UNISYS

RHC/FQHC 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

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STANDARDS FOR PARTICIPATION

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

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

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

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

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

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

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

Picking and Choosing Services

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

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

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

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

Statutorily Mandated Revisions to All Provider Agreements

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

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

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

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

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

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

Surveillance Utilization Review

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

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

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

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

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

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

Fraud and Abuse Hotline

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

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

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.

MEDICAID PROSPECTIVE PAYMENT SYSTEM

In accordance with Section 1902(aa)/the provisions of the Benefits Improvement Act (BIPA) of 2000, effective January 1, 2001, payments to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Medicaid services will be made under a Prospective Payment System (PPS) and paid on a per visit basis.

The PPS per visit rate is provider specific. To establish the interim baseline rate for 2001, each RHC/FQHC's 1999 and 2000 allowable costs as taken from the RHC/FQHC's filed 1999 and 2000 Medicaid cost reports were totaled and divided by the total number of Medicaid patient visits for 1999 and 2000. The baseline calculation includes all Medicaid coverable services provided by the RHC/FQHC regardless of existing methods of reimbursement for said services. This includes, but is not to be limited to ambulatory, transportation, laboratory (where applicable), KidMed and dental services previously reimbursed on a fee-for-service or other non-encounter basis. **The per visit rate is all-inclusive. RHC/FQHC's are not eligible to bill separately for any Medicaid covered services.** The final PPS rate will be based on audited final cost reports for 1999 and 2000.

For an RHC/FQHC which enrolls and receives approval to operate on or after January 1, 2001, the facility's initial PPS per visit rate will be determined first through comparison to other RHCs/FQHCs in the same town/city/parish. Scope of services will be considered in determining which proximate provider most closely approximates the new provider. For FQHCs which enroll and receive approval to operate on or after October 21, 2004, the facility will receive the Statewide Average Rate of all FQHCs.

Reimbursement Adjustments

The PPS per visit rate for each facility will be increased annually by percentage increase in the published Medicare Economic Index (MEI) for primary care services. The MEI will be applied on July 1 of each year.

NOTE: Please direct all cost reporting concerns to Shelton Evans at (225) 342-6253.

REMINDER: RHCs must submit an annual cost report. The cost report must be sent to Trispan at the following address:

Trispan Health Services
5420 Corporate Boulevard, Suite 201
Baton Rouge, LA 70808

Phone: 225/925-8115

RHC/FQHC PROGRAM OVERVIEW

There are 3 components that may be provided under the RHC/FQHC Program: Encounter Visits, KIDMED Screening Services, and EPSDT Dental, Adult Denture Services and Expanded Dental Services for Pregnant Women (EDSPW)

RHC/FQHC Encounter Visits

Encounter visits must be billed using procedure code T1015. **It is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered. If the encounter detail is not included the claim will deny.**

For obstetrical (OB) services the RHC/FQHC providers must bill the encounter code T1015 with modifier TH and all services performed on that date of service should be listed as detail lines.

RHC/FQHC KIDMED Screening Services

RHC/FQHC KIDMED screening services must be billed using the 837P Professional format, including the K3 KIDMED segment or the revised KM3 form using encounter code T1015 along with modifier EP. (Please see page 62 for further information regarding the filing of electronic claims.) It will be necessary for providers to indicate the specific screening services provided by entering the individual procedure code for each service rendered on the appropriate line. If a registered nurse performs the screening, providers must enter the appropriate procedure code followed by the modifier TD next to 'Screening Completed by a Nurse'. If immunizations are given at the time of the screening, then those codes continue to be billed on the CMS1500, along with encounter code T1015 and modifier EP. All claims billed using the T1015 and EP modifier **must include** supporting detail procedures.

RHC/FQHC EPSDT Dental, Adult Denture Services and Expanded Dental Services for Pregnant Women (EDSPW)

Dental services must be billed on the 2006 ADA claim form using the encounter code D0999. It will be necessary for providers to indicate on subsequent lines the specific dental services provided by entering the individual procedure code and description. All claims billed using D0999 **must include** supporting detail procedures.

NOTE: The dental encounter, D0999, may be billed on the same date of service as the encounter codes T1015(RHC/FQHC), T1015 TH(OB encounter), or T1015 EP(KIDMED screening).

RHC/FQHC ENCOUNTER VISIT

RHC/FQHC Medical Encounter

A medical encounter is defined as receipt of services from a licensed practitioner and includes physicians, nurse practitioners and physicians' assistants.

- Upon presentation at the clinic, a full mental, physical and dental assessment shall be done and any health problems identified must be addressed to the highest degree possible **at that encounter**.
- Encounter must include an assessment and written plan for each identified problem noted in the history and physical exam.
- Encounters for those recipients under the age of 21 must include all the aspects of a well-child screening visit.
- The documented Medical Encounter* level of service, **at a minimum**, is to include

    - An expanded, problem-focused history (chief complaint, brief history of present illness, problem pertinent system review)
    - An expanded, problem-focused exam (limited exam of the affected body area or organ system and other symptomatic or related organ systems)
    - Low level complexity of medical decision making (limited number of diagnoses, limited complexity of data to review, the risk of complications and management options- low)

- A new patient medical encounter level of service is to include the following:

    - A detailed history (chief complaint, history of present illness, problem pertinent system review, pertinent past, family, social history)
    - A detailed exam with low-to moderate complexity decision making

RHC/FQHC Clinical Social Worker Encounter

A clinical social worker encounter is defined as receipt of services from a clinical social worker.

- Problems identified at an encounter must be addressed to the highest degree possible *at that encounter*.

- The documented initial face-to-face clinical social worker encounter is to include, **at a minimum**;

    - The collection of current demographic data
    - Assessment/identification of current needs and make appropriate referrals with written contact information
    - Record any observable or reported deficits in function

- The documented subsequent face-to-face clinical social worker encounter should include, at a minimum:

    - The identification and coordination of referrals as indicated or requested
    - Discussion of services with the patient
    - Assessment of patient understanding of information discussed
    - Coordinate with facilities, physician, and others the completion of appropriate medical information as required to assist the patient

* These definitions are modeled after those found in the *Current Procedural Terminology Manual* – 2007 (CPT) currently used by the medical provider community to determine the level of medical care provided. These are minimal requirements from the Louisiana Department of Health and Hospitals, however providers are still required to comply with additional requirements outlined in the CPT manual.

RHC/FQHC visits may be generated by the following licensed health care practitioners:

- Physicians
- Nurse Midwives (under a physician's direction)
- Clinical Psychologists (under a physician's direction)
- Physician Assistants (under a physician's supervision)
- Specialized Nurse Practitioners (in accordance with an approved protocol and under a physician's direction)
- Clinical Social Workers (under a physician's direction)
- Nurse Practitioners (in accordance with an approved protocol and under a physician's direction)
- Dentists

NOTE: Providers must obtain a Professional Services manual and training packet as a reference for policy regarding professional services.

