UNISYS

HOME HEALTH PROVIDER TRAINING

Spring 2006

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

ABOUT THIS DOCUMENT

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

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

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

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS
FOR CHILDREN AND YOUTH

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

MR/DD MEDICAID WAIVER SERVICES

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

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

SUPPORT COORDINATION

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

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

MENTAL HEALTH REHABILITATION SERVICES

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

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

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

EPSDT/KIDMED EXAMS AND CHECKUPS

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

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

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

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

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

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

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

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

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

OTHER MEDICAID COVERED SERVICES

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

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

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

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

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

METROPOLITAN HUMAN SERVICES DISTRICT
1010 Common Street, 5th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

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

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

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

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

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

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

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

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

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

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STANDARDS FOR PARTICIPATION

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

- Provider agreement and enrollment with the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH);

- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;

- Agreement to accept as payment in full the amounts established by the BHSF and refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.

- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services;

- **NOTE: Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, or the state Attorney General's Medicaid Fraud Control Unit.**

- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1978*, and, where applicable, *Title VII of the 1964 Civil Rights Act*.

Picking and Choosing Services

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

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

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

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

Statutorily Mandated Revisions to All Provider Agreements

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

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

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

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

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

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

Surveillance Utilization Review

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

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

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

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

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

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

Fraud and Abuse Hotline

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

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

HOME HEALTH SERVICES

Description Of Services

Medicaid will make payment for home health services only when the services are ordered by a licensed physician who certifies that the recipient meets the medical criteria to receive the services in the home.

Medicaid will make payment for the listed Home Health Services:

1. Intermittent or part-time nursing services furnished by a Home Health Agency;

2. Personal care services provided by a Home Health Agency in accordance with the plan of treatment recommended by the attending physician;

3. Physical Therapy, Speech Therapy, Occupational Therapy services provided by a Home Health Agency;

4. Medical Supplies recommended by the physician as required in the care of the recipient and suitable for use in the home are covered under the DME program when approved by the Prior Authorization Unit.

The Home Health Services listed above are payable by Medicaid only if the providing agency has been specifically Medicare approved to provide the services by the Office of Licensing and Certification.

Home Health Services are payable by Medicaid only if the service is provided in the patient's home or place of residence. The recipient's place of residence cannot be a hospital or nursing home. The attending physician must certify that the recipient meets the medical criteria to receive the services in the home, and is in need of the Home Health Services on an intermittent basis. This certification must be maintained on file at the Home Health Agency along with the physician's plan of care for the recipient. The plan of care must be reviewed by the physician at least every sixty (60) days.

Aide Services Only

In some situations a Medicare/Medicaid recipient requires only home health aide visits. Medicare will not pay for this service unless skilled services (skilled nurse service, physical therapy, occupational therapy, or speech pathology) are also required. However, Medicaid will pay for aide visits if only aide visits are required. It is not a Medicaid requirement that skilled services be ordered as a prerequisite to receive home health aide services. Payment is made in accordance with stated program limitations.

Evaluation Of Aides

In the December 2001 issue of the Louisiana Register, Health Standards published their Minimum Standards for Home Health agencies. Included was a change regarding Supervision of Aides. Periodic on site supervision with the home health aide present shall be established as part of the agency's policies and procedures. If the patient is receiving a skilled service (nursing, physical therapy, occupational therapy, or speech-language pathology), the supervisory visits shall be made to the patient's residence at least once every two weeks (not to exceed 20 days) by the RN or appropriate therapist to assess relationships and determine whether goals are being met. If the patient is not receiving skilled services, an RN must make a supervisory visit to the patient's residence at least once every 62 days. In order to ensure that the aide is properly caring for the patient, the supervisory visit must occur while the home health aide is providing patient care. **Medicaid should not be billed for the supervisory visit since a service is not being provided to the recipient.**

Physical Therapy Assistants

According to Health Standards Minimum Standards for Home Health, Physical Therapy Assistants (PTA) must be currently licensed by the Louisiana State Board of Physical Therapy Examiners and must be supervised by a licensed physical therapist. The PTA must have, at a minimum, one year of experience as a licensed PTA before assuming responsibility for a home health caseload. The PTA's duties shall not include interpretation and implementation of referrals or prescriptions, performance evaluations, or the determination of major modifications of treatment programs.

Home Health Agency Service Limits For Visits

- **Under age 21:** There are no annual service limits for recipients under the age of 21. Multiple, same day visits may be allowed when medically necessary with prior approval from the Unisys Prior Authorization Unit.

- **Age 21 or older:** Medicaid will reimburse only one visit per day and 50 visits per calendar year for each recipient. Absolutely **NO EXCEPTIONS will be made**.

- Home Health visits and rehabilitation visits can be performed on the same day but not at the same time. However, please remember therapy services must be prior authorized and recipients 21 and older are limited to 50 home health nurse/aide visits per calendar year.

Responsibilities Of The Home Health Agency

All providers are responsible for filing the correct billing codes on a claim. If an LPN provided services, the provider must submit the appropriate LPN code for payment. Likewise, if an RN delivers the service, the claim must identify the code associated with the appropriate service. Home Health providers should perform a self-audit to identify claims paid incorrectly and report any overpayments to Program Integrity. All providers are responsible in assuring that your professional employees (ex. RNs, LPNs, Aides, etc.) are only practicing within the limitations established by their licensing boards.

The home health agency must provide to the bureau upon request the supporting documentation used to document medical necessity criteria (i.e. MD script, etc.) which must be met in order to receive home health services.

The home health agency must report a complaint of abuse or neglect of home health recipient(s) to the appropriate authorities if the agency has knowledge that a minor child, or a nonconsenting adult or mentally incompetent adult, has been abused or is not receiving the proper medical care due to neglect or lack of cooperation on the part of the legal guardians or caretakers. This includes knowledge that a patient is routinely being taken out of the home by a legal guardian or caretaker against medical advice, or when it is obviously medically contraindicated.

HOME HEALTH NURSE/AIDE VISITS

NOTE: For procedure codes G0154 and G0156 Medicaid defines 1 Unit = 1 Visit.

Description	REV Code Options ***	New Standard Code	Description	Fee Per Unit
Skilled Nursing Care-RN (Initial Visit)	550 551 580 581	G0154** plus Modifier of TD	Services of Skilled Nurse in Home Health Setting, each 15 min. **Note:** Although the CPT code book indicates 15 min. is equal to one (1) unit, **per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes.**	$68.65
Home Health Aide (Initial Visit)	570 571	G0156**	Services of Home Health Aide in Home Health Setting, each 15 min. **Note:** Although the CPT code book indicates 15 min. is equal to one (1) unit, **per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes.**	$24.38
Skilled Nurse Hourly Charge	552 582	S9123* S9124*	Nursing Care, in the Home; by Registered Nurse (RN), per hour (Only code to be used when reporting extended hours) Nursing Care, in the Home; by Licensed Practical Nurse (LPN), per hour (Only code to be used when reporting extended hours)	$24.50 $24.50
Nurse Visits After Initial-RN-Multiple Visits	550 551 580 581	G0154** plus Modifier of TD	Services of Skilled Nurse in Home Health Setting, each 15 min. **Note:** Although the CPT code book indicates 15 min. is equal to one (1) unit, **per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes.**	$68.65

