UNISYS

HOSPITAL 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

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

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

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

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

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

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

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

GENERAL POLICY REMINDERS

Billing Medicaid Recipients

MEDICAID RECIPIENTS MAY BE BILLED FOR NON-COVERED SERVICES, NOT DENIED SERVICES. Recipients may not be held responsible for claims denied due to provider error such as failure to obtain a PCP referral, failure to obtain prior authorization or pre-certification, failure to timely file claims, incorrect TPL carrier code, etc.

In cases where a hospital submits a pre-certification request which is denied because it does not meet pre-certification criteria for medical necessity, and the hospital admits and performs services without that approval, neither the hospital nor the physician services are payable and the recipient may not be billed.

Medicaid providers are also reminded that if they accept Medicaid reimbursement for services rendered, any reimbursement is considered payment in full for those services and the Medicaid recipient cannot be billed for the difference.

Timely Filing Guidelines

To be reimbursed for services rendered, all providers must comply with the following filing limits set by the Louisiana Medicaid Program.

- Straight Medicaid claims must be filed within **12** months of 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 regulation. (Claims which fail to cross over via tape and have to be filed hard copy must be filed within **6** months of the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within **1** year from the date of service.)
- Claims with third-party payment must be filed within **12** months of the date of service.
- KIDMED claims must be filed within **60** days of the date of service.
- Claims for recipients with retroactive eligibility coverage, e.g., spend-down medically needy claims, should be sent to Unisys with a note of explanation **AND** a copy of Form 18-SSI (Medicaid Program Notice of Decision) or other official documentation from DHH indicating the recipient's retroactive status within **12** months of the date retroactive eligibility was granted. The Unisys mailing address is as follows:

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

All claims for recipients with retroactive medical coverage will be forwarded to the Medicaid Program for review and authorization.

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.

Claims for Dates of Service over Two-Years Old

Acute Care 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 two conditions listed below:

- The recipient was certified for retroactive Medicaid benefits (e.g., spend-down medically needy, or the recipient won a Medicare or SSI appeal granting retroactive Medicaid benefits), and the provider submits the claim within **12** months of the date retroactive eligibility was granted.

- The claim was submitted to Medicaid within **12** months of the date of service and failure of the claim to pay was the fault of the Medicaid Program rather than the provider's fault **each** time the claim was adjudicated.

All requests 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 condition that has been met and must attach supporting documentation. Supporting documentation includes, but is not limited to, evidence of the qualifying condition and proof of timely filing.

Claims submitted without a cover letter, proof of timely filing, and/or supporting documentation of the qualifying condition will be returned to the provider without consideration. Any requests submitted directly to DHH staff will be rerouted to UNISYS Provider Relations.

Emergency Room Services

Providers must bill revenue code 450 or 459 when submitting claims for outpatient emergency room services along with the appropriate HCPC code 99281 – 99285. Only one (1) revenue code 450 or 459 may be used per emergency room visit. Claims for emergency room services are not to be billed as a single line item. Claims must include all revenue codes (i.e., pharmacy, lab, x-rays and supplies) which were utilized in the patients' treatment, using their appropriate revenue code and HCPC code where applicable.

Medicaid will approve three (3) emergency room visits per calendar year per recipient, 21 years of age or older, or who is a foster care child. Medicaid does not give extensions for use of the emergency room to hospitals. Although the use of the emergency room will deny after three visits, Medicaid will continue to reimburse the hospital for any other covered services (i.e., lab, x-rays) which are medically necessary.

Recipients under the age of 21 and all CommunityCARE recipients have unlimited emergency visits as long as medical necessity for an emergency room visit is met.

When an emergency visit results in an inpatient admit, providers must bill all charges associated with the emergency visit on the inpatient bill. This policy applies to patients admitted from the ER or if the patient has been seen in the ER within 24 hours either prior to admit or after the inpatient discharge. Providers must not bill all ER charges utilizing Revenue code 500 as stated in previous years. The emergency room charge (Revenue code 450 or 459) must be billed as a separate line. All associated charges (i.e., pharmacy, lab, x-rays) for the emergency visit, must be included by revenue code with the total charges for the inpatient stay.

Billing Reminder

There are limits placed on the number of line items that are allowed when filing claims.

Outpatient claims are limited to 23 total lines, including the line showing the total charges. Inpatient claims are limited to a total of 28 total lines, including the line showing the total charges. Please adhere to the following guidelines when submitting a two page UB-92 on inpatient claims:

- 1st page must indicate page 1 of 2
- 1st page should not include a subtotal and/or a total
- 2nd page must indicate page 2 of 2
- 2nd page should indicate the total of both pages only, not a subtotal
- Pages should be stapled together with the 1st page on top
- The total charges must not exceed $999,999.99

ORGAN TRANSPLANTS

When a Louisiana Medicaid recipient receives an organ transplant, all charges incurred with the transplant are to be included in the recipient's inpatient hospital charges. This includes all procedures involved in the harvest of the organ from the donor. All services must be included on the claim form using the appropriate revenue codes from the 300 and 800 range for the services provided.

Donor search costs are included in the recipient's inpatient bill and will not be paid on an outpatient basis. Testing for Bone Marrow donors (lab tests) can be billed on an outpatient claim.

Medicaid does not pay for harvesting of organs when a Louisiana Medicaid recipient is the donor to a non-Medicaid recipient.

Prior Authorization Request for Transplant Procedures

All organ transplants must be authorized by the Prior Authorization Unit prior to the performance of the surgery. This policy also applies to out-of-state hospitals, including those located in the trade area. Prior authorization is not required **if** a recipient has both Medicare and Medicaid and the transplant is covered **and** reimbursed by Medicare. However, if the recipient has private insurance and that insurance considers the transplant a covered service, prior authorization is required.

The Prior Authorization Request for Transplant Procedure(s) form (TP-01) must be completed and used by all Hospital Transplant Coordinators when requesting approval for transplant procedures. A copy of the form appears on the following page. The form should be completed and any documentation that supports medical necessity attached. The completed TP-01 form should be mailed to:

Unisys Prior Authorization
P.O. Box 14919
Baton Rouge, La. 70898-4919

Once the transplant has been approved, a letter will be sent to the hospital. The hospital must attach a copy of the approval letter to their PCF-01 request when pre-certification is requested for the inpatient admission. A copy of the organ transplant approval letter is provided for reference.

When billing for the transplant services, the hospital and all physicians involved must attach a copy of the approval letter, and a dated operative report to the claims. Hospitals should share a copy of the transplant approval letter with all other providers involved in the patient's transplant.

TP-01 Form

Prior Authorization Request For Transplant Procedure(s)

Louisiana Department of Health and Hospitals
Bureau of Health Services
Medical Assistance Program

Date of Request : ____/____/____ _____ Original Request _____ Re-Evaluation Request

1) Patient's Name _____ 2) Date of Birth: __/_____/_____

3) Patient's Medicaid Identification Number(13-digits): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

4) Type of Transplant : _____ 5) Primary Diagnosis :_____

6) Secondary Diagnosis: _____ 7) Procedure Description :_____

8) Prognosis (with and without transplant, specifying morbidity, mortality, life expectancy and any other considerations: _____

9) Patient's history of present illness is attached and includes the following: _____Yes _____No
__Pertinent social history, clinical findings, consults, and key test results (representing the patient's current status).

10) Copy of Transplant Selection Committee's Notes and/or Minutes is attached and signed by a Transplant Committee Physician and includes the following information: _____Yes _____No
__Listing of Committee members present (Name & Title) , their discussions including any psychosocial concerns, e.g., e.g., drug or alcohol abuse, on patient suitability, quality of life, and compliance.

11) Do Urgent or Emergency conditions exist? _____Yes _____No (If Yes, please attach explanation).

NOTE: For each item above, please attach additional information to support your request for transplant(s).

Emergency Requests can be submitted by faxing all documentation to:

UNISYS PRIOR AUTHORIZATION DEPARTMENT (EMERGENCY TRANSPLANT REQUEST) AT (225)-929-6803

I certify that the requested transplant is not investigational or experimental and is regarded as standard therapy by the medical community. This transplant program is in compliance with DHH Medicaid transplant registration and approval requirements for organ or tissue. Our transplant program will notify you if there are pertinent changes between approval and actual date of transplant that could necessitate reconsideration of tl request. We are submitting or preparing to submit scientific documentation for recent applicable transplant developments.

12)_____
(Physician Name and Title , Please Print)

13) _____
(Physician Signature and Title)

14)_____
(Transplant Coordinator or Contact Person)

15)_____
(Telephone Number / Fax Number)

16)Site Where Transplant is to be Performed (Hospital Name & Address) _____

_____

_____

TP-01 FORM, Issued 04/97

Mail to: Unisys / La. Medicaid , Prior Authorization Dept., P.O. Box 14919, Baton Rouge, La. 70898-4919

Telephone Number for Unisys Prior Authorization Dept. (800) 488-6334 or (225) 928-5263

Transplant Approval Letter

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H
SECRETARY

March 22, 2006

Reference:
ID#:
SS#:

Dear Ms. Holloman:

This is to confirm that a autologous hematopoietic stem cell transplant has been approved for to be done at Coverage is authorized for the evaluation, transplant and follow-up care.

The approval for this procedure is contingent upon your acceptance of Medicaid payment as payment in full and that you are a Louisiana Medicaid enrolled provider. To be reimbursed for services rendered, all providers must comply with timely filing guidelines set by the Louisiana Medicaid Program. Also, the client must be eligible for Medicaid on dates of services in order to receive reimbursement from Medicaid. If you have any questions regarding the reimbursement rate, you may call Ms. Darlene White at (225) 342-2119.

Please attach a copy of this letter to your claim form as your authorization when billing Unisys Corporation for this service and share this letter with all other providers associated with this transplant.

You have the right to appeal this decision. If you wish to do so, please write to the Department of Health and Hospitals, Bureau of Appeals, P. O. Box 4183, Baton Rouge, LA 70821-4183 within thirty (30) days of receipt of this letter

Sincerely,

Jerry Phillips
Acting Medicaid Director

JP/SG/sgw

cc: D. Gough
J. Womack
S. Guarino
P. Misner

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE # 225/342-3891 • FAX # 225/342-9508
"AN EQUAL OPPORTUNITY EMPLOYER"

NEWBORN/NURSERY CHARGES

In the past, Medicaid has required all claims for Mother/Baby to be combined for reimbursement. Effective February 1, 2005, all Mother/Baby claims must be submitted separately for those claims with a date of service on or after February 1, 2005.

When billing the Mother's claim, all Non-State Hospitals are still required to obtain precertification. That number is still required on the claim and the claim is to include only her room/board and ancillary charges. The separate baby claim must include only nursery and ancillary charges for the baby. The mother's pre-cert number is not required on this claim. All baby claims will zero pay and receive an EOB code of 519 (Newborn zero paid). State Hospitals will continue to have no pre-certification requirements. Should providers not follow this established procedure, a denial will be received with an EOB code of 522 (Mother/Newborn must be billed separately).

These instructions only apply to Newborn Well Baby Claims with a Type of Admission code 4 (Newborn) and Source of Admission code 1 (Normal Delivery).

Claims for newborns that remain hospitalized after mom's discharge must be split billed.

The first portion of the claim should be for the charges incurred on the dates that mom was hospitalized. This is the first part of a split –billing claim and rules for split billing should be followed i.e. Form Locator 4 (Bill type) should reflect 112 (first part of split), Form Locator 19 (Type of Admission) should be 4 (Newborn) Form Locator 20 should be 2 (Premature Delivery) 3 (Sick Baby) or 4 (Extramural Birth) and Form Locator 22 (Status) should reflect 30 (still a patient).

The second part of the split bill should be for the days after mom's discharge. The baby assumes the mother's discharge date as it's admit date, and will require precertification. Split billing rules will also apply, i.e. Form Locator 4 (Bill type) should reflect 114 (final part of split), Form Locator 19 (Type of Admission) should be 4 (Newborn), Form Locator 20 (Source of Admission) codes for newborn admissions should reflect 2 (Premature Delivery) 3 (Sick Baby) or 4 (Extramural Birth), and Form Locator 22 (Status) should reflect that the patient is no longer in the facility.

- Providers should continue to follow established procedures for newborns that are admitted directly into a Neonatal Intensive Care Unit. These claims should continue to be precerted under the baby's name and Medicaid number beginning on the date of birth.

- In those instances when a Non-Medicaid Mother gives birth to a deemed Medicaid eligible newborn, current policy will remain. A pre-certification will still be required for the baby only.

ACT NO. 269 – NEWBORN CHILD HEALTH INSURANCE COVERAGE

The Louisiana Health Insurance Premium Payment (LaHIPP) program provides group health insurance premium reimbursements to Medicaid recipients whenever it is formulaically determined to be less expensive than paying the total cost of health care services generally used by the recipient.

Information regarding the above rules may be obtained from the LaHIPP Program at (225) 342-1737 or 866-362-5253.

Third Party Liability (TPL) Notification of Newborn Children Form

Hospitals must complete the Third Party Liability (TPL) Notification of Newborn Children (TPLN 1-2005) Form which will begin the process of potentially providing health insurance premium reimbursements to a Medicaid eligible recipient.

The TPLN 1-2005 Form is located at www.lamedicaid.com under Forms/Files/User Guides.

ACT No. 269 "Baby Bill" – Legislative Summary

Effective Date: 06/15/2005. The purpose of the Baby Bill is to establish reasonable requirements for the enrollment of newborns as dependents for health insurance coverage by health insurance issuers.

A newborn child that has access to dependent coverage under a mother, father or caregiver's health insurance plan is considered enrolled as of the effective date of the birth of the child. This applies to individual and group policies.

If a newborn child has access to dependent coverage and is potentially eligible for Medicaid at the time of birth, then the hospital must notify DHH and the Health Insurance Issuer(s) (HIIs) by completing a Third Party Liability (TPL) Notification of Newborn Child(ren) form within seven (7) days. The notice should be sent to the Department of Health and Hospitals, Bureau of Health Services Financing, Third Party Liability/Medicaid Recovery. Notice to the Health Plans should be sent to a designated department that has been communicated to the provider or to the department that would normally be notified when a newborn child is added to a policy.

Upon receiving notice from the providers, HIIs must provide notice to the policyholder in the case of an individual policy, the employer and employee with regard to a group policy, and the healthcare facility that rendered any medical services provided to the newborn prior to discharge. The notice must include information:

1. verifying that coverage is available to the newborn child or if such coverage is not available, an explanation of why such coverage is not available;
2. determining the amount of additional premium due, if any
3. designating a contact including a telephone number and physical address to represent the HII to facilitate all matters relative to the newborn child.

HIIs must give DHH 90 day's prior written notice of the intent to cancel the newborn child's coverage due to non-payment of premium. Within 3 days of sending the letter to DHH, HII must notify each provider that has either submitted a claim, made the HII aware that it has treated, or requested/obtained a pre-certification to render services to the newborn child that the premium has been cancelled in which case the newborn would be covered under Medicaid. The notice must contain the following information:

1. group or individual identification / policy number
2. summary of benefits, including applicable co-pays and deductibles
3. amount of additional premium due
4. name(s) of the member subscriber of the newborn child, including, but not limited to, the names of any and all other dependents and the effective date of coverage for each person named as a dependent
5. designated point of contact

PLEASE NOTE: HOSPITALS ARE STILL OBLIGATED TO COMPLETE THE ELIGIBILITY INQUIRY FOR NEWBORNS (152N) FORM TO FACILITATE THE PROCESS OF ACQUIRING A MEDICAID IDENTIFICATION NUMBER FOR BABIES BORN TO MOTHERS WHO ARE MEDICAID ELIGIBLE.

FREE-STANDING AND DISTINCT PART PSYCHIATRIC REIMBURSEMENT

Free-standing psychiatric hospitals and distinct part psychiatric units within acute care hospitals are recognized by Medicaid differently for reimbursement purposes if the unit/facility meets the Medicare criteria for exclusion from Medicare's Prospective Payment System (PPS excluded unit). This per diem is paid to all providers of inpatient psychiatric care, whether they are a distinct part psychiatric unit within an acute care general hospital or a free-standing psychiatric hospital. Distinct part psychiatric units are reimbursed for services provided to patients of any age. Free-standing psychiatric hospitals are reimbursed for services provided to patients either under 21 years of age or 65 years of age and older. Excluded are those patients 21 to 64 years of age.

Acute care general hospitals with a distinct part psychiatric unit which meets the Medicare criteria for designation as a PPS-exempt unit, must complete a new Medicaid provider enrollment form (PE-50) allowing the distinct part psychiatric unit to be enrolled separately and reimbursed in accordance with the prospective per diem rate for inpatient psychiatric care. This per diem includes payment for all services provided to an inpatient of such a unit, except for physician services, which should be billed separately. Reimbursement for the costs of all therapies (individual/group counseling or occupational therapy) is included in this per diem. The costs for services provided in the distinct part psychiatric units and free-standing psychiatric facilities are not subject to the cost settlement process.

The hospital must set up the distinct part psychiatric unit as a separate cost center and file it as a subprovider on the hospital's cost report. More information regarding this criteria may be obtained from the Bureau of Health Services Financing Health Standards Section at (225) 342-0148. Review of the hospital by the Health Standards Section for adherence to these guidelines is necessary prior to enrollment as a distinct part psychiatric unit.

Providers must bill on the hospital claim form (UB-92) for these services. In-state facilities will be reimbursed at the psychiatric per diem rate for in-state hospitals. Out-of-state facilities will be reimbursed at the lesser of the following:

- 60% of billed charges for patients under 21 years of age and 40% for patients ages 21 and older, or

- per diem. (Only facilities in bordering states are given a per diem rate. Facilities in all other states will be paid the appropriate percentage of charges.)