RHC/FQHC Visit Codes

RHC/FQHC encounter visits are billed using code T1015. Each visit counts as one of the allowable physician outpatient visits per calendar year for recipients who are 21 years of age or older. Only one encounter visit is billable per recipient per day. **All services performed at the visit must be included on the claim form as detail lines.**

- Providers who bill their claims electronically should list all services performed in addition to encounter code T1015.
- Providers who bill their claims hardcopy should list the top 5 services performed in addition to encounter code T1015.
- The attending provider number MUST BE included in block 24J to indicate the individual provider performing the services. If a clinical social worker or psychologist provide the services, the number entered must be the RHC/FQHC group number.

Tuberculosis (TB)

When a recipient returns to the facility only to have a TB skin test read, the RHC or FQHC may not charge an encounter fee. The reading of the test is considered a part of the entire TB test.

Outpatient Services

For all services rendered at the RHC/FQHC facility, in a nursing home, or home visits, the RHC/FQHC provider identification number must be used as the billing provider number in block 33 of the CMS 1500.

Inpatient Services

Physician inpatient services are billed through the physician's individual provider number. Physicians are not allowed to bill through their RHC/FQHC group number for inpatient services.

Obstetrical Care Billing

Code **T1015, along with the modifier of TH**, is used by RHCs/FQHCs to bill for obstetrical (OB) services. This code is also reimbursable at the clinic's encounter rate. All services performed at the encounter are to be listed on the claim form as detail lines along with the encounter code.

NOTE: When the encounter is modified with TH, it is not counted towards the outpatient visit service limit for recipients 21 years of age or older.

RHC/FQHC CMS 1500 CLAIMS FILING

Billing Encounters On The CMS 1500

- The encounter should be billed using T1015. If the encounter is obstetrical, the modifier TH should be appended. If the encounter is for a KIDMED screening, the modifier EP should be appended.

- For all services rendered at the RHC/FQHC facility, in a nursing home, or home visits, the RHC/FQHC provider identification number must be used as the billing provider number in block 33 of the CMS 1500.

- Physician inpatient services are billed through the physician's individual provider number. Physicians are not allowed to bill through their RHC/FQHC group number for inpatient services.

- All services provided to the patient on a date of service should be listed as detail lines on the claim form following encounter code T1015, T1015 –TH or T1015 –EP. All detail lines following the encounter code should be billed at $0 or usual and customary fees.

- For KIDMED providers: If immunizations are given at the time of the medical screening, the specific vaccine CPT codes are listed on the CMS 1500, along with encounter T1015 and modifier EP. The EP modifier signifies a screening of a recipient under age 21. All claims billed using the T1015 with modifier EP must include one or more supporting detail procedures.

REMINDER: Only <u>1</u> T1015 procedure code will be paid per Date of Service.

- If the encounter code is missing, the detail line item(s) will deny.
- If the encounter code is denied, the detail line item(s) will deny.
- If the encounter code is present and passes all edits but the detail line item(s) is/are missing, the encounter code will deny.
- If the encounter code is present and passes all edits, it will deny if all detail line items deny.
- If the encounter code and detail line items are present, correct, and pass all edits, the encounter code will pay at the provider's encounter rate and the detail line item(s) will be approved (paid) at zero ($0).
- All detailed procedures must be covered services under the Louisiana Medicaid RHC/FQHC program.

Below are instructions for completing the claim form. Completed examples are shown following the instructions for completion.

Certain items on the CMS-1500 are mandatory, as indicated 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.

NOTE: These instructions are for hard copy claims ONLY.

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.	
5	Patient's Address	**Optional** – Print the recipient's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
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.	
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.	

Locator #	Description	Instructions	Alerts
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 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.	

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**	**RHC/FQHCs who administer drugs and biologicals must enter this new drug-related information in**

Locator #	Description	Instructions	Alerts
24 cont.		**shall include the NDC from the label of the product administered.** 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	**the SHADED section of 24A – 24G of appropriate detail lines only.** **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. If the CommunityCARE emergency indicator is needed, the indicator number ("3") is **required** to be entered.	**This indicator was formerly entered in block 24I.**
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered. Enter the appropriate encounter procedure code on the first line. **Encounter Codes:** RHC/FQHC encounter visit: T1015 RHC/FQHC obstetrical services: T1015 with modifier TH RHC/FQHC KIDMED services: T1015 with modifier EP	**If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 (above) is required.**

Locator #	Description	Instructions	Alerts
24D cont.		In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered.	
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 (U&C) charges or zero for detail lines.	
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 20 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.**
32b	Unlabelled	**Optional.**	**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.	

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

Example of an RHC/FQHC Encounter

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) X | MEDICAID (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): Gardner, June

3. PATIENT'S BIRTH DATE MM DD YY: 03 04 70 | SEX M | F X

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 6 Digit 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.

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 _____

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Authorization #

17b. NPI if applicable

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. 149.0

2.

3.

4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: (Prior Auth # if applicable)

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	01 06 07	01 06 07	72		T1015		1	95 00	1		NPI	1234567 / 1234567890
2	01 06 07	01 06 07	72		99213		1	0 00	1		NPI	1234567 / 1234567890
3	01 06 07	01 06 07	72		85025		1	0 00	1		NPI	1234567 / 1234567890
4	N45390509910 UN10 Proleukin 01 06 07	01 06 07	72		J9015		1	0 00	1		NPI	1234567 / 1234567890
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 $ 95 00

