UNISYS

HOME AND COMMUNITY BASED WAIVER SERVICES PROVIDER TRAINING

Spring 2006

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

ABOUT THIS DOCUMENT

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

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

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

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

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

MR/DD MEDICAID WAIVER SERVICES

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

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

SUPPORT COORDINATION

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

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

MENTAL HEALTH REHABILITATION SERVICES

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

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

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

EPSDT/KIDMED EXAMS AND CHECKUPS

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

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

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

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

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

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

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

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

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

OTHER MEDICAID COVERED SERVICES

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

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

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

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

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

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

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

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FAX: (985) 449-5180
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FAX: (337) 262-5233
Toll Free: 1-800-648-1484

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Toll Free: 1-800-631-8810

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Toll Free: 1-800-862-1409

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FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
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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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PROGRAMMATIC AND LICENSING/CERTIFICATION CHANGES PURSUANT TO GOVERNOR'S HEALTH CARE REFORM INITIATIVES

In October 2004, Governor Blanco issued Executive Order KBB 2004-43 that described her views on long-term care and initiated a planning process to develop a comprehensive plan designed to reform Louisiana's health care delivery system and improve access to quality health care. During the past year, DHH has worked with national health care experts, legislative and other government leaders, health care providers, business leaders, consumers, and interested citizens to ensure the process of health care reform continues on a steady course. Listed below are important preliminary changes that have occurred subsequent to implementation of these reform initiatives.

PROGRAMMATIC CHANGES

To improve coordination and access to services and consolidate administrative functions under the most appropriate program office, **effective immediately**, the administrative and oversight functions listed below have been redesigned as follows:

- The Bureau of Community Supports and Services (BCSS) was dissolved and program responsibilities were reassigned.

- Waiver issues pertaining to children and adults with developmental disabilities (e.g., New Opportunities Waiver and Children's Choice Waiver populations) are now administered by the Office for Citizens with Developmental Disabilities (OCDD) - Waiver Supports and Services (WSS), the program office within the Department of Health and Hospitals (DHH) that provides supports and services to children and adults with developmental disabilities.

- Waiver issues pertaining to the elderly and disabled adults (e.g., Elderly and Disabled Adult Waiver and Adult Day Health Care Waiver populations) are now administered by the Division of Long Term Supports and Services (DLTSS), a newly created division within the Department of Health and Hospitals, Bureau of Health Services Financing.

- The Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) is now responsible for administrative oversight of Support Coordination for Early Periodic Screening Diagnosis and Treatment (EPSDT), Nurse Family Partnership and Infant and Toddlers (Early Steps) targeted populations.

- Support Coordination for the HIV targeted population is now administered by the Division of Long Term Supports and Service (DLTSS).

- The Long Term-Personal Care Services program (LT-PCS) is now administered by the Division of Long Term Supports and Services (DLTSS).

- The Nursing Facility Admissions Review process is now administered by the Division of Long Term Supports and Services.

LICENSING & CERTIFICATION CHANGES

To reduce duplication/fragmentation of licensing and certification functions, and to encourage a more efficient and timely licensing/certification process, effective immediately, the following changes are in place:

- Licensing and certification authority (including related survey and compliance activities) previously administered by the Department of Social Services (DSS – Licensing process), and the BCSS (Certification/Enrollment process) for Personal Care Attendant (PCA) services agencies, Supervised Independent Living (SIL) services agencies, Centered-Based Respite services agencies, Family support services agencies, and Adult day care agencies has been transferred to the DHH, Health Standards Section (HSS).

- Licensing and certification authority (including related survey and compliance activities) of Support Coordination and Adult Day Health Care (ADHC) agencies previously administered by the BCSS has been transferred to the DHH/Health Standards Section (HSS).

We appreciate your continued support and commitment to making a positive difference in the lives of individual recipients of home and community-based services. If you have any questions concerning these changes, please contact the DLTSS by calling (225) 219-0200, OCDD-WSS by calling (225) 219-0200, or HSS by calling (225) 342-0415.

ELDERLY AND DISABLED ADULT (EDA) WAIVER
Waiver Eligibility Segment Code 00257

SERVICES PROCEDURE CODES/RATES

The following procedure codes represent current information.

Provider Type	Proc. Code	MOD	HIPAA Service Description	Units
08	Z0178		EDA High Risk Case Management	Monthly $157.00
08	Z0195		EDA Case Management	Monthly $140.00
15	Z0060		Environmental Modifications – Ramp	Lifetime Cap- Based on plan of care
15	Z0061		Environmental Modifications - Lift	
15	Z0062		Environmental Modifications - Bathroom	
15	Z0063		Environmental Modifications- Adaptations	
16	Z0058		Personal Emergency Response System (PERS) - Installation	Initial Installation $30.00
16	Z0059		Personal Emergency Response System – Monthly Fee	Monthly $27.00
82	S5125		Attendant Care Services (ACS)	15 minutes $3.00
82	S5130		Homemaker	15 minutes $2.00
82	S5135	U1	Companion Care (Adult)	15 minutes $2.00
	S5135	UJ	Companion Care (Adult)	15 minutes $1.50

The specified modifier is required for this procedure code.
Modifiers: Certain procedure codes will require a modifier in order to distinguish services.
The following modifiers are applicable to Elderly and disabled Adult Waiver provider:
U1 = Day
UJ = Night

Reissued May 11, 2004 BCSS-PC-04-002
Replaces Marc 29, 2004 Issuance

DEPARTMENT OF HEALTH AND HOSPITALS
DIVISION OF LONG TERM SUPPORTS AND SERVICES

ELDERLY & DISABLED ADULT (EDA) WAIVER FACT SHEET

Description	The Elderly and Disabled Adult (EDA) Waiver provides home and community-based services to individuals who would otherwise require nursing home level of care. The Department of Health and Hospitals (DHH) maintains an Elderly and Disabled Adult (EDA) Request for Services Registry (RFSR). To determine available EDA Waiver services, DHH gives priority to persons on the EDA Request for Services Registry (RFSR). Based on date of first request for services, priority is given to individuals who are in a nursing home and who can return to their homes if EDA Waiver services are provided, as well as those who have indicated that their medical condition is such that they are likely to go into a nursing home within the next 120 days, unless waiver services are provided. Remaining EDA Waiver "slots", if any, are offered on a first-come, first-served basis to individuals who qualify for admission to a nursing home, but who are not at high risk of being admitted to a nursing home. Persons wishing for their name to be added to the EDA Request for Services Registry (RFSR) should contact the Louisiana Options in Long Term Care through the toll free statewide Help Line at: 1-877-456-1146 (TDD Line: 1-877-465-1172). The EDA Waiver application process does not begin until an EDA Waiver "slot" is offered to a person on the EDA Request for Services Registry (RFSR) in accordance with the priorities set forth above. At that time, medical and financial eligibility determinations are performed at the same time. Individuals who do not satisfy both the medical and financial eligibility criteria will not be approved for EDA Waiver services and will be removed from the EDA Request for Services Registry (RFSR). Those who are approved for services have freedom of choice among providers. There are eight (8) services provided under this waiver: Case Management, Transition Intensive Case Management, Household Supports, Personal Supervision (day), Personal Supervision (night), Environmental Modifications, Personal Emergency Response System and Transitional Service (lifetime maximum assistance for individuals transitioning from a nursing home to the community). **At the present time, the approved Cost Cap is an average of $60.00 a day.**
Level of Care	Requestors **must meet the level of care criteria** for admission to a long term nursing facility. Medical and social information must be submitted to support this determination.
Population	Age → 65 or older, and 21 or older who are disabled according to Medicaid standards or SSI disability criteria.
Financial	• Income → For 2006, the income limits are $1,809 (up to 3 times the SSI amount) for an individual and $3,618 for a couple when both spouses need long-term care. • Resources → For 2006, countable resources cannot be worth more than $2,000 for an individual or $3,000 for a couple when both spouses need long-term care. For 2006, under Spousal Impoverishment rules, a couple can have up to $99,540 in countable resources, as long as there is a spouse at home who does not get long-term care. • These income and resources limits are subject to change each year.

** All new requests for the EDA Waiver should be directed to the Louisiana Options in Long Term Care Statewide Toll Free Help Line at: 1-877-456-1146 (TDD Line: 1-877-465-1172)

Reissued January 6, 2006 DLTSS-RC-05-001
Replaces November 10, 2005 Page 1 of 1

CHILDREN'S CHOICE WAIVER

SERVICE PROCEDURE CODES/RATES

Proc. Code	MOD	Service Description	Units
9E001		Children's Choice Case Management	Monthly $125.00
H2011		Crisis Intervention	15 minutes $3.25
S5125		Attendant Care Services	15 minutes $3.25
T1005	HQ	Respite Care	15 minutes $2.25
S5111		Home Care Training-Family	Based on CPOC
T2028		Specialized Supplies	
S5165	U4	Home Modifications	
S5165	U5	Home Modifications	
S5165		Home Modifications	
T2039		Vehicle Modifications	
H2011	UN	Crisis Intervention	15 minutes $2.44
S5125	UN	Attendant Care Services	15 minutes $2.44
H2011	HQ	Crisis Intervention	15 minutes $2.44

The specified modifier is required for this procedure code.

Modifiers

Certain procedure codes will require a modifier in order to distinguish services. The following modifiers are applicable to Children's Choice Waiver providers:

HQ = Group Setting
UN = 2 people
U4 = ramp
U5 = bathroom

CHILDREN'S CHOICE WAIVER FACT SHEET

Description	• Began February 21, 2001 to offer supplemental support to children with developmental disabilities who currently live at home with their families, or who will leave an institution to return home. • Children's Choice is an option offered to children on the NOW Request for Services Registry as funding permits. • Families choose to either apply for Children's Choice or remain on the NOW Request for Services Registry. • Participants are eligible for all medically necessary Medicaid services, including EPSDT screenings and extended services, and will also receive up to $15,000 per year in Children's Choice services (including required Support Coordination (case management). • Service package is designed for maximum flexibility. • Children who "age out" (reach their 19th birthday) will transfer with their slot to an appropriate NOW waiver as long as they remain eligible for waiver services. • There are 6 waiver services not available to other Medicaid recipients which are provided in lieu of institutional care: 1. Case Management - services that assist the families in life planning for the child including gaining access to needed waiver and State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the service to which access is gained. Home visits are required. 2. Family Support - services provided directly to the child that enable a family to keep the child at home and that enhance family functioning. 3. Center-Based Respite - services provided on a short-term basis to children unable to care for themselves due to the absence or need for relief of the parents or to others who normally provide care and supervision. 4. Environmental Accessibility Adaptations - physical adaptations to the home or vehicle necessary to ensure health, welfare, and safety of the child, or which enable the child to function with greater independence in the home, and without which additional supports institutionalization would be required. Excluded are adaptations of general use or those that add to the total square footage of the home. Excluded are fire alarms, smoke detectors, and fire extinguishers. 5. Family Training - training and education services for the families of recipients that is provided by professional organizations or practitioners appropriate to the needs of the child and approved by BCSS. 6. Diapers - for children age 3 and older. • A family that chooses Children's Choice may later experience a crisis that increases the need for paid supports to a level that would be more than the $15,000 cap on Children's Choice expenditures. During an initial one-year trial period, special provisions have been made to provide additional supports during the crisis period until other arrangements can be made. • A family may also experience a temporary Anon-crisis@ that could increase the need for additional supports beyond the $15,000 cap and allow the participant's name to be restored to NOW Request For Services Registry. Current Children's Choice Waiver services will not be terminated as a result of restoring the name to the registry. Special provisions have been made to allow someone to be restored to the registry until a NOW waiver opportunity becomes available.
Level of Care	Recipients must meet ICF/MR level of care for medical and/or psychological criteria. Procedure and requirements for admission to the waiver are the same as for ICF/MR determination.
Population	Age - Birth through age 18 Disability - Meets the federal definition for mental retardation or a developmental disability.
Eligibility	Income - Up to 3 times SSI amount. Income of other family members is not considered. Needs Allowance - Three times the SSI amount. Resources - Less than $2,000 Non-financial - meets all Medicaid non-financial requirements (citizenship, residence, Social Security number, etc.) Other - Same resource, disability, parental deeming, etc. as ICF/MR.

