UNISYS

DME 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.

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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
CSRAs

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 Fee: 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 FOR PARTICIPATION

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

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

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

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

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

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

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

Picking and Choosing Services

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

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

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

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

Statutorily Mandated Revisions to All Provider Agreements

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

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

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

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

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

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

Surveillance Utilization Review

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

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

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

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

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

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

Fraud and Abuse Hotline

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

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

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.

NEW DME POLICY

Disposable Incontinence Products (T4521 - T4535)

Standards of Coverage:

Diapers are covered for individuals age four years through age twenty years when:

- Specifically prescribed by the recipient's physician, and
- The individual has a medical condition resulting in permanent bowel/bladder incontinence, and
- The individual would not benefit from or has failed a bowel/bladder training program when appropriate for the medical condition.

Pull-on briefs are covered for individuals age four years through age twenty years when:

- Specifically prescribed by the recipient's physician, and
- There is presence of a medical condition resulting in permanent bowel/bladder incontinence, and
- The recipient has the cognitive and physical ability to assist in his/her toileting needs.

Liners/guards are covered for individuals age four years through age twenty years when:

- Specifically prescribed by the recipient's physician, and
- They cost-effectively reduce the amount of other incontinence supplies needed.

Note: Permanent loss of bladder and/or bowel control is defined as a condition that is not expected to be medically or surgically corrected and that is of long and indefinite duration.

Recipients who have a diagnosis of nocturnal incontinence, including those who do not have a problem in the daytime but are not able to wake up to go to the bathroom at night, may be qualified to receive a diaper or pull-up for nighttime use.

Documentation: The prescription request form for disposable incontinence products may be completed, or a physician's prescription along with the required documentation as listed below.

Documentation must reflect the individual's current condition and include the following:

- Diagnosis (specific ICD-9-CM code) of condition causing incontinence (primary and secondary diagnosis)
- Item to be dispensed
- Duration of need *(physician must provide)*
- Size
- Quantity of item and anticipated frequency the item requires replacement
- Description of mobility/limitations

To avoid unnecessary delays and need for reconsideration, care should be taken to use the correct HCPC code from among T4521-T4535.

Documentation for extraordinary needs must include all of the above and:

- Description of mental status/level of orientation
- Indicate current supportive services
- Additional supporting diagnosis to justify increased need for supplies

If completed, DHH's "Prescription Request Form for Disposable Incontinence Supplies" collects this information.

Approved providers of incontinence products:

- Pharmacy
- Home health agency
- Durable medical equipment provider

Prior Authorization Requirements: Prior authorization is required for all disposable incontinence supplies. The PA requests shall meet all previously defined criteria for:

- Eligible recipient.
- Eligible provider.
- Covered product.
- Documentation requirements - the prescription request form for disposable incontinence products may be completed, or a physician's prescription along with the required documentation as indicated above.

Quantity Limitations:

- Disposable incontinence supplies are limited to six per day.
- ICF-MR and nursing facility residents are excluded as these products are included in the facility per diem.
- Additional supporting documentation is required for requests that exceed the established limit.

Dispensing and Billing:

- Only a one-month supply may be dispensed at any time as initiated by the recipient.
- Bill one unit per item. Shipping costs are included in the DHH maximum allowable payment and may not be billed separately.
- Although specific brands are not required, DHH maximum allowable amounts may preclude the purchase of some products. The rate has been established so that the majority of products on the market are obtainable. Providers should always request authorization for the appropriate product for the recipient's current needs.
- Providers must provide at the minimum, a moderate absorbency product that will accommodate a majority of the Medicaid recipient's incontinence needs. Supplying larger quantities of inferior products is not an acceptable practice.
- For recipients requesting a combination of incontinence supplies, the total quantity shall not exceed the established limit absent approval of extraordinary needs.
- Because payment cannot exceed the number of units prior authorized, providers who choose to have incontinent supplies shipped directly from the manufacturer to the recipient's home shall be responsible for any excess over the number of supplies approved by the prior authorization.

BHSF Form DIP1
Revised 05/06

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information

Name: _____ Date of birth: _____ Age: _____

Medicaid ID: _____ Height: _____ Weight _____

Recipient's Address _____

Prescribing Provider:

Prescriber's Name: _____ Phone #: _____

Address: _____ Fax # _____

➤ **Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD-9 CM code):**

Primary: _____ **Secondary:** _____

➤ **Specify Urine/Fecal incontinence diagnoses (Specify ICD-9 CM code):**

Primary: _____ **Secondary:** _____

➤ **Mobility**

- ☐ Ambulatory
- ☐ Transfer Assistance
- ☐ Minimal assistance ambulating
- ☐ Confined to bed or chair

➤ **Extraordinary Needs**

Supporting documentation for acute medical condition and/or extenuating circumstances for incontinence products (more than six per day).

➤ **Mental Status/Level of Orientation**

- ☐ Has the ability to communicate needs
- ☐ Sometimes communicates needs
- ☐ Unable to communicate needs

Frequency of anticipated change

During Day time (6 AM-10PM) every _____ hrs.
During Night time (10PM – 6 AM) every _____hrs.

➤ **Additional supporting Diagnoses (Specific ICD-9-CM Code)**

_____
_____

Indicate current supportive services

- ☐ Home Health
- ☐ Skilled Nursing Services
- ☐ Personal Care Services
- ☐ Other _____

➤ **List any medications and/or nutritional therapy that would increase urine or fecal output:**

_____

➤ **Specify incontinence supply, size, quantity/24 hours and duration of need:**

_____
_____
_____

By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient's medical record.

Prescriber's Signature:

_____

Date:

_____

➤ **Comments**

_____
_____
_____
_____
_____
_____
_____
_____

☐ Additional documentation attached

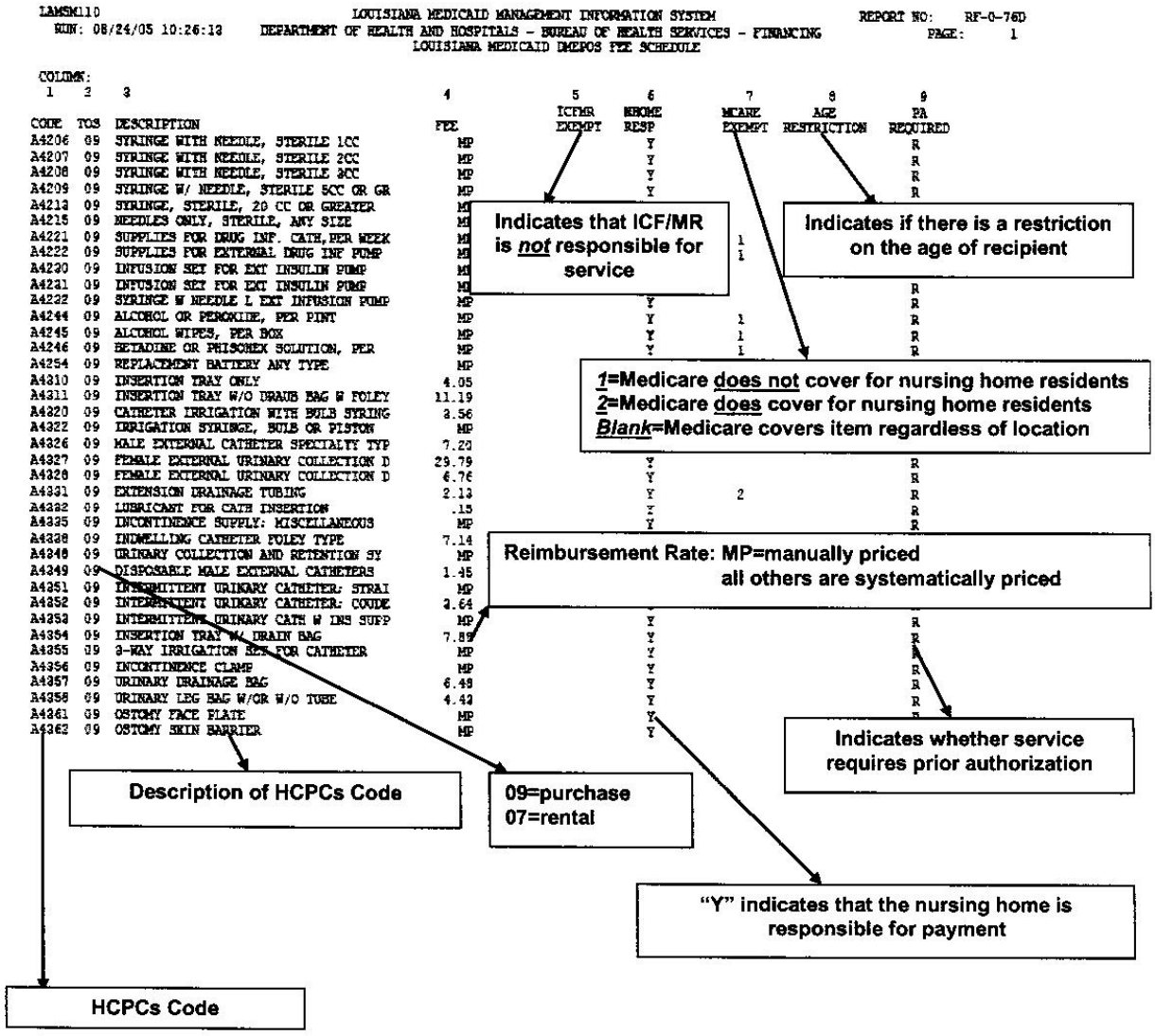
Durable Medical Equipment and Supplies for Long Term Care Recipients

The Unisys Prior Authorization Unit was instructed to deny all authorization requests for durable medical equipment and supplies for recipients residing in nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Please note that the cost of durable medical equipment and supplies is included in the facilities per diem rate.

DME ITEMS FOR MEDICARE/MEDICAID RECIPIENTS

Providers can ascertain the reimbursement for services by downloading the fee schedule from the following website: www.lamedicaid.com. The last page of the fee schedule explains the columns noted and details a description of the various codes used.



DME POS COVERAGE

Ambulatory Assistance Equipment
Canes
Crutches
Walkers

Apnea Monitor and Accessories
Apnea Monitor with Recorder
Electrodes
Lead Wires

Augmentative and Alternative Communication Device
Non-electronic Board
Accessory for SGD (Speech Generating Devices)

Bath and Toilet Aids
Bath Rail
Bed Pans
Commode Chair
Footrest
Raised Toilet Seat
Toilet Rail

Diabetic Equipment and Supplies
Ambulatory Insulin Pump
Glucometer
Supplies for Insulin Pump

Enteral Therapy and Nutritional Supplements
Enteral Pump
Nutritional Supplements
Oral Feeding Supplies
Pole
Tube Feeding Supplies
Tubing

Home Dialysis Equipment and Supplies
Blood Pressure Cuff
Blood Pressure Monitor
Blood Pump
Blood Testing Supplies
Hemodialysis machine
Tubing

Hospital Beds and Related Equipment
Fracture Frame
Hospital Beds, Fully Electric
Hospital Beds, Semi-electric

Mattresses
Side Rails
Traction Equipment
Trapeze Equipment

Incontinence Products (EPDST)
Diapers
Pull-ups
Liners

Intravenous Therapy and Administrative Supplies
IV Pole
IV Pump, Stationary
IV Pump, Ambulatory
Supplies
Tubing

Miscellaneous Equipment and Supplies
Bilirubin (Phototherapy) Lamp (EPSDT)
Feeding Chair (EPSDT)
Gait Trainer (EPSDT)
Intrathecal Baclofen Pump
Miscellaneous Supplies (no codes available)
Miscellaneous Equipment (no codes available)
Osteogenic Bone Growth Stimulators
Positioning Chair (EPSDT)
Syringes and Needles
Stander (EPSDT)

Nebulizer
Compressor (for use with specialized nebulizers)
Nebulizer with Compressor

Oxygen, Oxygen Equipment, and Related Supplies
Oxygen Concentrator
Portable Oxygen (EPSDT)
Portable Oxygen Batteries (EPSDT)
Tubing

Patient Lift
Manually Operated Hoyer Lift
Patient Lift Slings
Patient Lift Seats

Pressure Reducing Support Surface
Alternating Pressure Pad
Eggcrate Type Mattress
Gel Mattress
Lambs Wool or Sheepskin Pad
Pressure Pad Pump

Respiratory Equipment and Supplies
CPAP and BiPAP
High Frequency Chest Wall Oscillation Vest
Humidifier
Masks
Mechanical Percussor
Mucous Clearance Device (Flutter)
Peak Flow Meter
Resuscitation Bag

Skin Care, Wound Care, and Infection Control
Alcohol
Dressings
Gauze
Gloves
Negative Pressure Wound Therapy Vacuum Assisted Closure Device
NPWT VAC Device Canisters
NPWT VAC Device Dressings
Sponges
Sterile Eye Pad
Tape

Tracheostomy and Suction Equipment; Related Supplies
Portable Suction Pump (EPSDT)
Suction Pump
Tracheostomy Supplies
Tracheostomy Tubes
Tracheostomy Mask

Urological and Ostomy Supplies
Adhesive Remover
Bedside Drainage Bottle
Catheters
Foley Catheters
Insertion Tray
Irrigation Supplies
Ostomy Lubricant
Ostomy Paste
Ostomy Pouch
Skin Wipes
Urinary Bags
Urinary Collection Devices

Vagus Nerve Stimulator and Related Supplies
VNS Generator
VNS Leads

Ventilator Equipment and Related Supplies
Battery
Battery Charger
Breathing Circuits

Pressure Support Ventilator
Tubing
Volume Ventilator

Wheelchairs and Wheelchair Accessories
Arm Rest
Battery
Battery Charger
Belt
Breathing Tube Kit
Calf Rest
Crutch and Cane Holders
Cushioned Headrest
Cushioned Seat
Customized Manual Wheelchair
Customized Motorized Wheelchair
Foot Rest
Head Controls
IV Hanger
Lateral Trunk/Hip Support
Leg Rest
Loop Heel
Loop Toe
Manual Swingaway
Repairs and Replacement Parts
Seats
Sip and Puff Interface
Special Joystick Handle
Standard Manual Wheelchairs
Standard Motorized Wheelchair
Tires
Transfer Board
Tray
Ventilator Tray
Wheels

Orthotics and Prosthetics
Shoes and Corrections
Surgical Stockings and Burn Garments
Orthotics and Prosthetics (artificial limbs and braces)
Prosthetic Eye
Prosthetic Larynx
Prosthetic Nose
Slings and Splints

Cochlear Implant (EPSDT)
Cochlear Implant
External Speech Processor

Hearing Aids (EPSDT)
Analog Hearing Aids

Digital Hearing Aids
Hearing Aid Batteries

Orthotic Shoes and Corrections
Diabetic shoes
Orthotic shoes
Shoe Heels
Shoe Inserts
Shoe Lifts (minimum .5 inch)
Shoe Modifications
Shoe Wedges
Surgical Boots

Surgical Stockings and Burn Garments
Jobst burn garments
Surgical stockings

NON-COVERED ITEMS

The following list of items and services **are not** reimbursed by Medicaid through the DME POS program.