Note: The Louisiana Medicaid Program will only reimburse out-of-state hospitals for a maximum of a **two-day** psychiatric stay for Louisiana Medicaid recipients. The out-of-state facility must, if continued inpatient care is necessary, transfer the patient to a Louisiana psychiatric facility after two days.

Inpatient Psychiatric Services In Long Term And Acute Care Facilities

When the primary diagnosis on the pre-certification file is in the 290-316 range, payment for each day of service will be made at the psychiatric per diem rate and not the long term or acute per diem rate.

REHABILITATION UNITS IN ACUTE CARE HOSPITALS

Medicaid does not issue separate provider numbers for Rehabilitation units. The Rehabilitation unit is considered part of the acute care hospital, and any billing for services provided in this unit should be billed with the acute care number. Reimbursement for inpatient stays in the Rehabilitation unit will be made at the same per diem as for the acute care part.

If you have been issued a provider number for the Rehabilitation unit by Medicare, which is not the same number assigned by Medicare for the acute care hospital part; you should report this number to our Provider Enrollment Unit at the address shown below. The Provider Enrollment Unit will then add this number to the MMIS crossover file so that your Medicare claims will correctly cross over for payment under your Medicaid provider number.

None of your Medicare crossover claims that have already been processed under the number assigned by Medicare for the Rehabilitation unit will be paid. After you have been notified by Provider Enrollment that the Medicare provider number assigned to the Rehab unit has been added to our crossover file, you may submit these claims to the Unisys Provider Relations Unit for payment by hardcopy. Be sure to include a copy of the Medicare EOB with each claim.

Unisys Provider Enrollment
P.O. Box 80159
Baton Rouge, LA 70898

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-certed (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

HOSPICE

Overview

Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

A recipient must be terminally ill in order to receive Medicaid hospice care. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

Payment Of Medical Services Related To The Terminal Illness

Once a recipient elects to receive hospice services, **the hospice agency is responsible for <u>either providing or paying for</u> all covered services related to the treatment of the recipient's terminal illness.**

For the duration of hospice care, an individual recipient waives all rights to Medicaid payments for:

- Hospice care provided by a hospice other than the hospice designated by the individual recipient or a person authorized by law to consent to medical treatment for the recipient.

- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected OR a related condition OR that are equivalent to hospice care, except for services provided by: (1) the designated hospice; (2) another hospice under arrangements made by the designated hospice; or (3) the individual's attending physician if that physician IS NOT an employee of the designated hospice or receiving compensation from the hospice for those services.

Payment For Medical Services Not Related To The Terminal Illness

Any claim for services submitted by a provider other than the elected hospice agency will be denied if the claim does not have attached justification that the service was medically necessary and **WAS NOT related to the terminal condition for which hospice care was elected.** If documentation is attached to the claim, the claim pends for medical review. Documentation may include:

- A statement/letter from the physician confirming that the service was not related to the recipient's terminal illness, or
- Documentation of the procedure and diagnosis that illustrates why the service was not related to the recipient's terminal illness.

If the information does not justify that the service was medically necessary and not related to the terminal condition for which hospice care was elected, the claim will be denied. If review of the

claim and attachments justify that the claim is for a covered service not related to the terminal condition for which hospice care was elected, the claim will be released for payment. *Please note, if prior authorization or precertification is required for any covered Medicaid services not related to the treatment of the terminal condition, that prior authorization/precertification is required and must be obtained just as in any other case.*

NOTE: Claims for prescription drugs will not be denied but will be subject to post-payment review.

PHARMACY SERVICES

Prior Authorization

The prescribing provider must request prior authorization for non-preferred drugs from the University of Louisiana – Monroe. Prior authorizations requests can be obtained by phone, fax, or mail, as listed below.

Contact information for the Pharmacy Prior Authorization department:

Phone: (866) 730-4357 (8 a.m. to 6 p.m., Monday through Saturday)
FAX: (866) 797-2329

University of Louisiana – Monroe
School of Pharmacy
1401 Royal Avenue
Monroe, LA 71201

The following page includes a copy of the "Request for Prescription Prior Authorization" form, as can be found on the LAMedicaid.com website under "Rx PA Fax Form".

Preferred Drug Listing (PDL)

The most current PDL can be found on www.lamedicaid.com.

Monthly Prescription Service Limit

An eight-prescription limit per recipient per calendar month has been implemented in the LA Medicaid Pharmacy Program.

The following federally mandated recipient groups are exempt from the eight-prescription monthly limitation:

- Persons under the age of twenty-one (21) years
- Persons living in long term care facilities such as nursing homes and ICF-MR facilities
- Pregnant women

If it is deemed medically necessary for the recipient to receive more than eight prescriptions in any given month, the provider must write "medically necessary" and the ICD-9-CM diagnosis on the script.

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).

Date of Request:*	Number of Fax Pages (including cover page):*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth:*
Call-Back Phone Number (include area code):*	
Fax Number (include area code):	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO
2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:
3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interaction(s) in the box below:
4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:*

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

CONFIDENTIALITY NOTICE
The documents accompanying this facsimile transmission may contain confidential information which is legally privileged. The information is intended only for the use of the individual or entity to which it is addressed. If you are not the intended recipient, you are hereby notified that any review, disclosure/redisclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy this information.

MEDICAL SUPPLIES OR EQUIPMENT PROVIDED TO PATIENTS IN THE HOSPITAL SETTING

Hospitals are required to provide medical supplies and equipment that are needed for treatment of patients in the hospital setting. Charges associated with billable medical supplies or equipment used in the treatment of hospital patients must be included on the inpatient or outpatient hospital bill. A Durable Medical Equipment (DME) provider may not bill Medicaid for supplies or equipment furnished to patients in the hospital setting.

OUTPATIENT HOSPITAL SERVICES

Diagnostic and therapeutic services which hospitals provide on an outpatient basis are covered by Medicaid. **This policy applies to all hospitals including charity facilities.** Federal regulations are specific in regard to the definition of both inpatient and outpatient services.

Louisiana Medicaid automatically deems a hospital stay of more than 24 hours in length inpatient. When outpatient duration of services exceed 24 hours, the services are deemed inpatient. Stays of less than 24 hours are NOT automatically considered outpatient. If a physician has formally admitted the patient, and the stay is less than 24 hours, the patient is deemed inpatient. Any outpatient services provided during the inpatient stay cannot be billed as outpatient, even if the stay is less than 24 hours. **All outpatient claims paid within 24 hours of the inpatient stay are subject to recoupment. Billing for outpatient services on a patient who is subsequently admitted as inpatient constitutes fraud.**

Clarification of the 24 Hour Rule

- All outpatient services performed within one (1) calendar day of the inpatient admission should be included in the inpatient stay and billed as part of the inpatient claim. The admission date on the claim should begin with the actual date of the inpatient admission. Exception: When a patient receives outpatient service and does not discharge home prior to being admitted as an inpatient. In these cases, the admission date should be the date the outpatient services were provided.

- Psychiatric patients admitted through the emergency room should have the ER charges rolled into the inpatient psychiatric bill (even when the facility has separate providers numbers for acute and psychiatric services), and the admission date of the inpatient psychiatric claim should be the date the patient is admitted to the psychiatric unit.

- When a patient is treated in the emergency room and requires surgery which cannot be performed for several hours, the services may be billed as outpatient provided that the patient is not admitted as inpatient and that the duration from entry into the emergency room until release is less than 24 hours.

- When a patient is treated in an emergency room, released and returns to the hospital within 24 hours and is admitted, all emergency room charges should be included in the inpatient stay.

- When a patient has outpatient surgery and is observed for several hours after the surgery in an observation room, the services may be billed as outpatient, provided that the patient is not admitted as inpatient and the duration of the treatment from beginning to discharge is less than 24 hours.

- When an inpatient stay results in outpatient services being performed at another facility, all outpatient charges should be included and billed on the inpatient hospital's claim. The hospital in which the patient is an inpatient is responsible for reimbursing the facility for performing any outpatient services. Only services for the professional component should be billed separately by the provider of the service.

As stated prior, if a stay is less than 24 hours, the stay is deemed inpatient if any physician has formally admitted the patient. If no physician has admitted the patient, and the stay is less than 24 hours, then the stay would be outpatient. The patient's chart notes should indicate if any physician has admitted the patient for a particular stay. If the patient's records indicate that a physician has admitted the patient, **EVERYONE** including the hospital should bill the stay as inpatient, even if the stay is less than 24 hours.

Outpatient Laboratory Services

Outpatient laboratory services are paid at a flat fee based on the Medicare fee schedule.

Hospital Laboratory Services-Independent Diagnostic Testing Facilities (IDTF's)

When a hospital contracts with a freestanding laboratory for the performance of the technical service only, it is the responsibility of the hospital to pay the laboratory. The laboratory cannot bill Medicaid for these services. If the hospital contracts with a freestanding laboratory for full service tests (both technical and professional components), the laboratory must bill Medicaid directly for these services.

Prenatal Laboratory Panels

Obstetrical lab panels should be billed using CPT code 80055. Refer to the CPT-4 code book for tests included in this panel.

Ultrasounds

Effective for dates of service on or after July 1, 2004, the reimbursement policy for ultrasounds during pregnancy has changed. Only 3 ultrasounds will be paid during a 270 day period, between both the Hospital Program and the Professional Services Programs. This includes ultrasounds performed in an acute care hospital on an outpatient basis.

Hyperbaric Oxygen Therapy

Codes for Hyperbaric Oxygen Therapy are currently being reviewed. There are differences between codes payable under both the Hospital and Physician Programs. We are attempting to coordinate benefits between the two programs. Once completed, information will be provided as to which codes are payable under both programs, and those if any, that will no longer be payable. Until such time as you are notified, you may continue to bill as usual.

Outpatient Rehabilitation Services

Hospitals are reimbursed for outpatient rehabilitation services including speech, occupational and physical therapies at a flat fee for service. These services are not cost settled. Hospitals are required to bill for these services using standard CPT codes. **Initial therapy and extended therapy plans require Prior Authorization.** Evaluation codes do not require prior authorization, but do have a limit of once per every 180 days.

The hospital rehabilitation services department must evaluate the recipient and complete a copy of the proposed plan of services, including the Request for Prior Authorization (PA-01) and Rehabilitation Services Request (PA-02) forms. Initial therapy and extended therapy plans must be submitted to the Unisys Prior Authorization Unit for approval prior to treatment of eligible Medicaid recipients. Completed requests are to be submitted to:

Unisys
Attn: Prior Authorization
P.O. Box 14919
Baton Rouge, La. 70898-4919

PA-01 and PA-02 forms must be completed in full when they are submitted for review. All initial requests for approval must have a copy of the physician's referral and the results of the evaluation of the patient which necessitates therapy attached. The request for therapy should be submitted within the first week of therapy, with an explanation and a request for approval from the start of therapy. In cases where delay of therapy would result in deterioration of the medical condition such as burn cases, accidents or surgery, the treatment may be instituted subject to later approval. Reimbursement for rehabilitation services provided without an approval plan for therapy will be dependent on the approval of the plan.

Requests for extensions should be submitted at least 25 days prior to the end of the approved period. This request should have current documentation attached that includes, but is not limited to, physical therapy notes, a current evaluation, goals and objectives, and a copy of the physician's referral.

If it is known that an inpatient recipient will require outpatient rehab services immediately following their discharge, a Prior Authorization request can be submitted prior to the outpatient rehab services using the patient's anticipated discharge date as the beginning date of service. This will help expedite the approval process.

NOTE: Durable Medical Equipment recommended by the physician, must be approved by the Prior Authorization Unit whether provided by the hospital or an independent durable medical equipment provider.

Description	Procedure Code
Speech/Language Evaluation	92506
Hearing Evaluation	92506
Speech/Lang/Hear Therapy – per 15 min	92507
Physical Therapy Evaluation	97001
Physical therapy – per 15 min	97110
Occupational Therapy Evaluation	97003
Occupational Therapy – per 15 min	97530

All services must be approved in advance by the Prior Authorization Unit except initial evaluations.

Note: Cardiac and Pulmonary/Respiratory therapy are not covered under Louisiana Medicaid. These services should not be prior authorized or billed using covered rehabilitation codes.

*****Please be aware that our Prior Authorization Unit is confirming medical necessity. Receiving an approved PA is not a guarantee that payment will be received.**

Instructions for Completing Prior Authorization Form (PA-01)

Note: Only The Fields Listed Below Are To Be Completed By The Provider Of Service. All Other Fields Are To Be Used By The Prior Authorization Department At Unisys.

1. Check the appropriate block to indicate the type of prior authorization requested.

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

3. Enter the recipient's social security number.

4. Enter the recipient's last name, first name and middle initial as it appears on their Medicaid card.

5. Enter the recipient's date of birth in MMDDYYYY format (MM=month, DD=day, YYYY= year).

6. Enter the provider's 7-digit Medicaid number. If associated with a group, enter the attending provider number only.

7. Enter the beginning and ending dates of service in MMDDYYYY format.

8. Enter the numeric ICD9-diagnosis code (primary & secondary) and the corresponding description.

9. Enter the day the prescription, doctor's orders was written in MMDDYYYY format.

10. Enter the name of the recipient's attending physician prescribing the services.

11. Enter the HCPCS/Procedure code.

    11A. Enter the corresponding modifiers (when appropriate)
    .

    11B. Enter the HCPCS/Procedure code's corresponding description for each procedure requested.

    11C. Enter the number of units requested for each individual HCPC/procedure.

    11D. Enter the requested charges for each individual HCPC/Procedure when it is appropriate for the requested HCPC/Procedure.

12. Enter the location for all services rendered.

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

14. Enter the name, mailing address and telephone number of the recipient's case manager, if available.

15. Provider/authorized signature are **required**. Your request will not be accepted if not signed. If using a stamped signature, it must be initialed by authorized personnel.

16. Date is required. Your request will not be accepted if field is not dated.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS:

Prior Authorization Toll-free number is 1-800-488-6334

Prior Authorization Unit number is 1-225-928-5263

Prior Authorization Fax number is 1-225-929-6803

Completed Prior Authorization Form (PA-01)

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

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

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2): 8 6 7 5 3 0 9 0 0 0 0 0 0

Social Security No. (3):

RECIPIENT LAST NAME: Firestone | FIRST: Andrew | MI (4):

DATE OF BIRTH (5): 05 27 1989

MEDICAID PROVIDER NUMBER (7- DIGIT) (6): 1 4 1 2 3 4 5

BEGIN DATE OF SERVICE (7) (MMDDYYYY): 12 08 2005

END DATE OF SERVICE (MMDDYYYY): 06 08 2006

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

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION
71942 Joint Pain/Up-arm
SECONDARY CODE & DESCRIPTION
71941 Joint Pain/Shoulder region

PRESCRIPTION DATE (9) (MMDDYYYY): 12 08 2005

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)
Dr. Cole James

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S
97110					Physical Therapy	384					

(12) PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY ___ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: ABC Hospital
ADDRESS: P. O. Box 1234
CITY: Anytown STATE: La ZIPCODE 70809
TELEPHONE: (337) 555 3825 FAX NUMBER: (337) 555 9680

(14) CASE MANAGER INFORMATION:
NAME:
ADDRESS:
CITY: STATE: ZIPCODE
TELEPHONE (____) ____ ____ FAX NUMBER: (____) ____ ____

(15) PROVIDER SIGNATURE: *Claire Belle*

(16) DATE OF REQUEST: 12/15/2005

PA-01 FORM

Prior Authorization Form (PA-01)

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

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

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (MMDDYYYY) (7)

END DATE OF SERVICE (MMDDYYYY)

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

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION
SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S	

(12)
PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY ___ OUTPATIENT HOSPITAL / CLINIC

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

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

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-01 FORM

Completed PA-02 Form

MAIL TO:
UNISYS / LA. MEDICAID
P.O. BOX 14919
Baton Rouge, La. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
REHABILITATION SERVICES REQUEST

Patient Name: **Firestone, Andrew** Age: **14** Provider Name: **ABC Hospital**

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: **Week ending 09/23/2005**

LIMITATIONS: ✓ AMBULATORY ___ NON - AMBULATORY ✓ YES ___ NO TRANSPORTATION AVAILABLE

AIDS NEEDED: ___ WALKER ___ CANE ___ WHEELCHAIR ___ LIMBS OR BRACES _____ OTHER

REHABILITATION PLAN

PLAN OF SERVICES: ✓ INITIAL _____ EXTENSION

IF INITIAL, INITIAL EVALUATION DATA AND MD REFERRAL / PRESCRIPTION MUST BE ATTACHED

IF EXTENSION, PRIOR ATTENDANCE: _____ REGULAR _____ NON-REGULAR. MUST ALSO ATTACH PROGRESS REPORTS

REQUESTED SERVICES:	PROCEDURE CODE	DESCRIPTION	FREQUENCY	TIME / VISIT	TOTAL UNITS
PHYSICAL THERAPY:	**97110**	**Physical Therapist**	**4 X Wk**		**384**
SPEECH THERAPY:					
OCCUPATIONAL THERAPY					

LENGTH OF PLAN SERVICE: FROM: **12** (MONTH) **08** (DAY) **2005** (YEAR) TO: **06** (MONTH) **08** (DAY) **2006** (YEAR)

DATE OF RE - EVALUATION: **06** (MONTH) **09** (DAY) **2006** (YEAR)

PROPOSED GOALS / COMMENTS: **Increase ROM L Elbow**

REQUESTED BY: *Mary Smith* DATE: **12/15/2005**

P.A 02 FORM (ISSUED 01/91)

