



UNISYS

MENTAL HEALTH REHABILITATION PROVIDER TRAINING

Fall 2007

**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 Fall 2007 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as recipient eligibility and ID cards, and third party liability. The 2006 Basic Training packet may be obtained 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.** Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828.

**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. Personal Care 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 must be ordered by a physician. The PCS 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.

Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

- *Doctor's Visits
- *Hospital (inpatient and outpatient) Services
- *Lab and X-ray Tests
- *Family Planning
- *Home Health Care
- *Dental Care
- *Rehabilitation Services
- *Prescription Drugs
- *Medical Equipment, Appliances and Supplies (DME)
- *Support Coordination
- *Speech and Language Evaluations and Therapies
- *Occupational Therapy
- *Physical Therapy
- *Psychological Evaluations and Therapy
- *Psychological and Behavior Services
- *Podiatry Services
- *Optometrist Services
- *Hospice Services
- *Extended Skilled Nurse Services
- *Residential Institutional Care or Home and Community Based (Waiver) Services
- *Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
- *Immunizations
- *Eyeglasses
- *Hearing Aids
- *Psychiatric Hospital Care
- *Personal Care Services
- *Audiological Services
- *Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
- *Appointment Scheduling Assistance
- *Substance Abuse Clinic Services
- *Chiropractic Services
- *Prenatal Care
- *Certified Nurse Midwives
- *Certified Nurse Practitioners
- *Mental Health Rehabilitation
- *Mental Health Clinic Services

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

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 225-342-5774.

If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD Request for Services Registry, you may be eligible for support coordination services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office. If you are a Medicaid recipient under age 21, and it is medically necessary, you may be able to receive support coordination services immediately by calling SRI (toll free) at 1-800-364-7828.

You may access other services by calling KIDMED at (toll-free) 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

If you live in a CommunityCARE parish, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES CSRA's

METROPOLITAN HUMAN SERVICES

DISTRICT

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

CAPITAL AREA HUMAN SERVICES

DISTRICT

Pamela Sund, CSRA
4615 Government St. – Bin#16 – 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-800-768-8824

REGION III

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

REGION IV

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

REGION V

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

REGION VI

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

REGION VII

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

REGION VIII

Deanne W. Groves, CSRA
122 St. John St. – Rm. 343
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES

AUTHORITY

Marie Gros, CSRA
21454 Koop Drive – Suite 2H
Mandeville, LA 70471
Phone: (985) 871-8300
FAX: (985) 871-8303
Toll Free: 1-800-866-0806

JEFFERSON PARISH HUMAN SERVICES

AUTHORITY

Stephanie Campo, CSRA
Donna Francis, Asst CSRA
3300 W. Esplanade Ave. – Suite 213
Metairie, LA 70002
Phone (504) 838-5357
FAX: (504) 838-5400

TABLE OF CONTENTS

STANDARDS OF PARTICIPATION	1
PICKING AND CHOOSING SERVICES.....	1
STATUTORILY MANDATED REVISIONS TO ALL PROVIDER AGREEMENTS.....	2
SURVEILLANCE UTILIZATION REVIEW.....	3
FRAUD AND ABUSE HOTLINE.....	4
DEFICIT REDUCTION ACT OF 2005	4
PROVIDER ENROLLMENT	5
ACCREDITATION	5
CHANGE OF ADDRESS/ENROLLMENT STATUS.....	5
CHANGE IN OWNERSHIP	7
REMINDERS.....	8
PROGRAM OPERATIONS REMINDERS.....	9
AGENCY OPERATIONS	9
SERVICE LOCATION.....	9
POLICY MANUAL	10
ORGANIZATIONAL STRUCTURE	10
ABUSE AND NEGLECT.....	10
RECIPIENT ORIENTATION	11
QUALITY IMPROVEMENT PLAN.....	11
EMPLOYMENT AND PERSONNEL POLICIES.....	11
DISASTER RECOVERY POLICY	12
STAFFING AND TRAINING	13
STAFF QUALIFICATIONS	13
STAFF RESPONSIBILITIES	17
SUPERVISION.....	19
COVERED SERVICES	20
ASSESSMENT/REASSESSMENT (REQUIRED SERVICE).....	20
SERVICE PLANNING/TEAM (REQUIRED SERVICE)	21
COMMUNITY SUPPORT (REQUIRED SERVICE).....	22
GROUP COUNSELING (REQUIRED SERVICE).....	23
INDIVIDUAL INTERVENTION/SUPPORTIVE COUNSELING (REQUIRED SERVICE).....	25
MEDICATION MANAGEMENT (REQUIRED SERVICE)	27
PARENT/FAMILY INTERVENTION (COUNSELING) (REQUIRED SERVICE).....	29
PARENT/FAMILY INTERVENTION (INTENSIVE) (OPTIONAL SERVICE)	31
PSYCHOSOCIAL SKILLS TRAINING – GROUP (ADULT) (OPTIONAL SERVICE)....	35
PSYCHOSOCIAL SKILLS TRAINING – GROUP (YOUTH) - REQUIRED	39
SERVICE ACCESS AND AUTHORIZATION.....	43
INITIAL ASSESSMENT AND REQUEST FOR INTERIM PRIOR AUTHORIZATION PROCESS.....	43
INTERIM PRIOR AUTHORIZATION PERIOD.....	44
REASSESSMENT FOR CONTINUATION OF MHR SERVICES	45

ACCESS TO EMERGENCY SERVICES	48
REQUEST FOR ADDITIONAL SERVICES	49
RECONSIDERATION AND APPEALS	52
TRANSFERRING CASES	52
READMISSIONS	53
PA CONTACT INFORMATION	53
REIMBURSEMENT/BILLING	54
GENERAL PROVISIONS FOR REIMBURSEMENT	54
CLAIMS FILING	57
ADJUSTMENT/VOID CLAIMS	68
INSTRUCTIONS FOR FILING ADJUSTMENT/VOID CLAIMS.....	69
THIRD PARTY LIABILITY PROCEDURE.....	74
THIRD PARTY LIABILITY ERROR CODES	74
ELECTRONIC DATA INTERCHANGE (EDI)	77
CLAIMS SUBMISSION.....	77
CERTIFICATION FORMS	77
ELECTRONIC DATA INTERCHANGE (EDI) GENERAL INFORMATION	78
ELECTRONIC ADJUSTMENTS/VOIDS.....	79
HARD COPY REQUIREMENTS	80
CLAIMS PROCESSING REMINDERS.....	81
IMPORTANT UNISYS ADDRESSES	83
TIMELY FILING GUIDELINES	84
DATES OF SERVICE PAST INITIAL FILING LIMIT	84
SUBMITTING CLAIMS FOR TWO-YEAR OVERRIDE CONSIDERATION	85
RECORD KEEPING	86
RETENTION OF RECORDS	86
OMH – QUALITY MANAGEMENT.....	87
ADMINISTRATIVE SANCTIONS	88
LEVELS OF ADMINISTRATIVE SANCTIONS.....	88
GROUNDS FOR SANCTIONING PROVIDERS.....	89
NOTICE AND APPEAL PROCEDURE	90
COMMUNITYCARE BASICS FOR NON-PCPS	91
PROGRAM DESCRIPTION	91
RECIPIENTS.....	91
HOW TO IDENTIFY COMMUNITYCARE ENROLLEES.....	92
PRIMARY CARE PHYSICIAN.....	92
IMPORTANT COMMUNITYCARE REFERRAL/AUTHORIZATION INFORMATION....	93
HOSPICE SERVICES.....	96
PROVIDER ASSISTANCE	98
UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT	98
UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP	100
UNISYS PROVIDER RELATIONS FIELD ANALYSTS.....	101
PROVIDER RELATIONS REMINDERS	103
PHONE NUMBERS FOR RECIPIENT ASSISTANCE	106

LOUISIANA MEDICAID WEBSITE APPLICATIONS	107
PROVIDER LOGIN AND PASSWORD	107
WEB APPLICATIONS	108
ADDITIONAL DHH AVAILABLE WEBSITES	111
PHARMACY SERVICES	112
PRIOR AUTHORIZATION	112
PREFERRED DRUG LIST (PDL)	112
MONTHLY PRESCRIPTION SERVICE LIMIT	112
HOW DID WE DO?	114

STANDARDS OF PARTICIPATION

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

- Provider agreement and enrollment with the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH);
- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;
- Agreement to accept as payment in full the amounts established by the BHSF and refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.
- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services;
- **NOTE: Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, or the state Attorney General's Medicaid Fraud Control Unit.**
- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1978*, and, where applicable, *Title VII of the 1964 Civil Rights Act*.

Picking and Choosing Services

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

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

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

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

Statutorily Mandated Revisions to All Provider Agreements

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

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

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

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

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

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

Surveillance Utilization Review

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

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

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

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

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

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

Fraud and Abuse Hotline

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

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

Deficit Reduction Act of 2005

Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC §1396(a)(68)), set forth in that subsection and as the Secretary of US Department of Health and Human Services may specify. As an enrolled provider, it is your obligation to inform all of your employees and affiliates of the provisions the provisions of False Claims Act. When monitored, you will be required to show evidence of compliance with this requirement.

- Effective July 1, 2007, the Louisiana Medicaid Program requires all new enrollment packets to have a signature on the PE-50 which will contain the above language.
- The above message was posted on LAMedicaid website, (<https://www.lamedicaid.com/sprovweb1/default.htm>), RA messages, and in the June/July 2007 Louisiana Provider Update
- Effective November 1, 2007, enrolled Medicaid providers will be monitored for compliance through already established monitoring processes.
- All providers who do \$5 million or more in Medicaid payments annually, must comply with this provision of the DRA.

