UNISYS

PERSONAL CARE 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
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-800-768-8824

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

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

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

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

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

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

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

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

TABLE OF CONTENTS

EPSDT - PERSONAL CARE SERVICES

EPSDT Personal Care Services are available to EPSDT eligibles (recipients up to age 21 years) that meet the medical necessity criteria for these services. Providers must obtain a Personal Care Services provider number (provider type 24) in order to provide these services.

These services are not intended to provide respite. In addition, EPSDT PCS may not be provided to an EPSDT eligible receiving Individual and Family Support services through the New Opportunities Waiver (NOW) program until the waiver limit has been exhausted.

EPSDT Personal Care Services are defined as:

- Tasks that are medically necessary as they pertain to an EPSDT eligible's physical requirements when physical limitations are due to illness or injury and necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements.

- Those services which prevent institutionalization and enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.

As part of establishing medical necessity, **the recipient must be of an age at which the tasks to be performed by the recipient would ordinarily be performed by the individual, if he/she was not disabled due to illness or injury.**

EPSDT PCS does not include medical tasks, such as medication administration, tracheostomy care, feeding tubes, or catheters. The Home Health program covers these services.

EPSDT PCS providers may also provide Children's Choice services on the same date to the same recipient; however, it may not be performed at the same time. Only recipients in Children's Choice can receive these services on the same day.

If the recipient is receiving Home Health, Respite, and/or any other related services, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider.

PCS vs. PCA

Medicaid distinguishes between Personal Care Services (PCS) offered through the EPSDT Program and Personal Care Attendant (PCA) services offered through the Waiver Program by services covered, scope of service, and reimbursement rates. It is important that the provider clearly identify which service is being requested for Prior Authorization. When submitting requests for Prior Authorization of PCS, the provider must insure that the request is worded properly on all paperwork. This includes the PA-14 form, the Plan of Care and the physician's prescription. While many of our PCS providers refer to their workers as Personal Care Attendants, requests for PCS prior authorization phrased as "PCA" will be denied.

EPSDT Personal Care Services include:

- Basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with dressing

- Assistance with bladder and/or bowel requirements or problems, including helping the client to and from the bathroom or assisting the client with bedpan routines, but excluding catheterization

- Assistance with eating and food, nutrition and diet activities, including preparation of meals—for the recipient only

- Performance of incidental household services, for the recipient only, not the entire household, which are essential to the recipient's health and comfort in his/her home. Examples are:

    - Changing and washing the recipient's bed linens

    - Rearranging furniture to enable the client to move about more easily in his/her own room

    - Clean up of meal preparation—for the recipient only

- Accompanying, not transporting, the recipient to and from his/her physician and/or medical facility for necessary medical services.

Conditions for Provisions of EPSDT PCS:

- EPSDT PCS is not to be provided to meet childcare needs nor as a substitute for the parent/guardian when the parent/guardian is not present.

- If an EPSDT eligible is fourteen years of age or younger, childcare arrangements must be specified when requesting approval for EPSDT PCS.

- A parent or other caregiver must be in the home with an EPSDT eligible fourteen years of age or younger. Recipients over 14 years of age must be mentally and intellectually competent to direct their own care if they are to be left with the PCS worker without the presence of a parent or other caregiver.

- EPSDT PCS is not allowable for the purpose of providing respite care for the primary care giver. Respite services are only available through some of the waiver programs.

- EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or must be provided by the Department of Education.

- The recipient must be under 21 years of age.

- The recipient must meet medical criteria to be eligible for at least an Intermediate Care Facility 1 and be impaired in at least 2 daily living tasks, as determined by BHSF.

- The recipient must have a new prescription every 180 days, and when changes to the Plan of Care occur.

- The PCS provider must maintain a Plan of Care.

- PCS must be prior authorized.

- PCS cannot be provided to a recipient who resides in an institution.

- PCS must be provided through a licensed PCA Medicaid provider. Staff assigned to provide personal care services shall not be a member of the recipient's immediate family. Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the recipient.

A physician must sign all referrals. Signatures by nurse practitioners or registered nurses are not acceptable.

Physician's Responsibilities Regarding the Authorization of PCS

Medical necessity for personal care services must be certified by the ordering physician, who must complete and sign the following:

- Form 90-L

- Plan of Care

- Prescription (signed by the physician and specifying the health/medical condition which necessitates EPSDT Personal Care Services and the number of hours requested)

In signing these documents, the physician certifies that:

1. The recipient is under his/her care;
2. The recipient requires/would require institutional level of care equal to an Intermediate Care Facility 1;
3. A face-to-face medical assessment was done on the recipient within the last 90 days;
4. These Personal Care Services are medically necessary;
5. There is a written plan for care that is approved by him/her; and
6. The plan will be reviewed periodically (at least every 180 days) by him/her.

Penalties, which may be imposed on physicians for inappropriate certification, include:

1. Referral to the Office of the Inspector General;
2. Criminal penalties in the U.S. District Court, resulting in fines and/or a jail sentence;
3. Civil prosecution in a U.S. District Court, resulting in fines and/or settlements;

4. Civil monetary penalties with an administrative law judge resulting in fines ($2,000 per line item);
5. If fraud is proven under the False Claims Act, tripling of damages and fines;
6. Simple sanction (barred from Medicare and Medicaid programs) by the Washington Office of the Inspector General.

CHRONIC NEEDS CASES

The Prior Authorization staff may designate some recipients as Chronic Needs Cases. Based on the recipient's medical condition, services are expected to be continuous and remain at the level currently approved. The Prior Authorization staff will notify both the provider and the recipient on the approval letter of this designation.

Once a recipient is deemed to be a Chronic Needs Case, providers shall only be required to submit a PA-14 form accompanied by a current statement from a physician verifying the recipient's condition has not improved and the services currently approved must be continued at the approved level. The provider must indicate "Chronic Needs Case" on the top of PA-14 form. This determination only applies to the services approved where requested services remain at the approved level. **Requests for an increase in these services will be treated as a traditional PA request and is subject to full review.**

PRIOR AUTHORIZATION LIAISON

The Prior Authorization Liaison (PAL) was established to facilitate the prior authorization approval process for Medicaid recipients under the age of 21 who are part of the MR/DD Request for Services Registry. When the prior authorization request cannot be approved because of a lack of documentation or a technical error, the request is given to the PAL. Examples of technical errors would include overlapping dates of services, missing or incorrect diagnosis codes, incorrect procedure codes or having a prescription that is not signed by the doctor.

The PAL will first contact the provider by telephone to resolve the problem. However, if the issue has not been resolved within 2 days, the PAL will send a "Notice of Insufficient Documentation" to the provider, the recipient and the recipient's support coordinator (if listed on the prior authorization request form). This notice advises of the specific documentation needed and the type of provider that can supply it. The needed documentation must be returned within 30 days to the PAL, or if an appointment is needed with a health professional, the PAL must be notified of the appointment date.

Because the support coordinator plays an integral part in assisting the recipient with accessing needed services, the support coordinator should work closely with the provider submitting the request. The support coordinator has been instructed to send a reminder letter to the provider no less than 45 or more than 60 calendar days prior to the expiration of the prior authorization. The PAL maintains a tracking system to ensure support coordinators remain aware of the status of prior authorization requests, submission and decision dates, and reconsiderations. Therefore, it is important that the support coordinator's name be included on the Request for Prior Authorization.

While the support coordinator may assist with obtaining the additional information being requested, the provider maintains the responsibility for requesting prior authorization for the service and completing all necessary documentation. For all recipients under the age of 21 who have a support coordinator, the provider is also responsible for sending a copy of the "Request for Prior Authorization" form to the support coordinator.

PRIOR AUTHORIZATION FOR EPSDT- PCS

EPSDT- Personal Care Services require Prior Authorization (PA), which is obtained by completing the PA14 form or through the electronic Prior Authorization (ePA) process which is available on the Louisiana Medicaid website (www.lamedicaid.com). Requests for authorization are forwarded to the Prior Authorization Unit, and are submitted along with the following documents:

Form 90-L
Prescription, Physician's Orders, or Physician's referral that specifies the medical condition that necessitates EPSDT PCS
Plan of Care
Social Assessment
Any supporting documentation to support medical necessity
Daily Time Schedule Form

COPIES OF THESE FORMS ARE AVAILABLE IN THE APPENDIX

REMINDER: PCS prior authorization requests phrased as PCA will be denied

NOTE: The PA-14 form may be obtained on the www.lamedicaid.com website, or from the Prior Authorization Unit at (800) 488-6334. Instructions for completing the PA-14 form and an example of the form are included on pages 15-16. A blank PA-14 form is available on page 17.

The completed PA-14 Form, along with all necessary documentation to substantiate the medical necessity of the requested services, must be submitted to the Unisys Prior Authorization Unit (PAU) at the following address:

Unisys
P.O. Box 14919
Baton Rouge, LA 70898-4919
Attn: Prior Authorization (PCS)

The PA request may also be faxed to (225) 237-3342.

Once the PA-14 form is received at Unisys, it will be screened for pertinent information prior to entry into the PA system. If the PA-14 form is incomplete, or the required documentation is missing/incomplete, the form will be returned to the provider with a cover letter indicating what is needed.

After the PA-14 form is screened and entered into the PA system, a unique nine-digit prior authorization number is assigned. The system will perform a series of front-end edits. It will check for a valid seven-digit Medicaid provider number, a valid thirteen-digit recipient number, recipient eligibility, a valid ICD-9 diagnosis code, age restrictions, etc. If any of the submitted information does not clear the editing process, the system will deny the request automatically and generate a letter of denial to be sent to the provider **and** the recipient.

If the PA-14 form passes the above editing process, it will be reviewed by the Unisys review nurse and/or physician consultant(s) to determine medical necessity. Once the decision is made, the status of the review is entered into the prior authorization system and an approval or denial letter is sent to the provider and the recipient within the next two days. Once the notification of approval is received, the provider may begin to render services. Approvals may be authorized for a period not to exceed six months.

ELECTRONIC PRIOR AUTHORIZATION

The Electronic Prior Authorization (ePA) Web Application provides a secure, web based tool for providers to submit prior authorization (PA) requests and to view the status of previously submitted requests. This tool is intended to eliminate the need for hard-copy paper PA requests as well as provide a more efficient and timely method of receiving PA request results. Each day, the Unisys Prior Authorization department will review and determine the approval/denial status of PA requests. The resulting decisions will be updated on a nightly basis back to the e-PA web application. This enables the provider to see the decision for a PA request the following business day after the status was determined.

The requirement to submit standard supporting documentation to the Unisys Prior Authorization department remains unchanged.

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 hard-copy PA submission methods.

