UNISYS

PROFESSIONAL SERVICES 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 post-payment review; 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

ABORTION

Induced Abortion

Medicaid payment for induced abortion is restricted to those that meet the following criteria:

- A physician has found, and so certifies in his/her own handwriting, that on the basis of his/her professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term.

- The certification statement must be attached to the claim form. The certification statement must contain the name and address of the patient. The diagnosis or medical condition which makes the pregnancy life endangering must be specified on the claim.

OR

- In the case of terminating a pregnancy due to rape or incest the following requirements must be met:

  - The Medicaid recipient shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest.

  - The report of the act of rape or incest to a law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest must be submitted to the Bureau of Health Services Financing along with the treating physician's claim for reimbursement for performing an abortion.

  - The Medicaid recipient shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician.

  - The OPH Certification of Informed Consent-Abortion form shall be witnessed by the treating physician.

In order for Medicaid reimbursement to be made for an induced abortion, providers must attach a copy of the OPH Certification of Informed Consent-Abortion form to their claim form. Copies of this form can be requested from the Office of Public Health at (504) 556-9842. A blank copy of the form can be found on the following page.

Claims associated with an induced abortion, including those of the attending physician, hospital, assistant surgeon, and anesthesiologist must be accompanied by a copy of the attending physician's written statement of medical necessity. Therefore, **only hard-copy claims will be reviewed** by the fiscal intermediary physician consultants for payment consideration.

To be completed by the Provider:
Name, address of facility:

_____

_____

_____

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
CERTIFICATION OF INFORMED CONSENT-ABORTION

Please initial each section to indicate the information was provided.

SECTION I. The following information was presented to me, orally and in person, at least 24 hours prior to the abortion by _____, who is (check one): ___the physician who is to perform the abortion, ___ a referring physician.

- The name of the physician who will perform the abortion.
- A description of the proposed abortion method, medical risks, and alternatives to the abortion.
- The probable gestational age of the unborn child at the time the abortion is to be performed and,
- If the unborn child is viable or has reached the gestational age of 24 weeks and the abortion may be otherwise lawfully performed under existing law, that:

  1. The unborn child may be able to survive outside the womb
  2. The woman has the right to request the physician to use the method of abortion that is most likely to preserve the life of the unborn child.
  3. If the unborn child is born alive, that attending physicians have the legal obligation to take all reasonable steps necessary to maintain the life and health of the child.

- The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed.
- The medical risks associated with carrying the child to term.
- Any need for anti-RH immune globulin therapy, if RH negative, the likely consequences of refusing such therapy; and a good faith estimate of the cost of the therapy.

Initials:
_____

SECTION II. The following information was presented to me, orally and in person, at least 24 hours prior to the abortion by _____, who is (check one): the physician who is to perform the abortion, ___a referring physician, ___a qualified agent of the physician (Psychologist, Licensed Social Worker, Licensed Professional Counselor, Registered Nurse, Physician).

- That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care. More detailed information on the availability of such assistance is contained in the directory.
- That the pamphlet describes the unborn child and contains a directory of agencies that offer abortion alternatives.
- That the father of the unborn child is liable to assist in the support of the child, even if he has offered to pay for the abortion. In the case of rape this information may be omitted.
- That I am free to withhold or withdraw my consent to the abortion at any time before or during the abortion without affecting my right to future care or treatment and without the loss of any state or federally funded benefits to which I might otherwise be entitled.

Initials:
_____

SECTION III. The following printed materials were provided to me by _____, who is (check one): ___the physician who is to perform the abortion, ___a referring physician,___ a qualified agent of the physician (Psychologist, Licensed Social Worker, Licensed Professional Counselor, Registered Nurse, Physician).

- The pamphlet titled "Abortion: Making A Decision" and the directory of agencies that offer abortion alternatives. [If you are unable to read, they shall be read to you.]

The pamphlet and directory were provided to me on:

Date:_____ Time:_____ A.M. or P.M. (Circle one)

Initials:
_____

PHS 16-IC 9/95

Threatened, Incomplete, or Missed Abortion

Claims for threatened, incomplete, or missed abortion must include the patient history and complete documentation of treatment.

Supportive documentation that will substantiate payment may include one or more of the following, but is not limited to:

- Sonogram report showing no fetal heart tones
- History indicating passage of fetus at home, en route, or in the emergency room
- Pathology report showing degenerating products of conception
- Pelvic exam report describing stage of cervical dilation

ALLERGY TESTING AND ALLERGEN IMMUNOTHERAPY

In billing for allergy testing and allergen immunotherapy, providers are to use the most appropriate and inclusive CPT code that describes the services provided. Unless otherwise listed, Louisiana Medicaid uses the definitions and criteria found in the Current Procedural Terminology Manual (CPT).

Definitions

Allergy testing describes the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the recipient. The number of test performed should be judicious and dependent upon the history, physical findings, and clinical judgment of the provider. All patients should not necessarily receive the same tests or the same number of tests.

Immunotherapy is the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy. The method of administration and the dosage administered should be included in the recipient's record. Indications for immunotherapy are determined by appropriate diagnostic procedures and clinical judgment. The procedure codes used for allergen immunotherapy include the necessary professional services associated with this therapy which includes the monitoring of the injection site and observation of the patient for adverse reactions. Office visit codes may be billed in addition to immunotherapy only if other significant identifiable services are provided at that time.

AMBULATORY SURGICAL CENTERS (NON-HOSPITAL)

- Ambulatory Surgical Centers (ASC) are reimbursed a flat fee per occurrence.
- The flat fee reimbursement is for facility charges only.
- Reimbursement is based on four groupings:

Group 1	$220.39
Group 2	$262.36
Group 3	$282.40
Group 4	$320.56

- Reimbursement amounts can be found on the Professional Services Fee Schedule* under type of service (TOS) 08. ('Evaluation and Management' and laboratory CPT codes also indicated as TOS 08 on the fee schedule DO NOT APPLY to ASC's.)
- Procedures not found on the fee schedule under TOS 08, but listed as TOS 03, are reimbursed at $300.00.
- Ambulatory Surgical Center claims should be completed on the CMS 1500 or 837P. There should be only one line item per claim form.
- Only one procedure code may be billed per outpatient surgical session.
- Chronic pain management is not a covered service. Funds reimbursed for this purpose are subject to recoupment.

*Professional Services Fee Schedule can be found at www.lamedicaid.com

ANESTHESIA SERVICES

Surgical Anesthesia

Procedure codes in the Anesthesia section of the Current Procedural Terminology manual are to be used to bill for surgical anesthesia procedures.

- Reimbursement for surgical anesthesia procedures will be based on formulas utilizing base units, time units (1= 15 min) and a conversion factor.
- Reimbursement for moderate sedation and maternity-related procedures, other than general anesthesia for vaginal delivery, will be a flat fee.
- Minutes must be reported on all anesthesia claims except where policy states otherwise.

The following modifiers are to be used to bill for surgical anesthesia services:

Modifier	Servicing Provider	Surgical Anesthesia Service
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA	CRNA service with direction by an anesthesiologist
QZ	CRNA	CRNA service without medical direction by an anesthesiologist

The following is an explanation of billable modifier combinations:

- Modifiers which can stand alone: AA and QZ.
- Modifiers which need a partner: QK, QX and QY.
- Legitimate combinations: QK and QX
QY and QX

***Medical Direction**

- Only anesthesiologists will be reimbursed for medical direction.
- The anesthesiologist must be physically present in the operating suite to bill for direction of concurrent anesthesia procedures.
- Medical direction is defined as:
    - Performing a pre-anesthetic examination and evaluation;
    - Prescribing the anesthesia plan;
    - Personally participating in the most demanding procedures in the anesthesia plan, including induction and emergence:
    - Ensuring that any procedures in the anesthesia plan that he/she does not perform are rendered by a qualified individual;
    - Monitoring the course of anesthesia administration at frequent intervals;
    - Remaining physically present and available for immediate diagnosis and treatment of emergencies; and
    - Providing the indicated post-anesthesia care.
- The anesthesiologist may bill for the direction of up to four concurrent anesthesia procedures for straight Medicaid recipients.
- Reimbursement will not be made for the direction of five or more anesthesia procedures being performed concurrently unless the patient is a Medicare/Medicaid beneficiary.

Reimbursement Formulas for Surgical Anesthesia

The formulas for determining payment for surgical procedures requiring anesthesia are as follows:

- Anesthesia performed personally by the anesthesiologist (AA)
  Base units plus time units times conversion factor = X - 20% = fee.

- Medical direction of 2, 3 or 4 concurrent anesthesia procedures by anesthesiologist (QY)
  Base units plus time units times conversion factor = X - 50% = Y - 20% = fee.

- Medical direction of one CRNA by an anesthesiologist (QK)
  Base units plus time units times conversion factor = X - 50% = Y - 20% = fee.

- CRNA service with medical direction by an anesthesiologist (QX)
  Base units plus time units times conversion factor = X - 50% = Y - 20% = fee.

- Anesthesia performed by the CRNA without medical direction (QZ)
  Base units plus time units times conversion factor = X - 20% = fee.

- In billing for anesthesia for second and third degree burn excision or debridement with or without skin grafting, report the total anesthesia time with code 01952 and report the appropriate number of units of body surface area with code 01953.

  - Reimbursement for code 01952 will be as follows:
    Base units of 01952 plus time units for 01952 and 01953 (1 = 15 minutes) times conversion factor ($16.41) = X - 20% = fee.

  - Reimbursement for code 01953 will be:
    One base unit for each unit of 01953 times the conversion factor ($16.41) = X -20% = fee. For 01953 only, report units instead of time in Item 24G.

Maternity-Related Anesthesia

REMINDER: Maternity-related services are exempt from the CommunityCARE referral process.

CPT codes in the Anesthesia Obstetric section are to be used by anesthesiologists and CRNAs to bill for maternity-related anesthesia services. The delivering physician should use CPT codes in the Surgery Maternity Care and Delivery section of CPT to bill for maternity-related anesthesia services. Reimbursement for these services shall be flat fee except for general anesthesia for vaginal delivery.

The following chart is an explanation of the billable modifiers used for maternity-related anesthesia, the Louisiana Medicaid billing definitions, and the provider type that may bill using the modifier.

Modifier	Provider Type That May Bill	Billing Definition
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction of two, three, or four concurrent anesthesia procedures
QX	CRNA	CRNA service with medical direction by an anesthesiologist
QZ	CRNA	CRNA service without medical direction by an anesthesiologist
47	Delivering Physician	Anesthesia provided by delivering physician
52	Delivering Physician or Anesthesiologist	Reduced services
QS**	Anesthesiologist or CRNA	Monitored Anesthesia Care Service

*Medical direction – explanation can be found after the Surgical Anesthesia section.

** The QS modifier is a secondary modifier only, and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA). The QS modifier indicates that the provider **did not introduce** the epidural catheter for anesthesia, but **did monitor** the patient after catheter placement.

Billing Add-on Codes for Maternity-Related Anesthesia:

- When an add-on code is used to fully define a maternity-related anesthesia service, the date of delivery should be the date of service for both the primary and add-on code.

- An add-on code in and of itself is not a full service and cannot be reimbursed separately to different providers.

- A group practice frequently includes anesthesiologists and/or CRNA providers. One member may provide the pre-anesthesia examination/evaluation, and another may fulfill other criteria. The medical record must indicate the services provided and must identify the provider who rendered the service. A single claim must be submitted showing one member as the performing provider for all services rendered. In other words, the billing of these services separately will not be reimbursed.

Billing for Maternity-Related Anesthesia

Use the following chart when:

Anesthesiologist performs complete service, or just supervision of CRNA;
OR
CRNA performs complete service with or without supervision by anesthesiologist.

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
Vaginal Delivery General Anesthesia	01960	Valid Modifier	Record Minutes	Formula
Epidural for Vaginal Delivery	01967	AA or QZ	Record Minutes	$324.00
		QK or QY		$162.00
		QX		$162.00
Cesarean Delivery, only (epidural or general)	01961	AA or QZ	Record Minutes	$403.76
		QK or QY		$201.88
		QX		$201.88
Cesarean Delivery after Epidural, for planned vaginal delivery	01967 + 01968	AA or QZ	Record Minutes	$324.00 $79.76
		QK or QY		$162.00 $39.88
		QX		$162.00 $39.88
Cesarean Hysterectomy after Epidural and Cesarean Delivery	01967 + 01969	AA or QZ	Record Minutes	$324.00 $79.76
		QK or QY		$162.00 $39.88
		QX		$162.00 $39.88

Use the following chart when:

The delivering physician provides the **entire** anesthesia service for a vaginal delivery. The most appropriate code from codes 59410, 59610, 59612 and 59614 should be billed with modifier 47. Delivering physician should bill delivery and anesthesia on a single claim line. Reimbursement for both services will be made in a single payment.

Vaginal Delivery

Complete Anesthesia Service by Delivering Physician

TYPE OF ANESTHESIA	CPT CODE	MODIFIER	TIME	ADDITIONAL REIMBURSEMENT for Anesthesia
Epidural	59410, 59610, 59612 or 59614	47	Record minutes	$325.08

Use the following charts when the anesthesia service for vaginal delivery is shared by:

The delivering physician and the anesthesiologist/CRNA

OR

The anesthesiologist and CRNA

Vaginal Delivery

Introduction Only, by Delivering Physician

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	ADDITIONAL REIMBURSEMENT for Anesthesia
Epidural	59410, 59610, 59612 or 59614	47and 52	Record minutes	$178.20

Vaginal Delivery

Introduction Only, by an Anesthesiologist

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
Epidural	01967	AA and 52	Record minutes	$178.20

Vaginal Delivery

Monitoring by Anesthesiologist or CRNA

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
Epidural	01967	AA and QS or QZ and QS Or QX and QS	Record minutes	$145.80

Use the following charts when the anesthesia service for **cesarean** delivery is shared by:

The delivering physician and the anesthesiologist/CRNA

OR

The anesthesiologist and CRNA

Cesarean Delivery

Introduction Only, by Delivering Physician

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	ADDITIONAL REIMBURSEMENT for Anesthesia
Most appropriate	59515, 59618, 59620 or 59622	47 and 52	Record minutes	$217.80

Cesarean Delivery

Introduction Only, by Anesthesiologist

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
C Delivery after Epidural	01961	AA and 52	Record Minutes	$213.99
C Delivery following epidural for planned vaginal delivery	01967 +01968	AA and 52	Record minutes	$178.20 $35.89

Cesarean Delivery

Monitoring by Anesthesiologist or CRNA

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
C Delivery after Epidural	01961	AA and QS Or QZ and QS Or QX and QS	Record minutes	$189.77
C Delivery following epidural for planned vaginal delivery	01967 +01968	AA and QS Or QX and QS	Record minutes	$145.80 $43.87
C Delivery following epidural for planned vaginal delivery	01967 +01968	QZ and QS or QX and QS	Record minutes	$145.80 $43.86

Anesthesia for Tubal Ligation or Hysterectomy

- Anesthesia reimbursement for tubal ligations and hysterectomies is formula-based with the exception of anesthesia for cesarean hysterectomy (code 01969).

- The reimbursement for code 01967 and code 01969 when billed together will be a flat sum of $403.76. Code 01968 is implied in code 01969 and should not be placed on the claim form if a cesarean hysterectomy was performed after C-section delivery.

- Anesthesiologists and CRNAs must attach Form 96, or OMB No. 0937-0166, "Consent to Sterilization", to their claims for reimbursement of a sterilization procedure, and Form 96-A, "Acknowledgement of Receipt of Hysterectomy Information", to their claims for reimbursement of a hysterectomy.

Pain Management

Epidurals administered for the prevention or control of acute pain, such as that which occurs during delivery or surgery, are covered by the Professional Services Program for this purpose only. Epidurals given to alleviate chronic, intractable pain are not covered.

If a recipient requests treatment for chronic intractable pain, the provider may submit a claim for the initial office visit. Subsequent services provided for the treatment or management of this chronic pain are not covered and are billable to the patient. Claims paid inappropriately are subject to recoupment.

Pediatric Moderate (Conscious) Sedation

Effective January 1, 2006, CPT codes 99141 and 99142 were deleted and have been replaced with CPT codes 99143 (Moderate sedation services…provided by the same physician performing the diagnostic or therapeutic service…requiring the presence of an independent trained observer to assist in the monitoring of the patient's…under 5 years of age, first 30 minutes intra-service time), 99144 (…age 5 years or older, first 30 minutes intra-service time), and add-on code 99145 (…each additional 15 minutes intra-service time).

- Claims for moderate sedation should be submitted hard copy indicating the medical necessity for the procedure. Documentation should also reflect pre- and post-sedation clinical evaluation of the patient.

- Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care (00100-01999).

- Moderate sedation is restricted to recipients from birth to age 13. (Exceptions to the age restriction will be made for children who are severely developmentally disabled-documentation attached must support this condition. No claims will be considered for recipients twenty-one years of age or older)

- Moderate sedation includes the following services (which are not to be reported/billed separately):
    - Assessment of the patient (not included in intraservice time);
    - Establishment of IV access and fluids to maintain patency, when performed;
    - Administration of agent(s);
    - Maintenance of sedation;
    - Monitoring of oxygen saturation, heart rate and blood pressure; and
    - Recovery (not included in intraservice time)
- Intraservice time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.
- Louisiana Medicaid has adopted CPT guidelines for procedures that include moderate sedation as an inherent part of providing the procedure. Louisiana Medicaid does not reimburse when a second physician other than the health care professional performing the diagnostic or therapeutic service provides the sedation. Claims paid inappropriately are subject to recoupment.

Additional Anesthesia Information

- CRNA's must place the name of their supervising doctor in Item 17 of the CMS 1500 or 837P claim form.
- Anesthesia time begins when the provider begins to prepare the patient for induction and ends with the termination of the administration of anesthesia.
- Time spent in pre- or postoperative care may not be included in the total anesthesia time.
- A surgeon who performs a surgical procedure will not also be reimbursed for the administration of anesthesia for the procedure.
- A group practice frequently includes anesthesiologists and/or CRNA providers. One member may provide the pre-anesthesia examination/evaluation, and another may fulfill other criteria. The medical record must indicate the services provided and must identify the provider who rendered the service. A single claim must be submitted showing one member as the performing provider for all services rendered. In other words, the billing of these services separately will not be reimbursed.
- Anesthesia for arteriograms, cardiac catheterizations, CT scans, angioplasties and/or MRIs should be billed with the appropriate code from the Radiological Procedures sub-heading in the Anesthesia section of CPT.

- CPT code 00952 (Anesthesia for vaginal procedures…; hysteroscopy and/or hysterosalpingography) pends to Medical Review and must be submitted hardcopy with the anesthesia record attached.

  When billed for anesthesia administered during a hysterosalpingogram, CPT code 58340, the documentation attached must indicate:

  - medical necessity for anesthesia (diagnosis of mental retardation, hysteria, and/or musculoskeletal deformities that would cause procedural difficulty) and

  - that the hysterosalpingogram (HSG) meets the criteria for that procedure (see the Medical Review section-Billing Information)

- Anesthesia for dental restoration should be billed under CPT anesthesia code 00170 with the appropriate modifier, minutes and most specific diagnosis code. Reimbursement is formula-based, with no additional payment being made for a biopsy. A provider does not have to perform a biopsy to bill this code.

- Anesthesia for multiple surgical procedures in the **same anesthesia session** must be billed on one claim line using the most appropriate anesthesia code with the total anesthesia time spent reported in Item 24 G on the claim form.

  The only secondary procedures that are not to be billed in this manner are tubal ligations and hysterectomies.

- Anesthesia claims with a total anesthesia time less than 10 minutes or greater than 224 minutes must be submitted hard copy with the appropriate anesthesia graph attached.

- Anesthesia claims for multiple but separate operative services performed on the same recipient on the same date of service must be submitted hard copy, with a cover letter indicating the above. The anesthesia graphs from the surgical procedures should be included and the claim with attachments should be submitted to Unisys at the address below.

- When anesthesia claims deny with error codes 749 (delivery billed after hysterectomy was done) or 917 (lifetime limits for this service have been exceeded), a new claim must be submitted to Unisys at the address below with a cover letter describing the situation.