- Clinically unproven equipment
- Air filters
- Computers and computer related equipment
- Dentures
- Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure
- Electric lifts (manual lifts are covered)
- Emergency and non-emergency alert devices
- Environmental modifications
- Van lifts
- Car seats
- Equipment designed for use by a physician or trained medical personnel
- Experimental equipment
- Facilitated communications (FC)
- Furniture and other items which do not serve a medical purpose
- Investigational equipment
- Items used for cosmetic purposes
- Personal comfort, convenience or general sanitation items
- Physical fitness equipment
- Rehabilitation Equipment
- Precautionary-type equipment (e.g. power generators, backup oxygen equipment)
- Routine and first aid items
- Scooters
- Seat lifts and recliner lifts
- Supplies or equipment covered by Medicaid per diem rates (nursing home residents may be approved for orthotics and prosthetics, but not for durable medical equipment and supplies)

- Televisions, telephones, VCR machines and devices designed to produce muse or provide entertainment
- Training equipment or self-help equipment.
- Wheelchair Lifts
- Wheelchair Ramps

HOME HEALTH SUPPLIES THROUGH THE DME PROGRAM

The following supplies are covered through the DME program only when provided in conjunction with a home health visit:

- Inflatable cushion (software mattress)
- Betadine Douche
- Enema (Fleets, mineral oil)
- Disposable enema administering kit
- Plastic, fracture pan
- Plastic bedpan
- Plastic male and female urinal
- Urinary Disposable collection devices (HAT)
- Sterile Irrigation Solutions (GI, acetic, and normal saline)
- Sterile Toppers
- Steri Strips
- Reston
- Telfa
- Sterile applicators (tongue blades and sterile Q tips)
- Skin staple remover
- Suture removal kit
- Sitz bath
- Elastoplast
- Foam Tapes
- Pericare Kit/Supplies
- Bile Bags
- Therabands/Putty
- Incontinent Supplies

Additional Supplies

Home Health Agencies often train recipients or their care givers to administer medications or to use certain equipment or supplies. As long as the Home Health Agency is monitoring the administration and is providing services to the recipient, the recipients can be provided DME IV covered supplies or other home health supplies for use in the home.

Pain Management

The DME program does not provide IV equipment or supplies for recipients over twenty-one (21) years of age for pain management.

Claims Filing

Claims for DME supplies must be billed on the CMS 1500 form if filed hardcopy, or 837P format for electronic billing. For hard copy claims, “DME” must be written across the top of the form. See pages 63 - 70 for billing instructions.

DME REMINDERS

- Billing for a service not rendered to a Medicaid recipient can be considered grounds for a provider fraud referral under Medicaid policy (Chapter 7, Medical Services Manual, page 12-2). The service (delivery, repair, or rented equipment) should always be rendered prior to billing for payment.

- The decision to make a rental or a purchase on a DME item depends on two factors: (1) patient's condition and (2) cost-effectiveness. If the physician indicates that the condition is of a temporary nature, the item will most likely be rented. If the physician uses a diagnosis that is more of a chronic nature, there is a greater likelihood that the authorization letter will indicate a purchase. Likewise, if the cost of a rental is negligibly less than that of a purchase, and the patient has a history of the same (or similar) condition, then the PA Unit will more likely deem it necessary to purchase the item instead of repeatedly renting it.

- Louisiana Medicaid does not purchase used or refurbished equipment. It is considered fraudulent for a provider to issue used equipment and seek reimbursement from Louisiana Medicaid. It is permissible to issue used equipment as a rental. However, if the PA Unit determines at a later date to purchase that same item, it will be necessary to switch out the used item and replace it with new equipment.

- Nebulizer drugs are covered by Medicaid only in the Pharmacy Program. For Pharmacy/DME providers, who bill through Medicare for these drugs, the claims can crossover to pay as a Pharmacy claim type. If the provider is enrolled as a DME provider only, we have no provision to pay them for nebulizer drugs, either for Medicare crossovers or for Medicaid only claims.

- POS users should retain the recipient's 13-digit identification number for DME billing purposes.

- Although DHH is aware that Medicare covers diabetic supplies under the DME program, there is no mechanism for Medicaid to reimburse DME providers for such services. Therefore, it is necessary for DME providers to refer the recipient to a pharmacy provider for these type services. It is not acceptable to bill the recipient for the co-insurance or deductible since it is a Medicaid-covered service.

- Supplies that are prior authorized over the telephone (as emergency requests) may only be authorized for one month at a time. Thereafter, requests should be submitted in writing as a routine request, making sure that the words "Continuation of Services "is written on the PA01.

PRIOR AUTHORIZATION

Prior authorization is an integral part of the DME program. With few exceptions, all services within the scope of DME require authorization. When a provider opts to provide a DME service, they may telephone the Prior Authorization Unit to obtain **emergency** authorization ***or*** submit a completed PA-01 form and mail/fax it to the Prior Authorization Unit or utilize the electronic PA via www.lamedicaid.com. In order to ensure a more optimal opportunity to receive reimbursement for the service, **prior** authorization is recommended. If a DME equipment or supply is not authorized prior to the service being rendered, providers have 6 months after date of service to request post authorization. Providers who neglect to obtain authorization within the first 6 months will not receive authorization and, therefore, will not receive reimbursement.

Emergency Requests

Providers can only request emergency requests when a delay in obtaining the medical equipment or supply would be life-threatening to the recipient. The following items are examples of medical equipment and supplies considered for emergency approval. However, other equipment will be considered on a case by case basis through prior authorization.

- Apnea monitors
- Breathing equipment
- Enteral Therapy
- Parenteral Therapy (Must be provided by a Pharmacy)
- Suction machines

Emergency requests can also be taken for the temporary rental of wheelchairs for post-operative needs and for items needed for hospital discharge.

Providers can reach the Prior Authorization Unit at 1-800-488-6334 or 1-225-928-5263.

Routine Requests

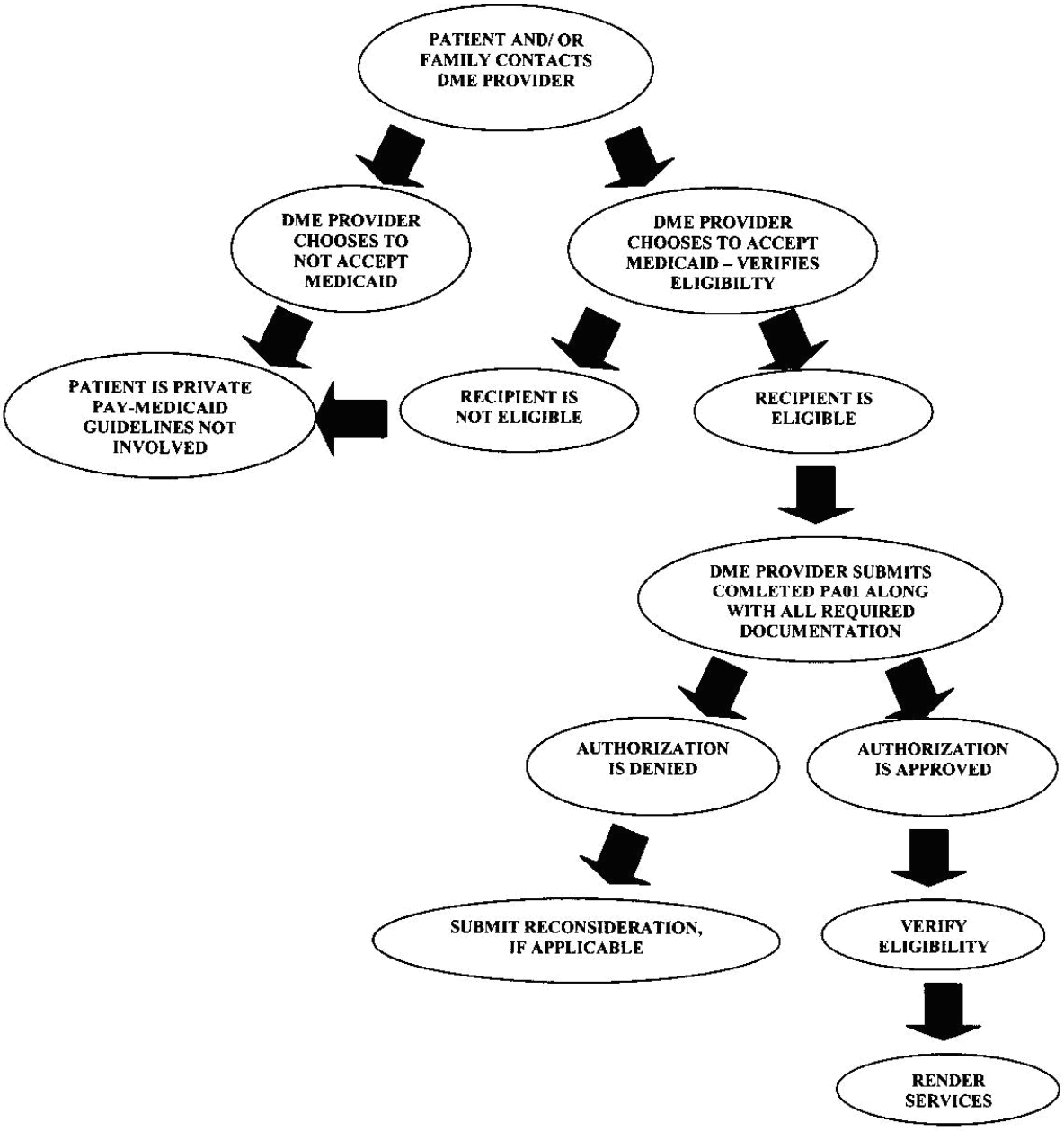
All requests that are not considered emergency requests can be completed hardcopy and mailed or faxed to the Prior Authorization Unit. Providers can also submit their requests through www.lamedicaid.com. All prior authorization packets should include:

- Completed PA01 form
- Medical information from the physician
    - Written prescription from a licensed physician or the physician's representative
    - Diagnosis related to the request
    - Length of time that the supply, equipment, or appliance will be needed
    - Other medical information needed to support the need for the requested item
- Statement as to whether recipient's age and circumstances indicate that they can adapt to or be trained to use the item effectively
- Medical care plan which includes a training program for any appliance which requires skill and knowledge to use
- Any other pertinent information, such as measurements