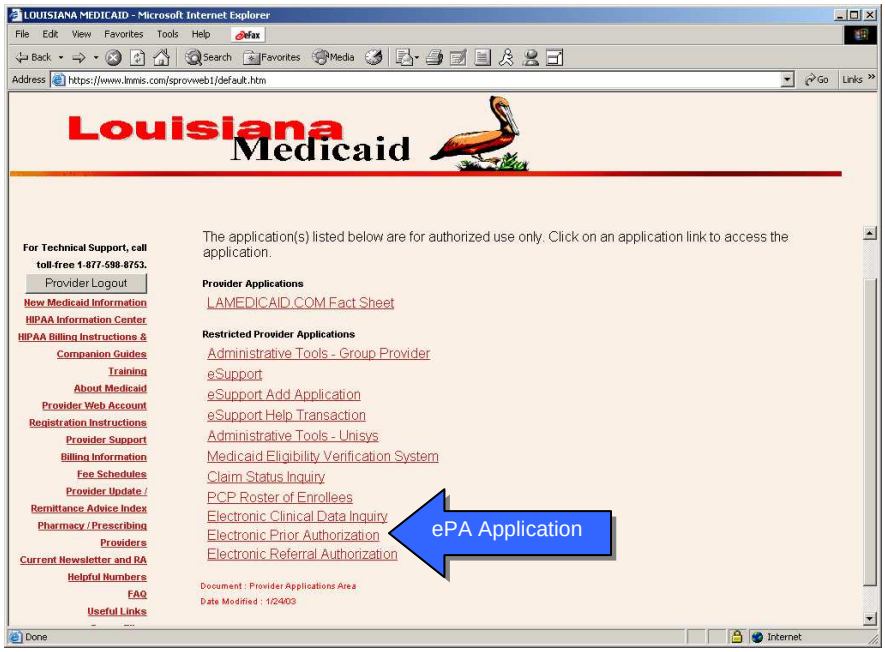
Reconsideration requests cannot be accepted via the e-PA web application and should be submitted using the existing process.

---------- Important Note ----------

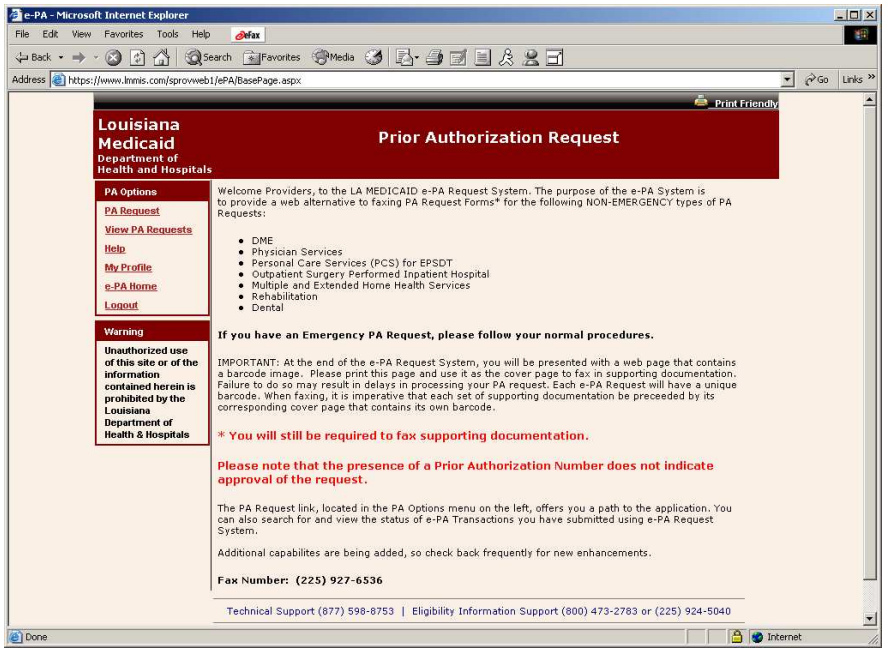
If the supporting documentation is not faxed to Unisys or the Request Response page is not used as a cover sheet or is un-readable, then the request will remain in a Pending Review status and will not be processed by the Unisys PA department. To identify whether or not the supporting documentation was received and processed without error, the provider can view the Request Response page (presented in Section 3.0 of this document) and review the Encounter # field at the bottom of the page. If this number is Zero (0), then the attachments have not been received or were not appropriately cross-referenced to the request. Reprint the request page and re-fax it and the supporting documentation again. If the faxed documentation is received and processed correctly, the encounter number field will reflect this change one business day after the documents were faxed.

The following screenshots illustrate the process in order to submit a prior authorization.

The **Provider Applications Area** screen is displayed. Select the **Electronic Prior Authorization** hyperlink.

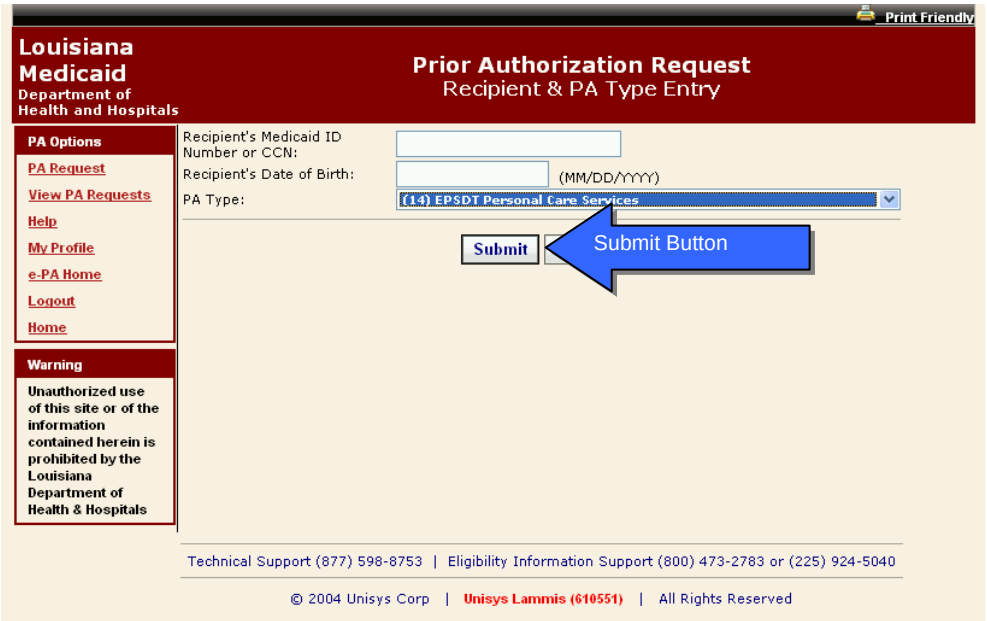


The **Louisiana Medicaid Prior Authorization Web Application** Home screen is displayed.

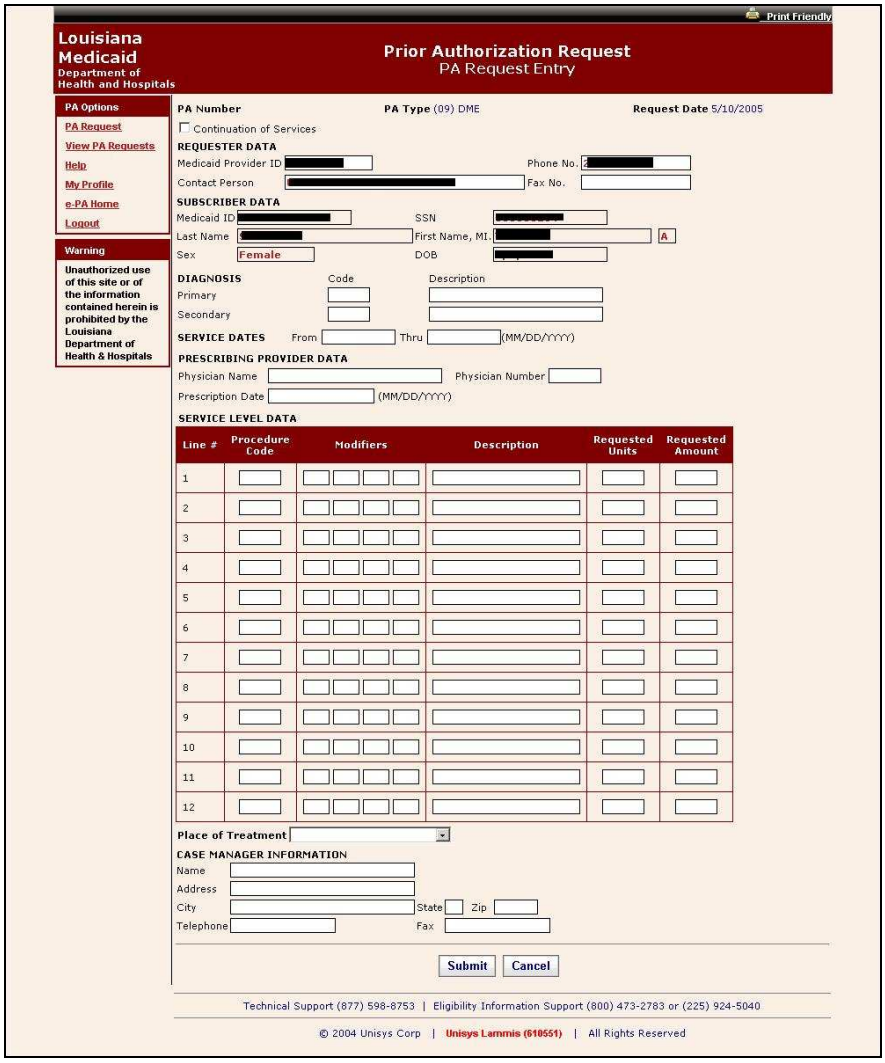


Select the PA Request link located in the upper left side of the main application page. The PA Type entry page will be displayed.