PA-02 Form

MAIL TO:
UNISYS / LA. MEDICAID
P.O. BOX 14919
Baton Rouge, La. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
REHABILITATION SERVICES REQUEST

Patient Name: _____ Age: _____ Provider Name: _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: _____

LIMITATIONS : ___ AMBULATORY ___ NON - AMBULATORY ___ YES ___ NO TRANSPORTATION AVAILABLE
AIDS NEEDED: ___ WALKER ___ CANE ___ WHEELCHAIR ___ LIMBS OR BRACES _____ OTHER

REHABILITATION PLAN

PLAN OF SERVICES: _____ INITIAL _____ EXTENSION
IF INITIAL , INITIAL EVALUATION DATA AND MD REFERRAL / PRESCRIPTION MUST BE ATTACHED
IF EXTENSION, PRIOR ATTENDANCE : _____ REGULAR _____ NON-REGULAR. MUST ALSO ATTACH PROGRESS REPORTS

REQUESTED SERVICES: PROCEDURE CODE DESCRIPTION FREQUENCY TIME / VISIT TOTAL UNITS

PHYSICAL THERAPY: _____

SPEECH THERAPY: _____

OCCUPATIONAL THERAPY _____

LENGTH OF PLAN SERVICE: FROM: _____ TO : _____
MONTH DAY YEAR MONTH DAY YEAR

DATE OF RE – EVALUATION: _____
MONTH DAY YEAR

PROPOSED GOALS / COMMENTS: _____

REQUESTED BY : _____ DATE: _____

P.A 02 FORM (ISSUED 01/91)

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

DATE 03/17/2006 RECIPIENT NAME
PRIOR AUTH. NBR RECIPIENT NUMBER

PROVIDER NUMBER

DEAR PROVIDER,

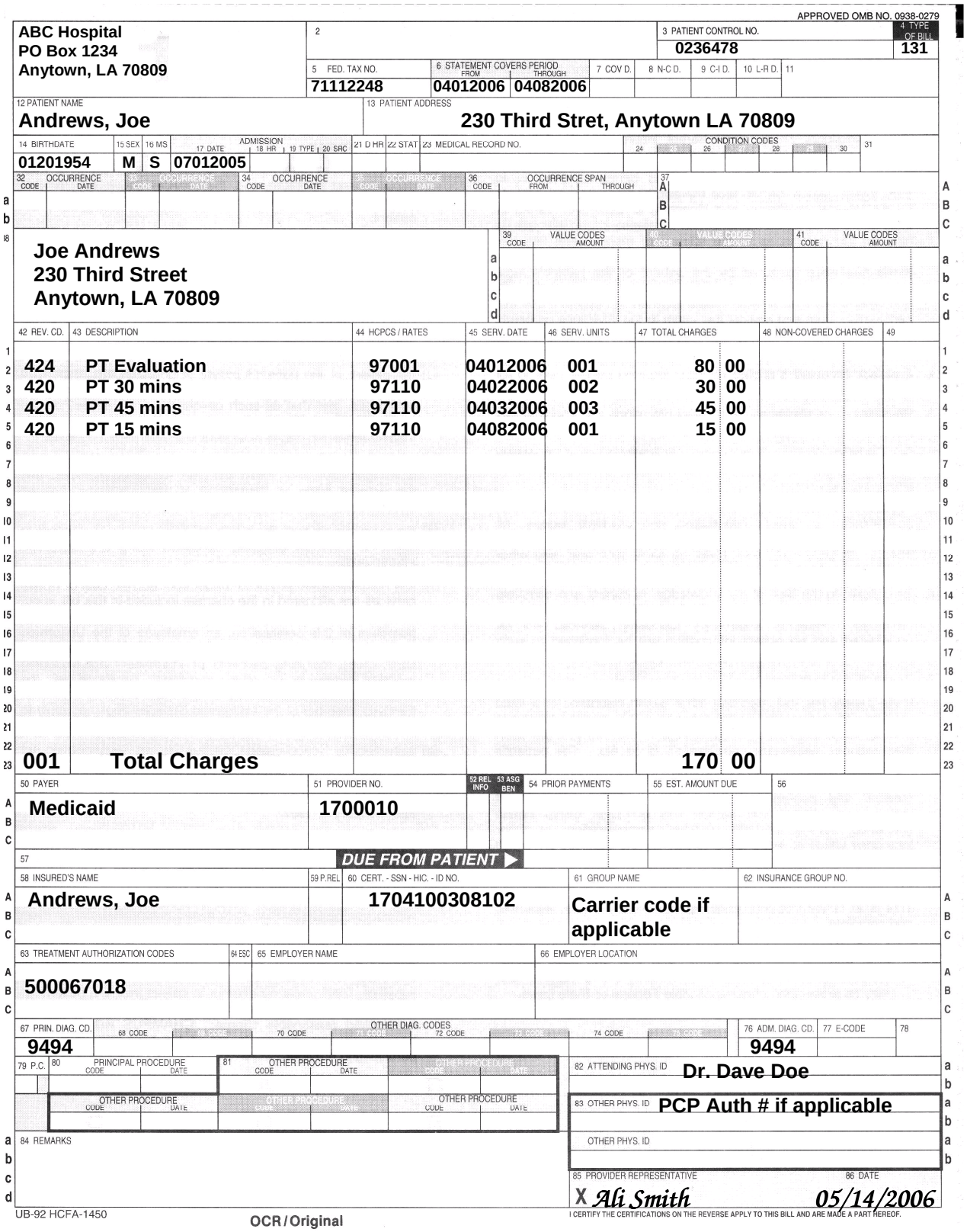
THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW. IF ANY OF THE APPROVED ASTERISKED(*) SERVICES ARE REQUIRED BEYOND THE APPROVED DATES OF SERVICE, YOU MUST FILE A REQUEST FOR A CONTINUATION OF APPROVED SERVICES BY 03/21/2006 (25 DAYS BEFORE THE END OF THE APPROVED SERVICE DATE). IF YOU FAIL TO SUBMIT A CONTINUATION OF SERVICES REQUEST BY 03/21/2006, THESE SERVICES WILL NOT BE CONTINUED.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
*97110 -THERAPEUTIC PROCEDURE,LOR	72	03/20/2006-04/15/2006	APPROVED

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

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

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



APPROVED OMB NO. 0938-0279

ABC Hospital PO Box 1234 Anytown, LA 70809	2	3 PATIENT CONTROL NO. 0236478	4 TYPE OF BILL 131
	5 FED. TAX NO. 71112248	6 STATEMENT COVERS PERIOD FROM 04012006	THROUGH 04082006

12 PATIENT NAME	13 PATIENT ADDRESS
Andrews, Joe	230 Third Stret, Anytown LA 70809

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
01201954	M	S	07012005														

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

Joe Andrews
230 Third Street
Anytown, LA 70809

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2	424	PT Evaluation	97001	04012006	001	80 00		
3	420	PT 30 mins	97110	04022006	002	30 00		
4	420	PT 45 mins	97110	04032006	003	45 00		
5	420	PT 15 mins	97110	04082006	001	15 00		
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11								
12								
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16								
17								
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19								
20								
21								
22								
23	001	Total Charges				170 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	1700010					

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Andrews, Joe		1704100308102	Carrier code if applicable	

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
500067018			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
9494									9494		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: Dr. Dave Doe

83 OTHER PHYS. ID: PCP Auth # if applicable

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Ali Smith

86 DATE: 05/14/2006

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

UB-92 HCFA-1450

OCR / Original

Cost – To – Charge Ratio (CCR)

All Private Acute Care, Rehab and Long Term Care facilities will be assigned a specific CCR based on their last filed cost report. DHH quarterly adjusts the CCR as cost reports are filed. Annually, an average CCR will be assigned to those providers who have never filed a cost report. Notification will be mailed quarterly and annually to those providers who are affected. Final reimbursement for outpatient services will continue to be adjusted at cost settlement to 83% of the allowable costs documented in the cost report, except for lab services subject to a fee schedule and outpatient surgeries.

DHH urges Hospitals and Rehabs to include the CPT/HCPC information on all outpatient charges. The detailed billing on the claim form along with the cost reports will form the basis for future rate determination.

****Please remember to always include an 8-digit date of service for each outpatient line item being billed.**

Outpatient Surgery Program (Ambulatory Surgery)

Health Insurance Portability and Accountability Act (HIPAA) regulations mandate that ICD-9 surgical procedure codes are no longer used for billing outpatient claims for Ambulatory Surgery. Effective with dates of service March 1, 2005, the Louisiana Medicaid program requires the use of CPT/HCPC codes for billing outpatient ambulatory surgery procedures.

Medicaid has adopted Medicare's list of payable ambulatory surgery codes and reimbursement groups. However, DHH is reviewing all CPT codes which fall in the range of 10021 through 69990 for possible inclusion in our ambulatory surgery list. As this is a very complicated and time consuming process, we have created a Hospital Outpatient Ambulatory Surgery Fee Schedule which has been placed on our website. This fee schedule will automatically update at the beginning of each month. The fee schedule may be accessed at the website www.lamedicaid.com. Click on Fee Schedules and then click on Hospital Outpatient Ambulatory Fee Schedule. There is no need to inform either DHH or Unisys Provider Relations of any codes which are not currently on the fee schedule.

Revenue code 490 is to be used for billing the ambulatory surgery along with the appropriate CPT/HCPC code. Outpatient ambulatory surgery claims are not to be billed as a single line claim. Services performed in conjunction with ambulatory surgical procedures should continue to be billed on the claim and will deny with a 774 (included in related procedure) code. Codes which have not been either assigned a group or are not considered ambulatory surgery will continue to receive a 114 denial code.

Claims can continue to contain multiple revenue code 490's. If a claim contains more than one (1) revenue code 490, only the approved revenue code 490 with the highest group will be reimbursed. A provider will not be reimbursed for multiple HR490's billed on a claim.

MEDICARE/MEDICAID COVERAGE

Provided in this section is the Medicaid coverage criteria for Medicare/Medicaid recipients.

Qualified Medicare Beneficiaries (QMBs)

QMBs are covered under the ***Medicare Catastrophic Coverage Act of 1988***. This act expands Medicaid coverage and benefits for certain persons aged 65 years and older as well as disabled persons who are eligible for Medicare Hospital Insurance (Part A) benefits and who:

- Have incomes less than 90 percent of the Federal poverty level,
- Have countable resources worth less than twice the level allowed for Supplemental Security Income (SSI) applicants,
- Have the general nonfinancial requirements or conditions of eligibility for Medical Assistance, i.e., application filing, residency, citizenship, and assignments of rights.

Individuals under this program are referred to as Qualified Medicare Beneficiaries (QMBs). The three groups of recipients under this category are: QMB Only, QMB Plus and Non-QMB.

QMBs	Status
QMB Only (Formerly Pure QMB)	Identified through the REVS and MEVS systems and are eligible only for Medicaid payment of deductibles and coinsurance for all Medicare covered services.
QMB Plus (Formerly Dual QMB)	Individuals who are eligible for both Medicare and traditional types of Medicaid coverage (SSI, etc). QMB Plus is identified by the REVS and MEVS systems and are eligible for Medicaid payment of deductibles and coinsurance for all Medicare covered services as well as for Medicaid covered services.
Non QMBs	Identified in the TPL segment of REVS. Non QMBs are eligible for only Medicare and Medicaid covered services.

In addition, for those persons who are eligible for Part A premium, but must pay for their own premiums, the State will now pay for their Part A premium, if they qualify as a QMB. The State will continue to also "buy-in" for Part B (Medical Insurance) benefits under Medicare for this segment of the population.

The Crossover Process

The hospital should submit the claims for Medicare Part A inpatient charges and Medicare Part B ancillary charges to their Medicare intermediary for reimbursement. After Medicare makes their payment, the claims will cross over to Unisys for payment of the co-insurance and deductible. In the event that a hospital does not receive any reimbursement for crossover claims, the hospital should contact the Provider Relations Unit to ascertain that the correct Medicare provider number is indicated on the MMIS cross reference file. Although the Medicare register may indicate that a claim was crossed over, the claim may fail to appear on the Medicaid remittance advice in some instances.

Claims failing to automatically cross over for Medicaid reimbursement after Medicare pays have been a continuous problem. Unisys and DHH have applied much time and effort toward rectifying the situation. Some of the identified causes for claims not crossing over automatically are:

- Providers' Medicare and Medicaid numbers not properly cross-referenced on Medicaid files
- Error on recipient files (such as an incorrect Medicare number)
- Bad tapes received from Medicare intermediaries

However, some claims not crossing over cannot be explained.

Crossover claims must be tracked by the provider to ensure that Medicaid receives and processes them. If a Medicare claim does not appear on the hospital's Medicaid remittance advice within four weeks of the date of the Medicare Explanation of Benefits (EOB), the hospital must submit a paper claim with the Medicare EOB attached to Unisys to ensure compliance with the timely filing limitations.

Claims for recipients with Medicare and Medicaid absolutely must be filed to Medicare within one year from the date of service. If the claim is being filed to Medicaid after one year from the date of service, the claim must be filed within six months of the date on the Medicare Explanation of Benefits (EOB).

Should your claim fail to crossover electronically, you should be certain to file your claim to Unisys exactly as it was submitted to Medicare. Always attach a copy of the EOMB when filing claims hard copy. DHH has received many different versions of electronic EOMBs which have been generated from an "internal" program. Providers should ensure that the hard copy EOB submitted for consideration is an official Medicare EOB.

Inpatient Part A Crossovers

The Medicare payment will be compared to the number of days billed times the Medicaid inpatient per diem rate. If the Medicare payment is more than what the Medicaid payment would have been, Medicaid will approve the claim at "zero". If the Medicare payment is less, then Medicaid will pay on the Deductible and Coinsurance, up to what Medicaid would have paid as a Medicaid only claim not to exceed the coinsurance and deductible amounts.

These claims will be indicated on the Remittance Advice as "Approved Claims", with an error code of 996 ("deductible and or coinsurance reduced to max allowable"), and a reduced or zero payment. **These are considered paid claims and may not be billed to the recipient.**

Pre-certification Requirements (for recipients with Medicare and Medicaid)

Coverage	Pre-certification Required?
Medicare Part A Only – not exhausted	No
Medicare Part A Only – exhausted	Yes – must have Medicare EOB to show the days are exhausted (with PCF01). EOMB should show the first denial date of Medicare exhaust for days.
Medicare Part B Only	Yes
Medicare Parts A and B – Part A not exhausted	No
Medicare Parts A and B – Part A exhausted	Yes – must have Medicare EOB to show the days are exhausted (with PCF01).

Note: Remember that the provider has only 60 days from the notification date on the EOB to precert.

Medicare Part A and B Claims

The hospital should bill the Medicare intermediary for the inpatient portion covered by Part A and the ancillaries covered by Part B. The Medicare intermediary will make payment and cross the claims over to Unisys for payment up to co-insurance and deductible amounts.

Medicare Part A Only Claims

If the recipient only has Medicare Part A coverage, then the hospital should submit an inpatient claim, including the ancillary charges, to its Medicare intermediary for reimbursement. The claim will cross over automatically to Medicaid for payment of the co-insurance and deductible amounts for the inpatient stay.

Exhausted Medicare Part A Claims

Occasionally Medicare/Medicaid recipients will exhaust not only their 90 days of inpatient care under Medicare Part A, but also their 60 lifetime reserve days. When this situation occurs, the hospital must submit a claim for the ancillary charges to its Medicare intermediary for reimbursement. Then the hospital must submit a paper claim with documentation of Medicare Part A being exhausted, e.g., a Notice of Medicare Claim Determination or the Medicare Part A EOB, and a copy of the Medicare Part B EOB to Unisys for processing.

The following items must be completed for the claim to be paid:

- **121 must be entered in form locator 4 as the type of bill.**
- **The amount in the Total Charges column of the Medicare EOB (the dollar amount billed to Medicare Part B, not what has been paid by Part B) must be entered in form locator 54 as a third party payment.**
- **"Medicare Part A Benefits Exhausted" should be written in form locator 84.**

The dates of service on the claim must match the dates of service on the Notice of Medicare Claim Determination or the Part A EOB to verify that Part A benefits have been exhausted. The exceptions to this rule are Medically Needy Spend-down claims where the effective date of Medicaid eligibility is after the date of admission and extended care claims from facilities designated as extended care hospitals by Medicaid.