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

AUDIOLOGY SERVICES

Payable Codes to Audiologists

SERVICE DESCRIPTION	CODE
Spontaneous Nystagmus; w/record	92541
Positional Nystagmus; w/record	92542
Caloric Vestibular Test; w/record	92543
Optokinetic Nystagmus; w/record	92544
Oscillating Tracking; w/record	92545
Use of Vertical Electrodes	92547
Screening Test, Pure Tone, Air Only	92551
Pure Tone Audiometry; Air Only	92552
Pure Tone Audiometry; Air and Bone	92553
Speech Audiometry Threshold	92555
Speech Audiometry Threshold; with speech recognition	92556
Comprehensive Audiometry	92557
Tone Decay Test	92563
Short Increment Sensitivity Index	92564
Stenger Test, Pure Tone	92565
Tympanometry	92567
Acoustic Reflex Testing; Threshold	92568
Acoustic Reflex Testing; Decay	92569
Filtered Speech Test	92571
Staggered Spondaic Word Test	92572
Sensorineural Acuity Level Test	92575
Synthetic Sentence ID Test	92576
Stenger Test, Speech	92577
Visual Reinforcement Audiometry (VRA)	92579
Conditioning Play Audiometry	92582
Select Picture Audiometry	92583
Electrocochleography	92584
Auditory Evoked Potentials; Comprehensive	92585
Auditory Evoked Potentials; Limited	92586
Evoked Otoacoustic Emissions; Limited	92587
Evoked Otoacoustic Emissions; Comprehensive	92588
Hearing Aid Exam/Selection; Monaural	92590
Hearing Aid Exam/Selection; Binaural	92591
Hearing Aid Check; Monaural	92592
Hearing Aid Check; Binaural	92593
Electroacoustic Evaluation Hearing Aid; Monaural	92594
Electroacoustic Evaluation Hearing Aid; Binaural	92595
Evaluation of Central Auditory Function w/report; init 60 Min	92620
Evaluation of Central Auditory Function; ea additional 15 Min	92621
Assessment of Tinnitus Assessment	92625

Restrictions

- Payment for the following codes is restricted to one **each** per recipient per 180 days

92552	92553	92555	92556	92557	92563	92564
92565	92567	92568	92569	92571	92572	92575
92576	92577	92579	92582	92583	92584	92585

- Audiologist are reminded that for recipients in the CommunityCARE program, there must be a written authorization from the recipient's PCP for the audiologist's services. This includes recipients that are referred to them by the Head Start program.

Audiologists Employed by Hospitals

Audiologists who are salaried employees of hospitals cannot bill Medicaid for their professional services rendered at that hospital because their services are included in the hospital's per diem rate. Audiologists can enroll and bill Medicaid if they are providing services at a hospital at which there is no audiologist on staff.

CHEMOTHERAPY

Chemotherapy administration is covered by Louisiana Medicaid. Providers are to use the appropriate chemotherapy administration procedure code in addition to the "J-code" for the chemotherapeutic agent. If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M procedure code may also be reported.

Providers may refer to the Professional Services Fee Schedule on the Louisiana Medicaid website at www.lamedicaid.com to verify coverage for specific chemotherapeutic agents and services. If a provider would like the Department to consider coverage of additional chemotherapeutic agents, the request should be submitted in writing to Medicaid at the address below:

DHH Program Operations
Professional Services Program Manager
P.O. Box 91030
Baton Rouge, LA 70821

CHIROPRACTIC SERVICES

Chiropractic spinal manipulation services are covered only for recipients up to the age of 21 years when medically necessary and provided as a result of a medical referral from an EPSDT medical screening provider (KIDMED) or the recipient's primary care physician. Referrals will not be accepted from other providers.

Billing Information

Procedure codes 97260 and 97261 have been deleted in the Current Procedural Terminology manual (CPT). Chiropractors are to bill for services using the appropriate, current CPT code (98940 or 98941) for the service provided. HCPCS modifier "AT" (Acute Treatment) may be appended.

Claims for chiropractic services pend to Medical Review and must be submitted hardcopy. The claim is to be accompanied by a written, dated, and signed referral statement from EPSDT medical screening provider or PCP **and** documentation substantiating the medical necessity of the services. The documentation should include, but is not limited to:

- Diagnosis and chief complaint
- Relevant history
- Subjective and objective diagnostic examination findings
- Acuity and severity of the patient's condition
- Results of X-ray, lab and other diagnostic tests
- Number of treatment sessions necessary to correct or alleviate the patient's symptoms or problem
- The level of care (relief, therapeutic, rehabilitative, supportive) planned
- Procedures performed and results
- Response to therapy
- Progress notes and patient disposition

CLINICAL NURSE SPECIALISTS/CERTIFIED NURSE PRACTITIONERS/CERTIFIED NURSE MIDWIVES

Billing Information

- Clinical Nurse Specialists (CNS), Certified Nurse Practitioners (CNP), and Certified Nurse Midwives (CNM) must obtain individual Medicaid provider numbers.

- CNS/CNP/CNM services are billed on the CMS-1500 form or the electronic 837P.

- CNS/CNP/CNM's not linked to a physician group must place their individual provider number in block 33 of the form as the billing provider.

- Physicians who employ or contract with CNS/CNP/CNM's must obtain a group provider number and link the individual provider number of the CNS/CNP/CNM to the group number. Physician groups must notify Provider Enrollment of such employment or contract(s) when CNS/CNP/CNM's are added/removed from the group.

    - Services provided by a CNS/CNP/CNM **must be identified** by entering the provider number of the CNS/CNP/CNM in block 24K and the group number in block 33 of the form.

    - CNS/CNP/CNM's employed or under contract to a group or facility may not bill individually for the same services for which reimbursement is made to the group or facility.

First Assistant in Surgery

Louisiana Medicaid will reimburse for **only one** first assistant in surgery. Ideally, the first assistant to the surgeon should be a qualified physician. However, in those situations when a physician does not serve as the first assistant; qualified, enrolled, advanced practice registered nurses (effective August 1, 2005) and physician assistants (effective July 1, 2005) may function in the role of a surgical first assistant and submit claims for their services under their Medicaid provider number. The reimbursement of claims for more than one first assistant is subject to recoupment.

Reimbursement

Services Prior to August 1, 2005

- Reimbursement for services provided on dates of service prior to August 1, 2005, will be limited to those included in Appendix C and Appendix D of the 2004 Professional Services Training manual. Immunizations and KIDMED medical, vision, and hearing screens are reimbursed at 100% of the physician fee on file. All other payable procedures are reimbursed at 80% of the physician fee on file.

Services On or After August 1, 2005

- Unless otherwise excluded by the Medicaid Program, coverage of services will be determined by individual licensure, scope of practice, and terms of the physician collaborative agreement. Collaborative agreements must be available for review upon request by authorized representatives of the Medicaid program.

- The reimbursement methodology will be the same as previously described above: Immunizations and KIDMED medical, vision, and hearing screens are reimbursed at 100% of the physician fee on file. All other payable procedures are reimbursed at 80% of the physician fee on file.

- Qualified CNS/CNP's who perform as first assistant in surgery should use the "AS" modifier to identify these services.

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

CONCURRENT CARE - INPATIENT

Inpatient Concurrent Care (Under Age 21 Only)

Inpatient concurrent care is defined as the provision of services by more than one physician to the same patient on the same day. Louisiana Medicaid does not pay for concurrent care for recipients age 21 and older. Concurrent care is reimbursed for recipients under the age of 21 only.

In order to qualify for concurrent care, a patient must have a condition(s) or a diagnosis(es) which requires the services of a physician(s) whose specialty, in the majority of cases, is different from that of the primary care physician. Additionally, the patient's condition(s) or diagnosis(es) must be of such severity and/or complexity that the medical community would consider the rendering of concurrent care to be reasonable and warranted. It must be expected that the request by the primary care physician for the provision of concurrent care services would be upheld by peer review. In all cases, concurrent care must be medically necessary, unduplicative, and reasonable. All claims are subject to post-payment review.

- Concurrent care for simple outpatient surgical procedures and uncomplicated diagnoses is not covered.
- Concurrent care policy does not apply to state-funded foster children.
- Concurrent care of patients in the intensive care areas of the hospital is allowed.
- Concurrent care by more than one provider of the same specialty will be sent to medical review prior to reimbursement. In these cases, a request for, and a review of the medical documentation will occur before the decision to authorize payment is made.
- Providers may bill only one hospital visit per day per recipient, even if the patient must be seen more than once daily. The level of code billed for that date should reflect all the services rendered that day.
- Hospital discharge day management codes should be billed on the date of discharge. Each concurrent care provider will be reimbursed for the services on the date of discharge, as long as his specialty is different from those of the other concurrent care providers.
- The patient's hospital records must be available for review, should it be necessary to substantiate the need for concurrent care.

Consultants and Inpatient Concurrent Care

A consultant may become a concurrent care provider on a case if his/her services after the consultation are necessitated by the condition of the patient, and meet the reasonableness test for standard of care. The consultant may bill for the initial consultation (if it meets the definition of a consultation described in the “Consultations” section of this manual), but not for additional consultations, as he/she cannot be both a consultant and a concurrent care provider on the same case. Subsequent care after the initial consultation should be submitted as the appropriate level hospital inpatient service.

If, after consultation, the surgeon’s role is assumed by the consultant, the consultant may bill for neither additional consultations nor follow-up care, as the global surgery period policy (GSP) supersedes this policy.

SAME-DAY OUTPATIENT VISITS

Same-Day Outpatient Visits (Under age 21 only)

- Same-day outpatient visit policy does not apply to state-funded foster children (aid category 15).
- Same-day outpatient visits are not covered if the patient's diagnosis is simple, or if the condition requires non-complex care.
- Same-day outpatient visits may be considered for payment for recipients under 21 if the visit can be justified when:
  - the physician needs to check on the progress of an unstable patient treated earlier in the day;
  - an emergency situation necessitates a second visit on the same day as the first; or
  - any other occasion arises in which a second visit within a 24-hour period is necessary to ensure the provision of medically necessary care to the recipient.
- Two same-day outpatient visits per specialty per recipient are allowed.

  In billing for the second same-day outpatient visit, no higher level visit than 99212 should be billed. CPT codes 99211 and 99212 may be billed twice on the same day, or in combination.
- The patient's medical record must be available for review and must substantiate the need for the second same-day visit.
- An outpatient visit and critical care services may be billed on the same day for the recipient.
- An emergency department visit and critical care services may be billed on the same day for the recipient.
- If a KIDMED screening has been paid, no higher level office visit than 99212 is payable for the same recipient, same date of service and same attending provider.
- A same day follow up office visit for the purpose of fitting eyeglasses is allowed, but no higher level office visit than 99211 should be billed for the fitting.

CONSULTATIONS

Note: Much of the confusion in reporting consultative services begins with terms used to describe the service requested. **The terms "consultation" and "referral" may be mistakenly interchanged. These terms are not synonymous.** Careful documentation of the services requested and provided will alleviate much of this confusion.

When a physician refers a patient to another physician it should not automatically be considered a consultation**.** A consultation would be appropriate if the service provided meets the criteria described below. **Services provided that do not meet the criteria below should not be billed using consultation codes.**

Louisiana Medicaid reimburses for a consultation, in either a hospital or office setting when:

- The service is performed by a physician other than the attending/primary care physician.
- The consultation is performed at the request of the attending/primary care physician, i.e., the 'requesting physician'. This physician's request for the consultation, as well as the need for the consultation, must be documented in the patient's medical record.
- Consultations should not be requested unless they are medically necessary, unduplicative, reasonable, and needed for adequate diagnosis and/or treatment. The patient's medical records must be available for review, and the documentation therein must substantiate the need for the consultation. Consultations for patients with simple diagnoses or who require non-complex care are not covered.
- The physician consultant may initiate diagnostic services.
- The consulting physician renders an opinion and/or gives advice to the requesting physician regarding the evaluation and/or management of a patient. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician.
- Both physicians' records should be reflective of the request for, and the results of the consultation.
- Confirmatory consultations are not covered.
- All claims are subject to post-payment review.

Billing for Consultations

The following criteria should be used to determine if a consultation code may be billed:

- **See "Note" and consultation criteria on the previous page to determine if the service is a "referral" or a "consultation" prior to billing for consultations.**

- If the consulting physician is to perform any indicated surgery, a consultation MAY NOT be billed. The appropriate level evaluation and management code may be billed if it does not conflict with global surgery policy. The GSP takes priority over consultation policy for recipients regardless of their age.

- If, by the end of the service, the consulting physician determines and documents in the patient's record that the patient does not warrant further treatment by the consultant, the consultation code should be billed. If the patient returns at a later date for treatment, subsequent visits should be billed using the appropriate level evaluation and management service codes.

- **If, by the end of the consultation, the consulting physician knows or suspects that the patient will have to return for treatment, the appropriate level evaluation and management code should be billed rather than the consultation code.** The patient's record should document the fact that the consulting physician expects to treat the patient again.

Recipients Age 21 or Older

One consultation may be billed in conjunction with diagnostic procedures, **if it meets the definition of a consultation as previously described.** Follow-up consultations for recipients who are age 21 or older are not covered by Louisiana Medicaid.

Recipients Under Age 21

Outpatient Consultations

- Outpatient consultation policy does not apply to state-funded foster children (aid category 15).

- Three office consultations per recipient per specialty per 180 days are allowed. (The consultant should be a specialist who is asked by the requesting physician to advise him on the management of a particular aspect of the recipient's care on three different occasions within a six month period.) If a fourth consultation is needed, reimbursement will be made only after the documentation has been reviewed and medical necessity of the additional consultations is approved by Medical Review.

Recipients Under Age 21 Cont'd

- A consultation by a provider of the same specialty as that of the requesting physician will be allowed when circumstances are of an emergent nature as supported by diagnosis; and the requesting physician needs immediate consultation regarding the patient's condition. In this circumstance, no higher consultation code than 99244 should be billed. These claims will be sent to Medical Review and a review of the documentation will be made before reimbursement is authorized.

- The consulting physician may always bill for the initial consultation, **if it meets the definition of a consultation as previously described.** However, if the consultant subsequently assumes responsibility for some or all of the patient's care after the initial consultation, he/she must bill evaluation and management codes for established patients. If a provider bills an evaluation and management code for the initial visit, the provider cannot then bill a consultation code for subsequent visits.

- Claims for consultations should indicate the name of the requesting provider, which should be different from that of the consulting physician.

- The consulting physician should not have served as the primary care or concurrent care provider within the 180 days prior to performing the consultation.

Inpatient Consultations

- Inpatient consultation policy does not apply to state-funded foster children.

- One initial and two follow-up consultations are allowed per recipient per specialty per 45 days. If a third follow-up consultation is needed, reimbursement will be made only after the documentation has been reviewed and medical necessity of the additional consultation is approved by Medical Review.

- A consultation by a provider of the same specialty as that of the requesting physician will be allowed when circumstances are of an emergent nature as supported by diagnosis; and the requesting physician needs immediate consultation regarding the patient's condition. In this circumstance, no higher consultation code than 99252 should be billed. These claims will be sent to Medical Review and a review of the documentation will be made before reimbursement is authorized.

- Only one same-specialty consultation will be allowed every 365 days.

- The consulting physician may always bill for his initial consultation, **if it meets the definition of a consultation as previously described.** However, if the consultant subsequently assumes responsibility for some or all of the patient's care after the initial consultation, he/she must bill subsequent hospital care codes for established patients for his daily visit services. If a provider bills a hospital visit code for his initial visit, the provider cannot then bill a consultation code for subsequent visits.

- Claims for consultations should indicate the name of the requesting physician, which should be different from that of the consulting physician. The consulting physician should not have served as the primary care or concurrent care provider within 730 days prior to performing the consultation.

EXCLUSIONS AND LIMITATIONS

The following is not an exhaustive list of services excluded or limited by Louisiana Medicaid. Included are items that have generated questions from providers.

Billing for Services Not Provided

Providers may not bill Medicaid or the recipient for a missed appointment or any other services not actually provided**. Additionally, services not documented are considered services not rendered and are subject to recoupment.**

Aborted Surgical Procedures

Medicaid will not pay professional, operating room or anesthesia charges of an aborted surgical procedure, regardless of the reason.

Infertility

Louisiana Medicaid does not pay for services relating to the diagnosis or correction of infertility, including sterilization reversal procedures. This policy extends to any surgical, laboratory, or radiological service when the primary purpose is to diagnose infertility or to enhance reproductive capacity. Claims for these services will be denied.

"New Patient" Evaluation and Management Codes

Louisiana Medicaid will pay no more than **one** "new patient" evaluation and management code per two-year period to the same group practice, regardless of specialty, except when identifying the initial pre-natal visit of each new pregnancy.

Outpatient Visit Service Limits

Medically necessary outpatient visits are limited to 12 physician/clinic visits per **calendar** year for eligible recipients age 21 or older. Recipients under the age of 21 are not subject to program limitations, other than the limitation of medical necessity.

With the exception of obstetrical visits, all visits performed at Federally Qualified Health Centers, Rural Health Clinics, Nursing Homes, and Skilled Nursing Facilities will be counted toward the total of 12 for patients over age 21. Nursing home and skilled nursing facility visits should be billed with the appropriate place of service – not as inpatient hospital.

Visits in excess of 12 per **calendar** year, which are not approved as medically necessary via an extension, are considered not to be covered Medicaid services and are billable to recipients. An extension must have been filed and denied as not medically necessary in order for the visit to be billed to the recipient.

Outpatient Visit Service Limits – Medicare/Medicaid Recipients

Recipients who are covered by Medicare and Medicaid but who are not QMBs are subject to the same limitation on outpatient medically necessary visits as are Medicaid only recipients. Deductible and coinsurance amounts resulting from visits in excess of the 12 per calendar year

may be billed to dually eligible recipients who are not QMBs if extensions are not approved for those excess visits, as the visits are considered not to be Medicaid-covered.

Outpatient Office Visit Extensions

In order for the Louisiana Medicaid Program to reimburse outpatient physician visits beyond the maximum allowed visits per state **calendar** year, the physician must request an extension from the Unisys Prior Authorization Unit. Extensions will be granted only for emergencies, life-threatening conditions, and life-sustaining treatments (ex: chemotherapy or radiation therapy for cancer).

Providers need to attach documentation to the 158-A Extension Form (see facsimile on the following page) substantiating the diagnosis justifying the office visit; therefore, all extensions of outpatient visits must be requested AFTER the service has already been rendered. The attached documentation may be clinical notes, patient history, pathology or laboratory reports or whatever else can support the diagnosis and services performed.

The ICD-9-CM diagnosis code and the appropriate-level CPT code correlating to the diagnosis must also be entered on the 158-A Extension Form. Incomplete extension forms will be rejected.

Unisys has extension forms available upon request at the address below. The physician should complete the top portion of the Form 158-A and submit it to Unisys, where approval/disapproval will be determined. Providers should send the 158-A form for approval to the following address:

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

Once a decision has been made, Unisys will return the extension form to the provider.

For **approved extensions**, the provider should submit a hardcopy claim, with a cover letter of explanation, and a copy of the approved 158-A form to Provider Relations, at the following address:

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

158-A Form

BHSF Form 158-A
Rev. 07/94
Prior Issues Usable

UNISYS for
Louisiana's **Medicaid Program**
P. O. Box 14919
Baton Rouge, LA 70898-4919

PHYSICIAN OUTPATIENT VISIT EXTENSION FORM

(Instructions for completion are on the reverse side of this form.)

I. TREATING PHYSICIAN - Complete this Section:

Date

Approval of additional **EMERGENCY** or **LIFE-SUSTAINING** physician outpatient visits is being requested for:

Patient's Name | DOB | Sex

Medicaid Identification Number | Social Security Number

Provide a specific DIAGNOSIS CODE for each **EMERGENCY** or **LIFE-SUSTAINING** visit extension request.
Attach documentation of nature of emergency (Pathology report, clinical notes, etc.)

1. Date of Visit — Diagnosis / Treatment
2. Date of Visit — Diagnosis / Treatment
3. Date of Visit — Diagnosis / Treatment
4. Date of Visit — Diagnosis / Treatment
5. Date of Visit — Diagnosis / Treatment
6. Date of Visit — Diagnosis / Treatment
7. Date of Visit — Diagnosis / Treatment
8. Date of Visit — Diagnosis / Treatment
9. Date of Visit — Diagnosis / Treatment
10. Date of Visit — Diagnosis / Treatment
11. Date of Visit — Diagnosis / Treatment

Physician's Name, Address & Vendor No:

Signature of Treating Physician

II. UNISYS - Prior Authorization Unit Use Only

❑ Extension of physician outpatient visits is approved for Date of Visit, Date of Visit, Date of Visit, Date of Visit, Date of Visit, Date of Visit, Date of Visit, Date of Visit, Date of Visit, Date of Visit, Date of Visit, Date of Visit

❑ Extension(s) not approved for Date(s) of Visit(s)

because _____

Date

Signature of Reviewing Physician

PHYSICIAN COPY

GLOBAL SURGERY PERIOD

Louisiana Medicaid's global surgery period (GSP) policy differs from Louisiana Medicare policy.

- Medicaid does not pay for the day before, the day of, and the assigned GSP after surgery. Louisiana Medicaid assigns a GSP 1, 10, or 90 days. If you look at the Professional Fee Schedule, the Global Surgery Period can be found in column 11.

