A print-friendly version of the information on each of the web pages will be accessible and suitable for the recipient's clinical chart.

The major benefits of the use of e-CDI by the practitioner will include:

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by all providers that have provided services to each individual recipient.
2. Provides the practitioner rapid access to current clinical data to help him/her evaluate the need for "modifications" of an individual Medicaid recipient's health care treatment.
3. Promotes the deliberate evaluation by a practitioner to help prevent duplicate drug therapy and decreases the ordering of duplicate laboratory tests, x-ray procedures, and other services.
4. Supplies a list of all practitioner types providing health care services to each Medicaid recipient.
5. Assists the practitioner in improving therapeutic outcomes and decreasing health care costs.

e-PA

The Electronic Prior Authorization (e-PA) Web Application has been developed for requesting prior authorizations electronically. E-PA is a web application found on the www.lamedicaid.com website and provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. This application is currently restricted to the following prior authorization types:

- 01 – Inpatient
- 05 – Rehabilitation
- 06 – Home Health
- 09 – DME
- 14 – EPSDT PCS
- 99 - Other

Providers who do not have access to a computer and/or fax machine will not be able to utilize the web application. However, prior authorization requests will continue to be accepted and processed using the current PA hard-copy submission methods.

NOTE: Dental electronic Prior authorization (e-PA) Web Application to be implemented at a later date. In order to utilize the Dental e-PA Web Application, the dental provider will be required to obtain the services of a vendor to submit the electronic attachment information to Medicaid. Complete Dental e-PA instructions will be provided upon implementation of Dental e-PA.

Reminders:

PA Type 01: Outpatient Ambulatory Surgery performed Inpatient on the first or second day of the stay. This is only for State Operated hospitals and Out-of-State hospitals that have a DHH approval letter for the out of state stay. Use ICD-9-CM procedure codes.

PA Type 99: Outpatient Ambulatory Surgery (CPT procedures) performed Inpatient on the first or second day of the stay. The surgery was performed at a State Operated hospital and Out-of-State hospital that has a DHH approval letter for the out of state stay. This is also used for specialized CPT procedures. This is for professional services only.

PA Type 05: Providers must always submit the PA02 Form with each request. Do not request authorization for the evaluation procedures, these do not require prior approval. Submit only units on the e-PA transaction, Do Not submit dollar amounts.

Home Health Providers submitting Rehab Services should use PA Type 05 and PA Type 09 when submitting DME Services.

PA Type 09: When submitting a request with a miscellaneous procedure code, the provider must submit a PA01 Form with the description of the item they are requesting.

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

RECONSIDERATION REQUESTS (RECONS) CANNOT BE SUBMITTED VIA THE e-PA WEB APPLICATION AND SHOULD BE SUBMITTED USING THE EXISTING PROCESS.

Additional DHH Available Websites

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

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

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

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

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

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

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

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

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

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

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

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

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) 216-6334**

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

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

☛ **Providers Relations cannot assist recipients. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.**

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

Unisys Provider Relations Correspondence Group

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

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

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

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

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

Requests to update Third Party Liability (TPL) should be directed to:

**DHH-Third Party Liability
Medicaid Recovery Unit
P.O. Box 91030
Baton Rouge, LA 70821**

“Clean claims” should not be submitted to Provider Relations as this delays processing. Please submit “clean claims” to the appropriate P.O. Box. A complete list is available in this training packet under “Unisys Claims Filing Addresses”.

NOTE: CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED “CLEAN” CLAIMS AND WILL NOT BE RESEARCHED.

Guidelines For Providers To Resolve Billing Issues

To effectively assist providers with billing and claim processing issues, it is necessary for **all providers** to follow the procedures in place for handling these problems, as shown below:

- Providers are to direct all billing and claim processing questions to the Unisys Provider Relations Inquiry Unit at (800)473-2783 or (225) 924-5040.
- If inquiry unit personnel are unable to resolve the issue, the inquiry unit staff will forward a request for provider contact to the appropriate personnel who will contact the provider to discuss the issue and resolve it or pursue additional information to reach a satisfactory conclusion.
- If Unisys is unable to resolve a provider's billing issues, the issue will be forwarded to the DHH state office for consultation. The DHH state office will respond to Unisys who will in turn notify the provider.