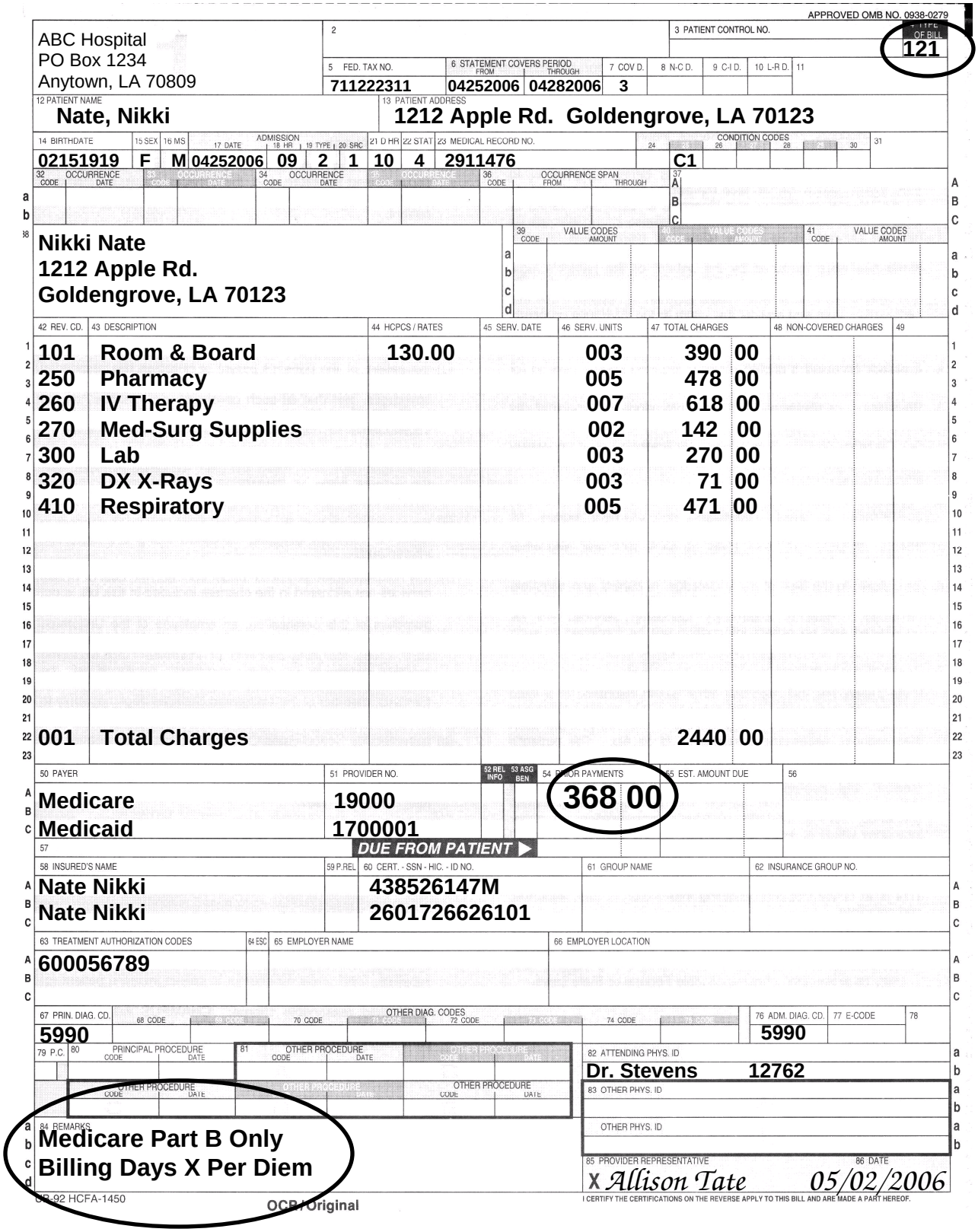
Medicare Part B Only Claims

If the recipient only has Medicare Part B coverage, then the hospital should submit a claim for the ancillary charges to its Medicare intermediary for reimbursement. After Medicare has made its payment, the hospital should submit a claim for the inpatient charges (**including ancillary charges**), with the Medicare Part B EOB attached, to Unisys. The following items must be completed for the claim to be paid.

- **121 must be entered in form locator 4 as the type of bill.**
- **The amount in the Total Charges column of the Medicare EOB (the dollar amount billed to Medicare Part B, not what has been paid by Part B) must be entered in form locator 54.**
- **"Medicare Part B Only" must be written in form locator 84.**

Unisys will process the claim for the allowable days and multiply the number of days by the hospital's per diem rate. The total Part B charges indicated in form locator 54 would then be deducted to calculate the payment for the claim.

NOTE: When filing for coinsurance and deductible on the ancillary charges, make sure that total charges filed to Part B equal total charges being filed on the UB92. A copy of the Medicare Part B EOB must be attached to the claim.



APPROVED OMB NO. 0938-0279

ABC Hospital
PO Box 1234
Anytown, LA 70809

2

3 PATIENT CONTROL NO.

TYPE OF BILL: 121

5 FED. TAX NO.: 711222311

6 STATEMENT COVERS PERIOD FROM: 04252006 THROUGH: 04282006

7 COV D.: 3

8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Nate, Nikki

13 PATIENT ADDRESS: 1212 Apple Rd. Goldengrove, LA 70123

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	31
02151919	F	M	04252006	09	2	1	10	4	2911476	C1	

32 OCCURRENCE CODE / DATE | 33 OCCURRENCE CODE / DATE | 34 OCCURRENCE CODE / DATE | 35 OCCURRENCE CODE / DATE | 36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37

38 Nikki Nate
1212 Apple Rd.
Goldengrove, LA 70123

39 VALUE CODES CODE / AMOUNT | 40 VALUE CODES CODE / AMOUNT | 41 VALUE CODES CODE / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
101	Room & Board	130.00		003	390 00		
250	Pharmacy			005	478 00		
260	IV Therapy			007	618 00		
270	Med-Surg Supplies			002	142 00		
300	Lab			003	270 00		
320	DX X-Rays			003	71 00		
410	Respiratory			005	471 00		
001	Total Charges				2440 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	19000			368 00		
Medicaid	1700001					
57	DUE FROM PATIENT ▶					

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Nate Nikki		438526147M		
Nate Nikki		2601726626101		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
600056789			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
5990									5990		

79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID: Dr. Stevens 12762

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS
Medicare Part B Only
Billing Days X Per Diem

85 PROVIDER REPRESENTATIVE: X Allison Tate

86 DATE: 05/02/2006

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

OCR-92 HCFA-1450

OCR/Original

RECOUPMENTS

Recoupments by TPL Collections Contractor – Health Management Systems

Recoupments are routinely made by Health Management Systems (HMS), a TPL Collections contractor. This private company is contracted by DHH to review payments and recoup any payment made as Medicaid primary when the recipient had Medicare or private insurance.

HMS identifies these claims and notifies the provider via letter with a claim report of Medicaid recipients whose claims paid as Medicaid primary when other resources were available. One week after the letter is mailed, the provider is contacted to verify receipt of the letter, to answer questions, and to discuss documentation. The providers are allowed approximately 60 days to bill Medicare or the private insurance company. Ten (10) days prior to date of recoupment, the provider will again be contacted by HMS ensuring that they understood requirements and time frames. At the end of the 60 days, information is sent to Unisys to recoup the payments. When an "H" appears at the beginning of the medical records number found on the Medicaid remittance advice, it is a HMS recoupment. For further information, the provider may call the HMS Provider Recoupment Team at (877) 259-3307.

Quarterly Medicare Recoveries By Unisys

Every quarter Unisys does a Medicare recovery where DHH has identified recipients who have Medicare coverage and Medicaid has paid claims that should have been submitted to Medicare for primary payment.

Approximately two weeks before these recoveries are made; the provider receives a letter with a listing of recipients for which the recoupments will be made. The recoupments are for Part A Medicare and appear as voids on the provider's Medicaid remittance advice. Examples of both the recoupment letter and a list of recipient recoupments follow.

********** MEDICARE RECOVERY ADJ/VOID NOTIFICATION **********

FEDERAL REGULATIONS REQUIRE THAT THE LA MEDICAL ASSISTANCE PROGRAM RECOVER MEDICAID PAYMENTS FOR SERVICES WHICH SHOULD HAVE BEEN COVERED BY MEDICARE PART A OR PART B WHICH MUST BE FILED TO THE PART A CARRIER. REVIEW THE ENCLOSED CLAIM LISTING WHICH SHOWS CLAIMS THAT WILL BE AUTOMATICALLY VOIDED (PART A SERVICES) OR ADJUSTED (DEDUCTION OF INPATIENT PART B ANCILLARY) BY UNISYS APPROXIMATELY 2 WEEKS AFTER RECEIPT OF THIS LETTER. CLAIMS WITH DATES OF SERVICE FROM JANUARY 1 THROUGH SEPTEMBER 30 CAN BE FILED TO MEDICARE UNTIL DECEMBER 31 OF THE FOLLOWING YEAR. CLAIMS WITH DATES OF SERVICE FROM OCTOBER 1 THROUGH DECEMBER 31 CAN BE FILED TO MEDICARE UNTIL DECEMBER 31 TWO YEARS FOLLOWING THE YEAR OF THE DATE OF SERVICE. IT IS RECOMMENDED THAT FILING TO MEDICARE BE DONE PROMPTLY UPON RECEIPT OF THIS NOTIFICATION. CLAIMS FILED TO PART A BLUE CROSS/BLUE SHIELD MISSISSIPPI, TO TEXAS BLUE CROSS (HEMODIALYSIS FACILITIES ONLY), OR TO MUTUAL OF OMAHA'S MEDICARE DIVISION AUTOMATICALLY CROSS TO LA MEDICAID FOR COINSURANCE AND DEDUCTIBLE PAYMENT RECONSIDERATION. CLAIMS FILED TO OTHER MEDICARE CARRIERS MUST BE REFILED HARDCOPY TO UNISYS WITH A COPY OF THE MEDICARE EOMB. ALL REFILES MUST BE PROCESSED EITHER BEFORE EXPIRATION OF ONE YEAR FROM DATE OF SERVICE OR SIX MONTHS FROM MEDICARE ADJUDICATION DATE. MAIL HARDCOPY CROSSOVERS TO UNISYS, PO BOX 91023, BATON ROUGE, LA 70821. THE INPATIENT PORTION OF YOUR CLAIM FOR A RECIPIENT WHO HAS PART B ONLY WILL REMAIN PAID AND YOU WILL BE ENTITLED ONLY TO COINSURANCE AND DEDUCTIBLE FOR THE ANCILLARIES ASSOCIATED WITH THE INPATIENT STAY. FOR A CLAIM THAT WAS VOIDED/ADJUSTED IN ERROR, MAIL TO ATTN: MEDICARE PROJECT COORDINATOR AT THE ADDRESS SHOWN BELOW (1) CLAIM FORM, (2) COPY OF CLAIM LISTING OR UNISYS REMITTANCE ADVICE SHOWING VOID, (3) OTHER PERTINENT INFORMATION - NOTATE IF CLAIM VOIDED IN ERROR. DO NOT SEND CLAIMS VOIDED IN ERROR TO UNISYS AS THEY WILL BE DENIED. QUESTIONABLE MEDICARE ENTITLEMENT WILL BE DETERMINED BY THE TPL/MEDICAID RECOVERY UNIT IN ORDER TO RESOLVE A CLAIM. IF PAYMENT FOR THE COINSURANCE AND/OR DEDUCTIBLE IS DENIED FOR ERROR CODE 911 (RECIPIENT HAS USED ALL ALLOWABLE HOSPITAL DAYS), SEND THESE CLAIMS TO ATTN: MEDICARE PROJECT COORDINATOR, ADDRESS SHOWN BELOW, AND INCLUDE (1) CLAIM FORM, (2) MEDICARE EOMB, (3) UNISYS REMITTANCE ADVICE SHOWING VOID AND 911 DENIAL.

ADDRESS - TPL/MEDICAID RECOVERY UNIT
PO BOX 91030
BATON ROUGE, LA 70821-9030

LAM2DO12 CP-O-12C
RUN:

LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS
DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAL (BHSF)

PROVIDER ID:

CYCLE:

MEDICARE RECOVERY PROJECT - CLAIM DETAIL LISTING

PAGE: 1

RECIPIENT ID	HIC	NAME	MEDICARE TYPE COVG	CLAIM ICN	PROC	DATES OF SERVICE	MEDICAID PAYMENT	HOSPITAL ANCILLARIES
			PART B		HR821	01/12/2004-01/12/2004	$123.99	$0.00
	*** TOTAL:	RECORDS 1					$123.99	$0.00

MEDICARE ADVANTAGE CHOICE CLAIMS

Medicare Advantage Plan Claims

All recipients participating in a Medicare Advantage Plan must have both Medicare Part A and Medicare Part B.

The Medicare Advantage Care Plans currently participating in this program are: Humana Gold Plus, Kaiser Permante, SelectCare of Texas, Sterling Option One, Tenet PPO, Tenet 65, United Healthcare of Florida Medicare and Wellcare. These plans have been added to the Medicaid third Party Resource File for the appropriate recipients with six-digit alpha-numeric carrier codes that begin with the letter "H".

When possible these plans will cross the Medicare claims directly to Medicaid electronically, just as Medicare carriers electronically transmit Medicare crossover claims. These claims will be processed just as claims crossing directly from a Medicare carrier. If claims do not cross electronically from the carriers within 30-45 days from the Medicare plan EOB date, providers must submit paper claims with the Medicare plan EOB attached to each claim.

NOTE: Sterling Option One will not electronically transmit claims to Unisys. Providers in the Sterling Option One network should submit claims hard copy to Unisys.

When it is necessary for providers to submit claims hard copy, the appropriate carrier code must be entered on each hard copy claim form in order for the claim to process correctly. The carrier codes follow:

Humana Gold Plus	H19510	Kaiser Permante	H05240
SelectCare of Texas	H45060	Sterling Option One	H50060
Tenet PPO	H19010	Tenet 65	H19610
United Healthcare of Florida Medicare	H90110	Wellcare	H19030

Hard copy claims submitted without the plan EOB and without a six-digit carrier code beginning with an "H" will deny 275 (Medicare eligible). Both the EOB and the correct carrier code are required for these claims to process properly.

Providers may not submit these claims electronically. Electronic submissions directly from providers will deny 966 (submit hard copy claim).

When it is necessary to submit these claims hardcopy, a Medicare Advantage Plan Institutional or Professional cover sheet **MUST** be completed in its entirety **for each claim** and attached to the top of the claim and EOB. Claims received without this cover sheet will be rejected. A example of these cover sheets is included in this packet and may also be obtained from the Louisiana Medicaid website at www.lamedicaid.com under "Forms/Files".

The calculated reimbursement methodology currently used for pricing Medicare claims will be used to price these claims. Thus, claims may price and pay a zero payment if the plan payment exceeds the Medicaid allowable for the service.

Timely filing guidelines applicable for Medicare crossover claims apply for Medicare Plus Choice claims.

MEDICARE ADVANTAGE INSTITUTIONAL CROSSOVER COVER SHEET UB-92

Review Instructions in their entirety before completing this form.

Inaccurate/Incomplete Cover Sheets will not be processed and will be returned for correction.

1. Medicaid Assigned Carrier Code

H					0

2. Medicare Paid Date (MM-DD-YYYY)

		-			-				

3. Provider Number

4. Recipient Identification Number (13 digits)

5. Total Deductible Amount

6. Blood Deductible Amount

7. Medicare Per Diem Rate

8. Total Medicare Payment Amount

9. Co-Pay Amount

Instructions – please review in their entirety before completing this form.

This form is to be completed for all Institutional Crossover Claims provided by a Medicare Advantage Carrier. This form is to be attached to the top of each UB-92 and must be completed in its entirety before submission of the claim. **Inaccurate/Incomplete Cover Sheets will be not be processed and will be returned for correction.**

---

1. **Medicaid Assigned Carrier Code** – enter the six- (6) digit carrier code assigned to the Medicare Advantage provider. All codes begin with H and ends with a trailing 0 (zero).
2. **Medicare Paid Date** – enter the date of the Medicare Advantage Carrier Explanation of Benefits.
3. **Medicaid Provider Number** – enter the seven (7) digit provider number of the billing provider
4. **Recipient Identification Number** – enter the thirteen (13) digit Louisiana Medicaid recipient identification number. (The sixteen (16) digit Card Control Number is not acceptable.)
5. **Total Deductible Amount** – enter the amount of Deductible identified on the Explanation of Benefits **IF** it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, do not enter anything in this box.
6. **Blood Deductible Amount** – enter the amount of blood deductible if identified on the Explanation of Benefits
7. **Medicare Per Diem Rate** – enter the Per Diem Rate as identified on the Explanation of Benefits, if applicable
8. **Total Medicare Payment Amount** – enter the amount paid by Medicare as identified on the Explanation of Benefits
9. **Total Co-Pay Amount** – enter the amount of Co-Pay identified on the Explanation of Benefits **IF** it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, enter the Deductible/Co-pay amount in this box.

MEDICARE ADVANTAGE PROFESSIONAL CROSSOVER COVER SHEET INSTRUCTIONS

Preparation

This form is to be completed for all Professional Crossover Claims provided by a Medicare Advantage Carrier. This form is to be attached to the top of each CMS1500 and must be completed in its entirety before submission of the claim. **Inaccurate/Incomplete Cover Sheets will not be processed and will be returned for correction.**

---

1. **Medicaid Assigned Carrier Code** – enter the six- (6) digit carrier code assigned to the Medicare Advantage provider. All codes begin with H. and end with a trailing 0.(zero).
2. **Medicare Paid Date** – enter the date of the Medicare Advantage Carrier Explanation of Benefits.
3. **Medicaid Provider Number** – enter the seven (7) digit provider number of the billing provider
4. **Recipient Identification Number** – enter the thirteen (13) digit Louisiana Medicaid recipient identification number. (The sixteen (16) digit Card Control Number is not acceptable.)
5. **Information for Line 1**
    - **Line Medicare Allowed Amount** –enter the amount Medicare allowed for the charges on the line.
    - **Total Deductible Amount** – enter the amount of Deductible identified on the Explanation of Benefits IF it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, do not enter anything in this box.
    - **Total Co-Pay Amount** – enter the amount of Co-Pay identified on the Explanation of Benefits IF it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, enter the Deductible/Co-pay amount in this box.
    - **Total Medicare Payment Amount** – enter the total amount Medicare paid on this line charge.
6. **Information for Lines 2-6** – enter the requested amount for each claim line as outlined in Information for Line 1

MEDICARE ADVANTAGE PROFESSIONAL CROSSOVER COVER SHEET CMS 1500

Review instructions in their entirety before completing this form.

Inaccurate/Incomplete Cover Sheets will not be processed and will be returned for correction.

