UNISYS

MENTAL HEALTH REHABILITATION PROVIDER TRAINING

Spring 2006

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

ABOUT THIS DOCUMENT

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

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

This packet does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability. Such information is presented only in the Basic Medicaid Information Training packet. This packet may be obtained by attending the Basic Medicaid Information workshop; by requesting a copy from Unisys Provider Relations; or by downloading it from the Louisiana MEDICAID website, www.lamedicaid.com.

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

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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PROVIDER ENROLLMENT

Effective August 20, 2004, a moratorium was implemented on the enrollment of MHR providers to participate in the Medicaid Program. The Department shall not approve for enrollment any new MHR provider, office location or change of ownership, regardless the status of their application.

ACCREDITATION

All enrolled providers of mental health rehabilitation services must maintain accreditation from one of the following national organizations:

- The Council on Accreditation,
- The Commission on Accreditation of Rehabilitation Facilities, or
- The Joint Commission on Accreditation of Health Care Organizations.

Denial or loss of accreditation status or any negative change in accreditation status must be reported to the Bureau or its designee by the provider. Written notification must be provided to the Bureau or its designee within five working days of the receipt of notice from the national accreditation organization. The written notification must include information on the following:

- The provider's denial or loss of accreditation status,
- Any negative change in accreditation status, and
- The steps and timeframes, if applicable, the accreditation organization is requiring from that provider to maintain accreditation.

If the provider loses accreditation at any time, there will be an automatic loss of certification.

Denial or loss of accreditation status, any negative change in accreditation status and/or failure to notify the Department of these events may result in sanctions to the mental health rehabilitation provider.

CHANGE OF ADDRESS/ENROLLMENT STATUS

Providers who have changes in enrollment information must provide written notification to the following:

OMH Monitoring and Enrollment Coordinator
210 State St., Cottage 3
New Orleans, LA 70118

BHSF/Program Operations/MHR Program
P.O. Box 91030
Baton Rouge, LA 70821-9030

Unisys
Provider Enrollment Unit
Post Office Box 80159
Baton Rouge, LA 70898--0159

DHH/Health Standards Section
Po Box 3767
Baton Rouge, LA 70821
Located at 500 Laurel St. Suite 100 Baton Rouge, La 70801-1811

Changes that must be reported are changes in:

- Address, email address or telephone number of any office,
- Required staff, including LMHP and psychiatrist,
- Accreditation status,
- Licensure,
- Services provided,
- Hours of operation,
- Any other occurrence which affects compliance with certification requirements or
- Change in population group served.

Providers who change their group affiliation must notify Provider Enrollment in writing to eliminate the possibility of payments being delivered to the wrong provider/group.

Note: Individual providers should close any and all group linkages with those groups they no longer have any affiliation with.

Establishment of an additional office location requires a new provider enrollment application to be submitted.

The Monitoring and Enrollment Unit will conduct a monitoring review in those instances where changes in ownership, addresses, office relocations, services provided, or required staff has been reported to ensure the provider is in compliance with all applicable federal and state regulations.

As the result of the monitoring review, the provider will be given a written notice of deficiencies and shall be required to submit a written corrective action plan to BHSF or its designee within 10 days from the receipt of the notice from the Department.

If the provider fails to submit a corrective action plan within 10 days from the receipt of the notice, sanctions may be imposed.

The Monitoring and Enrollment supervisor shall ensure that changes in provider address or office location are reflected on the Freedom of Choice list.

CHANGE IN OWNERSHIP

Change in ownership is not allowed under the current moratorium. However, the policy is provided here because the moratorium can be lifted at any time.

MAPIL regulation 46:437.13(2) (b) requires a **60 day prior notice** of ownership change. In addition, the following requirements must be met:

- Written notification with copies to:

  OMH Monitoring and Enrollment Coordinator
  210 State St., Cottage 3
  New Orleans, LA 70118

  BHSF/Program Operations/MHR Program
  P.O. Box 91030
  Baton Rouge, LA 70821-9030

  Unisys
  Provider Enrollment Unit
  Post Office Box 80159
  Baton Rouge, LA 70898—0159

  DHH/Health Standards Section
  Po Box 3767
  Baton Rouge, LA 70821
  Located at 500 Laurel St. Suite 100 Baton Rouge, La 70801-1811

- A new ADC license, if applicable, as the previous provider license shall not be used past the date of sale.

- New Freedom of Choice forms must be completed for all recipients.

The Monitoring and Enrollment Unit will conduct a monitoring review in those instances where changes in ownership, addresses, office relocations, services provided, or required staff has been reported to ensure the provider is in compliance with all applicable federal and state regulations.

As the result of the monitoring review, the provider will be given a written notice of deficiencies and shall be required to submit a written corrective action plan to BHSF or its designee within 10 days from the receipt of the notice from the Department.

If the provider fails to submit a corrective action plan within 10 days from the receipt of the notice, sanctions may be imposed.

Note: Services cannot be provided or billed on the new number until the new provider has met all requirements for enrollment as a MHR provider.

REMINDERS

- Provider must obtain and maintain a line of credit from a federally insured, licensed lending institution in an amount of at least $50,000 as proof of adequate finances. It is the provider's responsibility to notify the Bureau in the event that the financial institution cancels or reduces the upper credit limit.

- Providers must obtain and maintain a general liability and a professional liability insurance policy with at least $1,000,000 coverage under each policy. The certificates of insurance for these policies shall be in the name of the MHR provider and certificate holder shall be the Department of Health and Hospitals. The provider shall notify the Bureau when coverage is terminated for any reason. Coverage shall be maintained continuously throughout the time services are provided.

- Each Medicaid enrolled MHR agency must have an independently enrolled practicing psychiatrist linked to the agency.

PROGRAM OPERATIONS REMINDERS

The criteria in this section specify operational requirements necessary to provide efficient services to Mental Health Rehabilitation recipients.

AGENCY OPERATIONS

- Services shall be available on an emergency basis 24-hours a day, seven days per week as outlined in a Crisis Management policy;
- Have required designated staff on site during business hours;
- Be immediately available to its recipients and the Bureau by telecommunications 24 hours per day.

SERVICE LOCATION

Every location where services are provided shall be established with the intent to promote growth and development, client confidentiality, and safety.

The MHR provider accepts full responsibility to ensure that its office locations meet all applicable federal, state and local licensing requirements. The transferring of licenses and certifications to new locations is strictly prohibited. It is also the responsibility of the MHR provider to immediately notify the Bureau of any office relocation or change of address and to obtain a new certification and license (if applicable). The provider must report to DHH the address of any off-site delivery location to be utilized twenty (20) or more hours per week.

Services may be delivered in off site service delivery locations that are:

- Publicly available for and commonly used by members of the community other than the provider (e.g. libraries, community centers, YMCA, church meeting rooms, etc.);
- Directly related to the recipient's usual environment (e.g. home, place of work, school); or
- Utilized in a non-routine manner (e.g. hospital emergency rooms or any other location in which a crisis intervention service is provided during the course of the crisis);
- Used solely for the provision of allowable offsite service delivery by a certified MHR provider. However, any such location must not be staffed by the provider at times when services are not being provided, must not house records of the provider, or be a place where the MHR provider routinely conducts business but for the allowable offsite service delivery.

Note: Services may not be provided in the home(s) of the MHR provider's owner, employees or agents. Group counseling and psychosocial skills training (adult and youth) may not be provided in a recipient's home or place of residence.

Note: Services may not be provided in the professional practitioner's private office.

POLICY MANUAL

The MHR provider shall develop and maintain an internal policy manual. The policies and procedures shall be implemented immediately upon acceptance of recipients for services.

The policy manual must be made available to all staff and the provider must document that the staff has been trained on its contents. **The policy manual shall be available to the recipients and any governing/monitoring authorities upon request.**

ORGANIZATIONAL STRUCTURE

The designated administrator shall have the overall responsibility for management. The provider must maintain a current, functional organizational chart which defines the lines of authority.

ABUSE AND NEGLECT

Providers must have a policy which clearly defines abuse and neglect and prohibits such conduct. In addition, it must be documented that all staff members and consultants have been trained and given a copy of the provider's policies and procedures on reporting suspected cases of abuse and neglect.

Procedures for reporting suspected abuse and neglect include the following:

- Any employee or consultant, who witnesses, has knowledge of or otherwise has reason to suspect that abuse or neglect has occurred must report such incidents to the administrator and cooperate in the investigation of the incident. This includes incidents that occur in the provider offices as well as situations that may arise outside the office.
- The administrator and provider staff is responsible for reporting suspected abuse and/or neglect to the appropriate state agencies such as Office of Community Services (Child Protection), Adult Protective Services and the appropriate OMH office.
- All providers shall have an internal procedure to investigate abuse and neglect allegedly committed by provider employees. The procedure shall include, at a minimum, the following process:
    - Any allegation of abuse and neglect lodged against an employee of the provider must be investigated.
    - Individuals under investigation are not to be part of the investigation team.
    - Individuals under investigation are prohibited from working or having any contact with the recipient who made the allegation.
    - The findings of the investigating team are to be reviewed at the appropriate administrative level and forwarded to the governing body.

- In substantiated cases of neglect, appropriate disciplinary action is to be taken to prevent a reoccurrence when the case is a systemic problem.
- Substantiated cases of abuse are to be reported to the appropriate law enforcement and state agencies, including the Bureau and its designee and the employee must be terminated.

RECIPIENT ORIENTATION

This policy must be provided to the recipient verbally and in writing and acknowledged in writing by the recipient. He/she must receive a copy of the signed form.

QUALITY IMPROVEMENT PLAN

The provider shall have systems and procedures for the ongoing monitoring of the quality, appropriateness and utilization of services. Personnel performing the Quality Improvements (QI) function should be knowledgeable regarding QI procedures and the function that is being reviewed. Findings should be used in program planning, financial planning, and resource planning, to identify training needs and to improve the quality of services. Input from recipients and other stakeholders must be an integral part of the process. This may be obtained through public hearings, representation on advisory committees, or small focus groups.

EMPLOYMENT AND PERSONNEL POLICIES

- A job description for all positions, including the duties, qualifications, and competencies. This applies to volunteers and student workers.
- Drug testing is mandatory and the documentation shall be readily retrievable upon request by the Bureau or its designee.
- Providers must conduct criminal background checks on the direct care and supervisory staff.

STAFFING AND TRAINING

The Bureau has established staffing requirements to maintain an adequate level of quality, efficiency, and professionalism in the provision of MHR services to ensure recipients receive acceptable services. The provider must ensure that the staff members possess the minimum requisite skills, qualifications, training, supervision, and coverage in accordance with the requirements described in this section.

Appropriate staffing must be available to adequately implement the MHR plan for each recipient served by the agency. Staff coverage must be documented in writing.

The agency must maintain a personnel record for all individuals employed or working for the agency on a contractual basis.

Personnel records must be maintained for all staff, volunteers and consultants. The record must contain documentation and verification of all relevant information necessary to determine the employee's eligibility for the position prior to him/her providing billable Medicaid services.

STAFF QUALIFICATIONS

MHR services shall be provided by individuals who meet the following education and experience requirements.