29. AMOUNT PAID $ TPL Amt

30. BALANCE DUE $ 95 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.)

Ted Johnson 1/7/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

RHC/FQHC Clinic

200 Anywhere Street

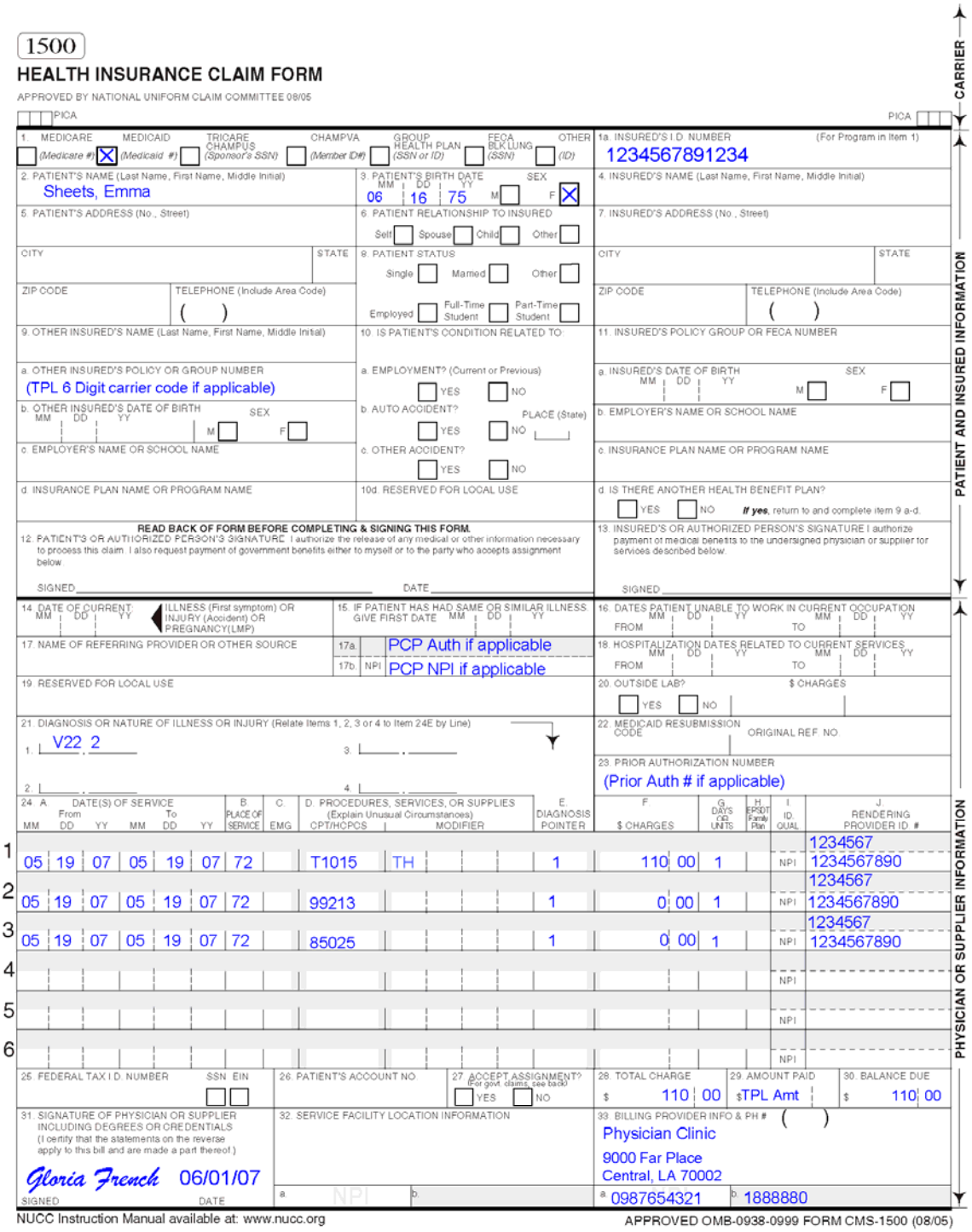
Central, LA

a. 0987654321 b. 1333330

NUCC Instruction Manual available at: www.nucc.org

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

Example of an RHC/FQHC Obstetrical Visit



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (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): Sheets, Emma

3. PATIENT'S BIRTH DATE MM DD YY: 06 16 75 SEX M [ ] F [X]

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: (TPL 6 Digit 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.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth if applicable

17b. NPI PCP NPI if applicable

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. V22.2

2. 3. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: (Prior Auth # if applicable)

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	05 19 07 | 05 19 07	72		T1015	TH	1	110 00	1		NPI	1234567890
2	05 19 07 | 05 19 07	72		99213		1	0 00	1		NPI	1234567890
3	05 19 07 | 05 19 07	72		85025		1	0 00	1		NPI	1234567890
4										NPI	
5										NPI	
6										NPI	

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 $ 110 00	29. AMOUNT PAID $TPL Amt	30. BALANCE DUE $ 110 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.)

Gloria French 06/01/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Physician Clinic

9000 Far Place

Central, LA 70002

a. 0987654321 b. 1888880

CARRIER

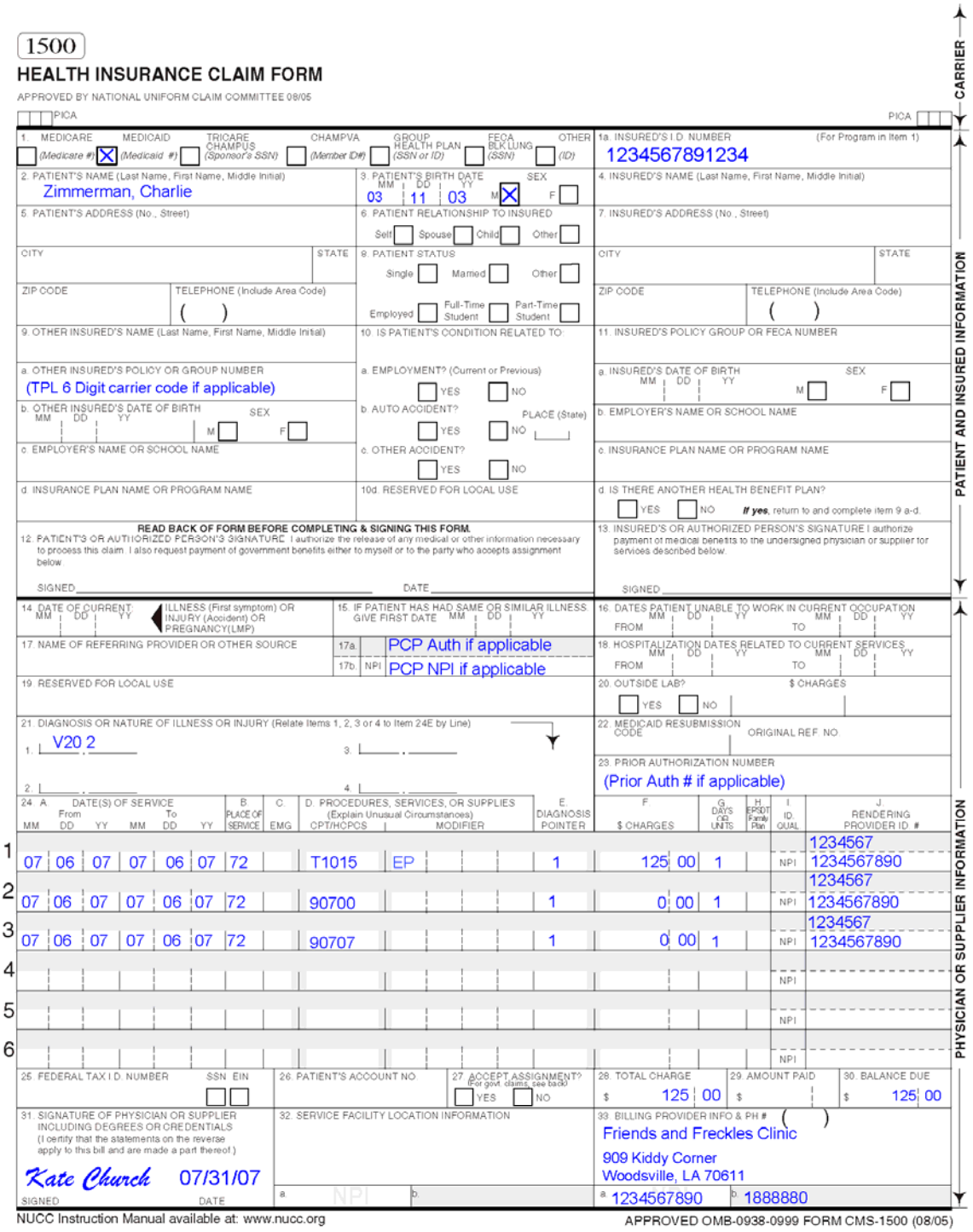
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