- If a procedure has a GSP of "1", the provider cannot bill for an evaluation and management service (E/M) the day before or the day of the procedure.

- If a procedure has a GSP of "10", the provider cannot bill for an E/M service the day before, the day of, or 10 days following the procedure.

- If a procedure has a GSP of "90", the provider cannot bill for an E/M service the day before, the day of, or 90 days following the procedure.

- Error code **690** (payment included in surgery fee) results when an E/M service is denied for a date of service within the GSP of the surgery or procedure that has been paid.

- Error code **691** (visit paid in GSP; void visit, rebill surgery) results when a surgery or procedure is denied because an E/M service has been paid for a date of service within the GSP of the surgery or procedure. The paid claim for the E/M service must be voided before the claim for the surgery or procedure can be considered for payment.

- E/M services should be billed separately only if the diagnosis and service rendered are unrelated to the diagnosis of the GSP procedure. If a visit is to be billed for a date of service within the GSP for unrelated diagnosis, it should be filed on a claim form separate from that of the GSP surgery or procedure.

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**. Claims with documentation attached to the claim will be sent to 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 pre-certification is required for any covered Medicaid services not related to the treatment of the terminal condition, that prior authorization/pre-certification 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.

HYSTERECTOMY

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

‘INCIDENT TO’ BILLING CLARIFICATION

Louisiana Medicaid issues the following clarification for billing services as ‘incident to’ a physician’s professional service.

- ‘Incident to’ a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness. This means that the physician, under whose provider number a service is billed, must perform or be involved with a portion of the service billed. Physician involvement may take the form of personal participation in the service or may consist of direct personal supervision coupled with review and approval of the service notes at a future point in time.

- Please note that direct personal supervision by the physician must be provided when the billed service is performed by auxiliary personnel. Direct personal supervision in an office means the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the service is performed.

- In addition to services performed by non-physicians, such as nurses or aides, services performed by other non-physicians whose licenses allow them to perform physician-type services (Nurse Practitioners, Physician Assistants, and others) may qualify as ‘Incident to’ a physician’s service. **However, it is important to remember that, even if the physician supervision requirements are met, the service does not qualify as ‘Incident to’ unless the physician performs or is involved with some portion of the service billed.**

- In situations where non-physicians such as an NP or PA provides all parts of the service independent of a supervising physician’s involvement, the service does not meet the requirements of ‘Incident to’ billing. Instead, the service must be billed using the provider number of the non-physician practitioner and must meet the specific coverage requirements of the practitioner’s scope of practice.

Provider Alert

It has come to the Department’s attention that some physicians have attempted to bill for services rendered within the scope of practice of associated non-physician providers such as the NP or PA as though ‘incident to’ the physician’s services. Supervision and ‘signing off’ of records does not constitute ‘incident to’. Services billed in this manner are subject to post payment review, recoupment, and additional sanctions as deemed appropriate by the Department.

INJECTABLE MEDICATIONS

- **Antibiotic injections** are covered for recipients under age 21.
    - For injectable antibiotics supplied and administered by the physician, providers are to use the specific HCPCS code for the antibiotic given.
    - When the dosage administered has no HCPCS code assigned, providers should calculate the appropriate number of units to enter in Item 24G of the claim form. (When any portion of a single dose vial is used, bill for the complete vial.) Providers are expected to procure medication that most closely matches dosages typically administered. Attempts to maximize reimbursement are subject to recoupment and additional sanction.
    - Medicaid does not reimburse separately for the administration of an antibiotic provided during the course of an evaluation and management service of a higher level than CPT code 99211.
- Physicians may write prescriptions for injectable medications covered by the Louisiana Medicaid pharmacy program and have the recipient bring the prescription to a Medicaid pharmacy to be filled.
    - The recipient may then bring the dispensed medication to the physician's office for injection. A low-level office visit (procedure code 99211) for the administration of the injection could be billed by the provider if a higher level visit had not been submitted for that recipient on that date.
    - If the injection is administered during the course of a more complex office visit, the appropriate code for the visit should be billed and there would not be a separate charge for administering the injection.
- **Immunizations**: see specific policy section in this manual.
- Providers should refer to the Professional Services Fee Schedule on www.lamedicaid.com for reimbursement information.

LABORATORY SERVICES

Specimen Collection

Physicians who collect specimens and forward them to an outside laboratory may not bill for collection of the specimen or performance of the test. Only the provider who has performed the test (i.e., the outside laboratory) may bill for the test. The collection of the specimen is included in the office visit fee.

CLIA Certification

Clinical Laboratory Improvement Amendments (CLIA) claim edits are applied to all claims for lab services that require CLIA certification. Those claims that do not meet the required criteria will deny.

Claims are edited to ensure payment is not made to:

- providers who do not have a CLIA certificate
- providers submitting claims for services rendered outside the effective dates of the CLIA certificate
- providers submitting claims for services not covered by their CLIA certificate

Louisiana Medicaid maintains a current provider CLIA file. Therefore, providers do not have to include their CLIA certification number on claim forms. In fact, the CLIA certificate number should not be entered on the claim form for Medicaid services.

Providers must submit a copy of the CLIA certification to Unisys Provider Enrollment initially to have the certification added to the provider file. Once the CLIA certification has been added to the file, certification updates are done automatically via CMS's file updating process (OSCAR) and are sent to Medicaid without provider involvement.

Providers with regular accreditation, partial accreditation, or registration certificate types are allowed by CLIA to bill for all lab codes.

Providers with waiver or provider-performed microscopy (PPM) certificate types shall be paid for only those waiver and/or provider-performed microscopy codes approved for billing by CMS.

Providers with waiver or provider-performed microscopy (ppm) certificates wishing to bill for codes outside their restricted certificate types should obtain the appropriate certificate through Health Standards. If the certificate type is upgraded, claims can be paid only for dates of service that fall within the upgraded certification dates.

Providers are notified of additions and deletions to the CLIA file through Provider Updates and Remittance Advice messages. CLIA information can also be obtained on the Louisiana Medicare website at www.lamedicare.com using the CLIA link.

MEDICAL REVIEW

The Medical Review Department is responsible for several functions, including post-procedural review of claims for manually priced procedures and designated procedures and diagnoses which require medical documentation to ensure compliance with Medicaid policy.

Expediting Correct Payment

Listed below are suggestions for facilitating correct payment:

- All attachments should be clear, legible, and easy-to-read copies.
- Correctly date all operative reports.
- Use specific, appropriate diagnosis codes.
- Submit requested documentation as soon as possible so that correct payment can be quickly determined. When submitting requested documentation, attach it behind a copy of the original claim form, as Unisys has no mechanism to match incoming medical records with previously submitted claims.
- Bill all procedures performed under the same anesthesia session on the same CMS-1500 form. Use correct modifiers and attach all pertinent documents with the claim.
- Assistant surgeons should always append an 80 modifier on each claim line. Assistant surgeons are not required to use the 51 modifier for secondary procedures.
- All reports (i.e. operative, history and physical, etc.) must be submitted as one sided for accurate imaging.

Billing Information

- **Bilateral Procedures**

  A 50 modifier indicates that a bilateral procedure was performed. Providers should submit the appropriate CPT code on one claim line, append modifier 50, and place a "1" in the "units" column of the claim form. These claims must be submitted hard copy with operative reports attached.

  The bilateral modifier can only be appended to the CPT code if the procedure can be surgically performed bilaterally. The 50 modifier is not to be added if the CPT definition reads "unilateral or bilateral".

- **Multiple Surgical Procedures**

  When more than one surgical procedure is submitted for a recipient on the same date of service, the claim is always reviewed by the Medical Review Unit, regardless of the method or timing of claim submittal.

  When submitting multiple surgical procedures within the same anesthesia session, providers should bill the major procedure with no modifier and append a 51 modifier on all other procedures, unless the code billed is listed in CPT as exempt from modifier 51.

  - If a 51 modifier is appended to a "modifier 51 exempt" code, the claim will be denied.
  - If a 51 modifier is required and is not appended, the claim will be denied.
  - Louisiana Medicaid no longer accepts a 51 modifier on add-on codes. Incorrectly paid add-on codes are subject to recoupment.

  If the provider has not designated a primary procedure by appending a 51 modifier to the secondary procedure(s), the claim will be processed as follows:

  - The lowest numerical CPT code will be paid as the primary procedure by the system.
  - Subsequent codes will pend to Medical Review.
  - The primary procedure will be paid at 100% of either the Medicaid allowable fee or the billed charge, whichever is lower. All other procedures will be paid at 50% of the Medicaid allowable fee, or 50% of the billed charge, whichever is less.

- **Multiple Surgical Modifiers**

  Multiple modifiers may be appended to a procedure code when appropriate. Billing multiple surgical procedures and bilateral procedures during the same surgical session should follow Medicaid policy for each type of modifier.

  Bilateral secondary procedures should be billed with modifiers 50/51 and if appropriate, will be reimbursed at 75% of the Medicaid allowable fee or 75% of the billed charges, whichever is lowest.

Additional Information

- **Keloid Policy**

  Providers will not be reimbursed for the removal of keloids if removal is/was for cosmetic reasons. The initial diagnostic visit is excluded from this policy. Such claims must be submitted hardcopy with a copy of the patient's chart notes documenting the visit and an

accompanying statement from the physician indicating that the visit was the **initial** visit during which the problem was diagnosed. (Follow-up visits for keloid removal are not payable.)

- **Auditory System Procedures To Be Included In Tympanostomy**

  The following auditory system procedures are included in the performance of tympanostomy (CPT code 69436):

  Code 69200 - Removal foreign body from external canal; without general anesthesia

  Code 69205 - Removal foreign body from external auditory canal; with general anesthesia

  Code 69210 - Removal impacted cerumen separate procedure; one or both ears

  Code 69401 - Eustachian tube inflation, transnasal; without catheterization

  Providers will receive payment for code 69436 only, even though the other four procedures may have been performed on the same recipient on the same date. Conversely, a payment for code 69200 for a particular recipient on a particular date of service will result in denials of claims for codes 69205, 69210, 69401, and 69436.

- **CPT Code 58340**

  Claims for CPT code 58340 (Catheterization and introduction of saline or contrast material for saline infusion sonohysterography [SIS] or hysterosalpingography) must be submitted hardcopy with attachments that indicate the purpose for and the radiological interpretation of the procedure.

  Reimbursement for this procedure is limited to the assessment of fallopian tube occlusion or ligation following a sterilization procedure.

  For anesthesia code 00952 billed during a hysterosalpingogram, the above criteria must be met.

  Louisiana Medicaid does not reimburse for the diagnosis and/or treatment of infertility.

- **Unlisted Procedures**

  Claims submitted for unlisted procedure codes are subject to review, and should be submitted hardcopy with operative reports attached. The operative reports should accurately describe the unlisted procedure; underlining such portions of the report that describes the services performed will expedite the medical review process. If a CPT code exists that describes the service that was billed as an unlisted procedure code, the claim will be denied.

MODIFIERS

For recipients with Medicare and Medicaid, providers should submit the claim to Medicaid with the same modifiers used for Medicare. For recipients without Medicare coverage, the following modifiers are to be used. Modifier usage is not applicable to all CPT codes. Please refer to the most current CPT manual for codes exempt from modifier usage.

Modifier	Use/Example	Special Billing Instructions	Reimbursement
22 – Unusual Service	Service provided is greater than that which is usually required (e.g., delivery of twins); not to be used with visit or lab codes	Attach supporting documentation which clearly describes the extent of the service	125% of the fee on file
26 – Professional Component	Professional portion only of a procedure that typically consists of both a professional and a technical component (e.g., interpretation of laboratory or x-ray procedures performed by another provider)		40% of the fee on file
Note: Louisiana Medicaid does not reimburse technical component only on straight Medicaid claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.			
50 – Bilateral Procedure	Procedure was performed bilaterally during the same operative session	Attach supporting documentation; bill on a single line with 1 unit	150% of the fee on file
51 – Multiple Procedures	More than one procedure was performed during the same operative session	Attach supporting documentation; use the modifier on all procedures except the primary one	100% of the fee on file for primary; 50% of the fee on file for all others
52 – Reduced Services	Service or procedure is reduced at the physician's election	Attach supporting documentation	75% of the fee on file
54 – Surgical Care Only	Surgical procedure performed by physician when another physician provides pre- and/or postoperative management		70% of the fee on file
55 – Postoperative Management Only	Postoperative management only when another physician has performed the surgical procedure		20% of the fee on file

Modifier	Use/Example	Special Billing Instructions	Reimbursement
56 – Preoperative Management Only	Preoperative management only when another physician has performed the surgical procedure		10% of the fee on file
Note: If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for surgical care only, post-operative care only, or preoperative care only. In order for all providers to be paid in the case when modifiers 54, 55, and 56 would be used, each provider must use the appropriate modifier to indicate the service performed. Claims that are incorrectly billed and paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.			
62 – Two Surgeons	Performance of procedure requiring the skills of two surgeons	Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each	80% of the fee on file
63 – Infants less than 4 kg	Indicates a procedure performed on an infant less than 4 kg	Attach supporting documentation if multiple modifiers are used (i.e. 51 and 63)	125% of the fee on file
66 – Surgical Team	Performance of highly complex procedure requiring the concomitant services of several physicians (e.g., organ transplant)	Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each	80% of the fee on file
In order for correct payment to be made in the case of two surgeons or a surgical team, all providers involved must bill correctly using appropriate modifiers. If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for two surgeons or surgical team. Payment will not be made for any procedure billed for both full service (no modifier) and for two surgeons or surgical team. If even one of the surgeons involved bills with no modifier and is paid, no additional payment will be made to any other surgeon for the same procedure. Claims which are incorrectly billed with no modifier and are paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.			
80 – Assistant Surgeon			MD's = 20% of the full service physician fee on file. Certified Nurse Midwives = 80% of MD's 'Assistant Surgeon' fee.

Modifier	Use/Example	Special Billing Instructions	Reimbursement
AS – First Assistant in Surgery: Qualified Phys. Assistant, Nurse Practitioner, or Clinical Nurse Specialist			80% of MD's 'Assistant Surgeon' fee
AT – Acute Treatment	Chiropractors use this modifier when reporting service 98940, 98941		Fee on file
GT – Telemedicine	Services provided via interactive audio and video telecommunications system	Modifier should be appended to all services provided via telemedicine and be documented in the clinical record at both sites.	100% of the fee on file
Q5 – Reciprocal Billing Arrangement	Services provided by a substitute physician on an occasional reciprocal basis not over a continuous period of longer than 60 days. Does not apply to substitution within the same group.	The regular physician submits the claim and receives payment for the substitute. The record must identify each service provided by the substitute.	100% of the fee on file
Q6 – Locum Tenens	Services provided by a substitute physician retained to take over a regular physician's practice for reasons such as illness, pregnancy, vacation, or continuing education. The substitute is an independent contractor typically paid on a per diem or fee-for-time basis and does not provide services over a period of longer than 60 days.	The regular physician submits claims and receives payment for the substitute. The record must identify each service provided by the substitute.	100% of the fee on file
TH – Prenatal Visits	Required to indicate E&M pre-natal services rendered in the MD office		Normal fee for prenatal services (exempts the recipient from the 12 visit limit)
QW - Laboratory	Required when billing certain laboratory codes (refer to Laboratory Section of packet)		Fee on file (use of the –QW does not increase or decrease reimbursement)

NEWBORN CARE AND DISCHARGE

Physician providers billing for initial newborn care should use code 99431 (history and examination of normal newborn infant, initiation of diagnostic and treatment programs, and preparation of hospital records) for the initial examination rendered. Code 99431 is limited to one per lifetime of the recipient.

Procedure code 99433 (subsequent hospital care, normal newborn, per day) should be billed for each day of normal newborn care subsequent to the date of birth other than the discharge date. Code 99433 is limited to 3 per lifetime of the recipient.

Discharge Services

- When the date of discharge is subsequent to the admission date, submit claims for newborn hospital discharge services using the appropriate hospital day management code.
- When newborns are admitted and discharged from the hospital or birthing room on the same date, use code 99435. This code is used for services within the first 24 hours of the child's life.

Routine Circumcision

As a non-covered service, this is a billable service to the recipient. All medically necessary circumcisions will continue to be a covered service.

Newborn Pre-certification

If newborn care procedure codes 99431, and/or 99433, and/or a discharge code of 99238 are billed within the initial 2 or 4 days of the mother's approved pre-cert, providers can submit claims as they normally would.

If the newborn is admitted to NICU, a pre-cert must be obtained with the baby's Medicaid number. After the pre-cert has been obtained, the physician's claims for these services should be submitted through regular claims processing channels.

If the newborn is not admitted to NICU but requires services other than normal newborn care and it is within the initial 2 or 4 days of the mother's approved pre-cert, no pre-cert is required. Claims for these services must be submitted hard copy with appropriate documentation to substantiate the medical necessity for the billing of codes other than normal newborn care. These hard copy claims and documentation must be submitted to Unisys Provider Relations with a cover letter requesting a pre-cert override.

If the newborn is not admitted to NICU but requires services after the initial 2 or 4 days of the mother's pre-cert, a pre-cert must be obtained with the baby's number. After the pre-cert has been obtained, claims should be submitted through regular claims processing channels.

The mother's pre-cert number should never be placed on the newborn's claim.

OBSTETRICAL SERVICES

All prenatal visit codes must be modified with -TH in order to process correctly and the modifier must be placed in the first position after the CPT code.

The -TH modifier is not required for observation or inpatient hospital physician services.

Initial Prenatal Visit(s)

Recipients shall be allowed two initial prenatal visits per pregnancy (270 days). These two visits cannot be performed by the same provider.

The appropriate CPT code from the 99201 through 99205 section of Office or Other Outpatient Services range of codes shall be billed for this service, as each pregnancy will be considered a new pregnancy whether or not the recipient is a new patient to the provider. Additionally, a pregnancy-related diagnosis code must be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, **which must be modified with -TH**, includes a routine dipstick urinalysis (CPT code 81002 or 81003), the examination, preparation of records, and health/dietetic counseling.

One laboratory obstetric panel is payable per pregnancy.

If the pregnancy is not verified or if the pregnancy test is negative, the appropriate level evaluation and management code from the 99201-99215 range of codes should be billed **WITHOUT** the -TH modifier.

Follow-Up Prenatal Visits

The appropriate CPT code from the range of 99211-99215 section of Office or Other Outpatient Services range of codes shall be billed for each follow-up prenatal office visit. The code for each of these visits **MUST BE MODIFIED WITH –TH**.

The reimbursement for this service shall include payment for routine dipstick urinalysis, the exam, routine fetal monitoring (excluding fetal non-stress testing-CPT code 59025), and diagnosis and treatment of conditions both related and unrelated to the pregnancy.

Delivery Codes

The most appropriate CPT code should be billed for deliveries.

In cases of multiple births (twins, triplets, etc.), providers must submit claims hardcopy. The diagnosis code must indicate a multiple birth and delivery records should be attached. A -22 modifier for unusual circumstances should be used with the most appropriate CPT code for a vaginal or C-Section delivery when the method of delivery is the same for all births. If the multiple gestation results in a C-Section delivery and a vaginal delivery, the provider should bill the most appropriate CPT code for the C-Section delivery without a modifier and should also bill the most appropriate CPT code for the vaginal delivery and append modifier -51.

Postpartum Care Visit

CPT code 59430, which does not need to be modified, shall be billed for the postpartum care visit. The reimbursement for this service shall include all the services (examination, routine dipstick urinalysis, weight and blood pressure checks, etc.) normally associated with releasing a patient from OB care.

Each recipient is allowed one postpartum visit. Payment for a second medically indicated postpartum visit can be requested by submission of Form 158A.

Laboratory Services

One laboratory obstetric panel is payable per pregnancy.

A complete urinalysis (CPT code 81000 or 81001) is payable only once per pregnancy per recipient per billing provider unless the primary diagnosis code for subsequent billings is within the 590-599 (Other Disease of Urinary System) diagnosis range or 646.6.

All lab work must be substantiated by appropriate diagnosis codes, e.g. urinalysis should be substantiated by a diagnosis of U.T.I.

Ultrasounds

Three ultrasounds shall be allowed per pregnancy. This includes ultrasounds performed by all providers regardless of place of treatment.

Payment for additional ultrasounds may be considered when medically necessary and must be submitted with the appropriate documentation. This documentation should include evidence of an existing condition or documentation to rule out a suspected abnormality. The patient's OB provider should forward the information supporting the additional ultrasounds to the radiologist when patients are sent to an outpatient facility for the procedure.

Reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists.

Providers should bill the most appropriate CPT code for the service rendered.