PROVIDER ENROLLMENT

ACCREDITATION

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

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

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

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

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

CHANGE OF ADDRESS/ENROLLMENT STATUS

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

OMH – Network Services
1885 Wooddale Blvd., 9th Floor
Baton Rouge, LA 70806

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

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

Changes that must be reported are changes in:

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

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

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

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

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

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

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

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

CHANGE IN OWNERSHIP

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

- Written notification with copies to:

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

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

OMH – Network Services
1885 Wooddale Blvd., 9th Floor
Baton Rouge, LA 70806

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

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

REMINDERS

- Provider must obtain and maintain a line of credit from a federally insured, licensed lending institution in an amount equal to three months' operating expenses. It is the provider's responsibility to notify the Bureau in the event that the financial institution cancels or reduces the upper credit limit.
- Providers must obtain and maintain a general liability and a professional liability insurance policy with at least \$1,000,000 coverage under each policy. The certificates of insurance for these policies shall be in the name of the MHR provider and certificate holder shall be the Department of Health and Hospitals. The provider shall notify the Bureau when coverage is terminated for any reason. Coverage shall be maintained continuously throughout the time services are provided.
- Each Medicaid enrolled MHR agency must have an independently enrolled practicing psychiatrist linked to the agency.
- Providers are no longer required to obtain an Adult Day Care license.
- All providers must obtain inspection and approval of their site(s) by the Office of State Fire Marshal and by the Office of Public Health.

PROGRAM OPERATIONS REMINDERS

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

AGENCY OPERATIONS

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

SERVICE LOCATION

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

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

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

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

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

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

POLICY MANUAL

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

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

ORGANIZATIONAL STRUCTURE

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

ABUSE AND NEGLECT

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

Procedures for reporting suspected abuse and neglect include the following:

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

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

RECIPIENT ORIENTATION

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

QUALITY IMPROVEMENT PLAN

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

EMPLOYMENT AND PERSONNEL POLICIES

- A job description for all positions, including the duties, qualifications, and competencies. This applies to volunteers and student workers.
- Drug testing is mandatory and the documentation shall be readily retrievable upon request by the Bureau or its designee.
- Providers must conduct criminal background checks through the Louisiana Department of Public Safety (State Police) on all employees prior to employment. If the results of any criminal background check reveal that the employee was convicted of any offenses listed in R.S. 40:1300.53, the employer shall not hire and/or shall terminate the employment of such person. In the case of an individual with a criminal background record involving an offense other than those detailed in R.S. 40:1300.53, the provider should exercise caution and good judgment in conjunction with their liability insurance carrier regarding hiring that individual.
If the provider offers services to children and/or adolescents, the background checks must be performed as required by R.S. 15:587.1 and R.S. 15:587.3. Under no circumstances may a provider hire an individual with a record as a sex offender.
- Each provider must coordinate processes to reduce the risk of infectious diseases such as tuberculosis (TB) in recipients and staff. Skin testing procedures should be made part of the agency's infection control program. All persons, prior to or at the time of employment, shall be free of TB in a communicable state.

Any employee who has a negative Mantoux skin test for TB shall be retested annually to remain employed. Any employee who has a positive Mantoux skin test must provide evidence of a normal chest x-ray, a statement from a physician certifying that the individual is noninfectious if the chest x-ray is other than normal, or completion of an adequate course of therapy as prescribed by a licensed physician, if active TB is diagnosed. Any employee who has a positive Mantoux skin test must provide an annual physician's statement that they are free of TB in a communicable state.

DISASTER RECOVERY POLICY

This policy refers to any occurrence which disrupts provision of services for one or more days, such as chemical spills, fire, flood, or hurricane.

Each provider must develop and implement an emergency preparedness plan for fire, natural, or declared disasters that includes:

- The measures that will be taken to ensure the safety and security of employees and recipients;
- Provisions to protect business records, including employee and recipient records; and
- A means of communication with the Bureau to report status of the provider post-disaster.

**** Note:** If the provider must close its offices due to the disaster, the provider may not resume provision of reimbursable services until authorized to do so by the Bureau.

STAFFING AND TRAINING

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

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

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

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

STAFF QUALIFICATIONS

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

Licensed Mental Health Professional (LMHP)

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

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

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

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

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

Psychologist

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

Advanced Practice Registered Nurse (APRN)

To be considered an LMHP an RN must be a clinical nurse specialist or nurse practitioner holding a master's degree with a concentration in one of the following specialties: Adult Psychiatric & Mental Health, Child/Adolescent Psychiatric & Mental Health, Family Psychiatric & Mental Health or Psychiatric & Mental Health and have two years of supervised post-master's experience in the delivery of mental health services. They must also enroll in Medicaid, be linked to the MHR provider number and operate under a collaborative practice agreement with a psychiatrist.

Registered Nurse

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

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

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

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

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

Social Worker

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

Licensed Professional Counselor

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

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

Mental Health Professional (MHP)

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

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

Mental Health Specialist (MHS)

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

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

or

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

or

- Has a high school degree or a GED;

and

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

Nurse

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

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

or

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

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

and

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

Licensed Practical Nurse

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

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

and

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

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

STAFF RESPONSIBILITIES

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

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

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

Psychiatrist

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

Psychologist

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

Advanced Practice Registered Nurse

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

Registered Nurse

- May provide Medication Management.

Social Worker

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

LPC

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

MHP

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

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

MHS

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

- Community support
- PFII
- Participate in quality improvement and staff training activities

Nurse

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

Licensed Practical Nurse

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

SUPERVISION

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

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

COVERED SERVICES

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

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

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

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

ASSESSMENT/REASSESSMENT (REQUIRED SERVICE)

Service Definition

Assessment is an integrated series of diagnostic and evaluation procedures conducted with the recipient and their significant others to provide the basis for the development of an effective, comprehensive, and individualized ISRP. It is an intensive clinical, psychosocial evaluation of a recipient's mental health condition which results in an Individualized Services and Recovery Plan (ISRP) for the recipient. It may also be used to determine recipient level of need and medical necessity. An initial assessment must be completed for all new MHR recipients and for those with a 12 month or more lapse in service. Reassessments are due at the end of the each prior authorization period—usually 90 day intervals.

Program Requirements

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

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

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

SERVICE PLANNING/TEAM (REQUIRED SERVICE)

Service Definition

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

Program Requirements

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

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

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

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

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

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

The certification statement must consist of a signed and dated statement from the treating psychiatrist that he/she has reviewed the ISRP and that the services it contains are medically necessary and appropriate for the recipient's diagnosis and service needs. In addition, it must note concurrence with any specific goals, objectives and interventions relating to medications, or medical management issues.

Service Authorization Periods

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

COMMUNITY SUPPORT (REQUIRED SERVICE)

Service Definition

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

Service Exclusions

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

Program Requirements

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

Each recipient enrolled in the Mental Health Rehabilitation Program shall have one designated provider who will serve as the “mental healthcare home” for the recipient and family as indicated on the Freedom of Choice form. Within this provider, each recipient will choose one designated community support worker who is the recipient/family’s primary point of contact. While this designated community support worker will provide the majority of community support activities, he/she may not be the exclusive provider of these activities.

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

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

Community Support may be provided in:

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

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

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

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

Service Authorization Periods

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

GROUP COUNSELING (REQUIRED SERVICE)

Service Definition

Group Counseling is a professional, therapeutic intervention using face to face verbal interaction between 2 to 8 recipients and the therapist/counselor to promote emotional, behavioral or psychological change as identified in the ISRP of each group member. The service is directed to the goals on the approved ISRP. Sessions are typically limited to one hour.

Service Exclusions

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

Clinical Exclusions

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

Program Requirements

This service may be provided in any of the following:

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

Group counseling will be limited to the following topical areas:

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

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

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

Service Authorization Periods

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

INDIVIDUAL INTERVENTION/SUPPORTIVE COUNSELING (REQUIRED SERVICE)

Service Definition

Individual intervention and supportive counseling are verbal interactions between the counselor/ therapist and the recipient that are brief, face to face and structured. Sessions are typically limited to 30 to 90 minutes. Individual Intervention (Youth) is a range of professionally delivered therapeutic strategies provided individually and face to face to the recipient. The purpose is to rehabilitate and restore the recipient to an optimal level of functioning and to reduce the risk of a more restrictive treatment intervention.

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

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

Service Exclusions

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

Program Requirements

This service may be provided in any of the following:

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

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

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

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

Service Authorization Period

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

MEDICATION MANAGEMENT (REQUIRED SERVICE)

Service Definition

Medication management is provided to:

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

Clinical Exclusions

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

Program Requirements

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

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

This service includes four primary activities:

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

This assessment is minimally inclusive of:

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

- **Medication Administration**—the administration of therapeutic doses of medication for the treatment of mental disorders which have been prescribed and are monitored by a psychiatrist (or other prescriber as allowed under applicable state law) and indicated in the recipient’s MHR ISRP. “Administration” shall be interpreted consistent with applicable state law but minimally is inclusive of injectables (shots), direct dosing of oral medications, and repackaging of oral medication into “pill boxes” or daily dosage boxes when pills are placed in the boxes directly by MHR staff credentialed to administer medications.
- **Medication Monitoring**—the ongoing review of symptoms, side effects, effectiveness, applicable lab or other measures, compliance, and prescription renewal and adjustment of psychotropic medications.
- **Medication Education**—involves the instruction of the recipient, family, significant others, and care givers on the expected effects of prescribed medication. Medication education may include but not be limited to include:
 - Proper use and storage of medications.
 - Rationale for the medication.
 - Possible side effects, including impact on pregnancy, and age, sex, or disability related.
 - Early warning signs of relapse and signs of non-adherence and noncompliance with medication prescription.
 - Circumstance/symptoms requiring contact with a medical professional.
 - Use/interactions with other substances (prescribed/non-prescribed).
 - Instruction on the proper self administration of medications.

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

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

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

- **Initial Medication Assessment** – completed and documented in the clinical record during the interim authorization period, not to exceed 30 days from the date eligibility was determined.
- **Monitoring** – provided as justified by recipient need but in no case less frequently than once every 90 calendar days.
- **Medication Administration** – frequency as required by prescription, orders and ISRP.
- **Medication Education** – as required by approved ISRP, but minimally must be documented in the clinical record at the time of any change in medication including dosage or type.
- The MHR provider shall have written policies and procedures regarding the administration of prescription and non-prescription medications used by the recipient while they are enrolled with the provider. The policies and

procedures shall provide a structure to ensure compliance with all applicable state law and policy included to but not limited to:

- Respective practice acts for the disciplines listed in the staffing requirements.
- Medical Assistance Program Integrity Law (MAPIL) LSA-RS 46:437. 1-46:440.3.