Example of Immunizations billed with an RHC/FQHC KIDMED Encounter



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (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): Zimmerman, Charlie

3. PATIENT'S BIRTH DATE: 03 11 03 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

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: (TPL 6 Digit carrier code if applicable)

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth if applicable

17b. NPI PCP NPI if applicable

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V20.2 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: (Prior Auth # if applicable)

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	07 06 07	07 06 07	72		T1015	EP	1	125 00	1		NPI	1234567 1234567890
2	07 06 07	07 06 07	72		90700		1	0 00	1		NPI	1234567 1234567890
3	07 06 07	07 06 07	72		90707		1	0 00	1		NPI	1234567 1234567890
4											NPI	
5											NPI	
6											NPI	

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 $ 125 00

29. AMOUNT PAID $

30. BALANCE DUE $ 125 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.)

Kate Church 07/31/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Friends and Freckles Clinic

909 Kiddy Corner

Woodsville, LA 70611

a. 1234567890 b. 1888880

NUCC Instruction Manual available at: www.nucc.org

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

UNISYS 213 ADJUSTMENT/VOID FORM

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

FORM COMPLETION

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

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

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

1. A claim is approved and paid on the R.A. dated 11/02/2007, ICN 7306567890123.

2. The claim is adjusted on the R.A. dated 11/16/2007, ICN 7320890123456.

3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (7320890123456) and R.A. date (11/16/2007) must be used.

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

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

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

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

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

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

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION

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

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

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

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

ADJUSTMENT

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

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

FISCAL AGENT COPY

UNISYS - 213
5/97

213 ADJUSTMENT/VOID INSTRUCTIONS

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

2. ***Patient's Name**

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

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

3. ***Patient's Date of Birth**

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

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

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

5. **Patient's Address and Telephone Number**

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

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

6. **Patient's Sex**

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

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

7. **Insured's Name**— Leave this space blank.

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

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

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

11. **Was Condition Related to:**—Leave this space blank.

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

13. **Date of:**—Leave this space blank.

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

15. **Has Patient Ever Had Same or Similar Symptoms**—Leave this space blank.

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

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

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

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

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

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

    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. **A through F**

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

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

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

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

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

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

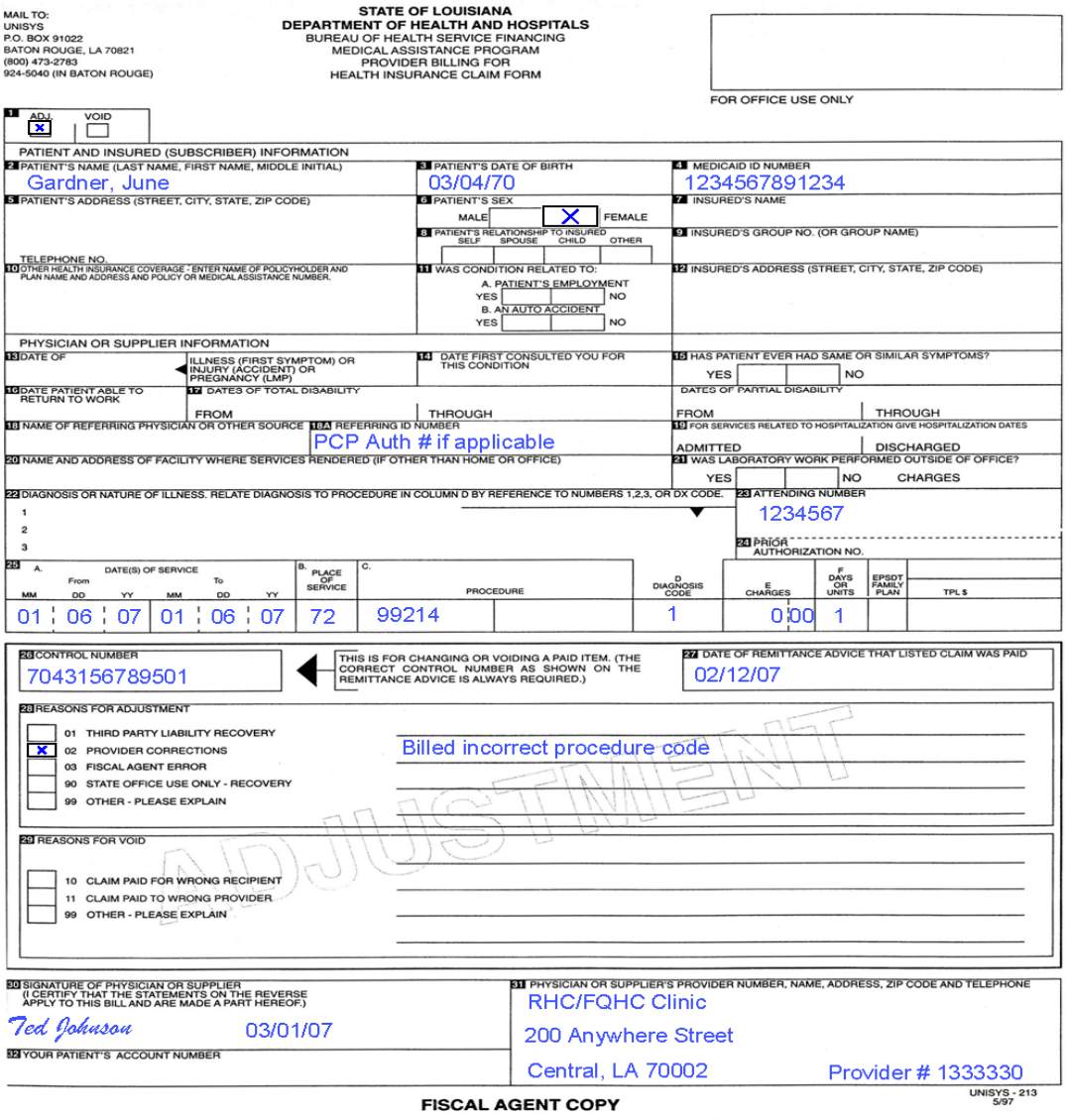
30. ***Signature of Physician or Supplier**—All Adjustment/Void forms must be signed.

31. **<u>*Physician's or Supplier's Name, Address, Zip Code and Telephone Number</u>**—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**—(Optional) Enter the patient's correct provider-assigned account number.

Marked (<u>*</u>) items must be completed or form will be returned.

Example of a completed 213 adjustment form



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

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

FOR OFFICE USE ONLY

1 ADJ [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Gardner, June
3 PATIENT'S DATE OF BIRTH: 03/04/70
4 MEDICAID ID NUMBER: 1234567891234
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [X]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER: PCP Auth # 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
2
3
23 ATTENDING NUMBER: 1234567
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
01	06	07	01	06	07	72	99214	1	0 00	1		

26 CONTROL NUMBER: 7043156789501
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: 02/12/07

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 procedure code

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.)
Ted Johnson 03/01/07
32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
RHC/FQHC Clinic
200 Anywhere Street
Central, LA 70002 Provider # 1333330

FISCAL AGENT COPY

UNISYS - 213
5/97

CROSSOVER PROCEDURES

If a patient has both Medicare and Medicaid coverage, providers should file claims in the appropriate manner with the regional Medicare Fiscal Intermediary/carrier, making sure they have included the recipient's Medicaid number on the Medicare claim form.