For Information About Accessing Children's Choice Services,
Please Contact Your Regional OCDD Office

Reissued February 1, 2005 BCSS-RC-03-002
Replaces September 17, 2004 Issuance

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CSRAs

METROPOLITAN HUMAN SERVICES DISTRICT
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Metairie, LA 70001
Phone: (504) 838-5357
FAX: (504) 838-5400

NEW OPPORTUNITIES WAIVER SERVICES

SERVICE PROCEDURE CODES/RATES

Proc. Code	MOD	Service Description	Units
Z0637		Case Management	Monthly
Z0177		Case Management	Monthly
S5136		Companion Care	Day $20.00
S5140		Foster Care, adult	Day $20.00
S5160		PER (Install & Test)	Initial installation $30.00
S5161		PER (Maintenance)	Monthly $27.00
T1002		RN Services	15 minutes $6.13
T1002	UN	RN Services, 2 persons	15 minutes $4.59
T1002	UP	RN Services 3 persons	15 minutes $4.04
T1003		LPN/LVN Services	15 minutes $6.13
T1003	UN	LPN/LVN Services	15 minutes $4.59
T1003	UP	LPN/LVN Services	15 minutes $4.03
S5125	U1	Attendant Care Services	15 minutes $3.50
S5125	UJ	Attendant Care Services	15 minutes $1.75
S5125	U1 AND UN	Attendant Care Services	15 minutes $2.63
S5125	U1 AND UP	Attendant Care Services	15 minutes $2.33
H2011	U7	Crisis Intervention Services	15 minutes $18.75
H2011	TD	Crisis Intervention Services	15 minutes $6.13
H2011	TE	Crisis Intervention Services	15 minutes $6.13
T2025		Waiver Services	15 minutes $3.50
T2025	UN	Waiver Services	15 minutes $2.00
H2017	U7	Psychosocial Rehabilitation Services	15 minutes $18.75
H2017	TD	Psychosocial Rehabilitation Services	15 minutes $6.13
H2017	TE	Psychosocial Rehabilitation Services	15 minutes $6.13

Proc. Code	MOD	Service Description	Units
H2017	AJ	Psychosocial Rehabilitation Services	15 minutes $9.38
H2014	U7	Skilled Training and Development	15 minutes $18.75
H2014	AJ	Skilled Training and Development	15 minutes $9.38
H2014	TD	Skilled Training and Development	15 minutes $6.13
Z0616		Environmental Access. (Ramp)	$4,000.00 per recipient; once the recipient reaches 90% or greater of the cap and the account has been dormant for 3 years, the recipient may access another $4,000.00
Z0617		Environmental Access. (Lift)	
Z0618		Environmental Access. (Bathroom)	
Z0620		Environmental Access. (Other)	
Z0621		Medical Equip. & Supplies (lifts)	$4,000.00 per recipient; once the recipient reaches 90% or greater of the cap and the account has been dormant for 3 years, the recipient may access another $4,000.00
Z0622		Medical Equip. & Supplies (switches)	
Z0623		Medical Equip. & Supplies (controls)	
Z0624		Medical Equip. & Supplies (other)	
T1005	HQ	Respite Care	15 minutes $2.87
H2023		Supported Employment	15 minutes $6.54
H2026		Ongoing Support to Maintain Employment	Day $50.00
H2025	TT	Ongoing Support to Maintain Employment	15 minutes $2.00
T2002		Non-Emergency Transportation	Day (Roundtrip) $12.00
A0130		Non-Emergency Transportation (wheelchair)	Day (Roundtrip) $20.00
T2019		Habilitation, Supported Employment	15 minutes $1.63
T2021		Day Habilitation Waiver	15 minutes $1.63
T2002	U6	Non-Emergency Transportation	Day (Roundtrip) $12.00
A0130	U6	Non-Emergency Transportation wheelchair	Day (Roundtrip) $20.00
T2038		Community Transition, Waiver	Lifetime $3,000.00
S5125	UN AND UJ	Attendant Care Services	15 minutes $1.32
S5125	UP AND UJ	Attendant Care Services	15 minutes $1.17

The specified modifier(s) is/are required for this procedure code.

Modifiers

Certain procedure codes will require a modifier (or modifiers) in order to distinguish services. The following modifiers are applicable to New Opportunities Waiver (NOW) providers:

AJ = Licensed Social Worker
HQ = Group Setting
TD = Registered Nurse (RN)
TE = Licensed Practical Nurse (LPN)
TT = Individual Service Provided to More than One Person
UJ = Night
U1 = Day
UN = 2 people
UP = 3 people
U6 = Day Habilitation
U7 = Psychologist

NEW OPPORTUNITIES WAIVER (NOW) FACT SHEET

Description	Home and Community-Based Services Waiver programs are based on federal criteria which allow services to be provided in a home or community-based setting for the recipient who would otherwise require institutional care. Due to the demand for these services, there is an MR/DD Request for Services Registry (RFSR) that lists individuals who meet the Louisiana MR/DD definition, and their request date. This waiver is offered on a first-come, first-served basis. Persons interested in being added to the MR/DD Request for Services Registry for this waiver should contact their local Regional Office of Citizens with Developmental Disabilities. The application process does not begin until a slot is available. At that time, medical and financial determinations are done simultaneously to validate that the individual has mental retardation or a developmental disability, and meets the financial and medical/psychological requirements for institutional care in an ICF/MR. Through freedom of choice, requestors choose their case management and direct service providers. NOW is only appropriate for those individuals whose health and welfare can be assured via the Comprehensive Plan of Care and for whom home and community-based waiver services represent a least restrictive treatment alternative. NOW is intended to provide specific, activity focused services rather than continuous custodial care. The following are the services provided under the NOW: Individualized and Family Support (IFS) Service-Day-Night, Shared Supports for some services, Center-Based Respite, Community Integration Development, Environmental Accessibility Modification, Specialized Medical Equipment and Supplies, Residential Habilitation-Supervised Independent Living, Day Habilitation and Transportation for Day Habilitation; Supported Employment and Transportation for Supported Employment; Facility-Based Employment, Professional Services, Professional Consultation, Personal Emergency Response System, Skilled Nursing Service, Substitute Family Care, Transitional Expenses; Transitional Professional Support Service.
Level of Care	Requestors must meet ICF/MR level of care for medical and/or psychological criteria. Procedure and requirements are the same as ICF/MR facility determination for admission.
Population	Age ≡Age 3 years and older and Mentally Retarded or Developmentally Disabled (MR/DD) which manifested prior to age 22. Must meet the Louisiana definition for MR/DD.
Financial	• Income: For 2005, the monthly income limit is up to 3 times the SSI amount. For children, income of other family members is not considered if the child receives SSI. Parental income is counted toward minor children for the month of admission only. The income of the minor and the income of the parent(s) with whom the child lived during that month are counted together. • Resources: For 2005, countable resources cannot be worth more than $2,000 for an individual or $3,000 for a couple who needs ICF/MR Level of Care. For 2005, under Spousal Impoverishment rules, a married couple can have up to $95,100 in countable resources, as long as there is a spouse still living at home. • These income and resources limits are subject to change each year.

For Information About Accessing NOW Services, Please Contact Your Regional OCDD Office.

Reissued February 1, 2005 BCSS-RC-03-002
Replaces September 17, 2004 Issuance

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CSRAs

METROPOLITAN HUMAN SERVICES DISTRICT
Janice Monetta, CSRA
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
Herman Bignar, CSRA
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
John Hall, CSRA
690 E. First Street
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

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

REGION V
Connie Mead, CSRA
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
Nora H. Dorsey, CSRA
429 Murray Street - Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
Rebecca Thomas, CSRA
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
Deanne W. Graves, CSRA
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
Marie Gros, CSRA
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
Stephanie Campo, CSRA
3101 W. Napoleon Ave – S140
Metairie, LA 70001
Phone: (504) 838-5357
FAX: (504) 838-5400

ADULT DAY HEALTH CARE
LEVEL OF CARE 27

SERVICES PROCEDURE CODES/RATES

The current rates for payment are effective from July 1, 2005 thru June 30, 2006.

Revenue Code	Service Description	Units
HR932	Medical Rehabilitation Day Program-Sub.Category 2-Full Day	$55.21-$58.95

Reissued August 15, 2005
Replaces All Previous Issue

BCSS-PC-04-005

DEPARTMENT OF HEALTH AND HOSPITALS
DIVISION OF LONG TERM SUPPORTS AND SERVICES

ADULT DAY HEALTH CARE (ADHC) WAIVER FACT SHEET

Description	The Adult Day Health Care (ADHC) Waiver provides home and community-based services to qualified individuals who would otherwise require nursing facility placement. The Department of Health and Hospitals (DHH) maintains an Adult Day Health Care (ADHC) Request for Services Registry (RFSR). To determine available ADHC Waiver services, DHH gives priority to persons on the ADHC Request for Services Registry (RFSR). Based on the date of first request for services, priority is given to individuals who are in a nursing facility and who can return to their homes if ADHC waiver services are provided as well as those who have indicated that their medical condition is such that they are likely to go into a nursing facility within the next 120 days, unless wavier services are provided. Remaining ADHC Waiver "slots", if any, are offered on a first come, first serve basis to individuals who qualify for admission to a nursing facility, but who are not at high risk of being admitted to a nursing facility. Persons interested in the ADHC Waiver should contact the Louisiana Options in Long Term Care Statewide Toll Free Help Line at: 1-877-456-1146 (TDD Line: 1-877-465-1172) to have their name added to the Adult Day Health Care (ADHC) Request for Services Registry (RFSR). The application process does not begin until an ADHC Waiver "slot" is offered to an individual on the ADHC Request for Services Registry (RFSR) in accordance with the priorities set forth above. At that time medical and financial eligibility determinations are performed at the same time. Individuals who do not meet both the medical and financial eligibility criteria will not be approved for ADHC Waiver services and will be removed from the ADHC Request for Services Registry (RFSR). Individuals who are approved for ADHC Waiver services have freedom of choice among providers. Adult day health care, which is provided at an ADHC facility, is the primary service provided under this waiver, other services include health services, direct care services, social services, nutrition, and transportation.
Population	Age – 65 years of age or older, who meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility; ***or*** age 22-64 who are disabled according to Medicaid standards or SSI disability criteria, meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility.
Criteria	Requestors **must meet the level of care criteria** for admission to a nursing facility. Medical and social information must be submitted to support this determination.
Financial	♦ Income - For 2006, the income limits are $1,809 (up to 3 times the SSI amount) for an individual and $3,618 for a couple when both spouses need long-term care. ♦ Resources - For 2006 countable resources cannot be worth more than $2,000 for an individual or $3,000 for a couple when both spouses need long-term care. For 2006, under Spousal Impoverishment rules, a couple can have up to $99,540 in countable resources, as long as there is a spouse at home who does not get long-term care. ♦ The income and resource limits are subject to change each year.