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

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

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

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

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

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

Service Authorization Periods

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

PARENT/FAMILY INTERVENTION (COUNSELING) (REQUIRED SERVICE)

Service Definition

Parent/Family Intervention (Counseling) is a therapeutic intervention involving the recipient and one or more of his/her family members. The primary goal of the service is

to help the recipient and family improve their overall functioning in the home, school, work and community settings. This goal is accomplished by helping the recipient and family increase effective coping mechanisms, healthy communication strategies, constructive problem-solving skills and increased insight into the nature of the recipient's difficulties and the impact on the family.

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

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

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

Service Exclusions

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

Program Requirements

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

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

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

Service Authorization Periods

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

PARENT/FAMILY INTERVENTION (INTENSIVE) (OPTIONAL SERVICE)

Service Definition

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

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

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

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

Service Exclusions

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

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

Clinical Exclusions

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

Program Requirements

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

Service parameters must encompass the following:

Duration of Treatment

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

Intensity of Services

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

Face to Face Contact and Location of Services

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

Flexible Scheduling

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

Team Caseload

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

Crisis Management

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

Availability

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

Planning and Management

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

Family Involvement

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

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

Individualized Treatment

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

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

Team Case Coordination

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

The team approach should incorporate flexible services and a capacity to address concrete therapeutic and environmental issues in order to stabilize the family situation as soon as possible. The best practice of such an approach should allow the child and family to view the services as delivered by a single organizational unit or team.

Comprehensive Mix of Services

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

- Crisis management;
- Intensive care coordination;
 - Identification of needed community resources,
 - Linkage to such resources, and
 - Follow-up to determine adequacy and appropriateness of resources.

- Individual and family counseling/therapy;
 - Skills training, including all skills training delineated in the Psychosocial Skills Training (Individual) service description.
- Behavioral management;
 - Development of behavior management plans,
 - Training of behavior management skills, and
 - Monitoring, updating and adapting behavior management plan.

System Collaboration

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

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

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

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

Service Authorization Period

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

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

Service Definition

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

ability to live successfully in the natural environments they choose. A recipient would normally participate in Psychosocial Skills Training Group (Adult) for six to 18 months.

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

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

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

Service Exclusions

This may not be combined on the ISRP with:

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

Clinical Exclusions

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

Program Requirements

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

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

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

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

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

- Daily and Community Living Skills:
 - Nutritional services,
 - Food planning, grocery shopping, cooking, and eating,
 - Household maintenance, including housecleaning and laundry,
 - Money management and budgeting,
 - Shopping for daily-living necessities,
 - Community awareness and current events,
 - Identification and use of social and recreational skills,
 - Use of available transportation, and
 - Personal responsibility.
- Socialization Skills:
 - Communication,
 - Interpersonal relationships, including those with roommate(s) and neighbors,
 - Problem solving/conflict resolution,
 - Management of sensory input and stress,
 - Natural support system development,
 - Self-directed engagement in community social activities (development of a social-recreational plan for the recipient), and
 - Decision making.
- Adaptation Skills:
 - Identification of behaviors that interfere with performance;
 - Development of interventions to alleviate problem behavior, including
 - Coping with symptoms of mental illness that affect the person's ability to successfully work and/or attend school;
 - Development of capacity to follow directions and carry out assignments;
 - and
 - Acquisition of appropriate work habits.
- Development of Leisure Time Interests and Skills.
- Symptom Management Skills – focusing on day to day management of symptoms. (Technical medication training should be provided under the Medication Management service).
- Identification and management of symptoms of mental illness; and
- Compliance with physician's medication orders.
- Education in Mental Health/Mental Illness.

- Management of symptoms of mental illness to minimize the negative effects of psychiatric symptoms which interfere with the recipient's daily living, financial management, personal development, and community integration (services that meet the definition of Medication Management should be provided by staff credentialed to offer that service).
- Developing skills necessary for the recipient to comply with prescribed medications.
- Family education and support designed to develop and maintain the family as a support system to the recipient.
- Work readiness activities as part of a clubhouse model (excepting skills related to a specific vocation, trade, or practice):
 - Work related social and communication skills;
 - Work related personal hygiene and attire;
 - Work related time management; and
 - Other related skills preparing the recipient to be employable.

Psychosocial Skills Training- Group (Adult) must have:

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

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

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

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

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

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

Service Authorization Periods

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

Psychosocial Skills Training – Group (Youth) - Required

Service Definition

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

The goals of the service include:

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

Service Exclusions

This service may not be combined on an ISRP with:

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

Clinical Exclusions

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

Program Requirements

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

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

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

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

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

- Socialization Skills
 - Communication,
 - Interpersonal relationships, including those with peers, family, and authority figures,
 - Problem solving/conflict resolution,
 - Management of sensory input and stress,
 - Natural support system development,
 - Self-directed engagement in community social activities (development of a social-recreational plan for the recipient), and
 - Decision making.
- Adaptation Skills
 - Identification of behaviors that interfere with performance;

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

- Evidence of a memorandum of understanding or other written agreement for the use and terms of the space,
- Allows for privacy and confidentiality, and
- Is appropriate to the age, level of need, and structure needed for the recipients.

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

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

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

Service Authorization Periods

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

Non Covered Services

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

SERVICE ACCESS AND AUTHORIZATION

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

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

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

All information sent to the Service Access and Authorization Unit is date stamped the day it is received. If information is received after 3:00 pm it is stamped the following day.

INITIAL ASSESSMENT AND REQUEST FOR INTERIM PRIOR AUTHORIZATION PROCESS

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

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

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

The provider will send the following to the PA staff:

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

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

Approval

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

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

Denial

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

INTERIM PRIOR AUTHORIZATION PERIOD

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

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

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

Approval

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

Partial Denial

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

Denial

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

REASSESSMENT FOR CONTINUATION OF MHR SERVICES

The reassessment is to ensure:

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

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

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

OMH/MHR Cover Sheet

A cover sheet must be attached to all requests submitted to Service Access and Authorization.

Submission Date: _____ Total # of pages submitted: _____

Recipient Social Security #:

--	--	--	--	--	--	--	--	--	--	--

Recipient Medicaid #:

--	--	--	--	--	--	--	--	--	--	--	--	--

Recipient Medicare # (if applicable): _____

Recipient: Last Name _____ First Name _____

DOB: ____/____/____ Age: _____

Parish Code for Recipient: _____ Provider #: _____ NPI # _____

AGENCY: _____

AGENCY Phone #: _____ Region: _____

Recipient Address (including zip code): _____

Phone # (include area code) _____

Custody: ____parent ____relative ____friend ____OCS ____OYD

Living Setting: ____home ____therapeutic foster care ____regular foster care ____ private pay foster care ____residential care

Guardian/Parent Name: _____

Address (if different): _____

Phone # (if different): _____

Transfer: ____yes ____no

Name of Approved Clinical Evaluator: _____

Name of LMHP: _____

Check one of the following and submit all documents list:

Note: You must enter LOCUS/CALOCUS ratings into MHRSIS prior to submitting a request.

_____ **New Recipient Assessment-Submit the following:**

Cover Sheet

MHRSIS Data Sheet (must be entered into MHRSIS and a data file sent prior to submission)

Freedom of Choice Form

Screening Form - 3 D's

Initial Assessment

Interim ISRP

A signed copy (with the current date) of the e-CDI screen. If e-CDI data is not available, print the e-CDI screen and document at the top why the information is not available.

_____ **Initial Authorization Request (first 90 day)-Submit the following:**

Cover Sheet

Initial Individual Service Recovery Plan (ISRP)

_____ **Subsequent Authorization Request-Submit the following:**

Cover Sheet

Reassessment Form

ISRP

A signed copy (with the current date) of the e-CDI screen. If e-CDI data is not available, print the e-CDI screen and document at the top why the information is not available.

_____ **Revision Request:**

Revision Request Form

Revised ISRP

Revised Crisis Intervention/Recovery Plan

Current LOCUS/CALOCUS Rating

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

e-CDI Screen Shot

e-CDI Clinical Drug Inquiry - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address: <https://192.60.97.227/sprovweb1/eCDI/ViewCDI.aspx>

Louisiana Medicaid

Department of Health and Hospitals

[Main Menu](#)

[Print](#)

Warning: Unauthorized use of this site or of the information contained herein is prohibited by the Louisiana Department of Health and Hospitals.

**Louisiana Medicaid Clinical Drug History
e-CDI Clinical Drug Inquiry**

Recipient's Medicaid ID Number or CCN: XXXXXXXXXX

Recipient's Date of Birth: XXXX/XX/XX

Recipient's Name: XXXXXXXXXX

Recipient's Sex: **F** Recipient's Age: **1**

CommCARE Ind: **Y** EPSDT Ind: **Y**

Click below to Select the Drug History Period:

☐ This Month
 ☐ Prior Month
 ☒ Last 4 Months

Paid Prescriptions filled this month: 03

PRESCRIPTIONS ARE LISTED IN REVERSE CHRONOLOGICAL ORDER (Most Recent Rx First)

Num	DOS	Brand/Trade Name	Generic Description	Strength	Route	Quantity	Days Supply	PT	PS
1	10/13/2003	WATER	WATER FOR INJE		2	10	1	33	37
2	10/13/2003	SYNAGIS	PALIVIZUMAB	50MG	C	1	1	33	37
3	10/13/2003	SYNAGIS	PALIVIZUMAB	100MG	C	1	30	20	06
4	09/15/2003	SYNAGIS	PALIVIZUMAB	100MG	C	1	30	20	06
5	09/15/2003	SYNAGIS	PALIVIZUMAB	50MG	C	1	1	33	37
6	09/15/2003	WATER	WATER FOR INJE		2	10	1	33	37
7	09/09/2003	WAFEPATIN SODIUM	WAFEPATIN SODIUM	1MG	1	30	60	60	86

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

Note the convenient **PRINT** button.