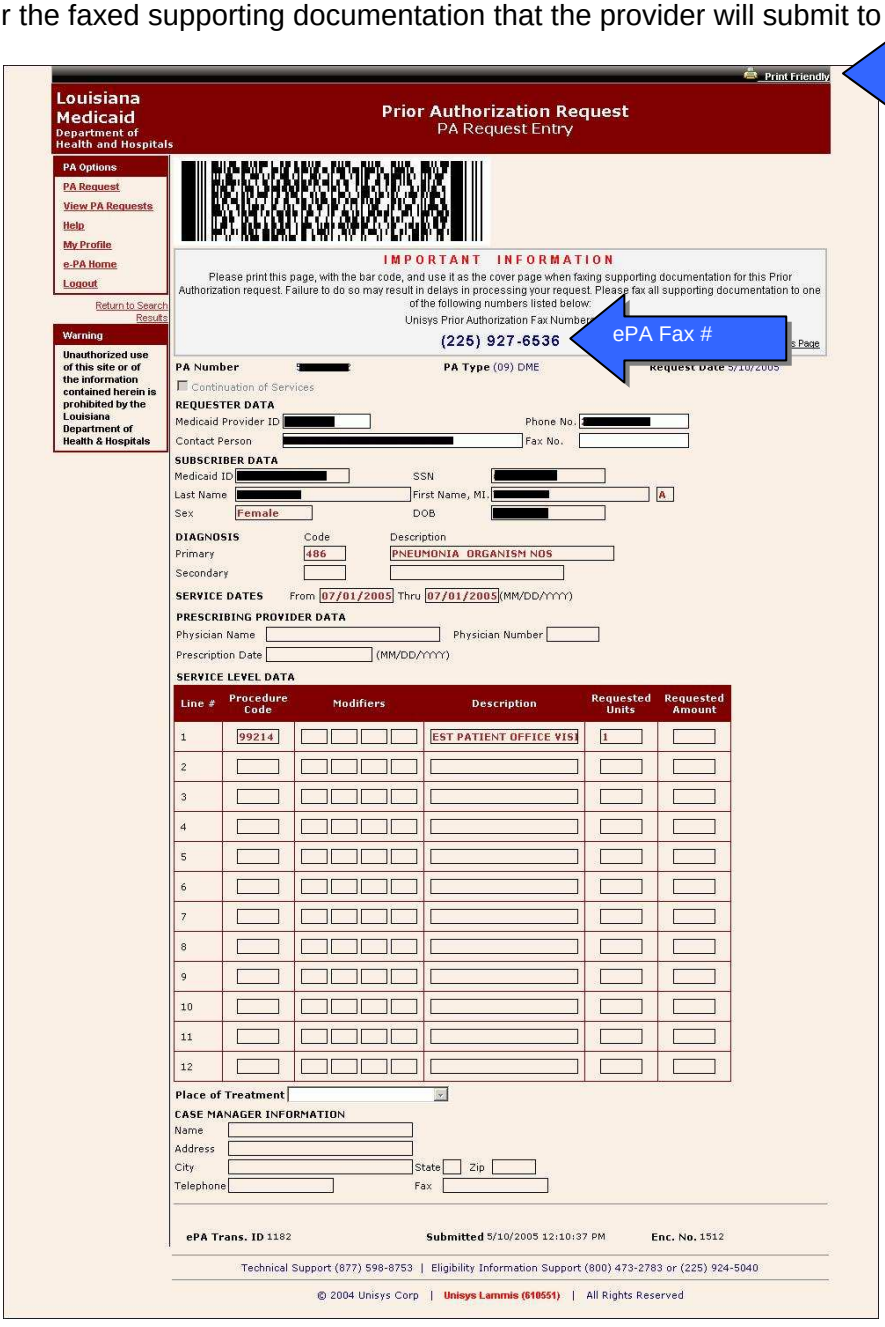
On the Recipient & PA Type Entry page, enter the recipient's Medicaid ID number or CCN and the date of birth in the appropriate boxes. In the PA Type drop-down list, select (14) EPSDT Personal Care Services as the type of PA request, then select the Submit button. The Prior Authorization Entry page will be displayed.



On the PA Request Entry page, enter the appropriate information as you would for any standard PA request. If you failed to fill in all the required fields, the application will present a user-friendly pop-up box, listing the required fields that must still be entered. Once you have completed all the required fields, select the Submit button at the bottom of the page. The PA Request Entry (response) page will then be displayed.



The PA Request Entry page will be displayed with the addition of a header at the top that includes a bar code. This bar code will enable Unisys to match the faxed supporting documentation to the original electronic PA request. This page must be printed and used as a cover sheet for the faxed supporting documentation that the provider will submit to Unisys.



Using the printed version of the PA Request Entry (response) page as a cover sheet, fax the request and the supporting documentation to the fax number indicated in the response header.

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

DATE 08/17/2005 RECIPIENT NAME DWAR M
PRIOR AUTH. NBR 5 259 RECIPIENT NUMBER 8: 096

*
. JT
702

PROVIDER NUMBER 1: 3

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW. IF ANY OF THE APPROVED ASTERISKED(*) SERVICES ARE REQUIRED BEYOND THE APPROVED DATES OF SERVICE, YOU MUST FILE A REQUEST FOR A CONTINUATION OF APPROVED SERVICES BY 02/02/2006 (25 DAYS BEFORE THE END OF THE APPROVED SERVICE DATE). IF YOU FAIL TO SUBMIT A CONTINUATION OF SERVICES REQUEST BY 02/02/2006, THESE SERVICES WILL NOT BE CONTINUED.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
*A4351 -INTERMITTENT URINARY CATH	$ 1,231.20	08/28/2005-02/27/2006	APPROVED
A4927 -GLOVES NON STERILE PER 10	6	08/28/2005-02/27/2006	APPROVED
*A4402 -OSTOMY LUBRICANT	$ 6.36	08/28/2005-02/27/2006	APPROVED

* RESUBMITTAL DATE: ____/____/_____

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

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

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

INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION FORM (PA-14)

NOTE: There are certain fields that must be completed in order for the Prior Authorization request to process. Those that are marked with an asterisk (*) must be filled out. If an asterisk (*) is not present, the field ***may*** be left blank. However, keep in mind that the information provided in these fields may assist the Prior Authorization Unit staff in ascertaining if the requested information is correct.

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

FIELD 3 - Enter the Social Security Number of the recipient.

FIELD 4 - Enter the recipient's last and first name as it appears on his/her Medicaid ID card.

FIELD 5 - Enter the recipient's date of birth in month, day, year format (MMDDYYYY).

FIELD 6* - Enter the 7-digit Medicaid provider number.

FIELD 7* - Enter in the "Begin" date of service block the first day the service is requested to start. Enter in the "End" date of service block the last day of service for that recipient's Treatment Plan.

FIELD 8 - Indicate whether the recipient is currently receiving Personal Care Services.

FIELD 9* - Enter **either** the numeric ICD-9 diagnosis code, both primary and secondary (if there is more than one diagnosis) **or** write out the description of the diagnosis.

FIELD 10 - Enter the day the prescription was written.

FIELD 11 - Enter the name of the physician prescribing the services.

FIELD 12A - Field is automatically populated with the procedure code.

FIELD 12B - Field is automatically populated with the required modifier.

FIELD 12C* - Enter the number of units being requested in order to fulfill the doctor's order during the Treatment Plan.

Calculate the total units requested (making sure that 1 unit is the equivalent of fifteen (15) minutes) by multiplying the number of units per day times the number of days per week times the number of weeks covered in the Treatment Plan. This will give the total units requested. For example:

If the physician requests five hours of service per day for seven days a week for six months, the provider would indicate 3,640 units in this field because:

Twenty (four units per hour multiplied by five, which is the number of days that service is needed) multiplied by seven (number of days per week receiving service) equals 140; multiply that number (140) by twenty-six (number of weeks in six months). The correct answer would equal 3,640 units.

FIELD 13* - Enter the name, mailing address, and telephone number of the service provider. As long as the name is present, the request will not be rejected.

FIELD 14 - Enter the name of the case management agency along with their address and telephone/fax numbers, if applicable.

FIELD 15* - Enter the signature of the Provider or an authorized representative. **IF USING A STAMPED SIGNATURE, AUTHORIZED PERSONNEL MUST INITIAL IT.**

FIELD 16* - Enter the date of request for the service

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

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

P.A. NUMBER

FAX TO: (225) 237-3342

CONTINUATION OF SERVICES ____YES ____NO

(1) PRIOR AUTHORIZATION TYPE:	(2) RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY #
14 – EPSDT PERSONAL CARE SERVICES	7 7 7 7 6 6 6 6 5 5 5 5 4 4 4 4	
	(4) RECIPIENT LAST NAME: DOE FIRST NAME: CAROLYN MI:	(5) DATE OF BIRTH

(6) MEDICAID PROVIDER NUMBER (7- DIGIT)	(7) SERVICE TREATMENT PLAN BEGIN DATE (MMDDYYY)	END DATE (MMDDYYY)	(8) IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE
1 1 2 2 3 3 8	0816 2005	02 15 2006	____YES ____NO	

(9) DIAGNOSIS:
PRIMARY CODE & DESCRIPTION: Cerebral Palsy
SECONDARY CODE & DESCRIPTION:

(10) PRESCRIPTION DATE (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

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

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

(12) PROCEDURE CODE	(12A) MODIFER	(12B) DESCRIPTION PERSONAL CARE SERVICE EACH 15 MINUTES	(12C) REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)
T1019	EP	EPSDT-Personal Care Service, each 15 minutes	2536			

(13)
PROVIDER NAME: A BETTER PCS AGENCY
ADDRESS: 111 Main Street
CITY: Velma STATE: LA ZIPCODE 00000
TELEPHONE: 225 555 1111 FAX NUMBER: (____) ____ ____

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

(15) PROVIDER SIGNATURE: Cathryn Jester

(16) DATE OF REQUEST: 8/01/05

PA- 14 FORM

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

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

P.A. NUMBER

FAX TO: (225) 237-3342

CONTINUATION OF SERVICES ____YES ____ NO

(1) PRIOR AUTHORIZATION TYPE:	(2) RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY #
14 – EPSDT PERSONAL CARE SERVICES	(4) RECIPIENT LAST NAME FIRST NAME MI	(5) DATE OF BIRTH
(6) MEDICAID PROVIDER NUMBER (7- DIGIT)	(7) SERVICE TREATMENT PLAN BEGIN DATE (MMDDYYY) END DATE (MMDDYYY)	(8) IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES ____ YES ____ NO
(9) DIAGNOSIS: PRIMARY CODE & DESCRIPTION SECONDARY CODE & DESCRIPTION	(10) PRESCRIPTION DATE (MMDDYYYY)	(11) PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER:

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

STATUS CODES:
2 = APPROVED
3 = DENIED

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

(12) PROCEDURE CODE	(12A) MODIFER	(12B) DESCRIPTION PERSONAL CARE SERVICE EACH 15 MINUTES	(12C) REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)

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

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

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA- 14 FORM

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

DATE 08/17/2005
PRIOR AUTH. NBR 5 951

RECIPIENT NAME NE H
RECIPIENT NUMBER / 068

E INC *

LA

PROVIDER NUMBER 1 8

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
T1019/EP/ -PERSONAL CARE SERVICE, EA	2536	08/16/2005-02/15/2006	APPROVED -666
T1019/EP/ -PERSONAL CARE SERVICE, EA		08/16/2005-02/15/2006	APPROVED -822
T1019/EP/ -PERSONAL CARE SERVICE, EA		08/16/2005-02/15/2006	APPROVED -823

666 - THIS REQUEST IS APPROVED FOR 4 HOURS PER DAY 7 DAYS A WEEK.
822 - THIS RECIPIENT HAS BEEN DEEMED AS A "CHRONIC NEEDS CASE". WRITE "CHRONIC NEEDS CASE " ON TOP OF NEXT P.A. REQUEST.
823 - SUBMIT ONLY P.A. FORM & DOCTORS STATEMENT STATING CONDITION OF PATIENT HAS NOT CHANGED.

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

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

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

Reconsideration Requests

If the request is denied, a notification letter with the PA number is generated giving the reason(s) for denial and is sent to the provider and the recipient. The recipient's letter will have a notice regarding his/her rights to appeal. A provider may then submit a reconsideration request to the Unisys Prior Authorization Unit and the physician consultant(s) will review the reconsideration request. To request a Reconsideration (RECON), providers should submit the following:

- A copy of the denial letter, with the word **RECON** written across the top of the denial letter, and the reason for requesting the reconsideration written at the bottom of the letter.

- Attach **all of the original documentation**, as well as any additional information or documentation, which supports medical necessity.

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

Unisys physician consultant(s) will review the reconsideration request for medical necessity. When the reconsideration request is approved or denied, another notification letter (with the same prior authorization number) will be generated and mailed to the provider and the recipient.