All new requests for the ADHC Waiver should be directed to the Louisiana Options in Long Term Care Statewide Toll Free Help Line at: 1-877-456-1146(TDD Line: 1-877-465-1172).

Reissued March 14, 2006
Replaces January 6, 2006

DLTSS-RC-05-002
Page 1 of 1

SUPPORT COORDINATION SERVICES

ENROLLMENT

A support coordination agency (case management) must request a separate enrollment and Medicaid provider number for each target or waiver group before providing services.

All applicants/enrolled agencies must comply with all published licensing and support coordination rules and the requirements contained in the Case Management Services Provider Manual reissued July 1, 2002.

Note: Services cannot be provided nor billed until all requirements for enrollment as a Support Coordination provider have been met.

Change Of Address/Enrollment Status

Providers who have changes in enrollment information should notify in writing:

Department of Health and Hospitals (DHH)
Health Standards Section (HSS)
P.O. Box 3767
Baton Rouge, LA 70821

AND

Unisys Provider Enrollment Unit
P.O. Box 80159
Baton Rouge, LA 70898-0159

Enrolled support coordination providers will be subject to review by DHH or its contractor, HSS for licensing and Medicaid certification and the U.S. Department of Health and Human Services to verify compliance with all Provider Enrollment requirements at any time subsequent to enrollment.

AGENCIES ENROLLED TO PROVIDE SUPPORT COORDINATION TO THE INFANTS AND TODDLERS WITH SPECIAL NEEDS POPULATION (EARLYSTEPS) MUST ALSO COMPLY WITH THE REQUIREMENTS CONTAINED IN THE EARLYSTEPS PRACTICE MANUAL LOCATED ON THE OPH WEBSITE:
WWW.OPH.DHH.LOUISIANA.GOV/CHILDRENSSPECIAL/EARLYINTERVENTIONSERVICES/

COVERED SERVICES

All requirements must be adhered to as outlined in the Case Management Services Provider Manual, Section 5.

Intake

The support coordinator must contact the participant within three (3) working days of receipt of the Freedom of Choice (FOC) to determine the participant's eligibility, need, appropriateness, and desire for Support Coordination services.

Assessment

- The initial assessment must begin within seven (7) calendar days and be completed within 30 calendar days of the referral.
- A reassessment must be completed within 7 days of notice of a change in the participant's status.
- Quarterly review of the CPOC, with the support coordinator and participant to determine if the participant's needs continue to be addressed.
- Annual Assessments/Re-certifications - Completed and approvable packet to DLTSS/OCDD Regional Office no later than 35 calendar days but as early as 60 days prior to expiration of the CPOC.

Comprehensive Plan of Care

The completed and approvable CPOC must be submitted and received by DLTSS/OCDD regional office within thirty-five (35) calendar days from the date of the referral.
The CPOC must be revised annually (or as necessary) to meet the needs of the participant and be received by the DLTSS/OCDD regional office no later than 35 calendar days prior to expiration.

Note: The 90-L may be completed 90 days prior to the expiration of the CPOC, but it must be received by DLTSS/OCDD Regional Office no later than 35 days prior to the expiration of the CPOC.

Changes in the CPOC

- The CPOC must be reviewed at least quarterly.
- The CPOC for Children's Choice participants must be reviewed at least 6 to 9 months after implementation.
- Routine changes must be submitted 15 working days prior to the change (vacations, family, and school out of session).
- Emergency changes must be submitted within 24 hours or the next working day.

Note: Changes in waiver service provider(s) can only be requested by the participant; any request for a change requires a completion of a Freedom of Choice (FOC) form.

Documentation

- A copy of the approved CPOC must be kept in the participant's home, in their case record at the Support Coordination agency, and in the service provider's files.
- A copy of the CPOC must be made available to all staff directly involved with the participant.

Note: After the initial CPOC is completed, all billable ongoing support coordination services must be provided according to the approved written CPOC.

Building and Implementing Supports

- The support coordinator is responsible for building and implementing the supports and services as described in the CPOC.
- The support coordinator should develop and access natural and non-paid supports prior to accessing shared and other paid supports.
- The support coordinator should not supplant natural and non-paid supports with the development of paid supports.

Monitoring Support Strategies

The support coordinator must contact the participant within 10 working days after services begin to assure the appropriateness and adequacy of the service delivery for participants receiving waiver services.

Monitor the service provider(s) quarterly through:

- Observation of the provision of direct services (NOW and EDA)
- Review of the service provider's current log
- Monthly telephone call

Support Coordination Transition/Closure

The transition or closure of support coordination services occurs in response to the request of the participant, or if the participant is no longer eligible for services.

The agency must complete Form 148 and submit it to the appropriate DLTSS/OCDD Regional Office along with any necessary supporting documentation. Data Entry into CMIS must also be completed.

NOTE: Providers are reminded that they should report to the DLTSS/OCDD Regional Office when participants (1) are arrested (convicted or not convicted); (2) are convicted of crimes (house arrest or incarcerated); or (3) are not receiving waiver services. These instances should at least be classified as an incident. Due to the 30-day rule of continuity of care, notification should be as soon as the incident occurs, but prior to 30 days non-compliance.

Procedures for Changing Providers

A participant may change support coordination agencies once after a six month period and for Good Cause.

Good Cause is defined as:

- The participant moves to a new region; or
- There is another family member receiving services and is assigned to another agency; or
- The participant and Support Coordination agency have unresolved difficulties and mutually agree to a transfer. This transfer must be approved by the DLTSS/OCDD Support Coordinator Administrator, prior to transfer.

Once the participant has selected a new Support Coordination provider and SRI has linked the participant to a provider, the new provider must complete the FOC file transfer. Also, the receiving agency must obtain the case record and authorized signature, and inform the transferring Support Coordination agency.

STAFFING REQUIREMENTS

All staffing requirements for education, experience and training as outlined in the Case Management Services Provider Manual, Section 6, and published rule must be adhered to.

On-Site Project Manager

Responsible for the overall operation of the agency and are responsible to DLTSS/OCDD for Quality Assurance and Self-Evaluation. The education and experience required of the On-Site Project Manager shall be identified by the agency. Each agency in each DHH region must have an On-Site Project Manager.

Support Coordinator

Experience gained while employed in a position in which ***minimum qualifications were not initially met*** cannot be counted toward the required experience.

Experience as a teacher does not qualify as direct services.

Support Coordinator Trainee

All requests for this position must be submitted in accordance with Section 6 of the manual and approved prior to implementation.

A support coordinator trainee's caseload may never exceed 20 participants.

The trainee position counts as one (1) of the eight (8) Support Coordinators under a supervisor's direction. There shall only be one (1) Support Coordinator trainee position per supervisor.

Support Coordination Supervisor or Any Other Individual Supervising Support Coordinators

All Support Coordination supervisors must meet the qualifications for education and experience as identified in the Case Management Services Provider Manual re-issued July 1, 2002.

Nurse Consultant

Support Coordination agencies must employ or contract a nurse to provide consultation on health related issues and education and training to the agency's staff and supervisors. He/she employed or contracted for a minimum of 4 hour per week and is to be on-site at the agency.

TRAINING

Support Coordinators need ongoing training to maintain and improve their performance. Such training must be provided by or arranged by the Support Coordinator's employer at the employer's expense.

- All training mandated by DHH is required.

A new employee **shall not be given** Support Coordination responsibility until the orientation is satisfactorily completed.

Note: Routine supervision shall not be considered training.

Mandatory DHH Training

Support Coordination agencies must ensure that support coordinator staff attend and satisfactorily complete mandated DHH training on support coordination policies and procedures. Certificates will be given for attendees and will indicate the hours and training category.

STAFF COVERAGE

The support coordination agency must ensure that support coordination services are available 24 hours a day, 7 days a week, through the toll free number.

Hours

Each support coordinator and supervisor must be employed 40 hours per week and work at least 50% of the time during normal business hours (8:00 a.m. to 5:00 p.m., Monday through Friday).

There must be one full time Support Coordination supervisor for every eight (8) support coordinators.

A supervisor must maintain on-site office hours at least 50% of the time during normal business hours.

A supervisor must also be continuously available to support coordinators by telephone or beeper at all times when not on site.

Sharing Onsite Project Managers

Agencies having more than one contract and request that project managers share administrative responsibilities must submit a plan to the DLTSS/OCDD Service Coordination Program Administrator for approval prior to implementation.

Caseload Size and Mix

Each full-time support coordinator can have a caseload of no more thirty-five (35) participants. For providers of Infants and Toddlers/EarlySteps support coordination, the maximum caseload is fifty (50).

Each support coordination supervisor must not supervise more than eight (8) full-time support coordinators or other professional-level human service staff.

- A supervisor may carry 1/8 of a caseload for each support coordinator supervised fewer than eight (8). But never more than 50% of their time can be used for caseloads
- A supervisor carrying a caseload must be supervised by an individual who meets the supervisory qualification in Section 6 of the Case Management Services Provider Manual re-issued July 1, 2002.
- A plan must be approved by DLTSS/OCDD prior to implementation.

PRIOR AUTHORIZATION PROCEDURES

All support coordination services must be in accordance with the approved Comprehensive Plan of Care (CPOC) and prior authorized before billing for services. Claims cannot be submitted until the billing cycle is completed and all data is entered into the Case Management Information Systems (CMIS), the required data system. A Prior Authorization (PA) number cannot be used for billing if the participant is not Medicaid eligible. If DLTSS/ OCDD or designee issues a PA

number that begins prior to the date on which the participant becomes Medicaid eligible, that PA number cannot be used to bill. It is the support coordination agency's responsibility to verify the participant's Medicaid eligibility and continued eligibility through MEVS/REVS.

Support coordination agencies must submit data for the statewide data base to obtain a PA number. Submissions are required at least weekly. Unless specified otherwise within a specific population, after support coordination services are entered into Case Management Information System (CMIS) PA's for the first two months of the quarter will be released; however, if services are not entered into CMIS which document the provision of the required services, PA's for the last month of the quarter will not be released.

Timely data entry is required. Services must be entered by the 14th of the month following the end of the calendar quarter in order for PA for the last month of the quarter to be released prior to billing. The month that a participant's case is closed becomes the last month of the quarter and all quarterly required services must be completed regardless of where the date falls in the quarter. The DLTSS/OCDD Quality Management personnel will monitor support coordination records to determine if documentation in the support coordination records supports CMIS entries. If documentation to support CMIS entries is not found in the support coordination records, recoupment will be made by DHH. Referral to SURS may be made since this is viewed as intentional misrepresentation of services provided. Information files must be submitted to DLTSS/OCDD or designee via e-mail.

New Opportunities Waiver (NOW)

New Participants

Freedom of Choice (FOC) for support coordination is provided to the participant only by OCDD or designee.