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

The following information will be reviewed:

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

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

Approval

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

Partial Denial

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

Denial

An authorization request for continued services may be denied.

ACCESS TO EMERGENCY SERVICES

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

New MHR Recipients

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

Established MHR Recipients

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

REQUEST FOR ADDITIONAL SERVICES

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

Request for Revision Form

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

Criterion 1: *Extraordinary or unanticipated event/circumstance.*

Documentation has been supplied that the recipient is:

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

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

Criterion 2: *Two-thirds of current/active and approved PA units have been utilized.*

Documentation confirms the provider delivered 2/3 of available units under current/active PA before a request for revision has been requested. To be considered for additional units, the

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

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

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

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

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

Approval

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

Partial Denial

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

Denial

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

Request for Revision Form

Additional Units Requested

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

LMHP Signature _____ DATE _____

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

Attachments:

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

Check all that apply

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

- ☐ A danger to self;
- ☐ A danger to others;
- ☐ The recipient is at risk for displacement (i.e., psychiatric hospitalization, therapeutic out of home placement, incarceration)

Explain each item checked:

- ☐ Two-Thirds of current/active units approved by PA have been utilized.
 - ☐ Appropriate and medically necessary specialty referrals have been made but the service(s) are not available
- Explain:

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

RECONSIDERATION AND APPEALS

Reconsideration

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

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

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

Denial/Appeal Processes

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

TRANSFERRING CASES

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

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

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

1. The Service Access and Authorization Unit must receive the signed Freedom of Choice from the new agency. The selected agency must enter the recipient in MHRIS and open the case prior to submitting the request.
2. The Service Access and Authorization Unit will issue a 60 day interim authorization (instead of 30 day interim authorization) to the new agency which includes:

Community Support	– 17 Units
Assessment	– 1 Unit
Medication Assessment	– 6 Units
Medication Admin - Oral	– Per Recipient Need
Medication Admin - Injection	– Per Recipient Need

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

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

READMISSIONS

If a recipient is readmitted by a provider who had previously provided services within the past year, a Reassessment form and ISRP must be submitted. An initial assessment will not be approved.

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

PA CONTACT INFORMATION

OMH / Service Access and Authorization Unit
1885 Wooddale Blvd., 9th Floor
Baton Rouge, LA 70806

Phone: 225.922.0006
800.558.4617 toll free (outside the Baton Rouge area)

Fax: 225.925.4789 & 225.922.2165
800.558.4618(outside the Baton Rouge area)

Questions regarding PA's, approved or denied, should be directed to OMH / Service Access and Authorization Unit.

REIMBURSEMENT/BILLING

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

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

GENERAL PROVISIONS FOR REIMBURSEMENT

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

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

Information Transfer/Billing Schedule

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

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

Documentation Requirements

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

Proper documentation for MHR services includes:

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

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

MHR - Fee Schedule effective 12/1/06

Service	Unit	Rates	Modifier	Code	HCPCS Code Description	Staff who can Perform the Service
Med Assmt, Monitoring and Education	15 minutes	\$ 49.64	none	90862	Pharmacologic Management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	Psychiatrist is paid 100% of fee on file, APRN is paid at 80% (\$39.71), RN is paid at 67% (\$33.26)
Med Administration, oral	Per Contact	\$ 3.23	none	H0033	Oral Medication administration, direct observation	Psychiatrist, APRN, RN, LPN
injection	Per Contact	\$ 3.23	none	90772	Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular	Psychiatrist, APRN, RN, LPN
Individual Intervention/Supportive Counseling	15 minutes	\$ 18.77	HR	H0004	Behavioral Health Counseling Therapy, Per 15 min	LMHP, MHP
Group Counseling	15 minutes	\$ 8.49	HQ	H0004	Behavioral Health Counseling Therapy, Per 15 min	LMHP, MHP
Parent Family Intervention - Counseling	15 minutes	\$ 18.77	HR, HS	H0004	Behavioral Health Counseling Therapy, Per 15 min	LMHP, MHP
Parent Family Intervention - Intensive	15 minutes	\$ 25.29	none	H2021	Community Based Wrap-around Services, Per 15 min	Team includes LMHP & either 2 MHP, or 1 MHP and 1 MHS
Community Supports	15 minutes	\$ 14.69	HO	H2015	Comprehensive Community Support Services, Per 15 min	LMHP, MHP
PSR skills training group	15 minutes	\$ 3.63	none	H2014	Skills Training and Development, Per 15 min	MHS
Assessment	per service	\$ 257.60	none	H0031	Mental Health Assessment, by non physician	LMHP, MHP, MHS
Reassessment	per service	\$ 103.04	52	H0031	Mental Health Assessment, by non physician	LMHP (in conjunction with any of the following: Psychiatrist, APRN, LCSW, Psychologist, LPC) (rate based on a 150 minute assessment)
						LMHP (in conjunction with any of the following: Psychiatrist, APRN, LCSW, Psychologist, LPC) (rate based on a 60 minute reassessment)

LMHP - Licensed Mental Health Professional

MHP - Mental Health Professional (under the supervision of a LMHP)

MHS - Mental Health Specialist (under the direct supervision of a LMHP or MHP)

APRN - Advanced Practice Registered Nurse (Must be a CNS in Psychiatry)

RN - Registered Nurse

LPN - Licensed Practical Nurse

Modifiers

HQ	Group Setting
HR	With Recipient Present
HS	Without Recipient Present
HO	Masters Degree Level
52	Reduced Services

CLAIMS FILING

Instructions for completing the CMS-1500 (08-05) follow. Items to be completed are either **required** or **situational**. **Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. **Situational** information may be required (but only in certain circumstances as detailed in the instructions below). **Optional** means that entry of information is at the discretion of the provider. Claims should be submitted to:

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

CMS-1500 Billing Instructions for Professional and General Services

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Situational – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	Patient Status	Optional.	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	<p>Situational – If recipient has no other coverage, leave blank.</p> <p>If there is other coverage, the state assigned 6-digit TPL carrier code is required in this block (the carrier code list can be found at www.lamedicaid.com under the Forms/Files link).</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	
9b	Other Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	Situational – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	Situational – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness Give First Date	Optional.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	<p>Situational – Complete if applicable.</p> <p>In the following circumstances, entering the name of the appropriate physician block is required:</p> <p>If services are performed by a CRNA, enter the name of the directing physician.</p> <p>If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.</p> <p>If services are performed by an independent laboratory, enter the name of the referring physician.</p>	
17a	Unlabelled	Situational – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is required to be entered.	The PCP's 7-digit referral authorization number must be entered in block 17a.
17b	NPI	Optional.	The revised form accommodates the entry of the referring provider's NPI.

Locator #	Description	Instructions	Alerts
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Reserved for future use. Do not use.	Usage to be determined.
20	Outside Lab?	Optional.	
21	Diagnosis or Nature of Illness or Injury	Required -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	
22	Medicaid Resubmission Code	Optional.	
23	Prior Authorization Number	<p>Situational – Complete if appropriate or leave blank.</p> <p>If the services being billed must be Prior Authorized, the PA number is required to be entered.</p>	
24	Supplemental Information	<p>Situational – Applies to the detail lines for drugs and biologicals only.</p> <p>In addition to the procedure code, the National Drug Code (NDC) is required by the Deficit Reduction Act of 2005 for physician-administered drugs and <u>shall be entered</u> in the shaded section of 24A through 24G. <u>Claims for these drugs shall include the NDC from the label of the product administered.</u></p> <p>To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the Qualifier N4 followed by the NDC. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.</p> <p>Providers should then leave one space then enter the appropriate Unit Qualifier (see below) and the actual units administered. Leave three spaces and then enter the brand name as the written description of the</p>	<p>Physicians and other provider types who administer drugs and biologicals must enter this new drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only.</p> <p>This information must be entered in addition to the procedure code(s).</p>

Locator #	Description	Instructions	Alerts
		<p>drug administered in the remaining space.</p> <p>The following qualifiers are to be used when reporting NDC units:</p> <p>F2 International Unit ML Milliliter GR Gram UN Unit</p>	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	<p>Required -- Enter the appropriate place of service code for the services rendered.</p> <p>MHR Service Code Options:</p> <p>03 – School 11 – Office 12 – Home 99 – Other</p>	
24C	EMG	<p>Situational – Complete if appropriate or leave blank.</p> <p>When required, the appropriate CommunityCARE emergency indicator is to be entered in this field.</p>	This indicator was formerly entered in block 24I.
24D	Procedures, Services, or Supplies	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).	
24E	Diagnosis Pointer	<p>Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block.</p> <p>More than one diagnosis/reference number may be related to a single procedure code.</p>	
24F	\$Charges	Required -- Enter usual and customary charges for the service rendered.	

Locator #	Description	Instructions	Alerts
24G	Days or Units	Required -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	Optional.	The revised form accommodates the entry of I.D. Qual.
24J	Rendering Provider I.D. #	<p>Situational – If appropriate, entering the Rendering Provider’s Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider’s NPI in the non-shaded portion of the block is optional.</p> <p>If billing for medication management, the psychiatrist/APRN rendering service Medicaid ID # must be entered.</p>	The revised form accommodates the entry of NPIs for Rendering Providers. The Rendering Provider must be linked to the MHR via a group linkage form.
25	Federal Tax I.D. Number	Optional.	
26	Patient’s Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	<p>Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter ‘0’ if the third party did not pay.</p> <p>If TPL does not apply to the claim, leave blank.</p>	

Locator #	Description	Instructions	Alerts
30	Balance Due	Situational – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Required -- The claim form MUST be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	The revised form accommodates entry of the Service Location NPI.
32b	Unlabelled	Situational – Complete if appropriate or leave blank. When the billing provider is a CommunityCARE enrolled PCP, indicate the site number of the Service Location. The provider must enter the Qualifier LU followed by the three digit site number . Do not enter a space between the qualifier and site number (example "LU001", "LU002", etc.)	
33	Billing Provider Info & Ph #	Required -- Enter the provider name, address including zip code and telephone number.	