Unisys Provider Relations Field Analysts

Upon request, Provider Relations Field Analysts are available to visit and train new providers and their office staff on site. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However, since Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

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

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

Department	Toll Free Phone	Phone	Fax
REVS - Automated Eligibility Verification	(800) 776-6323	(225) 216-7387	
Provider Relations	(800) 473-2783	(225) 924-5040	(225) 216-6334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 216-6381	(225) 216-6334
Electronic Media Claims (EMC) - Unisys		(225) 216-6000 option 2	(225) 216-6335
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 929-6803
Home Health P.A. - Unisys EPSDT PCS P.A. - Unisys	(800) 807-1320		(225) 216-6342
Dental P.A. - LSU School of Dentistry		(225) 216-6470	(225) 216-6476
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 216-6370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline – Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – DHH	(800) 834-3333 (225) 342-9808	Providers may request verification of eligibility for presumptively eligible recipients; recipients may request a new card or discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - Vaccines for Children Program	(504) 838-5300	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Specialty Care Resource Line - ACS	(877) 455-9955	Providers and recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED. Providers may inquire about PCP assignment for CommunityCARE recipients and CommunityCARE monitoring/certification, and obtain information on KIDMED linkage, referrals, monitoring, and certification.
CommunityCARE Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - OPH	(866) 327-5978	Providers and recipients may obtain information on EarlySteps Program and services offered
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4153	Providers may request termination as a recipient's lock-in provider.
Division of Long Term Supports and Services (DLTSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding waiver services to waiver recipients.

DHH PROGRAM MANAGER REQUESTS

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

KIDMED Program Manager
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

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

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

IMPORTANT UNISYS ADDRESSES

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

Type of Claim	P.O. Box	Zip Code
Pharmacy	91019	70821
<div style="text-align: center;"><u>CMS-1500 Claims</u></div> <div style="display: flex; justify-content: space-between;"> <div> Case Management Chiropractic Durable Medical Equipment EPSDT Health Services FQHC Hemodialysis Professional Services </div> <div> Independent Lab Mental Health Rehabilitation PCS Professional Rural Health Clinic Substance Abuse and Mental Health Clinic Waiver </div> </div>	91020	70821
Inpatient & Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long Term Care	91021	70821
Dental, Home Health, Rehabilitation, Transportation (Ambulance and Non-ambulance)	91022	70821
ALL Medicare Crossovers and All Medicare Adjustments and Voids	91023	70821
KIDMED	14849	70898

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

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

CLAIMS PROCESSING REMINDERS

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

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

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

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

Attachments

All claim attachments should be standard 8 1/2 x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper. If it is necessary to attach documentation to a claim, the documents must be placed directly behind each claim that requires this documentation. Therefore, it may be necessary to make multiple copies of the documents if they must be placed with multiple claims.

Changes to Claim Forms

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

Data Entry

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

Rejected Claims

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

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

The criteria for legible claims are:

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

APPENDIX

EarlySteps

EarlySteps is Louisiana's Early Intervention System which provides services to families with infants and toddlers who have special needs. These services can be rendered in the recipient's home or "natural setting".

Qualifications for the EarlySteps program are as follows:

- The recipient's age must be from birth to age 3
- The recipient must have a developmental delay of at least 2 SD (standard deviations) below the mean or are functioning at least 33% below their age in months in one of the following developmental areas; or children who have a developmental delay of 1.5 SD below the mean or are functioning at least 25% below their age in months in two or more of the following areas:
 - Cognitive development
 - Physical development (vision, hearing, fine and gross motor)
 - Communication development
 - Social or emotional development
 - Adaptive skills development (also known as self-help or daily living skills)

EarlySteps provides the following Medicaid-covered services:

- Occupational Therapy
- Physical Therapy
- Speech/Language Therapy
- Audiology
- Psychology
- Support Coordination (Family Service Coordination)

EarlySteps also provides the following services not covered by Medicaid:

- Nursing Services/Health Services (Only to enable an eligible child/family to benefit from the other EarlySteps services)
- Medical Services for diagnostic and evaluation purposes only
- Special Instruction
- Vision Services
- Assistive Technology devices and services
- Social Work
- Counseling Services/Family Training
- Transportation
- Nutrition
- Sign language and cued language services

If providers should come into contact with recipients that may meet the qualifications noted above, they may refer them to the local System Point of Entry (SPOE) detailed on the following pages, or have them call EarlySteps at (866) 327-5978.