Changing PCS Providers

If a recipient is changing PCS providers within an authorization period, the current agency must send a letter to the Unisys Prior Authorization Unit notifying them of the recipient's discharge so that a new PA can be issued to the new PCS provider that has been selected.

The new provider must submit an initial request for PA to the PA Unit using current documentation and must submit all required documentation necessary for an initial PA request.

Units approved for one provider CANNOT be transferred to another provider.

RECON

DEPAR TALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 08/17/2005 RECIPIENT NAME :IN ENRY
PRIOR AUTH. NBR 5: 52 RECIPIENT NUMBER 4 53 O

RP *

LA

PROVIDER NUMBER 1 06

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
T1019/EP/ -PERSONAL CARE SERVICE, EA	1456	08/17/2005-02/17/2006	APPROVED -654
T1019/EP/ -PERSONAL CARE SERVICE, EA		08/17/2005-02/17/2006	APPROVED -046
T1019/EP/ -PERSONAL CARE SERVICE, EA	1456	08/17/2005-02/17/2006	DENIED -278

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW,
654 - THIS REQUEST IS APPROVED FOR 2 HOURS PER DAY 7 DAYS A WEEK.
046 - DOCUMENTATION DOES NOT WARRANT CHANGING ORIGINAL DECISION.
278 - THE TOTAL NUMBER OF HOURS REQUESTED / OR AN INCREASE IN PCS / OR HOME HEALTH SERVICES ARE NOT MEDICALLY NECESSARY.

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

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

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

Additional Documentation Attached to Justify 4 Hours Per Day

LONG TERM - PERSONAL CARE SERVICES (LT- PCS)

The LT-PCS program began on January 19, 2004. The purpose of personal care services is to provide limited assistance with the activities of daily living and instrumental activities of daily living. It is not intended to be a substitute for available family or community supports.

These services must be prescribed by a physician and prior authorized. Physician delegation of medical tasks or complex medical procedures is not a component of personal care services.

Recipients interested in receiving LT-PCS services must contact ACS at 1-866-229-5222. If the recipient is unable to contact them directly, his/her family may make the contact. However, **under no circumstance may the provider contact ACS to initiate services on behalf of the recipient.**

Recipient Criteria

In order to qualify for LT-PCS, a Medicaid recipient must have the following conditions met:

- Be age 65 or older, or 21 years of age or older with a disability. Disabled is defined as criteria established by the Social Security Administration;
- Qualify for admission to a nursing facility, including all Preadmission Screening and Annual Resident Review (PASARR) requirements;
- Be able to participate in his/her care and self-direct the services of the personal care worker independently, or through a responsible representative;
- Face a substantial possibility of deterioration in mental or physical condition if either home and community based services, or nursing facility services, were not provided within the next 120 days. This criterion is considered met if:
    - The recipient is in a nursing facility and could be discharged if community-based services were available
    - Is likely to require nursing facility admission within the next 120 days
    - Has a primary caregiver who has a disability or is over 70 years old

Covered Services

In order to qualify for LT-PCS, the recipient must need assistance with ADLs (Activities of Daily Living). Assistance may be either the actual performance of the personal care task for the recipient, or supervising and prompting so the recipient performs the task.

ADLs are personal, functional activities required by an individual for continued well-being, health, and safety. These activities are usually performed on a daily basis and include:

- Bathing
- Grooming
- Dressing
- Ambulation
- Eating
- Transferring
- Toileting

IADLs (Instrumental Activities of Daily Living) are routine tasks that are essential for sustaining the individual's health and safety, but these tasks may not need to be performed every day. These tasks include:

- Laundry
- Meal preparation and storage
- Grocery Shopping
- Light Housekeeping tasks
- Assistance with scheduling medical appointments, if necessary
- Accompaniment to medical appointments, if necessary
- Assistance with accessing transportation, if necessary
- Medication *reminders*

Medication Reminders

The personal care worker may only verbally remind the recipient to take his/her medicine, assist with opening the bottle or bubble pack, reading the directions from the label, checking the dosage chart from the label directions, and assist in ordering the medicine from the store.

The personal care worker cannot give the medicine to the recipient or set up pill organizers.

Physician delegation of medical tasks is not covered under personal care services.

Transportation

- Medicaid offers reimbursement for both emergency (ambulance) and non-emergency medical transportation if the recipient has no other means in which to obtain transportation to a Medicaid-covered service provider.

- If a provider opts to provide transportation services to their recipients, they must accept all liability for their employee transporting the recipient and ensure that the personal care worker has a current, valid driver's license as well as minimum liability coverage as designed by state law.

Excluded Services

Long-Term Personal Care Services do not include:

- Insertion and sterile irrigation of catheters (although changing and emptying the catheter bag is allowed)
- Irrigation of any body cavity, which requires sterile procedures
- Application of dressing, which involves prescription medication and aseptic techniques
- Skilled nursing services as defined in the State Nurse Practices Act, which include medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks
- Teaching a family member or other caregiver how to care for a recipient who requires frequent changes of clothing or linen due to partial/total incontinence for which no bowel or bladder training program is possible
- Teaching of signs/symptoms of disease process, diet and medications of any new or exacerbated disease process
- Specialized aide procedures, such as: rehabilitation of the recipient, measuring or recording of vital signs, measuring or recording of intake or output of fluids, specimen collection, special procedures such as non-sterile dressings, special skin care of decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight management, enemas
- Administration of medications
- Rehabilitative services, such as those performed by a licensed therapist
- Laundry, other than those incidental to the care of the recipient
- Food preparation or shopping for groceries or household items other than items required specifically for the health and maintenance of the recipient
- Housekeeping tasks in areas not used solely by the recipient
- Companionship
- Supervision
- Respite of primary caregiver

Delegation of Medical Tasks

The performance of complex and non-complex medical procedures is not a component of personal care services. If the recipient's physician delegates the performance of medical tasks and the agency agrees to provide these tasks, the agency accepts all liability for their employee's performance of the task. The agency must have a current, signed and dated statement from the recipient's physician stating what medical procedures are being delegated. It is recommended that the statement is updated annually or whenever the recipient changes physicians.

Assessments

Initial assessments and reassessments are the responsibility of ACS staff. These assessments enable staff members to gather medical and non-medical information in order to assist in the development of a Plan of Care. Although the hours approved from this meeting may not be satisfactory, it is essential that the provider initiate services until an interim assessment can be performed. By withholding the service plan they are preventing the recipient from receiving needed services. Providers that submit the service plan can at least begin the approved services until the interim change has been approved or denied.

Service Location

LT-PCS may be provided in the recipient's home or in another location, outside of the home, if the provision of these services allows the recipient to participate in normal life activities as they pertain to the IADLs as cited in the Plan of Care.

A recipient's home is defined as:

- Recipient's place of residence, including his/her own house or apartment
- Boarding house
- House or apartment of a family member or unpaid primary caregiver

The place of service must be documented in the service plan **and** service log.

Services performed outside of the recipient's home do not include travel outside of the state of Louisiana, unless the recipient lives in an area adjacent to the state's border and it is customary to seek medical and other services in the neighboring state.

These services cannot be performed in the personal care worker's home unless it can be satisfactorily assured that:

- The place of service is consistent with the recipient's choice
- The recipient's health and safety can be maintained when services are provided in the worker's home
- ***Services do not substitute for otherwise available family and community supports***

NOTE: PCS cannot be provided in a hospital, an institution for mental disease, a nursing facility, or an intermediate care facility for the mentally retarded (ICF/MR)

Service Limitations

Hours are approved on an individual basis. The determination of hours is based on the recipient's assessment, Plan of Care, and supporting documentation.

Changing Service Providers

A recipient may change providers without cause once after every 3 (three) month service authorization period. A recipient may change providers with good cause at any time during the service authorization period. Good cause is defined as the failure of the provider to furnish services in compliance with the service plan. DHH, or its designee, shall determine good cause. All requests for change in provider shall be submitted in writing to the contractor. Providers will receive written notification when approval has been given for the recipient to change providers.

When a provider becomes aware that a recipient is changing providers, it is crucial that the provider continue providing services as per the service plan. These services should not be altered until the agency receives notice from ACS that services have ended. Likewise, the provider that will receive the recipient should not begin to provide services until the appropriate notification from ACS has been received.

Termination of Services

According to Section 30.7.6 of the 05/01/2004 Revised Personal Care Services Manual, a provider must provide written notification to the recipient or the responsible representative when discontinuing services. The notice must be sent at least 30 days before the date on which the services are to be discontinued. In addition, the provider must notify the contractor within 24 hours of decision to discontinue services. This section of the manual also identifies those situations in which it is permissible to give a notice that is less than 30 days. Providers must be familiar with these regulations and ensure that they are being fulfilled.

Clarification of Service Provision Regions and Parish Borders

Personal Care Service providers must maintain an office in each region where services are provided. DLTSS will consider an agency's request to provide services in one adjacent parish to its designated service region if that parish's border is within a 50 mile radius of the agency's office. Any provider who wishes to add a parish to its designated region should send a written request to DLTSS. The letter should specify the parish which the provider desires to add and be addressed to:

Division of Long Term Support and Services
Long Term Personal Care Services
446 North 12th Street
Baton Rouge, LA 70802

Attention: Program Manager

Reassessments

Reassessments are conducted annually to determine on-going qualification for services.

Recipients Currently in Nursing Homes

If a recipient residing in a long-term care facility requests LT-PCS, a provisional assessment must be performed to determine qualification for services. If the recipient is approved for services, a provisional approval notice will be issued for a 2-month certification period. A provisional prior authorization notice will be issued to the selected provider for a 2-month service authorization period. A provisional service plan must be developed prior to the recipient leaving the facility.

Services will not begin until the recipient leaves the facility.

Once the recipient has left the nursing facility, an in-home assessment will be completed. Based on the results of the assessment, a new Plan of Care will be developed and the certification period will be issued for 12 months. A second prior authorization notice will be issued to the provider for the new service authorization period.

Solicitation

Medicaid providers are prohibited from offering material or financial gain directly or indirectly to Medicaid recipients in order to influence them in their choice of providers. In addition, 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.

PRIOR AUTHORIZATION FOR LT- PCS

All services for LT-PCS must be prior authorized. Prior authorization will be effective the date the Service Plan is approved. Payment will not be made for services provided prior to the authorization date.

If an EDA waiver recipient requests LT-PCS, ACS staff will complete the recipient intake form and forward it to the Division of Long Term Supports and Services. The recipient's support coordinator (formerly known as the case manager) is responsible for contacting the recipient, scheduling and completing the in-home assessment and developing the Plan of Care. The support coordinator will then forward the information to the Division of Long Term Supports and Services for approval. Upon approval, the Division of Long Term Supports and Services will send ACS the prior authorization information. ACS will issue the prior authorization to the provider.