Locator #	Description	Instructions	Alerts
33a	NPI	Optional.	The revised form accommodates the entry of the Billing's Provider's NPI.
33b	Unlabelled	Required – Enter the billing provider's 7-digit Medicaid ID number.	Format change with addition of 33a and 33b for provider numbers.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CHILD EXAMPLE

<input type="checkbox"/> PICA										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567899999									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) May, Maggie										3. PATIENT'S BIRTH DATE MM DD YY SEX 04 01 94 M F									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										4. INSURED'S NAME (Last Name, First Name, Middle Initial) 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER 6 digit TPL number here, if applicable b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE									
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 _____										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
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									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. RESERVED FOR LOCAL USE									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 313.81 3. _____ 2. _____ 4. _____										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____ 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 1234567									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER 1. 07 01 07 07 01 07 11 H0004 HR 1										F. \$ CHARGES G. DAYS OR UNITS H. EPDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID # 37 54 2 NPI 1234567 1234567890									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>									
28. TOTAL CHARGE \$ 37 54 29. AMOUNT PAID \$ TPL Amt. 30. BALANCE DUE \$ 37 54										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE'S OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Ima Biller 7/1/07									
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # () MHR USA 123 Happy St. Anywhere, LA 7000 a. 1234567890 b. 1234567									

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ADULT EXAMPLE

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S ID NUMBER (For Program in Item 1) 1234999999999									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, John										3. PATIENT'S BIRTH DATE MM DD YY 09 14 60									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER 6 digit TPL number here, if applicable b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE									
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 _____										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.									
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 17a. _____ 17b. NPI _____									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 19. RESERVED FOR LOCAL USE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 301.7 3. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 123456700									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPOT FARM Pmt I. ID QUAL J. RENDERING PROVIDER ID #									
1 03 01 07 03 01 07 11 H2014 1 188 76 52 NPI 1234567										1234567890									
2 03 01 07 03 01 07 11 H2015 1 44 05 5 NPI 1234567										1234567890									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Ima Biller 3/15/07										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____									
28. TOTAL CHARGE \$ 232 81 29. AMOUNT PAID \$ TPL Amt. 30. BALANCE DUE \$ 232 81										33. BILLING PROVIDER INFO & PH # MHR's R Us 123 Happy St. Anywhere, LA 7000 8. 1234567890 9. 1234567									

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

ADJUSTMENT/VOID CLAIMS

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

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

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

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

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

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

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

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column. An example of an adjustment appears on page 88.

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

INSTRUCTIONS FOR FILING ADJUSTMENT/VOID CLAIMS

- *1. REQUIRED ADJ/VOID—Check the appropriate block
- *2. REQUIRED Patient's Name
 - a. Adjust—Print the name exactly as it appears on the original claim if not adjusting this information
 - b. Void—Print the name exactly as it appears on the original claim
- 3. Patient's Date of Birth
 - a. Adjust—Print the date exactly as it appears on the original claim if not adjusting this information
 - b. Void—Print the name exactly as it appears on the original claim
- *4. REQUIRED Medicaid ID Number—Enter the 13 digit recipient ID number
- 5. Patient's Address and Telephone Number
 - a. Adjust—Print the address exactly as it appears on the original claim
 - b. Void—Print the address exactly as it appears on the original claim
- 6. Patient's Sex
 - a. Adjust—Print this information exactly as it appears on the original claim if not adjusting this information
 - b. Void—Print this information exactly as it appears on the original claim
- 7. Insured's Name— Leave blank
- 8. Patient's Relationship to Insured—Leave blank
- 9. Insured's Group No.—Complete if appropriate or blank
- 10. Other Health Insurance Coverage—Complete with 6-digit TPL carrier code if appropriate or leave blank
- 11. Was Condition Related to—Leave blank
- 12. Insured's Address—Leave blank
- 13. Date of—Leave blank
- 14. Date First Consulted You for This Condition—Leave blank

- 15. Has Patient Ever Had Same or Similar Symptoms—Leave blank
- 16. Date Patient Able to Return to Work—Leave blank
- 17. Dates of Total Disability-Dates of Partial Disability—Leave blank
- 18. Name of Referring Physician or Other Source—Leave this space blank
- 18a. Referring ID Number—Enter The CommunityCARE authorization number if applicable or leave blank.
- 19. For Services Related to Hospitalization Give Hospitalization Dates—Leave blank
- 20. Name and Address of Facility Where Services Rendered (if other than home or office)—Leave blank
- 21. Was Laboratory Work Performed Outside of Office—Leave blank
- *22. REQUIRED Diagnosis of Nature of Illness
 - a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information
 - b. Void—Print the information exactly as it appears on the original claim
- 23. Attending Number—Enter the attending number submitted on original claim, if any, or leave this space blank
- 24. Prior Authorization #—Enter the PA number if applicable or leave blank
- *25. REQUIRED A through F
 - a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information
 - b. Void—Print the information exactly as it appears on the original claim
- *26. REQUIRED Control Number—Print the correct Control Number as shown on the Remittance Advice
- *27. REQUIRED Date of Remittance Advice that Listed Claim was Paid—Enter MM DD YY from RA form
- *28. REQUIRED Reasons for Adjustment—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary
- *29. REQUIRED Reasons for Void—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary

- *30. REQUIRED Signature of Physician or Supplier—All Adjustment/Void forms must be signed
- *31. REQUIRED Physician's or Supplier's Name, Address, Zip Code and Telephone Number—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number
The form will be returned if this information is not entered.
- 32. Patient's Account Number—Enter the patient's provider-assigned account number

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

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

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

FOR OFFICE USE ONLY

1 ADJ. <input checked="" type="checkbox"/> VOID <input type="checkbox"/>	
PATIENT AND INSURED (SUBSCRIBER) INFORMATION	
2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) Smith, John	3 PATIENT'S DATE OF BIRTH 9/14/1960
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	4 MEDICAID ID NUMBER 1234999999999
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER. 6 digit TPL #, if applicable	6 PATIENT'S SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>
11 WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. IN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	7 INSURED'S NAME 8 PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>
12 DATE FIRST CONSULTED YOU FOR THIS CONDITION	9 INSURED'S GROUP NO. (OR GROUP NAME)
13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	14 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
16 DATE PATIENT ABLE TO RETURN TO WORK	15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
17 DATES OF TOTAL DISABILITY FROM THROUGH	18 DATES OF PARTIAL DISABILITY FROM THROUGH
19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	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 <input type="checkbox"/> NO <input type="checkbox"/> CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.	23 ATTENDING NUMBER
25 A. DATE(S) OF SERVICE From To MM DD YY MM DD YY 03 01 07 03 01 07 B. PLACE OF SERVICE 11 C. PROCEDURE H2014 D. DIAGNOSIS CODE 1 E. CHARGES 174 F. DAYS OR UNITS 24 48 G. EPSDT FAMILY PLAN H. TPL \$	
26 CONTROL NUMBER	27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID 3/13/07
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 Billed incorrect number of units	
29 REASONS FOR VOID 10 CLAIM PAID FOR WRONG RECIPIENT 11 CLAIM PAID TO WRONG PROVIDER 99 OTHER - PLEASE EXPLAIN	
30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.) Ima Biller 07/01/07	31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE MHR's R Us 123 Happy St. Anywhere, LA 70000 1234567
32 YOUR PATIENT'S ACCOUNT NUMBER	

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. <input type="checkbox"/> VOID <input type="checkbox"/>															
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)				6 PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		7 INSURED'S NAME									
8 TELEPHONE NO.				9 PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		10 INSURED'S GROUP NO. (OR GROUP NAME)									
11 OTHER HEALTH INSURANCE COVERAGE: ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.				12 WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>		13 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)									
PHYSICIAN OR SUPPLIER INFORMATION															
14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15 DATE FIRST CONSULTED YOU FOR THIS CONDITION		16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>											
17 DATE PATIENT ABLE TO RETURN TO WORK		18 DATES OF TOTAL DISABILITY FROM <input type="text"/> THROUGH <input type="text"/>		19 DATES OF PARTIAL DISABILITY FROM <input type="text"/> THROUGH <input type="text"/>											
20 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		21 REFERRING ID NUMBER		22 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED <input type="text"/> DISCHARGED <input type="text"/>											
23 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)				24 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES <input type="text"/>											
25 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.				26 ATTENDING NUMBER											
27 PRIOR AUTHORIZATION NO.															
A. DATE(S) OF SERVICE From <input type="text"/> To <input type="text"/>		B. PLACE OF SERVICE		C. PROCEDURE		D. DIAGNOSIS CODE		E. CHARGES		F. DAYS OR UNITS		EPSDT FAMILY PLAN		TPL \$	
28 CONTROL NUMBER		29 THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)						30 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID							
31 REASONS FOR ADJUSTMENT															
<input type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY															
<input type="checkbox"/> 02 PROVIDER CORRECTIONS															
<input type="checkbox"/> 03 FISCAL AGENT ERROR															
<input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY															
<input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN															
32 REASONS FOR VOID															
<input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT															
<input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER															
<input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN															
33 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)										34 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE					
35 YOUR PATIENT'S ACCOUNT NUMBER															

FISCAL AGENT COPY

UNISYS - 213
5/97

THIRD PARTY LIABILITY PROCEDURE

If a recipient has private insurance primary to Medicaid, the provider must bill the private insurance for the services before billing Medicaid. The claim and the EOB are then filed to the fiscal intermediary. Reimbursement will be made up to the Medicaid allowable amount less any amount paid by the private insurance carrier.

NOTE: If the recipient's private insurance is HMO coverage which requires prior authorization of mental health services, or requires the recipient to choose a provider from the HMO's provider list, Medicaid will not reimburse if the recipient fails to comply with the HMO rules and regulations.