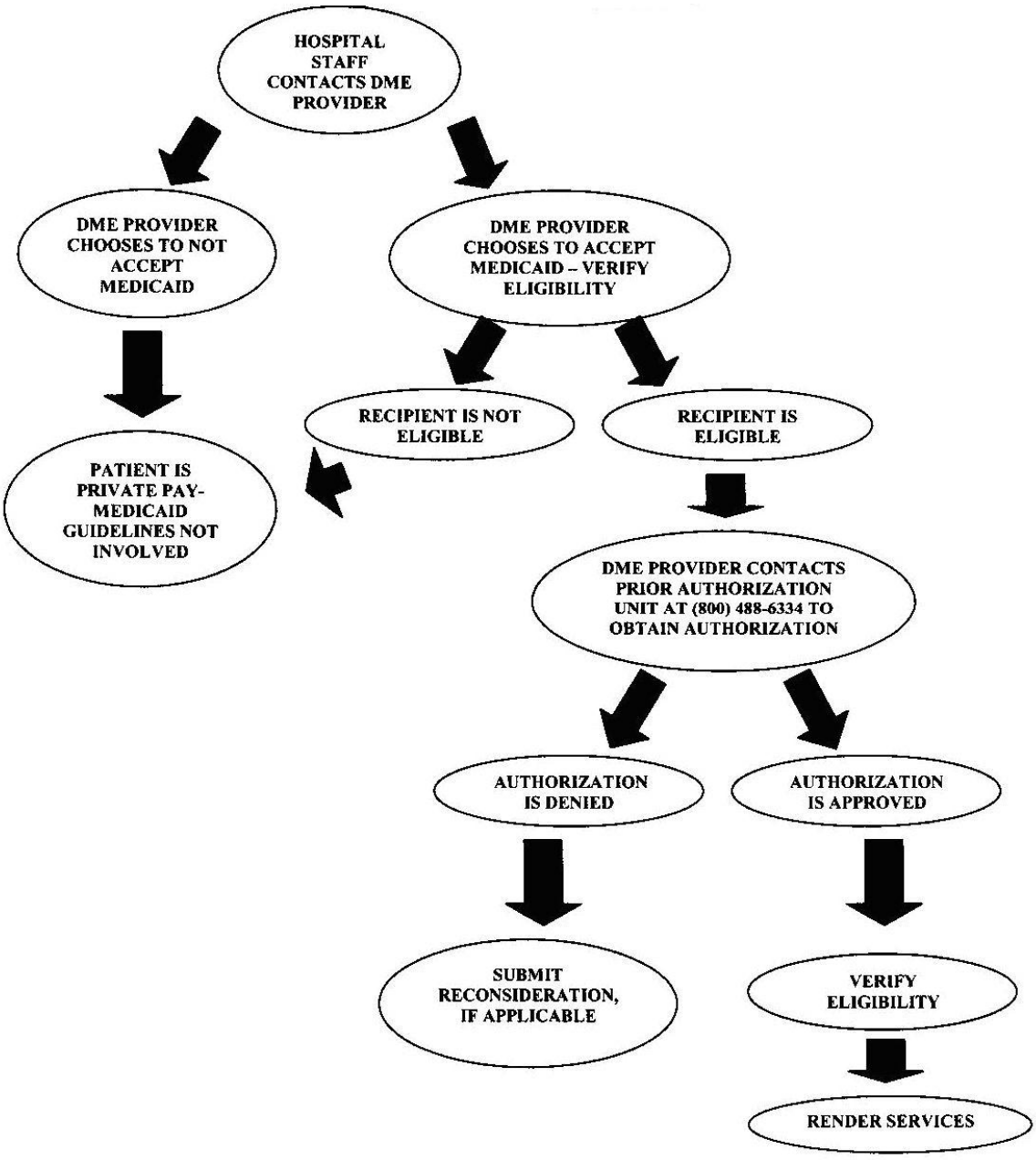
Mail the completed Prior Authorization packet to:

Unisys
P.O. Box 14949
Baton Rouge, LA 70898
Attn: Prior Authorization Unit

Prior Authorization Process: Routine Request



Prior authorization Process: Hospital Discharge/Emergency Request



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

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

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

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

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

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (MMDDYYYY) (7)

END DATE OF SERVICE (MMDDYYYY)

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

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

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

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

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

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

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

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

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-01 FORM

INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION FORM (PA-01)

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

Field 1*	Check the appropriate block to indicate the type of prior authorization requested.
Field 2*	Enter **either** the recipient's 13-digit Medicaid ID number or the 16-digit CCN number.
Field 3	Enter the Social Security Number of the recipient.
Field 4*	Enter the recipient's last and first name as it appears on their Medicaid ID card.
Field 5	Enter the recipient's date of birth in month, day, year format (MMDDYYYY).
Field 6*	Enter the 7-digit Medicaid provider number.
Field 7*	Enter the Beginning and ending dates of service in month, day, year format (MMDDYYYY).
Field 8*	Enter **either** the numeric ICD-9 diagnosis code, both primary and secondary (if there is more than one diagnosis) **or** write out the description of the diagnosis.
Field 9	Enter the day the prescription was written.
Field 10	Enter the name of the physician prescribing the services.
Field 11*	Enter the HCPCS/Procedure code.
Field 11A*	Enter the appropriate modifier for the service being requested.
Field 11B*	Enter the corresponding description for each HCPCS/Procedure code being requested.
Field 11C*	Enter the number of units requested for each individual HCPCS/Procedure code, when appropriate (850 PAC).
Field 11D	Enter the requested charges for each individual HCPCS/Procedure code, when appropriate (880 PAC).
Field 12	Enter the location for all services rendered.
Field 13*	Enter the name, mailing address, and telephone number of the service provider. As long as name is present, request will not be rejected.
Field 14	Enter the name of the case management agency along with their address and telephone/fax numbers, if applicable.
Field 15*	Enter the signature of the Provider or an authorized representative. **IF USING A STAMPED SIGNATURE, AUTHORIZED PERSONNEL MUST INITIAL IT.**
Field 16*	Enter the date of request for the service.

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

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

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

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

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2): 7770000011112222

Social Security No. (3):

RECIPIENT LAST NAME: Carabella | FIRST: Travis | MI (4):

DATE OF BIRTH (5):

MEDICAID PROVIDER NUMBER (7- DIGIT) (6): 1111113

BEGIN DATE OF SERVICE (7) (MMDDYYYY): 08 28 2007

END DATE OF SERVICE (MMDDYYYY): 02 27 2008

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

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION: CHF
SECONDARY CODE & DESCRIPTION:

PRESCRIPTION DATE (9) (MMDDYYYY): 08 26 2007

STATUS CODES:
2 = APPROVED
3 = DENIED

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

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)
A4351					Catheters		1231.20				
A4927					Non-Sterile Gloves	6					
A4402					Ostomy Lubricant		6. 36				

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

(13)
PROVIDER NAME: The Best DME Agency
ADDRESS: 111 Main Street
CITY: Solomon STATE: LA ZIPCODE 00000
TELEPHONE: (_____) _____ _____ FAX NUMBER: (_____) _____ _____

COMMENTS:

(14)
PROVIDER SIGNATURE: Connie David

(15)
DATE OF REQUEST: 8/13/2007

PA-01 FORM

ELECTRONIC PRIOR AUTHORIZATION

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

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

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

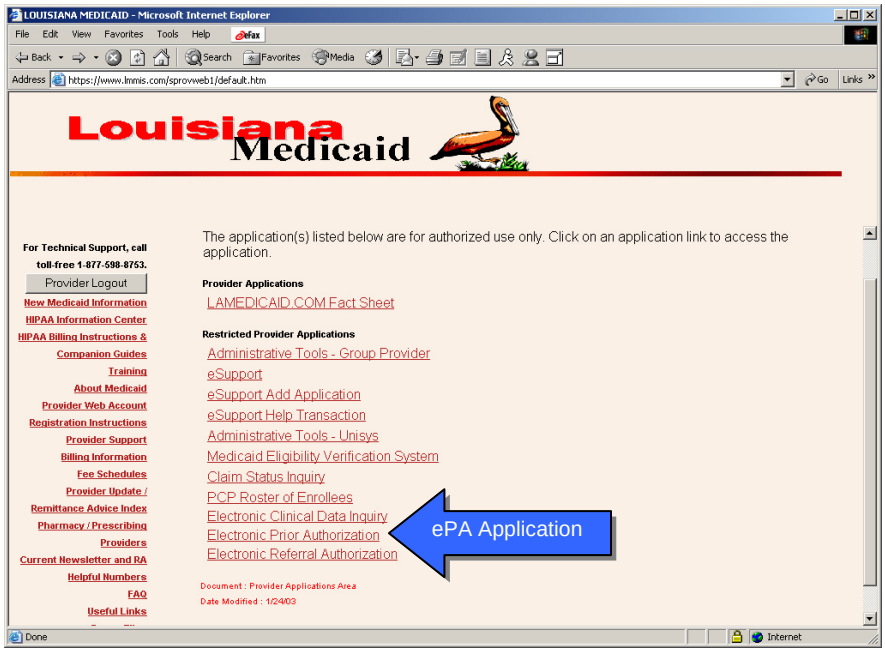
RECONSIDERATION REQUESTS CAN BE ACCEPTED VIA THE e-PA APPLICATION AS LONG AS THE ORIGINAL REQUEST WAS SUBMITTED USING e-PA.

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

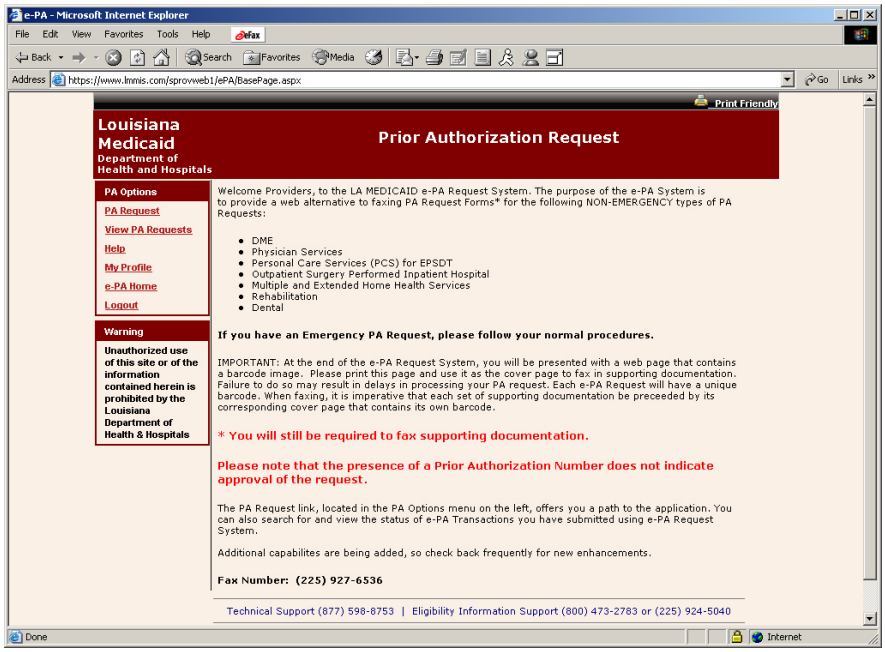
If the supporting documentation is not faxed to Unisys or the Request Response page is not used as a cover sheet or is un-readable, then the request will remain in a Pending Review status and will not be processed by the Unisys PA department. To identify whether or not the supporting documentation was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

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

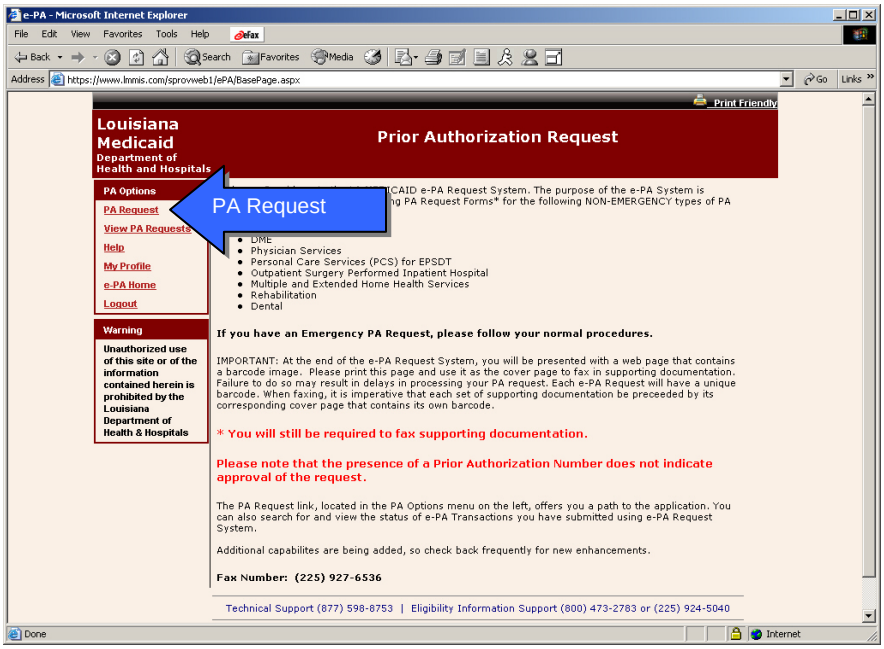
The **Provider Applications Area** screen is displayed. Select the **Electronic Prior Authorization** hyperlink.



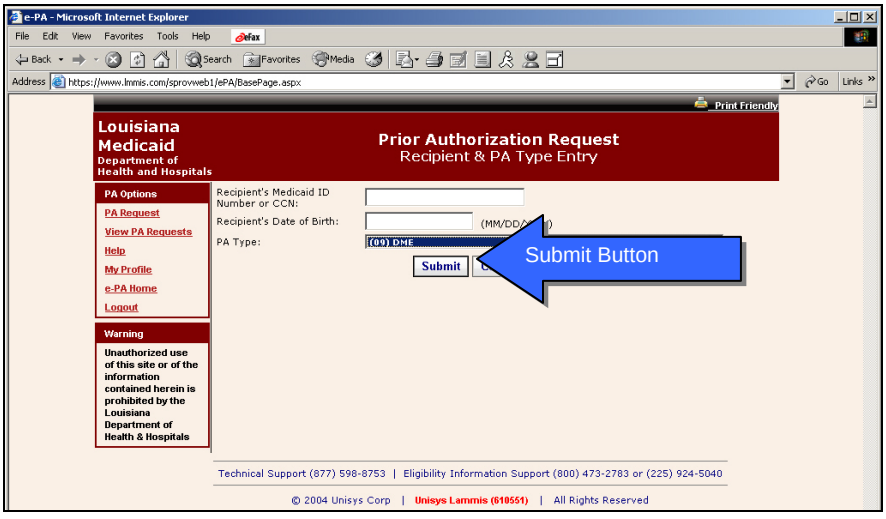
The **Louisiana Medicaid Prior Authorization Web Application** Home screen is displayed.