EarlySteps

Louisiana's Early Intervention System

System Point of Entry (SPOE's)

DHH Region	SPOE	Parishes	Contractor-Information
1	Jefferson Parish Human Service Authority	Orleans, St. Bernard, Jefferson , Plaquemines	Denise O'Guinn, Program Supervisor 201 Evans Road Bldg 1 Suite 100 Harahan, LA 70123 Phone (504) 888-7530 Toll Free 1-866-296-0718 Fax (504) 838-5284 E-mail: doguinn@fhfgno.org
2	Southeast Louisiana Area Health Education Center	East Baton Rouge, West Baton Rouge, East Feliciana, West Feliciana, Pointe Coupee, Iberville, Ascension	Brian Jakes III, Program Manager 3060 Teddy Drive Suite A Baton Rouge, LA 70809 Phone (225) 925-2626 Toll Free 1-866-925-2426 Fax (225) 925-1370 E-mail: ahecbpi@I-55.com
3	Southeast Louisiana Area Health Education Center	Assumption, St. John, St. Charles, St. James, Terrebonne, Lafourche, St. Mary	Brian Jakes III, Program Manager 602 Parish Road Thibodaux, LA 70301 Phone (985) 447-6550 Toll Free 1-866-891-9044 Fax (985) 447-6513 E-mail: ahecbpi@I-55.com
4	First Steps Referral and Consulting LLC	Lafayette, Iberia, St. Martin, Vermillion, St. Landry, Evangeline, Acadia	Mary F. Hockless, CEO 134 East Main Street, Suite 4 New Iberia, LA 70560 Phone (337) 359-8748 Toll Free 1-866-494-8900 Fax (337) 359-8747 E-mail: teamfsrc@bellsouth.net
5	First Steps Referral and Consulting LLC	Beauregard, Jefferson Davis, Allen, Cameron, Calcasieu	Mary F. Hockless, CEO 134 East Main Street, Suite 4 New Iberia, LA 70560 Phone (337) 359-8748 Toll Free 1-866-494-8900 Fax (337) 359-8747 E-mail: teamfsrc@bellsouth.net
6	Families Helping Families at the Crossroads of Louisiana	Vernon, Rapides, Winn, Grant, LaSalle, Catahoula, Concordia, Avoyelles	Teresa Harmon, Program Supervisor 2840 Military Highway Suite B Pineville, LA 71360 Phone (318) 640-7078 Toll Fee 1-866-445-7672 Fax (318) 640-5799 E-mail: tiharmon891@hotmail.com

7	Families Helping Families at the Crossroads of Louisiana	Caddo, Bossier, Webster, Claiborne, Bienville, Natchitoches, Sabine, DeSoto, Red River	Jennifer Boyll, Program Supervisor 2620 Centenary Blvd. Bldg. 2 Suite 249 Shreveport, LA 71104 Phone (318) 226-8038 Toll Free 1-866-676-1695 Fax (318) 425-8295 E-mail: jennifer@spoe.ntcmail.net
8	Easter Seals of Louisiana	Ouachita, Union, Jackson, Lincoln, Caldwell, Morehouse, West Carroll, East Carroll, Richland, Franklin, Tensas, Madison	Peyton Fisher, Director 1300 Hudson Lane, Suite 5 Monroe, LA 71201 Phone (318) 322-4788 Toll Free 1-877-322-4788 Fax (318) 322-1549 Email: pfisher@bayou.com
9	Southeast Louisiana Area Health Education Center	St. Tammany, Livingston, Tangipohoa, Washington, St. Helena	Brian Jakes III, Program Manager 1302 J.W. Davis Drive Hammond, LA 70403 Phone (985) 429- 1252 Toll Free 1-866-640-0238 Fax (985) 429-1613 Email: ahcebpi@l-55.com

REFERRAL FOLLOW UP FORM

<i>Patient Name</i>	<i>Date of Birth</i>	<i>Date Referred</i>	<i>Reason for referral</i>	<i>Referred to</i>	<i>Appointment date</i>	<i>Follow up effort 1</i>	<i>Follow up effort 2</i>	<i>Follow up complete</i>