Hospital Observation Care

Louisiana Medicaid considers "Initial Observation Care", CPT codes 99218-99220, a part of the evaluation and management services provided to patients that are designated as "observation status" in a hospital. The key components of the codes used to report physician encounter(s) are defined in CPT's "Evaluation and Management Services Guidelines". These guidelines indicate that professional services include those face-to-face and/or bedside services rendered by the physician and reported by the appropriate CPT code. In order to submit claims to the Louisiana Medicaid program for hospital observation care, the service provided by the physician must include face-to-face and/or bedside care.

Expanded Dental Services for Pregnant Women

Eligibility Information

The Expanded Dental Services for Pregnant Women (EDSPW) Program provides coverage for certain designated dental services for Medicaid eligible pregnant women ages 21 through 59 years in order to address their periodontal needs during pregnancy. Eligibility for this program ends at the conclusion of the pregnancy.

Referral Information

In order to access services covered in the EDSPW Program, the patient must be referred to the dentist by the medical professional providing her pregnancy care using the BHSF Form 9-M. The BHSF Form 9-M is used to verify pregnancy as well as provide additional important information from the physician to the dentist. The patient may be referred to the dentist if at least one condition that is listed on the BHSF Form 9-M, Part II applies to that patient. All items on the BHSF Form 9-M must be completed and the form must be signed by the medical professional providing the pregnancy care.

The original completed form must be given to the patient so that she can provide it to her dentist prior to receiving dental services. The original form is necessary for the dentist to receive reimbursement and must be kept in the patient's dental record. The medical professional must keep a copy of the completed form in the patient's medical record.

The BHSF Form 9-M, issue date 12/03, is the only referral form accepted by Medicaid for this program. A copy of this form can be found on the following page. Blank forms may be photocopied for distribution as needed. Additional copies of this form may also be obtained from Unisys Provider Relations by calling (800) 473-2783 or (225) 924-5040; or from the following website: www.lamedicaid.com

BHSF Form 9-M
Issued 12/03

Medicaid Program

Referral For Pregnancy Related Dental Services

(Must Be Completed By The Medical Professional Providing Pregnancy Care)

Part I: All Items Must Be Complete

Name of Patient: _____

Street Address: _____ City: _____ Zip Code: _____

Medicaid Recipient ID #: _____

Estimated Date of Delivery (MM/DD/YYYY): _____

Part II: Check (☑) All Conditions That Apply

- ❑ **Bleeding Gums**
- ❑ **Swollen, puffy gums**
- ❑ **Spaces between the teeth that were not there before**
- ❑ **Teeth with obvious decay**
- ❑ **Teeth that appear longer**
- ❑ **Pain associated with teeth or gums**
- ❑ **Bad breath odor that does not go away with normal brushing**
- ❑ **Loose teeth**
- ❑ **Inability to chew or swallow properly**
- ❑ **Tender gums that bleed when brushing**

Are there any medical or perinatal complications that the dentist should be aware of prior to the delivery of dental services?
❑ **YES** ❑ **NO**
If yes, please describe below:

_____

_____

Is pre-medication or other medication required prior to dental treatment? ❑ **YES** ❑ **NO**
(If yes, please attach a photocopy of the prescription.)

Part III: Check (☑) Any Services That Are Contraindicated

- ❑ Local Anesthetic
- ❑ Radiograph(s)
- ❑ Teeth Cleaning
- ❑ Restoration(s)
- ❑ Gum Treatment – Ultrasonic Cleaning and/or Scaling Below the Gum Line
- ❑ Extraction(s)

Part IV: Please include other comments and/or recommendations below:

_____

_____

I have confirmed the pregnancy with diagnostic testing for the above-named patient.

_____	_____	(___)_____	_____
Medical Professional Signature (Required)	**Provider Type & License #**	**Office Telephone #**	**Date**

To locate a Medicaid enrolled dentist, you may contact the
Medicaid Referral Assistance Hotline toll-free at 1-877-455-9955.

ORAL AND MAXILLOFACIAL SURGERY PROGRAM

Medically necessary oral and maxillofacial medical procedures are reimbursed when required in the treatment of injury or disease related to the head and neck.

Enrolled dental providers are limited in the types of surgical services that may be billed through the Professional Services Program. Please refer to the 2006 Dental Services Provider Training Packet for additional information regarding Dental program policy and billing procedures.

Non-Covered Services

- Tooth extractions for recipients age 21 and older except for those covered in the Expanded Dental Services for Pregnant Women Program

- Procedures performed for cosmetic purposes

ORGAN TRANSPLANT SERVICES

When a Louisiana Medicaid recipient receives an organ transplant, all charges incurred in the transplant are to be billed under the Medicaid recipient's name and Medicaid ID number. This includes all procedures involved in the harvest of the organ from the donor. However, Medicaid does not pay for harvesting of organs when a Louisiana Medicaid recipient is the donor of an organ to a non-Medicaid recipient.

All claims for organ transplants must be submitted hard copy with a copy of the approved authorization letter and a dated operative report. Examples of the transplant prior authorization form (TP-01) and the transplant approval letter follow.

If Medicare covers and pays on the transplant, you do not need an approval letter for the transplant, however, if the recipient has private insurance and the transplant is covered, you do need an approval letter for the transplant.

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 th request. We are submitting or preparing to submit scientific documentation for recent applicable transplant developments.

12)_____ 13) _____
(Physician Name and Title , Please Print) (Physician Signature and Title)

14)_____ 15)_____
(Transplant Coordinator or Contact Person) (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

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

July 20, 2005

Reference:
ID#:
SS#:

Dear Ms.

This is to confirm that a kidney 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.

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,

Darlene White

for Ben A. Bearden
Director

BAB/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"

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 List (PDL)

The most current PDL can be found on the LAMedicaid.com website.

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 override" and the ICD-9-CM diagnosis code that directly relates to each drug prescribed on the prescription.

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.

PHYSICIAN ASSISTANTS

Louisiana Medicaid enrolls and issues individual Medicaid provider numbers to Physician Assistants (PA). The effective date for use of the provider number is dates of service July 1, 2005, forward. As of that date, Medicaid requires that all services provided by the PA be billed identifying the physician assistant as the **attending** provider.

Unless otherwise excluded by Louisiana Medicaid, the services covered are determined by individual licensure, scope of practice, and supervising physician delegation. The supervising physician must be a Medicaid enrolled physician. Clinical practice guidelines and protocols shall be available for review upon request by authorized representatives of Louisiana Medicaid.

Services provided by a physician assistant shall not be billed when he/she is employed by or under contract with providers whose reimbursement is based on costs that include these salaries.

The reimbursement for services rendered by a physician assistant shall be 80% of the professional services fee schedule and 100% for KIDMED medical, vision, and hearing screens and immunizations.

Billing Information

Please note the following billing instructions and enrollment requirements regarding PA services

- PA services are billed on the CMS 1500/837P form.
- Services provided by the PA must be identified by entering the provider number of the PA in block 24K, and the group number must be entered in block 33.
- Physicians who employ or contract with PAs must obtain a group provider number and link the PA's individual provider number to the group number. Physician groups must notify Provider Enrollment of such employment or contracts when PAs are added or removed from the group.
- Qualified PA's who perform as first assistant in surgery should use the "AS" modifier to identify these services.

Effective July 1, 2005, services rendered by the physician assistant that are billed and paid by Medicaid using a physician's number as the attending provider are subject to recoupment.

First Assistant in Surgery

Louisiana Medicaid will reimburse for **only one** first assistant in surgery. Ideally, the first assistant to the surgeon should be a qualified physician. However, in those situations when a physician does not serve as the first assistant; qualified, enrolled, advanced practice registered nurses (effective August 1, 2005) and physician assistants (effective July 1, 2005) may function in the role of a surgical first assistant and submit claims for their services under their Medicaid provider number. The reimbursement of claims for more than one first assistant is subject to recoupment.

PODIATRY

A listing of procedures payable by Louisiana Medicaid can be found in Appendix A. These procedures fall within the scope of practice for podiatrists as defined by the Louisiana Podiatry Practice Act and may be billed to the Louisiana Medicaid Program by any currently licensed podiatrist who is enrolled as a Medicaid provider.

If there is a service that is within the scope of practice for podiatrists that is not on the list of reimbursable services a request for consideration may be submitted in writing to Louisiana Medicaid at the following address:

DHH Program Operations
Professional Services Program Manager
PO Box 91030
Baton Rouge, LA 70821

PRE-CERTIFICATION POLICY

Billing Recipients When Pre-Certification Is Denied

If a request for pre-certification is denied because medical necessity is not met, the recipient cannot be billed. If the case had met medical necessity, it would have been pre-certified; thus, if it was not medically necessary for the recipient to be in the hospital, the provider should never have admitted the patient. This same logic applies to the extensions - if it is not medically necessary for the patient to be in the hospital, then discharge would be in order.

Also, providers should not bill recipients simply because they were late in submitting their pre-certification information.

One situation in which a provider could bill the recipient is when the recipient presents himself to the hospital as a private-pay patient, not informing the hospital of his Medicaid coverage.

When a hospital's pre-certification request (initial request or extension request) is denied due to timely submittal, or if the hospital fails to request initial pre-certification, the physician can get their services paid, but the claim must be special handled. Providers should send their claim, along with an admit and discharge summary and a cover letter requesting a pre-certification override, to the following address:

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

Providers should note that claims that are special handled may still deny if they contain errors. Overriding the pre-certification requirement does not negate Medicaid policy regarding claim completion. Providers should ensure that claims submitted for pre-certification overrides are correctly completed.

Retrospective Eligibility Pre-Certification

For true retrospective eligibility pre-certification reviews, the pre-certification may be considered filed timely if the request is submitted within a year from the date that the eligibility decision was added to the recipients eligibility file. If the retrospective review is received within a year of the eligibility decision and the date of service is already over one year old, the normal timely filing restriction may be overridden.

Outpatient Surgery Performed on an Inpatient Basis

Outpatient surgeries performed on an inpatient basis require prior authorization if the surgery is done within the first two days of a hospital stay. The hospital Utilization Review department must complete a PCF02 and submit it to the Unisys Pre-certification Department to have the procedure added to the pre-certification file.

If the surgery is performed on the third or succeeding days, no prior authorization is required.

Submitting Physician Charges - Days Not Pre-Certified

SITUATION	PHYSICIAN VISITS COVERED	PHYSICIAN PROCEDURE
Hospital did not request pre-certification because it does not accept Medicaid*	YES	Physician submits claim with admit and discharge summary to the Correspondence Unit.
Hospital did not request pre-certification on the recipient in question, even though the hospital accepts Medicaid*	YES	Physician submits claim with admit and discharge summary to the Correspondence Unit.
Hospital did not request pre-certification timely on the recipient in question, even though the hospital accepts Medicaid*	YES	Physician submits claim with admit and discharge summary to the Correspondence Unit.
Hospital obtained pre-certification; however, the days billed by the physician were within the same hospital stay but not approved under the pre-certification*	YES	If the days in question were never applied for by the hospital, the physician can submit the claim with the admit and discharge summary to the Correspondence Unit. Cannot bill the recipient**
Hospital requested pre-certification, but it was denied because it did not meet medical necessity criteria (applicable also to extension)*	NO	Cannot bill the recipient**

***Please Note:** Hospital admission should be based on medical necessity as outlined by LA Medicaid pre-certification policy.

****Please Note:** Should the recipient choose to remain hospitalized once their stay is deemed not medically necessary the recipient should be informed that they will be responsible for charges incurred from that point on.

Providers should be aware that only the hospital may obtain approval for inpatient stays. Physicians cannot request approval for admission and need to contact the hospital's Utilization Review Department with questions concerning approval status. The attending physician will receive a copy of the pre-certification letters IF the hospital indicated the attending physician's Medicaid ID number on the PCF01 form.

PRIOR AUTHORIZATION

A prior authorization number is assigned when a provider requests authorization of procedures or items requiring prior approval.

- In order to receive payment, prior approval (PA) must be obtained.

- Certain services/procedures **always** require approval from the Unisys Prior Authorization Unit before they can be reimbursed; however, many surgical codes do not require PA if the procedure is performed in an outpatient setting.

- To identify the CPT codes which require Prior Authorization, see the Professional Services Fee Schedule at www.lamedicaid.com. **For clarification on whether or not a code requires PA, contact Unisys Provider Relations at (225) 924-5040 or (800) 473-2783.**

- **The physician** performing the procedure that requires PA **must submit the prior authorization request** for the services to be rendered.

- To obtain prior authorization for a procedure, providers must complete the PA01 form, attach any necessary documentation, and mail the packet to the PA Unit at the following address:

Unisys Corporation
ATTN: Prior Authorization Unit
P.O. Box 14919
Baton Rouge, LA 70898-4919

Providers are notified via letter whether or not the procedure has been approved. The letter indicates the prior authorization number assigned to the request, and this number must be entered in item 23 of the CMS 1500 form or 837P for claims resulting from the procedure.

A blank PA-01 form and instructions for completion can be found in this section. Providers can obtain blank PA-01 forms by accessing the www.lamedicaid.com web-site.

If the request is denied, a letter of denial will be generated with the appropriate denial message(s) and sent to the provider and recipient. A provider may resubmit the request for reconsideration as follows:

- Write the word “Reconsideration” across the top of the denial letter, and write the reason for the request of reconsideration at the bottom of the letter.

- Attach all original documentation, and any additional information which confirms medical necessity, to the request and mail to the Prior Authorization Department address above.

Post authorization may be obtained for a procedure that normally requires prior authorization if a recipient becomes retroactively eligible for Medicaid. However, such requests must be submitted within six months from the date of Medicaid certification of retroactive eligibility.

Gastrointestinal Surgery

Recipient Qualifications

To qualify for gastric restrictive surgery or gastric bypass, a recipient:

- Must be a minimal age of 16 years of age;
- Must have a documented weight that falls in the morbidly obese range, as defined by a body mass index of greater than 40;
- Must have at least three failed efforts at non-surgical methods of weight reduction;
- Must have a current obesity-related medical condition(s) which is/are classified as being high risk for morbidity and mortality;
- Must not have a current/recent history of alcohol abuse or abuse of other substance(s);
- Must be capable of complying with the modified food intake regimen and prescribed program which will follow surgery.

A letter documenting recipient qualifications and medical necessity from the physician submitted with the prior authorization request shall include confirmatory evidence of co-morbid condition(s).

Electronic Prior Authorization (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 restricted to the following provider types:

01 – Inpatient	10 – Adult Dental (to be implemented at a later date)
05 – Rehabilitation	11 – EPSDT Dental (to be implemented at a later date)
06 – Home Health	12 – EDSPW Dental (to be implemented at a later date)
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: Reconsideration requests cannot be accepted via the e-PA web application and should be submitted using the existing process.

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.

Field No. 1	Check the appropriate block to indicate the type of prior authorization requested.
Field No. 2	Enter recipient's 13-digit Medicaid ID number or the 16-digit CCN number.
Field No. 3	Enter the recipient's Social Security number.
Field No. 4	Enter the recipient's last name, first name and middle initial as it appears on their Medicaid card.
Field No. 5	Enter the recipient's date of birth in MM/DD/YYYY format (MM=month, DD=day, YYYY=year).
Field No. 6	Enter the provider's 7-digit Medicaid number. If associated with a group, enter the attending provider number only.
Field No. 7	Enter the beginning and ending dates of service in MM/DD/YYYY format (MM=month, DD=day, YYYY=year).
Field No. 8	Enter the numeric ICD9-diagnosis code (primary & secondary) and the corresponding description.
Field No. 9	Enter the day the prescription, doctor's orders was written in MM/DD/YYYY format (MM=month, DD=day, YYYY=year).
Field No. 10	Enter the name of the recipient's attending physician prescribing the services.
Field No. 11	Enter the HCPCS/procedure code.
Field No. 11A	Enter the corresponding modifiers (when appropriate).
Field No. 11B	Enter the HCPCS/procedure code's corresponding description for each procedure requested.
Field No. 11C	Enter the number of units requested for each individual HCPCS/procedure.
Field No. 11D	Enter the requested charges for each individual HCPCS/procedure when it is appropriate for the requested HCPCS/procedure.
Field No. 12	Enter the location for all services rendered.
Field No. 13	Enter the name, mailing address and telephone number for the provider of service.
Field No. 14	Enter the name, mailing address and telephone number of the recipient's case manager, if available.

Field No. 15	Provider/authorized signature is required. Your request will not be accepted if not signed. If using a stamped signature, it must be initialed by authorized personnel.
Field No. 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:

Toll-free number **800-488-6334**

Fax **225-929-6803**

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

PROFESSIONAL FEE SCHEDULE EXPLANATION

The most current version of the professional fee schedule can be found on the Louisiana Medicaid website (www.lamedicaid.com). Providers are encouraged to view the fee schedule on the website monthly for review of additions, deletions and updates. Providers will continue to be notified of significant fee schedule changes through RA messages and Provider Updates.

The following two pages include an example page from the fee schedule and the legend that is found at the end of the schedule.

Column 5 displays any age restrictions on the codes. At this time, the system cannot display months or days; therefore, providers should follow CPT coding guidelines in lieu of the fee schedule.

Column 10 displays service limitations as they apply to the individual code. Any limitations guided by policy for groups/combinations of codes will not be displayed here. For example, a group of ultrasound codes for pregnancy is limited by policy to 3 per pregnancy (any combination) but not by the individual code. This limitation does not display on our fee schedule, but is explicit in policy publications.

Example Page of Professional Fee Schedule

LAM5M110 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEM REPORT NO: RF-0-76
RUN: 02/27/06 19:18:19 DEPARTMENT OF HEALTH AND HOSPITALS - BUREAU OF HEALTH SERVICES - FINANCING PAGE: 265
LOUISIANA MEDICAID PROFESSIONAL SERVICES FEE SCHEDULE

COLUMN:

1	2	3	4	5		6	7	8	9	10	11	12	13	14
				AGE		MED					GSP	BASE	X-	UVS
TS	CODE	DESCRIPTION	FEE	MIN	MAX	REV	PA	SEX	PSR	SL	DAY	UNITS	OVERS	>001
07	62291	INJECT FOR SPINE DISK X-RAY	305.09	00	15									
03	62292	INJECTION INTO DISK LESION	507.60								90			
07	62292	INJECTION INTO DISK LESION	507.60	00	15						90			
03	62294	INJECTION INTO SPINAL ARTERY	260.73								90			
07	62294	INJECTION INTO SPINAL ARTERY	679.65	00	15						90			
03	62310	INJECT SPINE C/T	182.09								1			
07	62310	INJECT SPINE C/T	188.04	00	15						1			
03	62311	INJECT SPINE L/S (CD)	182.13								1			
07	62311	INJECT SPINE L/S (CD)	190.36	00	15						1			
03	62318	INJECT SPINE W/CATH, C/T	190.58								1			X
07	62318	INJECT SPINE W/CATH, C/T	196.76	00	15						1			X
03	62319	INJECT SPINE W/CATH L/S (CD)	184.97								1			
07	62319	INJECT SPINE W/CATH L/S (CD)	185.38	00	15						1			
02	62350	IMPLANT SPINAL CATHETER	81.02			X			X					
03	62350	IMPLANT SPINAL CATHETER	405.09				X		X		90			
07	62350	IMPLANT SPINAL CATHETER	405.09	00	15		X		X		90			
02	62351	IMPLANT SPINAL CATHETER	119.80			X			X					
03	62351	IMPLANT SPINAL CATHETER	598.99				X		X		90			
07	62351	IMPLANT SPINAL CATHETER	637.24	00	15		X		X		90			
03	62355	REMOVE SPINAL CANAL CATHETER	335.34				X		X		90			
07	62355	REMOVE SPINAL CANAL CATHETER	335.34	00	15		X		X		90			
03	62360	INSERT SPINE INFUSION DEVICE	129.87				X		X		90			
07	62360	INSERT SPINE INFUSION DEVICE	177.44	00	15		X		X		90			
03	62361	IMPLANT SPINE INFUSION PUMP	310.97				X		X		90			
07	62361	IMPLANT SPINE INFUSION PUMP	324.92	00	15		X		X		90			
02	62362	PROGRAMMABLE PUMP INCLUDE PREP OF PU	81.48			X			X					X
03	62362	IMPLANT SPINE INFUSION PUMP	407.36				X		X		90			
07	62362	IMPLANT SPINE INFUSION PUMP	407.95	00	15		X		X		90			
03	62365	REMOVE SPINE INFUSION DEVICE	333.46				X		X		90			
07	62365	REMOVE SPINE INFUSION DEVICE	338.11	00	15		X		X		90			
03	62367	ANALYZE SPINE INFUSION PUMP	39.61						X					
05	62367	ANALYZE SPINE INFUSION PUMP	15.84											
07	62367	ANALYZE SPINE INFUSION PUMP	44.74	00	15				X					
03	62368	ANALYZE SPINE INFUSION PUMP	59.46						X					
05	62368	ANALYZE SPINE INFUSION PUMP	23.78											
07	62368	ANALYZE SPINE INFUSION PUMP	97.08	00	15				X					
02	63001	RELIEVE SPINAL CORD PRESSURE	207.43											
03	63001	RELIEVE SPINAL CORD PRESSURE	1,037.20								90			
07	63001	RELIEVE SPINAL CORD PRESSURE	1,039.88	00	15						90			
02	63003	RELIEVE SPINAL CORD PRESSURE	207.43											
03	63003	RELIEVE SPINAL CORD PRESSURE	1,037.20								90			
07	63003	RELIEVE SPINAL CORD PRESSURE	1,050.99	00	15						90			

Professional Fee Schedule Legend

LOUISIANA MEDICAID PROFESSIONAL SERVICES FEE SCHEDULE LEGEND

Listed below are some aids we hope will help you understand this fee schedule. If, after reading the information below, you need further clarification of an item, please call Unisys Provider Relations at 1-800-473-2783.