Once the Medicare intermediary/carrier has processed the Medicare portion of the core visit, the provider must send a hard copy claim to Unisys for co-insurance and deductible payment. To process hard copy RHC/FQHC Medicare crossover claims, the provider must do the following:

- Make a copy of the claim filed to Medicare
- Put the **Medicaid provider number and recipient Medicaid number** in the appropriate form locators
- Attach the Medicare EOB to the claim

RHC/FQHC Medicare crossover claims that are not submitted in this format will be returned to the provider unprocessed. The provider may submit a copy of the Medicare EOB provided the copy is legible. In addition, all of the EOB data, such as patient name and dates of service must match.

NOTE: This is the only instance where Louisiana Medicaid may be billed on the *UB92/UB04 for RHC/FQHC services. Straight Medicaid claims must be processed on the CMS-1500 claim form.

***Once UB04 is required by Medicaid, UB92's will not be accepted.**

Medicare crossover claims should be sent to the following address for processing:

Unisys
P.O. Box 91023
Baton Rouge, LA 70821

RHC/FQHC KIDMED SCREENING POLICY

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is a Medicaid program that was established by the Federal government in 1967. The purpose of the program is to provide low-income children with comprehensive health care. Louisiana began EPSDT services in 1972. The screening component of EPSDT is called KIDMED and includes medical, vision, and hearing screening services.

KIDMED providers have the responsibility for coordinating medical, vision, and hearing screenings. Medical, vision, and hearing screenings should be performed on the same day to prevent the child from having to return at a later date. The following pages discuss the elements of KIDMED screenings. Additional information, including a description of each component and who may conduct each component, is found in the KIDMED provider manual.

KIDMED Linkage

☞ **Providers cannot obtain KIDMED linkage through traditional forms of eligibility verification, such as REVS, MEVS, or e-MEVS. In order to obtain KIDMED linkage, providers must call Unisys or ACS. When requesting KIDMED linkage, providers must be specific as to whether they are requesting KIDMED or CommunityCARE linkage. In addition, when rendering a screening, the recipient must either be linked to the screening provider, or the screening provider must have a contractual agreement with the provider to whom the recipient is linked.**

Medical Screening

Billing for these screenings should be completed hard copy on the KM-3 Form or electronically with the 837P claim transaction including the K3 segment. Billing may not be submitted for a medical screening unless all of the following components are administered:

COMPONENTS OF THE MEDICAL SCREENING
1. Comprehensive health and developmental history (including assessment of both physical and mental health and development)
2. Comprehensive unclothed physical exam or assessment
3. Appropriate immunizations according to age and health history (unless medically contraindicated or parents or guardians refuse at the time)
4. Laboratory tests (including appropriate neonatal, iron deficiency anemia, urine, and blood lead screening)
5. Health education (including anticipatory guidance)

NOTE: All components, including specimen collection, must be provided on-site during the same medical screening visit.

The following procedure codes are used to bill for the medical screening:

99381*	Initial comprehensive preventive medicine; Infant (age under 1 year)
99382*	Initial comprehensive preventive medicine; Early Childhood (ages 1-4)
99383*	Initial comprehensive preventive medicine; Late Childhood (ages 5-11)
99384*	Initial comprehensive preventive medicine; Adolescent (ages 12-17)
99385*	Initial comprehensive preventive medicine; Adult (ages 18-20)
99391*	Periodic comprehensive preventive medicine; Infant (age under 1 year)
99392*	Periodic comprehensive preventive medicine; Early Childhood (ages 1-4)
99393*	Periodic comprehensive preventive medicine; Late Childhood (ages 5-11)
99394*	Periodic comprehensive preventive medicine; Adolescent (ages 12-17)
99395*	Periodic comprehensive preventive medicine; Adult (ages 18-20)

***Providers should use the TD Modifier in conjunction with the appropriate CPT code to report a screening that was performed by a nurse.**

Note: Providers must use the age appropriate code in order to avoid claim denial.

Vision Screening

The purpose of the vision screening is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malfunctions, eye diseases, strabismus, amblyopia, refractive errors, and color blindness.

Subjective Vision Screening

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of

- any eye disorders of the child or his family
- any systemic diseases of the child or his family which involve the eyes or affect vision
- behavior on the part of the child that may indicate the presence or risk of eye problems
- medical treatment for any eye condition

Objective Vision Screening

KIDMED objective vision screenings (99173-EP) may be performed by trained office staff under the supervision of a LICENSED Medicaid physician, physician assistant, registered nurse, or optometrist. The interpretive conference to discuss findings from the screenings must still be performed by a licensed physician, physician assistant, or registered nurse, as is currently the stated policy in the KIDMED manual.

Objective vision screenings begin at **age 4**. The objective vision screening must include tests of:

- visual acuity (Snellen Test or Allen Cards for preschoolers and equivalent tests such as Titmus, HOTV or Good Light, or Keystone Telebinocular for older children);
- color perception (must be performed at least once after the child reaches the age of 6 using polychromatic plates by Ishihara, Stilling, or Hardy-Rand-Ritter); and
- muscle balance (including convergence, eye alignment, tracking, and a cover-uncover test).

The following procedure code is used to bill for vision screening:

99173 with **EP** modifier	Vision Screening

Hearing Screening

The purpose of the hearing screening is to detect central auditory problems, sensorineural hearing loss, conductive hearing impairments, congenital abnormalities, or a history of conditions which may increase the risk of potential hearing loss.

Subjective Hearing Screening

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of

- the child's response to voices and other auditory stimuli
- delayed speech development
- chronic or current otitis media
- other health problems that place the child at risk for hearing loss or impairment

Objective Hearing Screening

KIDMED objective hearing screenings (92551) may be performed by trained office staff under the supervision of a LICENSED Medicaid audiologist or speech pathologist, physician, physician assistant, or registered nurse. The interpretive conference to discuss findings from the screenings must still be performed by a licensed physician, physician assistant, or registered nurse, as is currently the stated policy in the KIDMED manual.

Objective hearing screenings begin at **age 4**. The objective hearing screening must test at 1000, 2000, and 4000 Hz at 20 decibels for each ear using the puretone audiometer, Welsh Allyn audioscope, or other approved instrument.

The following procedure code is used to bill for hearing screening:

92551	Hearing Screening

NOTE: Age appropriate hearing and vision screening should be performed in conjunction with an RHC/FQHC KIDMED medical screening. These services are not payable separately. If a hearing and/or vision screening is done separately from the KIDMED medical screening, an encounter may not be billed, and the services will not be paid.

Immunizations

Appropriate immunizations (unless medically contraindicated or the parents/guardians refuse) are a federally required medical screening component, and failure to comply with or properly document the immunization requirement constitutes an incomplete screening and is subject to recoupment of the total medical screening fee. KIDMED follows the current Childhood Immunization Schedule recommended by Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP), which is updated yearly. Providers are responsible for obtaining current copies of the schedule.