Licensed Mental Health Professional (LMHP)

A LMHP is a person who has a graduate degree in a mental health-related field from an accredited institution and is licensed to practice in the state of Louisiana by the applicable professional board of examiners. An LMHP provides professional mental health services within the scope and ethical boundaries allowed by the professional license. In order to qualify as a mental health-related field, an academic program must have curriculum content in which at least 70 percent of the required courses for the major field of study are based upon the core mental health disciplines. The following professionals are considered to be LMHPs:

Each MHR provider shall implement and maintain a contract with a psychiatrist(s) to provide consultation and/or services on site as medically necessary. The psychiatrist must be a licensed medical doctor (M.D. or D.O.) who is board-certified or board-eligible, authorized to practice psychiatry in Louisiana and enrolled to participate in the Louisiana Medicaid Program. A board eligible psychiatrist may provide psychiatric services to MHR recipients if he/she meets all of the following requirements:

- The physician must hold an unrestricted license to practice medicine in Louisiana and unrestricted Drug Enforcement Administration (DEA) and state and federal controlled substance licenses. If licenses are held in more than one state or jurisdiction, all licenses held by the physician must be documented in the employment record and also be unrestricted.

- The physician must have satisfactorily completed a specialized psychiatric residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), as evidenced by a copy of the certificate of training or a letter of verification of training from the training director which includes the exact dates of training and verification that all ACGME requirements have been satisfactorily met. If training was completed in child and adolescent psychiatry, the training director of the child and adolescent psychiatry program must document the child and adolescent psychiatry training.

Note: All documents must be maintained and readily retrieved for review by the Bureau or its designee.

Psychologist

An individual who is licensed as a practicing psychologist under the provisions of R.S. 28:2351– 2370.

Advanced Practice Registered Nurse (APRN)

An advanced practice registered nurse, licensed as a registered nurse in the State of Louisiana by the Board of Nursing, who is a clinical nurse specialist in psychiatry. An APRN must operate under an OMH approved collaborative practice agreement with an OMH approved board certified psychiatrist.

Registered Nurse

A nurse who is licensed as a registered nurse in the State of Louisiana by the Board of Nurses must:

- Be a graduate of an accredited program in psychiatric nursing and have two years of post-master's supervised experience in the delivery of mental health services;

or

- Have a master's degree in nursing or a master’s degree in a mental health-related field and two years of supervised post master's experience in the delivery of mental health services;

Note: Supervised experience is experience in mental health services delivery acquired while working under the formal supervision of a LMHP

and

- Six CEUs regarding the use of psychotropic medications, including atypicals, prior to provision of direct service to MHR recipients.

Note: Every registered nurse providing MHR services shall have documented evidence of five CEUs annually that are specifically related to behavioral health and medication management issues.

Social Worker

An individual who has a master's degree in social work from an accredited school of social work and is a licensed clinical social worker under the provisions of R.S. 37:2701 – 2718.

Licensed Professional Counselor

An individual, who has a master's degree in a mental health-related field, is licensed under the provisions of R.S. 37:1101 – 1115 and has two years post-masters experience in mental health.

The following MHR staff does not meet the LMHP qualifications, but may provide other services as allowed in policy.

Mental Health Professional (MHP)

A Mental Health Professional is supervised by an LMHP and meets both of the following criteria:

- Has a Master of Social Work degree

or

- Has a Master of Arts degree in a mental health related field

or

- Has a Master of Science degree in a mental health related field

or

- Has a master of Education degree in a mental health related field

and

- Has a minimum of 15 hours of graduate level course work and/or practicum experience in applied intervention strategies/methods designed to address behavioral and/or emotional and/or mental problems. These hours may be obtained as a part of or in addition to the master's degree.

Mental Health Specialist (MHS)

A Mental Health Specialist is supervised by an LMHP and meets one or more of the following criteria:

- Has a Bachelor of Arts degree in a mental health related field;

or

- Has a Bachelor of Science degree in a mental health related field;

or

- Has a bachelor's degree and is a college student pursuing a graduate degree in a mental health related field and has completed at least two courses in that identified field;

or

- Has a high school degree or a GED;

and

- Has four years experience providing direct services in a mental health, physical health, social services, education or correctional setting.

Nurse

A registered nurse who is licensed by the Louisiana Board of Nursing may provide designated components of medication management services if he/she meets the following requirements:

- A bachelor's degree in nursing and one year of supervised experience as a psychiatric nurse which must have occurred no more than five years from the date of employment or contract with the MHR provider;

or

- An associate degree in nursing and two years of supervised experience as a psychiatric nurse which must have occurred no more than five years from the date of employment or contract with the MHR provider;

Note: Supervised experience is experience in mental health services delivery acquired while working under the formal supervision of a LMHP.

and

- Six CEUs regarding the use of psychotropic medications, including atypicals, prior to provision of direct service to MHR recipients.

Licensed Practical Nurse

A licensed practical nurse who is licensed by the Louisiana Board of Practical Nurse Examiners may perform medication administration if he/she has:

- One year of experience as a psychiatric nurse which must have occurred no more than five years from the date of employment/contract with the MHR provider;

and

- Six CEUs regarding the use of psychotropic medications, including atypicals, prior to provision of direct service to any recipient.

Note: Every registered nurse and licensed practical nurse providing MHR services shall have documented evidence of five CEUs annually that are specifically related to behavioral health and medication management issues.

STAFF RESPONSIBILITIES

The LMHP is responsible for all clinical services and supervision of all non-licensed staff. The following are functions of the LMHP:

- Assessment - The LMHP must direct the gathering of data for the assessment. The LMHP must conduct, at a minimum, one face to face interview with the recipient and their family/significant others as well as sign and date the assessment document. The integrated summary section must also be developed and signed by the LMHP.
- Administer and score LOCUS/CALOCUS, if an Approved Clinical Evaluator (ACE).
- Service planning team- Act as team leader, sign and date the Individualized Services and Recovery Plan (ISRP) and Quarterly Report.
- Provide supervision to assigned staff.
- Provide crisis intervention services for community support staff as needed.
- Notify the provider's staff psychiatrist of any significant change in a recipient's physical or mental status.
- May provide all core services except Medication Management, unless specifically qualified to provide it per policy.
- Acts as team leader for a PFII team.
- May provide staff training as needed.
- May perform the Quality Improvement function as needed.

In addition to the job responsibilities listed above, staff may perform duties as indicated below:

Psychiatrist

- Must sign the ISRP.
- Must be available to participate in crisis intervention emergencies.
- Must provide face - to - face consultation and services on site each month for each recipient who has selected the provider's staff psychiatrist.
- May provide DSM-IV (or its successor) diagnosis, Axes I-V.
- May provide Medication Management.

Psychologist

- May provide DSM-IV (or its successor) diagnosis, Axes I-V.

Advanced Practice Registered Nurse

- May provide DSM-IV (or its successor) diagnosis, Axes I-V.
- May provide Medication Management.

Registered Nurse

- May provide Medication Management.

Social Worker

- May provide DSM-IV (or its successor) diagnosis, Axes I-V.

LPC

- May provide DSM-IV (or its successor) diagnosis, Axes I-V.

MHP

The MHP may provide the following services under the supervision of an LMHP:

- Community support
- Individual and/or group counseling
- Group Psychosocial Skills Training
- PFII
- Participate in quality improvement and staff training activities

MHS

The MHS may provide the following services under the supervision of an LMHP:

- Community support
- Individual and/or group counseling
- Group Psychosocial Skills Training
- PFII
- Participate in quality improvement and staff training activities

Nurse

- May provide Medication Management Services, including education and administration as described in the Covered Services section of the manual.

Licensed Practical Nurse

May provide medication administration as described in the Covered Services section of the manual.

SUPERVISION

Every unlicensed MHR employee providing direct clinical services shall receive continuing direct and documented clinical supervision from a licensed mental health professional. Supervision shall be carried out by the LMHP who is directly responsible for the recipient. Documentation of supervision shall be noted in the employee's personnel record.

Non-LMHP staff shall receive face-to-face supervision and observation for a minimum of two hours each week for the first three months of employment while they are providing eligible services and for at least one hour per month thereafter. This policy shall not supersede any professional practices act. The policy shall cover supervision and observation and shall be documented in the employee's supervision record.

COVERED SERVICES

The MHR provider shall provide all mandatory services and these services shall not be subcontracted. The provider may choose to provide the optional services, either in house or through a subcontractor. Should the provider choose to furnish optional services through a subcontract, they must ensure that the subcontractor meets all provider participation requirements to provide such services including, but not limited to, licensing and certification requirements.

Each provider shall have a policy wherein they agree to identify and either provide or contract services as identified in every individual service agreement. The provider shall be qualified to provide services, and the recipient shall be eligible to receive the services. The services for each individual shall be included in the 90-day ISRP.

The child or adolescent shall be served within the context of the family and not as an isolated unit. Services shall be appropriate for:

- Age;
- Development;
- Education; and
- Culture.

ASSESSMENT (REQUIRED SERVICE)

Service Definition

Assessment is an integrated series of diagnostic and evaluation procedures conducted with the recipient and their significant others to provide the basis for the development of an effective, comprehensive, and individualized ISRP. It is an intensive clinical, psychosocial evaluation of a recipient's mental health condition which results in an Individualized Services and Recovery Plan (ISRP) for the recipient. It may also be used to determine recipient level of need and medical necessity. The assessment must be completed for all new MHR recipients and for those with a 12 months or more lapse in service.

Program Requirements

In order to ensure adequate and recovery/resiliency focused assessment, providers are required to utilize a variety of methods to gather assessment data regarding a recipient. This data is collected in the form of an assessment document that is completed within 30 calendar days and submitted for approval by BHSF or its designee. This data is the foundation of the recipient's ISRP.

Unless otherwise noted, information to assess each item must be based on current circumstances (within 30 days) and face to face interviews with the recipient and if the recipient is a minor, his/her parent or guardian.

Extensions may be granted, on a case by case basis, under exceptional circumstances at the discretion of the Prior Authorization Unit. Requests for extensions should be thoroughly documented and directly related to the reason for the delay. (Example: Recipient is hospitalized for 15 days, so a 15 day extension is requested.)

SERVICE PLANNING/TEAM (REQUIRED SERVICE)

Service Definition

Service Planning is the team process of developing the recipient's ISRP, periodically reviewing progress toward the goals of the ISRP, and modifying as indicated. The ISRP is an individualized, structured, goal-oriented schedule of services developed jointly by the recipient and treatment team. Recipients must be actively involved in the planning process and have a major role in determining the direction of their ISRP. The ISRP must identify the goals, objectives, interventions, and units of service which are based on the results of an Assessment, and agreed to by the adult or youth and his/her parent/guardian. Service Planning/Team does not include regular team meetings, staff training or staff supervision.

Service Exclusions

The assessment must be completed and the recipient determined eligible prior to a request for services.

Program Requirements

Services and service frequency should accurately reflect the needs, goals, and abilities of each recipient for the authorization period.

All service requests on the ISRP must be individualized to meet the needs of the recipient. It is not permissible to use terms such as 'as needed' or 'PRN' to describe frequency or duration of services.

An ISRP must be developed and reviewed according to the following schedule (all time frames are calendar days and must be tracked by the date of recipient signature).

Initial ISRP – completed within 30 days of notice to MHR provider of recipient's eligibility.
Subsequent ISRPs – completed every 90 days.

The MHR provider must have an original completed, dated sign-in team meeting document as well as evidence of invitations extended to the meeting such as copies of letters, emails or service logs.

A written draft of the proposed ISRP may be developed outside of the Service Planning/Team meeting with final changes made during the meeting.