Description	REV Code Options ***	New Standard Code	Description	Fee Per Unit
Aide Visits After Initial Visit	570 571	G0156**	Services of Home Health Aide in Home Health Setting, each 15 min. **Note:** Although the CPT code book indicates 15 min. is equal to one (1) unit, **per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes.**	$24.38
Skilled Nursing Care-RN/Multiple Recipients	550 551 580 581	G0154** plus Modifier of TD and TT~	Services of Skilled Nurse in Home Health Setting, each 15 min. **Note #1:** Although the CPT code book indicates 15 min. is equal to one (1) unit, **per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes.** **Note #2: TD modifier must be appended first.**	$34.32
Skilled Nursing Hourly Rate-Multiple Recipients	552 582	S9123* plus Modifier of TT S9124* plus Modifier of TT	Nursing Care, in the Home; by Registered Nurse (RN), per hour (Only code to be used when reporting extended hours for multiple recipients in the same home) Nursing Care, in the Home; by Licensed Practical Nurse (LPN), per hour (Only code to be used when reporting extended hours for multiple recipients in the same home)	$12.25 $12.25
Skilled Nursing Care-LPN (Initial Visit)	550 551 580 581	G0154** plus Modifier of TE	Services of Skilled Nurse in Home Health Setting, each 15 min. **Note:** Although the CPT code book indicates 15 min. is equal to one (1) unit, **per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes.**	$54.92

Description	REV Code Options ***	New Standard Code	Description	Fee Per Unit
Nurse Visit After Initial-LPN-Multiple Visits	550 551 580 581	G0154** plus Modifier of TE	Services of Skilled Nurse in Home Health Setting, each 15 min. **Note:** Although the CPT code book indicates 15 min. is equal to one (1) unit, **per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes.**	$54.92
Skilled Nursing Care-LPN/Multiple Recipients	550 551 580 581	G0154** plus Modifier of TE and TT~	Services of Skilled Nurse in Home Health Setting, each 15 min. **Note #1:** Although the CPT code book indicates 15 min. is equal to one (1) unit, per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes. **Note #2: TE modifier must be appended first.**	$27.46

Valid Home Health Procedure Modifiers For Nurse and Aide Services:

TD = RN
TE = LPN
TT = Multiple Recipients

*** Requires Prior Authorization**

**** Prior Authorization is only required for more than one service per day.**

***** When multiple revenue codes are listed, please choose the most appropriate revenue code from the options listed.**

~ When billing G0154 for MULTIPLE recipients, the TD or TE modifier must be the first modifier followed by modifier TT as the second modifier.

*****REVENUE CODE DESCRIPTIONS**

Revenue Code	Description
550	HH/Skilled Nurse/Other
551	HH/Skilled Nurse/Visit
552	HH/Skilled Nurse/Hourly
570	Aide/General
571	Aide/Visit
580	HH/Other/General
581	HH/Other/Visit
582	HH/Other/Hourly

HOME HEALTH VISITS REQUIRING PRIOR AUTHORIZATION FOR NURSE/AIDE SERVICES

Extended nursing care or multiple visits are covered for children under the age of 21. All extended/multiple visits require prior authorization.

These services cannot be authorized for patients 21 and older.

Extended Nursing Care

Prior authorization is required for **all extended hours**.

A completed PA-07 is submitted to the PAU indicating the total number of hours needed for the requested period of time.

When billing for extended nursing visits use the appropriate procedure code for the specified date of service on one claim line and indicate the total number of hours in the units column (Form Locator 46 on the UB-92 Form).

Multiple Visits

Service limits allow for one initial visit and three additional visits per day **with prior authorization required after the initial visit.**

A completed PA-07 is submitted to the PAU indicating what additional visits are being requested for the same date of service.

When billing for multiple visits, the initial and follow up visits by the nurse/aide are entered on one claim line of the UB-92 claim form with the total number of visits (units) indicated in Form Locator 46 on the UB-92 Form.

Example:

Jane Doe needs a registered nurse to visit her three times a day. She will need these services from December 15, 2005 through January 15, 2006.

A PA-07 is completed by the provider requesting approval for the two additional visits a day, and submitted to the PAU. Documentation needed to substantiate the medical necessity of the additional visits is sent with the request. The request is approved and the 9-digit PA number to be used when billing is issued by the PAU.

The claim is completed by the provider with the 9-digit PA number in the appropriate field (hardcopy or EMC). **The initial and follow up visits by the registered nurse are entered on one claim line of the UB-92 claim form with a unit of 3.** Each additional date of service should be entered on a subsequent claim line of the UB-92 claim form.

Each different kind (i.e. LPN, Aide, RN) of visit must be billed on a separate line for each date of service. Please be sure to use the correct procedure code and modifier (if applicable) for each line item.

☛ **Please be sure to enter the correct PA number for the dates of service billed in the appropriate field on the claim form. Only one PA number may be entered per claim form. Use of an incorrect PA number will cause the claim to deny.**

- ☞ **PROVIDERS ARE RESPONSIBLE FOR OBTAINING PRIOR AUTHORIZATION FOR EXTENDED NURSING CARE AND/OR MULTIPLE VISITS. IT IS THE PROVIDERS' RESPONSIBILITY TO BILL ONLY FOR THOSE SERVICES RENDERED AND FOR WHICH PRIOR AUTHORIZATION HAS BEEN OBTAINED.**

Prior Authorization Form – Initiated Hard Copy

The PA07 form used when requesting Prior Authorization for multiple or extended visits is provided in this training packet and can also be found on the www.lamedicaid.com website.

The completed PA-07, along with all necessary documentation to substantiate the medical necessity of the requested services, must be submitted to the Unisys Prior Authorization Unit (PAU), either at fax number (225) 237-3342, or at the following address:

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

Home Health Toll-Free Number: 1-800-807-1320

After the review process has been completed and the request has been approved or denied, the home health agency and the recipient will receive written notification informing them of the determination. When requests are approved, a **9-digit prior authorization (PA) number** will be issued **within 10 working days** and a letter containing the PA number will be mailed to the provider.

Electronic Prior Authorization (e-PA)

A system for requesting prior authorization electronically has been developed. 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. With this web application, following the electronic submission, providers are required to fax all necessary documentation to substantiate the medical necessity of the requested service to the fax number listed in the user guide for e-PA on the www.lamedicaid.com website under the user guide link in forms/files/user guides. Providers who do not have access to a computer and/or fax machine will not be able to utilize the web application. However, prior authorization requests will continue to be accepted and processed using the current PA hard-copy submission methods.

NOTE: Reconsideration requests cannot be accepted via the e-PA web application and should be submitted using the existing process.

PA-07 Blank Form

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

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

P.A. NUMBER

FAX TO: (225) 237-3342

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)	RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)	Social Security No. (3)
06 - Home Health Services	RECIPIENT LAST NAME FIRST MI (4)	DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)	SERVICE TREATMENT PLAN (7) BEGIN DATE (MMDDYYYY)	END DATE (MMDDYYYY)	IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES (8) ____ YES ____ NO	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (9)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (10) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (11)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (12)	MODIFIERS (12A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (12B)	REQUESTED UNITS (12C)	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)

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

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

(15) PROVIDER SIGNATURE: _____

(16) DATE OF REQUEST: _____

PA-07 FORM

PA-07 Sample Form

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

P.A. NUMBER

FAX TO: (225) 237-3342

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)	RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)	Social Security No. (3)
06 - Home Health Services	8 0 6 0 7 0 5 0 3 0 0 0 9	987 65 4321
	RECIPIENT LAST NAME: Brown / FIRST: Leroy / MI (4)	DATE OF BIRTH (5): 06 03 1994

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)	SERVICE TREATMENT PLAN (7) BEGIN DATE (MMDDYYYY)	END DATE (MMDDYYYY)	IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES (8)	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE
1 4 1 2 3 4 5	12 10 2005	06 10 2006	X YES ____ NO	

DIAGNOSIS : (9)
PRIMARY CODE & DESCRIPTION
78001 Coma
SECONDARY CODE & DESCRIPTION
3499 Disorder of Nervous System

PRESCRIPTION DATE (10) (MMDDYYYY): 12 10 2005

STATUS CODES: 2 = APPROVED 3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (11) Dr. Mike Johnson

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (12)	MODIFIERS (12A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (12B)	REQUESTED UNITS (12C)	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)
S9123					Skilled Nurse (RN) Hourly Charge	2184					

(13)
PROVIDER NAME: CM Home Health Inc.
ADDRESS: 123 M & M Ave.
CITY: Patterson STATE: LA ZIPCODE 71111
TELEPHONE: (225) 555 3825 FAX NUMBER: (225) 555 9680

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

(15)
PROVIDER SIGNATURE: *Claire Belle*

(16)
DATE OF REQUEST: *12/17/05*

PA-07 FORM

Instructions For Completing Prior Authorization Form (PA-07)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS.