Since Medicare does not cover most MHR services, the provider is not required to file with Medicare prior to billing Medicaid; however, it is recommended. After post payment review, in some instances, Medicaid reimbursement for services found to be payable under Medicare may be recouped.

NOTE: Medicare/Medicaid recipients who are Pure QMB are not eligible for MHR services, since only Medicare covered services are payable by Medicaid for such recipients.

Third Party Liability Error Codes

ERROR CODE 273 - 3RD PARTY CARRIER CODE MISSING - REFER TO CARRIER CODE LIST
Cause: No carrier code was indicated on the claim for a recipient with other insurance coverage.
Resolution: Verify the recipient's third party liability carrier code using REVS, MEVS, and e-MEVS. Resubmit the claim with the six-digit carrier code in the appropriate block and attach the EOB from the third party liability.
If you have verification that the recipient was not covered by other insurance for the date(s) of service, send a copy of the claim and the verification to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 290 - NO EOB ATTACHED FOR RECIPIENT WITH OTHER RESOURCE INDICATED

Cause: 1. No EOB from the other insurance was attached to the claim for a recipient with other insurance coverage for Mental Health Services, OR

2. There is a carrier code indicated on the claim form, but no EOB from the carrier is attached to the claim.

Resolution: Resubmit the claim with a copy of the EOB from the third party carrier.

If the carrier code was indicated on the claim form in error, remove it and resubmit the claim.

If you have verification that the recipient was not covered by other insurance for Mental Health Services on the date(s) of service, send a copy of the claim and the verification to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 292 - NO TPL AMOUNT INDICATED ON CLAIM/REQUIRES REVIEW

Cause: A carrier code was indicated on the claim form, but no TPL amount was entered on the claim.

Resolution: Indicate the amount paid by the third party carrier in the appropriate block on the claim form and resubmit the claim (including the third party carrier EOB).

If the carrier code was indicated on the claim form in error, remove it and resubmit the claim.

ERROR CODE 032 - EOB(S) ATTACHED/CARRIER CODE DOES NOT MATCH

Cause: The EOB attached to the claim does not appear to be from the third party carrier indicated on the State resource file for the recipient.

Resolution: Verify the recipient's third party liability carrier code using REVS, MEVS, and e-MEVS. Correct the carrier code if necessary and resubmit the claim (including the third party carrier EOB).

If the carrier code on the claim is correct, ensure that the EOB submitted with the claim is from the correct third party carrier. If not, attach the correct EOB if necessary and resubmit the claim. If the EOB submitted with the claim is from the correct third party carrier, submit the claim and the EOB to Unisys Provider Relations Correspondence Unit along with a cover letter explaining the problem.

ERROR CODE 918 – MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE

Cause: The amount paid by third party liability (as indicated on the claim form) has been subtracted from the amount Medicaid would usually pay.

Resolution: Ensure that the amount shown in the "deductions" column of the remittance advice is the same as the other insurance payment on the claim form. If the claim form was completed incorrectly, indicating an incorrect amount paid by other insurance, an adjustment must be filed to obtain correct payment.

Note: The message is to notify the provider why the payment is not the usual reimbursement amount.

ERROR CODE 490 –Must Utilize HMO services
Cause: The primary insurance carrier denied services due to the recipient not utilizing the HMO service requirements
Resolution: If the recipient did not follow the HMO service requirements, then Medicaid will deny also.
Note: The recipient will be responsible for these charges.

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 Provider Enrollment link, click on Forms to Update Existing Provider Information.

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 EDI Department at Unisys, call (225) 216-6000 and select option 2. Providers may write to Unisys EDI 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 EDI Department.

With the exception of Non-Ambulance Transportation, all claim types may be submitted as approved HIPAA compliant 837 transactions.

Non-Ambulance Transportation claims may be submitted under proprietary specifications (not as HIPAA-compliant 837 transactions).

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.

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** (EDI 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** (EDI 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 EDI Contract and a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Enrollment Requirements For 835 Electronic Remittance Advices

- All EDI billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EDI 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 EDI 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, 11/20/07
KIDMED Submissions	4:30 P.M. Tuesday, 11/20/07
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/21/07

Important Reminders For EDI Submission

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

- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.
- The total amount of the submitted file must equal the amount indicated on the Unisys response file.
- **All claims submitted must meet timely filing guidelines.**

HARD COPY REQUIREMENTS

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

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

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

CLAIMS PROCESSING REMINDERS

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

Electronic claims submission is the preferred method for submitting claims; however, 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. Claim forms **must be two sided** documents and include the standard information on the back regarding fraud and abuse. If a copy is submitted, it should be 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 if the claim form requires a signature. 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.
- Claims submitted should be two-sided documents and include the standard information on the back regarding fraud and abuse.
- **Do not use white out or a marking pen to omit claim line entries. To correct an error, draw a line through the error and initial it. 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 8 1/2 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. Claims with insufficient information are rejected prior to keying.

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, difficult to read, or **IS NOT IN THE CORRECT LOCATION**, the claim will not process correctly.

Rejected Claims

Each year, Unisys returns more than 250,000 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. The most common reasons for rejection are listed as follows:

- A signature or handwritten initials were missing (**except UB-04 claim forms**)
- The provider number 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

Correct Claims Submission

We have learned that some providers are incorrectly submitting claims directly to DHH at P.O. Box 91030 rather than correctly submitting claims to Unisys to the appropriate post office box for the program type. Unless specifically directed to submit claims directly to DHH, providers should cease this practice and submit claims to the appropriate Unisys post office box for processing. The correct post office boxes can be found on the following page of this packet and in training materials posted on the **Tracking** link of the www.lamedicaid.com website.

IMPORTANT UNISYS ADDRESSES

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

Type of Claim	P.O. Box	Zip Code
Pharmacy	91019	70821
<div style="text-align: center;"><u>CMS-1500 Claims</u></div> <div style="display: flex; justify-content: space-between;"> <div> Case Management Chiropractic Durable Medical Equipment EPSDT Health Services FQHC Hemodialysis Professional Services </div> <div> Independent Lab Mental Health Rehabilitation PCS Professional Rural Health Clinic Substance Abuse and Mental Health Clinic Waiver </div> </div>	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
EDI, 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.

NOTE: Claims over two years old will only be considered for processing if submitted in writing as indicated above. These claims may be discussed via phone to clarify policy and/or procedures, but they will not be pulled for research or processing consideration.

RECORD KEEPING

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

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

RETENTION OF RECORDS

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

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

Confidentiality and Protection of Records

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

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

OMH – QUALITY MANAGEMENT

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

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

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

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

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

ADMINISTRATIVE SANCTIONS

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

LEVELS OF ADMINISTRATIVE SANCTIONS

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

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

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

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

GROUND FOR SANCTIONING PROVIDERS

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

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

NOTICE AND APPEAL PROCEDURE

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

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

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

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

COMMUNITYCARE BASICS FOR NON-PCPS

Program Description

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

Recipients

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

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

If a CommunityCARE enrollee's Medicaid type changes to one that is exempt from CommunityCARE, the PCP linkage will end either at the end of the month that the enrollee's Medicaid file is updated with the new information, or at the end of the second following month, depending on when the file is updated.

How to Identify CommunityCARE Enrollees

- CommunityCARE enrollees may be identified through any of the Medicaid eligibility verification systems:
 - eMEVS (the Unisys website – www.lamedicaid.com),
 - REVS (telephone recipient eligibility verification system),
 - MEVS (swipe card Medicaid eligibility verification system).

NOTE: When a Medicaid eligible requests services, it is the Medicaid provider's responsibility to verify recipient eligibility and CommunityCARE enrollment status before providing services by accessing the REVS, MEVS, or eMEVS.

- When providers check recipient eligibility through REVS, MEVS, or eMEVS, the system will list the PCP's name and telephone number if the recipient is linked to a CommunityCARE PCP. If there is no CommunityCARE PCP information given, then the recipient is NOT linked to a PCP and may receive services without a referral/authorization.

Primary Care Physician

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

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

There are some Medicaid covered services, which do not require referral/authorization from the CommunityCARE PCP. The current list of exempt services is as follows:

- Chiropractic service upon KIDMED referrals/authorizations, ages 0-21
- Dental services for children, ages 0-21 (billed on the ADA claim form)
- Dental Services for Pregnant Women (ages 21-59), billed on the ADA claim form
- Dentures for adults
- The three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but **do require POST authorization**. Refer to "Emergency Services" in the CommunityCARE Handbook.

- Inpatient Care that has been pre-certed (this also applies to public hospitals even without pre-certification for inpatient stays): hospital, physician, and ancillary services billed with inpatient place of service.
- EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program
- Family planning services
- Prenatal/Obstetrical services
- Services provided through the Home and Community-Based Waiver programs
- Targeted case management
- Mental Health Rehabilitation (privately owned clinics)
- Mental Health Clinics (State facilities)
- Neonatology services while in the hospital
- Ophthalmologist and Optometrist services (age 0-21)
- Pharmacy
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists services
- Transportation services
- Hemodialysis
- Hospice services
- Specific outpatient laboratory/radiology services
- Immunization for children under age 21 (Office of Public Health and their affiliated providers)
- WIC services (Office of Public Health WIC Clinics)
- Services provided by School Based Health Centers to recipients age 10 and over
- Tuberculosis clinic services (Office of Public Health)
- STD clinic services (Office of Public Health)
- Specific lab and radiology codes
- Children's Special Health Services (CSHS) provided by OPH

Important CommunityCARE Referral/Authorization Information

- Any provider other than the recipient's PCP must obtain a referral from the recipient's PCP, **prior to rendering services**, in order to receive payment from Medicaid. Any provider who provides a non-exempt, non-emergent (routine) service for a CommunityCARE enrollee, without obtaining the appropriate referral/authorization prior to the service being provided risks non-payment by Medicaid. **DHH and Unisys will not assist providers with obtaining referrals/authorizations for care not requested in accordance with CommunityCARE policy.** PCPs are not required to respond to requests for referrals/authorizations for non-emergent/routine care not made in accordance with CommunityCARE policy: i.e. requests made after the service has been rendered.
- When ancillary services such as DME or Home Health are ordered by a provider other than the PCP, the ordering provider is responsible for obtaining the CommunityCARE referral/authorization. For example, when a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to

coordinate with the patient's PCP to obtain the appropriate referral/authorization. The hospital physician/discharge planner, not the ancillary provider, has all of the necessary documentation needed by the PCP. The ancillary provider should use one of the Medicaid Eligibility Verification systems to confirm that the referral/authorization they received is from the PCP that the recipient was linked to on the date of service. The ancillary provider cannot receive reimbursement from Medicaid without the appropriate PCP referral/authorization.