Non-waiver and ADHC recipients requesting LT-PCS will be sent a 90-PCS form to be completed by his/her physician. Once the signed and completed 90-PCS is received at ACS, an ACS representative will schedule an appointment for an in-home assessment. The ACS staff will be responsible for completing the Plan of Care and forwarding all information to DHH for review. If approved for services, the recipient will receive a written notification of the approval, 2 copies of the Plan of Care and a list of enrolled Medicaid LT-PCS agencies in his/her region. The recipient will be instructed to contact his/her preferred agency. If the agency chooses to accept the recipient as a client, the agency will retain a copy of the Plan of Care for their records. The provider will need to forward the following documents to ACS within 14 days so that a Prior Authorization Number can be established for these services:

- Signed service plan (based on the Plan of Care)
- Signed Agreement to Provide Services including the date the provider will be available to begin services once the service plan is approved.

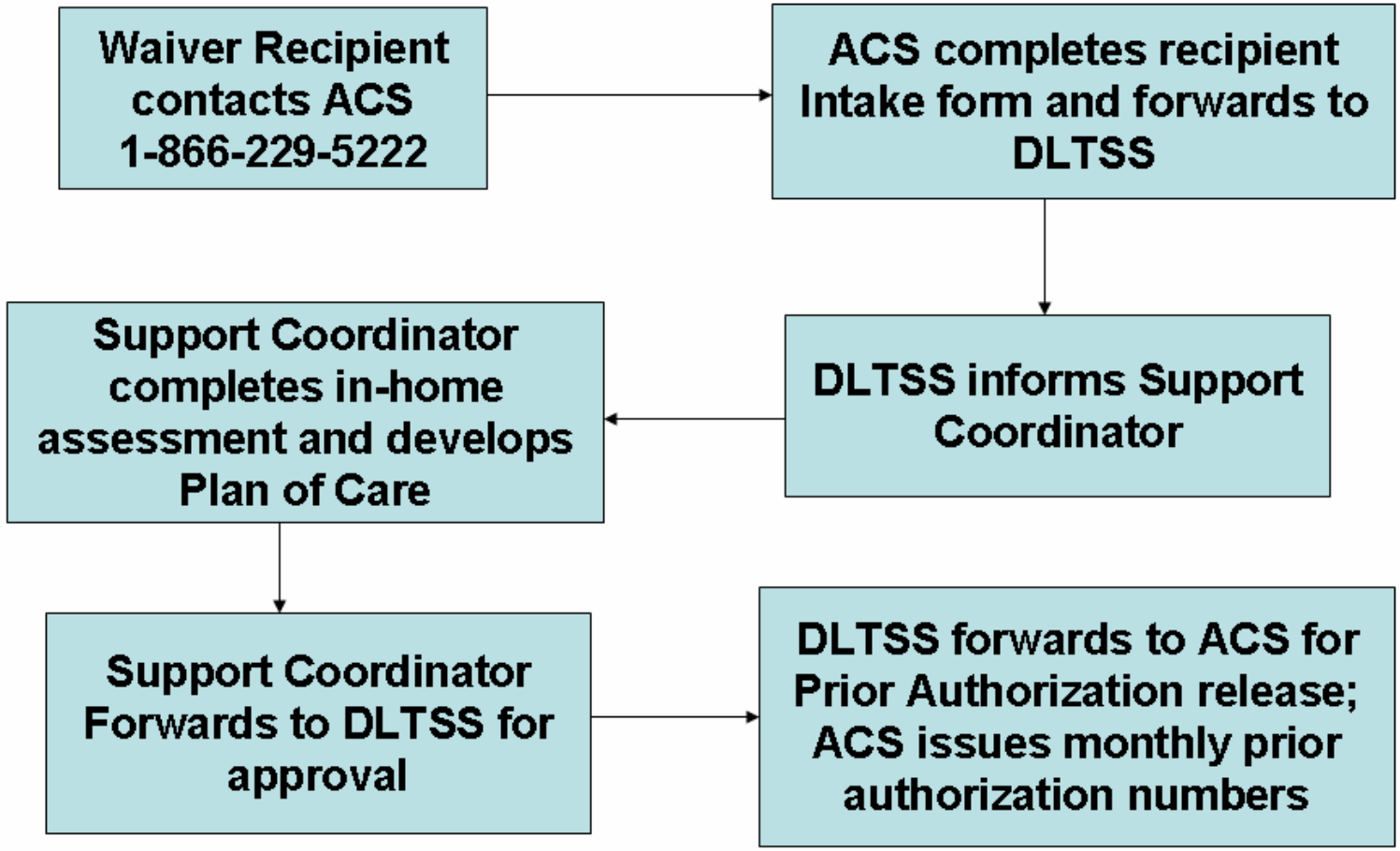
The information must be mailed or faxed to ACS:

Affiliated Computer Services
5700 Florida Boulevard, 13th floor
Baton Rouge, LA 70806
Fax: (225) 231-8151
Attn: Long Term-Personal Care Services

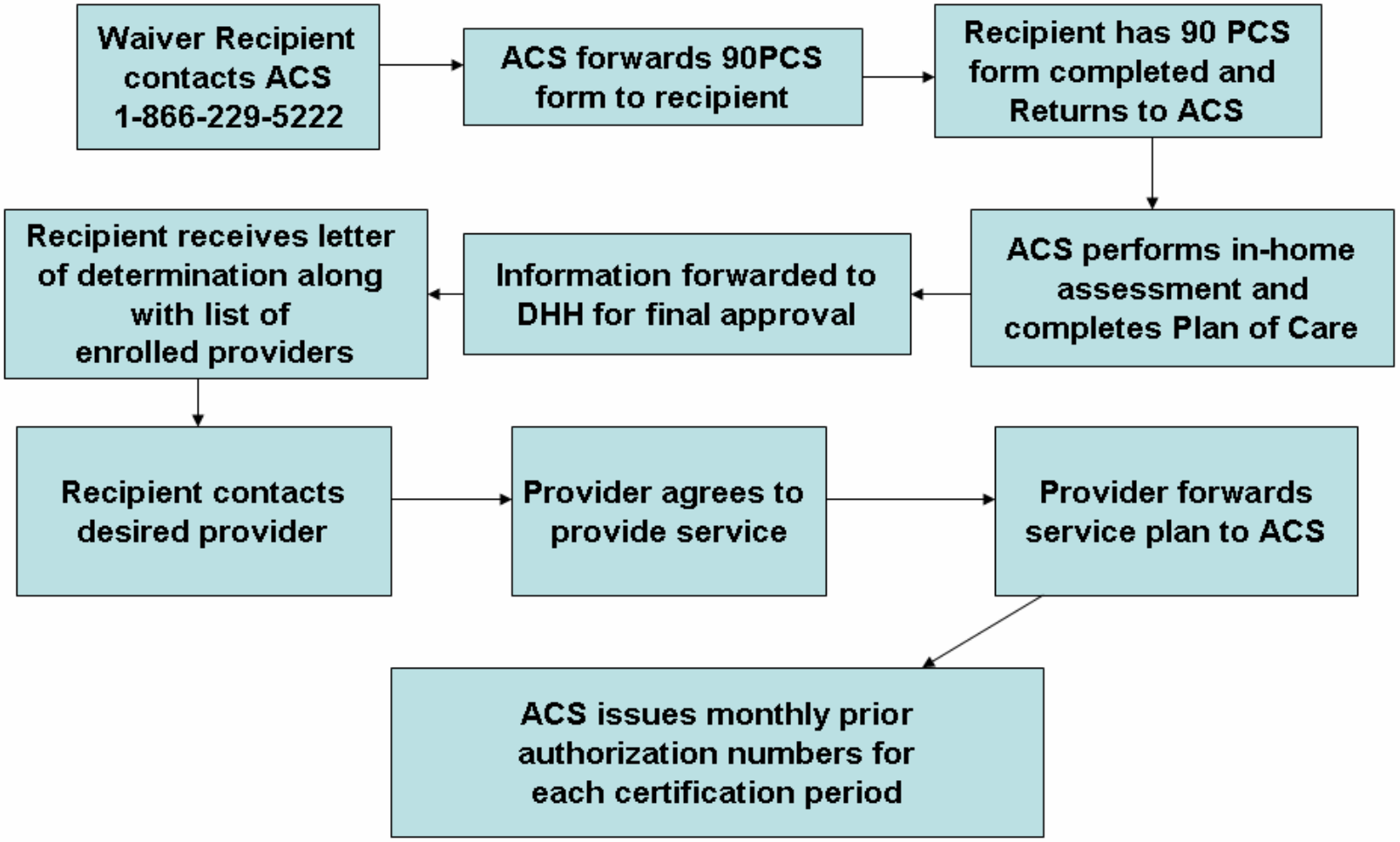
An example of a Prior Authorization letter from ACS is located on page 31.

The recipient or his/her responsible representative must initiate all requests for changes in services and/or hours. An interim assessment will be conducted for all requests for changes in services and/or service hours.

Prior Authorization: Waiver Recipient



Prior Authorization: Non-Waiver Recipient



DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

Provider Name
Street Address
City, LA Zip Code

Date

Recipient Name

Recipient Number

AUTHORIZATION NOTICE

This letter is to notify your agency of the following regarding Medicaid Long Term-Personal Care Services (LT-PCS):

☐ The above named recipient is authorized to receive services from _____to _____. Listed below are authorization numbers, approved units of service, and authorized dates of service for this certification period.

☐ The above named recipient is authorized to receive an increase in units of service from _____ to _____. For the current month of _____, the recipient is authorized to receive _____ additional units of service. Listed below are authorization numbers, approved units of service, and authorized dates of service for this change.

☐ The above named recipient has moved from a long-term care facility to reside in the community. A provisional authorization has been issued from _____ to _____. The recipient will be reassessed prior to the termination date, and a new authorization notice will be issued at that time. Listed below are authorization numbers, approved units of service, and authorized dates of service.

Authorization Numbers	Units of Service	Begin Date	End Date

☐ We have been notified that the above named recipient wishes to change LT-PCS providers. Effective _____ your authorization to provide these services to this recipient will end.

Agency Representative

Phone Number

LT-PCS 4 Provider Authorization
Reissued 06 06 05 Prior Issues Obsolete

BILLING FOR PCS

All personal care services are prior authorized and billed with the provider number associated with a type 24 provider number.

EPSDT Services:

Procedure Code	Modifier	Description	Unit Size	Reimbursement Rate
T1019	EP	EPSDT – Personal Care Services	15 min	$2.03

Long Term Services:

Procedure Code	Modifier	Description	Unit Size	Reimbursement Rate
T1019	UB	LT – Personal Care Services	15 min	$3.00

Providers must be sure to bill within the date span indicated on the PA letter.

Providers can bill in any time increment desired, as long as the date span and unit amount are within the scope of the prior authorization number.

Providers billing for Long Term PCS should be sure to closely follow the approved Service Plan. It is vital that all services are performed in 15 minute increments in order for full reimbursement to be received. Amounts of time which are not multiples of 15 minutes cannot be billed.

Providers should contact Provider Relations Inquiry Unit for assistance with all denied claims. For claims denied relative to the prior authorization number, the provider may be referred to the agency that issued the prior authorization for further assistance.

CLAIMS FILING

Personal Care Services are billed to Medicaid on the CMS-1500 claim form. The following pages explain the proper completion of the claim form.