OCDD or designee will link participants to their first choice, if the support coordination agency has not reached their capacity.

OCDD or designee notifies the linked support coordination agency of a new NOW participant by faxing the FOC form to the support coordination agency and BHSF or designee.

The PA will be issued with an effective date of the 51NH Admission Date and ending the last day of the month prior to the CPOC expiration date.

Group Home Conversion or Developmental Center Discharges

OCDD will approve payment for up to 4 months prior to the discharge date from a Developmental Center or Group Home Conversion. In order to receive the PA number for this time period you must submit the following:

1. Group Home/Developmental Center Discharge to Community request form (BCSS-PF-04-003),
2. Form 51-NH,
3. Form 148 (with the reason for discharge noted) from the discharging agency,
4. All progress notes for the 4 month time period prior to discharge, and
5. The approval page of the CPOC.

These requests are to be submitted to the OCDD State Office for the Support Coordination Administrator's approval. (Authorization will be issued only for each month in which the requirements are documented as met.)

High Need (Intensive) Support Coordination

Prior authorization for High Need support coordination is available for individuals transitioning from a nursing facility or an ICF-MR. Requests for payment at this rate are to be submitted to the DHH Support Coordination Section for approval as outlined in BCSS-C-02-023 dated October 22, 2002.

Children's Choice Waiver

New Participants

FOC forms for support coordination are provided to the participant by OCDD or designee.

OCDD or designee links the participant to their choice of support coordination agency, depending on availability. If the participant is an EPSDT targeted population participant currently linked as receiving EPSDT targeted population (ETP) support coordination, they will remain with the same agency and will be dually linked with a targeted type of CC. The ETP prior authorization number will be issued or modified for a two month period. If the participant is not currently linked as targeted type-ETP and is a Medicaid participant, OCDD or designee will link the participant for EPSDT targeted population support coordination with a targeted type-CCTR (Children's Choice Transition Participant) for a two month period. If the participant does not have Medicaid they will be linked as ADMN for a two month period.

OCDD or designee notifies the linked support coordination agency of a new CC participant by faxing the FOC to the agency and BHSF or designee. Only linkages from OCDD or designee are valid.

The PA for support coordination providers will begin on the first day of the month after the 51NH admission date or on the 51NH admission date if no overlapping PA exists.

Elderly And Disabled Adult Waiver (EDA)

New Participants

Freedom of Choice (FOC) for support coordination is provided to the participant only by DLTSS or designee.

DLTSS or designee will link participants to their first choice of support coordination agency.

DLTSS or designee notifies the linked support coordination agency of a new Elderly and Disabled Adult Waiver participant by faxing the FOC to the support coordination agency and BHSF or designee. Only linkages from DLTSS or designee are valid.

The PA will be issued in accordance with the effective date on the 51NH Admission Date and ending the last day of the month prior to the CPOC expiration date.

Transition Intensive Support Coordination (Case Management)

Transition Intensive Support Coordination (Case Management) services are available in the EDA Waiver (HIPAA Code 20178) for individuals transitioning from a nursing facility who may require a more intense level of support coordination during the transition period. Requests for payment at this rate are to be incorporated in the CPOC and submitted to the DLTSS regional office for review and approval and prior authorized. Support Coordination agencies cannot bill for support coordination and Transition Intensive Support Coordination at the same time.

Adult Day Health Care (ADHC)

New Participants

The DLTSS or designee will provide a Freedom of Choice (FOC) for those individuals on the ADHC Request for Services Registry (RFSR) requesting Adult Day Health Care Waiver services. The participants will be linked to their first choice of ADHC Facility by the ADHC provider FOC Form.

The DLTSS or designee notifies the linked ADHC Facility of a new participant being evaluated for ADHC Waiver eligibility by facsimile and mail of a copy of the ADHC FOC Form. Only linkages from DLTSS are valid.

The Prior Authorization (PA) will be issued in accordance with the approved Comprehensive Plan of Care (CPOC) and the effective date on the 51 NH Admission date section and ending the last day of the month prior to the CPOC expiration date. No services will be provided without an approved CPOC and PA.

Those individuals requesting to be evaluated for an ADHC Waiver opportunity (slot) must be on the ADHC RFSR. The ADHC Waiver application process does not begin until an ADHC Waiver "slot" is offered to a person on the ADHC RFSR. At that time, medical and financial eligibility

determinations are completed simultaneously. Individuals who do not satisfy both the medical and financial eligibility criteria will not be approved for ADHC Waiver services and will be removed from the ADHC RFSR. A call to Louisiana Options in Long Term Care 1-877-456-1146 is necessary to request ADHC Waiver services.

HIV Targeted Population

New Participants

FOC forms for support coordination are provided to the participant by DLTSS or designee. The participant can choose to have the FOC form mailed (or faxed) to the address of their choice. If it is an address other than their own, form BCSS-RF-04-011 will be filled out. After completing the form, the participant then returns the form by mail (or fax) to DLTSS or designee along with the participant data sheet for HIV support coordination linkage (form BCSS-CM-03-008).

DLTSS or designee will link participants to their choice of support coordination agency.

DLTSS or designee notifies the linked support coordination agency of a new participant by faxing the support coordination agency the FOC form. This will be followed by the electronic upload of linkage notification. DLTSS or designee also notifies the participant of the assigned agency. Only linkages from DLTSS or designee are valid.

The support coordination agency mails the Client Data Form, including Medicaid number, along with the signature page of the approved CPOC/Plan of Care to DLTSS or designee no more than 60 days from the beginning of the CPOC/Plan of Care meeting date. The packet will not be accepted by telephone or fax.

The PA number is issued with the effective starting date as the approval date listed on the Signature Page with the following exception:

If the PA Packet is received by DLTSS or designee more than 60 days from the CPOC/Plan of Care meeting date, the PA number will be issued with an effective starting date of 60 days prior to the receipt date.

The PA will be issued with an effective date of the signature on the approved CPOC/Plan of Care and ending the last day of the month prior to the CPOC/Plan of Care expiration date. PA will never be issued with an effective date prior to the FOC date.

Exception to the FOC of choice policy for New HIV Participants: If the licensed and Medicaid enrolled Support Coordination agency has already been serving the participant through Ryan White funds and the participant becomes Medicaid eligible and wishes to switch to Medicaid funded HIV support coordination while remaining with the same support coordination agency, the support coordination agency will send the Client Data Form along with the signature page of the Plan of Care to DLTSS or designee. The support coordination agency should make sure to include the participant's Medicaid number and indicate on the form the date the agency will begin providing Medicaid Support Coordination Services.

Case Closure

The support coordination agency is required to submit the CMIS Closure form to DLTSS or its designee with the reason for closure noted. The PA time period will be modified to end on the date of closure. DLTSS of designee will send the modified PA (void link notice) electronically to the support coordination agency.

All Populations (NOW, Children's Choice, EDA)

Transfer of Participant

FOC forms for support coordination are provided to the participant only by DLTSS, OCDD, or designee.

DLTSS/OCDD or designee will notify the linked support coordination agency of a new participant by faxing the FOC to the agency indicating the transferring agency. Only linkages from DLTSS/ OCDD or designee are valid.

The receiving support coordination agency must contact the transferring agency to obtain the required records. Both the transferring and receiving agencies complete the Transfer of Records Section on the FOC form. The receiving agency is responsible for delivering services to the participant beginning on the transfer of records date. The transferring agency is responsible for delivering services to the participant through the transfer of records date. The receiving agency mails the completed FOC form/Transfer of Records Section to DLTSS/OCDD or designee. The FOC form/Transfer of Records Section will not be accepted by telephone or fax.

A new PA number will be issued with an effective starting date of the first day of the first month after the date of transfer of records but in no case will DLTSS/OCDD or designee backdate the PA prior to the first day of the month in which the FOC form/Transfer of Records Section is received by DLTSS/ OCDD or designee. The transferring agency's PA number will expire on the date of transfer of records.

NOTE: Lack of cooperation in the transfer of records process must be reported to the DLTSS/OCDD regional office. All allegations of failure to cooperate will be reviewed by the DLTSS/OCDD Support Coordination Program Administrator.

Renewal PAs

DLTSS/OCDD or designee will automatically issue PA numbers upon receipt of the approved annual CPOC/plan of care for the following CPOC year ending the last day of the month prior to the CPOC expiration date.

Replacement PAs

Replacement PA numbers required because of incorrect Medicaid numbers will be issued for the exact date range of the original PA number. A request for a replacement PA number must be sent in writing to DLTSS/OCDD or designee on the Replacement PA form. Requests will not be accepted by telephone.

Case Closure

The month that a participant's case is closed becomes the last month of the quarter and all quarterly required services must be completed.

The support coordination agency is required to submit the Form 148 to the DLTSS/OCDD Regional office with the reason for closure noted. The PA time period will be modified to end on the date of closure. DLTSS/OCDD or designee will send the modified PA (void link notice) electronically to the support coordination agency.

Data System

All agencies must submit current data into the DLTSS/OCDD approved statewide database maintained by the data contractor. Data must be sent at least weekly to SRI via E-mail. All participant files must be current prior to billing. Agencies that fail to enter all data will be assessed sanctions. At the end of each quarter a review will be done of all data collected to determine what services have been provided. Failure to comply with data requirements shall result in sanctions and/or recoupment. All data reflecting services provided must be entered into the computer system no later than the 14th day following the end of the quarter.

Note: SRI process files daily. Files received by 3:00 p.m. will be processed that day.

Note: A replacement PA due to an incorrect or replaced Medicaid number will be issued for the exact date range of the original PA number. A request for a replacement PA must be submitted in writing to Statistical Resources Inc (SRI). Requests cannot be made over the telephone or E-mail.

REIMBURSEMENT

General Requirements

Candidates for Support Coordination services must be Medicaid eligible. Medicaid eligibles must be certified as a member of the targeted populations by the Medicaid agency or its designee. Payment for targeted or waiver Support Coordination services is dictated by the nature of the activity and the purpose for which the activity is performed. These activities must be related to and obtain the outcomes identified in the approved CPOC. All Support Coordination services billed must be provided by qualified support coordinators and meet the DHH definition of Support Coordination services provided by qualified staff to the targeted or

waiver population to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services.

For waiver participants who are institutionalized (enter a hospital, nursing facility, or ICF/MR), Support Coordination that is a waiver service cannot be billed during the time the participant is institutionalized.

Federal Regulations

Federal regulations require that the Medicaid Program ensure that payments made to providers do not duplicate payments for the same or similar services furnished by other providers or under other authority such as an administrative function or as an integral part of a covered service. Therefore, Support Coordination providers must not bill Medicaid for Support Coordination services at the same time they bill another funding source for the same service.

General Provisions for Reimbursement

The reimbursement rate for optional targeted and waiver Support Coordination services is a monthly rate as defined by negotiated amount in the contract for contracted agencies, or the amount specified by the DHH, which is associated with intake, ongoing assessment, planning (development of the CPOC), building/implementing supports, monitoring support strategies and transition closure. These fees are established based on the cost of providing these services to an eligible participant of a target or waiver group.