The certification statement must consist of a signed and dated statement from the treating psychiatrist that he/she has reviewed the ISRP and that the services it contains

are medically necessary and appropriate for the recipient's diagnosis and service needs. In addition, it must note concurrence with any specific goals, objectives and interventions relating to medications, or medical management issues.

Service Planning/Team shall only be billed by the LMHP who must review and approve the ISRP and is billable only after completion the service.

Service Authorization Periods

- Interim – 30 days
- Initial – 90 days
- Subsequent – 90 days

COMMUNITY SUPPORT (REQUIRED SERVICE)

Service Definition

Community Support is the provision of one to one mental health rehabilitation services and supports necessary to assist the recipient in achieving and maintaining rehabilitative, resiliency and recovery goals. The service is designed to meet the educational, vocational, residential, mental health treatment, financial, social and other treatment support needs of the recipient. Community Support is the foundation of the recovery and resiliency-oriented ISRP and is essential to all MHR recipients. Its goal is to increase and maintain competence in normal life activities and gain the skills necessary to allow recipients to remain in or return to naturally occurring supports.

Service Exclusions

This service may not be combined on an ISRP with Parent/Family Intervention (Intensive).

Clinical Exclusions

Community Support cannot be the only service on the ISRP.

Program Requirements

Community Support is an individualized service and is not billable if delivered to a group or with more than one recipient per staff per contact.

Each recipient enrolled in the Mental Health Rehabilitation Program shall have one designated provider who will serve as the "mental healthcare home" for the recipient and family as indicated on the Freedom of Choice form. Within this provider, each recipient will choose one designated community support worker who is the recipient/family's primary point of contact. While this designated community support worker will provide

the majority of community support activities, he/she may not be the exclusive provider of these activities.

Community Support is primarily a face to face service and is primarily provided in the home or other community setting. 60% of the contacts provided during an authorization period must be face to face. No less than 80% of those face to face contacts must be provided in the home or community. Face to face contacts occur during times and locations best suiting the recipient's needs including after school, after work, evenings and weekend hours.

The recipient's designated primary Community Support worker acts as the first responder (triage, support and intervention) for MHR recipients in crisis, which may include face to face contact. When unavailable, the designated primary Community Support worker must have a backup worker. The name of the back up worker and how to contact him/her must be provided in writing to the recipient and the family (if the recipient is a minor) or care giver. If the emergency is of a clinical nature, the MHP/MHS must consult with the LMHP or psychiatric director if the recipient's circumstances are beyond his/her ability to ensure the safety of the recipient and others.

Community Support may be provided in:

- Recipient's home;
- School;
- Other community environment which allows for privacy and confidentiality and is appropriate to the age, level of need, and structure needed for the recipients; or
- The MHR facility.

The following activities must be face to face and may include:

- Contributing to development of the ISRP and Quarterly Report for review and approval by an LMHP (ACE), in conjunction with the service planning team.
- Contributing to the development of the recipient's crisis contingency plan.

Note: Services which meet the service definition of Medication Management are excluded.

Service Authorization Periods

- Interim – 30 days
- Initial – 90 days
- Subsequent – 90 days

GROUP COUNSELING (REQUIRED SERVICE)

Service Definition

Group Counseling is a professional, therapeutic intervention using face to face verbal interaction between 2 to 8 recipients and the therapist/counselor to promote emotional,

behavioral or psychological change as identified in the ISRP of each group member. The service is directed to the goals on the approved ISRP. Sessions are typically limited to one hour.

Service Exclusions

This service may not be combined on an ISRP with Parent/Family Intervention (Intensive).

Clinical Exclusions

This service is not appropriate for MHR recipients for whom group counseling is the only needed or requested MHR service.

Topics and interventions (including those conducted in multi-family groups) must be directed exclusively to treatment of the recipient and issues identified on the recipient's ISRP.

Provider shall not admit any recipient into this service who would pose a documented health and safety risk to the recipient or to other recipients and for whom the provider cannot provide the necessary care.

Program Requirements

This service may be provided in any of the following:

- An MHR facility, school, or other designated professional environment meeting all of the following requirements:
  - Consistent location for the duration of the service.
  - Evidence of a memorandum of understanding or other written agreement for the use and terms of the space.
  - Allows for privacy and confidentiality.
  - Is appropriate to the age, level of need, and structure needed for the recipients.
  - This service shall not be provided to recipients (or their families) at a site that serves as a group living environment, such as a board and care facility, group home or apartment building that serves as a residence for more than one MHR recipient.
  - Sessions are scheduled frequently enough to provide effective treatment consistent with the ISRPs of group members.
  - The service should be available at times best suiting the recipient/family needs and requests, including evenings and weekends.
  - Group counseling is a face-to-face service.
  - Group size may not exceed a ratio of one staff member to eight group participants. A staff member must be present at all times during the group session.
  - Participants in each group must be of similar developmental level and psychosocial need. It is expected that recipients will participate in groups

of recipients of similar age. For children, if age difference exceeds three years, the provider must document the basis for inclusion in the group.
- If a group is co-facilitated by more than one staff member, only one staff member can bill for each recipient.

Group counseling will be limited to the following topical areas:

- Anger management
- Behavior management
- Grief/Loss
- Trauma (sexual/physical/verbal)
- Sexual offenders
- General Symptom Management Skills, including
  - Identification and management of symptoms of mental illness; and
  - Compliance with physician's medication orders.
  - Reduction and alternatives to aggression.

Multi-family group counseling may be offered. Topics must be consistent with the above and be directed exclusively to goals on the recipient's ISRP. Parenting skills training related to these topics may also be included.

NOTE: Collateral contacts or other non-face to face contacts are not billable under this service code.

Service Authorization Periods

- Interim – None
- Initial – 90 days
- Subsequent – 90 days

INDIVIDUAL INTERVENTION/SUPPORTIVE COUNSELING (REQUIRED SERVICE)

Service Definition

Individual intervention and supportive counseling are verbal interactions between the counselor/ therapist and the recipient that are brief, face to face and structured. Individual Intervention (Youth) is a range of professionally delivered therapeutic strategies provided individually and face to face to the recipient. The purpose is to rehabilitate and restore the recipient to an optimal level of functioning and to reduce the risk of a more restrictive treatment intervention.

Individual Intervention (Youth) and Supportive Counseling (Adult) are services provided to ameliorate the psychosocial barriers that impede the development or enhancement of skills necessary to function in the community. Individual intervention and supportive counseling are relevant to the needs of the recipient and relate directly to the individualized goals and objectives specified in the recipient's ISRP. These services are

based on psychological treatment principles. Specifically, these include counseling and therapy services that:

- Maximize strengths;
- Reduce behavioral problems;
- Change behavior;
- Improve interpersonal skills;
- Explore and clarify values;
- Facilitate interpersonal growth and change; and
- Increase psychological understanding.

Service Exclusions

This service may not be combined on an ISRP with Parent/Family Intervention (Intensive).

Clinical Exclusions

This service is not appropriate for MHR recipients for whom Individual Intervention and Supportive Counseling is the only needed or requested service.

Program Requirements

This service may be provided in any of the following:

- Recipient's home;
- A MHR facility;
- School; or other designated professional environmental meeting all of the following requirements:
  - Consistent location for the duration of the service.
  - Evidence of a memorandum of understanding or other written agreement for the use and terms of the space.
  - Allows for privacy and confidentiality.
  - Is appropriate to the age, level of need, and structure needed for the recipients.

The service should be available at times of operation best suiting the recipient's needs and requests, including evenings and weekends.

Individual Intervention and Supportive Counseling are face-to-face services and the recipient must be present the entire time for services to be reimbursable.

NOTE: Collateral contacts or telephone contacts are not billable under this service code.

Service Authorization Period

- Interim – None
- Initial – 90 days
- Subsequent – 90 days

MEDICATION MANAGEMENT (REQUIRED SERVICE)

Service Definition

Medication management is provided to:

- Assess,
- Monitor a recipient's status in relation to treatment with medication,
- Instruct the recipient, family, significant others or caregivers of the expected effects of therapeutic doses of medications or,
- Administer prescribed medication when ordered by the supervising physician as part of a mental health rehabilitation plan which is inclusive of additional rehabilitation services and supports.
- The recipient and/or their family face to face and shall not be delivered in a group setting.

Clinical Exclusions

This service is not appropriate for recipients for whom medication management is the only needed or requested MHR service. (Exception: Children in state custody residing in group homes may receive this service if requested by the case manager or person legally authorized to consent to medical care.)

Recipients who are receiving their medications prescribed to treat a psychiatric disorder and are monitored by a physician not employed or subcontracted by the MHR provider shall only receive medication education and medication administration.

Program Requirements

This service may be provided at the approved provider site or in a recipient's natural environment (schools, home, etc) as appropriate to recipient needs and circumstances and in compliance with privacy and confidentiality requirements.

Note: Services may not be provided in an individual practitioner's private office.

This service includes four primary activities:

- Initial Medication Assessment—the initial assessment of the need for, type and dosage of medications directed toward maximizing a recipient's functioning and reducing symptoms.

This assessment is minimally inclusive of:

- Medical history-general health.
- Review of past medication history.
- Other prescriptions including non-psychotropics.
- Untoward side effects and contraindications.
- History of compliance.
- Efficacy of past/current medication prescribed to treat a behavioral disorder.
- Review of abuse history (prescription/non-prescribed).
- Medication type and dosage ordered as a result of the assessment.

- Medication Administration—the administration of therapeutic doses of medication for the treatment of mental disorders which have been prescribed and are monitored by a psychiatrist (or other prescriber as allowed under applicable state law) and indicated in the recipient's MHR ISRP. "Administration" shall be interpreted consistent with applicable state law but minimally is inclusive of injectables (shots), direct dosing of oral medications, and repackaging of oral medication into "pill boxes" or daily dosage boxes when pills are placed in the boxes directly by MHR staff credentialed to administer medications.

- Medication Monitoring—the ongoing review of symptoms, side effects, effectiveness, applicable lab or other measures, compliance, and prescription renewal and adjustment of psychotropic medications.

- Medication Education—involves the instruction of the recipient, family, significant others, and care givers on the expected effects of prescribed medication. Medication education may include but not be limited to include:
  - Proper use and storage of medications.
  - Rationale for the medication.
  - Possible side effects, including impact on pregnancy, and age, sex, or disability related.
  - Early warning signs of relapse and signs of non-adherence and noncompliance with medication prescription.
  - Circumstance/symptoms requiring contact with a medical professional.
  - Use/interactions with other substances (prescribed/non-prescribed).
  - Instruction on the proper self administration of medications.

If an individual is in crisis and the prescribing practitioner on staff changes the medication or dosage, medication education must be provided within one business day if the psychiatrist or nurse is not physically present during the crisis.

All activities of medication management must be provided face to face and at a minimum shall, be available to recipients during normal operating hours.

The following frequency of service requirements apply to all recipients on psychotropic medications for which the provider is the primary prescribing and monitoring entity:

- Initial Medication Assessment – completed and documented in the clinical record during the interim authorization period, not to exceed 30 days from the date eligibility was determined.
- Monitoring – provided as justified by recipient need but in no case less frequently than once every 90 calendar days.
- Medication Administration – frequency as required by prescription, orders and ISRP.
- Medication Education – as required by approved ISRP, but minimally must be documented in the clinical record at the time of any change in medication including dosage or type.
- The MHR provider shall have written policies and procedures regarding the administration of prescription and non-prescription medications used by the recipient while they are enrolled with the provider. The policies and procedures shall provide a structure to ensure compliance with all applicable state law and policy included to but not limited to:
    - Respective practice acts for the disciplines listed in the staffing requirements.
    - Medical Assistance Program Integrity Law (MAPIL) LSA-RS 46:437. 1-46:440.3.