Medicaid Assigned Carrier Code

H | | | | | 0

Medicare Paid Date (MM-DD-YYYY)

| | | - | | | - | | | | |

Provider Number

Recipient Identification Number (13 digits)

Information for Claim Line 1

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 2

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 3

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 4

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 5

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 6

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

* If EOB combines Total Deductible & Co-Pay Amounts, enter total in Co-Pay only (Leave Deductible Amount blank).

OUT-OF-STATE HOSPITALS

Out-Of-State Services

The Louisiana Medicaid Program will reimburse claims for medical services provided to Louisiana Medicaid eligible recipients who are temporarily absent from the state when an emergency is caused by accident or illness, when the health of the recipient would be endangered if the recipient undertook travel to return to Louisiana or when the health of the recipient would be endangered if medical care were postponed until the recipient returns to Louisiana. For reimbursement, the out-of-state provider must enroll as a Louisiana Medicaid Provider by contacting Provider Enrollment at 225-216-6370, and must follow established timely filing guidelines for submitting claims.

Our Out-of-State policy requires prior authorization for all non-emergency hospitalizations, which includes both inpatient and outpatient procedures for providers located either within or outside the trade area. If a recipient is both Medicare and Medicaid eligible, authorization is not required unless transportation services are being requested in addition to the hospitalization.

Louisiana Medicaid will provide reimbursement to those approved out-of-state facilities to provide medically necessary services to Louisiana Medicaid recipients when the needed services are not available in Louisiana, after approval by the Prior Authorization Unit (PAU) at Unisys. This includes requests for Transplants.

Non-emergency services are also covered when provided by facilities located within the Trade Area. The facilities located within the Trade Area will be treated the same as those within our state. Policies governing both prior authorization and pre-certification apply. Please see their sections for complete instructions.

For those providers outside the trade area, reimbursement for inpatient hospitalizations will be made at the rate of 40% of billed charges for recipients 21 and over, or at the rate of 60% of billed charges for recipients under the age of 21. Outpatient hospital services will be reimbursed at 31.04% of billed charges except for ambulatory surgical procedures, outpatient laboratory procedures, and rehabilitation services, which are reimbursed in accordance with a fee schedule.

Trade Area

Effective March 1, 2005, the definition of the Louisiana Trade Area was changed. The trade area consists of those counties located in Mississippi, Arkansas and Texas that border the State of Louisiana. The facilities located within this trade area will be treated the same as those within our state.

The policy remains that the Medicaid program will reimburse claims for medical services provided to eligible recipients who are temporarily absent from the state when an emergency is caused by accident or illness, when the health of the recipient would be endangered if the recipient undertook travel to return to Louisiana, or when the health of the recipient would be endangered if medical care were postponed until the recipient returns to Louisiana.

Authorization may be approved if the medical care or needed supplemental resources are not available in Louisiana. In-state providers must utilize resources available within the state prior to referring recipients out-of-state for treatment. Prior Authorization will not be granted outside the trade area unless in-state resources have been exhausted or are not available. Below is a list of those counties which are located in our trade area.

Arkansas Counties	**Mississippi Counties**	**Texas Counties**
Chicot County	Hancock County	Cass County
Ashley County	Pearl River County	Marion County
Union County	Marion County	Harrison County
Columbia County	Walthall County	Panola County
Lafayette County	Pike County	Shelby County
Miller County	Amite County	Sabine County
	Wilkinson County	Newton County
	Adams County	Orange County
	Jefferson County	Jefferson County
	Claiborne County	
	Washington County	
	Issaquena County	
	Warren County	

Out-Of-State Hospitals – Outpatient Surgery Performed On An Inpatient Basis

Out-of-state providers requesting authorization for outpatient surgery performed on an inpatient basis must use the Prior Authorization request form (PA-01) located on page 70. In addition, to expedite the review process, providers must continue to attach the appropriate medical data to substantiate the need for the service being provided in an inpatient setting. Documentation of extenuating circumstances should be submitted along with the request.

Medical authorization for the surgical procedure does not replace or in any way affect other policy requirements which may apply to surgical claims; e.g., sterilization consent requirements, recipient ineligibility for inpatient services and timely filing requirements. Medical authorization means only that the proposed procedure meets Louisiana Medicaid requirements of medical necessity for the service to be performed on an inpatient basis. If otherwise eligible for payment, a claim for the described services will be paid.

NOTE: When both the primary and secondary procedures require PA, all procedure codes must be listed on the PA-01 request for authorization.

Completed PA-01 forms should be submitted to the address indicated on the form which is:

Unisys/Louisiana Medicaid
P.O. Box 14919
Baton Rouge, La. 70898-4919

The PA-01 form should be submitted prior to the surgery; however, post authorization may be requested in certain instances. Approval for inpatient performance of these procedures will be granted only when one or more of the following exception criteria exist:

- The presence of documented medical condition(s) which make prolonged pre-and/or postoperative observation by a nurse or skilled medical personnel a necessity;
- The procedure is likely to be time consuming or followed by complication;
- An unrelated procedure is being done simultaneously which requires hospitalization;
- There is a lack of availability of proper postoperative care;
- It is likely that another major surgical procedure could follow the initial procedure, e.g., mastectomy;
- Technical difficulties as documented by admission or operative notes could exist; and/or
- The procedure carries high patient risk.

Note: Prior Authorization is not required if the procedure is performed on an outpatient basis.

Reimbursement to hospitals for surgical procedures approved for inpatient performance will be made in accordance with either the hospital's per diem rate or a percentage of billed charges based on the recipient's age.

Inpatient Stays For Psychiatric And Substance Abuse (Out-Of- State Hospitals)

Inpatient stays for psychiatric or substance abuse treatment are only covered in out-of-state hospitals in the event of a medical emergency, for a maximum of two (2) days, to allow time for the patient to be stabilized and transferred to a Louisiana psychiatric hospital when appropriate. Outpatient psychiatric and substance abuse services provided by a hospital are not covered. Foster children are excluded from this policy.

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

March 22, 2006

Reference:
ID#:
SS#:

Dear

This is to confirm that out-of-state hospitalization for the above referenced recipient at has been approved.

The approval for this procedure is contingent upon your acceptance of the Medicaid payment as payment in full and that you are a Louisiana Medicaid enrolled provider. Reimbursement for inpatient hospitalizations will be made at the rate of 40% of billed charges for recipients age 21 and over or at the rate of 60% of billed charges for recipients under the age of 21. These rates are in accordance with our approved State Plan and therefore are non-negotiable.

Reimbursement for outpatient hospital services will be reimbursed at 31.04% of billed charges except for ambulatory surgical procedures, outpatient laboratory procedures, and rehabilitation services, which are reimbursed in accordance with a fee schedule. Physicians will be reimbursed in accordance with the physician fee schedule for the appropriate CPT code up to the maximum allowed amount. Also, the client must be eligible for Medicaid on dates of services in order to receive reimbursement from Medicaid. To be reimbursed for services rendered, all providers must comply with timely filing guidelines set by the Louisiana Medicaid Program.

Please attach a copy of this letter to your claim form as your authorization when billing Unisys Corporation for this service.

You have the right to appeal this decision. If you wish to do so, please write to the Department of Health and Hospitals, Bureau of Appeals, P. O. Box 4183, Baton Rouge, LA 70821-4183 within thirty (30) days of receipt of this letter.

Sincerely,

Jerry Phillips
Acting Medicaid Director

JP/SG/jab

cc: J. Womack
D. Gough
S. Guarino
P. Misner

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE # 225/342-3891 • FAX # 225/342-9508
"AN EQUAL OPPORTUNITY EMPLOYER"

CONSENT FORM PROCEDURES

Hysterectomies

Federal regulations governing payment of a hysterectomy under Medicaid (Title XIX) prohibit payment for a hysterectomy under the following circumstances:

- If the hysterectomy is performed solely for the purpose of terminating reproductive capability

OR

- If there was more than one purpose for performing the hysterectomy, but the procedure would not have been performed except for the purpose of rendering the individual permanently incapable of reproducing.

In addition, according to Louisiana Medicaid Program guidelines, if a hysterectomy is performed, payment can be made only if the patient is informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing and only if she has signed a written acknowledgment of receipt of this information.

This regulation applies to all hysterectomy procedures, regardless of the woman's age, fertility, or reason for the surgery.

BHSF Form 96-A

Providers should use BHSF Form 96-A, which can be obtained from BHSF or providers may copy and use the example that follows this section.

The BHSF Form 96-A must be signed and dated by the recipient on or before the date of the hysterectomy, and it must be attached to the physician's hard copy claim when submitted for processing. In addition, the physician should share the consent form with all providers involved in that patient's care, (such as attending physician, hospital, anesthesiologist, and assistant surgeon) as each of these claims must also have a valid consent form attached.

When billing for services that require a hysterectomy consent form, the name on the Medicaid file for the date of service in which the form was signed should be the same as the name signed at the time consent was obtained. If the patient name changes before the claim is processed for payment, the provider must attach a letter from the physician's office from which the consent was obtained. The letter should be signed by the physician and should state that the patient's name has changed and should include the patient's social security number and date of birth. This letter should be attached to all claims requiring consent upon submission for claims processing

It is not necessary to have someone witness the recipient signing the BHSF 96-A form, unless the recipient meets one of the following criteria:

- Recipient is unable to sign her name and must indicate "x" on signature line;

- There is a diagnosis on the claim that indicates mental incapacity.

If a witness does sign the BHSF Form 96-A, the signature date **must** match the date of the recipient signature. The witness must both sign and date the form; if the dates do not match or the witness does not sign and date the form, all claims related to the hysterectomy will deny.

Exceptions

Obtaining a Form 96-A consent is unnecessary only in the following circumstances:

- The individual was already sterile before the hysterectomy, and the physician who performed the hysterectomy certifies in his own writing that the individual was already sterile at the time of the hysterectomy and states the cause of sterility.

- The individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician certifies in his own writing that the hysterectomy was performed under these conditions and includes in his narrative a description of the nature of the emergency.

- The individual was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy certifies in his own writing that the individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing. In addition, if the individual was certified retroactively for benefits, and the hysterectomy was performed under one of the two other conditions listed above, the physician must certify in writing that the hysterectomy was performed under one of those conditions and that the patient was informed, in advance, of the reproductive consequences of having a hysterectomy**.**

In any of the above events, the written certification from the physician **must** be attached to the hard copy of the claim in order for the claim to be considered for payment.

BHSF Form 96-A
Revised 07/94
Prior Issues Usable

Medicaid Program
Acknowledgement of Receipt of Hysterectomy Information

Recipient Name: _____
ID No.: _____
Physician Name: _____
Provider No.: _____

Payment by Louisiana's **Medicaid Program cannot** be authorized for the performance of **any** hysterectomy committed **solely** for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose for the procedure, the hysterectomy **would not** be performed but for the purpose of rendering the individual permanently incapable of reproducing.

Medicaid payment for a medically indicated hysterectomy can be authorized **only** if:
(1) the individual and her representative*, if any, are informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing; **and**,
(2) the individual and her representative*, if any, have signed a written acknowledgement of receipt of that information. The written acknowledgement **must** be signed and dated prior to the operation and **must** be attached to the claim form which is submitted for payment.

* A representative is that person who has the legal authority to act for an individual. For purposes of this acknowledgement, a representative shall be defined as either the curator of an interdicted woman or the tutor or parent of an unmarried minor. A minor emancipated by marriage is deemed capable of acting for herself in the matter.

I hereby acknowledge that I have been informed orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom the procedure is performed permanently incapable of bearing children.

_____ _____
Signature of Recipient Date

_____ _____
Signature of Representative, if any Date

Physician's Copy

Sterilizations

In accordance with Federal requirements, Medicaid payments for sterilization of a mentally competent individual aged 21 or older requires that:

- The individual is at least 21 years old at the time that consent was obtained;
- The individual is not a mentally incompetent individual;
- The individual has voluntarily given informed consent in accordance with all federal requirements;
- At least 30 days, but no more then 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Sterilization Form with Consent Signed Less Than 30 Days

An individual may consent to be sterilized at the time of emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization.

The consent form must contain the signatures of the following individuals:

- The individual to be sterilized;
- The interpreter, if one was provided;
- The person who obtained the consent; and
- The physician who performed the sterilization procedure. (If the physician who performs the sterilization procedure is the one who obtained the consent, he/she must sign both statements.)

Consent Forms and Name Changes

When billing for services that require a sterilization consent form, the name on the Medicaid file for the date of service in which the forms were signed should be the same as the name signed at the time consent was obtained. If the patient name changes before the claim is processed for payment, the provider must attach a letter from the physician's office from which the consent was obtained. The letter should be signed by the physician and should state that the patient's name has changed and should include the patient's social security number and date of birth. This letter should be attached to all claims requiring consent upon submission for claims processing.

Requests for Sterilization Consent Forms

Consent forms for sterilization (BHSF Form 96) may be obtained by calling (225) 342-1304 or by sending a written request to:

BHSF Program Operations
ATTN: Professional Services Program Manager
P.O. Box 91030
Baton Rouge, LA 70821

Additional Form (OMB No. 0937-0166)

Louisiana Medicaid accepts a sterilization consent form that was approved by the Office of Management and Budget (OMB). The form is typically distributed through area health units and is available through written request to:

OPA Clearinghouse
P.O. Box 30686
Bethesda, MD 20824-0686

This form can also be obtained via website access at:

http://opa.osops.dhhs.gov/pubs/publications.html

Consent Completion

Included in this training are sections and numbered examples instructing providers on the correct completion of the sterilization consent form. The consent blanks are assigned reference numbers in order to explain correctable areas. Completed examples of accepted sterilization forms are on the following pages.

- One example illustrates a correctly completed sterilization form for a sterilization that was done **less than** 30 days after the consent was obtained. In this case, you will note "premature delivery" is confirmed with a "check mark", the expected date of delivery **is included** and **is equal to or greater than 30 days** after the date of the recipient's signature.

- In order to facilitate correct submission of the sterilization consent when a premature delivery occurs, the following clarification is provided. "Prematurity" is defined as the state of an infant born prior to the 37th week of gestation. Physicians should use this definition in the completion of the sterilization consent when premature delivery is a factor."

- The consent was (and must be) obtained at least 72 hours before sterilization was performed.

- Physicians and clinics are reminded to obtain valid, legible consent forms.

- **Copies must be shared with any provider billing for sterilization services, including the assistant surgeon, hospital, and anesthesiologist.**

Must be group or individual who gave information about sterilization procedure

BHSF Form 96
Rev. 01/92
Prior Issue Usable

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) Womans OB/GYN Group. When I first asked for *(doctor or clinic)* the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D. C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) tubal ligation. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (3) 12/06/74 *Month Day Year*

I, (4) Mary Smith, hereby consent of my own free will to be sterilized by (5) Dr. T.A. Jones *(doctor)*

by a method called (6) tubal ligation. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Hospitals

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) Mary Smith *Signature* Date: (8) 03/2/06 *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

II ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) *Interpreter* (11) *Date*

III ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) Mary Smith *name of individual* signed the consent form, I explained to him/her the nature of the sterilization operation (13) tubal ligation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I expalined that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(14) Sue Andrews, R.N. *Signature of person obtaining consent* (15) 03/2/06 *Date*

(16) Womans OB/GYN Group *Facility*

(17) 433 3rd St., Pine, LA 70776 *Address*

IV ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon (18) Mary Smith on (19) 3/30/06 *Name of individual to be sterilized* *Date of sterilization*, I explained to him/her the nature of the *operation* sterilization operation (20) tubal ligation *specify type of operation*, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I expalined that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the Paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (Check applicable box and fill in information requested):

(21)
- ☒ Premature delivery
- ☒ Individual's expected date of delivery: 5/1/06
- ☐ Emergency abdominal surgery:

(describe circumstances):

(22) Dr. T. A. James *Physician*

Date (23) 4/6/06

MUST MATCH

AT LEAST 30 DAYS

COMPLETE

SIGN AFTER SURGERY COMPLETE

PATIENT'S COPY

Form Approved: OMB No. 0937-0166
Expiration date: 08/31/2006

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) Woman's OB/GYN group (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal Funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) tubal ligation. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: (3) 12/06/74 (Month Day Year)

I, (4) Mary Smith, hereby consent of my own free will to be sterilized by (5) Dr. T. A. Jones (doctor)

by a method called (6) tubal ligation. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) Mary Smith (Signature) Date: (8) 03/2/06 (Month Day Year)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (Interpreter's Signature) (11) _____ (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) Mary Smith (name of individual) signed the consent form, I explained to him/her the nature of sterilization operation (13) tubal ligation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) Sue Andrews, RN (Signature of person obtaining consent) (15) 3/2/06 (Date)

(16) Woman's OB/GYN Group (Facility)

(17) 433 10rd St., Pine, LA 70776 (Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon (18) Mary Smith (name of individual) on (19) 3/20/06 (date of sterilization)

I explained to him/her the nature of the sterilization operation (20) tubal ligation (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☒ Premature delivery
(21) Individual's expected date of delivery: 5/1/06

☐ Emergency abdominal surgery: _____
(describe circumstances): _____

(22) Dr. T. A James (Physician's Signature) (23) 4/6/06 (Date)

Must be group or individual who gave information about sterilization procedure.

CONSENT FORM

6HSF F/ •
Rev. 06/00
Prior Issue Usable

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (1) Woman's OBGYN Group (Doctor or Clinic) When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as FITAP or Medicaid, that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I **DO NOT** WANT TO BECOME **PREGNANT**, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and have chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) tubal ligation. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time.

I am at least 21 years of age and was born on (3) 3/14/74 (Month/Day/Year).

I, (4) Mary Smith, hereby consent of my own free will to be sterilized by (5) Dr. John Cutter (Doctor)

by a method called (6) tubal ligation. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: *Representatives of the Department of Health and Hospitals; employees of programs or projects funded by that Department but only for determining if Federal laws were observed.*

I have received a copy of this form.