Certain items on the CMS-1500 are mandatory, as indicated below by an asterisk (*). 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. Such claims cannot be processed until corrected and resubmitted by the provider.

Completed claim forms should be mailed to:

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

1. Enter an "X" in the box marked Medicaid (**Medicaid #**)

*1A. **Insured's ID Number** - Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using REVS, MEVS or e-MEVS at www.lamedicaid.com website.

*2. **Patient's Name** - Print the name of the recipient: last name, first name, and middle initial. Spell the name exactly as indicated through eligibility verification.

3. **Patient's Birth Date and Sex** - Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, REVS, or e-MEVS 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 recipient's sex.

4. **Insured's Name** - Leave blank

5. **Patient's Address** – Leave blank

6. **Patient Relationship to Insured** - Leave blank

7. **Insured's Address** - Leave blank

8. **Patient Status** - Leave blank

9. **Other Insured's Name** - Leave blank

9A. **Other Insured's Policy or Population Number** – Leave blank

9B. **Other Insured's Date of Birth** - Leave blank

9C. **Employer's Name or School Name** - Leave blank

9D. **Insurance Plan Name or Program Name** - Leave blank

10. **Was Condition Related To** - Leave blank

11. **Insured Policy Population or FECA Number** - Leave blank

11A. **Insured's Date of Birth** - Leave blank

11B. **Employer's Name or School Name** - Leave blank

11C. **Insurance Plan Name or Program Name** - Leave blank

12. **Patient's or Authorized Person's Signature** - Leave blank

13. **Insured's or Authorized Person's Signature** - Leave blank

14. **Date of Current Illness** - Leave blank

15. **Date of Same or Similar Illness** - Leave blank

16. **Dates Patient Unable to Work** - Leave blank

17. **Name of Referring Physician or Other Source** – Leave blank

17A. **ID Number of Referring Physician** – Leave blank

18. **Hospitalization Dates Related to Current Services** - Leave blank

19. **Reserved for Local Use** - Leave blank

20. **Outside Lab** - Leave blank

*21. **Diagnosis or Nature of Illness or Injury – EPSDT-PCS**: Enter the ICD-9-CM diagnosis code and, if desired, narrative description of the diagnosis. This information is required for EPSDT-PCS claims; **LT-PCS**: Leave blank

22. **Medical Resubmission Code** - Leave blank

*23. **Prior Authorization** – Enter the 9 digit Prior Authorization number indicated from the PA letter

*24A. **Date of Service** - Enter the date range for the service. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable. Make sure to enter the correct number of units in block 24G.

*24B. **Place of Service** - Enter either **12** (Home) or **99** (Other)

24C. **Type of Service** - Leave blank

*24D. **Procedure Code** – Enter appropriate procedure code based on date of service; make sure to apply the correct modifier if it is applicable on that date of service.

*24E. **Diagnosis Code – EPSDT-PCS**: Reference which ICD-9-CM diagnosis indicated in block 21 is related to the procedure code in block 24D.
LT-PCS: Leave blank

*24F. **Charges** - Enter usual and customary charges for this procedure

*24G. **Days or Units** - Enter the number of units of provided service for date range indicated

24H. **EPSDT** - Leave blank

24I. **EMG** - Leave blank

24J. **COB** - Leave blank

24K. **Reserved for Local Use** - Leave blank

25. **Federal Tax ID Number** - Leave blank

26. **Your Patient's Account Number** - (Optional) Enter the recipient's medical record number or other individual provider-assigned number to identify the patient. This number will appear on the Remittance Advice (RA).

27. **Accepts Assignment** - Leave blank

*28. **Total Charge** – Enter the same dollar amount indicated in block 24F.

29. **Amount Paid** - Leave blank

30. **Balance Due** – Enter the same dollar amount indicated in block 24F.

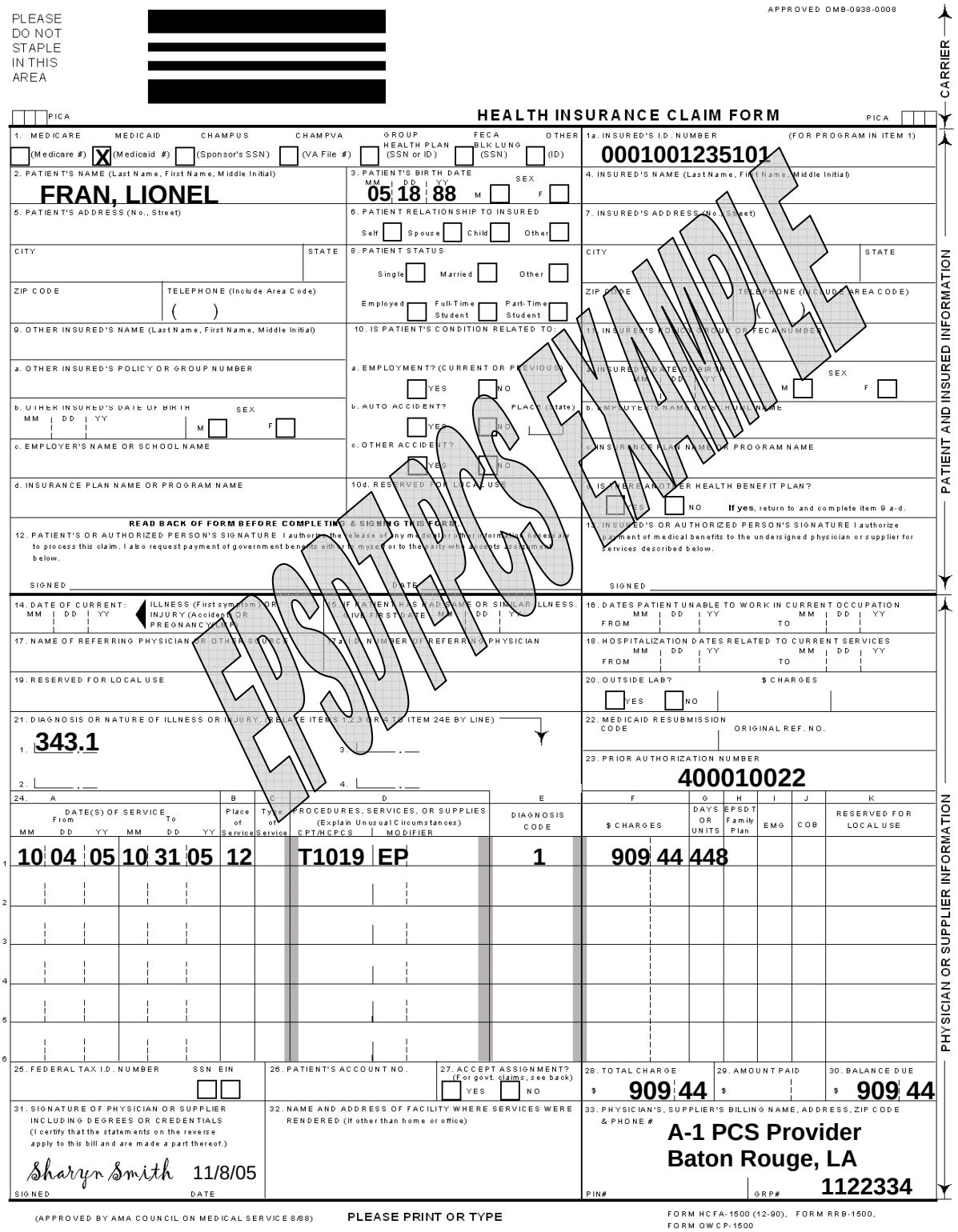
*31. **Signature of Physician/Supplier** - The claim form **MUST** be signed. Although the provider does not have to sign the form, an authorized representative from that office must sign the claim. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the provider 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.**

Date - Enter the date of the signature

32. **Name and Address Where Services Were Rendered** - Leave blank

*33. **Physician's or Medical Assistance Supplier's Name, Address, Zip Code and Telephone Number and PIN** - Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid provider number must be entered in the space next to "GRP #."

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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0001001235101

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

3. PATIENT'S BIRTH DATE MM DD YY: 05 18 88 | SEX: M

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 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. 343.1 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 400010022

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 10 04 05	10 31 05	12		T1019	EP	1	909 44	448				
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 $ 909 44

29. AMOUNT PAID $

30. BALANCE DUE $ 909 44

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.)

Sharyn Smith 11/8/05

SIGNED DATE

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

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

A-1 PCS Provider
Baton Rouge, LA

PIN# GRP# 1122334

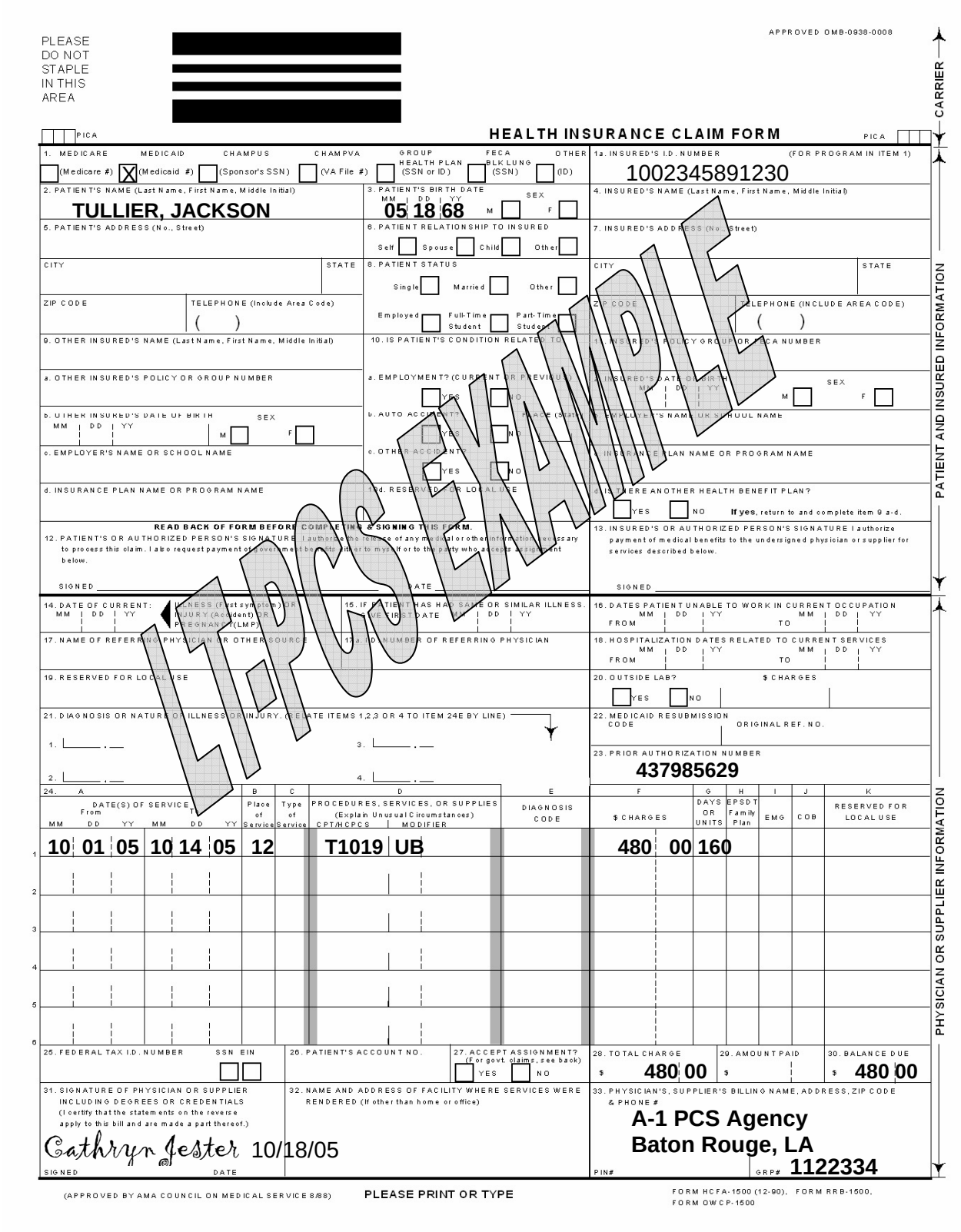
PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