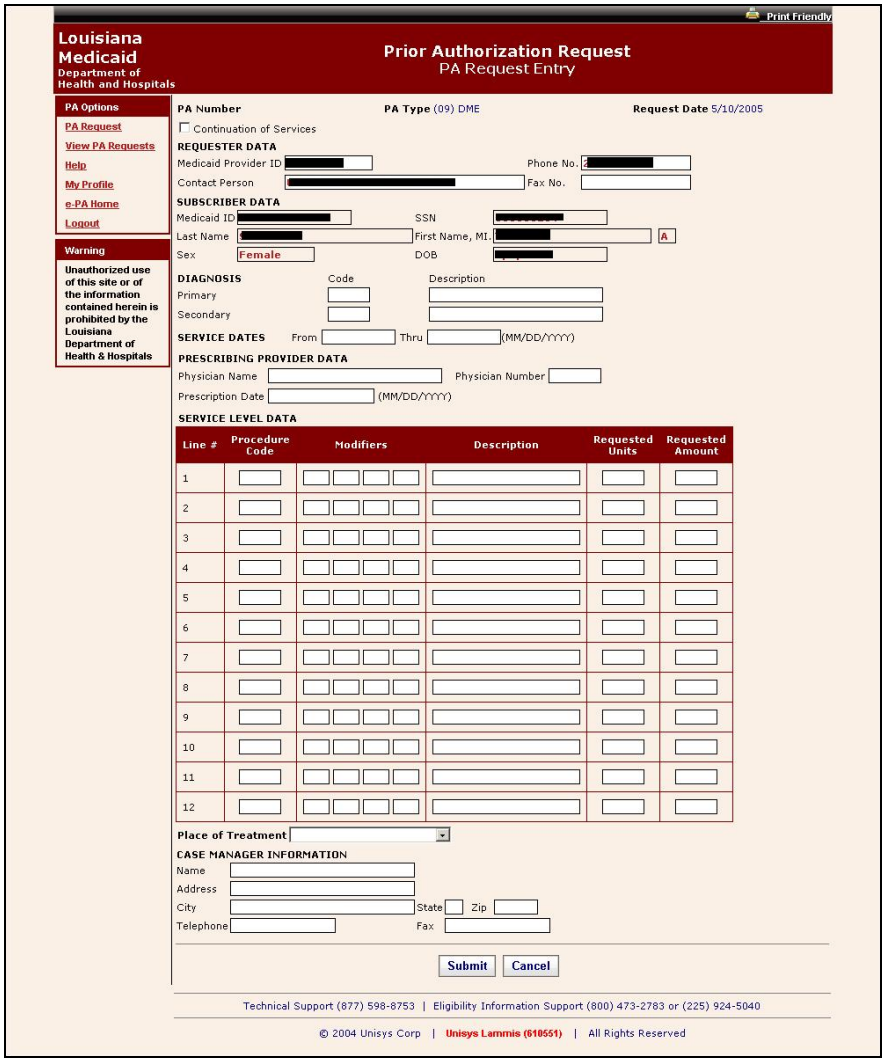
Select the PA Request link located in the upper left side of the main application page. The PA Type entry page will be displayed.



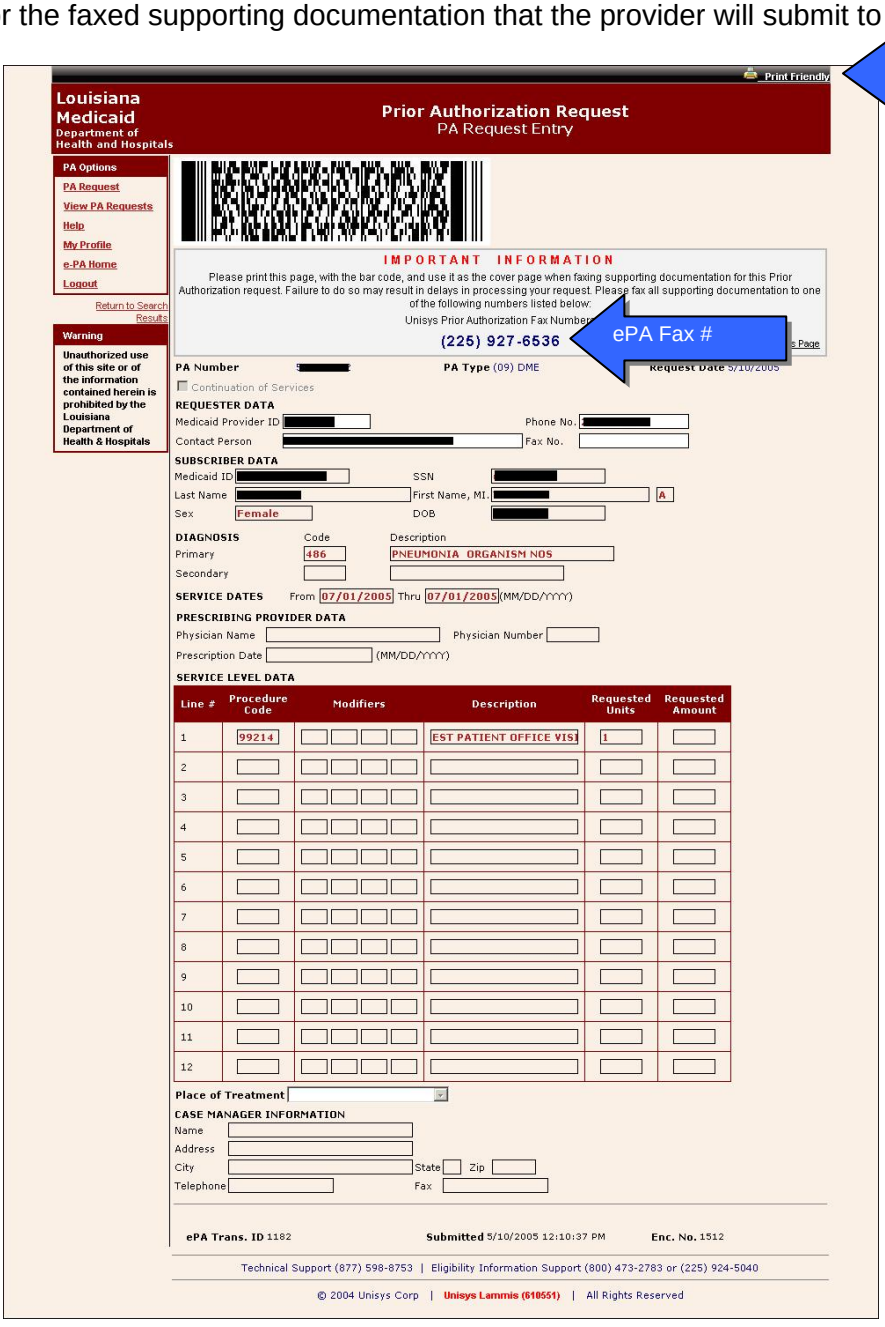
On the Recipient & PA Type Entry page, enter the recipient's Medicaid ID number or CCN and the date of birth in the appropriate boxes. In the PA Type drop-down list, select (09) DME as the type of PA request, then select the Submit button. The Prior Authorization Entry page will be displayed.



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



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



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

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

DATE 08/17/2007 RECIPIENT NAME DWAR M
PRIOR AUTH. NBR 5 259 RECIPIENT NUMBER 8: 096

*
. JT
702

PROVIDER NUMBER 1: 3

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW. IF ANY OF THE APPROVED ASTERISKED(*) SERVICES ARE REQUIRED BEYOND THE APPROVED DATES OF SERVICE, YOU MUST FILE A REQUEST FOR A CONTINUATION OF APPROVED SERVICES BY 02/02/2008 (25 DAYS BEFORE THE END OF THE APPROVED SERVICE DATE). IF YOU FAIL TO SUBMIT A CONTINUATION OF SERVICES REQUEST BY 02/02/2008. THESE SERVICES WILL NOT BE CONTINUED.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
*A4351 -INTERMITTENT URINARY CATH	$ 1,231.20	08/28/2007 -02/27/2008	APPROVED
A4927 -GLOVES NON STERILE PER 10	6	08/28/2007 -02/27/2008	APPROVED
*A4402 -OSTOMY LUBRICANT	$ 6.36	08/28/2007 -02/27/2008	APPROVED

* RESUBMITTAL DATE: ____/____/_____

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

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

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

CHANGING DATE OF SERVICE FOR PRIOR AUTHORIZATION

It is a requirement of Medicaid that providers not bill for durable medical equipment, services, supplies, prosthetics, or orthotics until the services have been rendered or the items have been delivered or shipped to the recipient. It is also a requirement that the date of service and the date of delivery be the same date in order for a claim to be paid.

When requesting authorization of payment for these items or services, the provider should request authorization on the actual date of the service, delivery, or shipment of the item, or if not known, the provider should request a span date of sufficient duration to allow for authorization by PAU and delivery of the service or item. This will prevent unnecessary denial of payment on the claim.

In the event a provider needs to change the date of service to match the date of delivery, a reconsideration request must be submitted to PAU. A copy of the delivery ticket must be attached if the delivery of the service or item has already been made.

Requests for adjustments to dates of service must be sent in writing to the Prior Authorization Unit at Unisys and should always include the reason for the adjustment and documentation of the delivery date. Telephone requests are not allowed for the change.

The following guidelines should be followed and considered in requesting a change in the dates of service from Unisys.

1. A telephone authorization has been obtained for DME services to be provided after a recipient's discharge from a hospital facility. If the discharge was delayed beyond the anticipated date of discharge and service, a date of service may be adjusted at the provider's request, to reflect the actual discharge date as the date of service.

2. A change in providers after prior authorization is given for services may justify a change in the "thru" or end date of services for the old provider's PA file.

3. When a delay in the delivery of an item, after its prior authorization by Unisys, is justified as unavoidable by the provider, the date of service would be adjusted to match the delivery date. The provider must document the reason for the delay and the actual date of delivery (documented with a delivery ticket). An adjustment of the date of service may only be considered, however, if the date of delivery is within six months of the original, anticipated date of service that was entered onto the prior authorization file when the request was approved. Any delays of delivery longer than six months after the date of service on the PA file cannot be considered for a date of service adjustment. Delays by the provider in submissions of a claim for payment, not involving a justified delay in delivery, cannot be considered by the Prior Authorization Unit as a reason for changing the date of service on the PA file. Any delays by the provider in submitting a claim after delivery, which result in a problem in meeting the timely filing deadlines, can be considered only for resolution through the established procedures for an override of the timely filing limits for claims.

4. If a provider is approved for a service and is able to deliver the approved item at an earlier time than the anticipated date of service that was entered on the Prior

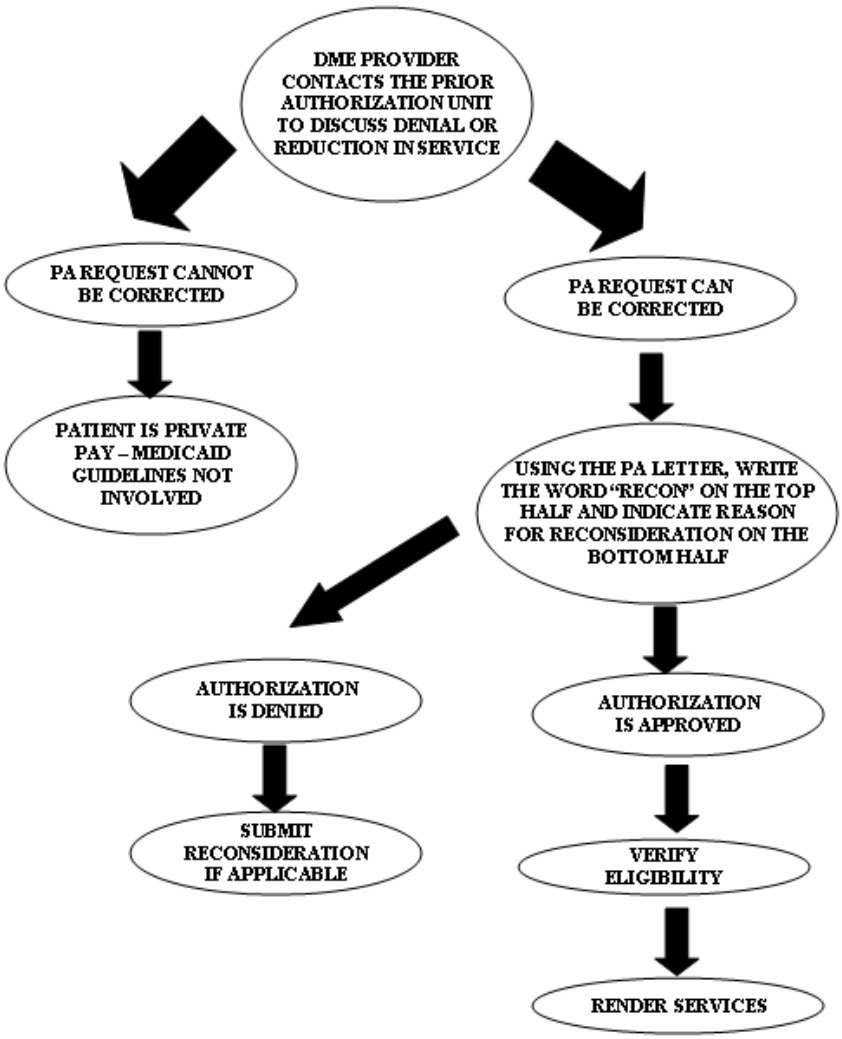
Authorization file, the provider may ask that the date of service be adjusted to an earlier date to match his/her earlier delivery date. The provider must send documentation (copy of the delivery ticket) with the request.