I (7) *Mary Smith* (Signature) (8) *3/2/06* (Date: Month/Day/Year)

You are asked to supply the following information, but it is not required: *Race and Ethnicity designation, please check.*

- ☐ American Indian or Alaska Native
- ☐ Black (not of Hispanic origin)
- ☐ Asian or Pacific Islander
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

II (10) (Interpreter Signature) (11) (Date: Month/Day/Year)

STATEMENT OF PERSON OBTAINING CONSENT

Before (12) Mary Smith (Name of Individual) signed the consent form, I explained to him/her the nature of the sterilization operation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

III (13) *Sue Andrews, RN* (Signature of Person Obtaining Consent) (14) *3/2/06* (Date: Month/Day/Year)

(15) Woman's OBGYN Group 433 10th St., Pine, LA 70001 (Name of Facility and Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (16) Mary Smith (Name of Individual to be Sterilized) on (17) *3/30/06* (Date: Month/Day/Year),

I explained to him/her the nature of the sterilization operation, (18) tubal ligation (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily asked to be sterilized and appeared to understand the nature and consequence of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (Cross out the paragraph which is not used.)

(3) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(4) This sterilization was performed less than 30 days, but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (Check the appropriate box and fill in the requested information):

(19) ☑ Premature delivery
☐ Emergency abdominal surgery:

(Describe circumstances): ☑ Individual's expected date of delivery: *5/1/06*

IV (20) *John Cutter, MD* (Physician's Signature) (21) *4/6/06* (Date: Month/Day/Year)

1ST MAY NOT SIGN AT LEAST 30 DAYS

COMPLETE IF < 30 DAYS

SIGN AFTER SURGERY COMPLETE

BHSF Form 96
Rev. 10/01
Prior Issue Usable

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from **(1) Woman's OB/GYN Group** (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as FITAP or Medicaid, that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I **DO NOT** WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and have chosen to be sterilized.

I understand that I will be sterilized by an operation known as a **(2) tubal ligation**. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time.

I am at least 21 years of age and was born on **(3) 3/14/74** (Month/Day/Year).

I, **(4) Mary Smith**, hereby consent of my own free will to be sterilized by **(5) Dr. John Cutter** (Doctor)

by a method called **(6) tubal ligation**. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: *Representatives of the Department of Health and Hospitals; employees of programs or projects funded by that Department but only for determining if Federal laws were observed.*

I have received a copy of this form.

(7) Mary Smith (Signature) **(8) 3/2/06** (Date: Month/Day/Year)

You are asked to supply the following information, but it is not required: *Race and Ethnicity designation, please check.*

☐ American Indian or Alaska Native ☐ Black (not of Hispanic origin) ☐ Asian or Pacific Islander
☐ Hispanic ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in **(9)** language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) (Interpreter Signature) **(11)** (Date: Month/Day/Year)

STATEMENT OF PERSON OBTAINING CONSENT

Before **(12) Mary Smith** (Name of Individual) signed the consent form, I explained to him/her the nature of the sterilization operation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(13) *Sue Andrews, RN* (Signature of Person Obtaining Consent) **(14) 3/2/06** (Date: Month/Day/Year)

(15) Woman's OB/GYN Group 433 10th St. Pine, LA 70001 (Name of Facility and Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon **(16) Mary Smith** (Name of Individual to be Sterilized) on **(17) 3/30/06** (Date: Month/Day/Year) I explained to him/her the nature of the sterilization operation, **(18) tubal ligation** (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily asked to be sterilized and appeared to understand the nature and consequence of the procedure.

Instructions for use of alternative final sentences: Use the first sentence below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second sentence below must be used. (Cross out the sentence which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days, but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (Check the appropriate box and fill in the requested information):

(19) ☒ Premature delivery ☒ Individual's expected date of delivery: **5/1/06**
☐ Emergency abdominal surgery:
(Describe circumstances):

(20) *John Cutter, MD* (Physician's Signature) **(21) 4/6/06** (Date: Month/Day/Year)

PATIENT'S COPY - WHITE **DOCTOR'S COPY - CANARY** **STATE OFFICE COPY - PINK**

Correcting the Sterilization Consent Form

- The **informed consent** must be obtained and documented prior to the performance of the sterilization, not afterward. Therefore, corrections to blanks 7, 8, 10, 11, 14, 15 **(BHSF 96 Form-Revised 01/92; OMB No. 093-0166)** and blanks 7, 8, 10, 11, 13, 14 **(BHSF 96 Form-Revised 06/00 and BHSF 96 Form-Revised 10/01)** may not be made subsequent to the performance of the procedure.

- Errors in sections I, II, III, and IV can be corrected, but **only by the person over whose signature they appear.**

- In addition, if the recipient, the interpreter, or the person obtaining consent returns to the office to make a correction to his portion of the consent form, the medical record must reflect his presence in the office on the day of the correction.

- To make a correction to the form, the individual making the corrections should line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction. Erasures, “write-overs”, or use of correction fluid in making corrections are unacceptable.

- Only the recipient can correct the date to the right of her signature. The same applies to the interpreter, to the person obtaining consent, and to the doctor. The corrections of the recipient, the interpreter, and the person obtaining consent must be made **before** the claim is submitted.

- The date of the sterilization may be corrected either before or after submission by the doctor over whose signature it appears. However, the operative report must support the corrected date.

- An invalid consent form will result in **denial of all claims** associated with the sterilization.

Consent forms will be considered invalid if errors have been made in correctable sections but have not been corrected, if errors have been made in blanks that cannot be corrected, or if the consent form shows evidence of erasures, “write overs”, or use of correction fluid.

Deliveries With Non-Payable Sterilizations

Medicaid allows payment of an inpatient hospital claim for a delivery/c-section when a non-payable sterilization is performed during the same hospital stay. When a valid sterilization form has not been obtained, the procedure code for the sterilization and the diagnosis code associated with the sterilization should not be reported on the claim form, and charges related to the sterilization procedure should not be included on the claim form. In these cases, providers will continue to receive their per diem for covered charges.

Claims for these services will not require any prior or post-authorization (other than pre-cert) and may be billed to Unisys on paper or electronically.

PREGNANCY-RELATED PROCEDURES

Ectopic Pregnancies

In order to receive Medicaid reimbursement for the termination of an ectopic pregnancy, commonly known as a tubal pregnancy, hospitals must submit billing on hardcopy with a copy of the operative report attached.

Providers must use an appropriate ICD-9 surgical procedure code that denotes the termination of an ectopic pregnancy rather than a sterilization procedure. Use of an improper ICD-9 surgical procedure may cause the claim to deny.

Molar Pregnancies

A molar pregnancy results from a missed abortion; i.e., the uterus retains the dead and organized products of conception. The Medicaid Program covers the termination of molar pregnancies. To bill for the termination of a molar pregnancy, providers should use one of the following procedure codes with a diagnosis of molar pregnancy:

68.0 Hysterectomy with removal of hydatidiform mole
69.0 Dilation and curettage of uterus
69.02 D & C following delivery or abortion
69.52 Aspiration curettage following delivery or abortion
69.59 Other aspiration of uterus

Claims with diagnosis of missed, spontaneous, or threatened abortion must be submitted hard copy with the following attachments:

1. Medical records (chart notes for dates of service)
2. Pathology report (if products of conception are sent to lab)
3. Operative report (if a procedure is performed)

Unisys Provider Relations has received questions concerning the denial 478 (Send written sonogram results with operative report, pathology report, and history). When a D&C is done for an incomplete or missed abortion and error 478 is received, the review team must have documentation to substantiate that the fetus was not living at the time of the D&C; that is, that this was not an abortion for pregnancy termination. This documentation may be 1) a sonogram report showing no fetal heart tones, 2) a history showing passage of fetus at home, in an ambulance, or in the emergency room, 3) a pathology report showing degenerating products of conception, or 4) an operative report showing products of conception in the vagina. All reports are not needed. These are examples of the information needed to provide enough documentation to properly review the claim and substantiate payment.

STATE-OPERATED HOSPITALS

State-Operated Hospitals And Physicians Services At State Hospitals

State-operated hospitals and physicians performing services at a state-operated hospital are not required to obtain pre-certification for inpatient hospital stays (except for state freestanding and distinct part psychiatric hospitals). These hospitals "are required" to obtain "prior authorization" as in accordance with our policy for outpatient surgical procedures performed on an inpatient basis.

Outpatient Surgery Performed On An Inpatient Basis (State Hospitals Only)

Providers requesting authorization for outpatient surgery done on an inpatient basis must use the Prior Authorization request form (PA-01). Copies of the PA-01 form follow on pages 70 and 71. In addition, to expedite the review process, providers must continue to attach the appropriate medical data to substantiate the need for the service being provided in an inpatient setting. Documentation of extenuating circumstances should be submitted along with the request.

Medical authorization for the surgical procedure does not replace or in any way affect other policy requirements which may apply to surgical claims; e.g., sterilization consent requirements, recipient ineligibility for inpatient services and timely filing requirements. Medical authorization means only that the proposed procedure meets Louisiana Medicaid requirements of medical necessity for the service to be performed on an inpatient basis. If otherwise eligible for payment, a claim for the described services will be paid.

NOTE: When both the primary and secondary procedures require PA, all procedure codes must be listed on the PA-01 request for authorization.

Completed PA-01 forms should be submitted to the address indicated on the form and as noted below:

Unisys/Louisiana Medicaid
P. O. Box 14919
Baton Rouge, LA 70898-4919

The PA-01 form should be submitted prior to the performance of the surgery, however, post authorization may be requested in certain instances.

Approval for inpatient performance of these procedures will be granted only when one or more of the following exception criteria exist:

- The presence of documented medical condition(s) which make prolonged pre-and/or postoperative observation by a nurse or skilled medical personnel a necessity;
- The procedure is likely to be time consuming or followed by complication;
- An unrelated procedure is being done simultaneously which requires hospitalization;
- There is a lack of availability of proper postoperative care;
- It is likely that another major surgical procedure could follow the initial procedure, e.g., mastectomy;
- Technical difficulties as documented by admission or operative notes could exist; and/or
- The procedure carries high patient risk.

NOTE: Authorization is not required if the procedure is performed on an outpatient basis.

Reimbursement to hospitals for surgical procedures approved for inpatient performance will be made in accordance with the hospital's per diem rate for the dates of service.

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

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

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
✓ 01-Outpatient Surgery
___ Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2): 1 2 3 4 5 9 7 8 9 1 2 3 4

Social Security No. (3):

RECIPIENT LAST NAME: Smith | FIRST: Johnny | MI (4):

DATE OF BIRTH (5): 09 08 1978

MEDICAID PROVIDER NUMBER (7- DIGIT) (6): 1 7 2 0 0 0 0

BEGIN DATE OF SERVICE (7) (MMDDYYYY): 04 13 2006

END DATE OF SERVICE (MMDDYYYY): 04 14 2006

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

DIAGNOSIS : (8)

PRIMARY CODE & DESCRIPTION: 360.4 Degenerated Conditions of Globe

SECONDARY CODE & DESCRIPTION:

PRESCRIPTION DATE (9) (MMDDYYYY): 04 13 2006

STATUS CODES: 2 = APPROVED 3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10) Dr. James Dean

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S
1149					Other Removal or Destruction of Corneal	1					

(12) PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY ___ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: We Care Charity Hospital
ADDRESS: 45 Oak St.
CITY: Sunny STATE: LA ZIPCODE 70000
TELEPHONE: (337) 555 3825 FAX NUMBER: (337) 555 9680

(14) CASE MANAGER INFORMATION:
NAME:
ADDRESS:
CITY: STATE: ZIPCODE
TELEPHONE (____) ____ FAX NUMBER: (____) ____

(15) PROVIDER SIGNATURE: *Claire Belle*

(16) DATE OF REQUEST: *04/01/2006*

PA-01 FORM

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

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

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

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

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S

(12)
PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY ___ OUTPATIENT HOSPITAL / CLINIC

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

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

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-01 FORM

UB-92 BILLING PROCEDURES

Use Of "V" And "E" Diagnosis Codes

Before the Pre-certification Department can make a determination that there is a legitimate medical reason for a hospital stay, they must have the specific ICD-9 classification from categories 001-999. "V" diagnosis codes are condition codes used for supplementary classification rather than true diagnosis codes. The medical reason for the hospital admit cannot be determined from these codes. A "V" code is useful to show what underlying cause or condition brought about the illness or immediate cause for hospitalization. In light of this information, a "V" code is acceptable only when pre-certifying a newborn born to a non-Medicaid mother.

“V” diagnosis codes are accepted for billing Louisiana Medicaid for inpatient or outpatient claims.

"E" diagnosis codes <u>ARE NOT</u> accepted for Louisiana Medicaid billing or precertification.

Split Billing

Split billing is permitted by the Louisiana Medicaid Program only in the following circumstances:

- Hospitals must split bill claims when the hospital changes ownership.
- Acute Care and State Operated Hospitals must split bill claims on June 30 - State's fiscal year.
- Hospitals must split bill claims at the end of the hospital's fiscal year.
- Hospitals may split bill neonatal, rehabilitation, cardiac, and extended care claims every 30 days.
- Distinct Part Hospitals must split bill at the end of the calendar year (December 31st).
- Due to total charges exceeding $999,999.99.

Split Billing Procedures

Providers submitting a hospital claim which crosses the date for the fiscal year end, should complete the claim in two parts: through the date of the fiscal year end and for the first day of the new fiscal year. In addition, providers should enter a note in the Remarks section of the claim indicating that the claim is part of a split billing.

More specific instructions for split billing on the UB-92 claim form are provided below:

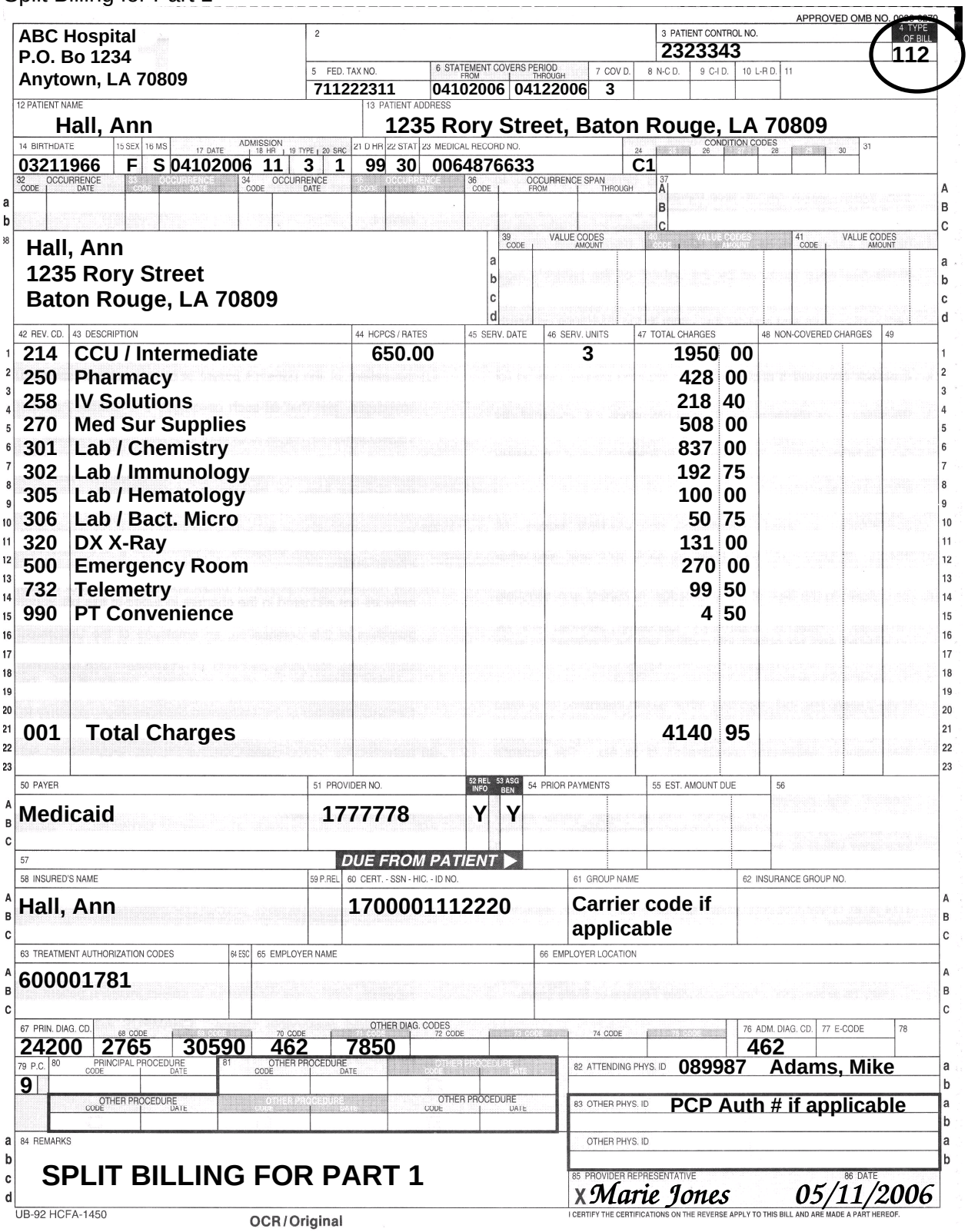
1. In the Type of Bill block (form locator 4), the hospital must enter code 112, 113, or 114 to indicate the specific type of facility, the bill classification, and the frequency for both the first part or the split billing interim and any subsequent part of the split billing interim.