FIELD NO. 2	ENTER RECIPIENT'S 13 DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER
FIELD NO. 3	ENTER THE RECIPIENT'S SOCIAL SECURITY NUMBER
FIELD NO. 4	ENTER THE RECIPIENT'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON RECIPIENT'S MEDICAID CARD
FIELD NO. 5	ENTER THE RECIPIENT'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)
FIELD NO. 6	ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER
FIELD NO. 7	ENTER THE FIRST DAY THE SERVICE IS REQUESTED TO START AND THE LAST DAY OF SERVICE FOR THAT INDIVIDUAL TREATMENT PLAN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)
FIELD NO. 8	PLACE A CHECK MARK IN THE 'YES' OR 'NO' BOX TO INDICATE WHETHER OR NOT THE RECIPIENT IS CURRENTLY RECEIVING SERVICES
FIELD NO. 9	ENTER THE NUMERIC ICD9-DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION
FIELD NO.10	ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY YYYY=YEAR)
FIELD NO.11	ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES
FIELD NO.12	ENTER HCPCS CODE
FIELD NO.12A	ENTER THE CORRESPONDING MODIFIER (WHEN APPROPRIATE)
FIELD NO.12B	ENTER THE HCPCS CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED
FIELD NO.12C	ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN, CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY (4 UNITS = 1 HOUR) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS REQUESTED (TAKEN FROM THE SERVICES TREATMENT DATES (FIELD NO. 7 ABOVE). THIS WILL GIVE THE TOTAL UNITS REQUESTED. EXAMPLE: 11 HOURS PER DAY, 7 DAYS PER WEEK, 26 WEEKS = 11 X 4 = 44 X 7 X 26 WEEKS = 8, 008

FIELD NO.13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE

FIELD NO 14 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE OF THE RECIPIENT'S CASE MANAGER, IF AVAILABLE

FIELD NO.15 PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.

FIELD NO.16 DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF THIS FIELD IS NOT DATED

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

HOME HEALTH TOLL-FREE NUMBER IS 1-800-807-1320

HOME HEALTH PRIOR AUTHORIZATION FAX NUMBER IS 1-225- 237-3342

CHRONIC NEEDS CASES

To Durable Medical Equipment (DME), Home Health, PCS, and Rehabilitation Services Providers

BHSF is pleased to announce minor changes to the Prior Authorization process for the above listed services. The Prior Authorization staff will begin designating some recipients as Chronic Needs Cases. These are recipients for whom prior authorized services are continuous and expected to remain at current levels based on their medical condition. Once a recipient is deemed to be a Chronic Needs Case, providers **must only submit a PA request form accompanied by a statement from a physician that the recipient's condition has not improved and the services currently approved must be continued at the approved level.** This determination only applies to the services approved on the affected authorized service to remain at the approved level. Request for an increase in these services will be treated as a traditional PA request and is subject to full review.

The staff and Unisys will identify these cases when reviewing requests for services and will notify both the provider and the recipient on the approval letter. The approval letter will give directions for future requests involving those services.

Previously, DME was excluded from being eligible for these services, however, the Department has decided to include DME services.

Should a recipient be deemed as a chronic needs case, the prior authorization that is generated will contain the following text messages:

822 – THIS RECIPIENT HAS BEEN DEEMED AS A "CHRONIC NEEDS CASE". WRITE "CHRONIC NEEDS CASE" ON TOP OF NEXT P.A. REQUEST

823 – SUBMIT ONLY P.A. FROM & DOCTORS STATEMENT STATING CONDITION OF PATIENT HAS NOT CHANGED.

REMINDERS FOR PRIOR AUTHORIZATION (PA) FOR MULTIPLE VISITS OR EXTENDED HOURS

- Providers should include their telephone number on the PA-07 before submission. This will enable the PA department to contact providers if there are any questions.
- The Plan of Care must be signed and dated by the Physician and Home Health Agency.
- For extended hours and multiple visits, the doctors' letter of medical necessity must be on their letterhead justifying the number of hours or additional visits they are requesting. This should also be signed and dated.
- PA will not authorize extended hours and multiple visits on the same recipient, same date of service.
- Home Health services can be approved for up to 6 months.
- If a patient has private insurance, this information should be given with the PA-07 to the Prior Authorization Unit. The private insurance should provide a letter indicating the number of hours per day as well as the cap amount they have allowed. This information must be attached to the PA-07 request.
- When requesting prior authorization for extended skilled nursing services codes S9123 (RN) and S9124 (LPN) should be used. The only time an agency needs to use a modifier is if there are multi-recipients. At that time, the agency would request and bill a TT modifier. PA requests will be denied if any modifier other than TT is requested.
- When requesting prior authorization electronically through e-PA providers should indicate the correct type, i.e. Home Health (for extended and multiple visits), Rehabilitation (for therapy requests). If the incorrect PA type is indicated the prior authorization will be denied.

Instructions For Submitting A Reconsideration

1. Write the word Reconsideration across the top of the denial letter. Write the reason for the request for the reconsideration at the bottom of the letter.
2. Attach all of the original documentation, as well as any additional documentation or information which supports medical necessity, to the letter.

Mail the letter and all documentation to the Prior Authorization Unit at Unisys.

RECONSIDERATION EXAMPLE: A reconsideration MUST be submitted when a recipient switches from one provider to another in mid treatment. There will be a problem with authorizing the second provider if the first provider already has authorization for the dates in question. The first provider must submit a reconsideration giving the exact end date of the PA and the exact number of units needed. Once the first PA has ended, the second PA can be approved.

COVERED HOME HEALTH REHABILITATION SERVICES

Louisiana Medicaid provides coverage for speech therapy and occupational therapy, as well as physical therapy, through the Home Health Program. These services require prior authorization.

Home health rehabilitation services are excluded from the service limit of 50 home health visits per calendar year for Medicaid recipients 21 years of age and older.

Free standing rehabilitation centers are allowed to provide speech, occupational, and physical therapy services in the homes of recipients with prior approval from the Unisys Prior Authorization Unit. A recipient's place of residence, for these services, does not include a nursing home. (Note: Billing should be done according to the policy and procedures set forth for this provider type.)

All services must be approved in advance by the Prior Authorization Unit except initial evaluations and wheelchair seating evaluations. A provider may bill for a wheelchair seating evaluation once every 180 days and one initial OT, PT, and ST evaluation per discipline, per recipient every 180 days. All evaluations must have an MD prescription which must be kept in the recipients' files.

Billing Instructions For Wheelchair Seating Evaluation

- If an evaluation is performed by a **physical therapist**, the service must be billed with the new standard **code 97001** (Physical Therapy Evaluation), using procedure **modifier UD** (wheelchair seating evaluation) and **revenue code 424**.