**REQUIRED KIDMED MEDICAL, VISION, AND HEARING SCREENING
COMPONENTS BY AGE OF RECIPIENT (EFFECTIVE APRIL 1, 1994)¹¹**

AGE	BIRTH ¹²	BY 1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	2 YR	3 YR	4 YR	5 YR	6 YR	8 YR	10 YR	12 YR	14 YR	16 YR	18 YR	20 YR
MEDICAL SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
INITIAL/INTERVAL HISTORY	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS																					
Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X	X	X											
Blood Pressure											X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL ASSESSMENT	S	S	SO	S	S	S	SO	S	S	SO	SO	SO	SO	S	S	S	S	S	S	S	S
UNCLOTHED PHYSICAL EXAM/ASSESSMENT¹³	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PROCEDURES																					
Immunization ¹⁴	X		X	X	X		X	X					X					X			
Neonatal Screening ¹⁵	---	X																			
Anemia Screening ¹⁶						---	X	(X	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Urine Screening ¹⁷							(X	---	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Lead Risk Assessment ¹⁸					X	X	X	X	X	X	X	X	X								
Blood Lead Screening ¹⁹							X			X											
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEALTH EDUCATION²⁰	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
VISION SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO
HEARING SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO

X = Required at visit for this age S = Subjective by history O = Objective by Medicaid – approved standard testing method
 --- = One test must be administered during this time frame

¹¹ Baseline lab and developmental screening must be done at the initial medical screening on all children under age six.

¹² The newborn screening examination at birth must occur prior to hospital discharge.

¹³ The physical examination/assessment must be unclothed or undraped and include all body systems.

¹⁴ The state health department immunization schedule must be followed per AAP recommendations.

¹⁵ If done less than 48 hours after birth, neonatal screening must be repeated.

¹⁶ Anemia screening is to be done once between 9 and 12 months or earlier if medically indicated, one year to four years, five years to 12 years, and between 13 and 20 years.

¹⁷ Urine testing (dipstick) is to be done once between one and four years, (as soon as toilet trained), five to 12 years, and between 13 and 20 years.

¹⁸ Anticipatory guidance and verbal risk assessment for lead must be done at every medical screening.

¹⁹ Screening beginning at six months corresponds to CDC guidelines. The frequency of screening using the blood lead test depends on the result of the verbal risk assessment.

²⁰ Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 through 20, must receive more intensive health education which addresses psychological issues, emotional issues, substance usage, and reproductive health issues at each screening visit.

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. <input type="checkbox"/> ORIGINAL <input type="checkbox"/> ADJUSTMENT <input type="checkbox"/> VOID	
2. REASON	3. ADJUSTMENT ICD

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

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	IMMUNIZATIONS				
MEDICAL SCREENING NURSE							29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
MEDICAL SCREENING PHYSICIAN							30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:				
VISION							A. <input type="checkbox"/> MEDICALLY CONTRAINDICATED				
HEARING							B. <input type="checkbox"/> PARENTAL REFUSAL				
ENCOUNTER (RHC/FQHC)							C. <input type="checkbox"/> OFF SCHEDULE				
TOTAL BILLED AMOUNT											

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

<input type="checkbox"/>	A. MEDICAL
<input type="checkbox"/>	B. VISION
<input type="checkbox"/>	C. HEARING
<input type="checkbox"/>	D. DENTAL
<input type="checkbox"/>	E. NUTRITIONAL
<input type="checkbox"/>	F. DEVELOPMENTAL
<input type="checkbox"/>	G. ABUSE/NEGLECT
<input type="checkbox"/>	H. PSYCHOLOGICAL/SOCIAL
<input type="checkbox"/>	I. SPEECH/LANGUAGE
<input type="checkbox"/>	J.
<input type="checkbox"/>	K.
<input type="checkbox"/>	L.

REFERRALS FOR SUSPECTED CONDITIONS

33.		34.		35.	
A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)	A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> No
E. REASON FOR REFERRAL		F. REFERRED TO		G.	
		H. PHONE NO. ()		I. TRANSPORTATION ASSISTANCE NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		H. PHONE NO. ()		I. TRANSPORTATION ASSISTANCE NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		H. PHONE NO. ()		I. TRANSPORTATION ASSISTANCE NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		H. PHONE NO. ()		I. TRANSPORTATION ASSISTANCE NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> 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 CONTRAINDICATED 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.