2. In the Patient Status block (form locator 22), the hospital must enter a 30 to show that the recipient is "still a patient." **When split billing, the hospital should never code the claim as a discharge.**

3. In the remarks section of the claim form (form locator 84), the hospital must write in the part of stay for which it is split billing. For example, the hospital should write in "Split billing for Part 1," if it is billing for Part 1.

Example claims to follow.

Split Billing for Part 1



ABC Hospital
P.O. Bo 1234
Anytown, LA 70809

3 PATIENT CONTROL NO. 2323343
4 TYPE OF BILL 112
5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 04102006 THROUGH 04122006
7 COV D. 3
12 PATIENT NAME Hall, Ann
13 PATIENT ADDRESS 1235 Rory Street, Baton Rouge, LA 70809
14 BIRTHDATE 03211966
15 SEX F
16 MS S
17 ADMISSION DATE 04102006
18 HR 11
19 TYPE 3
20 SRC 1
21 D HR 99
22 STAT 30
23 MEDICAL RECORD NO. 0064876633
CONDITION CODES C1
38 Hall, Ann
1235 Rory Street
Baton Rouge, LA 70809

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	214	CCU / Intermediate	650.00		3	1950 00	
2	250	Pharmacy				428 00	
3	258	IV Solutions				218 40	
4	270	Med Sur Supplies				508 00	
5	301	Lab / Chemistry				837 00	
6	302	Lab / Immunology				192 75	
7	305	Lab / Hematology				100 00	
8	306	Lab / Bact. Micro				50 75	
9	320	DX X-Ray				131 00	
10	500	Emergency Room				270 00	
11	732	Telemetry				99 50	
12	990	PT Convenience				4 50	
21	001	Total Charges				4140 95	

50 PAYER Medicaid
51 PROVIDER NO. 1777778
52 REL INFO Y
53 ASG BEN Y
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
DUE FROM PATIENT
58 INSURED'S NAME Hall, Ann
60 CERT. - SSN - HIC. - ID NO. 1700001112220
61 GROUP NAME Carrier code if applicable
63 TREATMENT AUTHORIZATION CODES 600001781
67 PRIN. DIAG. CD. 24200
OTHER DIAG. CODES 2765 30590 462 7850
76 ADM. DIAG. CD. 462
79 P.C. 9
82 ATTENDING PHYS. ID 089987 Adams, Mike
83 OTHER PHYS. ID PCP Auth # if applicable
84 REMARKS SPLIT BILLING FOR PART 1
85 PROVIDER REPRESENTATIVE X Marie Jones
86 DATE 05/11/2006
UB-92 HCFA-1450
OCR / Original
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Last portion of a split bill

APPROVED OMB NO. 0938-0279

ABC Hospital P.O. Bo 1234 Anytown, LA 70809	2						3 PATIENT CONTROL NO. 2323343			4 TYPE OF BILL 114
	5 FED. TAX NO. 711222311	6 STATEMENT COVERS PERIOD FROM 04132006	THROUGH 04152006	7 COV D. 2	8 N-C D.	9 C-I D.	10 L-R D.	11		

12 PATIENT NAME	13 PATIENT ADDRESS
Hall, Ann	1235 Rory Street, Baton Rouge, LA 70809

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
03211966	F	S	04102006	11	3	1	99	01	0064876633	C1							

	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
												C

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT	
Hall, Ann 1235 Rory Street Baton Rouge, LA 70809	a						a
	b						b
	c						c
	d						d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	110	RM and Board	320 00		2	640 00			1
2	250	Pharmacy				120 00			2
3	270	Med-Surg				64 00			3
4	301	Lab/Chemistry				48 00			4
5	320	DX X-ray				115 00			5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13	001	Total Charges				987 00			13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
A	Medicaid	1777778	Y	Y				A
B								B
C								C
57		DUE FROM PATIENT ▶						

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	Hall, Ann		1700001112220	Carrier code if applicable		A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
A	600001781				A
B					B
C					C

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 POA	70 CODE	71 POA	72 CODE	73 POA	74 CODE	75 POA	76 ADM. DIAG. CD.	77 E-CODE	78
24200	2765		30590	462	7850				462		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID		
9							089987	Adams, Mike	a
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	PCP Auth # if applicable	b
									a
							OTHER PHYS. ID		b

	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a			
b			
c	LAST PORTION OF A SPLIT BILL	X Marie Jones	05/11/2006
d			

UB-92 HCFA-1450 OCR / Original

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

UB-92 Billing Instructions

Hospitals should use the UB92 claim form to bill for hospital services provided to Medicaid recipients. Fields noted with an * are required and claims will be denied if not entered.

Locator #	Description	Instructions
*1	Provider Name, Address, Telephone #	**Required** - Enter the name and address of the facility
2	Unlabeled Field (State)	Leave blank
3	Patient Control No.	Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 16 characters.
*4	Type of Bill	**Required** - Enter the 3-digit code indicating the specific type of facility, bill classification and frequency. This 3-digit code requires one digit each, in the following format: <u>a. First digit-type facility</u> 1 Hospital 7 Clinic 8 Special Facility <u>b. Second digit-classification</u> 1 Inpatient Medicaid and/or Medicare Part A or Parts A & B 2 Inpatient Medicaid and Medicare Part B only 3 Outpatient or Ambulatory Surgical Center 4 Other (Non-patient) <u>c. Third digit-frequency</u> 0 Non-Payment claim 1 Admission through discharge 2 Interim-first claim 3 Interim-continuing 4 Interim-last claim 7 Replacement of prior claim 8 Void of prior claim
5	Federal Tax No.	Not required
*6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required** - Enter the beginning and ending service
*7	Covered Days	**Required for inpatient** - Enter the number of days approved by the Utilization Review Committee as medically necessary. The number of covered days plus the number of non-covered days (Form Locator 8) must equal the number

		of days represented by the billing period in Form Locator 6. If the From and Through dates in Form Locator 6 are equal, enter "1" in "Covered Days."
8	Non-Covered Days	For inpatient, if applicable - Enter the number of days not approved by the Utilization Review Committee as medically necessary or leave days when not in the hospital for part of the stay. The number of non-covered days, plus the number of covered days (Form Locator 7), must equal the number of days represented by the billing period in Form Locator 6.
9	Co-Insurance Days	Required for Medicare Crossover.
10	Lifetime Reserve Days	Required for Medicare Crossover.
11	Patient's Phone No.	Not required - State Assigned.
*12	Patient's Name	**Required** - Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.
13	Patient's Address (City, State, Zip)	Enter patient's permanent address.
14	Patient's Birthdate	Enter the patient's date of birth using 8 digits (MMDDYYYY). If only one digit appears in a field, enter a leading zero.
15	Patient's Sex	Enter sex of the patient as M = Male F = Female U = Unknown
16	Patient's Marital Status	Not required
*17	Admission Date	**Required for inpatient** - Enter 6 digits for the date of admission (MMDDYY). If there is only one digit in a field, enter a leading zero.
*18	Admission Hour	**Required for inpatient services** - Enter the 2-digit code which corresponds to the hour the patient was admitted for inpatient care as: <u>Code Time</u> 00 12:00 - 12:59 midnight 01 01:00 - 01:59 A.M. 02 02:00 - 02:59 03 03:00 - 03:59 04 04:00 - 04:59 05 05:00 - 05:59 06 06:00 - 06:59 07 07:00 - 07:59 08 08:00 - 08:59 09 09:00 - 09:59 10 10:00 - 10:59 11 11:00 - 11:59 12 12:00 - 12:59 noon

		13 01:00 - 01:59 P.M. 14 02:00 - 02:59 15 03:00 - 03:59 16 04:00 - 04:59 17 05:00 - 05:59 18 06:00 - 06:59 19 07:00 - 07:59 20 08:00 - 08:59 21 09:00 - 09:59 22 10:00 - 10:59 23 11:00 - 11:59
*19	Type Admission	**Required for inpatient** - Enter one of the appropriate codes indicating the priority of this admission. 1 Emergency 2 Urgent 3 Elective 4 Newborn
20	Source of Admission	**Required for inpatient** - enter the appropriate code from the list of "Code Structure for Adult and Pediatrics: shown below. * Newborn coding structure must be used when the type of admission code in Form Locator 19 is "4" <u>Valid codes if type of admission is 1, 2, or 3</u> 1 Physician Referral 2 Clinic Referral 3 HMO Referral 4 Transfer from a Hospital 5 Transfer from a Skilled Nursing Facility 6 Transfer from Another Health Care Facility 7 Emergency Room NOTE: 8 Court/Law Enforcement – is not a valid source of admission code. *Valid code if type of admission is "4" 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth
21	Discharge Hour	Inpatient only - Enter the two-digit code which corresponds to the hour the patient was discharged. (See code structure under Admission Hour, Form Locator 19.)
*22	Patient Status	**Required for inpatient** - Enter the appropriate code to indicate patient status as of the Statement Covers through date. Valid codes are listed as follows:

		01 Discharged (routine) 02 Discharged to another short-term general hospital 03 Discharged to Skilled Nursing Facility 04 Discharged to Intermediate Care Facility 05 Discharged to another type of institution 06 Discharged to home under care of organized home health services 07 Left against medical advice 08 Discharge/Transfer to home care of Home IV provider 20 Expired 30 Still Patient * If interim billing, the patient status code must be "30", (frequency code 2 or 3 under type bill). Interim billing should only be submitted when the stay spans the hospital's fiscal year end.
23	Medical Record No.	Optional - Enter patient's medical record number (up to 16 characters)
*24-30	Condition Codes	Must be a valid code if entered. Valid codes are listed as follows: <u>Insurance</u> 01 Military service related 02 Condition is employment related 03 Patient is covered by insurance not reflected here 04 HMO Enrolled 05 Lien has been filed 06 End stage renal disease in first 18 months of entitlement covered by employer group insurance <u>Accommodations</u> 38 Semi-private room not available 39 Private room medically necessary 40 Same day transfer <u>Special Program Indicators</u> A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning <u>PRO Approval</u> C1 Approved as billed
31	Unlabeled Field	(National) Leave blank.
32-35	Occurrence Codes/Dates	a. Enter, if applicable. b. Each code must be two position numeric and have an associated date. c. Dates must be valid and in MMDDYY format. d. Valid codes are listed as follows:

		01 Accident/Medical Coverage 02 Auto accident/no fault 03 Accident/tort liability 04 Accident/employment related 05 Accident/No Medical Coverage 06 Crime victim 21 UR/PSRO notice received 22 Date active care ended 24 Date insurance denied 25 Date benefits terminated by primary payer 40 Scheduled date of admission 41 Date of first test for pre-admission testing 42 Date of discharge when "Through" date in Form Locator 6 (Statement Covers Period) is **not** the actual discharge date **and** the frequency code in Form Locator 4 is that of final bill. A3,B3,C3 Benefits exhausted
36	Occurrence Span (Code and Dates)	Enter, if applicable - A code and related dates that identity an event that relates to the payment of the claim. Code and date must be valid. Date must be (MMDDYY) format. Valid codes are listed as follows: 72 First/Last visit 74 Non-covered Level of Care
37	A,B,C ICN/DCN # Original Bill	Not used for an adjustment of a Medicaid paid claim. Continue to use remarks section, Form Locator 84.
38	Responsible Party Name and Address	Not required.
*39-41	Value Codes and Amounts	**Required for benefit determination**. The value code structure is intended to provide reporting capability for those data elements that are routinely used but do not warrant dedicated fields. Value codes are listed as follows: 02 Hospital has no semi-private rooms. Entering the code requires $0.00 amount to be shown. 06 Medicare blood deductible 08 Medicare lifetime reserve first CY 09 Medicare coinsurance first CY 10 Medicare lifetime reserve second year 11 Coinsurance amount second year 12 Working Aged Recipient/Spouse with employer group health plan 13 ESRD (End Stage Renal Disease) Recipient in the 12-month coordination period with an employer's group health plan 14 Automobile, no fault or any liability insurance 15 Worker's Compensation including Black Lung

		16 VA, PHS, or other Federal Agency 30 Pre-admission testing - this code reflects charges for pre-admission outpatient diagnostic services in preparation for a previously scheduled admission. 37 Pints blood furnished 38 Blood not replaced - deductible is patient's responsibility 39 Blood pints replaced 80 Medicaid eligibility requirement that Medicare recipients utilize lifetime reserve days is not met. Recipient refuses to use available days. A1,B1,C1 Deductible A2,B2,C2 Coinsurance
*42	Revenue Code	**Required** - Enter the applicable revenue code(s) which identifies a specific accommodation and ancillary service. Accommodation codes require a rate in Form Locator 44. Revenue Codes 300-319 and 490 for outpatient also require a CPT/HCPCS procedure code in Form Locator 44. Must be a valid code. Must be in ascending sequence except for final entry for total charges (001). Revenue codes should be summed at the "zero" level (general classification) wherever possible. See Matrix for Revenue Codes to be used at detail line. If a revenue code is present, the amount charged must be present in Form Locator 47.
43	Revenue Description	For inpatient and outpatient claims. Enter the narrative description of the revenue code in the space preceding the dotted line.
*44	HCPCS/Rates HCPCS/CPT Code (Outpatient DX Lab)	**Required for inpatient** - Enter the accommodation rate for any accommodation revenue codes entered in Form Locator 42. If present, must be numeric. For revenue codes 300-319, enter the appropriate CPT/ HCPCS procedure code describing each lab service. For revenue code 490, enter the appropriate HCPCS procedure code for Ambulatory Surgical Services.
*45	Date of Service (Outpatient Only)	Enter the date of service for outpatient services in the last six digits of the revenue description. The date must be a valid date in (MMDDYYYY) format.
*46	Units of Service	Enter the quantity of services rendered by Revenue Category for the recipient.
*47	Total Charges	**Required** - Enter the total charges pertaining to the related revenue codes. Must be numeric. Revenue Code "001" represents the total amount charged for this bill, and should be the last entry.
48	Non-Covered Charges	Indicate charges included in column 47 which are not payable under the Medicaid Program.
49	Unlabeled Field	Leave blank.

	(National)	
50-A,B,C	Payer ID	Enter Medicaid on Line "A" and other payers on Lines "B" and "C". If another insurance company is primary payer, enter name of insurer. If the patient is a Medically Needy Spend-down recipient or has made payment for non-covered services, indicate the patient as payer and the amount paid. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period. Value codes for payer identification are M = Medicaid Z = Medicare 4 = All other TPL carriers (specify)
*51-A,B,C	Provider Number	Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program. If the Medicaid provider number is not on line A, circle or otherwise highlight this number so that it can readily be recognized and keyed.
52-A,B,C	Release of Information	Not required.
53-A,B,C	Assignment of Benefits Cert. Ind.	Not required.
*54-A,B,C	Prior Payments	Enter the amount the hospital has received toward payment of this bill from private insurance carrier noted in Form Locator 50 B, C. If the patient has Medicare Part B only, enter the amount billed to Medicare.
55-A,B,C	Estimated Amt. Due	Not required.
56 & 57	Unlabeled Fields (56 State/57 National)	Leave blank.
*58-A,B,C	Insured's Name	**Required** - Enter the name of the insured as it appears on the Medicaid identification card. Enter the last name first, first name, middle initial. If there is insurance coverage carried by someone other than the patient, enter the name of that individual to correspond with 50 A,B,C.
59-A,B,C	Pt's. Relationship Insured	Enter the patient's relationship to insured from Form Locator 50 A, B, and C that relates to the insured's name in Form Locator 58 A, B, and C. Acceptable codes are as follows: 01 Patient is insured 02 Spouse 03 Natural child/Insured has financial responsibility 04 Natural child/ Insured does not have financial responsibility 05 Step child 06 Foster child

		07 Ward of the court 08 Employee 09 Unknown 10 Handicapped dependent 11 Organ donor 13 Grandchild 14 Niece/Nephew 15 Injured Plaintiff 16 Sponsored dependent 17 Minor dependent of minor dependent 18 Parent 19 Grandparent
*60-A,B,C	Insured's ID. No.	Enter the recipient/patient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60-A. If there are other payers, enter the recipient's identification number as assigned by the other payers.
*61-A,B,C	Insured's Group Name (Medicaid not Primary)	If there is third party insurance, enter carrier code of the insurance company indicated in 50, on the corresponding line.
62-A,B,C	Insured's Group No. (Medicaid not Primary)	Enter the number or code assigned by the carrier or administrator to identify the group under which the individual is covered.
*63-A,B,C	Treatment Auth. Code	For services, requiring prior authorization or pre-certification, enter the prior authorization or pre-certification number. Do not bill more than one treatment authorization code per UB-92 and bill only the services covered by that one prior authorization or pre-certification code.
64-A,B,C	Employment Status Code	To determine primary/secondary responsibility for the bill. Valid codes are listed as follows: 1 Employed full time 2 Employed part-time 3 Not employed 4 Self-employed 5 Retired 6 On active military duty 9 Unknown
65-A,B,C	Employer Name	Enter the name of the employer that may provide health coverage for the patient.
66-A,B,C	Employer Location	Not required.
*67	Principal Diagnosis Codes	**Required** - Enter the ICD-9-CM code for principal diagnosis. Codes beginning with "E" or "M" are not acceptable for any diagnosis code.
68-75	Other Diag. Codes	Codes for diagnoses other than the principal diagnosis are

		entered in Form Locators 68-75.
76	Admit Diag. Code	Inpatient only.
77	External Cause Injury Code	Not required.
78	Unlabeled Field (State)	Leave blank.
79	Procedure Coding Method Used	Not required.
*80	Principal Procedure Code and Date	Required for Inpatient. For Outpatient required on dates of service prior to 10/01/04 for all surgical procedures. Enter a valid ICD-9-CM VOL III code and date for principal procedure. Date must be (MMDD) format. Date must be within date period shown in Form Locator 6.
81-A-E	Other Procedure Codes and Dates	Enter codes other than principal procedure performed during billing period. Must be completed for Inpatient. For Outpatient must be completed for all surgical procedures for dates of service prior to 10/01/04.
82	Attending Physician ID	Enter the name and/or number which identifies the physician. This can be the Medicaid ID No., the Louisiana Licensing NO., or the UPIN. ***Note: For sterilization procedures, the surgeon's name must appear in item 82.***
*83	Other Physician ID	Enter any other physician's licensing number (other than attending physician), i.e., surgeon when surgical procedure(s) are performed. ***Note: If the recipient is in the CommunityCARE program, enter the seven-digit referral/ authorization number from the primary care physician in 83A.***
84	Remarks	If Admission Source is "4" (transfer from a hospital) enter the name of the hospital the patient was transferred from. If adjustment or void (Form Locator 4, third digit equal "6" or "8") enter the ICN of the paid Medicaid claim and an "A" or "V" to indicate whether adjustment or void. Also enter a reason code: **Adj.** — **Void** 01 TPL Recovery paid for wrong recipient — 10 Claim 02 Provider correct paid to wrong provider — 11 Claim 03 Fiscal Agency error — 00 Other 99 Other
*85	Provider Rep.	Enter the signature and title of the appropriate person at the

	Signature	facility who is authorized to submit Medicaid billing (Stamped signatures must be initialed).
*86	Date Bill Submitted	Enter the date the bill was signed and submitted for payment. Must be a valid date (MMDDYY) format. Must be greater than the through date in Form Locator 6.