All Support Coordination activities must lead to the presence of the personal outcomes defined and prioritized by the participant during the person centered planning process, and/or be associated with organizational processes which lead to the presence of personal outcomes as identified and documented in the approved CPOC for the individuals served. All Support Coordination activities must be appropriately documented as specified in the Record Keeping Documentation section and Services section of the Case Management Services Provider Manual re-issued July 1, 2002.

- Documentation in the required data system must be current prior to billing for service. Sanctions will be assessed to non-compliant agencies.

COST REVIEWS AND AUDITS

Cost reviews and/or audits will be conducted based on allowable cost in accordance with the guidelines prescribed by the ***Provider Reimbursement Manual*** not to exceed limitations established by the Medicaid Program.

All agencies are required to submit a yearly external audit as per licensing and contract requirements. Agencies shall not have outstanding or unresolved audit disclaimers with DHH.

GENERAL RECORD KEEPING

Failure to comply may result in one or more of the following: recoupments, sanctions, loss of enrollment, or referral to Surveillance and Utilization Review Systems (SURS).

NOTE: See BCSS-C-04-019/BCSS-P-04-015/BCSS-ADM-04-005 dated 7/23/04.

Components of Record Keeping

All records must be maintained in an accessible, standardized order and format at the agency's enrolled DHH Administrative Regional site. The Support Coordination agency must have sufficient space, facilities, and supplies to ensure effective record keeping.

The provider must keep sufficient records to document compliance with DHH Support Coordination requirements for the target or waiver populations served and the provision of Support Coordination services.

A separate Support Coordination record must be maintained on each participant that fully documents services for which payments have been made. The provider must maintain sufficient documentation to enable DHH to verify that each charge is due and proper prior to payment.

The provider must make available all records that DHH finds necessary to determine compliance with any federal or state law, rule, or regulation.

Retention of Records

The Support Coordination agency must retain records for whichever of the following time frames is longer:

Until records are audited and all audit questions are answered

OR

Five (5) years from the date of the last payment

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

Confidentiality and Protection of Records

Records, including administrative and participant, must be the property of the Support Coordination agency and the agency, as custodian, must secure the records against loss, tampering, destruction or unauthorized use throughout the retention period whether the agency is in operation or closed.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the participants or their families, directly or indirectly, to any

unauthorized person. The provider must safeguard the confidentiality of any information from which participants or their families might be identified. Conditions for release of information are identified in the Case Management Services Provider Manual.

Note: Under no circumstances should the Support Coordination agency allow Support Coordination staff to take case participant records out of the office.

Support Coordination Agencies are responsible for compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1999.

Review by State and Federal Agencies

Providers must make all administrative, personnel and participant records available to DHH and appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of participant information in accordance with HIPAA rules and regulations.

Participant Records

A provider must have a separate written record for each participant served by the Support Coordination agency.

Support Coordinator providers will document progress as follows:

Service Logs/Progress Notes-Chronology of events and contacts, which support justification of critical case management elements for Prior Authorization of services in the CMIS system. Each service contact is to be defined (i.e., telephone call, face to face visit) with narrative in the form of a progress note that elaborates on the services provided and the substance of the contact.

Progress Summary-Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress/lack of progress toward desired outcomes and changes to the social history. This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other support coordinators or their supervisors, and allows for evaluation of activities by program monitors.

Table of Documentation Schedule

Service Providers				
Waiver	**Service Log/ Payroll Sheet**	**Progress Notes**	**Progress Summary**	**Case Closure/ Transfer**
Children's Choice	At Time Of Activity	At Time Of Activity	Between The 6th And 9th Month Or More Frequently, If Indicated	Within 14 Days Of Discharge
Elderly And Disabled Adult	At Time Of Activity	At Time Of Activity	At Least Every 90 Days	Within 14 Days Of Discharge
New Opportunities Waiver	At Time Of Activity	At Time Of Activity	At Least Every 90 Days	Within 14 Days Of Discharge
Targeted Population	At Time Of Activity	At Time Of Activity	At Least Every 90 Days	Within 14 Days Of Discharge

Availability of Participant Records

Providers must always safeguard the confidentiality of participant information in accordance with HIPAA rules and regulations. Under no circumstances should the Support Coordination agency b allow Support Coordination staff to take records home. The Support Coordination agency can release confidential information only under the following conditions:

- By court order; or
- By the participant's written informed consent for release of information. In cases where the participant has been declared legally incompetent, the individual to whom the participant's rights have devolved must provide informed written consent.

Storage of Participant Records

Providers must provide reasonable protection of participant records against loss, damage, destruction, and unauthorized use. Administrative, personnel and participant records must be retained until records are audited and all audit questions are answered or five (5) years from the date of the last payment, whichever is longer.

Supervisory Record Keeping

- Each supervisor must maintain a file on each support coordinator supervised and hold supervisory sessions at least on a weekly basis.

QUALITY ASSURANCE / QUALITY IMPROVEMENT PLANS AND REVIEW

Quality Assurance/Quality Improvement (QA/QI) PLAN

An agency's QA/QI plan must be submitted within 60 days following licensure. An agency's QA/QI plan must be submitted to the DLTSS/OCDD QA/QI manager.

Agency Self-Evaluation

Six (6) months after licensure, and annually thereafter, the agency is required to conduct an agency self-evaluation and to submit a report on the findings of the self-evaluation to the DLTSS/OCDD QA/QI manager. The findings of the report are subject to the approval of DLTSS/OCDD . More frequent self-evaluation by the agency may be required as part of a corrective action plan.

Report Of Self-Evaluation Findings

The agency must submit a report of the findings of the self-evaluation to:

The Division of Long Term Supports and Services (DLTSS)
QA/QI Program Manager
446 North 12th Street
Baton Rouge, LA 70802-4613

Or
Office for Citizens with Developmental Disabilities Waiver Supports and Services (OCDD)
QA/QI Program Manager
446 North 12th Street
Baton Rouge, LA 70802-4613

The initial self-evaluation is due 6 months after approval of the QA/QI plan, and then once a year after the first report.

PROGRAM MONITORING

As a result of Act 483 of the 2005 Louisiana Legislature Session and the Department's Immediate Action Plan for Health Care Reform the licensing authority was transferred from the Department of Social Services (DSS) to the Department of Health and Hospitals (DHH), Health Standards Section for:

- Personal Care Attendant
- Supervised Independent Living
- Respite
- Center-Based Respite
- Family Support
- Support Coordination (Case Management) and
- Adult Day Health Care

One of the reasons for this transfer was to consolidate the licensing and Medicaid regulatory authority oversight in one department in an effort to reduce duplication and streamline the process. Health standards will monitor the licensing and Medicaid certification for the Direct Service Providers and Support Coordination (Case Management).

IMPORTANT INFORMATION/REMINDERS

HOSPICE SERVICES

Beginning July 1, 2005, Medicaid only and "Dual Eligible Recipients" (simultaneously Medicaid and Medicare eligible) will NOT be permitted to receive both waiver and hospice services at the same time. Waiver participants considering hospice services must be provided the documentation necessary for them to make an informed choice. Should hospice be selected, the participant and the support coordinator must sign the Hospice Election Form.

(Refer to attached Memorandum BCSS-P-05-024/BCSS-C-05-007: Clarification and Continuation of Waiver-Hospice Policy.)

There will be no grandfathering in of participants.

SERVICE AREA/REGIONS

Support Coordination agencies may not provide services in regions outside of the region in which the agency is licensed and the license is not transferable between regions of the state.

COMPRENSIVE PLAN OF CARE

All CPOC planning must be person centered.

- **The support coordinator should develop and access natural and non-paid supports prior to accessing shared and other paid supports.**
- **The support coordinator should not supplant natural and non-paid supports with paid supports.**

NOTE: REFER TO THE DIRECT SERVICE PROVIDER SECTION OF THIS TRAINING PACKET FOR INFORMATION ON THEIR REQUIREMENTS AS IT RELATES TO INDIVIDUALIZED BACK-UP PLANS AND EMERGENCY EVACUATION RESPONSE PLANS.

PROGRESS NOTES

Progress Notes should be a "snapshot in time" documenting what is happening, what is observed, outcomes of the meeting, and follow-up required. They should contain at least the following information:

- the name of all participants (it must be clear if the participant is present)
- the place of the contact
- the date/time of the contact
- the reason for contact, support coordinator's observation of the meeting, and outcome of the contact
- the signature of the person writing the notes and the date they were written

Quarterly meetings should address all personal outcomes on the CPOC and the progress toward each.

Progress notes should be legible. Corrections shall be made by drawing a line through the erroneous information, writing "error" by the correction, and initialing the correction. Correction fluid shall not be used in participant records.

CPOC IMPLEMENTATION DATES

A. NOW and Children's Choice Waivers – Direct services cannot begin until the OCDD Regional Office approves the CPOC. This includes initial certifications and any subsequent revisions to the CPOC. Support Coordination agencies are fiscally liable for any services they authorize providers to perform due to misinformation. All approvals must be in writing.

B. Elderly and Disabled Adult Waivers – Direct services cannot begin until the DLTSS Regional Office approves the CPOC. This includes initial certifications and any subsequent revisions to the CPOC. Support Coordination agencies are fiscally liable for any services they authorize providers to perform due to misinformation. All approvals must be in writing.

MEDICAID ELIGIBILITY

Waiver population participants are not normally subject to change in eligibility as frequently as the targeted populations. Nevertheless, it is the support coordinator's responsibility for verifying eligibility.

MEDICAID WAIVER AND SUPPORT COORDINATION SERVICES POLICY AND REIMBURSEMENT

The Support Coordination agency should contact the DLTSS/OCDD Regional Office in their area first, and then the DLTSS/OCDD Support Coordination Section, and/or the Waiver Management Section as applicable for interpretation/clarification of all Medicaid policies and reimbursement issues.

FREEDOM OF CHOICE

A. Support Coordination – only the Department's data contractor may offer freedom of choice to a participant.

- OCDD is the point of entry for NOW Waiver, Children's Choice
- LA Options on Long Term Care is the point of entry for the Elderly and Disabled Adults (EDA) Waiver and Adult Day Health Care (ADHC) Waiver
- Licensed HIV agencies are the point of entry for HIV Targeted population

B. Service Providers – only the Support Coordination agency may offer freedom of choice of direct service providers

C. No one is to solicit a participant to choose any provider.

D. Any knowledge of violations of this policy should be reported to the DLTSS/OCDD regional office immediately.

E. The provider must maintain computer equipment, internet accessibility, and software compatible with those needed to conduct business with the Department (DLTSS, OCDD).

SERVICE LOGS/DATA ENTRY

Effective August 15, 2005, the following changes were made to CMIS:

Service Logs

1. Added to the list of service activities:
    17. Appeal Assistance
    18. EPSDT PA Tracking
    26. Annual Staffing (VACP only)
2. Added to the list of participants:
    12. Waiver Provider
    13. Medicaid Provider (non-waiver)
    14. Non-Medicaid Provider
    15. PAL
    16. Advocacy representative
3. Removed from the list of participants:
    06. Medicaid/Waiver Service Provider
4. For place of service, the following label changes were made:
    13. Case Management Agency became 13. Support Coordination Agency
    19. Waiver Service Provider's Place of Business became 19. Service Provider's Place of Business
5. End time of service is required for all services

Reports

Required Action Report: For NOW and EDA populations, the observation of services requires the waiver service provider to be present. Support Coordinators must use the new participant code of 12 for the required observations.