- If an evaluation is performed by an **occupational therapist**, the service must be billed with the new standard **code 97003** (Occupational Therapy Evaluation), using procedure **modifier UD** (wheelchair seating evaluation) and **revenue code 434**.

NOTE: When billing for a wheelchair seating evaluation, a paper claim **must** be submitted with a copy of the MD script attached to the claim, (8 ½ X 11 sheet), and the original script **must** be kept in the recipients' file.

NOTE: Home Health agencies are not to bill Medicaid for rehabilitation in nursing homes. As per the Code of Federal Regulations, section 440.70, "A recipient's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded."

HOME HEALTH REHABILITATION CODES

REV Code Options **	Code	Description	Fee Per Unit
444	92506	Evaluation of Speech, Language, Voice, Communication, Auditory Processing, and/or Aural Rehabilitation Status	$49.50
440 441	G0153*	Services of Speech and Language Pathologist in Home Health Setting, each 15 min.	$8.25
424	97001	Physical Therapy Evaluation	$59.40
420 421	G0151*	Services of Physical Therapist in Home Health Setting, each 15 min.	$11.00
434	97003	Occupational Therapy Evaluation	$56.10
430 431	G0152*	Services of Occupational Therapist in Home Health Setting, each 15 min.	$8.80
424	97001 plus Modifier of UD	Wheelchair seating evaluation: Physical Therapist	$59.40
434	97003 plus Modifier of UD	Wheelchair seating evaluation: Occupational Therapist	$56.10

UD =Wheelchair Seating Evaluation (State Assigned)

***Requires Prior Authorization**

****When multiple revenue codes are listed, please choose the most appropriate revenue code from the options listed.**

*****Revenue Code Descriptions**

Revenue Code	Description
420	Physical Therapy/General
421	Physical Therapy/Visit Charge
424	Physical Therapy/Evaluation
430	Occupational Therapy/General
431	Occupational Therapy/Visit Charge
434	Occupational Therapy/Evaluation
440	Speech/Language/Path/General
441	Speech/Language/Path/Visit Charge
444	Speech/Language/Evaluation

PRIOR AUTHORIZATION FOR REHABILITATION SERVICES

Home Health Agencies must evaluate the recipient and complete a copy of the proposed plan of services, including PA-01 and PA-02 forms. PA-01 and PA-02 forms must be completed in full when they are submitted for review. All initial requests for approval must have a copy of the physician's referral and the results of the evaluation of the patient attached, which necessitates therapy.

All extension requests for approval must include a copy of the physician's referral and progress notes that document the need for the continuation of therapy. Extension requests should be submitted at least 25 days prior to the end of the approved period.

When billing for therapy visits, each different kind (PT, ST, OT) of visit must be billed on a separate line for each date of service. Please be sure to use the correct revenue and HCPCS code for each line item.

Please be sure to enter the correct PA number for the dates of service billed in the appropriate field on the claim form. Only one PA number may be entered per claim form. Use of an incorrect PA number will cause the claim to deny.

Prior Authorization Form – Initiated Hard Copy

Note: Blank and completed PA-01 and PA-02 forms can be found on the following pages.

Completed requests with all required documentation should be mailed to the following address:

Unisys
Attention: Prior Authorization
P. O. Box 14919
Baton Rouge, LA 70821-4919

Once the review process has been completed and the request has been approved or denied, the home health agency and the recipient will receive written notification informing them of the determination.

The PA-01 and PA-02 forms used when requesting Prior Authorization for rehabilitation services are provided in this training packet and can also be found on the www.lamedicaid.com website.

Electronic Prior Authorization (e-PA)

A system for requesting prior authorization electronically has been developed. 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. With this web application, following the electronic submission, providers are required to fax the PA-02 form and all necessary documentation to substantiate the medical necessity of the requested service to the fax number listed in the user guide for e-PA on the

www.lamedicaid.com website under the user guide link in forms/files/user guides. Providers who do not have access to a computer and/or fax machine will not be able to utilize the web application. However, prior authorization requests will continue to be accepted and processed using the current PA hard-copy submission methods.

NOTE: Reconsideration requests cannot be accepted via the e-PA web application and should be submitted using the existing process.

NOTE: The PA-02 Form is required for rehabilitation prior authorization requests regardless of the method of submission.

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BATON ROUGE, LA. 70898-4919

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

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____NO

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

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

Social Security No. (3): 423 45 6789

RECIPIENT LAST NAME: FIRESTONE
FIRST: ANDREW
MI (4):
DATE OF BIRTH (5): 05 27 1989

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

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

END DATE OF SERVICE (MMDDYYYY): 06 08 2006

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

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION
719.42 JOINT PAIN/UP-ARM
SECONDARY CODE & DESCRIPTION
719.41 JOINT PAIN/SHOULDER REGION

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

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)
DR. JAMES BOND

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)
G0151					SERVICES OF PT HOME HLTH SETTING	24	974.00				

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

(13)
PROVIDER NAME: CM HOME HEALTH INC.
ADDRESS: 123 M&M AVE.
CITY: PATTERSON STATE: LA ZIPCODE 71111
TELEPHONE: (337) 555 3825 FAX NUMBER: (337) 555 – 9680

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

(15) PROVIDER SIGNATURE: *Claire Belle*

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

PA-01 FORM

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

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

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

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

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

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

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

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

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

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

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

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

(13)

PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE _____

TELEPHONE: (___) ___ ___ FAX NUMBER: (___) ___ ___

(14) CASE MANAGER INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE; _____ ZIPCODE _____

TELEPHONE (___) ___ ___ FAX NUMBER: (___) ___ ___

(15)

PROVIDER SIGNATURE: _____

(16)

DATE OF REQUEST: _____

PA-01 FORM

Instructions For Completing Prior Authorization Form (PA-01)

NOTE: Only the fields listed below are to be completed by the provider of service. All other fields are to be used by the prior authorization department at Unisys.

Field No. 1	Check the appropriate block to indicate the type of prior authorization requested.
Field No. 2	Enter recipient's 13-digit Medicaid ID number or 16-digit CCN number.
Field No. 3	Enter the recipient's social security number.
Field No. 4	Enter the recipient's last name, first name and middle initial as it appears on their Medicaid card.
Field No. 5	Enter the recipient's date of birth in mmddyyyy format (mm=month, dd=day, yyyy=year).
Field No. 6	Enter the provider's 7-digit Medicaid number. If associated with a group, enter the attending provider number only.
Field No. 7	Enter the beginning and ending dates of service in mmddyyyy format (mm=month, dd=day, yyyy=year).
Field No. 8	Enter the numeric ICD9-diagnosis code (primary & secondary) and the corresponding description.
Field No. 9	Enter the day the prescription, doctor's orders was written in mmddyyyy format (mm=month, dd=day, yyyy=year).
Field No. 10	Enter the name of the recipient's attending physician prescribing the services.
Field No. 11	Enter the HCPCS code.
Field No. 11A	Enter the corresponding modifiers (when appropriate).
Field No. 11B	Enter the HCPCS code's corresponding description for each procedure requested.
Field No. 11C	Enter the number of units requested for each individual procedure.
Field No. 11D	Enter the requested charges for each individual procedure you entered when it is appropriate for the requested procedure.
Field No. 12	Enter the location for all services rendered.
Field No. 13	Enter the name, mailing address and telephone/fax numbers of the provider of service
Field No. 14	Provider/authorized signature is required. Your request will not be accepted if not signed. If using a stamped signature, it must be initialed by authorized personnel.
Field No. 15	Date is required. Your request will not be accepted if field is not dated

If you have any questions concerning the prior authorization process, please contact the prior authorization department at Unisys:

Prior authorization toll-free number is 800-488-6334.