* Required Fields **- If not completed the claim will be denied.**

Adjustments/Voids

A provider should initiate an adjustment or void immediately upon discovering an incorrect payment by Medicaid. To correct the payment, Unisys recommends filing a paper or electronic adjustment/void rather than sending a refund check. Adjusting or voiding is beneficial as it is faster and leaves a paper trail. Claims may only be adjusted or voided within two years of payment. Claims over two years old are dropped from Unisys history files and must be resolved via a refund check.

Recipient and Provider Numbers are items, which cannot be adjusted.

To adjust or void more than one claim line on an outpatient claim form, a separate UB92 form is required for each claim line since each line has a different Internal Control Number.

NOTE: If a TPL payment was not processed by the Fiscal Intermediary, an adjustment must be filed using reason code '01' (Third Party Liability Recovery).

When filing an adjustment or void on the UB92 Form Locator 84 "Remarks" and Locator 4 "Type of Bill" must be completed as follows:

UB-92 Form Locator 4

- Enter a three-digit code indicating the specific type of facility, bill classification and frequency.

- First Digit - Type Facility
  1 - Hospital
  8 - Special Facility

- Second Digit - Classification
  1 - Inpatient Medicaid and/or Medicare Part A or Parts A & B
  2 - Inpatient Medicaid and Medicare Part B Only
  3 - Outpatient or Ambulatory Surgical Center
  4 - Other - (Nonpatient)

- Third Digit - Frequency
  7 - Adjustment for Prior Claim
  8 - Void of Prior Claim

Example: Outpatient adjustment, type of bill would be 137.
Outpatient void, type of bill would be 138.

UB-92 Form Locator 84

- Enter an" A" for an adjustment or a" V "for a void.
- Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.
- Enter one of the appropriate reason codes:

Adjustments

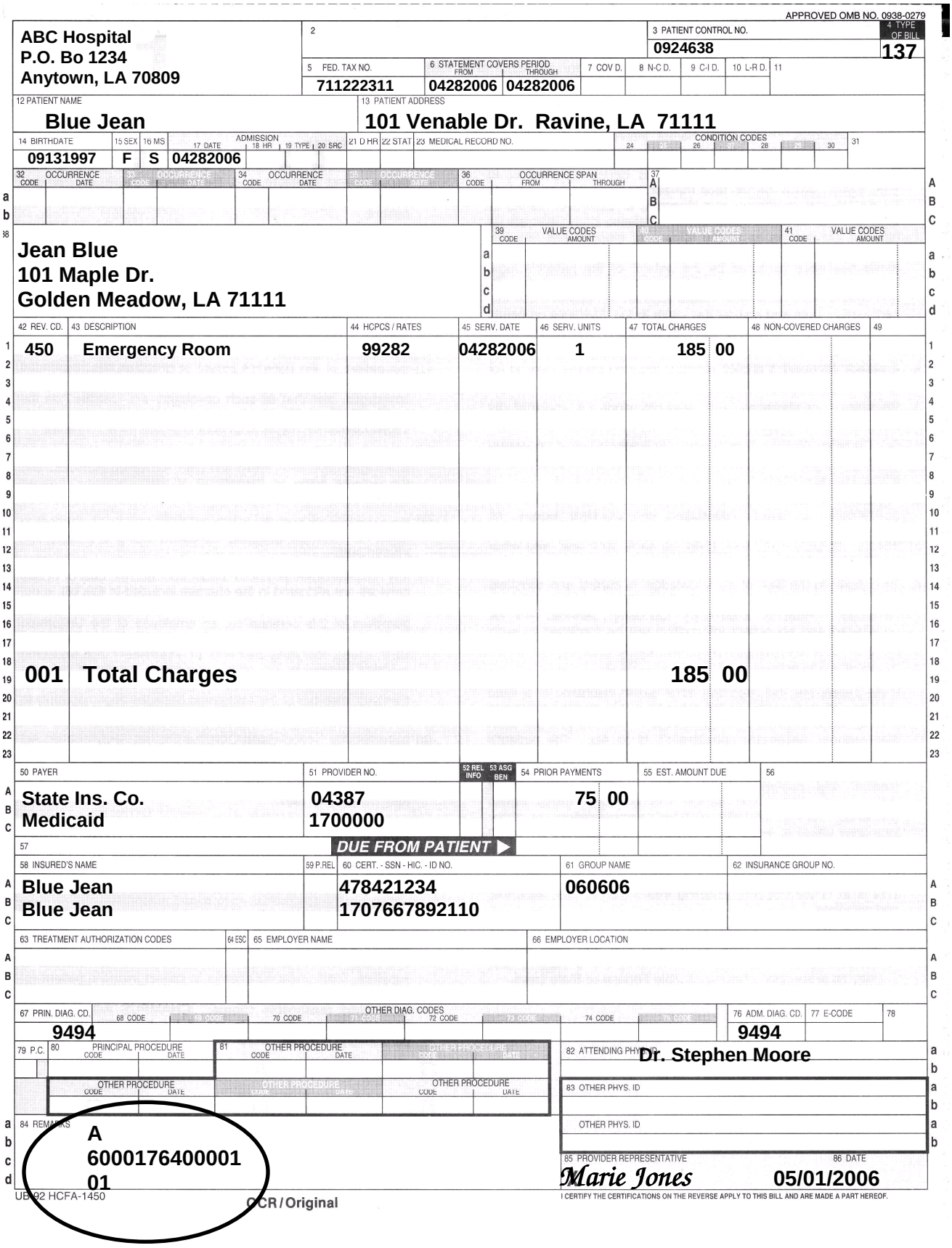
01 - Third Party Liability Recovery
02 - Provider Correction
03 - Fiscal Agent Error
90 - State Office Use Only – Recovery
99 - Other - Please Explain

Example: A
5000562646500
02

Voids

10-Claim Paid for Wrong Recipient
11-Claim Paid for Wrong Provider
00-Other

Example: V
5000164253000
00



APPROVED OMB NO. 0938-0279

1 ABC Hospital P.O. Bo 1234 Anytown, LA 70809	2	3 PATIENT CONTROL NO. 0924638	4 TYPE OF BILL 137
5 FED. TAX NO. 711222311	6 STATEMENT COVERS PERIOD FROM 04282006	THROUGH 04282006	7 COV D. 8 N-C D. 9 C-I D. 10 L-R D. 11
12 PATIENT NAME Blue Jean	13 PATIENT ADDRESS 101 Venable Dr. Ravine, LA 71111		
14 BIRTHDATE 09131997	15 SEX F	16 MS S	ADMISSION 17 DATE 04282006
21 D HR 22 STAT 23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30 31		
32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE CODE DATE
36 OCCURRENCE SPAN CODE FROM THROUGH	37 A B C		
38 Jean Blue 101 Maple Dr. Golden Meadow, LA 71111	39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
450	Emergency Room	99282	04282006	1	185 00		
001	Total Charges				185 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
State Ins. Co. Medicaid	04387 1700000			75 00		
57	DUE FROM PATIENT ▶					

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Blue Jean Blue Jean		478421234 1707667892110	060606	

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 69 70 71 72 73 74 75	76 ADM. DIAG. CD.	77 E-CODE	78
9494		9494		

79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	82 ATTENDING PHYSICIAN Dr. Stephen Moore
	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	83 OTHER PHYS. ID
				OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
A 6000176400001 01	Marie Jones	05/01/2006

UB-92 HCFA-1450 OCR / Original

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

CMS-1500 Claims Filing Instructions

Hospital-Based Physicians (HBP) are those persons who are either contracted or employed by the hospital to perform professional services. This group may include emergency room physicians, pathologists, radiologists, dentists, certified registered nurse anesthetists (CRNAs) and other physician specialties. These Professional services are billed on the CMS-1500 claim form. Instructions for completing the CMS-1500 form follow. Items to be completed are either **required** or **situational**. **Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. Situational information may be required (but only in certain circumstances as detailed in the instructions below). Claims should be submitted to:

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

1. **Required** Enter an "X" in the box marked Medicaid (Medicaid #)
1A. **Required** Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid swipe card (MEVS) or through REVS

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

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

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

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

4. Situational Complete correctly if appropriate or leave blank

5. Situational Print the recipient's permanent address

6. Situational Complete if appropriate or leave blank

7. Situational Complete if appropriate or leave blank

8. Situational Leave blank

9. Situational Complete if appropriate or leave blank

9A.	Situational	If recipient has no other coverage, leave blank. If there is other coverage, put the state assigned 6-digit TPL carrier code in this block – make sure the EOB is attached to the claim.
9B.	Situational	Complete if appropriate or leave blank
9C.	Situational	Complete if appropriate or leave blank
9D.	Situational	Complete if appropriate or leave blank
10.	Situational	Leave blank
11.	Situational	Complete if appropriate or leave blank
11A.	Situational	Complete if appropriate or leave blank
11B.	Situational	Complete if appropriate or leave blank
11C.	Situational	Complete if appropriate or leave blank
12.	Situational	Complete if appropriate or leave blank
13.	Situational	Obtain signature if appropriate or leave blank
14.	Situational	Leave blank
15.	Situational	Leave blank
16.	Situational	Leave blank
17.	Situational	If services are performed by a CRNA, enter the name of the directing physician. If services are performed by a nurse practitioner or clinical nurse specialist, enter the name of the directing physician. If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.
17A.	Situational	If the recipient is linked to a PCP, the Primary Care Physician referral authorization number must be entered here.
18.	Situational	Leave blank
19.	Situational	Leave blank
20.	Situational	Leave blank
21.	**Required**	Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.
22.	Situational	Leave blank

23. Situational		Complete if required or leave blank
24A.	**Required**	Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.
24B.	**Required**	Enter the appropriate code from the approved Medicaid place of service code list.
24C.	Situational	Leave blank
24D.	**Required**	Enter the procedure code(s) for services rendered.
24E.	**Required**	Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a “1”, “2”, etc. More than one diagnosis may be related to a procedure. Do not enter ICD-9-CM diagnosis code.
24F.	**Required**	Enter usual and customary charges for the service rendered
24G.	**Required**	Enter the number of units billed for the procedure code entered on the same line in 24D
24H.	Situational	Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral
24I.	Situational	Leave blank
24J.	Situational	Leave blank
24K.	Situational	Enter the attending provider number if group number is indicated in block 33
25. Situational		Leave blank
26. Situational		Enter the provider specific information assigned 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. Situational		Leave blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.
28. **Required**		Total of all charges listed on the claim
29. Situational		If block 9A is completed, indicated the amount paid; if no TPL, leave blank
30. Situational		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. **Required** The claim form **MUST** be signed. The practitioner is not required to sign the claim form. However, the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed.

Date Enter the date of the signature

32. Situational complete as appropriate or leave blank

33. **Required** Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid billing provider number must be entered in the space next to "Group (Grp) #."

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **1234567891011**

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

3. PATIENT'S BIRTH DATE MM DD YY: **06 01 1999** SEX: F [X]

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **6-digit TPL Carrier Code (if applicable)**

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

CommunityCARE Authorization # (if applicable)

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. **250.00**
2. _____.__
3. _____.__
4. _____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	04 01 06	04 01 06	23		99282		1	75 00	1				1333333
2													
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 75 00

29. AMOUNT PAID $ **TPL Pmt**

30. BALANCE DUE $ 75 00

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

Cole James 04/04/2006

SIGNED DATE

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

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

Moon Medical Center
1020 Main St.
Sunny, LA 70821 1790000

PIN# GRP#

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

Instructions for Completing the 213 Adjustment/Void form

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

2. **REQUIRED** Patient's Name

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

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

3. Patient's Date of Birth

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

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

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

5. Patient's Address and Telephone Number

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

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

6. Patient's Sex

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

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

7. Insured's Name— Leave blank

8. Patient's Relationship to Insured—Leave blank

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

10. Other Health Insurance Coverage—Complete with 6-digit TPL carrier code if appropriate or leave blank

11. Was Condition Related to—Leave blank

12. Insured's Address—Leave blank

13. Date of—Leave blank

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

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

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

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

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

18a. Referring ID Number—Enter The CommunityCARE authorization number if applicable or leave blank.

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

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

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

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

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

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

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

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

25. **REQUIRED** A through F

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

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

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

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

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

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

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

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

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

REQUIRED items must be completed or form will be returned.

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

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

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): **Smith, Maureen**

3 PATIENT'S DATE OF BIRTH: **06011999**

4 MEDICAID ID NUMBER: **1234567891011**

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

TELEPHONE NO.

6 PATIENT'S SEX: MALE [ ] [X] FEMALE

7 INSURED'S NAME

8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]

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

10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
6-digit TPL Carrier Code (if applicable)

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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

14 DATE FIRST CONSULTED YOU FOR THIS CONDITION

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

16 DATE PATIENT ABLE TO RETURN TO WORK

17 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18A REFERRING ID NUMBER
CommunityCARE Auth # (if applicable)

19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

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

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

22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 **690.1**
2
3

23 ATTENDING NUMBER: **1333333**

24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
04	02	2006	04	02	2006	23	99283		1	55 00	1		**TPL Pmt. (if any)**

26 CONTROL NUMBER: **6095612876000**

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: **04/28/2006**

28 REASONS FOR ADJUSTMENT

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

Billed wrong date of service in error

ADJUSTMENT

29 REASONS FOR VOID

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Greta Biller **05/01/2006**

32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Downtown Medical Center
1020 Main St.
Sunny, LA 70808 **1790000**

UNISYS - 213
5/97

FISCAL AGENT COPY

Address For Claim / Adjustment Submissions

Straight UB-92 claims and straight UB-92 adjustments and voids should be submitted to the following address:

Unisys
P.O. Box 91021
Baton Rouge, LA 70821

CMS-1500 claims and 213 adjustment/void forms for hospital-based physician services should be submitted to the following address:

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

All crossover claims and Medicare adjustment and void claims should be submitted to:

Unisys
P.O. Box 91023
Baton Rouge, LA 70821

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.**

HARD COPY REQUIREMENTS

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

HARDCOPY CLAIM(S) & REQUIRED ATTACHMENT(S)	BILLING REQUIREMENTS
Spend Down Recipient – 110MNP Spend Down Form	Continue hardcopy billing
Third Party/Medicare Payment – EOBs. (Includes Medicare adjustment claims)	Continue hardcopy billing
Failed Crossover Claims – Medicare EOB	Continue hardcopy billing
Retroactive eligibility – copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing
Recipient eligibility Issues – copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing – letter/other proof i.e., RA page	Continue hardcopy billing
Exhausted Medicare Part A – documentation of Medicare being exhausted (MEOB), note in FL 84 (Remarks)	Continue hardcopy billing
All unlisted procedures – medical documentation	Continue hardcopy billing
Sterilization procedures – Sterilization Consent Form	Continue hardcopy billing
Abortion procedures – Abortion Informed Consent Form, signed statement from recipient, treating physician statement, medical necessity	Continue hardcopy billing
Hysterectomy procedures – Form 96A Hysterectomy Form	Continue hardcopy billing
Breast Reconstruction procedures – medical documentation	Continue hardcopy billing
Reduction Mommoplasty – pathology report & approval letter, photographs	Continue hardcopy billing
Transplants – DHH approval letter, operative report	Continue hardcopy billing
Neurobehavioral testing (codes 96115, 96117) – interpretive report signed by correct specialty	Continue hardcopy billing
Incomplete Abortion – history, sonogram, discharge summary, treatment	Continue hardcopy billing
Sonograms (codes 76815, 76816) – medical necessity, dated notes	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.

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

Changes To Claim Forms

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

Data Entry

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

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.

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
CMS-1500 Claims Case Management Chiropractic Durable Medical Equipment EPSDT Health Services FQHC Hemodialysis Professional Services Independent Lab Mental Health Rehabilitation PCS Professional Rural Health Clinic Substance Abuse and Mental Health Clinic Waiver	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

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:

Hospital 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.

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; and
- 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; and
- 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
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

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

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

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

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 PA-02 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 PA-01 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

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: HOSPITAL					

What topic was most beneficial to you?_____

Please provide constructive comments and suggestions:_____

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