- Depending on the medical needs of the enrollee as determined by the PCP, referrals/authorizations for specialty care should be written to cover a specific condition and/or a specific number of visits and/or a specific period of time not to exceed six months. There are exceptions to the six month limit for specific situations, as set forth in the CommunityCARE Handbook. When the PCP refers a recipient to a specialist for treatment of a specific condition, it is appropriate for the specialist to share a copy of the PCP's written referral/authorization for additional services that may be required in the course of treating **that** condition.

Examples:

- An oncologist has received a written referral/authorization from the PCP to provide treatment to his CommunityCARE patient. During the course of treatment, the oncologist sends a patient to the hospital for a blood transfusion. The oncologist should send the hospital a copy of the written referral/authorization that he received from the PCP. **The hospital SHOULD NOT require a separate referral/authorization from the PCP for the transfusion.**

However, if the oncologist discovers a **new** condition not related to the condition for which the original referral/authorization was written, and that new condition requires the services of a different specialist, the PCP must be advised. The PCP would then determine whether the enrollee should be referred for the new condition.

- The PCP refers his CommunityCARE patient to a surgeon for an outpatient procedure and sends the surgeon a written referral/authorization. The surgeon must provide a copy of that written referral/authorization to any other provider whose services may be needed during that episode of care (i.e. DME, Home Health, and anesthesia).
- Recipients **may not** be held responsible for claims denied due to provider errors or failure to follow Medicaid policies/procedures, such as **failure to obtain a PCP referral/authorization**, prior authorization or pre-cert, failure to timely file, incorrect TPL carrier code, etc.

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

Providers:

- Unisys - (800) 473-2783 or (225) 924-5040 - CommunityCARE Program policy, procedures, and problems, complaints concerning CommunityCARE
- ACS - (800) 259-4444 PCP - assignment for CommunityCARE recipients, inquiries related to monitoring, certification
- ACS - (877) 455-9955 – Specialty Care Resource Line - assistance with locating a specialist in their area who accepts Medicaid.

Enrollees:

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

- CommunityCARE Enrollee Hotline (800) 259-4444: Provides assistance with questions or complaints about CommunityCARE or their PCP. It is also the number recipients call to select or change their PCP.
- Specialty Care Resource Line (877) 455-9955: Provides assistance with locating a specialist in their area who accepts Medicaid.
- Louisiana Medicaid Nurse Helpline (866) 529-1681: Is a resource for recipients to speak with a nurse 24/7 to obtain assistance and information on a wide array of health-related topics.
- www.la-communitycare.com
- www.lamedicaid.com

HOSPICE SERVICES

Overview

Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

A recipient must be terminally ill in order to receive Medicaid hospice care. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

Payment of Medical Services Related To The Terminal Illness

Once a recipient elects to receive hospice services, the hospice agency is responsible for either providing or paying for all covered services related to the treatment of the recipient's terminal illness.

For the duration of hospice care, an individual recipient waives all rights to Medicaid payments for:

- Hospice care provided by a hospice other than the hospice designated by the individual recipient or a person authorized by law to consent to medical treatment for the recipient.
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected OR a related condition OR that are equivalent to hospice care, except for services provided by: (1) the designated hospice; (2) another hospice under arrangements made by the designated hospice; or (3) the individual's attending physician if that physician IS NOT an employee of the designated hospice or receiving compensation from the hospice for those services.

Payment For Medical Services Not Related To The Terminal Illness

Any claim for services submitted by a provider other than the elected hospice agency will be denied if the claim does not have attached justification that the service was medically necessary and WAS NOT related to the terminal condition for which hospice care was elected. If documentation is attached to the claim, the claim pends for medical review. Documentation may include:

- A statement/letter from the physician confirming that the service was not related to the recipient's terminal illness, or
- Documentation of the procedure and diagnosis that illustrates why the service was not related to the recipient's terminal illness.

If the information does not justify that the service was medically necessary and not related to the terminal condition for which hospice care was elected, the claim will be denied. If review of the claim and attachments justify that the claim is for a covered service not related to the terminal

condition for which hospice care was elected, the claim will be released for payment. *Please note, if prior authorization or precertification is required for any covered Medicaid services not related to the treatment of the terminal condition, that prior authorization/precertification is required and must be obtained just as in any other case.*

Once a claim from a non-hospice provider is denied by the Medical Review staff, resubmitted for reconsideration and denied a second time, the only recourse for appeal of the decision is through the official DHH Appeals process. Requests for hearings must be made in writing to the address below and must include an explanation of the reason for the request, the claim(s) in question, and supporting documentation.

**DHH Bureau of Appeals
P.O. Box 4183
Baton Rouge, La. 70821**

NOTE: Claims for prescription drugs will not be denied but will be subject to post-payment review.

PROVIDER ASSISTANCE

The Louisiana Department of Health and Hospitals and Unisys maintain a website to make information more accessible to LA Medicaid providers. At this online location, www.lamedicaid.com, providers can access information ranging from how to enroll as a Medicaid provider to directions for filling out a claim form.

Below are some of the most common topics found on the website:

[New Medicaid Information](#)
[National Provider Identifier \(NPI\)](#)
[Disaster](#)
[Provider Training Materials](#)
[Provider Web Account Registration Instructions](#)
[Provider Support](#)
[Billing Information](#)
[Fee Schedules](#)
[Provider Update / Remittance Advice Index](#)
[Pharmacy](#)
[Prescribing Providers](#)
[Provider Enrollment](#)
[Current Newsletter and RA](#)
[Helpful Numbers](#)
[Useful Links](#)
[Forms/Files/User Guidelines](#)

- ☞ The website also contains a section for Frequently Asked Questions (FAQ) that provide answers to commonly asked questions received by Provider Relations.

Along with the website, the Unisys Provider Relations Department is available to assist providers. This department consists of three units, (1) Telephone Inquiry Unit, (2) Correspondence Unit, and (3) Field Analyst. The following information addresses each unit and their responsibilities.

Unisys Provider Relations Telephone Inquiry Unit

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification; ordering printed materials; billing denials/problems; requests for Field Analyst visits; etc.

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

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

The following menu options are available through the Unisys Provider Relations telephone inquiry phone numbers. Callers should have the 7-digit LA Medicaid provider number available to enter the system. Please listen to the menu options and press the appropriate key for assistance.

Press #2 - To order printed materials only**

Examples: Orders for provider manuals, Unisys claim forms, and provider newsletter reprints. To choose this option, press “2” on the telephone keypad. This option will allow providers to leave a message to request printed materials **only**. Please be sure to leave (1) the provider name, (2) provider number, (3) contact person, (4) complete mailing address, (5) phone number and (6) specific material requested.

- ☞ Only messages left in reference to printed materials will be processed when choosing this option. Please review the other options outlined in this section for assistance with other provider issues.
- ☞ Fee schedules, TPL carrier code lists, provider newsletters, provider workshop packets and enrollment packets may be found on the LA Medicaid website. Orders for these materials should be placed through this option **ONLY** if you do not have web access.
- ☞ Provider Relations staff mail each new provider a current copy of the provider manual and training packet for his program type upon enrollment as a Medicaid provider. An enrolled provider may also request a copy of the provider manual and training packet for the Medicaid program in which he is enrolled. A fee is charged for provider manuals and training packets ordered for non-providers (attorneys, billing agents, etc.) or by providers wanting a manual for a program for which they are not enrolled. All orders for provider manuals and training packets should be made by contacting the Provider Relations Telephone Inquiry Unit. Those requiring payment will be forwarded to the provider once payment is received.

Provider Relations cannot assist recipients. The telephone listing in the “Recipient Assistance” section found on page 80 should be used to direct Medicaid recipient inquiries appropriately. 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.

Press #3 - To verify recipient or provider eligibility; Medicare or other insurance information; Primary Care Physician information; or service limits.

- Recipient eligibility
- Third Party (Insurance) Resources
- CommunityCARE
- Lock-In

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

Press #4 - To resolve a claims problem

Provider Relations staff are available to assist with resolving claim denials, clarifying denial codes, or resolving billing issues.

NOTE: Providers must use e-CSI to check the status of claims and e-CSI in conjunction with remittance advices to reconcile accounts.

Press #5 – To obtain policy clarification, procedure code reimbursement verification, request a field analyst visit, or for other information.

Unisys Provider Relations Correspondence Group

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

Providers who wish to submit problem claims for research and want to receive a written response, **must submit a 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.

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: Many providers submit claims that do not require special handling to the Provider Relations Department hoping to expedite processing of these claims. However, this actually delays claim processing, as the claims must pass through additional hands before reaching the appropriate processing area. In addition, it diverts productivity that would otherwise be devoted to researching and responding to provider requests for assistance with legitimate claim problems. Providers are asked to send claims that do not require special handling directly to the appropriate post office box for that claim type.

Eligibility File Updates: Provider Relations staff also handles requests to update recipient files with correct eligibility. Staff in this unit 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.