02/03

36. SIGNATURE OF PROVIDER

37. DATE

KM-3

FISCAL AGENT COPY

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. <input type="checkbox"/> VOID <input type="checkbox"/>																			
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)				6 PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		7 INSURED'S NAME													
				8 PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		9 INSURED'S GROUP NO. (OR GROUP NAME)													
TELEPHONE NO.				11 WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>		12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)													
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.																			
PHYSICIAN OR SUPPLIER INFORMATION																			
13 DATE OF		14 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 <input type="checkbox"/> NO <input type="checkbox"/>												
16 DATE PATIENT ABLE TO RETURN TO WORK		17 DATES OF TOTAL DISABILITY FROM THROUGH			18 DATES OF PARTIAL DISABILITY FROM THROUGH		19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED												
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				18A REFERRING ID NUMBER		21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES													
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)				22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.		23 ATTENDING NUMBER													
25 A. DATE(S) OF SERVICE From To MM DD YY MM DD YY B. PLACE OF SERVICE C. PROCEDURE D. DIAGNOSIS CODE E. CHARGES F. DAYS OR UNITS EPSDT FAMILY PLAN TPL \$						24 PRIOR AUTHORIZATION NO.													
26 CONTROL NUMBER				27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID															
28 REASONS FOR ADJUSTMENT <table border="0" style="width:100%"><tr><td><input type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY</td><td>_____</td></tr><tr><td><input type="checkbox"/> 02 PROVIDER CORRECTIONS</td><td>_____</td></tr><tr><td><input type="checkbox"/> 03 FISCAL AGENT ERROR</td><td>_____</td></tr><tr><td><input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY</td><td>_____</td></tr><tr><td><input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN</td><td>_____</td></tr></table>										<input type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY	_____	<input type="checkbox"/> 02 PROVIDER CORRECTIONS	_____	<input type="checkbox"/> 03 FISCAL AGENT ERROR	_____	<input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY	_____	<input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN	_____
<input type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY	_____																		
<input type="checkbox"/> 02 PROVIDER CORRECTIONS	_____																		
<input type="checkbox"/> 03 FISCAL AGENT ERROR	_____																		
<input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY	_____																		
<input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN	_____																		
29 REASONS FOR VOID <table border="0" style="width:100%"><tr><td><input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT</td><td>_____</td></tr><tr><td><input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER</td><td>_____</td></tr><tr><td><input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN</td><td>_____</td></tr></table>										<input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT	_____	<input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER	_____	<input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN	_____				
<input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT	_____																		
<input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER	_____																		
<input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN	_____																		
30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)					31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE														
32 YOUR PATIENT'S ACCOUNT NUMBER																			

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UNISYS - 213
5/97

Universal Screening Documentation Tools – Optional

A universal screening documentation tool is one that can be used at the screening provider's option. The tool is attached. This tool should be completed thoroughly and accurately to ensure all components of a screening are documented. Providers should be familiar with the program requirements of a screening as explained in the KIDMED provider manual. Any additional information necessary to support the screening should also be found in the patient's chart. This tool was designed to incorporate necessary items for a screening in a clear, concise manner. **We are not requiring this tool to be used; it is for your convenience, only.**

However, any tool used must document that all five components of a medical screening as stated in the KIDMED manual, were completed. Program compliance reviews will look for such documentation. Furthermore, be aware that the same documentation applies to a "well-child" visit which must also conform to the requirements mandatory for a KIDMED screening. If you do not wish to use this documentation, you may develop your own.

DATE: _____

Age:

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

INITIAL SCREENING
AGES 6 TO 21 YEARS

DATE:

Patient Name:

Age:

Family History <input type="checkbox"/> Allergy or Asthma _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Sickle Cell _____ <input type="checkbox"/> T.B. _____ <input type="checkbox"/> Other: _____ <i>(Please note family member's relation to patient)</i>		Birth History <input type="checkbox"/> Term <input type="checkbox"/> Premature <input type="checkbox"/> Post-mature <input type="checkbox"/> Prenatal care <input type="checkbox"/> Complications Note: _____ <input type="checkbox"/> NVD <input type="checkbox"/> C-Section <input type="checkbox"/> Neonatal Complications _____		Past Medical History <input type="checkbox"/> Major Illness _____ <input type="checkbox"/> Hospitalizations _____ <input type="checkbox"/> Allergies _____																																																				
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">HT.</td> <td style="width: 15%;">WGT.</td> <td style="width: 15%;">B.P.</td> <td style="width: 15%;">T.</td> <td style="width: 15%;">P.</td> <td style="width: 15%;">R.</td> </tr> </table> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Labs</td> <td style="width: 15%;">Hct or Hgb: WNL</td> <td style="width: 15%;">UTD</td> <td style="width: 15%;">UTO</td> <td style="width: 15%;">Urine Dipstick: WNL</td> <td style="width: 15%;">UTD</td> <td style="width: 15%;">UTO</td> </tr> <tr> <td></td> <td colspan="3">Value: _____</td> <td colspan="3">Comments: _____</td> </tr> </table>			HT.	WGT.	B.P.	T.	P.	R.	Labs	Hct or Hgb: WNL	UTD	UTO	Urine Dipstick: WNL	UTD	UTO		Value: _____			Comments: _____			Developmental Assessment <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Appropriate verbal communication</td> <td style="width: 10%;">Yes</td> <td style="width: 20%;">No</td> </tr> <tr> <td>Drugs/Alcohol/Tobacco</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Hobbies & Sports</td> <td>Yes</td> <td>No</td> </tr> <tr> <td colspan="3"> </td> </tr> <tr> <td>Family/Peer Relationship</td> <td>WNL</td> <td>Poor</td> </tr> <tr> <td>School/Job Performance</td> <td>WNL</td> <td>Poor</td> </tr> </table>			Appropriate verbal communication	Yes	No	Drugs/Alcohol/Tobacco	Yes	No	Hobbies & Sports	Yes	No				Family/Peer Relationship	WNL	Poor	School/Job Performance	WNL	Poor													
HT.	WGT.	B.P.	T.	P.	R.																																																			
Labs	Hct or Hgb: WNL	UTD	UTO	Urine Dipstick: WNL	UTD	UTO																																																		
	Value: _____			Comments: _____																																																				
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Signature: _____

**PERIODIC SCREENING
BIRTH THROUGH 5 YEARS**

DATE: _____

Patient Name: _____

Age: _____

<p align="center">Family History</p> <p><input type="checkbox"/> No changes since last screen</p> <p><input type="checkbox"/> Allergy or Asthma _____</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> Cancer _____</p> <p><input type="checkbox"/> Heart Disease _____</p> <p><input type="checkbox"/> Sickle Cell _____</p> <p><input type="checkbox"/> T.B. _____</p> <p><input type="checkbox"/> Other: _____</p> <p align="center"><i>(Please note family member's relation to patient)</i></p>	<p align="center">Recent Medical History</p> <p><input type="checkbox"/> No changes since last screen</p> <p><input type="checkbox"/> Major Illness _____</p> <p><input type="checkbox"/> Hospitalizations _____</p> <p><input type="checkbox"/> Allergies _____</p> <p><input type="checkbox"/> Current Medications _____</p> <p>Neonatal Screen: WNL Repeated</p> <p>Results requested: Yes No</p> <p>Comments: _____</p>	<p align="center">Environmental Assessment</p> <p><input type="checkbox"/> No changes since last screen</p> <p>Water supply: City Well None</p> <p>Sewer: City Septic None</p> <p>Smokers in home: _____</p> <p>Pets in home: _____</p>
<p>HT. WT. T P R</p> <p>Head Circ. (0-2yrs): Blood Pressure (3yrs and up):</p>		<p align="center">Developmental Assessment</p> <p>Subjective Assessment WNL Suspect</p> <p>Objective Assessment WNL Delayed</p> <p align="center"><i>(Objective Assessment Must Be In Chart)</i></p>
<p>Hct or Hgb: WNL UTD UTO Urine Dipstick: WNL UTD UTO Lead: Drawn UTD UTO</p> <p>Value: Comments: <input type="checkbox"/> Not required at this time</p>		
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Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

HOW DID WE DO?

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

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

Provider Subspecialty (if applicable): _____

FACILITY	Poor					Excellent
The seminar location was satisfactory	1	2	3	4	5	
Facility provided a comfortable learning environment	1	2	3	4	5	
SEMINAR CONTENT						
Materials presented are educational and useful	1	2	3	4	5	
Overall quality of printed material	1	2	3	4	5	
UNISYS REPRESENTATIVES						
The speakers were thorough and knowledgeable	1	2	3	4	5	
Topics were well organized and presented	1	2	3	4	5	
Reps provided effective response to question	1	2	3	4	5	
Overall meeting was helpful and informative	1	2	3	4	5	
SESSION: KIDMED						

What topic was most beneficial to you? _____

Please provide constructive comments and suggestions: _____

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(800) 473-2783 or (225) 924-5040