⇒ **The immunization administration fee is included in the KIDMED encounter reimbursement. Immunizations may not be reimbursed separately. If a recipient is too ill to receive immunizations at the time of a KIDMED medical screening, the reason should be documented in the chart and they should be scheduled to return at a later date for immunization administration. An encounter visit cannot be charged for the return visit, because immunization administration was reimbursed in the original visit payment.**

Laboratory

Age-appropriate laboratory tests are required at selected age intervals. Specimen collection must be performed in-house at the medical screening visit. A child cannot be sent to an outside laboratory to have blood drawn. Documented laboratory procedures provided less than six months prior to the medical screening should not be repeated unless medically necessary. **Iron deficiency anemia screening and urine screening when required are included in the KIDMED medical screening fee and CANNOT be billed separately.**

Providers should not bill Medicaid for lab services not performed in their own office.

Neonatal Screenings

The initial or repeat neonatal screening results for PKU, hypothyroidism, and sickle cell disease must be documented in the medical record for all children less than 6 months of age. Children over 6 months of age do not need to be screened for these conditions unless it is medically indicated.

Billing Information

Only KIDMED medical, vision, and hearing screenings should be billed on the KM-3 hard copy KIDMED claim form. If billing electronically, KIDMED medical, vision, and hearing screenings must be billed on the 837P with the K-3 (KIDMED) segment completed (see pages 61 – 63) for further details).

Immunizations, laboratory tests, interperiodic screenings, and low level office visits in conjunction with a KIDMED screening are billed electronically on the 837P or hard copy on the CMS 1500 claim form.

KIDMED providers billing services hardcopy on the KM-3 claim form may enter TPL information on this form when a recipient has other primary insurance coverage. Please see the KM-3 claim form instructions for the appropriate placement of the required TPL carrier code and payment amount.

NOTE: Providers must obtain a KIDMED manual and training packet as a reference for policy regarding KIDMED services.

SCREENING PERIODICITY POLICY

One important obligation of the KIDMED provider is to provide services according to the periodicity schedule (a copy of which may be found on the following page and in the Appendix of this training packet). **KIDMED providers should follow the most current copy of the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices(ACIP), and American Academy of Family Physicians (AAFP) Recommended Childhood Immunization Schedule. This schedule should be replaced by KIDMED providers each year as revisions are published.**

Initial Screening

Initial screenings must be scheduled within the time limits given below upon notification by the Louisiana KIDMED office:

Newborns - immediately
Children one month to three years of age - within 45 days
Children three to six years of age - within 60 days
Children six to 21 years of age - within 120 days

Periodicity Restrictions

Screenings must be performed on time at the ages shown on the Periodicity Chart. For example, the screening due when the child is six months old must be performed after he or she has reached the age of six months, but before the seven-month birthday. The screening scheduled for three years of age must be performed between the child's third and fourth birthdays. In addition, the periodic screenings performed on children under two must be performed at least 30 days apart. Screenings performed after the child's second birthday must be at least six months apart. Claims submitted for KIDMED periodic screenings performed at an inappropriate time will not be paid.

Off-Schedule Screenings

If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring him or her up to date at the earliest possible time. **However, all screenings on children under two years of age must be at least 30 days apart, and those on children age two through six years of age must be at least six months apart.**

REQUIRED KIDMED MEDICAL, VISION, AND HEARING SCREENING COMPONENTS BY AGE OF RECIPIENT (EFFECTIVE APRIL 1, 1994)[1]

AGE	BIRTH [2]	BY 1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	2 YR	3 YR	4 YR	5 YR	6 YR	8 YR	10 YR	12 YR	14 YR	16 YR	18 YR	20 YR
MEDICAL SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
INITIAL/INTERVAL HISTORY	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS																					
Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X	X	X											
Blood Pressure											X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL ASSESSMENT	S	S	SO	S	S	S	SO	S	S	SO	SO	SO	SO	S	S	S	S	S	S	S	S
UNCLOTHED PHYSICAL EXAM/ASSESSMENT [3]	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PROCEDURES																					
Immunization [4]	X		X	X	X		X	X				---	X	---				X	---		
Neonatal Screening [5]	---	X																			
Anemia Screening [6]						---	X	(X	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Urine Screening [7]							(X	---	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Lead Risk Assessment [8]					X	X	X	X	X	X	X	X	X								
Blood Lead Screening [9]							X			X											
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEALTH EDUCATION [10]	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
VISION SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO
HEARING SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO

X = Required at visit for this age S = Subjective by history O = Objective by Medicaid – approved standard testing method
--- = One test must be administered during this time frame

[1] Baseline lab and developmental screening must be done at the initial medical screening on all children under age six.

[2] The newborn screening examination at birth must occur prior to hospital discharge.

[3] The physical examination/assessment must be unclothed or undraped and include all body systems.

[4] The state health department immunization schedule must be followed per AAP recommendations.

[5] If done less than 48 hours after birth, neonatal screening must be repeated.

[6] Anemia screening is to be done once between 9 and 12 months or earlier if medically indicated, one year to four years, five years to 12 years, and between 13 and 20 years.

[7] Urine testing (dipstick) is to be done once between one and four years, (as soon as toilet trained), five to 12 years, and between 13 and 20 years.

[8] Anticipatory guidance and verbal risk assessment for lead must be done at every medical screening.

[9] Screening beginning at six months corresponds to CDC guidelines. The frequency of screening using the blood lead test depends on the result of the verbal risk assessment.

[10] Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 through 20, must receive more intensive health education which addresses psychological issues, emotional issues, substance usage, and reproductive health issues at each screening visit.

INTERPERIODIC SCREENINGS

Interperiodic screenings may be performed if medically necessary. Any parent, medical provider or qualified health, developmental, or educational professional that comes into contact with the child outside the formal health care system may request the interperiodic screening.

An interperiodic screening can only be billed if the recipient has been given an age-appropriate medical screening. If their medical screening has not been performed, the provider should bill an age-appropriate medical screening. It is not acceptable to bill for an interperiodic screening if the age-appropriate medical screening had not been performed.

An interperiodic screening by a KIDMED provider must include all of the components required in the periodic screening. This includes a complete unclothed exam or assessment, health and history update, measurements, health education, and other age-appropriate procedures.

An Interperiodic screening may be performed and billed for a required Headstart physical or school sports physical but must include all of the components required in the periodic screening.

Providers should document in the recipient's records who requested the interperiodic screening, why it was requested, and the outcome of the screening. The concern, symptoms or condition that led to the request must be documented, as well as any diagnosis and/or referral resulting from the screening. Documentation must indicate that all components of the screening were completed.

There is no limit on the number or frequency of medically necessary interperiodic screenings, or on their proximity to other screenings. Therefore, documenting who requested the interperiodic screening, why it was requested, and the outcome of the screening is essential.

Medically necessary laboratory, radiology, or other procedures may also be performed and should be billed separately. **A well diagnosis is not required.**

These codes are billed hard copy on the CMS-1500 form or electronically using the 837P claim transaction and are listed on the following page. Completed hard copy examples are on pages 38 and 39.