BILLING

In an effort to reduce the number of Support Coordination claim denials, Statistical Resources, Inc. suggests the following procedures:

1. Enter data daily.
2. Create and send an information file daily before 2:30 p.m. (Note: Statistical Resources, Inc. has a 3:00 p.m. deadline for receipt for files. If a file is received after 3:00 p.m., it will not be processed until the next business day and PA releases will be delayed.)

Following the above procedures will insure that PA numbers will be released to Unisys and the statewide data/monitoring information is updated on a timely basis.

For questions regarding:	Contact:
Support Coordination policy and procedures	OCDD Waiver Supports and Services (NOW and Children's Choice): (225) 219-0200 DLTSS (EDA): (225) 219-0200
Support Coordination software and data entry	Statistical Resources at (225) 767-0501
Verification of receipt of files	Statistical Resources at (225) 767-0501 (Statistical Resources will be able to verify the last file received and processed as of the prior business day.)
Prior authorization numbers (denial error codes 190 and 191)	Statistical Resources at (225) 767-0501
Denied claims or billing issues	Unisys Provider Relations at (800) 473-2783 or (225) 924-5040

DIRECT SERVICE PROVIDER (DSP)

GENERAL INFORMATION/REQUIREMENTS

- The DSPs are licensed and Medicaid certified for Medicaid Provider enrollment by the DHH, HSS.

- The DSP must meet all assurances of licensing, Medicaid certification and enrollment, HIPAA, mandatory Provider Training and Standards and any other requirements by the department.

- The DSP must comply with and maintain compliance with all requirements contained in the Home and Community Based Services Waiver Program Standards for Participation as published in the LR 29:1829 (September 20, 2003).

- **The DSP should always focus on meeting the individualized needs and preferences of waiver participants in their care. The amount, type and delivery of services provided should be in accordance with the supports and services identified in the approved CPOC and should never be based on the needs/ convenience of the provider.**

- The individual has the freedom to choose the Direct Service Provider from whom they want to receive services. The Support Coordination Agency offers the Freedom Of Choice (FOC) via an approved DLTSS/OCDD FOC list to the individual. Refer to www.dhh.la.gov/bcss for the FOC listing and the provider request form for requesting changes/providing updated information.

- **The DSP is not to solicit business. Refer to LRS 46:438.2, Illegal Remuneration (MAPIL).** The following is an excerpt from RS 46:438.2, §438.2 Illegal Remuneration:

    - No person shall solicit, receive, offer, or pay any remuneration, including but not limited to kickbacks, bribes, rebates, or bed hold payments, directly or indirectly, overtly or covertly, in cash or in kind, for the following:
        - In return for referring an individual to a health care provider, or for referring an individual to another person for the purpose of referring an individual to a health care provider, for the furnishing or arranging to furnish any good, supply, or service for which payment may be made, in whole or in part, under the medical assistance programs.
        - In return for purchasing, leasing or ordering, any good, supply, or service, or facility for which payment may be made, in whole or in part, under the medical assistance program.
        - To a recipient of goods, services, or supplies, or his representative, for which payment may be made, in whole or in part, under the medical assistance programs.
        - To obtain a recipient list, number, name or any other identifying information.

- The Support Coordinator assists the individual in the coordination of all services needed by the individual. The Support Coordination Agency is responsible for developing an

initial and subsequent annual, comprehensive plan of care (CPOC). The CPOC must reflect the individual's service needs, preferences and choice of services. The Direct Service Provider (DSP) should be in attendance during initial and annual CPOC planning meetings to facilitate the planning process, and to better understand and meet the needs of the individual. **The DSP is responsible for developing and implementing an individualized, person-centered service plan in accordance with the approved CPOC, and for ensuring that all services are provided in accordance with that plan.**

- The DSP is required to have functional Individualized Back-Up Plans and Emergency Evacuation Response Plans that are consistent with the participant's CPOC. (See the Section below on Individualized Back up plans and Emergency Evacuation Response Plans for additional information).

- The DSP shall possess the capacity to provide the supports and services required by the participant in order to assure the individual's health and safety as outlined in the CPOC.

- The DSP is responsible for the timely submission of the Individualized Back-Up Plan and Emergency Evacuation Response Plan in accordance with Department policies and procedures to assure the plans are incorporated in the CPOC.

- The appropriate DLTSS OR OCDD must review and approve all CPOCs before authorization of services is given.

- All services are approved in the CPOC, and prior authorized (PA) before the DSP can receive reimbursement for providing those services. If services are provided without being listed in the approved CPOC, and/or prior to receiving prior approval (PA) – DLTSS or OCDD CANNOT reimburse the DSP for services rendered.

- The DSP is expected to keep accurate and timely documentation regarding service provision. This includes documentation in the form of progress notes, service logs, time sheets verifying services, and the like. Simple checklists alone will not be considered as adequate documentation.

- The DSP must keep the HSS informed, in accordance with provider standards, of any changes in address, telephone numbers, change of ownership, and/or any changes that impact their ability to comply with the minimum Provider Standards of Participation as an enrolled provider of waiver services.

- The DSP is to keep the Support Coordinator informed regarding any changes that affect delivery of services as specified in the CPOC.

- The Support Coordinator is responsible for the planning and coordination of services for the participant. The DSP is required to communicate and cooperate with the planning and implementation process.

- The DSP is required to report critical incidents to the appropriate waiver office (DLTSS or OCDD) within 2 hours of first knowledge of the incident. Immediate jeopardy situations shall be handled immediately and as outlined in the Provider Standards for Participation. Refer to the DLTSS or OCDD website (www.dhh.la.gov/bcss) for the critical incident policy and reporting forms.

- The Support Coordinator Agency and the DSP are responsible to assist in the provision of information for the individual who elects to transfer by FOC to another provider.

- The DSP is to provide all required documentation to facilitate a smooth transition between providers and as directed by the Department.

- When a Children's Choice Waiver participant transfers from one DSP to another, the transferring DSP is to complete a service balance report to reflect the dollar amount of services used to date, and the remaining service balance for current CPOC year. This log must be submitted to the Support Coordinator along with the revision to the CPOC reflecting the change in DSP.

DIRECT SERVICE PROVIDER CHANGES

Only the wavier participant can request a provider change. This request is facilitated through the support coordinator (case manager).

The following policy clarification and implementation is being given to all waiver providers:

Waiver Service Provider Changes

NOW and Children's Choice Provider changes for "good cause" require review by the Regional Manager who will make a "good cause" determination as defined in the respective wavier policies. If it is deemed approvable, the Regional Manager will sign and forward to the Contracted Agent for Prior Authorization.

The **Elderly and Disabled Adult Waiver** policy is hereby amended to specify that provider changes may occur:

> Once every services authorization quarter (3 months) with the effective date being the beginning of the following quarter (January, April, July, or October). The request must be received to the DLTSS Regional Office at least 30 days prior to the beginning of the Service Authorization Quarter.

The only exception to the above is for "good cause." In this case "good cause" determination is made by the DLTS Regional Manager as described above. Good cause in the EDA waiver is defined as:

> The participant moves to a new region; or,
> The participant and direct service provider agency have unresolved difficulties and mutually agree to a transfer;
> Safety, health, and welfare have been compromised and/or the direct service provider has not rendered satisfactory services to the participant.

All waiver provider changes which are requested in the middle of a quarter (for good cause) must have an attached CPOC Balance Report and documentation from the old provider stating what services are expected to be used prior to the transfer; this must be approved by the family.

INDIVIDUALIZED BACK-UP PLANS AND EMERGENCY EVACUATION RESPONSE PLANS

Direct Service Providers are required to have functional Individualized Back Up Plans and Emergency Evacuation Response Plans that are consistent with the participant's approved Comprehensive Plan of Care (CPOC).

Direct Service Provider agencies shall possess the capacity to provide the support and services required by the participant in order to assure the participant's health and safety outlined in the approved CPOC.

Backup plans cover situations that may occur from time to time when direct support workers are absent, unavailable or unable to work for any reason. The participant's Support Coordinator (Case Manager), through a person-centered process, is responsible for working with the participant, his/her family, friends and providers during initial and subsequent annual CPOC planning meetings to establish plans to address these situations. Backup plans must be updated annually, or more frequently as needed, to assure information is kept current and applicable to the participant's needs at all times.

The Support Coordinator shall assist the participant and his/her circle of support to identify individuals who are willing and able to provide a backup system during times when paid supports are not scheduled on the participant's CPOC. When supports are scheduled to be provided by the direct service provider, providers must have back up systems in Place. It is unacceptable for the Direct Service Provider to use the participant's informal support system (i.e., friends and family) as a means of meeting the agency's individualized backup plan, and/or emergency evaluation response plan requirements. Families and others identified in the participant's circle of support may elect to provide back up but this does not exempt the provider from the requirement of providing the necessary staff for back up purposes.

The backup plan must include detailed strategies and person-specific information that addresses the kind of specialized care and supports needed by the participant, as specified in their individualized Comprehensive Plan of Care (CPOC).

The agency must have in place policies and procedures that outline the protocols the agency has established to assure that backup direct support staff are readily available, with lines of communication and chain-of-command have been established, and procedures for dissemination of the backup plan information to participants and Support Coordinators are in place. Protocols outlining how and when direct support staff are to be trained in the care and supports needed by the participant must also be included. Note: Training for workers must occur prior to the worker being solely responsible for the support of the participant.

An Emergency Evacuation Response Plan must be developed and included in the participant's CPOC. An Emergency Evacuation Response Plan provides detailed information for responding to potential emergency situations such as but not limited to fires, hurricanes, hazardous materials release or spills, tropical storms, flash flooding, ice storms, and terrorist acts. The Emergency Evacuation Response Plan must include at a minimum the following components:

- Individualized risk assessment of potential health emergencies, geographical and natural disaster emergencies, as well as potential for any other emergency conditions;

- A detailed plan to address participant's individualized evacuation needs, including a review of individualized backup plans;

- Policies and procedures outlining the agency's protocols regarding implementation of Emergency Evacuation Response Plans and how these plans are coordinated with the local Office of Emergency Preparedness and Homeland Security, establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and Support Coordinators; and

- Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation Response Plan implementation and post emergency protocols. Note: Training for direct support staff must occur prior to worker being solely responsible for the support of the participant and participants must be provided with regular, planned opportunities to practice the Emergency Evacuation Response Plan.

Due to the requirements of HCBS Waivers to assure the health and welfare of Waiver participants, Direct Service Providers who are deemed to be out of compliance in the provision of necessary supports may be removed from the Freedom of Choice listing and steps taken by the licensing and Medicaid certification authority for sanction or exclusion from the Medicaid Program.

DSP agencies are to provide plans to support coordinators timely to be included with the CPOC to insure timelines are met.

PRIOR AUTHORIZATION

All waiver services require prior authorization, which is transmitted through Statistical Resources, Incorporated (SRI). In order to obtain and process prior authorization, all providers must use the Louisiana Service Tracking System (LAST) for data tracking purposes.

Louisiana Service Tracking Software System (LAST)

All service events, modifications completion logs, and distribution of diapers logs must be entered in the LAST system.

Information files must be sent to SRI prior to billing. Units of service are released based upon the data entered and received from the DSP.

LAST software, training, and technical support is provided by DLTSS/OCDD to direct service providers.