The provider is allowed to wait to deliver until prior authorization has been approved; however, the item must be delivered before the claim can be submitted; (it is a violation of Federal and State Medicaid Policy to bill for a service that has not been delivered but has been ordered). Please remember that information on DME claims (not prior authorization request) cannot be changed after submittal.

The prior authorization system was designed to act on an original request with the receipt of medical information or a request for extension of services which is considered a “new” request and must contain all necessary information in order for the Prior Authorization Unit to approve the service. This includes the original/current diagnosis, an up-to-date prescription and other pertinent documentation to support that the services, supplies, and equipment are on going. Request that simple include a statement that this is a lifetime condition or a reference to previously submitted information will not be approved. The prescription date shown in field 9 should fall within 60 days of the initial request or re-request (continuation). The Department has initiated two support mechanisms to assist the provider in securing approval for the request in a timely manner. The reconsideration process “and the PAL” are both in place to assist the providers who service clients. If you, as a provider, are experiencing difficulties with the Prior Authorization process and you have exhausted the resources available through both these, you may consider contacting the Provider Relations Unit for a visit to review your internal process for a request.

If the actual delivery day is 6 months or more past the authorized date(s), the provider must submit the request for the date of service change to the DME Program Manager at DHH.

Reconsideration Process



POINTS TO REMEMBER:
YOU CAN ONLY SUBMIT 3 RECONSIDERATIONS ON ONE PA NUMBER. THEN YOU MUST SUBMIT A BRAND NEW PA01.

EVERY RECONSIDERATION SUBMITTED THROUGHT THE MAIL MUST CONTAIN THE SAME DOCUMENTATION THAT WAS WITH THE ORIGINAL PA01, ALONG WITH ANY ADDITIONAL DOCUMENTATION TO SUBSTANTIATE MEDICAL NECESSITY.

FOR RECONSIDERATIONS SUBMITTED USING e-PA, PROVIDERS ARE NOT REQUIRED TO RESUBMIT DOCUMENTATION THAT WAS ORIGINALLY SUBMITTED UNDER THE SAME PA NUMBER, AS LONG AS THE DOCUMENTATION IS RECENT AND NOTHING HAS CHANGED. PROVIDERS ARE STILL REQUIRED TO SUBMIT ANY ADDITIONAL DOCUMENTATION TO SUBSTANTIATE MEDICAL NECESSITY.

NOTE: IF A CODE BECOMES OBSOLETE IN THE MIDST OF A PRIOR AUTHORIZATION SPAN, A RECONSIDERATION DOES NOT HAVE TO BE SUBMITTED.

RECON

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

DATE 08/17/2007 RECIPIENT NAME [illegible] ALD
PRIOR AUTH. NBR 5 16 RECIPIENT NUMBER 2[illegible]

PROVIDER NUMBER 1

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW. IF ANY OF THE APPROVED ASTERISKED(*) SERVICES ARE REQUIRED BEYOND THE APPROVED DATES OF SERVICE, YOU MUST FILE A REQUEST FOR A CONTINUATION OF APPROVED SERVICES BY 09 /04/2007 (25 DAYS BEFORE THE END OF THE APPROVED SERVICE DATE). IF YOU FAIL TO SUBMIT A CONTINUATION OF SERVICES REQUEST BY 09 /04/2007, THESE SERVICES WILL NOT BE CONTINUED.

PROCEDURE/MOD1/MOD2/DESCRIPTION		UVS/AMOUNT	DATES OF SERVICE	STATUS
*A5500	-DIAB SHOE FOR DENSITY INS	2	09/29/2007 - 09/29/2007	APPROVED
K0628	-DIABETIC SHOE DIRECT FORM	2	09/29/2007 - 09/29/2007	APPROVED
E0607	-HOME BLOOD GLUCOSE MONITO		09/29/2007 - 09/29/2007	DENIED -164

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW, IN ACCORDANCE WITH POLICY REFERENCED IN THE MEDICAID ELIGIBILITY MANUAL, SECTIONS 0-100 THROUGH 0-204.
164 - NEED MEDICAL DOCUMENTATION THAT THE PATIENT IS INSULIN DEPENDENT.

* RESUBMITTAL DATE: ____/____/_____

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

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

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

DOCUMENTATION ATTACHED SUBSTANTIATING INSULIN DEPENDENCE

CHRONIC NEEDS CASES

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

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

PRIOR AUTHORIZATION LIAISON

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

The PAL will first contact the provider by telephone to attempt to resolve the problem. If the issue has not been resolved after 2 days, the PAL will telephone the recipient and/or support coordinator (if listed on the prior authorization request form) by telephone and inform them of the information that is needed. If the requested information has not been received after 10 days of initial contact with the provider, the PAL will send a "Notice of Insufficient Documentation" to the provider, the recipient and the recipient's support coordinator advising them of the specific documentation needed and the type of provider that can supply it. The needed documentation must be returned within 30 days to the PAL, or if an appointment is needed with a health professional, the PAL must be notified of the appointment date.

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

While the support coordinator may assist with obtaining the additional information being requested, the provider maintains the responsibility for requesting prior authorization for the service and completing all necessary documentation.

PRIOR AUTHORIZATION CRITERIA

Continuous Positive Airway Pressure (CPAP)

A CPAP (Continuous Positive Airway pressure) machine is used to treat recipients who have moderate to severe obstructive sleep apnea.

A respiratory cycle is defined as an inspiration, followed by an expiration. Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It must include sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG), and electrooculogram (EOG), and a submental electromyogram (EMG). It must also include at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment.

Apnea is defined as the cessation of airflow for at least 10 seconds documented on a polysomnogram.

Hypopnea is defined as an abnormal respiratory event lasting at least 20 seconds associated with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation.

The apnea-hypopnea index (AHI) is defined as the average number of episodes of apnea and Hypopnea per hour and must be based on a minimum of 2 hours of sleep without the use of a positive airway pressure device, reported by Polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected).

Criteria for Adults:

A single level continuous positive airway pressure (CPAP) device is covered if the recipient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (1 or 2):

1) The AHI is greater than or equal to 15 events per hour; or,
2) The AHI is from 5 to 14 events per hour with documented symptoms of:
   a) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
   b) Hypertension, ischemic heart disease, or history of stroke.

For the purpose of this policy, polysomnographic studies must be performed in a facility based sleep study laboratory and not in the home or in a mobile facility. These labs must be qualified providers of Medicare or Medicaid services and comply with all applicable state regulatory requirements.

For the purpose of this policy, polysomnographic studies may not be performed by a DME provider.

Pediatric Criteria (Under Age 21)

A single level continuous positive airway pressure (CPAP) device is covered if the recipient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and there is:

1. Documentation of physical exam (including airway) and of any other medical condition, which may be correctable (e.g., tonsillectomy and/or adenoidectomy) prior to the institution of assisted ventilation.
2. Documentation of how sleep disturbance reduces the quality of life and affects the activities of daily living.
3. Prescription by a physician with training and expertise in pediatric respiratory sleep disorders.
4. Documentation of the medical diagnosis, which is known to cause respiratory/sleep disorders.
5. Sleep or respiratory study documenting two or more of the following:
    a) Oxygen saturation of less than 90% pulse oximetry or partial pressure of transcutraneous or arterial of less than 60mm. Hg.;
    b) Carbon dioxide greater than 55 mm. Hg. Bye end tidal, transcutaneous, arterial, or capillary blood measurement;
    c) Apnea of 10 to 20 seconds duration on the average of one per hour.
6. A follow up plan should be submitted identifying the responsible physician or facility, giving data collected to demonstrate the success of failure of intervention, and showing a visit within the first month of use and a second assessment within the first three months of use.
7. Indication of a responsible, committed home environment and of caregivers properly trained in appropriate respiratory care.
8. A written plan for home health follow up care.

Wound Care Supplies

Wound care supplies may receive prior authorization approval for 3 months at a time. The prior authorization request must reflect the submitted prescription. It is necessary to document the following factors in order to meet criteria:

- Wound dimensions for each wound
- Number of times per day these are being changed
- If a home health agency is involved in the care (saline or irrigation supplies will be approved only if a home health agency is doing visits)
- Prescription must be updated for any extensions

Enteral Therapy

Enteral therapy may be provided safely and effectively in the home by nonprofessional persons who have undergone special training. Medicaid will not pay for any services furnished by non-physician professionals.

Enteral nutritional therapy is considered reasonable and necessary for a recipient when medical documentation, such as hospital records and clinical findings, support an independent conclusion that the recipient has a permanently inoperative internal body organ or function which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with his/her general condition. For purposes of this policy, permanent means an indefinite period of at least months.

Prescriptions for enteral feedings must be for an average of at least 750 calories per day over the prescribed period and must constitute at least 70% of the daily caloric intake to be considered for coverage by Medicaid. Coverage of prescribed feedings of less than an average of 750 calories per day may only be considered with additional physician documentation and justification of the reason for prescribing less than an average of 750 calories per day. Baby food and other regular grocery products than can be used with an enteral system are not covered.

All requests must include the following information:

- Name of the nutrient product or nutrient category
- Number of calories prescribed by enteral feeding per day (100 calories equals 1 unit) and whether the prescribed amount constitutes 70% or more of the daily caloric intake.
- Frequency of administration per day
- Method of administration (oral or, if tube, whether syringe, gravity, or pump fed)
- Route of administration, if tube fed (i.e. nasogastric, jejunostomy, gastrostomy, percutaneous enteral gastrostomy, or naso-intestinal tube)
- Reason for use of a pump, if prescribed

Enteral nutritional therapy will not be approved for temporary impairments or for convenience feeding via gastrostomy.

Enteral feedings can only be provided for the most economic package equivalent in calories and ingredient content to the needs of the patient as established by medical documentation. The physician(s) must document the reason for prescribing a formula higher than category I-A (HCPC B4150) or category II (HCPC B4152). This includes any formula in category I-B (HCPC B4151) or categories III through IV (HCPC B4153 through B4156).

Approved requests shall be reviewed at periodic intervals not to exceed six (6) months.

Approval may be granted for up to six (6) months at a time. Medicaid, however, will pay for no more than one month's supply of enteral nutrients at any one time.

NOTE: *Nutritional supplements given between meals to boost daily protein-caloric intake or as the mainstay of a daily nutritional plan may be covered for recipients under age 21 where medical necessity is established. Nutritional supplements will not be covered, however, for recipients age 21 years or older.*

Enteral Infusion Pump

A standard enteral infusion pump will be approved only with documented evidence that the pump is medically necessary and that syringe or gravity feedings are not satisfactory due to complications such as aspiration, diarrhea, dumping syndrome, etc.

Medicaid can pay for the rental, as well as the delivery and set up, for a standard enteral infusion pump and accessories. Medicaid can pay for repairs not covered by the warranty or lease agreement.

Ambulatory Assistance Equipment

Wheelchairs

Wheelchairs are approved only when the recipient is confined to bed or chair, without the use of a wheelchair.

Requests for **Standard Type Wheelchairs** should indicate the recipient's ability to walk unassisted and whether the request is for a first chair or replacement chair. The standard types of wheelchairs require documentation of medical necessity. Standard attachments to standard-type wheelchairs will also be provided by Medicaid. Standard attachments/replacement parts include:

Foot rests
Brakes
Desk arms
Elevating leg rests
Trays
Restraining straps
Belts
Head supports
Special seats
Tires
Other standard components with documentation of need

Requests for **Special Wheelchairs** or customized wheelchairs with special attachments or construction are approved only if documented medical and social data relating to the diagnosis supports the medical necessity, and if the chair will be used by the recipient to meet a specific need.

The request shall include the following information:

Recipient's age, height, weight, and seat size
Recipient's ability to use the chair effectively
Any special physical limitations
Time period required
Whether training programs are in progress
For multiple deformities, state which deformities the chair is designed to correct

All requests shall include an evaluation by the rehabilitation therapist of whether the wheelchair will meet the recipient's needs. If the recipient already has a wheelchair, state whether repairs can be made, and if so, the costs of those repairs.

Canes and Crutches
Requests for canes (wooden or metal), quad canes (four-prong) and all types of crutches may be approved if the recipient's condition impairs ambulation and when there is a potential for ambulation.

Walkers and Walker Accessories
A standard walker and related accessories are covered if all of the following criteria are met:

1. It is prescribed by a physician for a recipient with a medical condition that impairs ambulation;
2. the recipient has a potential for ambulation; and
3. the/she has a need for greater stability and security than can be provided by a cane or crutches.

Wheeled Walker
A wheeled walker is one with two, three, or four wheels.
It may be fixed height or adjustable height. It may or may not include glide-type brakes (or equivalent). The wheels may be fixed or swivel.
A wheeled walker shall be approved only the recipient is unable to use a standard walker due to severe neurological disorders, restricted use of one hand, or due to other medically reasons. The request must contain supporting documentation from the prescribing physician that substantiates why a wheeled walker is needed rather than a standard walker.

Heavy Duty Walker
A heavy-duty walker may be approved for patients who meet the criteria for a standard walker and who weigh more than 300 pounds.