Prior authorization unit number is 225-928-5263.

Prior authorization fax number is 225-929-6803.

MAIL TO:
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P.O. BOX 14919
Baton Rouge, La. 70898-4919

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

Patient Name: **Firestone, Andrew** Age: **16** Provider Name: **CM Home Health, Inc.**

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: **Week ending 9/26/2005**

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

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

REHABILITATION PLAN

PLAN OF SERVICES: ✓ INITIAL _____ EXTENSION

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

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

REQUESTED SERVICES:	PROCEDURE CODE	DESCRIPTION	FREQUENCY	TIME / VISIT	TOTAL UNITS
PHYSICAL THERAPY:	**G0151**	**Services of PT Home Health Setting**		**X Week**	**24**
SPEECH THERAPY:					
OCCUPATIONAL THERAPY					

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

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

PROPOSED GOALS / COMMENTS: **⇧ ROM L Elbow**
⇧ Strength L Elbow
PT to be able to tolerate joint Mobilization & PROM stretches

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

P.A 02 FORM (ISSUED 01/91

MAIL TO:
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P.O. BOX 14919
Baton Rouge, La. 70898-4919

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

Patient Name: _____ Age: _____ Provider Name: _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: _____

LIMITATIONS : ____ AMBULATORY ____ NON - AMBULATORY ____ YES ____ NO TRANSPORTATION AVAILABLE

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

REHABILITATION PLAN

PLAN OF SERVICES: _____ INITIAL _____ EXTENSION

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

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

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

PHYSICAL THERAPY: _____

SPEECH THERAPY: _____

OCCUPATIONAL THERAPY _____

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

DATE OF RE – EVALUATION: _____
MONTH DAY YEAR

PROPOSED GOALS / COMMENTS: _____

REQUESTED BY : _____ DATE: _____

P.A 02 FORM (ISSUED 01/91

BILLING INSTRUCTIONS FOR HOME HEALTH SERVICES

The UB-92 claim (hard copy) or 837I electronic transaction is required for use when filing for Medicaid reimbursement of services provided under the Medicaid Home Health Program. All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

As a reminder, when submitting to Medicaid for reimbursement of services the recipient's **attending physician's** name and/or provider number is always required. Should the recipient have a CommunityCARE PCP, the **referral authorization number** is also required. Please see chart below for correct placement of this information on the UB-92 Claim Form and 837I Electronic Format.

- ☞ Providers must complete both fields if the recipient being treated is in the CommunityCARE Program even if the attending physician and the CommunityCARE PCP are the same.

UB-92 Claim Form	837I Electronic Format
Form Locator 82 – Attending Physician (Required) Enter the name or 7 digit Medicaid provider number of the physician ordering the plan of care.	**Loop 2310A, REF02 segment** **OR** **Loop 2420A, REF02 segment** Enter the name of 7 digit Medicaid provider number of the physician ordering the plan of care.
Form Locator 83A – Other Physician (Situational) Enter the referral authorization number from the CommunityCARE Referral Form if the claim is for a CommunityCARE recipient.	**Loop 2310C, REF02 segment** **OR** **Loop 2420C, REF02 segment** Enter the referral authorization number from the CommunityCARE Referral Form if the claim is for a CommunityCARE recipient.

Home Health hardcopy claims should be submitted to:

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

Instructions For Completing UB-92 Claim Form for Home Health Claims

UB-92 CLAIM FORM			
Form Locator	**Field Name**	**Entry**	**Action**
1	N/A	Required	Enter the appropriate provider name, address, and telephone number. When entering the provider address, enter the appropriate street or post office box number, city, state, and zip code
2	N/A	Leave Blank	
3	PATIENT CONTROL NO.	Situational	Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 16 characters.
4	TYPE OF BILL	Required	Enter using three characters as follows: • **The first digit indicates the type of facility, 3 = home health** • **The second digit indicates the bill classification, 3 = outpatient** • The third digit indicates frequency of services: 1 = Admitted through discharge 2 = Interim – first claim 3 = Interim – continuing claim 4 = Interim – final claim 7 = Adjusted 8 = Void
5	FED. TAX NO.	Leave Blank	
6	STATEMENT COVERS PERIOD FROM/THROUGH	Required	This field should be completed in 8 character format (MMDDYYYY) and should include the appropriate from and through dates.
7	COV D.	Leave Blank	
8	N-C D.	Leave Blank	
9	C-I D.	Leave Blank	
10	L-R D.	Leave Blank	
11	N/A	Leave Blank	
12	PATIENT NAME	Required	Enter the recipient's name as shown on the recipient's Medicaid plastic swipe card (See the UB-92 manual for further instructions).
13	PATIENT ADDRESS	Required	Enter the patient's permanent address.
14	BIRTHDATE	Required	Enter the patient's birth date in 8 character format (MMDDYYYY). If only one digit appears in this field, enter leading zeros (05032005)

UB-92 CLAIM FORM			
Form Locator	**Field Name**	**Entry**	**Action**
15	SEX	Required	Enter the patient's gender as follows: M = Male F = Female U = Unknown
16	MS	Situational	Enter the patient's marital status.
17	ADMISSION DATE	Required	Enter the start of care date. This field should be completed in 8 character format (MMDDYYYY).
18	ADMISSION HR	Leave Blank	
19	ADMISSION TYPE	Leave Blank	
20	ADMISSION SRC	Required	Enter the source of admission. This field is one character in length, either alpha or numeric as follows: 1 = Physician Referral B = Transfer from another HH agency
21	D HR	Leave blank	
22	STAT	Required	Enter the appropriate patient 2 digit status values as follows: 01 = Discharged to home or self care (routine discharge) 04 = Discharged to an ICF facility 07 = Discontinued care 20 = Expired 30 = Still a patient
23	MEDICAL RECORD NO.	Situational	Enter the patient's medical record number up to 16 characters in length.
24 - 30	CONDITION CODES	Leave Blank	
31	N/A	Leave Blank	
32 - 35	OCCURRENCE CODES/DATES	Situational	Enter the 2 digit alpha/numeric code as follows: 01 = Auto accident 02 = No Fault Insurance involved 03 = Accident/Tort liability 04 = Accident/Employment Rel. 05 = Other Accident 06 = Crime victim 24 = Date insurance denied 25 = Date benefits terminated by primary payer
36	OCCURRENCE SPAN FROM/THROUGH	Leave Blank	

UB-92 CLAIM FORM			
Form Locator	**Field Name**	**Entry**	**Action**
37 A, B, C	N/A	Leave Blank	
38	N/A	Leave Blank	
39 - 41	VALUE CODES CODE(S)/AMOUNT	Situational	Enter a 2 digit alpha/numeric character in the value code field, Enter up to 8 characters in the value code amount field.
42	REV CD	Required	Enter a 3 digit numeric value in this field using the following values: 420 = Physical Therapy – general 421 = Physical Therapy – Visit charge 424 = Physical Therapy – evaluation 430 = Occupational Therapy – general 431 = Occupational Therapy – Visit charge 434 = Occupational Therapy – evaluation 440 = Speech/Language Path – general 441 = Speech/Language Path – Visit charge 444 = Speech/Language – evaluation 550 = HH – Skilled Nurse –other 551 = HH – Skilled Nurse – visit 552 = HH - Skilled Nurse – hourly 570 = Aide – general 571 = Aide - visit 580 = HH – other – general 581 = HH – other - visit 582 = HH – other – hourly
43	DESCRIPTION	Required	Enter the appropriate description for the value entered in the revenue code field.
44	HCPCS/RATES	Required	Enter a 5 digit alpha/numeric character value in this field as follows: Note: Although the CPT code book indicates 15min. is equal to one (1) unit for procedure codes G0154 and G0156, per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes. Codes G0154 – Skilled Nurse HH setting; (15) minutes G0156 – Services of HH Aide in HH setting G0151 – Services of Physical Therapy in HH setting; (15) minutes G0152 – Services of Occupational Therapy