COLUMN 1. TS (Type Service): Definition: Files on which codes are loaded and from which claims are paid. The file to which a claim goes for pricing is determined by, among other things, the type of provider who is billing and by the modifier appended to the procedure code.
Listed below is an explanation of the types of service found on this schedule.
01 - Anesthesia. Anesthesia claims are priced off this file.
02 - Assistant Surgeon. Assistant surgeon (MD) claims are priced off this file. Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Midwife, and Physician Assistant claims are paid at 80% of this fee.
03 - Full service. The file from which physician, physician-owned lab and independent lab services are paid. Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives, and Physician Assistants are paid at 80% of this fee, except that immunizations and KIDMED medical, vision and hearing screens are reimbursed at 100%.
04 - Lab services billed by "sole community hospitals" are paid from this file.
05 - Professional component. Claims with modifier -26 are priced from this file.
07 - Full service file for CommunityCARE PCP enhanced services and other enhanced physician services based on recipient age.
08 - Lab services billed by "other hospitals" and Ambulatory Surgery Centers (non-hospital) are paid from this file.
COLUMNS 2, 3 and 4. CODE, DESCRIPTION and FEE: Codes with modifier TH are prenatal obstetrical visits.
COLUMN 5. AGE MIN and MAX: Codes with minimum or maximum age restrictions. If the recipient's age on the date of service is outside the minimum or maximum age, claims will deny.
COLUMN 6. MED REV (Medical Review): Claims with some codes pend to Medical Review for review of the attachments or for manual pricing.
COLUMN 7. PA (Prior Authorization): Some services must be prior authorized before they are rendered. If a PA request is approved, a PA number will be issued for inclusion on the claim. If a PA request is not approved, no payment for the service will be made.
COLUMN 8. SEX (Restriction): Some procedure codes are indicated for only one sex.
COLUMN 9. PSR (Provider Specialty Restriction): If a code has a provider specialty restriction, reimbursement for its performance will not be made to other specialties.
COLUMN 10. SL (Service Limitation): Codes with frequency limitations.
COLUMN 11. GSP (Global Surgery Period): Indicates the number of days in the code's global surgery period.
COLUMN 12. BASE UNITS: The base units for anesthesia codes.
COLUMN 13. X-OVERS (Only): These codes are payable for Medicare/Medicaid recipients only.
COLUMN 14. UVS>001: An 'X' in this column means more than one unit of service per day may be billed.

RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENTS

Billing Information

Providers should use the appropriate HCPCS code for the radiopharmaceutical imaging agent provided when submitting claims to Medicaid. When there is a payable HCPCS code available, claims for these agents may be submitted electronically, as an invoice will no longer be required in this instance.

If there is a diagnostic imaging agent that is used by a provider that is not currently on our file, a request that it be considered for payment may be submitted in writing to Medicaid at the following address:

DHH Program Operations
Professional Services Program Manager
P.O. Box 91030
Baton Rouge, LA 70821

STERILIZATION

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.osophs.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.

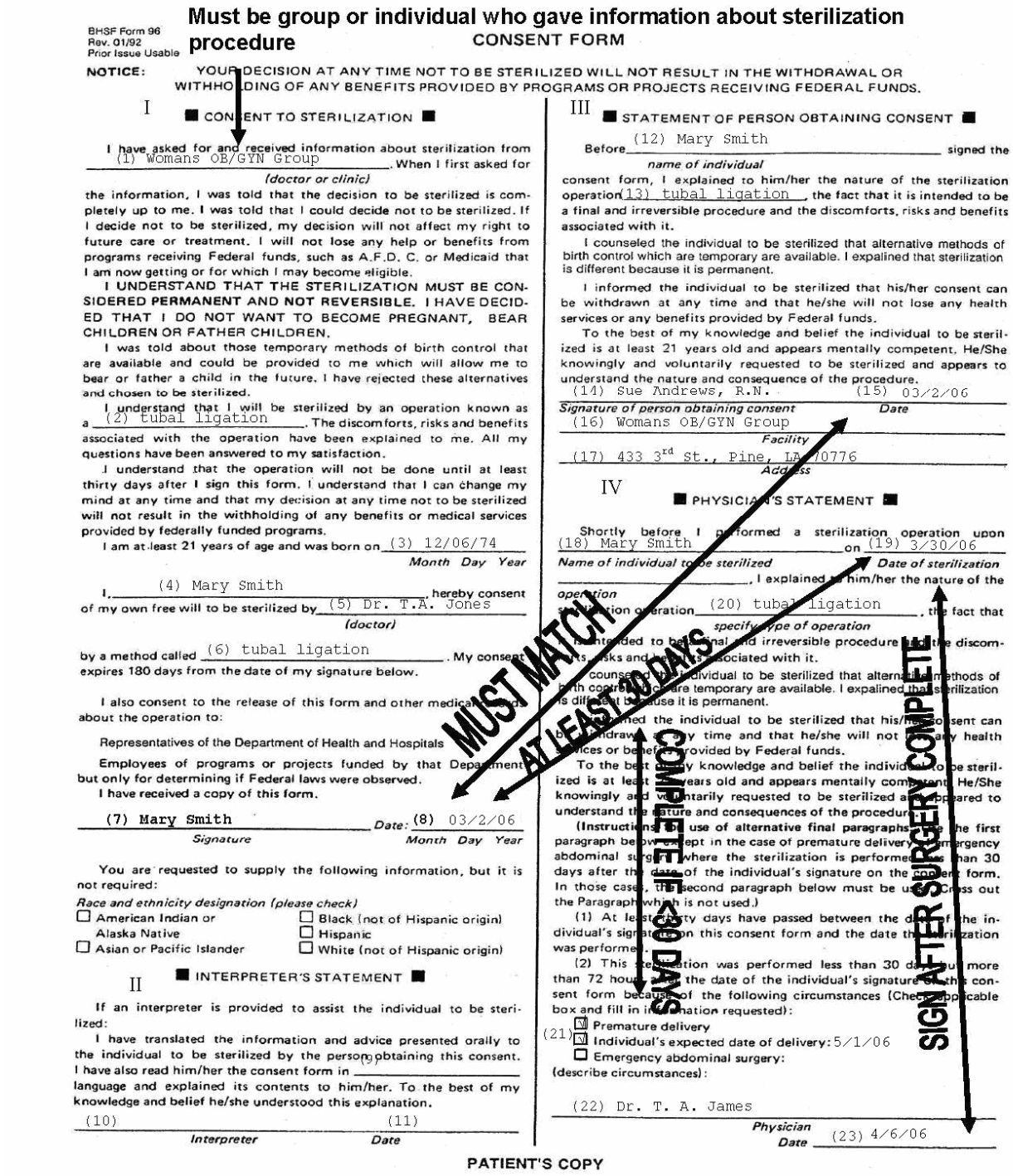
- One example illustrates a correctly completed sterilization form for a sterilization that was done **less than** 30 days after the consent was obtained. In this case, you will note "premature delivery" is confirmed with a "check mark", the expected date of delivery **is included** and **is equal to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

BHSF Form 96
Rev. 01/92
Prior Issue Usable

procedure

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 (9) 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 30 DAYS
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 ☑ Individual's expected date of delivery: *5/1/06*

☐ Emergency abdominal surgery:

(Describe circumstances):

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

COMPLETE AT LEAST 30 DAYS MUST MATCH SIGNS

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.

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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
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(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.

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(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.

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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.

SUBSTITUTE PHYSICIAN BILLING (LOCUM TENENS)

Louisiana Medicaid has revised the substitute physician billing policy as described below. Medicaid will continue to allow both the reciprocal billing arrangement and the locum tenens arrangement. Claims submitted under these arrangements are subject to post-payment review.

Reciprocal Billing Arrangement

A reciprocal billing arrangement is when a regular physician or group has a substitute physician provide covered services to a Medicaid recipient on an occasional reciprocal basis. A physician can have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

The recipient's regular physician may submit the claim and receive payment for covered services which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if:

- The regular physician is unavailable to provide the services.
- The substitute physician does not provide the services to Medicaid recipients over a continuous period of longer than 60 days*.
- The regular physician identifies the services as substitute physician services by entering the **HCPCS Q5** modifier after the procedure code on the claim form in item 24d. By entering the Q5 modifier, the regular physician (or billing group) is certifying that the services billed are covered services furnished by the substitute physician for which the regular physician is entitled to submit Medicaid claims.
- The regular physician must keep on file a record of each service provided by the substitute physician and make the record available to the Department or its representatives upon request. All Medicaid related records must be maintained in a systematic and orderly manner and be retained for a period of five years.

This situation **does not apply** to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the service must be identified.

[*A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid recipients of the regular physician, and ends with the last day on which the substitute physician provides these services to the recipients before the regular physician returns to work. This period continues without interruption on days on which no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work. If the regular physician does not come back after the 60 days, the substitute physician must bill for the services under his/her own Medicaid number.]

Locum Tenens Arrangement

A locum tenens arrangement is when a substitute physician is retained to take over a regular physician's professional practice for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician generally has no practice of his/her own. The regular physician usually pays the substitute physician a fixed amount per diem, with the substitute physician being an independent contractor rather than an employee.

The regular physician can submit a claim and receive payment for covered services of a locum tenens physician who is not an employee of the regular physician if:

- The regular physician is unavailable to provide the services.
- The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis.
- The substitute physician does not provide the services to Medicaid recipients over a continuous period of longer than 60 days**.
- The regular physician identifies the services as substitute physician services by entering **HCPCS modifier Q6** after the procedure code in item 24d of the claim form.
- The regular physician must keep on file a record of each service provided by the substitute physician and make the record available to the Department or its representatives upon request. All Medicaid related records must be maintained in a systematic and orderly manner and be retained for a period of five years.

[**A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid recipients of the regular physician, and ends with the last day on which the substitute physician provides these services to the recipients before the regular physician returns to work. This period continues without interruption on days on which no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work. If the regular physician does not come back after the 60 days, a new 60-day period can begin with a different locum tenens doctor.]

TELEMEDICINE

Telemedicine is generally described as the use of an interactive audio and video telecommunications system to permit real time communication between distant site health care practitioners and patients. Louisiana Medicaid requires that providers use the HIPAA compliant modifier to identify services provided via telemedicine.

Claim Submission

Medicaid covered services provided using telemedicine must be identified on claim submissions by appending the modifier "GT" (via interactive audio and video telecommunications system) to the applicable procedure code. The recipient's clinical record at both the originating and distant sites should reflect that the service was provided through the use of telemedicine.

VACCINES FOR CHILDREN & LOUISIANA IMMUNIZATION NETWORK FOR KIDS STATEWIDE

Vaccines For Children (VFC)

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

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

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

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

Providers can obtain an enrollment packet by contacting the Office of Public Health's (OPH) Immunization Section at (504) 838-5300.

Louisiana Immunization Network For Kids Statewide (LINKS)

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

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

LINKS can be accessed through the OPH website: https://linksweb.oph.dhh.louisiana.gov.

LINKS will assist providers within their medical practice by offering:

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

LINKS will assist patients by offering:

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

Providers can obtain an enrollment packet, or learn more about LINKS by calling the Louisiana Department of Health and Hospitals, Office of Public Health Immunization Program at (504) 838-5300.

IMMUNIZATIONS

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

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

Reimbursement

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

Billing For a Single Administration

Providers should bill CPT code 90471 (Immunization administration…one vaccine) when administering one immunization. The next line on the claim form must contain the specific CPT code for the vaccine, with $0.00 in the "billed charges" column (see p. 96 for an example).

Billing For Multiple Administrations*

When administering more than one immunization, providers should bill as described above for the single administration. Procedure code 90472 (Immunization administration…each additional vaccine) should then be listed with the appropriate number of units for the additional vaccines placed in the "units" column. The specific vaccines should then be listed on subsequent lines. The number of specific vaccines listed after CPT code 90472 should match the number of units associated with CPT code 90472. An example of this scenario is on page 97.

*Hard Copy Claim Filing for Greater Than Four Administrations

When billing hard copy claims for more than four immunizations and the six-line claim form limit is exceeded, providers should bill on two CMS-1500 claim forms. The first claim should follow the instructions above for billing the single administration. A second CMS-1500 claim form should be used to bill the remaining immunizations as described above for billing multiple administrations. An example is shown on pages 98 and 99.

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

Pediatric Flu Vaccine: Special Situations

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

The following chart lists vaccines for immunization services.

Billable Vaccine Codes	
Vaccine Code	**Description**
90476^	Adenovirus vaccine, type 4, live, for oral use
90477^	Adenovirus vaccine, type 7, live, for oral use
90581^	Anthrax vaccine, for subcutaneous use
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633*	Hepatitis A vaccine pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
90634*	Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645	Hemophilus Influenza B vaccine (Hib), HBOC conjugate, 4-dose schedule, for intramuscular use
90646	Hemophilus Influenza B vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647*	Hemophilus Influenza B vaccine (Hib) PRP-OMP conjugate, 3-dose schedule, for intramuscular use
90648*	Hemophilus Influenza B vaccine (Hib), PRP-T conjugate, 4-dose schedule, for intramuscular use
90655*	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90657*	Influenza Virus vaccine, split virus, 6-35 months dosage, for intramuscular use
90658*	Influenza Virus vaccine, split virus, 3 years and above dosage, for intramuscular use
90660*	Influenza Virus vaccine live, for intranasal use
90665^	Lyme Disease vaccine, adult dosage, for intramuscular use
90669*	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
90675^	Rabies vaccine, for intramuscular use
90676^	Rabies vaccine, for intradermal use
90680	Rotavirus vaccine, tetravalent, live, for oral use
90690^	Typhoid vaccine, live, oral use
90691^	Typhoid vaccine, VI capsular polysaccharide (VICPS), for intramuscular use
90692^	Typhoid vaccine, heat-and phenol-inactivated (H-P) for subcutaneous or intradermal use
90693	Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (US Military)
90698	Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Haemophilus influenza Type B, and Poliovirus vaccine, inactivated, (DTaP-Hib-IPV) for intramuscular use
90700 *	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP) for use in individuals younger than 7 years, for intramuscular use
90701	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine (DTP), for intramuscular use
90702*	Diphtheria and Tetanus Toxoids (DT) absorbed for use in individuals younger than 7

Billable Vaccine Codes	
Vaccine Code	**Description**
	years, for intramuscular use
90703	Tetanus Toxoids for trauma, for intramuscular use
90704	Mumps Virus vaccine, live, for subcutaneous use
90705	Measles Virus vaccine, live, for subcutaneous use
90706	Rubella Virus vaccine, live, for subcutaneous use
90707*	Measles, Mumps and Rubella Virus vaccine (MMR), live, for subcutaneous
90708	Measles and Rubella Virus vaccine, live, for subcutaneous use
90710*	Measles, Mumps, Rubella, and Varicella vaccine (MMRV), live, for subcutaneous use
90712	Poliovirus vaccine, any type(s), (OPV), live, for oral use
90713*	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714*	Tetanus and diphtheria toxoids, (Td) absorbed, preservative free, for use in individuals seven years or older, for intramuscular use
90715*	Tetanus, diphtheria toxoids and acellular pertusis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
90716*	Varicella Virus vaccine, live, for subcutaneous use
90717	Yellow Fever vaccine, live, for subcutaneous use
90718*	Tetanus and Diphtheria Toxoids (Td) adsorbed for use in individuals 7 years or older, for intramuscular use
90719	Diphtheria Toxoid, for intramuscular use
90720	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine and Hemophilus Influenza B vaccine (DTP-HIB), for intramuscular use
90721*	Diphtheria, Tetanus Toxoids, and Acellular Pertussis vaccine and Hemophilus Influenza B vaccine (DTaP-HIB), for intramuscular use
90723*	Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Hepatitis B, and Poliovirus vaccine, inactivated (DTaP-HEPB-IPV), for intramuscular use
90725	Cholera vaccine for injectable use
90727	Plague vaccine, for intramuscular or jet injection use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
90734*	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735	Japanese Encephalitis Virus vaccine, for subcutaneous use
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 3-dose schedule, for intramuscular use
90743	Hepatitis B vaccine, adolescent, 2-dose schedule, for intramuscular use
90744*	Hepatitis B vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90746*	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 4-dose schedule, for intramuscular use
90748*	Hepatitis B and Hemophilus Influenza B vaccine (HepB-Hib), for intramuscular use

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

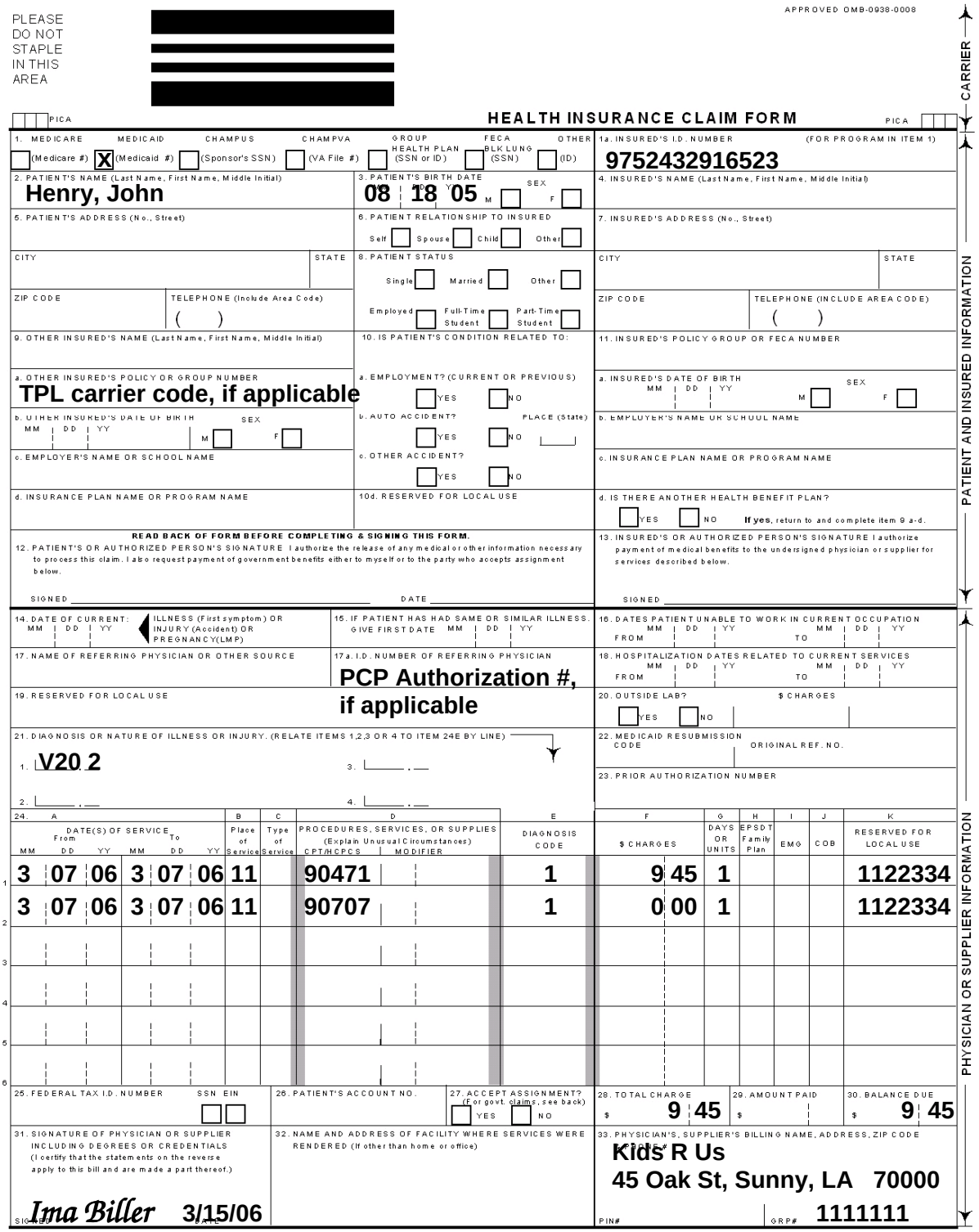
REMINDERS:

- Procedure code 90703 (Tetanus Toxoid for Trauma) will be payable at the rate of $2.42, and it is not available through the VFC program.