Heavy Duty, Multiple Braking System, Variable Wheel Resistance Walker
A heavy duty, multiple braking system, variable wheel resistance walker is a four-wheeled, adjustable height, folding walker that has all of the following characteristics:
It is capable of supporting individuals who weigh more than 350 pounds; and
as hand operated brakes that: cause the wheels to lock when the hand levers are released; can be set so that either one or both can lock the wheels; and are adjustable so that the individual can control the pressure of each hand brake; there is an additional braking mechanism on the front crossbar; and at least two wheels have brakes that can be independently set through tension adjustability to give varying resistance.

A heavy duty, multiple braking system, variable wheel resistance walker is considered medically necessary for members who weigh greater than 350 pounds, and who meet coverage criteria

for a standard walker, and who are unable to use a standard walker due to a severe neurological disorder or other condition causing the restricted use of one hand. Obesity, by itself, is not considered a medically necessary indication for this walker.

Leg Extensions
Leg extensions are considered medically necessary for members 6 feet tall or more.

Arm Rests
Armrest attachments are considered medically necessary when the member's ability to grip is impaired.

Reimbursement for Walkers and Walker Accessories

1. Reimbursement for walkers and walker accessories is at 70 percent of the Medicare fee schedule and at the same amount for the HIPAA compliant codes which replaced them, or;
2. 70 percent of the Medicare fee schedule under which the procedure code first appeared, or;
3. 70 percent of the Manufacturer=s Suggested Retail Price (MSRP) amount, or;
4. Billed charges, whichever is the lesser amount, or;
5. If an item is not available at the rate of 70 percent of the applicable established flat fee or 70 percent of the MSRP, the flat fee that will be utilized is the lowest cost at which the item has been determined to be widely available by analyzing usual and customary fees charged in the community.

Not Covered By Medicaid

Walker with Enclosed Frame
A walker with enclosed frame is a folding wheeled walker that has a frame that completely surrounds the patient and an attached seat in the back. Walkers with enclosed frames are not considered medically necessary because their medical necessity compared to a standard folding wheeled walker has not been established.

Enhancement Accessories
Medicaid considers enhancement accessories of walkers, canes and crutches not medically necessary. An enhancement accessory is one that does not contribute significantly to the therapeutic function of the walker, cane or crutch. It may include, but is not limited to style, color, hand operated brakes (other than those described in the section above on heavy duty, multiple braking system, variable wheel resistance walker), seat attachments, tray attachments, or baskets (or equivalent).

Walking Belts
Medicaid considers walking belts (belt used to support and guide the member in walking) not medically necessary because they are not primarily medical in nature and are normally of use to persons who do not have a disease or injury.

Patient Lifts

Recipient Qualifications

Lifts are approved only if all of the following conditions are met:

1. If the recipient is confined to bed, chair or room and is unable to transfer or unable to achieve needed movement with or without assistance;

2. If the caregiver is unable without the use of a lift to provide periodic movement necessary to arrest or retard deterioration in the recipient=s condition, thus affecting improvement in rehabilitation;

3. When the caregiver is unable to transfer recipient from chair to bed or bath (or vice versa) e.g., because of recipient=s size or weight.

Medicaid covers hydraulic lifts. Medicaid does not cover electric lifts.

Procedure code E0630 also includes the Hoyer Lift.

Lift Slings

Lift slings or seats, either canvas or nylon, are considered part of the lift and are only covered as replacement items.

Apnea Monitors

“Apnea monitors” are defined as cardiorespiratory monitoring devices capable of providing continuous or periodic two-channel monitoring of the heart rate and respiratory rate and must meet current Food and Drug Administration (FDA) guidelines for products in this class. Apnea monitors must have alarming mechanisms to alert care givers of cardiorespiratory distress or other events which require immediate intervention and must be capable of recording and storing events and of providing event recording downloads or printouts of such data.

Medical Criteria for Authorization of Payment for Apnea Monitor

Home apnea monitors may be approved for rental or purchase when any of the following criteria are met:

1. Apnea of prematurity occurs. Apnea of prematurity is defined as sudden cessation of breathing that lasts for at least 20 seconds or is accompanied by bradycardia or oxygen desaturation (cyanosis) in an infant younger than 37 weeks gestational age.

2. Apnea of infancy occurs. Apnea of infancy is defined as an unexplained episode of cessation of breathing for 20 seconds or longer, or a shorter respiratory pause associated with bradycardia, cyanosis, pallor, and/or marked hypotonia. The term apnea of infancy generally refers to infants with gestational age of 37 weeks or more at the onset of apnea. Louisiana Medicaid defines bradycardia for infants as a resting heartbeat of less than 80 beats per minute at 1 month of age, less than 70 beats per minute at 2-3 months of age, and less than 60 beats per minute at 3 months of age or older.

3. For subsequent siblings of Sudden Infant Death Syndrome (SIDS) victims up to the age of 8 months of age.

4. Following an apparent life-threatening event (ALTE). An apparent life-threatening event is characterized by some combination of central apnea or occasionally obstructive apnea, color change (usually cyanotic or pallid but occasionally erythematous or plethoric), and a marked change in muscle tone (usually marked limpness), choking, or gagging, which required vigorous intervention or cardiopulmonary resuscitation (CPR).

5. Children requiring home oxygen therapy, central hypoventilator, tracheotomy, and/or home ventilator support will be considered on a case-by-case basis.

Bath and Toileting Aids

Adaptive Hygiene Equipment for Bathroom Use
Adaptive hygiene equipment includes:

1. Elevated toilet seats;
Elevated toilet seat are approved when the recipient is unable to go from a seating to a standing position without assistance.

2. Bath or shower chairs;
Bath or shower chairs are approved only for severe incapacitating problems such as paraplegia or cerebral palsy. Approval is based on medical necessity and appropriateness for home use.

3. Safety guardrails;
Safety guardrails are approved for recipients who are unable to stand up in the tub or get out of the tub without assistance.

4. Footrest for use with toilet.
A footrest for a toilet may be covered when the recipient's feet won't touch the floor and it is needed for balance and support.

Commode Chairs
A commode chair is covered when the patient is physically incapable of utilizing regular toilet facilities. This would occur in the following situations:

1. The patient is confined to a single room, or;
2. The patient is confined to one level of the home environment and there is no toilet on that level, or;
3. The patient is confined to the home and there are no toilet facilities in the home.
   An extra wide/heavy duty commode chair is covered for a patient who weighs 300 pounds or more. If the patient weights less than 300 pounds but the basic coverage criteria for a commode chair are met, payment will be based on the least costly medically appropriate alternative.

A request for payment for a mobile commode chair will be denied as not medically necessary. If basic coverage criteria for a commode chair are met, payment will be based on the least costly medically appropriate alternative stationary commode chair.

Commode Chairs with Detachable Arms
A commode chair with detachable arms is covered if the detachable arms feature is necessary to facilitate transferring the patient or if the patient has a body configuration that requires extra width. If these additional criteria are not met but the basic coverage criteria for a commode chair are met, reimbursement will be authorized based on the least costly medically appropriate alternative.

Urinals (Hospital Type) and Bed Pans
Urinals (hospital type) and bed pans may be approved if the recipient is confined to bed and is able to use it.

Not Covered By Medicaid

Hand Held Showers
Environmental Modifications

Ambulatory Insulin Pump

Continuous Subcutaneous Insulin External Infusion Pumps

A continuous subcutaneous insulin external infusion pump is a portable, battery operated, insulin pump. It is about the size and weight of a small pager. The pump delivers a continuous basal infusion of insulin. Insulin pumps can be automatically programmed for multiple basal rates over a 24-hour time period. This can be useful for such situations as nocturnal hypoglycemia and the dawn phenomenon. Before meals or at other times (e.g., hyperglycemia after unanticipated caloric intake), the pump can be set to deliver a bolus of insulin, similar to taking an injection of pre-meal regular insulin for someone using multiple daily injections.

Payment for a continuous subcutaneous insulin external infusion pump and related supplies will be authorized in the home setting, for treatment of Type I diabetes, when the following conditions are met:

- The diabetes needs to be documented by a C-peptide level less than 0.5.

- The pump must be ordered by and follow-up care of the patient must be managed by a physician who manages patients with continuous subcutaneous insulin infusion (CSII) and who works closely with a team including nurses, diabetes educators and dietitians who are knowledgeable in the use of CSII.

- The patient has completed a comprehensive diabetes education program; And has been on a program of multiple daily injections of insulin, (at least three injections per day), with frequent self-adjustments of insulin dose for at least six months prior to initiation of the insulin pump; and has documented frequency of glucose self-testing an average of a least four times per day during the two months prior to initiation of the insulin pump; AND meets one or more of the following criteria while on the multiple daily injection regimen:

  1. has a glycosylated hemoglobin level (HbAlc) greater than 7.0 percent;
  2. has a history of recurring hypoglycemia;
  3. has wide fluctuations in blood glucose before mealtime;

4. has dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl;
5. has a history of severe glycemic excursions.

Not Covered

Continuous subcutaneous insulin external infusion pumps shall be denied as not medically necessary and reasonable for all Type II diabetics including insulin-requiring Type II diabetics.

Glucometers

A glucometer, or glucose monitor, is a device for home use used to measure blood glucose levels. Glucometers are provided to Medicaid recipients who are insulin-dependent, insulin-requiring, or who are gestational diabetics.

In order to qualify for payment for a glucometer, a recipient must have a signed prescription from the treating physician. The physician documentation may be on the prescription for the glucometer stating:

1. The recipient is an insulin-dependent, insulin-requiring, or the recipent's diagnosis is gestational diabetes;
2. The recipient or someone on his/her behalf can be trained to use the glucometer correctly, and;
3. The monitor is for home use.

Hearing Aids

Hearing aids are only provided to eligible recipients under the age of 21 (EPSDT eligibles) and approved only when there is a significant hearing loss documented by audiometric data from both an ear specialist (otologist) and a hearing aid provider.

A hearing loss greater than 20 decibels average hearing level in the range 250 -2000 hz is considered significant.

Reimbursement is $575 per hearing aid. Hearing aids must have a two year warranty and should normally be expected to last at least three years before replacement. Repairs are reimbursed at the invoice price up to $40 per hour for labor.

Repair and batteries do not require prior authorization.

Hospital Beds and Mattresses

Hospital Beds (Standard and Total Electric Types)

Hospital beds and mattresses will be approved by Medicaid if the recipient is confined to bed and his condition necessitates positioning the body, especially the head, chest, legs, and feet, in a way that would not be possible in an ordinary bed.

Standard Hospital Beds

A standard hospital bed is defined by Medicaid as a variable height or semi-electric bed.

Variable Height Hospital Beds

A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments.

A variable height hospital bed will be approved only if one of the following indications is met:

1. The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed, or;

2. The patient requires traction equipment which can only be attached to a hospital bed, and;

3. The patient requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position.

Semi-electric Hospital Beds

A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments.

A semi-electric hospital bed will be approved only if one of the following indications is met:

1. The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed, or;

2. The patient requires traction equipment that can only be attached to a hospital bed.

Total Electric Hospital Beds

A total electric bed is one with electric height adjustment and with electric head and leg elevation adjustments. Total electric hospital beds will be approved only when a standard hospital bed (variable height or semi-electric) cannot be effectively used in the home by recipient or recipient=s caretaker.

Hospital Bed Mattresses

Hospital bed mattresses are considered part of the hospital bed and will only be approved to replace mattresses that are no longer functional, when the recipient meets the criteria to receive a hospital bed.

Side rails for beds other than hospital beds are approved only if the recipient's medical condition necessitates use of rails on a regular bed.

Orthopedic Shoes and Corrections

Orthopedic shoes and corrections may be approved only when:

1. the shoes are attached to braces,
2. are needed to protect gains from surgery or casting, or
3. are medically necessary to prevent clinical deterioration of the foot as with recipients with severe diabetes or
4. are medically necessary to prevent clinical deterioration of the foot as with recipients with severe peripheral vascular disease.

Diabetics

Special shoes and corrections are covered for diabetics. Coverage is provided for extra-depth or custom molded shoes, as well as inserts or modifications, for individual whose physician documents that the recipient has diabetes AND certifies that the recipient is being treated under a comprehensive plan of care for his or her diabetes and that he or she needs therapeutic shoes, AND documents that the recipient has one or more of the following conditions:

Previous amputation of the foot or part of the foot due to complications that resulted from diabetes;

History of previous foot ulceration;

Pre-ulcerative callus formation, or peripheral neuropathy with a history of callus Formation;

Foot deformity; or

Poor circulation.

Shoe Lifts

Shoe lifts are covered only when greater than ½ inch. Inserts are only covered for shoes which are attached to braces, or when there is sufficient physician documentation from the treating physician to justify medically coverage without the attachments to braces.

Reimbursement

Because Medicare requires that the recipient either have diabetes with peripheral complications or the shoe must always be attached to braces, Medicaid will allow prior authorization for consideration of payment when Medicare's criteria are not met. The provider must use a GY modifier when submitting the PA request for consideration or the claim for payment

Not Covered By Medicaid

Cables

Cables are not considered braces.

Shoes for Minor Orthopedic Problems

Payment will not be made for shoes for recipients due to minor orthopedic problems, i.e., pes planus, metatarsus adductus, and internal tibial torsion.

Traction Equipment

Traction equipment is approved only if the recipient has significant orthopedic impairment, which prevents ambulation.

Cervical traction collars are considered under Orthotic Devices.

Trapeze Bars

Trapeze bars are approved if the recipient requires assistance to sit up in bed because of a respiratory condition or a need to change body position for other medical reasons.