EDI PCS EXAMPLE

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

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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1002345891230

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

3. PATIENT'S BIRTH DATE: 05 18 68 SEX: M

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

11a. 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)

11b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

11c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO **If yes**, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 437985629

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 10 01 05 10 14 05	12		T1019	UB		480 00	160				
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 $ 480 00

29. AMOUNT PAID $

30. BALANCE DUE $ 480 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.)

Cathryn Jester 10/18/05

SIGNED DATE

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

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

A-1 PCS Agency
Baton Rouge, LA

PIN# GRP# **1122334**

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

Unisys 213 Adjustment/Void Form

The Unisys 213 adjustment/void is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Unisys by calling Provider Relations at (800) 473-2783. Electronic submitters may electronically submit adjustment/void claims.

Form Completion

Only one (1) control number can be adjusted or voided on each 213 form.

Only an **approved** claim can be adjusted or voided.

Blocks 26 and 27 must contain the claim's **most recently approved** control number and R.A. date. For example:

1. A claim is approved on the RA dated 11/23/2004, ICN 4295067890123.

2. The claim is adjusted on the RA dated 12/28/2004, ICN 4352090123456.

3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (4352090123456) and RA date (12/28/2004) must be used.

Provider numbers and recipient Medicaid ID numbers cannot be adjusted. They must be voided and then resubmitted.

Adjustments: 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.

Voids: 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).

Only one (1) claim line can be adjusted or voided on each adjustment/void form.

213 Adjustment/void forms should be mailed to the following address for processing:

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

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

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

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): **TULLIER, JACKSON**
3 PATIENT'S DATE OF BIRTH: **05/15/68**
4 MEDICAID ID NUMBER: **1002345891230**
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. **437985629**

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
10	01	05	10	14	05	12	T1019	UB	1	432 00	144		

26 CONTROL NUMBER: **5326064949600**
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: **11/22/2005**

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 units for date range

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.)
Cathryn Jester 11/29/2005
32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
A-1 PCS AGENCY
Baton Rouge, LA
1122334

FISCAL AGENT COPY

UNISYS - 213
5/97

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION

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

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

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT

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

ADJUSTMENT

29 REASONS FOR VOID

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

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

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

32 YOUR PATIENT'S ACCOUNT NUMBER

UNISYS - 213
5/97

FISCAL AGENT COPY

Instructions for Completing the 213 Adjustment/Void form

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

2. **REQUIRED** Patient's Name

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

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

3. Patient's Date of Birth

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

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

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

5. Patient's Address and Telephone Number

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

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

6. Patient's Sex

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

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

7. Insured's Name— Leave blank

8. Patient's Relationship to Insured—Leave blank

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

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

11. Was Condition Related to—Leave blank

12. Insured's Address—Leave blank

13. Date of—Leave blank

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25. **REQUIRED** A through F

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

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

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

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

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

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

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

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

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

REQUIRED items must be completed or form will be returned.

CLAIM DENIAL RESOLUTION

This section is designed to assist providers in resolving claim denials. The most frequently encountered error codes are listed, along with an explanation of each denial and how to correct it.

Hardcopy Claim Denial Resolution

The following explanations assume that, if the claim was filed hardcopy, no data entry errors occurred. If the information on the Remittance Advice does not match the data on the claim (recipient ID number, date of service, procedure code, recipient name, charges, etc.), then a data entry error occurred. Providers may call Unisys Provider Relations department (see p. 54) to report the problem and request that the claim be reprocessed.

For Further Information

The topics of recipient eligibility verification (using REVS, MEVS, and e-MEVS), spend-down medically needy eligibility, third party liability, timely filing guidelines, SURS, and others are discussed in detail in the 2006 Basic Medicaid Provider Training packet. Providers may obtain a copy of this document by attending a 2006 Basic Medicaid Provider Training workshop or by requesting the packet from Provider Relations.

General Claim Form Completion Error Codes

ERROR CODE 003–RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS	
Cause:	The recipient ID number on the claim form was less than 13 digits in length or included letters or other non-numeric characters.
Resolution:	Verify the correct 13-digit recipient ID number using REVS or MEVS and enter this number where required on the claim form.

ERROR CODE 009-SERVICE THRU DATE GREATER THAN DATE OF ENTRY	
Cause:	The claim was received by Unisys prior to one or more dates of service billed.
Resolution:	Correct the date span on the claim and rebill **OR** wait until all dates of service on the claim have passed and rebill.

Duplicate Claim Error Codes

ERROR CODE 813 - EXACT DUPLICATE ERROR: IDENTICAL CLAIMS	
Cause:	The claim is a duplicate of one that has already been paid by Unisys.
Resolution:	On the Remittance Advice, the denial refers the provider to the conflicting control number and adjudication date of the previously paid claim. Refer to that Remittance Advice date indicated to find the paid claim. Do not resubmit the claim if it has already been paid.
	If the wrong number of units were paid for that date range, submit an adjustment in order to receive correct payment.

Recipient Eligibility Error Codes

ERROR CODE 215-RECIPIENT NOT ON FILE	
Cause:	The recipient ID number on the claim form is not in the Unisys eligibility files.
Resolution:	Verify the correct 13-digit recipient ID number using REVS, MEVS, or e-MEVS and enter this number where required on the claim form. If there is a printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 216-RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE	
Cause:	The recipient ID number on the claim is in the Unisys eligibility files, but the recipient's eligibility does not cover the date of service filed on the claim.
Resolution:	Verify the recipient's eligibility using REVS, MEVS, or e-MEVS for all dates of service on the claim. If there is a printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter explaining the problem.

ERROR CODE 217-NAME AND OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD	
Cause:	1. The name on the claim form does not match the recipient ID number as recorded in the Unisys eligibility files. This is sometimes caused when a recipient marries and changes her surname, or if several family members have similar ID numbers, **OR**
	2. The first and last names have been entered in reverse order on the claim form.
Resolution:	Verify the correct spelling of the name via REVS, MEVS, or e-MEVS using the 13-digit recipient ID number. Ensure that the first and last names are entered in the correct order on the claim. Make corrections if necessary and resubmit.
Occasionally a recipient's name may be changed on the Unisys eligibility files after PA is issued but before billing can occur. In such cases, the provider should contact Unisys Prior Authorization Unit to request that the name on the prior authorization record be changed to reflect the new name.	

ERROR CODE 222 – RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE (S)	
Cause:	The recipient ID number on the claim is in the Unisys eligibility files, but the recipient's eligibility does not cover all dates of service filed on the claim.
Resolution:	Verify the recipient's eligibility using REVS, MEVS, or e-MEVS for all dates of service on the claim. If there is a MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

Timely Filing Error Codes

ERROR CODE 272-CLAIM EXCEEDS 1 YEAR FILING LIMIT	
Cause:	The date of service on the claim form is more than 1 year prior to the date the claim was received by Unisys and no proof of timely filing was attached.
Resolution:	Resubmit the claim with proof of timely filing attached. Proof of timely filing is usually a copy of a RA page that shows the claim was processed by Unisys within one year from the date of service. Such claims may be mailed with a cover letter requesting an override for proof of timely filing to the Unisys Correspondence Unit.
A history can be ordered to assist in determining if payment has been made or if a claim has been filed timely. This may be done by calling the Provider Relations Telephone Inquiry Unit. The Field Analyst for your territory may also assist in placing such an order.	

ERROR CODE 030-SERVICE "THRU" DATE MORE THAN TWO YEARS OLD	
Cause:	The date of service on the claim form is more than two years prior to the date the claim was received by Unisys.
Resolution:	Timely filing guidelines dictate that, in general, claims with dates of service over two years old are not payable. Unisys staff does not have the authority to override such claims. In the case of retroactive eligibility, DHH must review the claim and approve any overrides for timely filing.

Prior Authorization Error Codes

Providers must bill services exactly as they are authorized via the PA letter. The Medicaid computer system compares several items which must be the same on both the claim form and the prior authorization record: PA number, Medicaid recipient ID number, provider number, procedure code, and date of service. The Remittance Advice (RA) reflects the PA number entered on each processed claim. This is found on the left-hand side of the RA page, just below the recipient name.

Several error codes pertain to the process the computer uses in matching items on the claim to items on the prior authorization record:

ERROR CODE 190–PA NUMBER NOT ON FILE	
Cause:	The number entered in block 23 of the CMS 1500 claim form is not a recognized number.
Resolution:	Review the PA letter, paying special attention to the Prior Authorization number. Make sure the number listed on the PA letter is the same as the number entered in block 23. Make any necessary corrections and resubmit.

ERROR CODE 191-PROCEDURE REQUIRES PRIOR AUTHORIZATION	
Cause:	No PA number entered in block 23.
Resolution:	Review recipient records to ascertain whether or not authorization had been given. If the prior authorization letter shows an approval for that service, be sure to indicate that specific PA number in block 23.

ERROR CODE 193-DATE ON CLAIM NOT COVERED BY PA	
Cause:	The date of service indicated on the claim form is not a date covered by that PA number.
Resolution:	1. Review recipient records to ascertain whether the date entered on the claim form is correct.
	2. Review the PA letter to ensure that the correct PA number is given.

ERROR CODE 196-CLAIM RECIPIENT ID DOES NOT MATCH ID ON PA FILE	
Cause:	Recipient ID on PA file is not the same as the one entered on the claim.
Resolution:	Review the PA letter, being sure to pay special attention to the recipient ID. When submitting the claim, all information on the PA must match the claim. Therefore, if a recipient has a different ID number on date of service than the PA record shows, the claim will deny.

ERROR CODE 197-PA PROVIDER ID NOT SAME AS CLAIM PROVIDER ID	
Cause:	The provider information on the PA file does not match the information on the claim form.
Resolution:	**EPSDT-PCS Claims only:** Review the PA letter, paying special attention to the Provider ID number. If there was a keying error or the provider did not indicate the correct ID number, a **Reconsideration** will need to be done in order for payment to be made. **LT-PCS Claims only:** Review the PA letter, paying special attention to the Provider ID number. If the provider number indicated on the PA letter is not correct, contact Provider Relations for follow up. If the provider number indicated on the claim form is incorrect, resubmit the claim with the correct provider number.