Document the administration of medications, medication errors, and drug reactions.

Document an interval for evaluation by a physician not to exceed 30 calendar days after the initial assessment and 90 calendar days thereafter.

Document the process for immediately notifying the attending physician of drug reactions, medication errors, and /or other related problems.

Document the storage of medications in accordance with applicable state and federal law including:

- All medications must be properly labeled and stored under lock and key.
- Medications for external use must be stored separately from internal and injectable medications.
- Disinfectants must be stored separately from all medications.
- Medications must be stored under proper conditions of sanitation, temperature, light, moisture and ventilation.
- Outdated medications must not be stocked.
- Only staff authorized to administer or supervise self-administration of medication shall have access to medications.
- Disposal of needles in accordance with established Occupational Safety Health and Administration (OSHA) policy for handling medical waste.

The telephone number of existing poison control centers, ambulance and other emergency medical centers should be readily accessible to the MHR staff and recipient.

Service Authorization Periods

- Interim – 30 days
- Initial – 90 days
- Subsequent – 90 days

PARENT/FAMILY INTERVENTION (COUNSELING) (REQUIRED SERVICE)

Service Definition

Parent/Family Intervention (Counseling) is a therapeutic intervention involving the recipient and one or more of his/her family members. The primary goal of the service is to help the recipient and family improve their overall functioning in the home, school, work and community settings. This goal is accomplished by helping the recipient and family increase effective coping mechanisms, healthy communication strategies, constructive problem-solving skills and increased insight into the nature of the recipient's difficulties and the impact on the family.

Parent/Family Intervention (Counseling) includes regularly scheduled face to face interventions with the recipient and their families designed to improve family functions. Specific interventions may include:

- Assisting the family with developing and maintaining appropriate structure within the home.
- Assisting the family with developing increased understanding of the recipient's symptoms and problematic behaviors and developing effective strategies to address these issues, and encouraging emphasis on building upon the recipient and family's strengths.
- Facilitating the family's ability to effectively manage, teach, and positively reinforce the recipient's strengths.
- Facilitating effective communication and problem solving between the recipient and family members.

Interventions are empirically sound and tailored to address the recipient's and family's needs. These services are intended to be time limited with services reduced and discontinued as the family functions more effectively.

Service Exclusions

This service may not be combined on an ISRP with Parent/Family Intervention (Intensive).

Clinical Exclusions

This service is not appropriate for MHR recipients for whom Parent/Family Intervention (Counseling) is the only needed or requested service.

Program Requirements

The service should be available at times of operation best suiting the recipient/family needs and requests, including evenings and weekends. It may be provided in any of the following:

- Recipient's home;
- An MHR facility;
- School; other designated professional environment meeting all of the following requirements:
  - Consistent location for the duration of the service.
  - Evidence of a memorandum of understanding or other written agreement for the use and terms of the space.
  - Allows for privacy and confidentiality.
  - Is appropriate to the age, level of need, and structure needed for the recipients.

Parent/Family Intervention (Counseling) is a face-to-face service. Collateral contacts or telephone contacts are not billable under this service code. The recipient must be present for Parent/Family Intervention (Counseling) sessions except where therapeutically contraindicated. Reasons for this must be documented in service logs for each meeting in which it occurs.

Service Authorization Periods

- Interim – None
- Initial – 90 days
- Subsequent – 90 days

PARENT/FAMILY INTERVENTION (INTENSIVE) (OPTIONAL SERVICE)

Service Definition

Parent/Family Intervention (Intensive) is a structured, intensive family preservation intervention service involving the recipient and one or more of his/her family members. To qualify for this service the recipient must be at risk of out of home therapeutic placement due to the recipient's mental illness or reintegrating from out of home placement and score a Level 5 on the CALOCUS. It is intended to stabilize the living arrangement, promote reunification, and prevent utilization of out of home therapeutic placement (i.e., psychiatric hospitalization, therapeutic foster care) for the recipient. These services are delivered to youth under the age of 21, primarily in their family's home with a family focus. It is a team based service and there must be evidence of team coordination and interaction with the recipient and their family as a single organizational unit. A recipient would normally receive services at this intensive level for a 90 to 180 day period, depending on medical necessity, with a period of less intensive services to follow.

If a provider does not offer PFII services, the recipient must be given a list of PFII providers from which to choose. All service planning must be done by the PFII provider until the recipient is no longer in need of intensive services. The referring provider may only provide Medication Management. At the completion of PFII services, the recipient may choose to return to the referring provider.

The goals of Parent/Family Intervention (Intensive) include but are not limited to:

- Defuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- Insure the linkage to needed community services and resources;
- Insure the clinical appropriateness of services provided; and
- Improve the recipient's ability to care for self (age appropriate), as well as the parent's or legal guardian's capacity to care for their children.

Service Exclusions

PFII includes all needed services with the exception of Medication Management and may not be combined on the ISRP with the services listed below:

- Community Support,
- Psychosocial Skills Training – Group (Adult),
- Psychosocial Skills Training – Group (Youth),
- Individual Intervention/Supportive Counseling, except by special authorization for unique needs,
- Group Counseling, or
- Parent/Family Intervention (Counseling).

Clinical Exclusions

Recipients whose families refuse to participate or to allow services in the home cannot receive this service.

Program Requirements

Services are individually designed for each family, in full partnership with the recipient and the family to minimize intrusion and maximize mastery and independence. Telephone contact and collateral contacts (face to face and telephone) are allowed subject to the overall face to face service ratio referenced below. In addition, the contacts must be relevant to the approved ISRP and appropriately documented.

Service parameters must encompass the following:

Duration of Treatment

Services normally range from 90 to 180 days, depending on the presenting stabilization needs of the recipient and family. Providers may request a service extension in exceptional cases. However, the vast majority of recipients served should complete this phase of treatment within the allotted time range.

Intensity of Services

Services typically follow a course of treatment with more intensive and extensive services in the early phases of treatment. A minimum of sixteen (16) contacts must occur within the first month. For the second and third months of services, an average of ten (10) contacts per month must occur. It is the expectation that service frequency will be gradually reduced over the last two (2) months. All service contacts are subject to the face to face and community ratios described below.

Face to Face Contact and Location of Services

The majority of service is provided face to face with the recipient (no less than 60% of contacts over the span of the authorization period) in the home or other natural setting (no less than 80% of contacts over the span of the authorization period).

Flexible Scheduling

Written policies and procedures must accommodate and encourage flexible scheduling and service delivery. Appointments must be made at a time and place convenient to the family in 90 to 100% of cases.

Team Caseload

Each team of three staff (see Staffing Requirements) may not exceed a caseload of 12 families at any given time. Staff to family ratio takes into consideration required evening and weekend coverage, crisis service needs, and geographical coverage.

Crisis Management

The provider must demonstrate the presence and application of policies and procedures addressing the following:

Availability

- 24/7 telephone response by the PFII team,
- Mobile outreach response available as needed, and
- Coordination of care, resources, and supports for each crisis episode.

Planning and Management

- Development, implementation, and modification of comprehensive crisis protocols, including triage for psychiatric hospitalization,
- Crisis needs assessment for all recipients and families,
- Full family participation in safety planning,
- Clearly defined intervention steps,
- Written crisis plan is present in each recipient record,
- Crisis plan incorporates natural supports and does not rely exclusively on professional resources, and
- If a crisis has occurred, evidence of plan evaluation and modification (if necessary).

Family Involvement

Services are family-driven and the family is an equal partner in all aspects of service delivery.

- Interactive involvement of recipient and parents in treatment planning as evidenced by inclusion of recipient and parent-driven goals,
- Children and/or parents shall sign the ISRP,
- Child and parents included in all service team planning meetings, and
- Progress notes should reflect a strength-based family partnership.

Individualized Treatment

Services are based on the individual's unique needs, strengths and family culture with the goal of self-sufficiency.

- ISRP and notes incorporate the child/family strengths and weaknesses,
- ISRP and notes reflect the unique culture and values of the child and family,
- Documented evidence of a decreased reliance on the formal system of providers, and
- Documented evidence of an increased reliance on family resources and informal supports.

Team Case Coordination

Because this is a team service, there must be documentation of team coordination on each case at least once per week. This is covered under the PFII fee and is not a separate billable service. A structured weekly time should be set aside for team case coordination and review. All changes in the care coordination plan must be documented in the ISRP.

The team approach should incorporate flexible services and a capacity to address concrete therapeutic and environmental issues in order to stabilize the family situation as

soon as possible. The best practice of such an approach should allow the child and family to view the services as delivered by a single organizational unit or team.

Comprehensive Mix of Services

PFII includes a comprehensive set of services designed to meet 100% of the mental health needs of the recipient and family. Services must be uniquely matched to each individual's presenting needs and context. Services shall include at a minimum:

- Crisis management;
- Intensive care coordination;
  - Identification of needed community resources,
  - Linkage to such resources, and
  - Follow-up to determine adequacy and appropriateness of resources.
- Individual and family counseling/therapy;
  - Skills training, including all skills training delineated in the Psychosocial Skills Training (Individual) service description.
- Behavioral management;
  - Development of behavior management plans,
  - Training of behavior management skills, and
  - Monitoring, updating and adapting behavior management plan.

System Collaboration

Services for the recipient must address coordination and collaboration with family and significant others, and with other professional systems of care, including but not limited to education, juvenile justice (Office of Youth Services), and child welfare/foster care (OFS/OCS) when appropriate.

The provider must take a lead role in facilitating collaborative meetings, which include the recipient and family, in the various environments where the formal and informal supports are located.

Development of working relationships with other systems of service (i.e., schools, OYS, OCS) may include written agreements such as memoranda of understanding, referral networks, etc. Such tools demonstrate the provider's capability and practice of providing services in the various related environments, including but not limited to homes (birth, relatives, adopted, foster), schools, temporary holding facilities, homeless shelters, etc.

Any requests for prior authorization of services for recipients involved in other systems of care shall include a copy of the treatment plan developed by that entity. This will ensure that a full range of needed services is provided and prevent duplication of effort.

Service Authorization Period

- Interim – None
- Initial – up to 90 days (review and/or authorization may be more frequent)
- Subsequent – up to 90 days (review and/or authorization may be more frequent)

Psychosocial Skills Training – Group (Adult) (OPTIONAL SERVICE)

Service Definition

Psychosocial Skills Training - Group (Adult) is a therapeutic, rehabilitative, skill building service for individuals to increase and maintain competence in normal life activities and gain the skills necessary to allow them to remain in or return to their community. It is designed to increase the recipient's independent function in his/her living environment through the integration of recovery and rehabilitation principles into the daily activities of the recipient. It is an organized program based on a psychosocial rehabilitation philosophy that assists persons with significant psychiatric disabilities to increase their ability to live successfully in the natural environments they choose. A recipient would normally participate in Psychosocial Skills Training Group (Adult) for six to 18 months.

If a provider does not offer Psychosocial Rehabilitation (PSR) services, the recipient must be given a list of PSR providers from which to choose. The name of the provider of choice is placed on the ISRP along with other requested services. The authorization staff will authorize all medically necessary services on the ISRP, by provider and send the authorization decision for each service to the appropriate provider. It is the responsibility of the Community Support Worker to ensure services are coordinated between the two providers. Providers should develop ongoing working relationships with PSR providers in their area which may include the development of a Memorandum of Understanding.