- If the units for 90472 are greater than the actual vaccines reported for procedure code 90472, the units will be cutback to reflect the number of vaccines codes being reported.

- If the units for 90472 are less than the actual vaccines reported for procedure code 90472, the entire claim will be approved and paid appropriately (based on the information given on the claim form).

Example of One Immunization Given



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID 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): **9752432916523**

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

3. PATIENT'S BIRTH DATE MM DD YY: **08 18 05** SEX M F

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **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 MM DD YY | SEX M F

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **PCP Authorization #, if applicable**

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. **V20.2**
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	3 07 06 | 3 07 06	11		90471		1	9 45	1				1122334
2	3 07 06 | 3 07 06	11		90707		1	0 00	1				1122334
3												
4												
5												
6												

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 $ 9 45

29. AMOUNT PAID $

30. BALANCE DUE $ 9 45

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

SIGNED *Ima Biller* DATE **3/15/06**

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

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

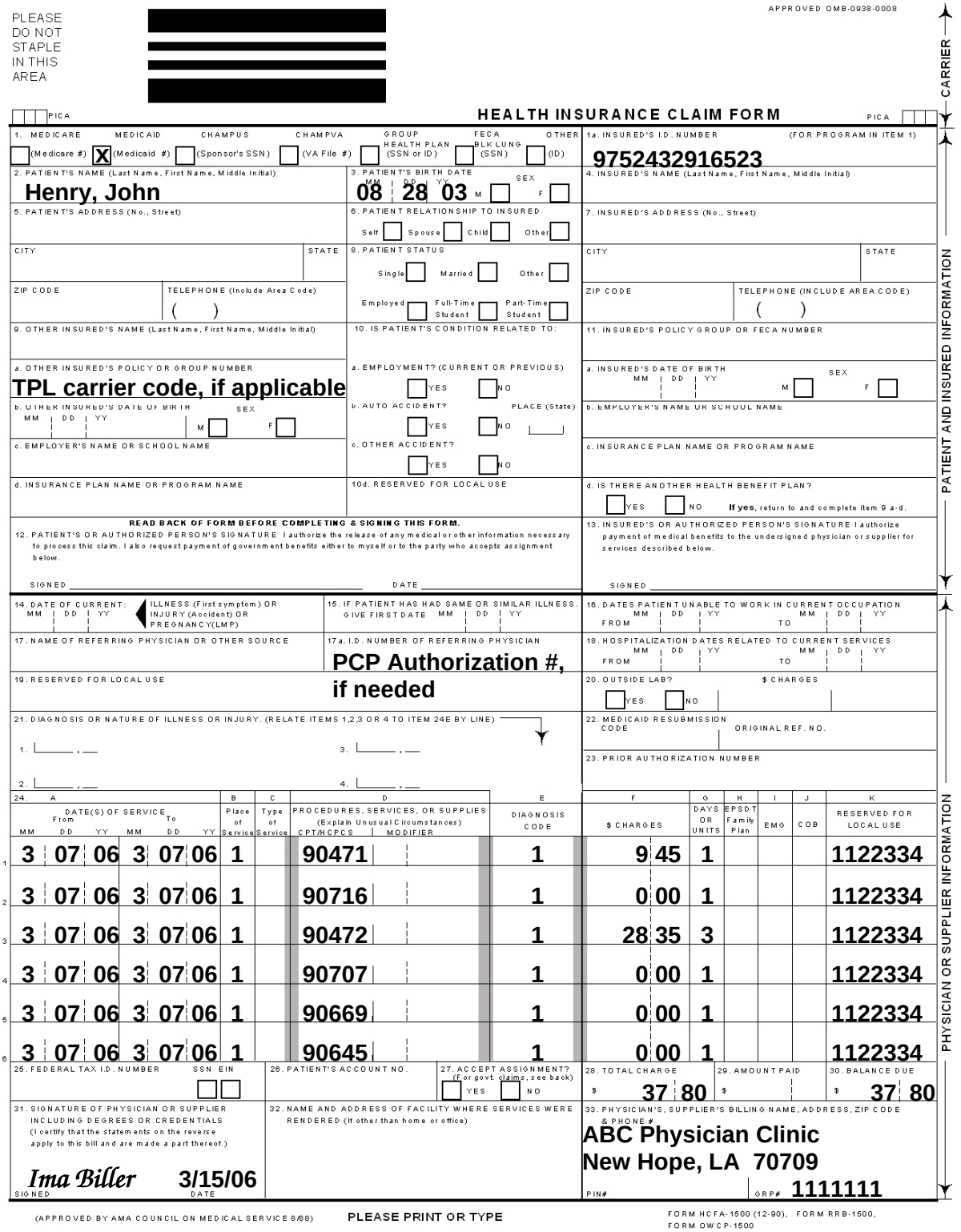
Kids R Us
45 Oak St, Sunny, LA 70000

PIN# GRP# **1111111**

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

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

Example of Four Immunizations Given



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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): **9752432916523**

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

3. PATIENT'S BIRTH DATE: **08 28 03** SEX: M [ ] F [ ]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **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 MM DD YY SEX: M [ ] F [ ]

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **PCP Authorization #, if needed**

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

19. RESERVED FOR LOCAL USE

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

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

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	3 07 06	3 07 06	1		90471		1	9 45	1				1122334
2	3 07 06	3 07 06	1		90716		1	0 00	1				1122334
3	3 07 06	3 07 06	1		90472		1	28 35	3				1122334
4	3 07 06	3 07 06	1		90707		1	0 00	1				1122334
5	3 07 06	3 07 06	1		90669		1	0 00	1				1122334
6	3 07 06	3 07 06	1		90645		1	0 00	1				1122334

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 $ **37 80**

29. AMOUNT PAID $

30. BALANCE DUE $ **37 80**

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

Ima Biller **3/15/06**

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 #

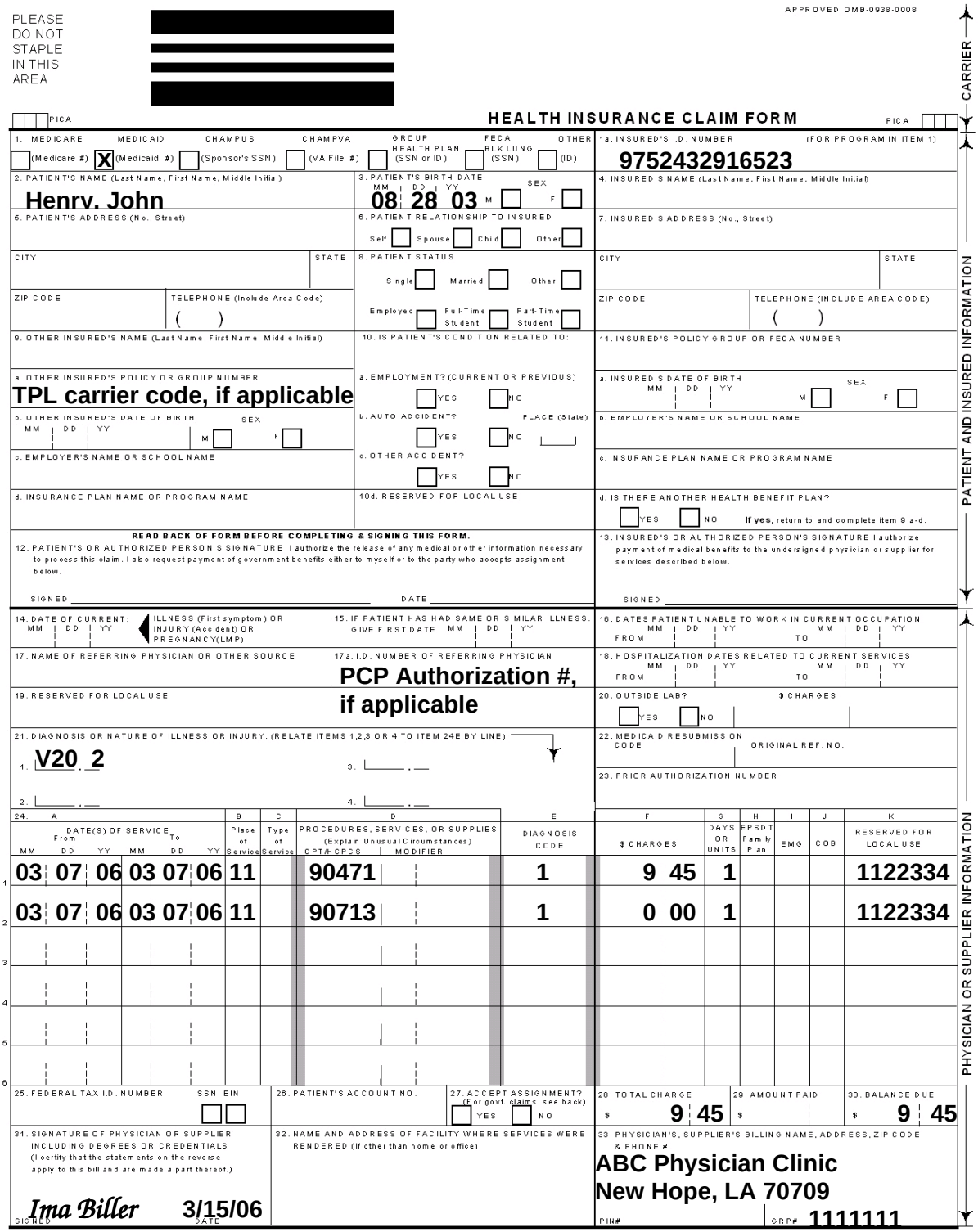
ABC Physician Clinic
New Hope, LA 70709

PIN# GRP# **1111111**

PHYSICIAN OR SUPPLIER INFORMATION

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

Example of Five Immunizations Given (Page 1 of 2)



PLEASE DO NOT STAPLE IN THIS AREA

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APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID 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): **9752432916523**

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

3. PATIENT'S BIRTH DATE MM DD YY: **08 28 03** SEX M F

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **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 MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

PATIENT AND INSURED INFORMATION

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **PCP Authorization #, if applicable**

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. **V20.2**
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 07 06	03 07 06	11		90471		1	9 45	1				1122334
2 03 07 06	03 07 06	11		90713		1	0 00	1				1122334
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 9 45

29. AMOUNT PAID $

30. BALANCE DUE $ 9 45

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

SIGNED *Ima Biller* DATE **3/15/06**

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

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

ABC Physician Clinic
New Hope, LA 70709

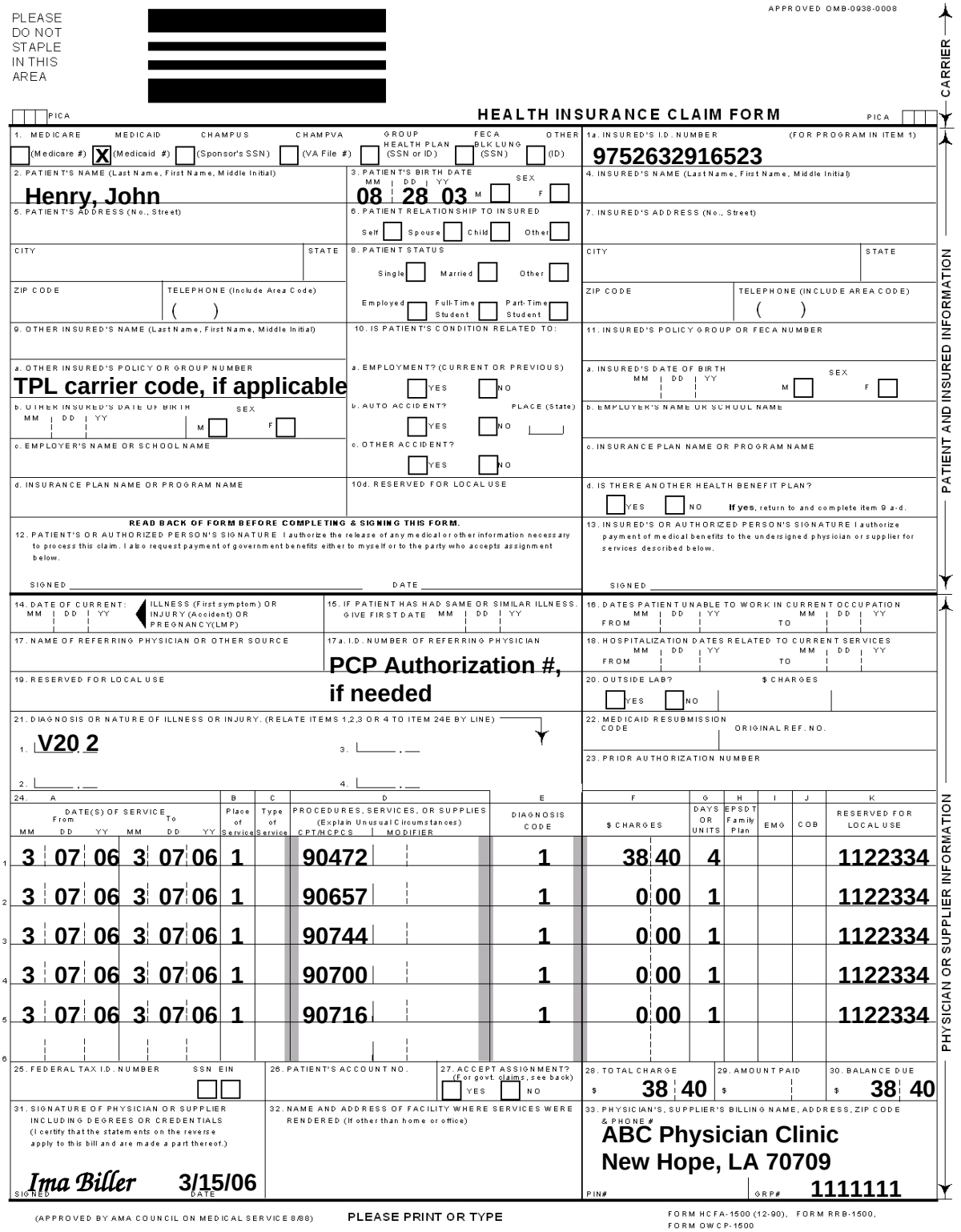
PIN# GRP# **1111111**

PHYSICIAN OR SUPPLIER INFORMATION

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

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

Example of Five Immunizations Given (Page 2 of 2)



PLEASE DO NOT STAPLE IN THIS AREA

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APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID [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): **9752632916523**

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

3. PATIENT'S BIRTH DATE MM DD YY: **08 28 03** SEX M [ ] F [ ]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **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 MM DD YY SEX M [ ] F [ ]

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **PCP Authorization #, if needed**

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

19. RESERVED FOR LOCAL USE

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

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

1. **V20.2**
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	3 07 06 3 07 06	1		90472		1	38.40	4				1122334
2	3 07 06 3 07 06	1		90657		1	0.00	1				1122334
3	3 07 06 3 07 06	1		90744		1	0.00	1				1122334
4	3 07 06 3 07 06	1		90700		1	0.00	1				1122334
5	3 07 06 3 07 06	1		90716		1	0.00	1				1122334
6												

PHYSICIAN OR SUPPLIER INFORMATION

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 $ 38.40

29. AMOUNT PAID $

30. BALANCE DUE $ 38.40

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

SIGNED *Ima Biller* DATE 3/15/06

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

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

ABC Physician Clinic
New Hope, LA 70709

PIN# GRP# **1111111**

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

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

CLAIMS FILING

Instructions for Completing CMS-1500

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

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

1.	**REQUIRED**	Enter an "X" in the box marked Medicaid (Medicaid #)
1A.	**REQUIRED**	Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid swipe card (MEVS), e-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, e-MEVS or REVS
3.	SITUATIONAL	Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, e-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 an independent laboratory, enter the name of the referring 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

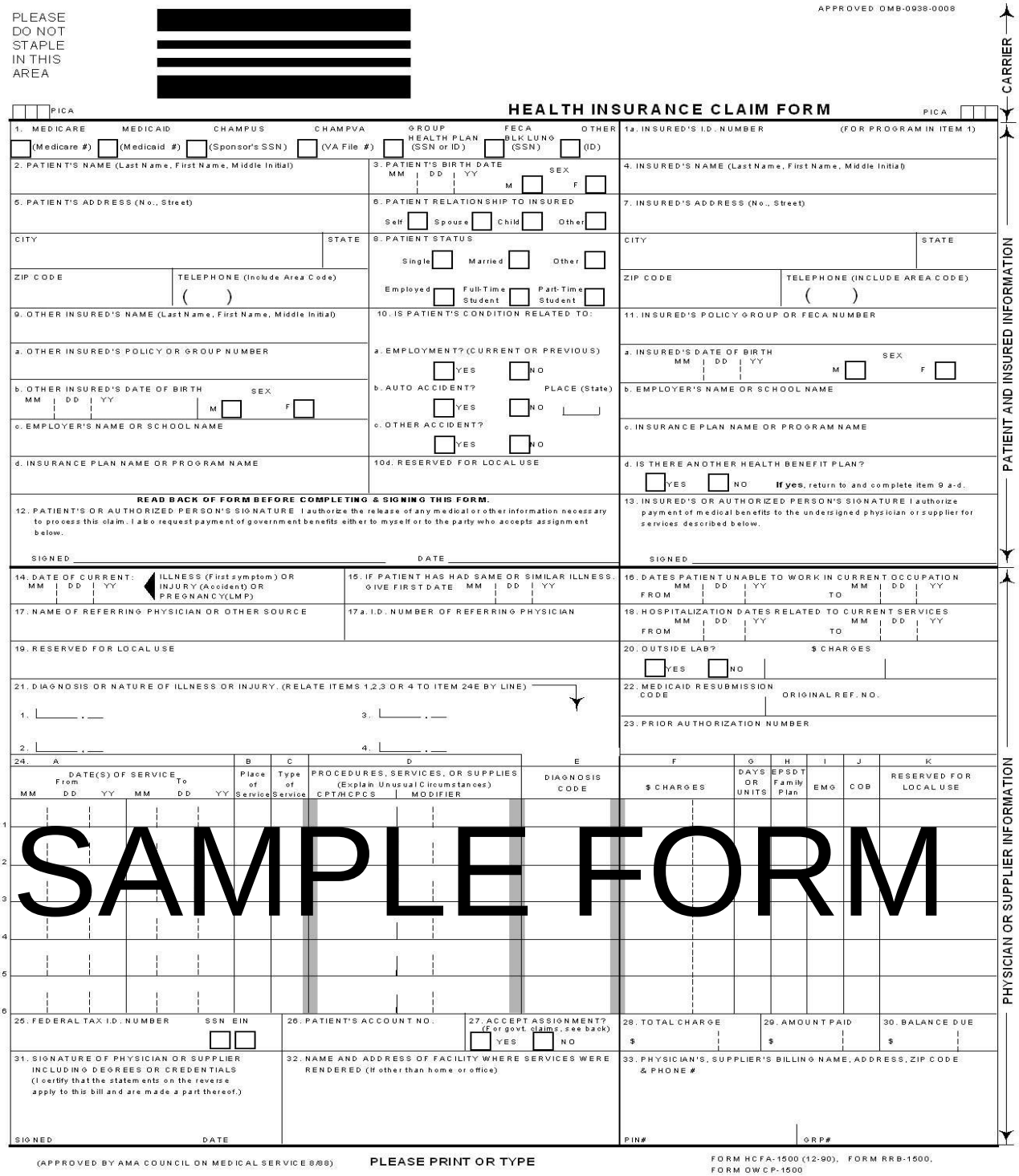
23.	SITUATIONAL	Complete if required or leave blank
24A.	**REQUIRED**	Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.
24B.	**REQUIRED**	Enter the appropriate code from the approved Medicaid place of service code list.
24C.	SITUATIONAL	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, indicate 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 item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned unprocessed.
	Date	Enter the date of the signature
32.	SITUATIONAL	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.

REQUIRED items must be completed or form will be returned.