IV Therapy and Administrative Supplies

IV therapy or intravenous therapy is a way of taking medicine so that it flows straight into the bloodstream.
IV medicines are given through flexible plastic tubes that are inserted into a vein, usually in the arm or the chest.
Medication that is given through an IV may be given with a syringe as a single dose (push), from a bag that is attached to the end of the tube (gravity infusion) or with a pump.
IV medication is used instead of medicine that is taken by mouth (oral) when

- The medicine needed is not available in oral form
- The doctor feels that IV medication will be more effective than oral medicine
- Patients are unable to take medication by mouth

Some of the different devices that are used to give IV medicines are called

- Cannulas
- Central lines, (Hickman's catheter)
- Picc(Peripheral Intravenous Central Catheter) lines
- Portacaths® (Infuse-a-port®, Mediport®)

Oxygen Concentrators

A. The attending physician, or a consultant physician who has personally examined the recipient at the request of the attending physician, must have seen the recipient within 30 - 60 days of prescribing oxygen therapy.

B. Initial requests for oxygen concentrators must include a prescription which is signed and dated by the treating physician and which includes:
    1. the oxygen flow rate;
    2. the frequency and duration of use;
    3. an estimate of the period of need; and
    4. the results of a current blood gas laboratory report done at rest and at room air (performed no more than 30 days prior to the prescription) from an appropriate facility giving the arterial blood gases (ABGs) and arterial saturation. However, oxygen saturation may be determined by pulse oximetry when ABGs cannot be taken.

C. The following diagnostic findings support the need for oxygen therapy:

1. Group I.

a. A current ABG with a $P0_2$ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken at rest, breathing room air.

b. A current ABG with a $P0_2$ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during sleep; or if there is a significant drop during sleep of more than 10 mm Hg of the arterial $P0_2$, or a drop of more than 5 percent of the arterial oxygen saturation, and this drop is associated with symptoms or signs reasonably attributable to hypoxemia.

Example: PO_2 while awake - 75 mm HG
PO_2 while asleep - 64 mm HG

Symptoms: nocturnal restlessness

c. A current ABG with a $P0_2$ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during exercise for a patient who demonstrates an arterial $P0_2$ at or above 56 mm Hg, or an arterial saturation at or above 89 percent while awake at rest. In this case, supplemental oxygen is provided during exercise if there is evidence that the use of oxygen improves the hypoxemia experienced during exercise while breathing room air.

2. Group II. Coverage is available for patients whose current arterial $P0_2$ is 56-59 mm hg or whose arterial blood oxygen saturation is 89 percent, if there is evidence of:

a. dependent edema suggesting congestive heart failure (CHF) (documentation from the physician must indicate the degree of edema and if it is associated with CHF);

b. "P" pulmonale on a current electrocardiogram (EKG) (documentation from the physician must indicate if the AP@ wave on an EKG taken within the last 30 days was greater than 3 mm in standard leads II, III, of AVF); or

c. Erythrocythemia with a current hematocrit greater than 56 percent.

3. Group III. Medicaid reimbursement will not be made for patients with arterial $P0_2$ levels at or above 60 mm Hg, or arterial blood saturation at or above 90 percent.

Portable Oxygen

May be approved for EPSDT recipients only.

A current criterion is that it may be approved when needed for medical appointments or travel to and from school.

Reimbursement for Oxygen Concentrators

A. Payment for an oxygen concentrator also includes the cost of providing all routine maintenance and servicing, and monitoring the proper usage in the home by a respiratory therapist. At the time of the initial request for prior authorization, the DME provider must describe a plan for routine checking and servicing of the machine and a plan for monitoring the proper usage in the home by a respiratory therapist as a prerequisite to authorization of purchase or rental of an oxygen concentrator from that provider.

B. Reimbursement fees for oxygen concentrators are $1,250 for purchase or $150 per month for rental, or billed charges, whichever is the lesser amount. If the item is not available at the established rate, the flat fee that will be utilized is the lowest cost at which the

item has been determined to be widely available by analyzing usual and customary fees charged in the community.

Pricing File

CODE	DESCRIPTION	PAC	Prci	RENT
A4616	TUBING (OXYGEN), PER FOOT	880	$3.05	
E0443	PORTABLE OXYGEN CONTENTS, GAS, PER UNIT	880	$8.00	
E1390	OXYGEN CONCENTRATOR, EQUIVALENT TO	880	$1,250.00	$150.0
K0738	PORTABLE GASEOUS OXYGEN SYSTEM	880		$36.14

FREQUENTLY ASKED QUESTIONS

Prior authorization

Q: Regarding wound care, who decides what is authorized as far as quantities? Who is supposed to estimate the quantity of tape, number of gauze bandages, etc.?
A: In requesting the quantities for prior authorization purposes, the provider calculates these based on the physician's prescription or order. If it appears that the quantities requested are not supported by the patient's diagnosis or condition or by other documentation, the approved quantities may be less than those requested.

Q: What if we run out of the supplies before the end of the prior authorization (PA) period?
A: In such an instance, the provider should request a reconsideration of the original PA to include the additional supplies.

Q: Do prescriptions have to have an original physician's signature? Will a stamped or computer-generated signature be acceptable?
A: Physician signatures must either be original signatures or, in the case of verbal orders recorded using a stamped physician's signature; the signature must also be signed with the full name and credentials of the nurse taking the order.

Q: We have received approval for an apnea monitor. When we submit a request for an extension by the date indicated on the PA letter, the request is denied stating that the data is not up-to-date enough. How do we deal with this problem?
A: In these instances criteria must be as up-to-date as possible. Providers may have to submit the extension request closer to the date on which the PA expires in order to have recent documentation to submit.

Q: When an extension is requested, do we have to send in all the original documentation with the extension request?
A: It is not necessary to send in all the original documentation with a request for an extension. An extension request requires a PA01 form and any other documentation substantiating the need for additional supplies or an extension of the span date of the prior authorization.

Q: If supplies are authorized for a 3-month period and the recipient wants all the supplies at one time, can we give those to the patient at one time?
A: Providers are normally to dispense supplies a month at a time. This is also for the provider's protection in case the recipient loses eligibility later during the prior authorization period. There would have to be some extenuating reason why the recipient should receive the supplies all at one time.

Q: If a Medicaid rental changes to a purchase and the recipient cannot be located to give them a new item, what can we do?
A: You may not bill Medicaid for the new equipment unless it is actually delivered and the recipient signs the delivery ticket verifying delivery.

Q: When emergency requests occur on the weekend when Unisys is closed, should we go ahead and deliver the service or should we wait until Unisys opens on Monday?
A: There is no definite answer to this question. Each provider must decide in such a situation whether he wants to deliver the service or not. DHH would encourage providers to consider the patient's well being as paramount and to act accordingly. However, there is no requirement that the provider goes ahead and delivers the service prior to obtaining prior authorization. Providers often are more willing to provide services under such circumstances if they have become familiar enough with the criteria for the particular service to be confident that the service would meet criteria and would eventually be approved.

Q: If we provide hearing aids, must we provide the batteries?
A: You would not be required to supply the batteries, but it might be more convenient for the recipient if he obtained both the hearing aid and the batteries from the same source.

Q: Can we get PAs that span dates up to a three-month period and not have to request a new PA each time we give out supplies?
A: Prior authorizations for most ongoing items or supplies may be requested for up to six months.

Q: Does the delivery ticket have to be signed by the recipient or responsible party, or someone with power of attorney? Can anyone else sign the delivery ticket?
A: The delivery ticket may be signed by a responsible party or one with power of attorney if the recipient is unable to sign the delivery ticket.

Q: If an IV pump purchase is authorized for a patient and the patient breaks it, can we request a new pump?
A: The provider may submit a request for a new item in such a circumstance. The request must contain documentation as to why the request is being made, including a statement that the patient broke the item and any available information regarding the circumstances under which the breakage occurred.

Q: What if such a request is denied?
A: Any denied prior authorization request may be submitted for reconsideration by the provider or for appeal by the recipient. If the provider does not understand the reason for the denial, he may contact the Unisys Prior Authorization unit to obtain clarification. Finally, the recipient may appeal the decision.

Q: Medicaid doesn't cover portable oxygen for over 21. Can we bill the patient for that?
A: Yes, you may bill the patient for this particular item.

Q: If a patient over 21 is receiving some kind of oxygen that is not covered by Medicaid, but they also receive Medicaid covered items from us, can we bill Medicaid for the covered items and bill the recipient for the non-covered items?
A: In general, Medicaid recipients may be billed for non-covered Medicaid items. This is not negated by the fact that that the provider receives payment for other items that are covered by Medicaid.

Q: You said a provider can appeal an approved service. We were told by the Prior Authorization department that the recipient had to initiate the appeal. Which is correct?
A: Providers may request a reconsideration of a prior authorization request. This process is detailed in the DME Medicaid provider manual and involves the provider and the Unisys Prior

Authorization Department. Only recipients may appeal a decision made about a prior authorization request, which is a formal process involving a hearing before an administrative law judge.

Q: Does PA have access to old records about the patient to help establish that the patient meets criteria for a current request?
A: The Unisys Prior Authorization department cannot access old prior authorization requests to assist in meeting criteria on a current request. It is the provider's responsibility to obtain and submit required documentation when making a prior authorization request.

Q: We have a patient who is abusive of the equipment we supply. We have requested repairs and replacements and have not been paid for all services. Is there any avenue to resolve a case like this?
A: You may report the situation by using the toll-free fraud & abuse hotline established by DHH to report abuse of Medicaid services. The telephone number is (800) 488-2917. Regarding payment for the services, we would need more information to assist you, such as whether the PA request was denied, or if the actual claim was denied, or what may be causing your claim denials. Our Provider Relations Telephone Inquiry Unit can assist you if you can provide more specific information.

Q: We have a patient who is getting home health. Can we still provide a wheelchair to this patient, even though the recipient is getting home health?
A: The fact that the recipient is receiving home health does not prevent the recipient from receiving DME; therefore, you may provide the recipient a wheelchair provided all criteria are met.

Newborns

Q: We see newborn babies. Are babies of Medicaid moms automatically eligible?
A: Babies born to a Medicaid mother are automatically considered eligible for Medicaid for the first year of life. However, paperwork must be completed in order to enroll and obtain a Medicaid ID number for each baby.

Q: Do I have to wait until the baby gets an ID number in order to request a prior authorization?
A: No. Since the Prior Authorization Unit considers medical necessity, they may review the request and issue a PA decision without a Medicaid number. However, the PA will be considered denied, having a 326 code (Medical approval is given, pending an eligible Medicaid recipient number). It is the provider's responsibility to update the PA file by contacting the Prior Authorization Unit and informing them of the baby's Medicaid ID number. Once the PA Unit updates the PA file with the Medicaid ID number, the PA file will change from a denied status to an approved status and another letter will be mailed indicating that the PA has been approved.

Eligibility/Medicare/TPL/Hospice

Q: How do we tell if a recipient is a QMB or has Medicare and Medicaid but is a non-QMB?
A: The messages returned by REVS and MEVS indicate this (please see the current Basic Training packet). QMB Only (formerly Pure QMB) recipients are indicated by the following message: "This recipient is only eligible for Medicaid payment of deductible and co-insurance of services covered by Medicare. This recipient is not eligible for other types of Medicaid assistance." QMB Plus (formerly Dual QMB) recipients are indicated by the following message: "This recipient is eligible for Medicaid payment of deductible and co-insurance of services

covered by Medicare." Non-QMB recipients have no corresponding message, but it is indicated that they have Medicare Part A and/or Part B.

Q: How do we know if a patient is in hospice?
A: The messages returned by REVS, MEVS and eMEVS will indicate if the recipient is in a hospice facility.

Q: How do we tell if the recipient has other insurance?
A: The messages returned by REVS, MEVS and e-MEVS indicate if the recipient has other insurance.

Q: If the TPL carrier shown on the Unisys files refuses even to process our claim to produce an EOB, what can we do?
A: If the TPL carrier will not assist you, you may contact the TPL Unit at DHH by calling (225) 342-9250.

Q: Can you explain how a Medicare HMO works with Medicaid secondary?
A: DHH pays the Medicare HMO for services rendered to Medicaid patients, and the Medicare HMO is responsible for reimbursing the provider of service. Unisys does not process any of these claims, nor does it issue payment.

Q: If one of the procedure codes that is supposed to bypass the Medicare edit is still being denied for error code 275, what can we do?
A: Please submit the claim and a copy of the RA page showing the denial to the Unisys Correspondence Unit (see page 60 of this packet for further information).

CommunityCARE

Q: Is the Community Care referral number required for DME claims?
A: If the recipient is linked to a Primary Care Physician, that physician's referral number must be entered in item 17A of the hardcopy CMS-1500 claim form or the corresponding data element in electronic claims.

Q: Can the CommunityCARE referral be used as the prescription when obtaining prior authorization?
A: No, the physician's prescription must be submitted to obtain prior authorization.

Billing

Q: Can we submit adjustments and voids electronically?
A: Electronic adjustments and voids of DME claims are accepted by Unisys.

Q: Are adjustments done on the CMS-1500 form?
A: Adjustments on paid DME claims are done on the Unisys 213 form, which is available at no charge from Unisys. Be sure to refer to pages 47-49 of this packet for further information and instructions.

Other

Q: Must we have a certificate of medical necessity for Medicaid?

A: The certificate of medical necessity (CMN) is a form required by Medicare but is not required by Medicaid.

Q: Can waiver recipients also receive DME?
A: Waiver recipients may receive DME as long as it is medically necessary and meets the same criteria that apply to any other Medicaid recipient.