Registered Nurse interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TD plus TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TD plus TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TD plus TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TD plus TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TD plus TS	Interperiodic Re-evaluation and Management (ages 18-21)

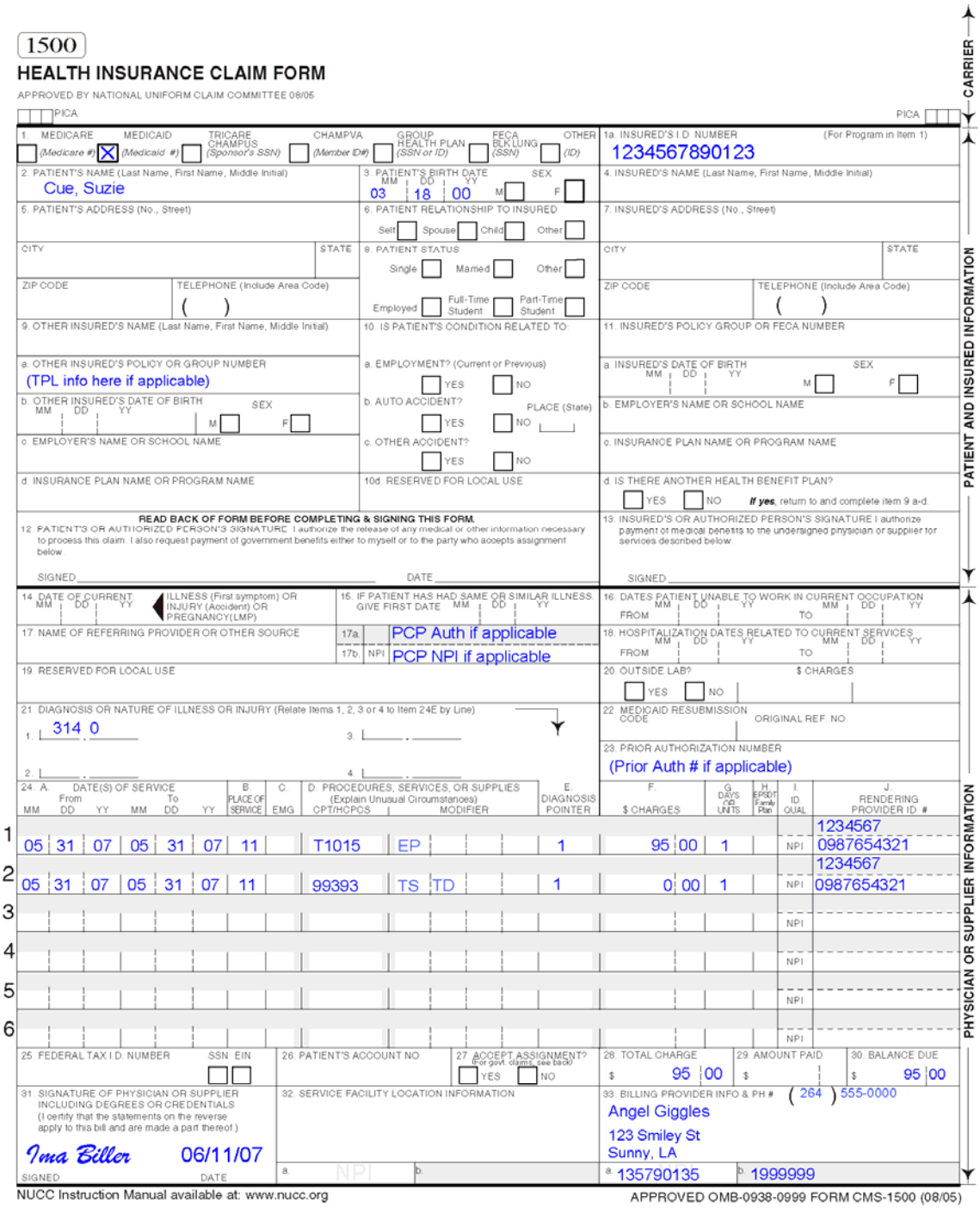
TD: To be used to report services provided by RN
TS: To be used to report interperiodic screenings

Physician interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TS	Interperiodic Re-evaluation and Management (ages 18-21)

TS = Interperiodic screening

Example of an Interperiodic Screening Performed by a Nurse on a 7 year old child



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) ☒ MEDICAID (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): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cue, Suzie

3. PATIENT'S BIRTH DATE MM DD YY: 03 18 00 SEX M ☐ F ☐

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: (TPL info here 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.

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 Auth if applicable

17b. NPI PCP NPI if applicable

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

1. 314.0 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: (Prior Auth # if applicable)

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 05 31 07	05 31 07	11		T1015	EP	1	95 00	1		NPI	1234567 0987654321
2 05 31 07	05 31 07	11		99393	TS TD	1	0 00	1		NPI	1234567 0987654321
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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 $ 95 00

29. AMOUNT PAID $

30. BALANCE DUE $ 95 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.)

Ima Biller 06/11/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (264) 555-0000

Angel Giggles

123 Smiley St

Sunny, LA

a. 135790135 b. 1999999

CARRIER

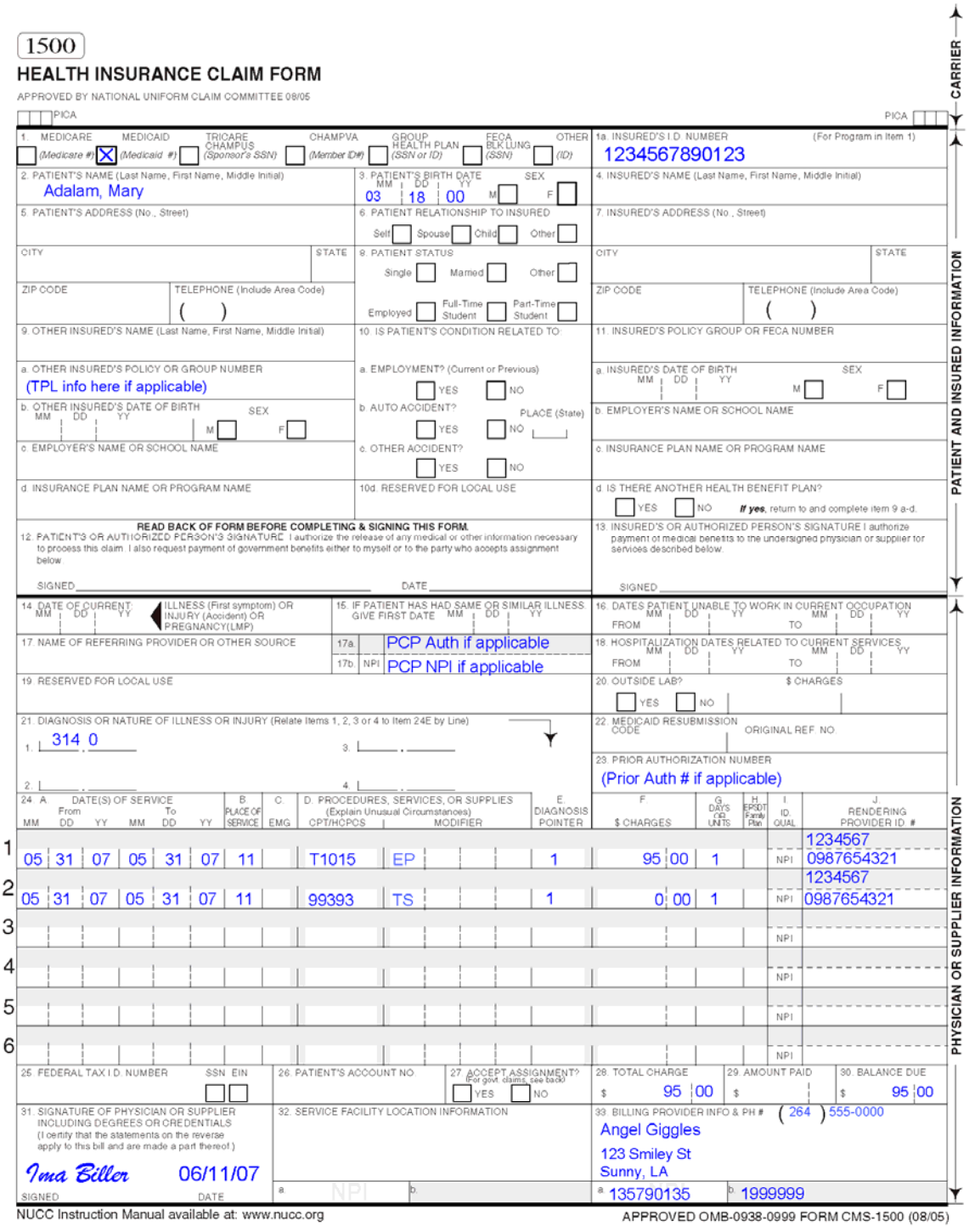
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