Sample CMS-1500 Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

SAMPLE FORM

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

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

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

PIN# GRP#

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **5923450122697**

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

3. PATIENT'S BIRTH DATE: **01 21 98** SEX: M | F

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **(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 MM DD YY; SEX: M | F

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **(PCP authorization # If applicable)**

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO; $ CHARGES

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

1. **V222**
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 **04 16 06**	**04 16 06**	**11**		**99203**		**1**	**65 00**	**1**				**1123987**
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 $ **65 00**

29. AMOUNT PAID $

30. BALANCE DUE $ **65 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.)

Ima Biller **4/20/06**

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 #

ABC Physician Clinic
New Hope, LA 70709

PIN# GRP# **1111111**

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

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

Completing the 213 Adjustment/Void Form

The 213 adjustment/void form is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Unisys by calling Provider Relations at (800) 473-2783 or at www.lamedicaid.com using the Forms/Files/User Guides link. Instructions and an example of a completed 213 adjustment form are shown on the following pages.

If a claim has been paid using the 837P claim transaction, an adjustment or void may be submitted electronically or by using the Unisys 213 adjustment/void form.

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

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

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

- A claim is paid on the RA dated 8-28-06, ICN 6240567890123
- The claim is adjusted on the RA dated 10-09-06, ICN 6282390123456
- If the claim requires further adjustment or needs to be voided, only ICN 6282390123456 may be used.

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

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column. An example of an adjustment appears on page 111.

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

Filing Adjustments for a Medicare/Medicaid Claim

When a provider has filed a claim with Medicare, Medicare pays, then the claim becomes a “crossover” to Medicaid for consideration of payment of the Medicare deductible or co-payment.

If, at a later date, it is determined that Medicare has overpaid or underpaid, the provider should rebill Medicare for a corrected payment. These claims may “crossover” from Blue Cross to Medicaid, but cannot be automatically processed by Medicaid (as the claim will appear to be a duplicate claim, and therefore must be denied by Medicaid).

In order for the provider to receive an adjustment, it is necessary for the provider to file a hard copy claim (Unisys Form 213) with Medicaid. These should be sent to Unisys, Attention: Crossover Adjustments, P.O. Box 91023, Baton Rouge, LA 70821, and should have a copy of the most recent Medicare explanation of benefits and the original explanation of benefits attached. In addition, the provider should write “2X7” at the top of the adjustment/void form to indicate the adjustment is for a Medicare/Medicaid claim.

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.

Blank Unisys 213 Adjustment/Void Claims

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
3 PATIENT'S DATE OF BIRTH
4 MEDICAID ID NUMBER
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX MALE FEMALE
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES NO
B. AN AUTO ACCIDENT YES NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES NO CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1
2
3
23 ATTENDING NUMBER
24 PRIOR AUTHORIZATION NO.

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

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT

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

ADJUSTMENT

29 REASONS FOR VOID

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

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

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

32 YOUR PATIENT'S ACCOUNT NUMBER

FISCAL AGENT COPY

UNISYS - 213
5/97

Example of Unisys 213 Adjustment

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): **Thyme Justin**
3 PATIENT'S DATE OF BIRTH: **01/21/98**
4 MEDICAID ID NUMBER: **5923450122697**
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [ ]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.: **060606**
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**
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): **Authorization # (if needed)**
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 **V222**
2
3
23 ATTENDING NUMBER: **1123987**
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	16	06	04	16	06	11	99203		1	65 00	1		45.00

26 CONTROL NUMBER: **6120100000147**
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: **05/05/06**

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

ADJUSTMENT

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Ima Biller 6/01/2006
32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
ABC Physician's Clinic
New Hope, LA 70709
Provider #1111111

UNISYS - 213
5/97

FISCAL AGENT COPY

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 tables below. The first table includes claims that must be mailed to Unisys Provider Relations correspondence Unit. The second table includes hard copy claims that should be mailed to P.O. Box 91023 for Medicare Crossovers and P.O. Box 91020 for all other claims.

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s) sent with a cover letter to: Unisys Provider Relation P.O. Box 91024 Baton Rouge, LA 70821
Multiple but separate anesthesia operative session – anesthesia graph from each surgery
Office Visits over limit - Form 158A for extension of office visits
Physician claims for inpatient visits (not newborn) when no pre-cert exists----Admit and Discharge summary
Physician hospital visits to newborn – medical necessity, letter requesting pre-cert edit override
Recipient Eligibility Issues - copy of MEVS printout, cover letter
Retroactive Eligibility - copy of ID card or letter from parish office, BHSF staff

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s) Mailed to the appropriate P.O. Box for “Clean” claims
Abortion procedures - Abortion Informed Consent Form, signed statement from recipient, treating physician statement, medical necessity
All unlisted procedures - medical documentation
Anesthesia claims for less than 10 minutes or more than 224 minutes -graph
Anesthesia for Arteriograms, Cardiac Catheterizations, CT Scans, Angioplasties, and MRIs (bill with appropriate anesthesia code)
Anesthesia for Intraperitoneal procedures in lower abdomen (code 00851) - BHSF Form 96
Bilateral procedures-operative notes
Breast Reconstruction procedures - medical documentation
Chiropractic claims for under age 21 – EPSDT/PCP medical screening referral, MD’s prescription, medical necessity, medical notes
Codes 62310, 62311, 62318, 62319 - operative & history reports

Consultation by Physician of same specialty - medical documentation
Critical Care services - medical necessity
Enterolysis (code 44005) - operative report
Failed Crossover Claims - Medicare EOB
Hysterectomy procedures - Form 96A Hysterectomy Form
Incomplete Abortion - history, sonogram, discharge summary, treatment
Infectious agent detection (code 87799) - description of test & methodology
Keloid initial visit - chart notes, statement from physician
Modifiers 22, 51, 52, 62, 66 - medical documentation
Neurobehavioral testing (codes 96115, 96117) - interpretive report signed by correct specialty
Norplant if reinserted in less than 5 years - medical documentation
Obstetrical ultrasounds >3 per pregnancy - medical necessity, dated notes
Operating Microscope (code 69990) - operative report
Pathology Consultations (codes 80500, 80502) - medical necessity, list of tests, test results, consult narrative
Pediatric Moderate (Conscious) Sedation codes (99143, 99144, & 99145) - medical necessity and anesthesia report
Reduction Mammoplasty - pathology report & approval letter, photographs
Resistance Testing in HIV recipients – medical necessity of test, results of test, history of recipient
Spend Down Recipient - 110MNP Spend Down Form
Stereotactic Procedures - operative report, medical necessity
Sterilization procedures - Sterilization Consent Form
Third Party/Medicare Payment - EOBs (Includes Medicare adjustment claims)
Timely filing - letter/other proof i.e., RA page
Transmyocardial revascularization - see Provider Update, 11/99 issue
Transplants - DHH approval letter, dated operative report

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

TIMELY FILING GUIDELINES

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

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

Dates of Service Past Initial Filing Limit

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

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

OR

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

OR

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

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

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

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

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

Submitting Claims for Two-Year Override Consideration

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

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

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

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

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

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

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	
Kelli 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:

Professional Services 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;
- Claims Status Inquiry (e-CSI) for inquiring on claims status; and
- Clinical Data Inquiry (e-CDI) for inquiring on recipient pharmacy prescriptions as well as other medical claims data
- Prior Authorization (e-PA) for requesting prior authorizations electronically.

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

e-MEVS:

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

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

e-CSI:

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

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

e-CDI:

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

The nine (9) clinical services information components are:

1. Clinical Drug Inquiry
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 PA02 Form with each request. Do not request authorization for the evaluation procedures, these do not require prior approval. Submit only units on the e-PA transaction, Do Not submit dollar amounts.

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

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

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

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

Additional DHH Available Websites

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

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

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

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

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

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

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

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

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

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

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

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

Podiatry

Proc	Description
A5500	DIAB SHOE FOR DENSITY INSERT
A5501	DIABETIC CUSTOM MOLDED SHOE
A5503	DIABETIC SHOE W/ROLLER/ROCKR
A5504	DIABETIC SHOE WITH WEDGE
A5505	DIAB SHOE W/METATARSAL BAR
A5506	DIABETIC SHOE W/OFF SET HEEL
A5507	MODIFICATION DIABETIC SHOE
A5508	DIABETIC DELUXE SHOE, PER SHOE
A5509	DIEBETIC SHOE DIRECT FORMED W/
A5510	DIEBETIC SHOE DIRECT FORMED PR
G0127	TRIMMING OF DYSTROPHIC NAILS,
L1930	AFO,CUSTOM FITTED, PLASTIC
10021	FNA W/O IMAGE
10060	DRAINAGE OF SKIN ABSCESS
10061	DRAIN SKIN ABSCESS COMPLICATED
10120	SIMPLE REMOVAL FOREIGN BODY
10121	COMPLICATED REMOVAL FOREIGN B
10140	INCISE/DRAIN SIMPLE HEMATOMA
10160	PUNCTURE DRAINAGE OF LESION
10180	INCISE/DRAIN COMPLEX POSTOP WO
11000	DEBRIDE EXT ECZEM/INFECT SKN;T
11001	EACH ADD 10% BODT SURF. DEBRID
11040	DEBRIDE SKIN,PARTIAL THICKNESS
11041	DEBRIDE SKIN,FULL THICKNESS
11042	DEBRIDE SKIN,SUBCUTANEOUS TISS
11043	DEBRIDE;SKIN,SUBCU TISSUE AND
11044	DEBRIDE;SKIN,SUBC TISS,MUSCL &
11055	TRIM SKIN LESION
11056	TRIM 2 TO 4 SKIN LESIONS
11057	TRIM OVER 4 SKIN LESIONS
11100	BIOPSY OF SINGLE LESION
11101	BIOPSY OF SKIN,EACH ADD LESION
11200	EXCISE UP TO 15 SKIN TAGS
11420	EXCISE BENIGN LESION TO 0.5 CM
11421	EXCISE BENIGN LESION 0.6 TO 1
11422	EXCISE BENIGN LESION 1.1 TO 2C
11423	EXCISE BENIGN LESION 2.1 TO 3C
11424	EXCISE BENIGN LESION 3.1 TO 4C
11426	EXCISE BENIGN LESION OVER 4.0
11620	EXCISE MALIGNANCY TO 0.5CM
11621	EXCISE MALIGNANCY 0.6 TO 1CM
11622	EXCISE MALIGNANCY 1.1 TO 2CM
11623	EXCISE MALIGNANCY 2.1 TO 3CM
11624	EXCISE MALIGNANCY 3.1 TO 4CM
11626	EXCISE MALIGNANCY OVER 4CM
11720	DEBRIDE NAIL, 1-5
11721	DEBRIDE NAIL, 6 OR MORE
11730	SIMPLE REMOVAL OF NAIL PLATE
11732	REMOVE ADDITIONAL NAIL PLATES
11740	EVACUATE HEMATOMA UNDER NAIL
11750	EXCISION NAIL & NAIL MATRIX
11752	EXCISE NAIL,MATRIX-AMPUTATE TU
11760	SIMPLE RECONSTRUCTION NAIL BED
11762	NAIL RECONSTRUCTION; COMPLICAT
11900	INTRALESIONAL INJECTION; UP TO
11901	INTRALESIONAL INJECTION; OVER
12001	SIMPLE WOUND REPAIR TO 2.5CM
12002	SIMPLE WOUND REPAIR 2.6 TO 7.5
12004	SIMPLE WOUND REPAIR 7.6 TO 12.
12005	SIMPLE WOUND REPAIR 12.6 TO 20
12006	SIMPLE WOUND REPAIR 20.1 TO 30
12007	SIMPLE WOUND REPAIR OVER 30CM
12020	TREAT SUPER.DEHISCIENCE;SIMPLE
12021	TREAT SUPER.DEHISCIENCE;W/PACK
12041	LAYER CLOSURE WOUND TO 2.5CM
12042	LAYER CLOSURE 2.6 TO 7.5CM
12044	LAYER CLOSURE 7.6 TO 12.5CM
12046	LAYER CLOSURE 20.1 TO 30CM
12047	LAYER CLOSURE WOUND OVER 30CM
13131	COMPLEX REPAIR 1.1 TO 2.5CM

Proc	Description
13132	COMPLEX REPAIR 2.6 TO 7.5CM
13160	EXT/COMP SECONDARY CLOSE/DEHIS
14040	TISSUE TRANSFER; TO 10 SQ CM
14041	TISSUE TRANSFER; 10.1 TO 30 SQ
14350	FILLETED FINGER OR TOE FLAP
15000	PREPARE RECIPIENT GRAFT SITE
15050	PINCH GRAFT; DEFECT UP TO 2CM
15100	SPLIT GRAFT; UP TO 100 SQ CM
15120	SPLIT GRAFT; UP TO 100 SQ CM
15240	FULL THICK GRAFT TO 20 SQ CM
15400	APPLY XENOGRAFT,SKIN
15610	INTERM DELAY FLAP SCALP/LIMBS
15620	INTERM DELAY FLAP CHIN/NECK/FE
15740	ISLAND PEDICLE FLAP GRAFT
15750	NEUROVASCULAR PEDICLE GRAFT
15860	IV AGENT/TEST BLOOD FLOW/FLAP-
16000	INIT TREAT 1ST DEGREE BURN
16020	DRESS/DEBRID BURN SMALL,NO ANE
16025	DRESS/DEBRID BURN MED,NO ANEST
16030	DRESS/DEBRID BURN LG,NO ANESTH
16035	ESCHAROTOMY B
17000	DESTROY LESION,FACE-1 LESION
17003	DESTROY 2-14 LESIONS
17004	DESTROY 15 & MORE LESIONS
17106	DESTRUCT CUT AN VASC LESIONS<1
17107	DESTRUCT CUT VASC LESIONS 10-5
17108	DESTRUCT CUT VASC LESIONS >50
17110	DESTROY FLAT WARTS,ANY METHOD,
17111	DESTRUCT LESION, 15 OR MORE
17250	CHEMICAL CAUTERY OF WOUND
17999	SKIN TISSUE PROCEDURE
20000	INCISION OF ABSCESS; SUPERFICI
20005	INCISION OF ABSCESS; DEEP
20100	EXPLORE WOUND, NECK
20101	EXPLORE WOUND, CHEST
20102	EXPLORE WOUND, ABDOMEN
20103	EXPLORE WOUND, EXTREMITY
20150	EXCISE EPIPHYSEAL BAR
20200	BIOPSY,MUSCLE,SUPERFICIAL
20205	BIOPSY,MUSCLE,DEEP
20520	REMOVE FOREIGN BODY; SIMPLE
20525	REMOVE FOREIGN BODY; COMPLICAT
20526	THER INJECTION CARPAL TUNNEL
20550	INJECT TENDON SHEATH/LIGAMENT
20551	INJECT TENDON ORIGIN/INSERT
20552	INJECT TRIGGER POINT, 1 OR 2
20553	INJECT TRIGGER POINTS, > 3
20600	ARTHROCENTESIS; SMALL JOINT/ B
20605	ARTHROCENTESIS; MED. JOINT/ BU
20650	SKELETAL TRACTION; WIRE OR PIN
20670	REMOVE IMPLANT; SUPERFICIAL
20680	REMOVE IMPLANT; DEEP
20690	APPLY ESTERNAL FIXATION SYS,ST
20694	REMOVAL UNDER ANESTH EXT FIX S
20838	REPLANT FOOT; TOTAL AMPUTATION
20900	BONE GRAFT; ANY DONOR AREA, SM
20902	BONE GRAFT, ANY DONOR AREA; LA
20924	TENDON GRAFT; DISTANT
20926	TISSUE GRAFTS; OTHER
20972	FREE OSTEOCUTAN FLAP..;METATAR
20973	FREE OSTEOCUTAN FLAP..;GREAT T
20979	US BONE STIMULATION
20982	ABLATE, BONE TUMOR(S) PERQ
20999	UNLISTED PROCEDURE; BONE/ MUSC
27603	DRAIN LOWER LEG LESION
27604	DRAIN LOWER LEG BURSA
27605	INCISION OF ACHILLES TENDON
27610	EXPLORE/TREAT ANKLE JOINT
27612	EXPLORATION OF ANKLE JOINT
27613	BIOPSY LOWER LEG SOFT TISSUE

Proc	Description
27614	BIOPSY LOWER LEG SOFT TISSUE D
27615	RAD RESECT TUMOR...LEG OR ANKL
27618	REMOVE LOWER LEG LESION
27619	REMOVE LOWER LEG LESION DEEP
27620	BIOPSY OF ANKLE JOINT
27625	REMOVE ANKLE JOINT LINING
27626	REMOVE ANKLE JOINT LINING
27630	REMOVAL OF TENDON LESION
27635	REMOVE LOWER LEG BONE LESION
27637	REMOVE/GRAFT LEG BONE LESION
27638	REMOVE/GRAFT LEG BONE LESION
27640	PARTIAL REMOVAL OF TIBIA
27641	PARTIAL REMOVAL OF FIBULA
27645	EXTENSIVE LOWER LEG SURGERY
27646	EXTENSIVE LOWER LEG SURGERY
27647	EXTENSIVE ANKLE/HEEL SURGERY
27648	INJECTION FOR ANKLE X-RAY
27650	REPAIR ACHILLES TENDON
27652	REPAIR/GRAFT ACHILLES TENDON
27654	REPAIR OF ACHILLES TENDON
27656	REPAIR FASCIAL DEFECT OF LEG
27680	RELEASE OF LOWER LEG TENDON
27681	TENOLYSIS....MULTIPLE, EACHS
27685	REVISION OF LOWER LEG TENDON
27686	LENGTHEN/SHORTEN TEND;MULTIPLE
27690	REVISE LOWER LEG TENDON
27691	REVISE LOWER LEG TENDON
27692	TRANSFER/PLANT TENDN,EACH ADD
27695	REPAIR OF ANKLE LIGAMENT
27696	REPAIR OF ANKLE LIGAMENTS
27698	REPAIR OF ANKLE LIGAMENT
27700	REVISION OF ANKLE JOINT
27702	RECONSTRUCT ANKLE JOINT
27703	ARTHROPLASTY, SECONDARY RECON. T
27704	REMOVAL OF ANKLE IMPLANT
27760	TREATMENT OF ANKLE FRACTURE
27762	TREATMENT OF ANKLE FRACTURE
27786	TREATMENT OF ANKLE FRACTURE
27788	TREATMENT OF ANKLE FRACTURE
27808	TREATMENT OF ANKLE FRACTURE
27810	TREATMENT OF ANKLE FRACTURE
27814	REPAIR OF ANKLE FRACTURE
27816	TREATMENT OF ANKLE FRACTURE
27818	TREATMENT OF ANKLE FRACTURE
27822	REPAIR OF ANKLE FRACTURE
27823	REPAIR OF ANKLE FRACTURE
27824	CLOSED TREATMENT OF FRACTURE O
27825	CLOSED TREATMENT OF FRACTURE O
27826	OPEN TREATMENT OF FRACTURE OF
27827	OPEN TREATMENT OF FRACTURE OF
27828	OPEN TREATMENT OF FRACTURE OF
27829	OPEN TREATMENT OF DISTAL TIBIO
27830	TREAT LOWER LEG DISLOCATION
27831	TREAT LOWER LEG DISLOCATION
27832	REPAIR LOWER LEG DISLOCATION
27840	TREAT ANKLE DISLOCATION
27842	TREAT ANKLE DISLOCATION
27846	REPAIR ANKLE DISLOCATION
27848	REPAIR ANKLE DISLOCATION
27860	FIXATION OF ANKLE JOINT
27870	FUSION OF ANKLE JOINT
27871	FUSION OF TIBIOFIBULAR JOINT
27888	AMPUTATION OF FOOT AT ANKLE
27889	AMPUTATION OF FOOT AT ANKLE
27892	DECOMPRESSION FASCIOTOMY, LEG;
27893	DECOMPRESSION FASCIOTOMY, LEG;
27894	DECOMPRESSION FASCIOTOMY, LEG;
27899	LEG/ANKLE SURGERY PROCEDURE
28001	DRAINAGE OF BURSA OF FOOT
28002	TREATMENT OF FOOT INFECTION