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 also 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 referrals/authorizations from the PCP.

There are some Medicaid covered services, which do not require referrals/authorizations from the CommunityCARE PCP. The current list of exempt services are 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, 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.

CLAIMS FILING

Professional services (including DME) are billed to Medicaid on the CMS-1500 claim form. Following are instructions for completing the claim form.

Certain items on the CMS-1500 are mandatory, as indicated below by **underlining and an asterisk (*)**. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. Such claims cannot be processed until corrected and resubmitted by the provider.

Completed DME claim forms should be mailed to:

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

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 must 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.	

Locator #	Description	Instructions	Alerts
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.	
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. 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). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
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.	

Locator #	Description	Instructions	Alerts
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.	
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	**Situational** – Complete if applicable. In the following circumstances, entering the name of the appropriate physician block is **required**: If services are performed by a CRNA, enter the name of the directing physician. If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name. If services are performed by an independent laboratory, enter the name of the referring physician.	

Locator #	Description	Instructions	Alerts
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.**
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	**Situational** – Complete if appropriate or leave blank. If the services being billed must be Prior Authorized, the PA number is **required** to be entered.	
24	Supplemental Information	**Situational –** Applies to the detail lines for drugs and biologicals only. 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 **shall be entered** in the **shaded** section of 24A through 24G. **Claims for these drugs shall include the NDC from the label of the product administered.**	**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.**

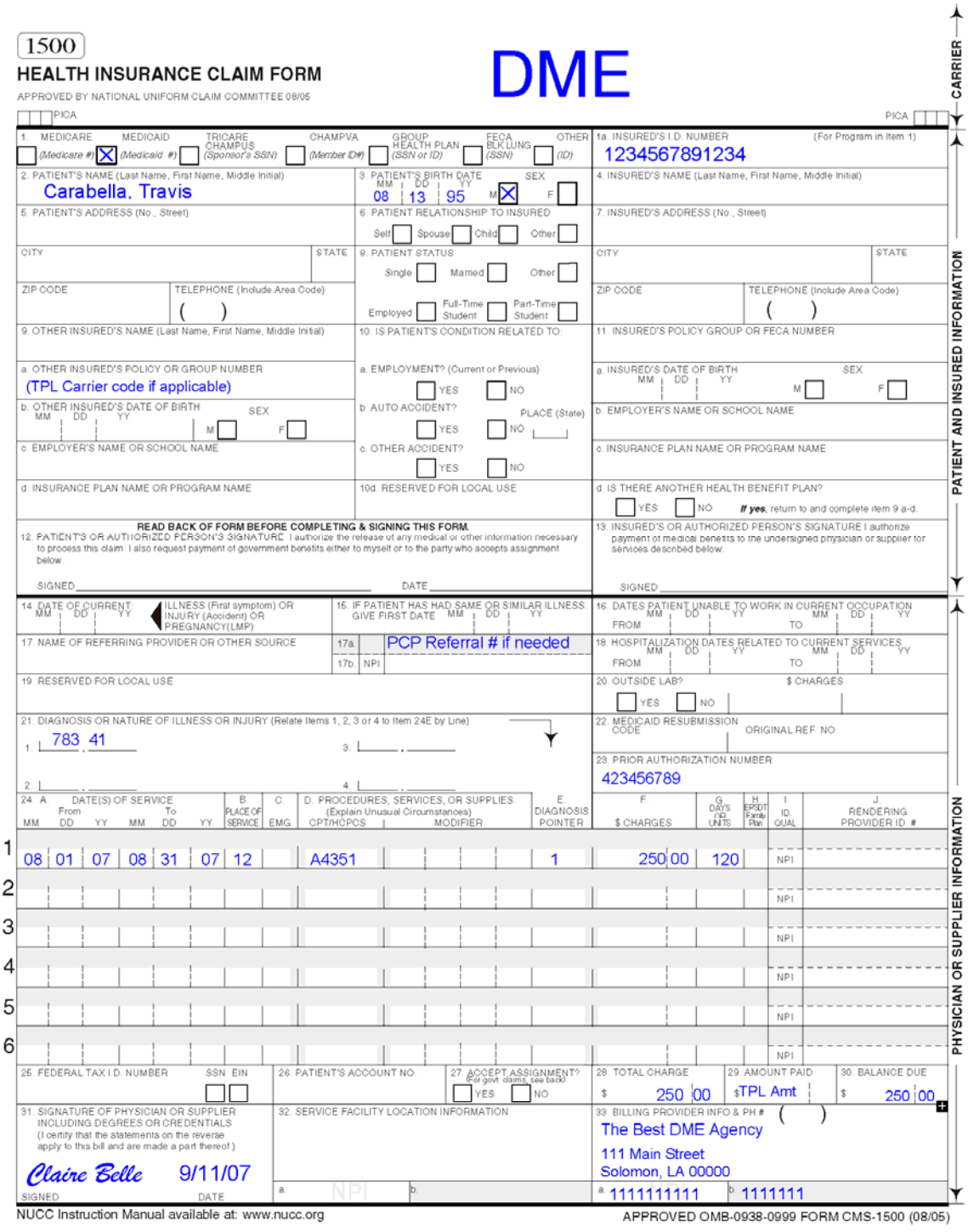
Locator #	Description	Instructions	Alerts
24 cont.		To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the **Qualifier N4** followed by the **NDC.** Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC. 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 drug administered in the remaining space. The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram UN Unit	**This information must be entered in addition to the procedure code(s).**
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	**Situational** – Complete if appropriate or leave blank. When required, the appropriate CommunityCARE emergency indicator is to be entered in this field.	**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).	

Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
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. #	**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**.	**The revised form accommodates the entry of NPIs for Rendering Providers**
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 16 characters.	
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	

Locator #	Description	Instructions	Alerts
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**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. If TPL does not apply to the claim, leave blank.	
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.**

Locator #	Description	Instructions	Alerts
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.)	**If PCP, enter Site Number and Qualifier of the service location.**
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
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.**

NOTE: "DME" must be entered on the top of the claim form! If "DME" is not entered on the top of the claim, the claim will be processed as a physician service and will deny.



1500

HEALTH INSURANCE CLAIM FORM

DME

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567891234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Carabella, Travis

3. PATIENT'S BIRTH DATE: 08 13 95 SEX: M [X] F [ ]

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: (TPL Carrier code if applicable)

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Referral # if needed

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 783.41 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 423456789

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) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 08 01 07	08 31 07	12		A4351		1	250 00	120		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 250 00

29. AMOUNT PAID $TPL Amt

30. BALANCE DUE $ 250 00

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

Claire Belle 9/11/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

The Best DME Agency

111 Main Street

Solomon, LA 00000

a. 1111111111 b. 1111111

NUCC Instruction Manual available at: www.nucc.org

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

ADJUSTING/VOIDING CLAIMS

Blank adjustment/void forms can be obtained from Provider Relations at (800) 473-2783 or download from www.lamedicaid.com and click on the Forms/Files link.

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

Only a **paid** claim can be adjusted or voided.

Electronic submitters may electronically submit adjustment/void claims.

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

A claim is paid on the RA dated 1/03/07, ICN 760056789100.

The claim is adjusted on the RA dated 3/07/07 ICN 760056789100.

All additional adjustment or voids on this claim would need to use ICN 760056789100.

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

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

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

Instructions for Completing the 213 Adjustment/Void form

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

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

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

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

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

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

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

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

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

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

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

25. **REQUIRED** A through F

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

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

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

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

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

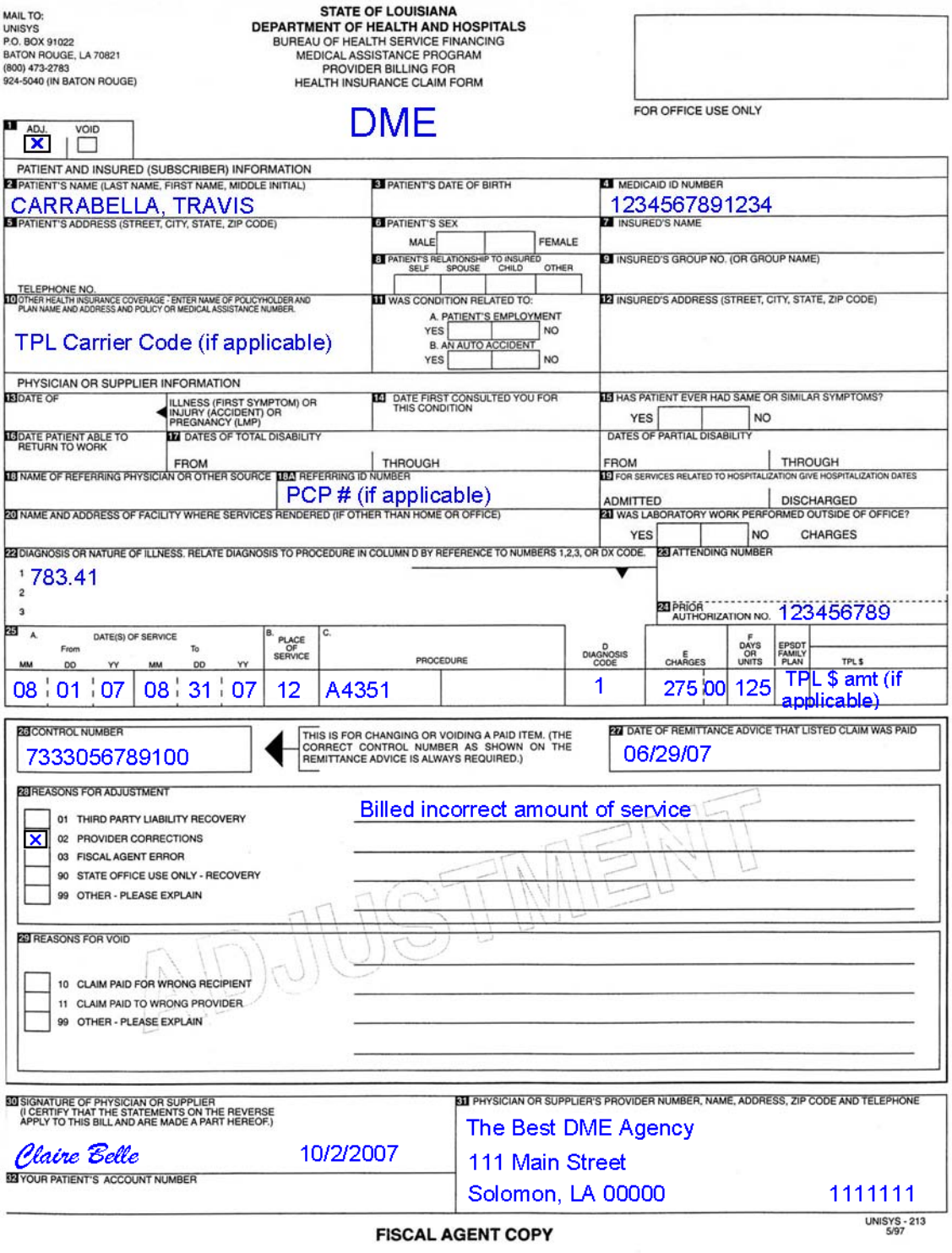
29. **REQUIRED** Reasons for Void—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary

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

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

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

REQUIRED items must be completed or the 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

DME

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): CARRABELLA, TRAVIS
3 PATIENT'S DATE OF BIRTH:
4 MEDICAID ID NUMBER: 1234567891234
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [ ]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
TPL Carrier Code (if applicable)
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO
B. AN AUTO ACCIDENT YES [ ] NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER: PCP # (if applicable)
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 783.41
2
3
23 ATTENDING NUMBER
24 PRIOR AUTHORIZATION NO. 123456789

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
08	01	07	08	31	07	12	A4351		1	275 00	125		TPL $ amt (if applicable)

26 CONTROL NUMBER: 7333056789100
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 06/29/07

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

ADJUSTMENT

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Claire Belle 10/2/2007
32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
The Best DME Agency
111 Main Street
Solomon, LA 00000 1111111

UNISYS - 213
5/97

FISCAL AGENT COPY

ELECTRONIC DATA INTERCHANGE (EDI)

Claims Submission

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

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

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

Certification Forms

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

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

Required Certification forms may be obtained from lamedicaid.com. Under the 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
Third Party/Medicare Payment – EOBs. (Includes Medicare adjustment claims)	Continue hardcopy billing
Failed Crossover Claims – Medicare EOB	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

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

Changes to Claim Forms

Louisiana Medicaid policy prohibits Unisys staff from changing any information on a provider's claim form. Any claims requiring changes must be made prior to submission. Please do not ask Unisys staff to make any changes on your behalf. 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 for payment or adjustments/voids, please utilize the following post office boxes and zip codes.

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

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

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

TIMELY FILING GUIDELINES

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

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

Dates of Service Past Initial Filing Limit

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

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

OR

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

OR

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

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

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

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

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

Submitting Claims for Two-Year Override Consideration

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

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

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

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

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

Claims submitted without a cover letter, proof of timely filing, and/or supporting documentation will be returned to the provider without consideration.

Any request submitted directly to DHH staff will be routed to Unisys Provider Relations.

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.

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.

Eligiblity 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 inquires 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 - (i.e. Professional, DME, Hospital, etc.)
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 **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 216-6342
Dental P.A. - LSU School of Dentistry		(225) 216-6470	(225) 216-6476
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 216-6370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline – Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – DHH	(800) 834-3333 (225) 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
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a 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.oph.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

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:_____

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