LAST software has incorporated numerous reports to assist you with the service management, including remaining balances, for a participant.

Computer Minimum Requirements

The provider must maintain computer equipment, internet accessibility, and software compatible with those needed to conduct business with the DLTSS/OCDD.

Issuance of Prior Authorized Waiver Services

- Quarterly for direct services
- Monthly for diapers (issued amount is based on CPOC)
- Based on job for modifications (issued amount is based on CPOC)

Direct services may be billed anytime within the PA cycle.

Diapers may be billed anytime after the PA cycle ends.

Modifications are initially issued for the CPOC year. The PA is then updated to reflect the actual completion date (once the completion form is received, indicating acceptance by the family).

CPOC Balance Report must be sent to the Support Coordinator (Support Coordinator) whenever there is a revision to the Plan of Care or participant is transferred to another provider.

BILLING

√ Staff at SRI can only prior authorize information that is submitted – they cannot make changes to the CPOC or Revision Plan. It is the provider's responsibility to ensure that the information contained on these forms is correct prior to submission to SRI.

√ SRI forwards all electronic prior authorizations to the direct service providers. Services are not authorized until an approved authorization form has been released from SRI thru the Louisiana Service Tracking Software System (LAST).

√ SRI releases the Prior Authorization number to Unisys two (2) working days after the provider has notified SRI of the service being completed. If the provider files the claim before Unisys' computer system is updated with this information, the claim will deny.

√ SRI will release the unit or dollar amount that corresponds with the provider's records (as transmitted through Louisiana Service Tracking Software System (LAST)), not the amount actually authorized.

√ SRI authorizes direct services on a quarterly basis. Services can be billed in any increment as long as the services have been provided and the billed dates and unit amounts fall within the span time allotted.

√ SRI authorizes diapers on a monthly basis. Services cannot be billed until the services have been provided and the span date has passed.

- √ Providers cannot bill for dates of services not yet performed-make sure the span date does not include future dates of service.

- √ Providers should only enter the first nine (9) digits of the Prior Authorization number in block 23 of the claim form.

- √ Providers must write “WAIVER” at the top of the claim form.

- √ The thirteen (13) digit Medicaid ID number must be used to bill all claims. This number is indicated on the authorization form. Never use the sixteen (16) digit number located on the plastic Medicaid card.

- √ When entering the diagnosis code in block 21, be sure to write it exactly as shown. This code will always be between three and five digits. Do not indicate a decimal point or add zeros. If this information cannot be located on the participant’s paperwork, contact the support coordinator. It is not necessary to purchase an ICD-9-CM book in order to obtain this information.

- √ Enter the appropriate Medicaid provider number for service type being performed.

- √ To resolve denied claims, please review the Remittance Advice (RA) thoroughly.

    - Denials between **190-198** should be directed to **SRI** at (225) 767-0501
    - Denial code **105, 109** should be directed to the appropriate LTSS or OCDD at (225) 219-0200
    - All other denial codes should be directed to **Unisys** at (800) 473-2783

Providers should be sure to always read the first two pages of their RA; changes to policy or new information that is critical to billing is disseminated through the Remittance Advice.

RECORD KEEPING

Documentation and Progress Notes

It is the responsibility of the direct service provider to provide adequate documentation of services offered to waiver participants for the purpose of continuity of care and support for the individual, and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of activities undertaken on behalf of the participant. Progress notes must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be drawn from the content of the note (general terms such as “called the participant” or “supported participant” or “assisted participant” is not sufficient and does not reflect adequate content). Check lists alone are not adequate documentation.

DLTSS/OCDD does not prescribe a format for documentation, but must find all components outlined below. The schedule for documentation differs based on each waiver/service system. Please see the table for documentation schedule.

NOTE: See BCSS-C-04-019/BCSS-P-04-015/BCSS-ADM-04-005 dated 7/23/04. Refer to the appropriate waiver manual.

Service providers will document progress as follows:

Service Logs/Payroll Sheets – Chronology of events and contacts, which support justification for Prior Authorization or payment of services.

Progress Notes – Narrative that reflects each entry into the service log/payroll sheet and elaborates on the activity of the contact.

Progress Summary – Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress or lack of progress toward desired outcomes and changes that may impact the CPOC and the needs of the individual. This summary should be sufficient in detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other direct support staff or their supervisors, and allows for evaluation of activities by program monitors.

Documentation of Progress

All notes and summaries of entries in a participant's record should include:

Name of author/person making entry
Signature of author/person making entry
Functional title of person making entry
Full date of documentation
Review by supervisor, if required
Written legibly, in ink
Narrative that follows definition for the type of documentation used

Discharge Summary for All Waivers

All transfers or closures will require a summary of progress prior to final closure.

Participant Records

A provider must have a separate written record for each participant served. It is the responsibility of the support coordinator agency and direct service provider to have the required documentation of services offered to waiver participants for the purposes of continuity of care and support for the individuals and the need for ongoing monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of activities undertaken on behalf of the participant.

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Targeted Population	At Time Of Activity	At Time Of Activity	At Least Every 90 Days	Within 14 Days Of Discharge

QUALITY ASSURANCE/QUALITY IMPROVEMENT MONITORING

Quality Assurance /Quality Improvement (QA/QI) PLAN

An agency's QA/QI plan must be submitted within 60 days following licensure. An agency's QA/QI plan must be submitted to the DLTSS/OCDD QA/QI manager.

Agency Self-Evaluation

Six (6) months after licensure, and annually thereafter, the agency is required to conduct an agency self-evaluation and to submit a report on the findings of the self-evaluation to the DLTSS/OCDD QA/QI manager. The findings of the report are subject to the approval of DLTSS/OCDD . More frequent self-evaluation by the agency may be required as part of a corrective action plan.

Report Of Self-Evaluation Findings

The agency must submit a report of the findings of the self-evaluation to:

The Division of Long Term Supports and Services (LTSS)
QA/QI Program Manager
446 North 12th Street
Baton Rouge, LA 70802-4613

OR

OCDD Waiver Supports and Services
QA/QI Program Manager
446 North 12th Street
Baton Rouge, LA 70802-4613

NOTE: The initial self-evaluation is due 6 months after approval of the QA/QI plan, and then once a year after the first report.

CHANGE OF ADDRESS/ENROLLMENT STATUS

Providers who have changes in enrollment information should notify in writing:

The Department of Health and Hospitals (DHH)
Health Standards Section (HSS)
P.O. Box 3767
Baton Rouge, LA 70821

AND

DHH Provider Enrollment
Post Office Box 91030, Bin 24
Baton Rouge, LA 70821-9030

Program Monitoring

As a result of Act 483 of the 2005 Louisiana Legislature Session and the Department's Immediate Action Plan for Health Care Reform the licensing authority was transferred from the Department of Social Services (DSS) to the Department of Health and Hospitals (DHH), Health Standards Section for:

- Personal Care Attendant
- Supervised Independent Living
- Respite
- Center-Based Respite
- Family Support
- Support Coordination (Case Management) and
- Adult Day Health Care

One of the reasons for this transfer was to consolidate the licensing and Medicaid regulatory authority oversight in one department in an effort to reduce duplication and streamline the process. Health standards will monitor the licensing and Medicaid certification for the Direct Service Providers and Support Coordination (Case Management).

MEDICAID STATE PLAN PERSONAL CARE SERVICES

Personal care services are available to ***all*** Medicaid-eligible recipients, as long as the recipient meets the appropriate criteria. **Personal Care Services are *not* waiver services**. Although waiver recipients may receive personal care services, it is a distinctly separate program with different guidelines than those set by Department.

There are two programs within the Medicaid State Plan for Personal Care Services:

1. **Early Periodic Screening, Diagnosis, and Treatment - Personal Care Services (EPSDT-PCS)**
2. **Long Term – Personal Care Services (LT-PCS)**

Providers must first be licensed and Medicaid certified by the Department's Health Standards Section (HSS) as a Personal Care Attendant Agency and then obtain a provider type case 24 provider number in order to provide personal care services. The 2006 Personal Care Services Training Packet can offer more detailed information on this program.

CLAIMS FILING

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

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

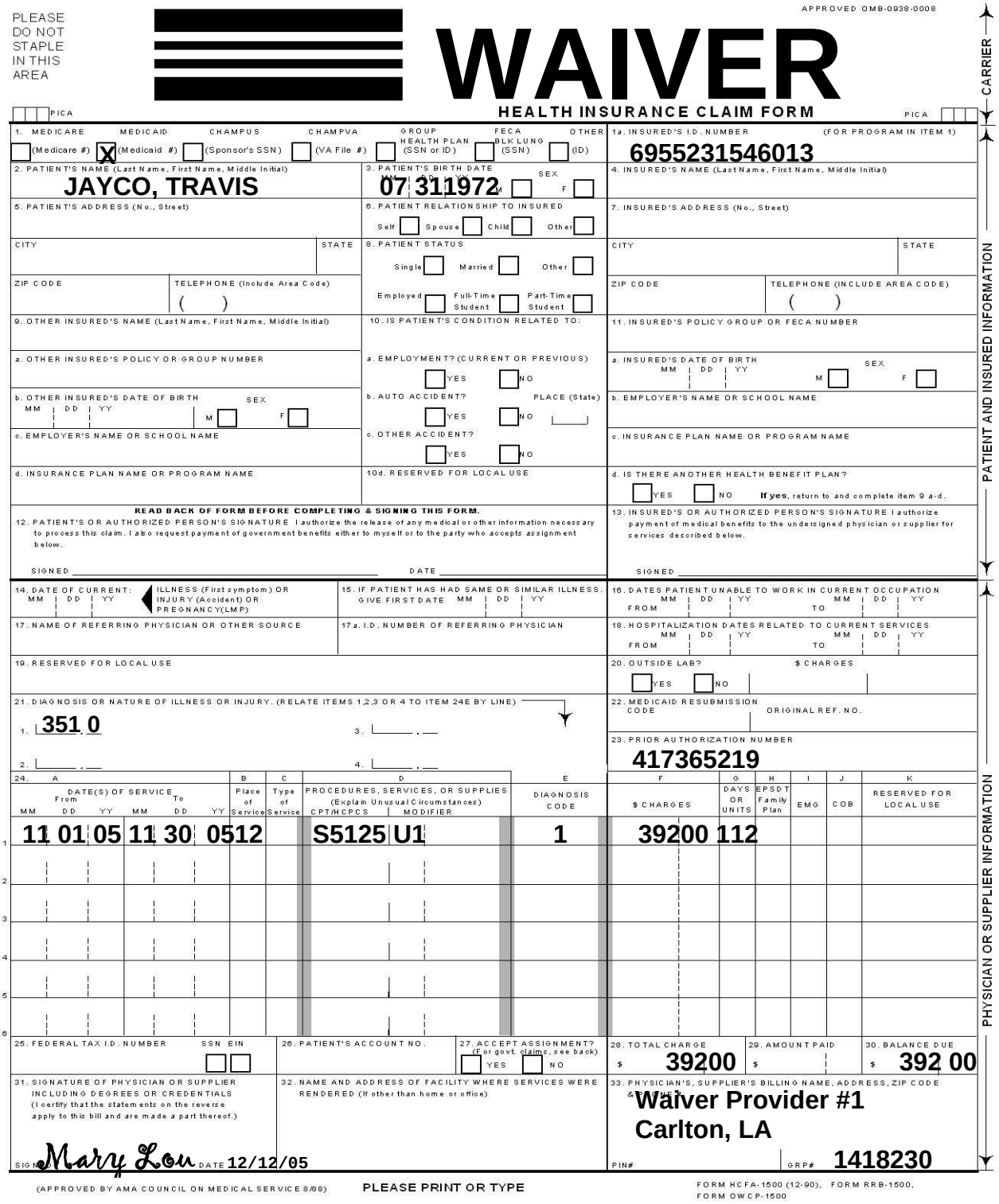
1.	REQUIRED	Enter an "X" in the box marked Medicaid (Medicaid #).
*1A.	REQUIRED	Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid swipe card (MEVS) or through REVS or e-MEVS. **NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable.** **NOTE: If the 13-digit Medicaid ID number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.**
*2.	REQUIRED	Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through e-MEVS, MEVS or REVS.
3.	SITUATIONAL	Enter the recipient's date of birth as reflected in the current Medicaid information available through e-MEVS, MEVS or REVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "x" in the appropriate box to show the sex of the recipient.
4.	SITUATIONAL	Leave blank.
5.	SITUATIONAL	Leave blank.
6.	SITUATIONAL	Leave blank.
7.	SITUATIONAL	Leave blank.
8.	SITUATIONAL	Leave blank.
9.	SITUATIONAL	Leave blank.