Psychosocial Skills Training - Group (Adult) should achieve the following outcomes:

- To enable the recipient to become a productive member of society, earn a wage, and live as independently as possible, thereby, reducing the recipient's dependency on state and/or federally funded programs.
- To achieve the restoration, reinforcement, and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of his/her psychiatric symptoms.
- To minimize the effect of mental illness.
- To maximize the recipient's strengths.

Service Exclusions

This may not be the only service requested or combined on the ISRP with:

- Parent/Family Intervention (Intensive)
- Psychosocial Skills Training – Group (Youth)

Clinical Exclusions

Provider shall not admit any recipient into this service who would pose a documented health and safety risk to the recipient or to other recipients and for whom the provider cannot provide the necessary care.

Program Requirements

Providers must be licensed and in good standing as an Adult Day Care Provider as required under LAC 48:I.Chapter 43.

Psychosocial Skills Training – Group (Adult) is a face to face service with the recipient. No collateral contact or other non-face to face service is billable under this service description.

This service shall not be provided at a site which serves as a group living environment, such as a board and care facility, group home or apartment building that serves as a residence for more than one MHR recipient.

A Psychosocial Skills Training program must be open and available for recipient participation no less than 25 hours a week, and no less than 5 hours per day. The service duration shall be based on individual need and as authorized on the recipient's ISRP.

Psychosocial Skills Training teaches skills necessary for the recipient to succeed in his/her environment including but not limited to:

- Daily and Community Living Skills:
  - Nutritional services,
  - Food planning, grocery shopping, cooking, and eating,
  - Household maintenance, including housecleaning and laundry,
  - Money management and budgeting,
  - Shopping for daily-living necessities,
  - Community awareness and current events,
  - Identification and use of social and recreational skills,
  - Use of available transportation, and
  - Personal responsibility.
- Socialization Skills:
  - Communication,
  - Interpersonal relationships, including those with roommate(s) and neighbors,
  - Problem solving/conflict resolution,
  - Management of sensory input and stress,
  - Natural support system development,
  - Self-directed engagement in community social activities (development of a social-recreational plan for the recipient), and
  - Decision making.

- Adaptation Skills:
  - Identification of behaviors that interfere with performance;
  - Development of interventions to alleviate problem behavior, including
    - Coping with symptoms of mental illness that affect the person's ability to successfully work and/or attend school;
    - Development of capacity to follow directions and carry out assignments;

      and
    - Acquisition of appropriate work habits.
- Development of Leisure Time Interests and Skills.
- Symptom Management Skills – focusing on day to day management of symptoms. (Technical medication training should be provided under the Medication Management service).
- Identification and management of symptoms of mental illness; and
- Compliance with physician's medication orders.
- Education in Mental Health/Mental Illness.
- Management of symptoms of mental illness to minimize the negative effects of psychiatric symptoms which interfere with the recipient's daily living, financial management, personal development, and community integration (services that meet the definition of Medication Management should be provided by staff credentialed to offer that service).
- Developing skills necessary for the recipient to comply with prescribed medications.
- Family education and support designed to develop and maintain the family as a support system to the recipient.
- Work readiness activities as part of a clubhouse model (excepting skills related to a specific vocation, trade, or practice):
  - Work related social and communication skills;
  - Work related personal hygiene and attire;
  - Work related time management; and
  - Other related skills preparing the recipient to be employable.

Psychosocial Skills Training- Group (Adult) must have:

- An ongoing process to ensure that recipients participate in the development and periodic revision of program curricula.
- A curriculum designed to improve or maintain the recipient's ability to function in normal social roles and ensure that the methods and materials utilized are age and developmentally appropriate and culturally relevant.

Psychosocial Skills Training – Group (Adult) must be offered at times to meet the recipient’s needs, including evenings and weekends.

A group recreational outing is not a billable service under Psychosocial Skills Training – Group (Adult).

Psychosocial Skills Training – Group (Adult) must utilize one or more of the following three OMH designated psychosocial rehabilitation program models or combine elements from each in a clearly delineated program approach:

- Boston Psychiatric Rehabilitation Model,
- Clubhouse Model, or
- Social Skills Training Model.

Training material must include activities that will allow each recipient to practice the taught skill(s) during the group session and in natural settings. This will allow the recipient to further develop and integrate the skill being taught. The training material must be organized into a specific number of sessions for each topic area (curriculum). If a recipient completes a curriculum but needs additional training, community support should be used during or after the group sessions as a more individualized method of training.

Service Authorization Periods

- Interim – None
- Initial – 90 days
- Subsequent – 90 days

Psychosocial Skills Training – Group (Youth) - Required

Service Definition

Psychosocial Skills Training – Group (Youth) is a therapeutic, rehabilitative, skill building service for children and adolescents to increase and maintain competence in normal life activities and gain the skills necessary to allow them to remain in or return to their community. It is an organized service based on models incorporating psychosocial interventions. Each group must have a curriculum which is no longer than 20 sessions in duration. A recipient would normally participate in Psychosocial Skills Training Group (Youth) for six to 18 months.

The goals of the service include:

- To achieve the restoration, reinforcement, and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of his/her psychiatric symptoms.
- To minimize the effect of mental illness.
- To maximize the recipient's strengths.
- To increase the level of the recipient's age-appropriate behavior.
- To increase the recipient's independent functioning to an appropriate level.
- To enhance pro-social skills
- To increase adaptive behaviors including:
  - Family
  - Peer relations
  - School
  - Community settings

Service Exclusions

This service may not be the only service requested or combined on an ISRP with:

- Parent/Family Intervention (Intensive)
- Psychosocial Skills Training – Group (Adult)

Clinical Exclusions

Provider shall not admit any recipient into this service whose presence would pose a documented health and safety risk to the recipient or to other recipients and for whom the provider cannot provide the necessary care.

Program Requirements

Psychosocial Skills Training – Group (Youth) is a face to face service with the recipient. No collateral contact or other non-face to face service is billable under this service description.

Participants in each group must be of similar developmental level and psychosocial need. It is expected that recipients will participate in groups of recipients of similar age. If age difference exceeds three years, the provider must document the basis for inclusion in the group.

Psychosocial Skills Training – Group (Youth) has a structured curriculum that is adapted to individual recipient need and teaches skills necessary for the recipient to succeed in his/her environment. The curriculum must be age and developmentally appropriate and culturally relevant. It must utilize materials which are current and considered to be within nationally recognized best practice standards.

Training material must include activities that will allow each recipient to practice the taught skill(s) during the group session and in natural settings. This will allow the recipient to further develop and integrate the skill being taught. The training material must be organized into a specific number of sessions, not to exceed 20 sessions, (services that meet the definition of Medication Management should be provided by staff credentialed to offer that service) for each topic area (curriculum). If a recipient completes a curriculum but needs additional training, community support should be used during or after the group sessions as a more individualized method of training.

The curriculum is designed to improve or maintain the recipient's ability to function in normal social roles and should include but not be limited to:

- Socialization Skills
  - Communication,
  - Interpersonal relationships, including those with peers, family, and authority figures,
  - Problem solving/conflict resolution,

    - Management of sensory input and stress,
    - Natural support system development,
    - Self-directed engagement in community social activities (development of a social-recreational plan for the recipient), and
    - Decision making.
- Adaptation Skills
    - Identification of behaviors that interfere with performance;
    - Development of interventions to alleviate problem behavior, including coping with symptoms of mental illness that affect the person's ability to successfully work and/or attend school;
    - Development of capacity to follow directions and carry out assignments;
    - Acquisition of appropriate school habits; and
    - Adaptation to community, environmental and/or family circumstances and realities.
- Education in Mental Health/Mental Illness
- Management of symptoms of mental illness to minimize the negative effects of psychiatric symptoms which interfere with the recipient's daily living, personal development, and community integration (services that meet the definition of Medication Management should be provided by staff credentialed to offer that service);
- Developing skills necessary for the recipient to comply with prescribed medications.
- Developmental issues including:
    - Physical changes,
    - Emotional changes,
    - Sexuality.
- Daily living skills for adolescents transitioning to independent living or as otherwise needed including:
    - Age and developmentally appropriate daily and community living skills;
    - Nutritional services;
    - Food planning, grocery shopping, cooking, and eating;
    - Personal hygiene and grooming skills;
    - Household maintenance, including housecleaning and laundry;
    - Money management and budgeting;
    - Shopping for daily-living necessities;
    - Community awareness and current events;
    - Identification and use of social and recreational skills;
    - Use of available transportation; and
    - Personal responsibility.
- Work readiness activities (excepting skills related to a specific vocation, trade, or practice):
    - Work related social and communication skills;
    - Work related personal hygiene and attire;
    - Work related time management; and
    - Other related skills preparing the recipient to be employable.
- Psychosocial Skills Training must have an ongoing process to ensure that recipients participate in the development and periodic revision of program curricula as appropriate to their age and developmental capacity.
- Training occurs after school and during weekend hours when this meets the recipient's needs.

- Psychosocial Skills Training – Group (Youth) may only be provided in:
  - An MHR facility;
  - School; or
  - Other designated professional environment meeting all of the following requirements:
    - Consistent location for the duration of the group/series,
    - Evidence of a memorandum of understanding or other written agreement for the use and terms of the space,
    - Allows for privacy and confidentiality, and
    - Is appropriate to the age, level of need, and structure needed for the recipients.

Note: Anger management and alternatives to aggressive behavior are more appropriately addressed in Group Counseling.

This service shall not be provided at a site which serves as a group living environment, such as a board and care facility, group home or apartment building that serves as a residence for more than one MHR recipient.

The MHR staff must be present at all times during the course of the group skills training. A group recreational outing is not a billable service under Psychosocial Skills Training – Group (Youth).

Service Authorization Periods

- Interim – None
- Initial – 90 days
- Subsequent – 90 days

Non Covered Services

- Transportation (Transportation is available through the Medicaid Non-Emergency Medical Transportation (NEMT) Program not through the MHR Program.)
- Tutoring
- Social Events - i.e., attending movies, ball games, going to the park
- Assisting recipient with finding a job
- Providing recipient with childcare
- Assisting recipient with bill paying and/or grocery shopping and medication purchases

PRIOR AUTHORIZATION

The Bureau or its designee will review and approve all requests for Mental Health Rehabilitation Services to ensure that the medical necessity and level of care criteria are met. All services must be authorized prior to service delivery. Services provided without prior authorization will not be reimbursed. Requests for authorization are subject to review by the Medical Review Psychiatrist. All denied requests will be evaluated by the Medical Review Psychiatrist.

The assessment is paid retrospectively based on the eligibility of the recipient. The provider must complete an assessment and send it to the prior authorization staff for approval. If the recipient is eligible for MHR services, the assessment is approved retroactively to the date the assessment is completed and signed. A package of interim services will be approved to allow time for completion of the ISRP.

Ongoing services may be approved for a 90 day time period beginning with the date of authorization of the service. All providers should submit requests for authorization 14 days prior to the expiration of the current authorization to assure timely processing.

All information sent to the prior authorization unit is date stamped the day it is received. If information is received after 3:00 pm it is stamped the following day.

If a packet is sent to the authorization unit and information is missing (such as Social Security Number, address, signature page, etc.) the PA staff will call the provider and the recipient to let them know what information is missing. The telephone call will be documented in the MHRSIS system as a request for more information. The time of the call and the person contacted will be noted. The provider will be requested to send in the information that day. If the information is not received by the 14th calendar day after the receipt of the original request, the request will be denied.