Proc	Description
28003	TREATMENT OF FOOT INFECTION
28005	TREAT FOOT BONE LESION
28008	INCISION OF FOOT FASCIA
28010	INCISION OF TOE TENDON
28011	INCISION OF TOE TENDONS
28020	EXPLORATION OF A FOOT JOINT
28022	EXPLORATION OF A FOOT JOINT
28024	EXPLORATION OF A TOE JOINT
28030	REMOVAL OF FOOT NERVE
28035	DECOMPRESSION OF TIBIA NERVE
28043	EXCISION OF FOOT LESION
28045	EXCISION OF FOOT LESION
28046	RAD RESECT TUMOR,SFT TISS-FOOT
28050	BIOPSY OF FOOT JOINT LINING
28052	BIOPSY OF FOOT JOINT LINING
28054	BIOPSY OF TOE JOINT LINING
28060	PARTIAL REMOVAL FOOT FASCIA
28062	REMOVAL OF FOOT FASCIA
28070	SYNOVECTOMY;INTERTAR/TARSOMET,
28072	SYNOVECTOMY,METATARSOPHAL..JNT
28080	EXCISE MORTON NEUROMA,SINGLE,E
28086	EXCISE FOOT TENDON SHEATH
28088	EXCISE FOOT TENDON SHEATH
28090	REMOVAL OF FOOT LESION
28092	REMOVAL OF TOE LESIONS
28100	REMOVAL OF ANKLE/HEEL LESION
28102	REMOVE/GRAFT FOOT LESION
28103	REMOVE/GRAFT FOOT LESION
28104	REMOVAL OF FOOT LESION
28106	REMOVE/GRAFT FOOT LESION
28107	REMOVE/GRAFT FOOT LESION
28108	REMOVAL OF TOE LESIONS
28110	PART REMOVAL OF METATARSAL
28111	PART REMOVAL OF METATARSAL
28112	PART REMOVAL OF METATARSAL
28113	PART REMOVAL OF METATARSAL
28114	REMOVAL OF METATARSAL HEADS
28116	REVISION OF FOOT
28118	PARTIAL REMOVAL OF HEEL
28119	REMOVAL OF HEEL SPUR
28120	PART REMOVAL OF ANKLE/HEEL
28122	PARTIAL REMOVAL OF FOOT BONE
28124	PARTIAL REMOVAL OF TOE
28126	CONDYLECTOMY...SING. TOE, EACH
28130	REMOVAL OF ANKLE BONE
28140	REMOVAL OF METATARSAL
28150	PHALANGECTOMY,TOE, SINGLE, EAC
28153	PARTIAL REMOVAL OF TOE
28160	HEMIPHALANGECTOMY....TOE,SING.
28171	RADICAL RESECTION FOR TUMOR,TA
28173	RADICAL RESECTION FOR TUMOR,ME
28175	RADICAL RESECTION FOR TUMOR PH
28190	REMOVAL OF FOOT FOREIGN BODY
28192	REMOVAL OF FOOT FOREIGN BODY
28193	REMOVAL OF FOOT FOREIGN BODY
28200	REP/SUT TEND,W/O GRAFT,EACH TE
28202	REP/SUT TEND,SECOND,W/GRFT, EA
28208	REP/SUT TEND....EACH TENDON
28210	REP/SUT TEND..W/GRAFT, EACH TE
28220	RELEASE OF FOOT TENDON
28222	RELEASE OF FOOT TENDONS
28225	RELEASE OF FOOT TENDON
28226	RELEASE OF FOOT TENDONS
28230	INCISION OF FOOT TENDON(S)
28232	INCISION OF TOE TENDON
28234	INCISION OF FOOT TENDON
28238	REVISION OF FOOT TENDON
28240	RELEASE OF BIG TOE
28250	REVISION OF FOOT FASCIA
28260	RELEASE OF MIDFOOT JOINT

Proc	Description
28261	REVISION OF FOOT TENDON
28262	REVISION OF FOOT AND ANKLE
28264	RELEASE OF MIDFOOT JOINT
28270	CAPSULOTOMY...EACH JOINT
28272	CAPSULECTOMY...INTERPHAL.,EACH
28280	FUSION OF TOES
28285	REVISION OF HAMMERTOE
28286	REVISION OF HAMMERTOE
28288	OSTECTOMY,PARTIAL..EACH METATA
28289	REPAIR HALLUX RIGIDUS
28290	CORRECTION OF BUNION
28292	CORRECTION OF BUNION
28293	CORRECTION OF BUNION
28294	CORRECTION OF BUNION
28296	CORRECTION OF BUNION
28297	BUNION CORREDTION-LAPIDUS TYPE
28298	CORRECTION OF BUNION
28299	CORRECTION OF BUNION
28300	INCISION OF HEEL BONE
28302	INCISION OF ANKLE BONE
28304	INCISION OF MIDFOOT BONES
28305	INCISE/GRAFT MIDFOOT BONES
28306	INCISION OF METATARSAL
28307	SEE 28306;1ST METATARSAL W/BON
28308	INCISION OF METATARSAL
28309	INCISION OF METATARSALS
28310	REVISION OF BIG TOE
28312	REVISION OF TOE
28313	RECONSTRUCT TOE,SOFT TISSUR ON
28315	SESAMOIDECTOMY FIRST TOE
28320	REPAIR OF FOOT BONES
28322	REPAIR OF METATARSALS
28340	RECONSTRUCT TOE,MACRODAC;SFT T
28341	SEE 28340;REQUIRING BONE RESEC
28344	RECONSTRUCT TOE;POLYDATYLY

Proc	Description
28345	SEE Z8344;SYNDACTYLY,W/WO GRFT
28360	RECONSTRUCT CLEFT FOOT
28400	TREAT CLSD CALC FX;W/O MANIP
28405	TREAT CLSD CALC FX W/MANIP...R
28406	TREAT CLSD CALC FX,MANIP/FIXAT
28415	REPAIR OF HEEL FRACTURE
28420	REPAIR/GRAFT HEEL FRACTURE
28430	TREAT CLSD TALUS FX,W/O MANIP
28435	TREAT CLSD TALUS FX,W/ MANIP
28436	TREAT CLSD TAL.FX,W/MANIP&PERC
28445	OPEN TX,CLSD/OPEN FX,W/W/O FIX
28450	TREAT CLSD TARSAL FX;W/O MANIP
28455	TREAT CLSD TARSAL FX;W/ MANIP,
28456	OPEN TX CLSD/OPEN FX W/RED&PIN
28465	OPEN TX,CLSD/OPEN FX,W/W/O FIX
28470	TREAT CLSD METATAR FX,W/O MANI
28475	TREAT CLSD METATAR FX;W/ MANIP
28476	TREAT CLSD FX,W/MANIP&PINNING,
28485	OPEN TX,CLSD/OPEN FX W/W/O FIX
28490	TREAT BIG TOE FRACTURE
28495	TREAT BIG TOE FRACTURE
28496	TREAT CLSD FX GREAT TOE...PINN
28505	REPAIR BIG TOE FRACTURE
28510	TREAT CLSD FX....W/O MANIP,EAC
28515	TREAT CLSD FX...W/ MANIP., EAC
28525	OPEN TX,CLSD FX..W/W/O FIX, EA
28530	TREAT CLOSED SESAMOID FRACTURE
28531	OPEN TREATMENT OF SESAMOID FRA
28540	TREAT FOOT DISLOCATION
28545	TREAT FOOT DISLOCATION
28546	TREAT FOOT DISLOCATION
28555	REPAIR FOOT DISLOCATION
28570	TREAT FOOT DISLOCATION
28575	TREAT FOOT DISLOCATION
28576	PERCUTANEOUS SKELETAL FIXATION

Proc	Description
28585	REPAIR FOOT DISLOCATION
28600	TREAT FOOT DISLOCATION
28605	TREAT FOOT DISLOCATION
28606	TREAT FOOT DISLOCATION
28615	REPAIR FOOT DISLOCATION
28630	TREAT TOE DISLOCATION
28635	TREAT TOE DISLOCATION
28636	PERCUTANEOUS SKELETAL FIXATION
28645	REPAIR TOE DISLOCATION
28660	TREAT TOE DISLOCATION
28665	TREAT TOE DISLOCATION
28666	PERCUTANEOUS SKELETAL FIXATION
28675	REPAIR OF TOE DISLOCATION
28705	FUSION OF FOOT BONES
28715	FUSION OF FOOT BONES
28725	FUSION OF FOOT BONES
28730	FUSION OF FOOT BONES
28735	FUSION OF FOOT BONES
28737	REVISION OF FOOT BONES
28740	FUSION OF FOOT BONES
28750	FUSION OF BIG TOE JOINT
28755	FUSION OF BIG TOE JOINT
28760	FUSION OF BIG TOE JOINT
28800	AMPUTATION OF MIDFOOT
28805	AMPUTATION THRU METATARSAL
28810	AMPUTATION TOE & METATARSAL
28820	AMPUTATION OF TOE
28825	PARTIAL AMPUTATION OF TOE
28899	FOOT/TOES SURGERY PROCEDURE
29345	APPLICATION OF LONG LEG CAST
29355	APPLICATION OF LONG LEG CAST
29358	APPLY LONG LEG CAST BRACE
29365	APPLICATION OF LONG LEG CAST
29405	APPLY SHORT LEG CAST
29425	APPLY SHORT LEG CAST

Proc	Description
29435	APPLY SHORT LEG CAST
29440	ADDITION OF WALKER TO CAST
29445	APPLY RIGID LEG CAST
29450	APPLICATION OF LEG CAST
29505	APPLICATION LONG LEG SPLINT
29515	APPLICATION LOWER LEG SPLINT
29540	STRAPPING OF ANKLE
29550	STRAPPING OF TOES
29580	APPLICATION OF PASTE BOOT
29590	APPLICATION OF FOOT SPLINT
29700	REMOVAL/REVISION OF CAST
29705	REMOVAL/REVISION OF CAST
29730	WINDOWING OF CAST
29740	WEDGING OF CAST
29750	WEDGING OF CLUBFOOT CAST
29799	CASTING/STRAPPING PROCEDURE
29891	ANKLE ARTHROSCOPY/SURGERY
29892	ANKLE ARTHROSCOPY/SURGERY
29893	SCOPE, PLANTAR FASCIOTOMY
29894	ARTHROSCOPY, ANKLE, SURGICAL;
29895	ARTHROSCOPY-PARTIAL SYNOVECTOM
29897	ARTHROSCOPY-LIMITED DEBRIDEMEN
29898	ARTHROSCOPY-EXT. DEBRIDEMENT
29899	ANKLE ARTHROSCOPY/SURGERY
29900	MCP JOINT ARTHROSCOPY, DX
29901	MCP JOINT ARTHROSCOPY, SURG
29902	MCP JOINT ARTHROSCOPY, SURG
35190	REP.ACQUIRED/TRAUMA FISTULA-EX
35226	REPAIR BLOOD VESSEL LESION
35256	REPAIR BLOOD VESSEL LESION
35286	REPAIR BLOOD VESSEL LESION
36415	VENIPUNCTURE MULTIPLE PATIENTS
64450	INJECTION FOR NERVE BLOCK
64702	REVISE FINGER/TOE NERVE
64704	REVISE HAND/FOOT NERVE

Proc	Description
64708	REVISE ARM/LEG NERVE
64722	RELIEVE PRESSURE ON NERVE(S)
64726	RELEASE FOOT/TOE NERVE
64774	REMOVE SKIN NERVE LESION
64776	REMOVE DIGIT NERVE LESION
64778	EXCISE NEUROMA;EACH ADD DIGIT
64782	REMOVE LIMB NERVE LESION
64783	EXCISE NEUROMA,HAND/FOOT,@ ADD
64788	REMOVE SKIN NERVE LESION
64795	BIOPSY OF NERVE
64831	REPAIR OF DIGIT NERVE
64832	SUTURE DIGIT NERVE;@ ADD DIGIT
64834	REPAIR OF HAND OR FOOT NERVE
64837	SUTURE EACH ADD NERVE,HAND OR
64840	REPAIR OF LEG NERVE
64890	NERVE GRAFT, HAND OR FOOT
64891	NERVE GRAFT, HAND OR FOOT
64892	NERVE GRAFT, ARM OR LEG
64893	NERVE GRAFT, ARM OR LEG
64895	NERVE GRAFT, HAND OR FOOT
64896	NERVE GRAFT, HAND OR FOOT
64897	NERVE GRAFT, ARM OR LEG
64898	NERVE GRAFT, ARM OR LEG
64901	NERVE GRAFT,@ ADD NERVE;SING.S
64902	NERVE GRAFT,@ ADD NERVE;MULTI
64905	NERVE PEDICLE TRANSFER
64907	NERVE PEDICLE TRANSFER
64999	NERVOUS SYSTEM SURGERY
73600	X-RAY EXAM OF ANKLE
73600	ANKLE 2 VIEWS
73610	X-RAY EXAM OF ANKLE
73610	ANKLE 4 VIEWS
73615	X-RAY ANKLE,ARTHROGRAPHY;SUPER
73620	X-RAY EXAM OF FOOT
73620	FOOT 3 VIEWS
73630	X-RAY EXAM OF FOOT
73630	FOOT 3 VIEWS
73650	X-RAY EXAM OF HEEL
73650	HEEL 2 VIEWS
73660	X-RAY EXAM OF TOE(S)
73660	TOE 3 VIEWS
76499	RADIOGRAPHIC PROCEDURE
81000	URINALYSIS WITH MICROSCOPY
81002	ROUTINE URINE ANALYSIS
81002	ROUTINE URINALYSIS
82947	ASSAY BODY FLUID, GLUCOSE
82948	STICK ASSAY OF BLOOD GLUCOSE
83051	ASSAY PLASMA HEMOGLOBIN
84450	UV-ASSAY TRANSAMINASE (SGOT)
84450	UV ASSAY TRANSAMINASE,SGOT
84550	ASSAY BLOOD URIC ACID
84560	ASSAY URINE URIC ACID
85002	BLEEDING TIME TEST
85007	DIFFERENTIAL WBC COUNT
85014	BLOOD COUNT OTHER THAN SPUN HE
85014	HEMATOCRIT
85018	HEMOGLOBIN, COLORIMETRIC
85610	PROTHROMBIN TIME
86430	RHEUMATOID FACTOR LATEX FIXATI
87040	BLOOD CULTURE FOR BACTERIA
87070	CULTURE SPECIMEN, BACTERIA
87081	BACTERIA CULTURE SCREEN
87081	BACTERIA CULTURE SCREEN
87101	SKIN FUNGUS CULTURE
87181	ANTIBIOTIC SENSITIVITY, EACH
87210	SMEAR, STAIN & INTERPRET
87220	TISSUE EXAMINATION FOR FUNGI
88300	SURGICAL PATHOLOGY, GROSS
88302	SURGICAL PATHOLOGY, COMPLETE
88304	SURGICAL PATHOLOGY, COMPLETE

Proc	Description
88305	SURGICAL PATHOLOGY, COMPLETE
88307	SURGICAL PATHOLOGY, COMPLETE
90471	IMMUNIZATION ADMIN, SINGLE
90472	IMMUNIZATION ADMIN, 2+
93740	TEMPERATURE GRADIENT STUDIES
93922	NONINVASIVE PHYSIOLOGIC STUDIE
93923	EXTREMITY STUDY
93924	EXTREMITY STUDY
93965	NON-INVASIVE PHYSIOLOGIC STUDI
93970	DUPLEX SCAN OF EXTREMITY VEINS
93971	DUPLEX SCAN OF EXTREMITY VEINS
95831	TEST MUSCLE,MANUAL;EXTREMITY/T
95851	RANGE OF MOTION;@ EXTREMITY,NO
96900	ACTINOTHERAPY
97001	PHYSICAL THERAPY EVALUATION
97001	PHYSICAL THERAPY EVALUATION
97003	OCCUPATIONAL THERAPY EVALUATIO
97003	OCCUPATIONAL THERAPY EVALUATIO
97016	PT-VASOPNEUMATIC DEVICES
97018	PT-PARAFFIN BATH
97032	ELECTRICAL STIMULATION,EACH 15
97032	APP OF A MOD TO ONE OR MO AREA
97033	ELECTRIC CURRENT THERAPY
97039	UNLISTED MODALITY
97110	THERAPEUTIC PROC, ONE OR MORE,
97110	THERAPEUTIC PROCEDURE,LOR MORE
97112	PT-NEUROMUSCULAR REDUCTION 15M
97116	GAIT TRAINING, EACH 15 MIN
97116	PT - GAIT TRAINING - 30 MIN
97124	MASSAGE, EACH 15 MIN
97124	PT-MASSAGE 15 MIN
97139	PT-UNLISTED PROCEDUR-SPECIFY
97703	PROSTHETIC CHECKOUT
97750	PHYSICAL PERFORMANCE TEST, 15
97750	PHYSICAL PERFORMANCE TEST 15MI

Proc	Description
99082	NEO-NATAL ESCORT-PER HOUR
99201	OFFICE,NEW,PROBLEM, STRAIGHTFO
99201	OFC, NEW PT, PROBLEM STRAIGHTF
99202	OFFICE,NEW PT,EXPANDED,STRAIGH
99202	OFC, NEW PT, EXPAND STRAIGHTFO
99203	OFFICE,NEW PT, DETAILED, LOW C
99203	OFC, NEW PT, DETAILED LOW COMP
99204	OFFICE,NEW PT, COMPREHEN, MOD
99204	OFC, NEW PT, COMPREHEN, MOD CO
99205	OFFICE,NEW PT, COMPREHEN, HIGH
99205	OFC, NEW PT, COMPREHEN, HIGH C
99211	OFFICE,EST PT, MINIMAL PROBLEM
99211	OFC, EST PATIENT, MINIMAL PROB
99212	OFFICE,EST PT, PROBLEM,STRAITF
99212	ESTAB PT, PROBLEM STRAIGHTFORW
99213	OFFICE,EST PT, EXPANDED, LOW C
99213	OFC, EST PT EXPANDED, LOW COMP
99214	OFFICE,EST PT, DETAILED, MOD C
99214	OFC, ESTAB PT DETAILED, MOD CO
99215	OFFICE,EST PT, COMPREHEN,HIGH
99215	OFC, ESTAB PT, COMPREHEN, HIGH
99218	INITIAL OBSERVATION CARE, PER
99219	INITIAL OBSERVATION CARE, PER
99220	INITIAL OBSERVATION CARE, PER
99221	INITIAL HOSP,COMPRE,STRTFWD,LO
99222	INITIAL HOSP,COMPRE,MOD CMPLX
99223	INITIAL HOSP,COMPRE, HIGH CMPL
99231	SUBSEQNT HOSP,PRBLM,STRTFWD R
99232	SBSQNT HOSP,XPANDED,MOD CMPLXT
99233	SBSQNT HOSP,DETAILED, HIGH CMP
99234	OBSERV/HOSP SAME DATE
99235	OBSERV/HOSP SAME DATE
99236	OBSERV/HOSP SAME DATE
99238	HOSPITAL DISCHARGE DAY MANAGEM
99241	OFF CONSULT,NRE PT,PRBLM,STRTF

Proc	Description
99242	OFF CONSLT,NRE PT,XPND PBLM, S
99243	OFF CNSLT,NRE PT,DTLD, LO CMPL
99244	OFF CNSLT,NRE PT,CMPHSV,MOD CM
99245	OFF CNSLT,NRE PT,CMPHSV,HI CMP
99251	INIT INPT CNSLT,NREST PT,PBLM,
99252	INIT INPT CNSLT,NRE PT,XPND,ST
99253	INIT INPT CNSLT,NRE PT,DTLD,LO
99254	INIT INPT CNSLT,NRE PT,CMPHSV,
99255	INIT INPT CNSLT,NRE PT,CMPHSV,
99281	EMER DEPT VST,PRBLM,STRTFWD
99282	EMER DEPT VST,PRBLM,LOW CMPLXT
99283	EMER DEPT VSTXXPAND,LOW CMPLST
99284	EMER DEPT VST,DETAILED,MOD CMP
99285	EMER DEPT VST,COMPHSV,HIGH CMP
99315	NURSING FAC DISCHARGE DAY
99316	NURSING FAC DISCHARGE DAY
99341	HOME,NEW PT, PROBLM, STRTFWD R
99342	HOME,NEW PT, EXPANDED, MOD COM
99343	HOME,NEW PT, DETAILED, HIGH CO
99344	HOME VISIT, NEW PATIENT
99345	HOME VISIT, NEW PATIENT
99347	HOME VISIT, ESTAB PATIENT
99348	HOME VISIT, ESTAB PATIENT
99349	HOME VISIT, ESTAB PATIENT
99350	HOME VISIT, ESTAB PATIENT
99360	PHYSICIAN STANDBY SERVICE, REQ
99381	INIT E&M HEALTHY INDV,NEW PT,T
99382	INIT E&M HEALTHY INDV,ERLY CHD
99383	INIT E&M HEALTHY INDV,LTE CHLD
99384	INIT E&M HEALTHY INDV,ADOLS,12
99385	INIT E&M,HEALTHY NEW PT,18-21
99429	UNLISTED PREVENTIVE MEDICINE S
99431	HIST/EXAM NORMAL NEWBORN
99432	NORMAL NEWBORN CARE IN OTHER T
99433	SUBSQNT HOSP,NORML NEWBORN,P D
99435	HOSPITAL NB DISCHARGE DAY
99440	NEBORN RESUSCITATION

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: Professional					

What topic was most beneficial to you?_____

Please provide constructive comments and suggestions:_____

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