9A.	SITUATIONAL	Leave blank.
9B.	SITUATIONAL	Leave blank.
9C.	SITUATIONAL	Leave blank.
9D.	SITUATIONAL	Leave blank.
10.	SITUATIONAL	Leave blank.
11.	SITUATIONAL	Leave blank.
11A.	SITUATIONAL	Leave blank.
11B.	SITUATIONAL	Leave blank.
11C.	SITUATIONAL	Leave blank.
12.	SITUATIONAL	Leave blank.
13.	SITUATIONAL	Leave blank.
14.	SITUATIONAL	Leave blank.
15.	SITUATIONAL	Leave blank.
16.	SITUATIONAL	Leave blank.
17.	SITUATIONAL	Leave blank.
17A.	SITUATIONAL	Leave blank.
18.	SITUATIONAL	Leave blank.
19.	SITUATIONAL	Leave blank.
20.	SITUATIONAL	Leave blank.
*21.	REQUIRED	Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is **mandatory**. Standard abbreviations of narrative descriptions are accepted.
22.	SITUATIONAL	Leave blank.
23.	REQUIRED	Enter the Prior Authorization number.
*24A.	REQUIRED	Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.

*24B.	REQUIRED	Enter either 12 (home) or 99 (other) for Place of Service.
24C.	SITUATIONAL	Leave blank.
*24D.	REQUIRED	Enter the procedure code(s) for services rendered.
*24E.	REQUIRED	Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a “1”, “2”, etc. Do not enter the ICD-9-CM diagnosis code.
*24F.	REQUIRED	Enter usual and customary charges for the service rendered.
*24G.	REQUIRED	Enter the number of units billed for the procedure code entered on the same line in 24D.
24H.	SITUATIONAL	Leave blank.
24I.	SITUATIONAL	Leave blank.
24J.	SITUATIONAL	Leave blank.
24K.	SITUATIONAL	Leave blank, unless providing **Professional Support Services**. If providing Professional Support Services, enter individual provider number. This number must be linked to direct service provider number indicated in block 33.
25.	SITUATIONAL	Leave blank.
26.	SITUATIONAL	Enter the provider specific information assigned to identify the patient. This number will appear on the Remittance Advice(RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.
27.	SITUATIONAL	Leave blank.
*28.	REQUIRED	Total of all charges listed on the claim.
29.	SITUATIONAL	Leave blank.
30.	SITUATIONAL	Carry total over from block 28.
*31.	REQUIRED	The claim form MUST be signed. Either the practitioner or an authorized representative of the practitioner must sign the form. Signature stamps or computer generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned unprocessed.
	Date	Enter the date of the signature.

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

REMINDER: MAKE SURE "WAIVER" IS WRITTEN IN BOLD, LEGIBLE LETTERS ON THE TOP OF THE CLAIM FORM


PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

WAIVER

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 695523154613

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

3. PATIENT'S BIRTH DATE: 07 31 1972 SEX M F

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. 351.0
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 417365219

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 05 11 30 05	12		S5125	U1	1	392 00	112				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 392 00

29. AMOUNT PAID $

30. BALANCE DUE $ 392 00

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

SIGNED Mary Lou DATE 12/12/05

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

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

Waiver Provider #1
Carlton, LA

PIN# GRP# 1418230

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

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

WAIVER

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **6955231546013**

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

3. PATIENT'S BIRTH DATE MM DD YY: **07 31 1972** SEX M [ ] F [ ]

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. 351 0
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: **417365220**

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 **11 01 05 11 30 05**	**12**		**H2017**	**U7**	**1**	**29424**	**48**				**1718199**
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ **29424**

29. AMOUNT PAID $

30. BALANCE DUE $ **294 24**

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

SIGNED Mary Lou DATE **12/12/05**

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

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

Waiver Provider #1
Carlton, LA

PIN# | GRP# **1418230**

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

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

FILING ADJUSTMENTS AND VOIDS

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

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

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

Electronic submitters may electronically submit adjustment/void claims.

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

1. A claim is paid on the RA dated 1-3-06, ICN 5360056789100.
2. The claim is adjusted on the RA dated 3-7-06, ICN 6060056789100.
3. If the claim requires further adjustment or needs to be voided, only ICN 6060056789100 may be used.

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

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

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

INSTRUCTIONS FOR FILING ADJUSTMENT/VOID CLAIMS

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

*2. **Patient's Name**
- **a. Adjust**—Print the name exactly as it appears on the original claim. Provider must submit voids in order to correct names.
- **b**. **Void**—Print the name exactly as it appears on the original claim.

3. **Patient's Date of Birth**
- **a. Adjust**—Print the date exactly as it appears on the original claim.
- **b. Void**—Print the name exactly as it appears on the original claim.

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

5. **Patient's Address and Telephone Number**
- **a. Adjust**—Print the address exactly as it appears on the original claim.
- **b. Void**—Print the address exactly as it appears on the original claim.

6. **Patient's Sex**
- **a. Adjust**—Print this information exactly as it appears on the original claim.
- **b. Void**—Print this information exactly as it appears on the original claim.

7. **Insured's Name**— Leave blank.

8. **Patient's Relationship to Insured**—Leave blank.

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

10. **Other Health Insurance Coverage**—Leave blank.

11. **Was Condition Related to**—Leave blank.

12. **Insured's Address**—Leave blank.

13. **Date of**—Leave blank.

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

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

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

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

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

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

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

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

*22. **Diagnosis of Nature of Illness**
   a. Adjust—Print the information exactly as it appears on the original claim if not adjusting this information.
   b. Void—Print the information exactly as it appears on the original claim.

23. **Attending Number**—If service is a Professional Support Service, enter the individual attending provider number; otherwise, leave blank.

*24. **Prior Authorization** #—Enter the PA number.

*25. **A through F**
   a. Adjust—Print the information exactly as it appears on the original claim if not adjusting this information.
   b. Void—Print the information exactly as it appears on the original claim.

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

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

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

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

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

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

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

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

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION

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

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

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

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

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

ADJUSTMENT

30 SIGNATURE OF PHYSICIAN OR SUPPLIER
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
32 YOUR PATIENT'S ACCOUNT NUMBER

UNISYS - 213
5/97

FISCAL AGENT COPY

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

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

WAIVER

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): JAYCO, TRAVIS
3 PATIENT'S DATE OF BIRTH: 07/31/1972
4 MEDICAID ID NUMBER: 695523154613
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [ ]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO [ ] CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 3510
2
3
23 ATTENDING NUMBER
24 PRIOR AUTHORIZATION NO. 417365219

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
11	01	05	11	30	05	12	S5125	U1	1	38500	110		

26 CONTROL NUMBER: 5360056789100
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 1/3/06

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

BILLED INCORRECT UNIT AMOUNT

ADJUSTMENT

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Mary Lou February 13, 2006
32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Waiver Provider #1
Carlton, LA
1418230

UNISYS - 213
5/97

FISCAL AGENT COPY

ELECTRONIC DATA INTERCHANGE (EDI)

CLAIMS SUBMISSION

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

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

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

CERTIFICATION FORMS

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

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

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

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

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

ELECTRONIC DATA INTERCHANGE (EDI) GENERAL INFORMATION

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

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

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

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

- Case Management services
- Non-Ambulance Transportation

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

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

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

Enrollment Requirements For EDI Submission

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

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

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

Enrollment Requirements For 835 Electronic Remittance Advices

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

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

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

ELECTRONIC ADJUSTMENTS/VOIDS

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

SUBMISSION DEADLINES
Regular Business Weeks

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

Thanksgiving Week

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

Important Reminders For EMC Submission

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

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

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

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

HARD COPY REQUIREMENTS

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

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

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

CLAIMS PROCESSING REMINDERS

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

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

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

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

Attachments

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

Changes to Claim Forms

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

Data Entry

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

Rejected Claims

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

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

The criteria for legible claims are:

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

IMPORTANT UNISYS ADDRESSES

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

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

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

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

TIMELY FILING GUIDELINES

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

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

DATES OF SERVICE PAST INITIAL FILING LIMIT

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

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

OR

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

OR

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

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

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

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

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

SUBMITTING CLAIMS FOR TWO-YEAR OVERRIDE CONSIDERATION

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

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

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

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

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

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

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
- Recipients who receive services from the Children's Special Health Services Clinics (Handicapped Children's Services) operated by the Office of Public Health

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 no 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 .

NOTE: It is the **waiver or support coordinator service** that is exempt from the CommunityCARE program, NOT the recipient. In most cases the recipient is linked to a PCP. If the waiver or support coordinator provider is assisting in the coordination of medical services for a waiver recipient, keep in mind that the recipient will need to obtain a PCP referral for those services that are not listed in this section.

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

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). This 1-800 phone number is also to be used by waiver participants and waiver service providers to report complaints regarding waiver services being provided (**does not include claim or billing problems or questions**).

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.
Health Standards Section (HSS)	(225) 342-0148	HSS licenses Health Care Facilities to operate in the state of Louisiana. HSS licenses and certifies these facilities/agencies for participation in Medicare and Medicaid. As of October 1, 2006, HSS is the licensing and certification authority for Direct Service Provider Agencies and Support Coordination (Case Management) Agencies.

DHH PROGRAM MANAGER REQUESTS

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

Program Manager - (i.e. DME, Hospital, etc.)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

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

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

LOUISIANA MEDICAID WEBSITE APPLICATIONS

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

www.lamedicaid.com

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

PROVIDER LOGIN AND PASSWORD

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

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

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

WEB APPLICATIONS

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

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

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

e-MEVS:

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

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

e-CSI:

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

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

e-CDI:

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

The nine (9) clinical services information components are:

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

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

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

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

e-PA

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

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

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

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

Reminders:

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

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

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

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

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

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

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

ADDITIONAL DHH AVAILABLE WEBSITES

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

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

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

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

www.la-kidmed.com: KIDMED – 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