INITIAL ASSESSMENT AND REQUEST FOR INTERIM PRIOR AUTHORIZATION PROCESS

The Licensed Mental Health Professional (LMHP) shall complete an Adult Screening Form or a Child/Adolescent Screening Form establishing the 3 D's (Diagnosis, Disability, and Duration). The recipient information is entered into MHRSIS.

If the recipient does not appear to qualify for MHR services, the provider shall refer the recipient to his/her primary care physician or community mental health clinic with copies of all available medical and social information. The referral must be documented.

If the recipient appears to qualify for services, the provider will continue with the assessment process which includes completion of the assessment, an interim ISRP, an integrated summary and completion of the LOCUS or CALOCUS.

The provider will send the following to the PA staff:

- Screening Form;
- The Assessment;
- The Integrated Summary;
- Interim ISRP;
- A Crisis Intervention Plan;
- MHRSIS Client Data Sheet;
- Cover Sheet Form; and
- E-CDI Screen Shot.

The PA staff has 14 calendar days to respond with decision.

Approval

If the assessment meets all criteria, the assessment will be approved. The approval will include the following:

- Assessment is approved back to the date the assessment was completed and signed.
- Interim ISRP begins on the date the assessment is completed and extends for 30 days from the date PA issues an approval.

Denial

An authorization request for the assessment may be denied. A denial letter is mailed to the provider and the recipient. The letter mailed to the recipient will include the right to appeal the decision.

INTERIM PRIOR AUTHORIZATION PERIOD

Once the Interim PA has been approved, the LMHP is responsible for preparing and submitting the ISRP. This plan should address the needs identified from the assessment process. The plan should be written in language which can be understood by the recipient and that is consistent with the strengths and needs of the individual. The focus of the plan is recovery.

The ISRP is submitted to the PA staff and is reviewed.

The PA staff has 14 calendar days to respond with one of the following decisions:

Approval

A Service PA for a 90 day period beginning on the date the PA staff reviews the information is authorized with services in the same types, amounts and/or frequencies as requested by the provider. If different types, amounts and/or frequencies of services are approved, the provider is issued an authorization for those services and the recipient is notified of the denial of a portion of services and given appeal rights.

Partial Denial

If different types, amounts and/or frequencies of services are approved, the provider is issued an authorization for those services that are approved and the recipient is notified and given appeal rights for those services that are changed from the requested amount.

Denial

An authorization request for the ISRP may be denied. If the request is denied, a denial letter is sent to the recipient with appeal rights. A letter is also sent to the provider.

QUARTERLY REVIEW FOR CONTINUATION OF MHR SERVICES

The quarterly review is to ensure:

- The recipient continues to meet the criteria for services;
- Services are appropriate to the needs of the recipient; and
- Services are medically necessary.

The provider must complete the following and send to the PA unit:

- The Quarterly Report Form (See Appendix);
- A copy of the ISRP. It must distinguish or identify any revisions made with brief explanations that provide clinical justification for the revisions;
- eCDI screen shot;
- The Cover Sheet Form.

OMH/MHR
Cover Sheet

A cover sheet must be attached to all requests submitted to Prior Authorization.

Submission Date: _____ Total # of pages submitted**:** _____
Recipient Social Security #:

			____			____				

Recipient Medicaid #:

Recipient Medicare # (if applicable):_____

Recipient: Last Name _____ First Name_____
DOB: ____/____/_____ Age: _____
Parish Code for Recipient: _____
AGENCY: _____ Provider #: _____
AGENCY Phone #:_____ Region: _____
Recipient Address (including zip code):_____
_____ Phone # (include area code) _____
Custody: ___parent ___relative ___friend ___OCS ___OYD
Living Setting: ___home ___therapeutic foster care ___regular foster care ___ private pay foster care ___residential care
Guardian/Parent Name: _____
Address (if different): _____
_____Phone # (if different): _____
Transfer: ___yes ___no

Name of Approved Clinical Evaluator: _____

Name of LMHP: _____

Check one of the following and submit all documents list:

____ **New Recipient Assessment-Submit the following:**
Cover Sheet
MHRSIS Data Sheet (must be entered into MHRSIS prior to submission)
Freedom of Choice List
Screening Form - 3 D's
Comprehensive Assessment
Interim ISRP
A signed copy (with the current date) of the e-CDI screen. If e-CDI data is not available, print the e-CDI screen and document at the top why the information is not available.

_____ **Initial Authorization Request (first 90 day)-Submit the following:**
Cover Sheet
Individual Service Recovery Plan (ISRP)

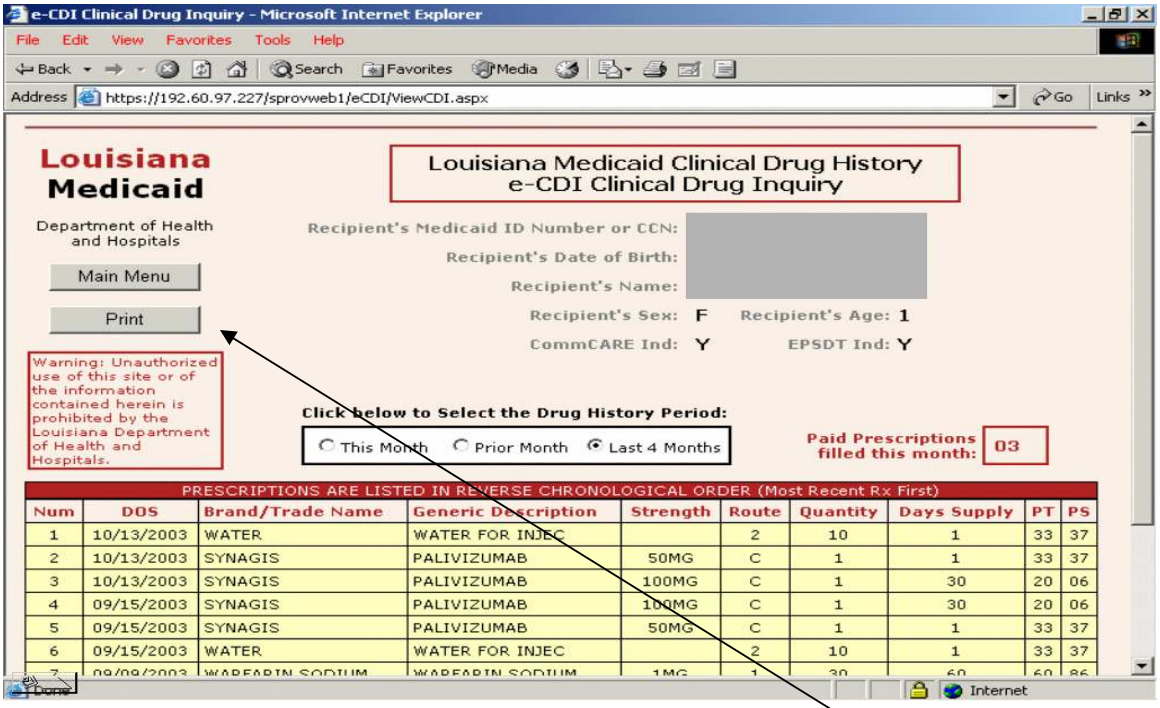
_____ **Subsequent Authorization Request-Submit the following:**
Cover Sheet
Quarterly Report
ISRP
Current LOCUS/CALCUS Rating
A signed copy (with the current date) of the e-CDI screen. If e-CDI data is not available, print the e-CDI screen and document at the top why the information is not available.

_____ **Revision Request:**
Revision Request Form
Revised ISRP
Revised Crisis Intervention/Recovery Plan
Current LOCUS/CALOCUS Rating

_____ **Additional Information as requested for Review: List:** _____

Rev. February 23, 2006

e-CDI Screen Shot



When applying for prior authorization, providers must include a signed copy with the current date of the e-CDI screen (shown above) along with the other required documentation as detailed in this document as well as in the Mental Health Rehabilitation Provider Manual.

Note the convenient **PRINT** button.

The PA staff reviews the Quarterly Report to ensure that appropriate services are delivered and that either anticipated progress is being made toward the established clinical goals or the ISRP is adjusted accordingly. This step allows the authorization staff to collect needed information to document the medical necessity of ongoing care.

The following information will be reviewed:

- The current requested services, the previous quarter's request and the amount of services delivered in the previous quarter. This comparison should reflect the ongoing need for the types and level of services.
- The number of crises or hospitalizations. A high number of crises may provide justification for a higher number of services and fewer crises may result in justification of a lower number of services.
- Symptoms and medication in comparison to the previous quarter.
- LOCUS or CALOCUS levels.
- The current and previous LOCUS/CALOCUS level to insure the levels are decreasing or that there is an explanation as to why the level has not decreased.
- The current and previous goals and objectives.

The PA staff has 14 calendar days to respond with one of the following decisions:

Approval

If the request for authorization meets the requirements stated in above, the request for services will be approved. A Service PA for a 90 day period is authorized with services in the same types, amounts and/or frequencies as requested by the provider.

Partial Denial

If different types, amounts and/or frequencies of services are approved, the provider is issued an authorization for those services that are approved and the recipient is notified and given appeal rights for those services that are changed from the requested amount.

Denial

An authorization request for continued services may be denied.

ACCESS TO EMERGENCY SERVICES

In order to assure the quality and accessibility of services to recipients with serious mental illness, a continuity of care procedure will be followed for recipients being discharged from any 24 hour care facility, when discharge is dependent upon the availability of follow-up mental health services. This may include, but is not limited to, juvenile detention facilities, psychiatric hospitals or distinct part psychiatric units.

New MHR Recipients

The provider selected by the recipient must participate in discharge planning with the facility. On the date of discharge from the 24 hour care institution, the assessment packet, if completed, must be signed and dated by the LMHP and faxed to the PA unit. The cover page must be marked, “Emergency PA” in black marker. The assessment packet includes the Cover Sheet, the MHRSIS Data Sheet, Freedom of Choice Form, the Screening Form, and the Comprehensive Assessment (which contains the Integrated Summary, Crisis Plan, Interim ISRP, Medical History and Developmental History). The discharge patient instruction form from the 24 hour care institution must be submitted to verify the date of discharge. The PA Unit will render a decision within one working day.

Established MHR Recipients

The provider must participate in discharge planning with the facility, taking care to note the expiration date of the existing authorization and submitting a new PA request or a Request for Revision on the date of discharge as appropriate. The cover page must be marked, “Emergency PA” in black marker. The discharge patient instruction form from the 24 hour care institution must be submitted to verify the date of discharge. The PA Unit will render a decision within one working day.

REQUEST FOR ADDITIONAL SERVICES

If a recipient needs additional services prior to the end of the authorization period, a Request for Revision form, an amended ISRP, an updated LOCUS/CALOCUS, and a Crisis Intervention/Recovery Plan must be submitted to the PA office.

Request for Revision Form

Documentation supporting the following criteria will be required during the Request for Revision process for all requests for units above established guidelines:

Criterion 1: ***Extraordinary or unanticipated event/circumstance.***
Documentation has been supplied that the recipient is:

a. Danger to Self
b. Danger to Others
c. At risk of displacement (i.e., psychiatric hospitalization, therapeutic out of home placement, incarceration)

Note: Supporting documentation for this criterion must include, but is not limited to revised and a verified change in LOCUS/CALOCUS.