TPL File Updates: 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: “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”. **CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED “CLEAN” CLAIMS AND WILL NOT BE RESEARCHED.**

Claims Over Two Years Old: Providers are expected to resolve claims issues within two years from the date of service on the claims. The process through which claims over two years old will be considered for re-processing is discussed in this training packet under the section, Timely Filing Guidelines. In instances where the claim meets the DHH established criteria, a detailed letter of explanation, the hard copy claim, and required supporting documentation must be submitted **in writing** to the Provider Relations Correspondence Unit at the address above. **These claims may not be submitted to DHH personnel and will not be researched from a telephone call to DHH or the Provider Inquiry Unit.**

Unisys Provider Relations Field Analysts

Provider Relations Field Analysts are available to visit and train new providers and their office staff on site, upon request. 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 the Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for material, or other policy documentation. These calls should not be directed to the Field Analysts but rather 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	Jefferson Orleans Plaquemines	St. Bernard St. Tammany (Slidell Only)
Stacey Fairchild (225) 216-6267	Ascension Assumption Calcasieu Cameron Jeff Davis Lafourche St. Charles	St. James St. John St. Martin (below Iberia) St. Mary Terrebonne Vermillion Beaumont (TX)
Tracey Guidroz (225) 216-6201	West Baton Rouge Iberville Tangipahoa St. Tammany (except Slidell)	Washington Centerville (MS) McComb (MS) Woodville (MS)
Ursula Mercer (225) 216-6273	Bienville Bossier Caddo Caldwell Claiborne Catahoula Concordia East Carroll Franklin Jackson	LaSalle Lincoln Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Vicksburg (MS) Marshall (TX)
Kelli Nolan (225) 216-6260	East Baton Rouge East Feliciana Livingston	Pointe Coupee St. Helena West Feliciana
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin (above Iberia)
Sherry Wilkerson (225) 216-6306	Avoyelles Beauregard DeSoto Grant Natchitoches Rapides	Red River Sabine Vernon Winn Jasper (TX) Natchez (MS)

Provider Relations Reminders

The Unisys Provider Relations inquiry staff strives to respond to provider inquiries quickly and efficiently. There are a number of ways in which the provider community can assist the staff in responding to inquiries in an even more timely and efficient manner:

- Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:
 - The correct 7-digit LA Medicaid provider number
 - The 13-digit Recipient's Medicaid ID number
 - The date of service
 - Any other information, such as procedure code and billed charge, that will help identify the claim in question
 - The Remittance Advice showing disposition of the specific claim in question
- Obtain the name of the phone representative you are speaking to in case further communication is necessary.
- Because of the large volume of incoming provider calls, Telephone Inquiry staff are not allowed to be put on hold after answering a call.
- PLEASE review and reconcile the remittance advice before calling Provider Relations concerning claims issues. Some providers call Provider Relations frequently, asking questions that could be answered if the RA was reviewed thoroughly. However, providers are encouraged to call Provider Relations with questions concerning printed policy, procedures, and billing problems.
- **Provider Relations WILL NOT reconcile provider accounts or work old accounts for providers. Calls to check claim status tie up phone lines and reduce the number of legitimate questions and inquiries that can be answered. It is each provider's responsibility to establish and maintain a system of tracking claim billing, payment, and denial. This includes thoroughly reviewing the weekly remittance advice, correcting claim errors as indicated by denial error codes, and resubmitting claims which do not appear on the remittance advice within 30 - 40 days for hard copy claims and three weeks for EDI claims.**
- **Providers can check claim status through the e-CSI (Claim Status Inquiry) web application found in the secure area of the Louisiana Medicaid website at www.lamedicaid.com. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on e-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 e-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 e-CSI or hard copy remittance advices for this purpose. This includes provider's direct staff and billing agents or vendors. A LA Medicaid/HIPAA Error Code Crosswalk is available on the website by accessing the link, Forms/Files.**

- If a provider has a large number of claims to reconcile, it may be to the provider's advantage to order a provider history. Please see the Ordering Information section for instructions on ordering a provider history.
- **Provider Relations cannot assist recipients.** The telephone listing in the "Recipient Assistance" section found in this packet should be used to direct Medicaid recipient inquiries appropriately. 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.
- Providers who wish to submit problem claims for a written response **must submit a cover letter** explaining the problem or question.
- Calls regarding eligibility, claim issues, requests for Unisys claim forms, manuals, or other policy documentation should not be directed to the Field Analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit.

DHH PROGRAM MANAGER REQUESTS

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

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

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	(800) 807-1320		(225) 216-6342
EPSDT PCS P.A. - Unisys			
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) 925-6606	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 about the LaCHIP Program that 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.
Louisiana Medicaid 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 - OCDD	(866) 327-5978	Providers and recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4149	Providers may request termination as a recipient's lock-in provider.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (866) 758-5035	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) 342-0095 (866) 783-5553	Providers and recipients may request assistance regarding waiver services to waiver recipients.
Family Planning Waiver	(225) 219-4153	Providers may request assistance about the family planning waiver.
DHH Rate and Audit	(225) 342-6116	For LTC, Hospice, PACE, and ADHC providers to address rate setting and claims or audit issues.

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

Provider Relations cannot assist recipients. 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) 925-6606	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.
Louisiana Medicaid 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 – OCDD	(866) 327-5978	Recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Recipients may obtain immunization information.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (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) 342-0095 (866) 783-5553	Recipients may request assistance regarding waiver services.
Family Planning Waiver	(225) 219-4153	Recipients may request assistance regarding family planning waiver services.

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

LOUISIANA MEDICAID WEBSITE APPLICATIONS

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


www.lamedicaid.com

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

Provider Login and Password

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

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

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

Web Applications

There are a number of web applications available on www.lamedicaid.com web site; however, the following applications are the most commonly used:

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

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

e-MEVS:

Providers can 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 | 5. Ancillary Services |
| 2. Physician/EPSTD Encounters | 6. Lab & X-Ray Services |
| 3. Outpatient Procedures | 7. Emergency Room Services |
| 4. Specialist 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 one-year 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 will 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) CAN BE SUBMITTED USING e-PA AS LONG AS THE ORIGINAL REQUEST WAS SUBMITTED THROUGH e-PA.

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.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.opd.dhh.louisiana.gov>: Louisiana Immunization Network for Kids Statewide (LINKS)

www.ltss.dhh.louisiana.gov/offices/?ID=152: 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=334: EarlySteps Program

www.dhh.louisiana.gov/rar: DHH Rate and Audit Review (Information on Nursing Home, Adult Day Healthcare, Hospice, Administrative Claiming, Sub-Acute Care, PACE, and Assisted Living; Cost Reporting Information, Contacts and FAQ's.)

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

PHARMACY SERVICES

Prior Authorization

The prescribing provider must request prior authorization for non-preferred drugs from the University of Louisiana – Monroe. Prior authorization requests can be obtained by phone, fax, or mail, as listed below.

Contact information for the Pharmacy Prior Authorization department:

Phone: (866) 730-4357 (8 a.m. to 6 p.m., Monday through Saturday)
FAX: (866) 797-2329

University of Louisiana – Monroe
School of Pharmacy
1401 Royal Avenue
Monroe, LA 71201

The following page includes a copy of the “Request for Prescription Prior Authorization” form, as can be found on the LAMedicaid.com website under “Rx PA Fax Form”.

Preferred Drug List (PDL)

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

Monthly Prescription Service Limit

An eight-prescription limit per recipient per calendar month has been implemented in the LA Medicaid Pharmacy Program.

The following federally mandated recipient groups are exempt from the eight-prescription monthly limitation:

- Persons under the age of twenty-one (21) years
- Persons living in long term care facilities such as nursing homes and ICF-MR facilities
- Pregnant women

If it is deemed medically necessary for the recipient to receive more than eight prescriptions in any given month, the provider must write “medically necessary override” and the ICD-9-CM diagnosis code that directly relates to each drug prescribed on the prescription.

Fax or Mail this form to:
 LA Medicaid Rx PA Operations
 ULM College of Pharmacy
 1401 Royal Avenue
 Monroe, LA 71201
 Fax: 866-RX PA FAX
 (866-797-2329)

State of Louisiana
Department of Health and Hospitals
 Bureau of Health Services Financing
 Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
 Issue Date: 3/1/2002

Voice Phone:
 866-730-4357

*Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).*

Date of Request: *	Number of Fax Pages (including cover page): *
Practitioner Information	Patient Information
Name: *	Name (last, first): *
LA Medicaid Prescribing Provider Number: *	LA Medicaid CCN or Recipient Number: *
LA Medicaid Billing Provider Number:	Date of Birth: *
Call-Back Phone Number (include area code): *	
Fax Number (include area code):	
Requested Drug Information	Projected Duration: *
Drug Name: *	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description: *

Please answer the following questions for your request to prescribe a non-preferred drug for your patient: *

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO
2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
 If YES, list the condition(s) in the box below:
3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
 If YES, list the interaction(s) in the box below:
4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
 If YES, list the side effects in the box below:

Practitioner Signature: *

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

CONFIDENTIALITY NOTICE

The documents accompanying this facsimile transmission may contain confidential information which is legally privileged. The information is intended only for the use of the individual or entity to which it is addressed. If you are not the intended recipient, you are hereby notified that any review, disclosure/redisclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy this information.

HOW DID WE DO?

In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a Unisys representative or leave it on your table. **Your opinion is important to us.**

Seminar Date: _____ Location of Seminar (City): _____

Provider Subspecialty (if applicable): _____

FACILITY	Poor					Excellent
The seminar location was satisfactory	1	2	3	4	5	
Facility provided a comfortable learning environment	1	2	3	4	5	
SEMINAR CONTENT						
Materials presented are educational and useful	1	2	3	4	5	
Overall quality of printed material	1	2	3	4	5	
UNISYS REPRESENTATIVES						
The speakers were thorough and knowledgeable	1	2	3	4	5	
Topics were well organized and presented	1	2	3	4	5	
Reps provided effective response to question	1	2	3	4	5	
Overall meeting was helpful and informative	1	2	3	4	5	
SESSION:						

Do you have internet access in the workplace? _____

Do you use www.lamedicaid.com? _____

What topic was most beneficial to you? _____

Please provide us with your business email address: _____

Please specify your Provider Number so we can cross reference it with your email address: _____

Please provide constructive comments and suggestions: _____

To order written materials provided by Unisys, please call Unisys Provider Relations Telephone Inquiry Unit at
(800) 473-2783 or (225) 924-5040