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
Recipient eligibility Issues – copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing – letter/other proof i.e., RA page	Continue hardcopy billing
Spend Down Recipient – 110MNP Spend Down Form	Continue hardcopy billing
Third Party/Medicare Payment – EOBs. (Includes Medicare adjustment claims)	Continue hardcopy billing
Retroactive eligibility – copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing

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

PROVIDER ASSISTANCE

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

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

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

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

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

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

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

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

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

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

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

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

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

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

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

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

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

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

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

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

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

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

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

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

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

DHH PROGRAM MANAGER REQUESTS

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

EPSDT-PCS Program
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

Division of Long Term Support and Services
Long Term Personal Care Services
446 North 12th Street
Baton Rouge, LA 70802

Attention: Program Manager

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.

ELECTRONIC DATA INTERCHANGE (EDI)

Claims Submission

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

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

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

Certification Forms

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

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

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

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

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

Electronic Data Interchange (EDI) General Information

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

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

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

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

- Case Management services
- Non-Ambulance Transportation

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

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

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

Enrollment Requirements For EDI Submission

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

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

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

Enrollment Requirements For 835 Electronic Remittance Advices

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

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

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

Electronic Adjustments/Voids

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

SUBMISSION DEADLINES
Regular Business Weeks

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

Thanksgiving Week

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

Important Reminders For EMC Submission

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

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

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

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

IMPORTANT UNISYS ADDRESSES

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

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

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

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

TIMELY FILING GUIDELINES

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

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

Dates of Service Past Initial Filing Limit

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

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

OR

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

OR

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

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

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

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

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

Submitting Claims for Two-Year Override Consideration

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

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

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

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

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

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

CLAIMS PROCESSING REMINDERS

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

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

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

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

Attachments

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

Changes to Claim Forms

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

Data Entry

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

Rejected Claims

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

- 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

APPENDIX A – FORMS FOR EPSDT- PCS

BHSF Form 90-L
Rev. 11/00

REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION

I. RECIPIENT INFORMATION

A. Recipient's Name:		SS #:	Medicaid #:
B. Address (City, State, Zip Code, Parish):		C. Responsible Party/Curator:	
		Address (City, State, Zip Code, Parish):	
Telephone #:	Race: Sex:		
Medicare #:	Date of Birth:	Relationship:	Telephone #:
D. What are/were the living arrangements: • Own home • Relative's home • Other			
E. What previous institutional care (including nursing facilities) has this person received?			
Facility: Date:		Facility: Date:	
Facility: Date:		Facility: Date:	
F. What Home/Community-based services have been used/considered: • ADHC • MR/DD • CC • PCA • ELDERLY • HH			
G. Why were services not suitable?			
H. Requesting Nursing Home placement: • Temporarily • Permanently			
I. Applicant/Responsible Party Signature:_____ Date:_____			

II. LEVEL OF CARE DETERMINATION

Institutional care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. The attending physician must designate the required level of care by selecting the appropriate level below. This requirement also applies to applicants requesting home or community-based waiver services to allow for a determination of the level of institutional care that would otherwise be required. Please select one of the following levels of care:

A. • Intermediate Care II (minimum care required) - Includes some aid in activities of daily living, diversionary activities, protection from hazards and/or a minimum

B. • Intermediate Care I (medium care required) - Includes need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization.

C. • Skilled Care (maximum care required) - Indicate special level, if indicated: • TDC • ID • NRTP (• Complex; • Rehab) Includes professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

D. • ICF/MR - Requires active treatment of mental retardation or a developmental disability under supervision of a qualified mental retardation or developmental disability professional.

E. Is this person likely to need services in a medical facility (hospital, nursing facility, etc.) for at least thirty (30) consecutive days ? • Yes • No

F. Home/community based services are adequate to meet the needs of this patient. • Yes • No

G. COMMENTS:

Recipient's Name:

III. MEDICAL INFORMATION

A. Diagnosis: _____

B. Medications:(Specify dosage, frequency, and route) ALLERGIES _____

1. _____ 5. _____ 9. _____

2. _____ 6. _____ 10. _____

3. _____ 7. _____ 11. _____

4. _____ 8. _____ 12. _____

C. Recent Hospitalizations: (include psychiatric) _____

D. Mental Status/Behavior: check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always

• Yes (1, 2, 3) • No 1. Oriented	• Yes (1, 2, 3) • No 4. Comatose	• Yes (1, 2, 3) • No 7. Hostile
• Yes (1, 2, 3) • No 2. Forgetful	• Yes (1, 2, 3) • No 5. Confused	• Yes (1, 2, 3) • No 8. Combative
• Yes (1, 2, 3) • No 3. Depressed	• Yes (1, 2, 3) • No 6. Wanders	

E. Activities of Daily Living: (check appropriate box)

- 1. Verbal
- 2. Non-verbal
- 3. Bowel Incontinence
- 4. Dentures _____
- 5. Impaired vision _____ • Glasses
- 6. Impaired hearing _____ • Hearing Aid
- 7. Bladder Incontinence _____
- 8. Urinary Catheter _____

SELF	ASSIST	TOTAL	
•	•	•	10. Eating
•	•	•	11. Bathing
•	•	•	12. Personal
•	•	•	13. Oral Hygiene
•	•	•	14. Ambulation

F. SPECIAL CARE/PROCEDURES: (check appropriate box: when appropriate give type, frequency, size, stage and site)

- 1. Ostomy care _____
- 2. Glucose Monitoring _____
- 3. Restraints _____
- 4. IV's _____
- 5. Suctioning _____
- 6. Specialized Rehab _____
- 7. MRSA _____
- 8. Diet/Tube Feeding _____
- 9. Dialysis _____
- 10. Respiratory _____
- 11. Decubitus _____
- 12. Other _____

G. PHYSICAL EXAMINATION: Height _____ Weight _____ Pulse _____ Resp _____ Temp _____ B/P _____
Lab Results: HCT _____ HGB _____ U/A _____ Radiology _____

General _____ Head and CNS _____

Mouth and EENT _____ Chest _____

Heart and Circulation _____ Abdomen _____

Genitalia _____ Extremities _____

Skin _____ Other _____

H. Physician's Name (Type or Print) _____ PHONE _____
Address: _____
Physician's Signature _____ Date _____

EPSDT Personal Care Services—Social Assessment
Must Be Submitted In Addition to Form 90-L

RECIPIENT NAME:_____ MEDICAID #_____

1. HOUSEHOLD COMPOSITION:

Name	Age	Relationship	School/Work?

2. PRIMARY CAREGIVER ASSESSMENT:

Name: _____ Age_____ Relationship_____ Phone_____

Does Primary Caregiver have physical or mental limitations which would affect his/her ability to care for the recipient?
☐Yes ☐No If yes, explain and attach medical documentation of limitations:

_____

_____

Will the primary caregiver supervise the PCS worker? ☐Yes ☐No

3. CHILDCARE ARRANGEMENTS:

Age of the recipient: _____ If fourteen years or younger, explain childcare arrangements when the parent is gone from the home. (ie., when parent is at work, before/after school when parent works, or when parent is away on errands).

_____

_____

4. RECIPIENT ASSESSMENT:

Does recipient attend school or work? ☐Yes ☐No If yes, specify hours attended and name of school or work:_____

Is recipient ☐ Verbal ☐ Nonverbal?
Does recipient utilize adaptive equipment? ☐Yes ☐No
If yes, specify what type equipment:_____

_____

Can recipient direct his/her own care? ☐Yes ☐No
If no, is primary caregiver or other caregiver in home? ☐Yes ☐No

Is recipient on medication: ( ) Yes ( ) No
If yes, who gives medication?_____

5. DIETARY FACTORS:

Who prepares meals?_____

Type of meals and number per day:_____
Assistive devices for eating (feeding tube, other): ( ) Yes ( ) No
If yes, specify:_____

6. HOME ENVIRONMENT:

Access (describe stairs, doors, walks, etc): _____

_____

Living Space:_____

_____

Location (rural, urban, on bus line, etc.):_____

_____

7. **Family Interpersonal Relationships:** Which family members assume major responsibilities for caring for recipient and what tasks do they perform?

_____

_____

8. SOCIAL SUPPORT SYSTEM: Are there other friends or relatives that assist in caring for the recipient or in giving relief to the primary caregiver?

_____

_____

9. OTHER SERVICES: What other services is the recipient receiving at this time (home health, respite, etc.)?

_____

_____

10. PCS SERVICES: What is the name of the agency that will provide PCS services?

_____

Signature(s) of person(s) completing assessment:

_____ Date:_____

_____ Date:_____

8-18

EPSDT PCS DAILY SCHEDULE

Client Name_____ Medicaid #_____

Specify hours of all services recieved by recipient. This includes EPSDT PCS as well as other services such as home health aide or nurse, respite or PCA from waiver or contract, physical therapy, etc. Be certain to show times the recipient is in school.

TIME	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
NOON							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							
12:00 PM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
Comments							

APPENDIX B – FORMS FOR LT- PCS

Long Term – Personal Care Services
Provider Service Plan

Check box	Recipient Name:	Medicaid ID#
[ ] New	Address:	Responsible Representative:
[ ] Revision		Responsible Representative's Phone #
Date Service Plan Prepared	Phone #	Responsible Representative's Alternate Phone #

Provider Agency:	Name of Contact Person:
Provider #	Phone #
Address:	Fax #
	E-mail address:

I have participated in the development of this service plan, and I am aware of the services that are to be provided through the Long Term – Personal Care Service program.

Recipient's Signature _____ **Date** _____

Responsible Representative's Signature _____ **Date** _____

Agency Representative's Signature _____ **Date** _____

LT-PCS Form SP
Issued 2/10/05

- 1 -

Activities of Daily Living				
Activity	Approved POC Activity	Support LT-PCS Agency Will Provide *Describe in DETAIL---* (How, where and when the tasks will be performed)	List the Day(s) Support Will Be Provided	Daily Time Allotment (Minutes/hours)
Eating	[ ] YES [ ] NO			
Bathing	[ ] YES [ ] NO			
Dressing	[ ] YES [ ] NO			
Grooming	[ ] YES [ ] NO			
Transferring	[ ] YES [ ] NO			
Ambulation	[ ] YES [ ] NO			
Toileting	[ ] YES [ ] NO			

Instrumental Activities of Daily Living				
Activity	Approved POC Activity	Support LT-PCS Agency Will Provide *Describe in DETAIL---* (How, where and when the tasks will be performed)	List the Day(s) Support Will Be Provided	Time Allotment (Min. or hrs. per day/wk/month)
Light Housekeeping	[ ] YES [ ] NO			
Food Preparation	[ ] YES [ ] NO			
Grocery Shopping	[ ] YES [ ] NO			
Laundry	[ ] YES [ ] NO			
Scheduling Medical Appointments	[ ] YES [ ] NO			
Accompany to Medical Appointments	[ ] YES [ ] NO			
Arrange Medical Transportation	[ ] YES [ ] NO			
Medication Reminders	[ ] YES [ ] NO			