UB-92 CLAIM FORM			
Form Locator	**Field Name**	**Entry**	**Action**
			in HH setting; (15) minutes G0153 – Speech/Language path. In HH setting; (15) minutes S9123 – Nurse care in home: RN S9124 – Nurse care in home: LPN
45	SERV. DATE	Required	Enter the actual date of service in 8 digit format (MMDDYYYY).
46	SERV. UNITS	Required	Enter the appropriate number of units of service.
47	TOTAL CHARGES	Required	Enter the appropriate amount for all charges.
48	NON-COVERED CHARGES	Leave Blank	
49	UNLABELED	Situational	Enter the appropriate modifier, when needed. Values are as follows: TD = RN TE = LPN TT = Multiple Recipients UD = Wheelchair Seating Evaluation
50 A, B, C	PAYER	Required	Enter “Medicaid” on line A. If there are other insurance carriers, enter the name(s) on lines B & C.
51 A, B, C 51 A, B, C (cont’d)	PROVIDER NO.	Required	Enter the 7 digit required provider identification number, which was assigned by the Title XIX (Medicaid) program on Line A.
52 A, B, C	REL INFO	Situational	Enter the ‘Release of Information Certification’ indicator.
53 A, B, C	ASG BEN	Situational	Enter the ‘Assignment of Benefits Certification’ indicator.
54 A, B, C	PRIOR PAYMENTS	Situational	Enter the prior payments in this field, unless the payment was denied, then place a ‘0.00’ in this field. Also attach a copy of the Explanation of Benefit (EOB) with this claim.
55 A, B, C	EST. AMOUNT DUE	Situational	Enter the estimated amount due.
56 - 57	UNLABELED	Leave Blank	
58 A, B, C	INSURED’S NAME	Required	Enter the last name, first name, and middle initial if any. Name on Line A must be the same as on the Medicaid patient’s plastic swipe card.

UB-92 CLAIM FORM			
Form Locator	**Field Name**	**Entry**	**Action**
59 A, B, C 59 (cont'd)	P REL	Required	Enter the patient's relationship to the insured using a 2 digit alpha/numeric value as follows: 01 = Patient is Insured
60 A, B, C	CERT. - SSN. – HIC. – ID NO.	Required	Enter the 13 digit Medicaid recipient ID number (not the CCN number from the card) on Line A. Note: The Certificate/Social Security Number/Health Insurance Claim/ID Number that is associated with other payers should be entered on the corresponding lines B & C when other payment is involved).
61 A, B, C	GROUP NAME	Situational	Enter the 6 digit TPL Carrier Code assigned by Medicaid for the non-title XIX (Medicaid) payers listed in form locator #50 on corresponding Line B or C.
62 A, B, C	INSURANCE GROUP NO.	Situational	Enter the insurance group number.
63	TREATMENT AUTHORIZATION CODES	Situational	If required for services on the bill, enter the 9 digit prior authorization number.
64	ESC	Situational	Enter the employment status code of the insured in this field.
65	EMPLOYER NAME	Situational	Enter the name of the employer.
66	EMPLOYER LOCATION	Situational	Enter the location of the employer.
67	PRIN. DIAG. CD.	Required	This field should be completed entering the appropriate ICD-9-CM code for the principal diagnosis requiring home health.
68 - 75	OTHER DIAG CODES	Situational	Enter other diagnosis codes, when appropriate.
76	ADM DIAG CD	Situational	Enter the admitting diagnosis/patient's reason for visit code.
77	E – CODE	Leave Blank	
78	UNLABELED	Leave Blank	
79	P.C.	Required	Enter the following Procedure Code Method: 5 = HCPCS (HCFA Common Procedure Coding System)
80	PRINCIPAL PROCEDURE CODE/DATE	Leave Blank	

UB-92 CLAIM FORM			
Form Locator	**Field Name**	**Entry**	**Action**
81	OTHER PROCEDURE CODE/DATE	Leave Blank	
82	ATTENDING PHYS. ID	Required	Enter the name or 7 digit Medicaid provider number of the physician ordering the plan of care.
83 A	OTHER PHYS. ID	Situational	Enter the referral authorization number from the CommunityCARE Referral Form if the claim is for a CommunityCARE recipient.
84	REMARKS	Situational	If the previously processed claim is either an adjustment or void, (noted as the 3rd digit in form locator 4 as either a “7” or “8”), then enter the ICN of the paid Medicaid claim, then an “A” or “V” to indicate whether an adjustment or void. Format is ICN/A or V/Reason as follows: Adjustment Reason Code 01 – TPL Recovery 02 – Provider correct 03 – Fiscal Agent error 99 – Other Void Reason Code 10 – Claim paid for wrong recipient 11 – Claim paid for wrong provider 00 – Other
85	PROVIDER REPRESENTATIVE	Required	Enter the signature of the authorized provider or provider’s representative, otherwise initial all stamped signatures.
86	DATE	Required	Enter the date the bill was submitted in 8 digit format (MMDDYYYY).

☛ **NOTE: Please be aware that revenue code 001 representing total claim charges is not required on the UB-92 form.**

APPROVED OMB NO. 0938-0279

CM Home Health, Inc 123 M & M Ave Patterson, LA71111	2			3 PATIENT CONTROL NO. 123456					4 TYPE OF BILL 332	
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 12082006	THROUGH 12312006	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11		

12 PATIENT NAME	13 PATIENT ADDRESS
Peters, Cheryl	2003 Drut Street, Patterson, LA 71111

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24–30 CONDITION CODES	31
06031994	M	S	120806			1		30			

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

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a		
	b		
	c		
	d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	582	HH – other - Hourly	S9123	12082006	10	245 00		
2	582	HH – other - Hourly	S9123	12102006	10	245 00		
3	582	HH – other - Hourly	S9123	12122006	10	245 00		
4	582	HH – other - Hourly	S9123	12142006	10	245 00		
5	582	HH – other - Hourly	S9123	12162006	10	245 00		
6	582	HH – other - Hourly	S9123	12182006	10	245 00		
7	582	HH – other - Hourly	S9123	12202006	10	245 00		
8	582	HH – other - Hourly	S9123	12212006	10	245 00		
9	582	HH – other - Hourly	S9123	12282006	10	245 00		
10	582	HH – other - Hourly	S9123	12312006	10	245 00		
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Medicaid	1412345			TPL Payment if applicable		
B						
C						

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A Brown, Leroy	01	8060705030009	TPL carrier code if applicable	
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A 500987653			
B			
C			

67 PRIN. DIAG. CD.	68 CODE	OTHER DIAG. CODES 69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
78001	3499										

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	82 ATTENDING PHYS. ID
5				Dr. Mike Johnson
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	83 OTHER PHYS. ID PCP Referral Auth if applicable
				OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a	X Claire Belle	01/15/07
b		
c		
d		

UB-92 HCFA-1450 OCR / Original

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

APPROVED OMB NO. 0938-0279

CM Home Health, Inc 123 M & M Ave Patterson, LA71111	2	3 PATIENT CONTROL NO. 123456	4 TYPE OF BILL 333
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 02012006 THROUGH 02282006	7 COV D. / 8 N-C D. / 9 C-I D. / 10 L-R D. / 11
12 PATIENT NAME: Smith, John	13 PATIENT ADDRESS: 625 Coulee Bend, Franklin, LA 70000		