Criterion 2: ***Two-thirds of current/active and approved PA units have been utilized.***
Documentation confirms the provider delivered 2/3 of available units under current/active PA before a request for revision has been requested. To be considered for additional units, the

Request for Revision form including a narrative justification for the request (i.e., *Why are more units needed?*) must be submitted with the following attachments:

1. Updated ISRP with specific and individualized interventions;
2. Updated LOCUS/CALOCUS with supporting documentation;
3. Updated Crisis Intervention/Recovery Plan.

Criterion 3: ***Appropriate and Medically Necessary Specialty Referrals have been made.***

If core and optional services provided under the MHR program seem insufficient to address the individualized needs of the recipient, and additional specialized needs have been identified, the provider must have made attempts to refer the recipient to those specialized services before the authorization of additional units will be considered. (Examples of such specialized service include, but are not limited to: Psychosocial Skills Training, Parent-Family Intervention (Intensive), Substance Abuse Counseling, Eating Disorder treatment, etc.

The PA staff has 14 calendar days to respond with one of the following decisions:

Approval

If the request for authorization meets the requirements stated in above, the request for services will be approved. A Service PA for the remainder of the 90 day period is authorized with services in the same types, amounts and/or frequencies as requested by the provider.

Partial Denial

If different types, amounts and/or frequencies of services are approved, the provider is issued an authorization for those services that are approved and the recipient is notified and given appeal rights for those services that are changed from the requested amount.

Denial

An authorization request for continued services may be denied for one or more of the reasons listed on the denial code list (see Appendix B).

Request for Revision Form

Additional Units Requested

	Frequency of Service:	Additional Units Request:
Service/Planning Team		
Medication Assessment, Monitoring, Education		
Medication Administration-Oral		
Medication Administration-Injection		
Counseling Bundle		
1. Individual Intervention/Supportive Counseling		
2. Parenting/Family Intervention-Counseling		
3. Group Counseling		
Counseling Bundle Total		
Parent/Family Intervention-Intensive		
Community Support		
Psychosocial Rehabilitation		
Assessment		
Name and Medicaid number of the PSR or PFII provider if different from the Mental Healthcare Home:		

LMHP Signature_____DATE_____

Instructions: Fully complete this application and submit it to Prior Authorization for review.

Attachments:

1. Updated ISRP with specific and individualized intervention;
2. Updated LOCUS/CALOCUS with supporting documentation;
3. Updated Crisis Intervention/Recovery Plan

Check all that apply

Recipient has an extraordinary or unanticipated event/circumstance. Documentation has been supplied that the recipient is (at least one of the following must be checked):

☐ A danger to self;

☐ A danger to others;

☐ The recipient is at risk for displacement (i.e., psychiatric hospitalization, therapeutic out of home placement, incarceration)

Explain each item checked:

☐ Two-Thirds of current/active units approved by PA have been utilized.

☐ Appropriate and medially necessary specialty referrals have been made but the service(s) are not available

Explain:

Describe why additional units are needed for each service identified below:

RECONSIDERATION AND APPEALS

Reconsideration

If the provider does not agree with the decision of the prior authorization unit, one reconsideration may be requested. The provider must FAX the original denial letter with RECON written across the front, including additional information, to the Office of Mental Health Prior Authorization Unit. If the case involves a dispute over the following it will be forwarded on to the psychiatrist for review:

- Medication concerns and issues of polypharmacy;
- Clinical eligibility concerns;
- Significant increase or decrease in medication management units; or
- Discrepancies between documented symptoms, history and the diagnosis.

The Medical Review psychiatrist will review the case (which could include a doctor to doctor contact with the recipient's treating physician). The PA staff will render an authorization or denial based on this review with that date as the authorization or denial date. There will be no backdating. The provider and recipient will be notified of the decision within 14 calendar days of the receipt of the request for reconsideration.

Denial/Appeal Processes

If the recipient continues to be dissatisfied with BHSF's decision, he/she may file an appeal through the DHH appeals process. The denial notice provides the recipient with the opportunity to appeal the decision. The recipient must send the request for a fair hearing to the DHH Appeals Office.

TRANSFERRING CASES

When a recipient decides to change providers during an authorization period, the provider delivering services must provide all requested documentation to the new provider upon receipt of Consent to Release Information form signed by the recipient. The authorization for the provider delivering services will be cancelled on the date the recipient notifies the PA staff they wish to change providers. This confirmation may be provided in writing or by telephone.

The new provider can be issued an Interim ISRP authorization. The provider will complete a Quarterly Report and a new ISRP for approval of ongoing services prior to the end of the 30 day interim period. A new assessment will not be approved unless authorized by the Secretary of DHH.

In cases where a provider is receiving two or more transfers at one time, such as in the case of a closing provider, the PA Unit should be contacted immediately. The following procedure can take place:

1. The PA Unit must receive the signed Freedom of Choice from the new agency. The selected agency must enter the recipient in MHRSIS and open the case prior to submitting the request.

2. The PA Unit will issue a 60 day interim authorization (instead of 30 day interim authorization) to the new agency which includes:

   4 units – Service Planning Team
   6 units – Medication Management
   32 units – Community Support (an increase from 16 units)

   These units are to be utilized while the new agency formulates the revised ISRP, Quarterly Report, and the LOCUS/CALOCUS rating. The signed e-CDI printout must also be submitted.

3. The PA Unit will end the 60 day interim authorization upon the agency's satisfactory submission of the above information. This will afford the agency the ability to prioritize the submission of packets according to the recipients' needs and give the agency time to establish rapport.

READMISSIONS

If a recipient is readmitted by a provider who had previously provided services within the past year, a new Quarterly Report and ISRP must be submitted. A new assessment will not be approved.

If the recipient has not received services for 12 months or more, the process for an initial assessment must be followed to re-determine eligibility for services.

PA CONTACT INFORMATION

OMH Prior Authorization Unit
617 North Blvd 2nd Floor
Baton Rouge, LA 70802

Phone: 225.219.1900/1901
800.558.4617 toll free (outside the Baton Rouge area)

Fax: 225.219.1905
800.558.4618(outside the Baton Rouge area)

Questions regarding PA's, approved or denied, should be directed to OMH PA Unit.

REIMBURSEMENT/BILLING

All MHR services must be prior authorized. Reimbursement for MHR services is based on fee-for-service and are billed using the hard copy CMS-1500 claim form or the electronic 837P electronic transaction.

The creation and transfer of information files and the submission of claims are related but separate processes. Each provider is responsible for submitting claims to the Bureau's financial intermediary in a timely manner.

GENERAL PROVISIONS FOR REIMBURSEMENT

Under the Mental Health Rehabilitation Program, a particular service shall be excluded from coverage if that service is determined to be the legal liability of any third party who is or may be liable to pay the expenditure for that service.

The Department will not reimburse claims determined through the prior authorization or monitoring process to be a duplicate service. Therefore, providers must not bill Medicaid for MHR services at the same time they bill another funding source for the same service or when a recipient is admitted to an institution or hospital. Such claims will be denied and may be considered fraud and referred to the Program Integrity Section for further action.

Information Transfer/Billing Schedule

To ensure the timely payment of claims, the procedures outlined below should be followed:

- Enter data on MHRSIS daily.
- Create and send an information file daily before 4:30 p.m. to Statistical Resources, Inc. If a file is received after 5:00 p.m., it will not be processed until the next business day.
- Bill for services at least two working days after submission of information to SRI.

Documentation Requirements

Payment decisions are often made based on information contained in the recipient's record. If these records are not properly documented, incorrect payments may be made and overpayments will be recouped. In some cases providers may be investigated for fraudulent billing.

Proper documentation for MHR services includes:

- Documentation of eligibility for MHR services.
- The MHR Assessment and any Quarterly Reports.
- The ISRP which includes specific goals and objectives that are individualized and developed using SMART criteria (Specific, Measurable, Attainable, Realistic, and Time Limited).
- eCDI screen shot.

Service logs for services provided which relate to the ISRP and are deemed medically necessary.

Procedure Codes/Modifiers

The following codes are used to request prior authorization and to bill for payment consideration.

Service	Unit	Rates	Modifier	Code	Staff who can Perform the Service
Service Planning Team	15 minutes	$ 23.12	None	H0032	Performed by a Team (all credentialed staff can participate-only LMHP may bill.)
Med Assmt, Monitoring and Education	15 minutes	$ 33.12	None	90862	Psychiatrist, APRN, RN
Med Administration, oral	Per Contact	$ 3.23	None	H0033	Psychiatrist, APRN, RN, LPN
Injection	Per Contact	$ 3.23	None	90782	Psychiatrist, APRN, RN, LPN
Individual Intervention/ Supportive Counseling	15 minutes	$ 18.77	HR	H0004	LMHP, MHP
Group Counseling	15 minutes	$ 8.49	HQ (group setting)	H0004	LMHP, MHP
Parent Family Intervention – Counseling	15 minutes	$ 18.77	HR (client present), HS (client not present)	H0004	LMHP, MHP
Parent Family Intervention – Intensive	15 minutes	$ 25.29	None	H2021	Team includes LMHP & either 2 MHP, or 1 MHP and 1 MHS
Community Supports	15 minutes	$ 14.69	HO (Master's degree) None	H2015	LMHP, MHP
	15 minutes	$ 8.81	None		MHS
PSR Skills Training Group	15 minutes	$ 3.63	None	H2014	LMHP, MHP, MHS
Assessment	Per service	$154.56	None	H0031	LMHP (in conjunction with any of the following: Psychiatrist, APRN, LCSW, Psychologist, LPC)

CLAIMS FILING

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) or through REVS or e-MEVS. **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 e-MEVS, MEVS or REVS.
3.	SITUATIONAL	Enter the recipient's date of birth as reflected in the current Medicaid information available through e-MEVS, 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—jmake 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 lock-in physician's name.
17A.	SITUATIONAL	If the recipient is linked to a Primary Care Physician (PCP) and the service requires a referral, the PCP 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. **MHR Service Code Options:** **03 – School** **11 – Office** **12 – Home** **99 – Other**
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 the 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	Leave blank.

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 the recipient has TPL then the amount the other insurance paid should be entered here – even if the amount is $0.00. Additionally, block 9A should also be completed.
30.	SITUATIONAL	If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from 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.

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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): **1234999999999**

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

3. PATIENT'S BIRTH DATE: **04 01 1995** SEX: M | F X

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **6 digit TPL number here, if applicable**

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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. **31381**
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: **1234567**

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 **04 01 06 04 01 06**	**11**		**H0004**	**HR**	**1**	**37 54**	**2**				
2											
3											
4											
5											
6											

Amount other insurance paid, if applicable.

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 54**

29. AMOUNT PAID $

30. BALANCE DUE $ **37 54**

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 **4/15/06**

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 #

MHR's R US
123 Happy St
Anywhere, LA 70000

PIN# GRP# **1234567**

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CHILD EXAMPLE

(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

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): **1234999999999**

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

3. PATIENT'S BIRTH DATE: **09 14 1960** SEX: M X 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: **6 digit TPL number here, if applicable**

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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. **3017**
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: **1234567**

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 01 06 03 01 06	11		H2014		1	188 76	52				
2 03 01 06 03 01 06	11		H2015		1	44 05	5				
3											
4											
5											
6											

Amount other insurance paid, if applicable.