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
01271942	M	S	01012006			1		30			

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

	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
a			
b			
c			
d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	550	Skilled Nurse (RN)	G0154	02012006	1	68 65		TD
2	550	Skilled Nurse (RN)	G0154	02082006	1	68 65		TD
3	550	Skilled Nurse (RN)	G0154	02152006	1	68 65		TD
4	550	Skilled Nurse (RN)	G0154	02222006	1	68 65		TD
5	550	Skilled Nurse (RN)	G0154	02282006	1	68 65		TD
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

SAMPLE

50 PAYER	51 PROVIDER NO.	52 REL INFO / 53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Medicaid	1412345		TPL Amount if needed		
B					
C					

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A Smith, John	01	1234567890123	TPL carrier code if applicable	
B				
C				

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

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 / 69 / 70 / 71 / 72 / 73 / 74 / 75	76 ADM. DIAG. CD.	77 E-CODE	78
71942	71941			

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE
5						

82 ATTENDING PHYS. ID	Dr. Courtney Jacob
83 OTHER PHYS. ID	PCP Referral Auth if applicable
OTHER PHYS. ID	

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a b c d	X Claire Belle	03/15/06

UB-92 HCFA-1450 OCR / Original

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

APPROVED OMB NO. 0938-0279

CM Home Health Inc 123 M & M Ave Patterson, LA71111	2	3 PATIENT CONTROL NO. 0236478	4 TYPE OF BILL 332
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 01012006 THROUGH 01312006	7 COV D. / 8 N-C D. / 9 C-I D. / 10 L-R D. / 11
12 PATIENT NAME: Firestone, Andrew	13 PATIENT ADDRESS: 1989 Wolves Ave. Morgan City, LA 70000		

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 26 28 30	31
05271989	M	S	01012006			1		30			

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

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
a			
b			
c			
d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	420	PT	G0151	01032006	2	22 00		
2	420	PT	G0151	01072006	2	22 00		
3	420	PT	G0151	01092006	4	44 00		
4	420	PT	G0151	01142006	3	33 00		
5	420	PT	G0151	01162006	2	22 00		
6	424	PT Evaluation	97001	01022006	1	60 00		
7	580	HH Visit – RN	G0154	01012006	1	70 00		TD
8	580	HH Visit – RN	G0154	01032006	1	70 00		TD
9	580	HH Visit – RN	G0154	01072006	1	70 00		TD
10	580	HH Visit – RN	G0154	01092006	1	70 00		TD
11	580	HH Visit – RN	G0154	01142006	1	70 00		TD
12	580	HH Visit – RN	G0154	01162006	1	70 00		TD
13	580	HH Visit – RN	G0154	01212006	1	70 00		TD
14	580	HH Visit – RN	G0154	01232006	1	70 00		TD
15	580	HH Visit – RN	G0154	01312006	1	70 00		TD
16								
17								
18								
19								
20								
21								
22								
23								

SAMPLE

	50 PAYER	51 PROVIDER NO.	52 REL INFO / 53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid	1412345		TPL Amount if needed		
B						
C						

57 DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Firestone, Andrew	01	8675309000000	TPL Carrier Code if applicable	
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	500012345			
B				
C				

67 PRIN. DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
71941											

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	82 ATTENDING PHYS. ID
5				Dr. James Bond
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	83 OTHER PHYS. ID: PCP Referral Auth if applicable

	84 REMARKS	OTHER PHYS. ID	
a			a
b			b
c			
d			

85 PROVIDER REPRESENTATIVE: X Claire Belle — 86 DATE: 02/15/06

UB-92 HCFA-1450 — OCR / Original

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

ADJUSTMENTS/VOIDS

Home Health Adjustment/Void Claims—Form UB-92

For Home Health Services, both claims and Adjustment/Voids to claims are filed on the UB-92 claim form. When filing an adjustment or void for Home Health services on the UB-92, Form Locator 4 “Type of Bill“ and Form Locator 84 “Remarks” must be completed.

Recipient and Provider Numbers are items that cannot be adjusted.

Form Locator 4

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

  First Digit – Type Facility
  3 – Home Health

  Second Digit – Classification
  3 - Outpatient

  Third Digit – Frequency
  7 – Replacement of Prior Claim (Adjustment)
  8 – Void/Cancel of Prior Claim

Form Locator 84

1. Enter an “A” for an adjustment or a “V” for a void.

2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.

3. Enter one of the appropriate reason codes:

Adjustments

01 – Third Party Liability Recovery
02 – Provider Correction
03 – Fiscal Agent Error
99 - Other, Please explain.

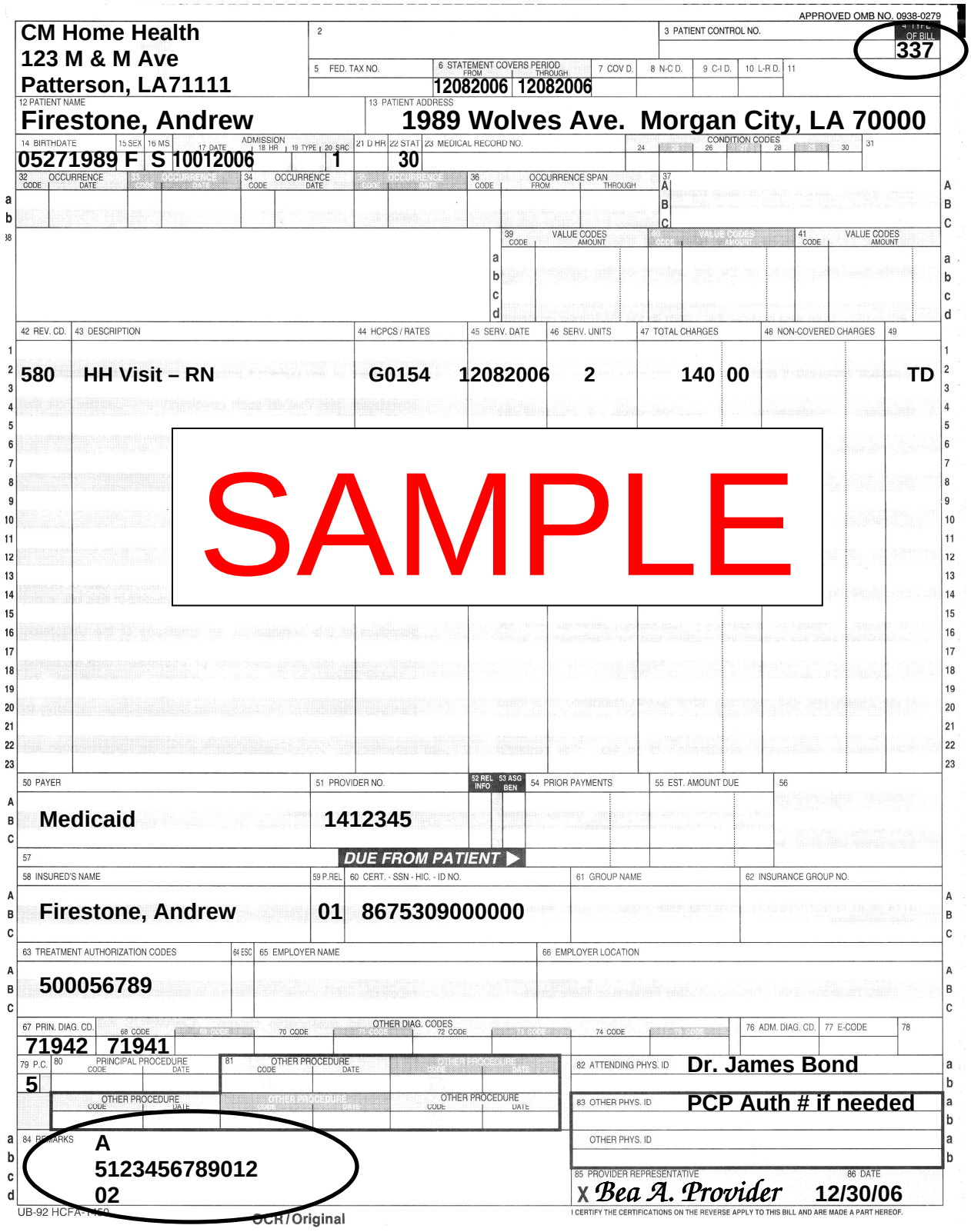
Example: A
5999000000000
02

Voids

10 – Claim Paid for Wrong Recipient
11 – Claim Paid to Wrong Provider
00 – Other

Example: V
5999000000000
00

To adjust or void more than one claim line on a Home Health claim, a separate UB-92 form is required for each claim line as each line has a different Internal Control Number, which must be indicated in Form Locator 84.



APPROVED OMB NO. 0938-0279

CM Home Health
123 M & M Ave
Patterson, LA71111

4 TYPE OF BILL: 337

5 FED. TAX NO.
6 STATEMENT COVERS PERIOD: FROM 12082006 THROUGH 12082006
7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Firestone, Andrew
13 PATIENT ADDRESS: 1989 Wolves Ave. Morgan City, LA 70000

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24–30 CONDITION CODES	31
05271989	F	S	10012006			1		30			

32–35 OCCURRENCE CODE / DATE
36 OCCURRENCE SPAN CODE / FROM / THROUGH
37 A B C

39–41 VALUE CODES CODE / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
580	HH Visit – RN	G0154	12082006	2	140 00		TD

SAMPLE

50 PAYER: Medicaid
51 PROVIDER NO.: 1412345
52 REL INFO | 53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56
57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Firestone, Andrew	01	8675309000000		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
500056789			

67 PRIN. DIAG. CD.: 71942
68–74 OTHER DIAG. CODES: 71941
76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C.: 5
80 PRINCIPAL PROCEDURE CODE / DATE
81 OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID: Dr. James Bond
83 OTHER PHYS. ID: PCP Auth # if needed
OTHER PHYS. ID

84 REMARKS: A 5123456789012 02

85 PROVIDER REPRESENTATIVE: X Bea A. Provider
86 DATE: 12/30/06

UB-92 HCFA-1450 OCR/Original

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

BILLING REMINDERS

- Hardcopy claims should be submitted on the UB-92 claim form. If you are an EMC biller, please remember to contact your software vendor to make the necessary updates for billing electronically on the 837I.

- For those services which require prior authorization, the nine-digit prior authorization number that is assigned by the Unisys Prior Authorization Unit should be entered in Form Locator 63. Only one PA number may be entered per claim form. Use of an incorrect PA number will cause the claim to deny.

- It is mandatory that the referring physician name/or provider number be included in Form Locator 82. **If this item is left blank, the claim will deny.**

- Home Health services are not exempt from the CommunityCARE Program. Please refer to the CommunityCARE section of this training manual for more information.

- If the claim is for a CommunityCARE recipient, the referral authorization number from the appropriate CommunityCARE PCP must be entered in Form Locator 83A. A copy of the CommunityCARE referral must be kept in the recipient's file.

- Medicaid does not pay claims unless a primary diagnosis is submitted with billing. Primary diagnosis should be the principle illness for which the recipient is receiving care. Medical records should substantiate the diagnosis.

- If patient has private insurance, the Explanation of Benefits (EOB) must be attached to the UB-92 form, the 6-digit State assigned carrier code must be in form locator 61, and the amount the private insurance paid must be entered in form locator 54.

NOTE: Regardless of the method of claims filing (hard copy or electronic), providers must adhere to the same policy and billing requirements as outlined in this packet and provider billing manual, including all hard copy billing examples.

HARD COPY REQUIREMENTS

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

HARDCOPY CLAIM(S) & REQUIRED ATTACHMENT(S)	BILLING REQUIREMENTS
Spend Down Recipient – 110MNP Spend Down Form	Continue hardcopy billing
Third Party/Medicare Payment – EOBs. (Includes Medicare adjustment claims)	Continue hardcopy billing
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
Failed Crossover Claims – Medicare EOB	Continue hardcopy billing
Timely filing – letter/other proof i.e., RA page	Continue hardcopy billing

COMMUNITYCARE

Program Description

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

Recipients

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

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

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

Primary Care Physician

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

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

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

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

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

Non-PCP Providers and Exempt Services

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

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

Providers:

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

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

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

Enrollees:

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

- CommunityCARE Enrollee Hotline (800) 259-4444: Provides assistance with questions or complaints about CommunityCARE or their PCP. It is also the number recipients call to select or change their PCP.

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

- CommunityCARE Nurse Helpline (866) 529-1681: Is a resource for recipients to speak with a nurse 24/7 to obtain assistance and information on a wide array of health-related topics.

- www.la-communitycare.com

- www.lamedicaid.com

TIMELY FILING GUIDELINES

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

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

Dates of Service Past Initial Filing Limit

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

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

OR

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

OR

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

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

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

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

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

Submitting Claims for Two-Year Override Consideration

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

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

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

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

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

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

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:

1. A signature or handwritten initials were missing,
2. The recipient number was invalid or missing, and
3. The provider # was missing or incomplete.

The criteria for legible claims are:

1. all claim forms are clear and in good condition,
2. all information is readable to the normal eye,
3. all information is centered in the appropriate block, and
4. all essential information is complete.

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.**

IMPORTANT UNISYS ADDRESSES

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

Type of Claim	P.O. Box	Zip Code
Pharmacy	91019	70821
CMS-1500 Claims Case Management Chiropractic Durable Medical Equipment EPSDT Health Services FQHC Hemodialysis Professional Services Independent Lab Mental Health Rehabilitation PCS Professional Rural Health Clinic Substance Abuse and Mental Health Clinic Waiver	91020	70821
Inpatient & Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long Term Care	91021	70821
Dental, Home Health, Rehabilitation, Transportation (Ambulance and Non-ambulance)	91022	70821
ALL Medicare Crossovers and All Medicare Adjustments and Voids	91023	70821
KIDMED	14849	70898

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

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

LOUISIANA MEDICAID WEBSITE APPLICATIONS

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

www.lamedicaid.com

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

Provider Login And Password

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

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

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

Web Applications

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

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

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

e-MEVS:

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

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

e-CSI:

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

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

e-CDI:

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

The nine (9) clinical services information components are:

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

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

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

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

e-PA

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

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

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

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

Reminders:

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

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

PA Type 05: Providers must always submit the PA-02 Form with each request. Do not request authorization for the evaluation procedures, these do not require prior approval. Submit only units on the e-PA transaction, Do Not submit dollar amounts.

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

PA Type 09: When submitting a request with a miscellaneous procedure code, the provider must submit a PA-01 Form with the description of the item they are requesting.

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

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

Additional DHH Available Websites

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

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

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

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

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

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

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

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

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

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

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

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

PROVIDER ASSISTANCE

Many of the most commonly requested items from providers including, but not limited to, the Field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, and program training packets are available online at www.lamedicaid.com.

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure/ information/clarification, ordering printed material, requesting a Field Analyst visit, etc., and may be reached by calling:

(800) 473-2783 or (225) 924-5040*
FAX: (225) 216-6334**

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

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

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

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

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

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

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

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

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

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

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

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

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

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

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:

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

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

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

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