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 $ **232 81**

29. AMOUNT PAID $

30. BALANCE DUE $ **232 81**

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 #

MHR's R US
123 Happy St
Anywhere, LA 70000

PIN# GRP# **1234567**

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

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

ADULT EXAMPLE

ADJUSTMENT/VOID CLAIMS

Claims paid on the CMS-1500 form are adjusted or voided using the Unisys 213 adjustment/void form. These may be ordered from Unisys at no cost.

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:

1. A claim is paid on the RA dated 7-15-05, ICN 5170567890123.
2. The claim is adjusted on the RA dated 8-19-05, ICN 5200590123456.
3. If the claim requires further adjustment or needs to be voided, only ICN 5200590123456 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 88.

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).

INSTRUCTIONS FOR FILING ADJUSTMENT/VOID CLAIMS

*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

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

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

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

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

3 PATIENT'S DATE OF BIRTH: **9/14/1960**

4 MEDICAID ID NUMBER: **1234999999999**

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

TELEPHONE NO.

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

7 INSURED'S NAME

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

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

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

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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

14 DATE FIRST CONSULTED YOU FOR THIS CONDITION

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

16 DATE PATIENT ABLE TO RETURN TO WORK

17 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 18A REFERRING ID NUMBER

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 **301.7**
2
3

23 ATTENDING NUMBER

24 PRIOR AUTHORIZATION NO. **437985629**

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 $
03	01	06	03	01	06	11	H2014	1	174 24	48		

26 CONTROL NUMBER: **6091507890100**

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: **12/24/06**

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

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

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 *14/20/06*

32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
MHR's R US
123 Happy St
Anywhere, LA 70000 **1234567**

FISCAL AGENT COPY

UNISYS - 213
5/97

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

3 PATIENT'S DATE OF BIRTH

4 MEDICAID ID NUMBER

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

TELEPHONE NO.

6 PATIENT'S SEX
MALE ☐ FEMALE ☐

7 INSURED'S NAME

8 PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

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

10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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

14 DATE FIRST CONSULTED YOU FOR THIS CONDITION

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

16 DATE PATIENT ABLE TO RETURN TO WORK

17 DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18A REFERRING ID NUMBER

19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

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

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

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

23 ATTENDING NUMBER

24 PRIOR AUTHORIZATION NO.

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

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

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

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

ADJUSTMENT

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

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

32 YOUR PATIENT'S ACCOUNT NUMBER

UNISYS - 213
5/97

FISCAL AGENT COPY

ELECTRONIC DATA INTERCHANGE (EDI)

Claims Submission

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

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

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

Certification Forms

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

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

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

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

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

Electronic Data Interchange (EDI) General Information

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

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

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

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

- Case Management Services.
- Non-Ambulance Transportation.

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

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

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

Enrollment Requirements For EDI Submission

- **Submitters wishing to submit EDI 837 transactions without using a Third Party Biller** - complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS** (EMC Contract).

- **Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse** – complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS** (EMC Contract) **and** a Limited Power of Attorney.

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

Enrollment Requirements For 835 Electronic Remittance Advices

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

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

- To request 835 Transactions – Electronic Remittance Advice, contact Unisys EMC Department at (225) 216-6000 ext. 2.

Electronic Adjustments/Voids

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

SUBMISSION DEADLINES
Regular Business Weeks

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

Thanksgiving Week

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

Important Reminders For EMC Submission

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

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

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

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

HARD COPY REQUIREMENTS

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

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

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

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, and
- 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, and
- 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 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.

RECORD KEEPING

All provider records must be maintained in an accessible order and standardized format at the MHR enrolled office site. The provider must have adequate space, facilities, and supplies to ensure effective record keeping.

- The provider must keep sufficient records to document compliance with the Bureau's requirements for the MHR recipients.
- A separate MHR record must be maintained on each recipient that fully documents services for which payments have been received. The provider must maintain sufficient documentation to enable the Bureau to verify that each charge is legitimate prior to payment.

RETENTION OF RECORDS

The provider must retain records for five years from the date of the last payment with one exception: If the provider is being audited, records must be retained until the audit is complete and all questions have been answered, even if the five years is exceeded.

Note: Upon agency closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements. The Bureau must be notified of the location of the records.

Confidentiality and Protection of Records

Administrative and recipient records must be the property of the provider. Records must be secured against loss, tampering, destruction or unauthorized use in accordance with HIPAA regulations.

Employees must not disclose or knowingly permit the disclosure of any information concerning the provider, the recipients or their families, directly or indirectly, to any unauthorized person.

MONITORING

The Office of Mental Health (OMH) staff conducts on-site reviews of each provider. These reviews are conducted to monitor the provider's compliance with:

- The Bureau's provider enrollment and participation requirements;
- Applicable state and federal regulations;
- Continued capacity for service delivery; and
- Quality and appropriateness of services provided.

All records, including but not limited to administrative records, quality improvement plan, personnel records, and a sample of the recipient records are reviewed as well as provider billing. Providers are also monitored regarding the recipient's access to needed services and may include the following:

- Quality of assessment and service planning;
- Appropriateness of MHR services provided;
- Intensity of services;
- Frequency of the recipients' input and satisfaction regarding the services;
- The achievement of the recipient's prioritized goals and objectives;
- Provision of a needed service or referral to an appropriate service provider.

The Bureau's staff is available to answer questions regarding the interpretation of MHR policy. A provider's failure to follow the Bureau's policies and procedures as outlined in the MHR Rule, MHR Medicaid Provider Manual, and any other notices or directives issued by the Bureau or its designee may result in recovery of Medicaid payments, administrative sanctions and may result in state and/or federal investigation and prosecution in cases of fraud. It is the responsibility of the provider to be knowledgeable regarding the policies and procedures governing MHR services and to be aware of all revisions issued by the Bureau. Providers must also adhere to all internal policies and procedures and those of the accrediting body.

ADMINISTRATIVE SANCTIONS

To ensure the quality of services in the Mental Health Rehabilitation program, the following administrative sanctions may be imposed against any provider that does not meet the requirements as established in laws, rules, regulations or policies. This section further explains and outlines the administrative actions and sanctions as they apply to any provider of MHR services. This listing, in combination with those listed in Chapter 6 of the Medicaid Provider's Manual, should be carefully reviewed by any provider providing MHR services. This is not an all inclusive listing.

LEVELS OF ADMINISTRATIVE SANCTIONS

The following sanctions may be applied to any provider independently, consecutively and/or collectively. These sanctions may be imposed in addition to those sanctions cited in the Surveillance and Utilization Systems (SURS) rule, LAC 50:1 Chapter 41 (Louisiana Register, Volume 29, Number 4).

- The provider's staff may be required to complete education and training, including training in MHR policy and billing procedures provided by DHH. The provider may also be required to obtain other education or training relevant to providing quality MHR services, such as psychosocial skills training, individual counseling, etc. which DHH will not provide.
- Payments for services rendered may be suspended or withheld until program compliance is verified by DHH.
- The provider may be terminated and all service authorizations will be canceled. Terminated providers, including all of the owners, officers, or directors may not apply for certification as an MHR provider for a period of up to five years. The provider shall cooperate with DHH in assisting the recipient in continuing MHR services with another provider.
- New requests for authorization may be suspended.
- The provider's current recipients shall be transferred to another provider if the Bureau determines that recipient health and safety are compromised. Recipients have freedom of choice regarding the selection of service providers.

Note: In the absence of an available provider, the recipient may be referred an alternate treatment resource.

Note: Health and safety issues will be resolved on a case-by-case basis by Departmental personnel making a determination after examining the circumstances surrounding each particular event or finding. The Department is allowed the flexibility to fully explore any and all circumstances surrounding each unique situation to ensure that the well-being of the recipient and the integrity of the Medicaid Program are protected.

GROUNDS FOR SANCTIONING PROVIDERS

The following are grounds for sanctioning of a Mental Health Rehabilitation (MHR) provider:

- Failure to comply at all times with any and all certification, administrative, accreditation, training or operational requirements at any time;
- Failure to provide the full range of services specified in the ISRP;
- Failure to uphold recipient rights when a violation may or could result in harm or injury;
- Failure to notify proper authorities of all suspected cases of neglect, criminal activity, or mental or physical abuse which could potentially cause, or actually cause harm to the recipient;
- Failure to maintain adequate qualified staff to provide necessary services;
- Failure to adequately document that services that were billed were actually performed;
- Failure of subcontractors to meet all required standards;
- Failure to fully cooperate with a DHH survey or investigation including but not limited to failure to allow DHH staff entry to the MHR provider's or subcontractor's offices or denial of access to any requested records during any survey or investigation;
- Failure to comply with all reporting requirements in a timely manner;
- Failure to provide documentation upon request from DHH or its designee, that verifies compliance with any or all requirements as set forth in this policy;
- Failure to comply with any or all federal or state regulations or laws applicable to either the Mental Health Rehabilitation Program or the Medical Assistance Program;
- Failure to protect recipients from harmful or potentially harmful actions of provider's employees or subcontractors; including but not limited to health and safety, coercion, threat , intimidation, solicitation and harassment;
- Failure to remain fully operational at all times for any reason other than a disaster;
- If in a one year period, the frequency pattern or nature of valid complaints filed against a MHR provider are substantiated;
- An owner or provider staff member knowingly, or with reason to know, makes a false statement of material fact in the:
  - Application for enrollment,
  - Data forms,
  - Recipient's record,
  - Any matter under investigation by the Department, or
  - Certification/recertification or accreditation process;
- If a provider uses false, fraudulent or misleading advertising;
- If any MHR provider fails to disclose a conviction for a criminal offense by a person who has ownership or controlling interest in the provider agency, or by a person who is an agent or managing employee of the provider; or
- If the facts as determined by the Department indicate a failure to provide optimum care in accordance with current standards of practice.

NOTICE AND APPEAL PROCEDURE

A provider that contests any adverse action taken by the Bureau may appeal such action by submitting a written request for an appeal to the Department's Bureau of Appeals. The request must be received by the Bureau of Appeals within 30 days of the provider's receipt of the written notification of the Department's action. The appeal request must specify, in detail the reasons for the appeal and state the reasons why the provider contends that it is aggrieved by the Department's action. The appeal should be sent to the following address:

Department of Health and Hospitals
P O Box 4183
Baton Rouge, LA 70821-4183

Sanctions in the form of a termination based on fraud and/or abuse or health and safety shall take effect immediately upon notice by the Department.

Except in cases involving Program Integrity issues where fraud or abuse is at issue, a sanctioned MHR provider who has timely filed an appeal shall be allowed to accept new recipients during the appeals process, unless the appeal is delayed beyond 90 days due to action on the part of the provider. If the appeal is delayed beyond 90 days due to action on the part of the provider, the provider may be prohibited from taking on new recipients until a ruling on the appeal has been issued.

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, 8 am-5 pm

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

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 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.

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

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

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

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

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

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

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

DHH PROGRAM MANAGER REQUESTS

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

Program Manager - (i.e. DME, Hospital, etc.)
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.

NOTE: Providers should not give their provider 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.

LOUISIANA MEDICAID WEBSITE APPLICATIONS

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

www.lamedicaid.com

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

Provider Login And Password

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

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

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

Web Applications

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

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

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

e-MEVS:

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

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

e-CSI:

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

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

e-CDI:

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

The nine (9) clinical services information components are:

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

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

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

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

e-PA

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

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

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

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

Reminders:

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

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

PA Type 05: Providers must always submit the 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 and CommunityCARE– (program information, provider listings, Frequently Asked Questions)

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

www.dhh.state.la.us/offices/?ID=105: 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

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.