Example of an Interperiodic Screening performed by a Physician on a 7 year old Child



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (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): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Adalam, Mary

3. PATIENT'S BIRTH DATE MM DD YY: 03 18 00 SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY STATE

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 info here 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.

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 Auth if applicable

17b. NPI PCP NPI if applicable

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 314 0 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: (Prior Auth # if applicable)

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	05 31 07	05 31 07	11		T1015	EP	1	95 00	1		NPI 1234567 0987654321
2	05 31 07	05 31 07	11		99393	TS	1	0 00	1		NPI 1234567 0987654321
3											NPI
4											NPI
5											NPI
6											NPI

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 $ 95 00

29. AMOUNT PAID $

30. BALANCE DUE $ 95 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.)

Ima Biller 06/11/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (264) 555-0000

Angel Giggles

123 Smiley St

Sunny, LA

a. 135790135 b. 1999999

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

DIAGNOSIS AND TREATMENT

One of the purposes of KIDMED screening services is to assure that health problems are found, diagnosed, and treated early before they become more serious and treatment more costly. KIDMED providers are responsible for identifying any general suspected conditions and reporting the presence, nature, and status of the suspected conditions. **Any referrals made for these conditions must also be reported and documented.**

Diagnosis

When a medical, vision, or hearing screening indicates the need for further diagnosis or evaluation of a child's health, the child must receive a complete diagnostic evaluation within 60 days of the screening.

An infant or toddler who meets or may meet the medical or biological eligibility criteria for EarlySteps (infant and toddler early intervention services) must be referred to the local System Point of Entry (SPOE) **within two working days of the screening.**

- ☞ EarlySteps is the responsibility of DHH/Office for Citizens with Developmental Disabilities (OCDD). For further information on EarlySteps refer to the Appendix.

Initial Treatment

Medically necessary health care, initial treatment, or other measures needed to correct or ameliorate physical or mental illnesses or conditions discovered in a medical, vision, or hearing screening must be initiated **within 60 days of the screening.**

Providing or Referring Recipients for Services

KIDMED providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the patient for care without delay. Necessary referrals should be made at the time of screening if possible.

KIDMED providers performing diagnostic and/or initial treatment services should do so at the screening appointment when possible. Otherwise, KIDMED providers must ensure that recipients receive the necessary services within 60 days of the screening.

It is the provider's responsibility to discuss referral options with parents or guardians. You must forward necessary medical information to the 'referred-to' provider, and request from that provider a report of the results of the exam or services provided. This information should be maintained in the recipient's record.

You must follow up and verify that the child keeps the appointment and receives the services. This must be documented in the medical record. If the child missed the appointment, <u>you must make at least two good faith efforts to re-schedule and have a process in place to document these efforts</u>.

A sample referral follow up form (providers may develop their own) has been included in the Appendix for provider use.

Providers and recipients may contact ACS to obtain the names of participating Medicaid providers for referrals to any additional medical services:

KIDMED Hotlines:

CommunityCARE/KIDMED Hotline – ACS (800) 259-4444
Specialty Care Resource Line – (877) 455- 9955
TTY Hotline for Hearing Impaired - (877) 544- 9544

Referrals should not be limited to those services covered by Medicaid. For services Medicaid does not cover, KIDMED providers should attempt to locate other providers who furnish the services at little or no cost. Parents or guardians should be made aware of costs associated with services that Medicaid does not cover.

In-House Referral

In-house referral charges are billed on the CMS 1500 claim form or electronically using the 837P claim transaction. Encounter code T1015 is listed on the first claim line along with the provider's encounter rate. The supporting detail lines are billed on the subsequent lines. The charges may be listed as the provider's usual & customary charges or $0.

During a KIDMED screening, a suspected condition may be identified. If this occurs and an in-house referral for treatment is made, encounter code T1015 is billed on the CMS-1500 and no office visit of a higher level than CPT code 99212 is to be billed as the supporting detail line by the same provider on the same date of service.

REMINDER: Only 1 T1015 procedure code will be paid per Date of Service. When encounter code T1015 is billed on a CMS-1500 claim form, along with supporting detail, on the same date of service that a KIDMED screening is billed on the KM3, one encounter rate will pay and the other will deny with error code 715 (Found Duplicate Visit Same Day).

WIC REFERRALS

WIC referrals and forms completion are a part of the KIDMED program. This is a federal requirement. Recipients should never be billed for these services.

If the WIC referral is not completed at the time of an encounter and the recipient returns solely for the completion of the form, the RHC or FQHC can not bill separately for this service as no medical service has been rendered.

VACCINES FOR CHILDREN (VFC) & LOUISIANA IMMUNIZATION NETWORK FOR KIDS STATEWIDE (LINKS)

Vaccines For Children (VFC)

VFC is covered under Section 1928 of the Social Security Act. Implemented on October 1, 1994, it was an "unprecedented approach to improving vaccine availability nationwide by providing vaccines free of charge to VFC-eligible children through public and private providers."

The goal of VFC is to ensure that no VFC-eligible child contracts a vaccine preventable disease because of his/her parent's inability to pay for the vaccine or its administration.

Persons eligible for VFC vaccines are between the ages of birth through 18 who meet the following criteria:

- Eligible for Medicaid
- No insurance
- Have health insurance, but it does not offer immunization coverage and they receive their immunizations through a Federally Qualified Health Center
- Native American or Alaska native

Providers can obtain an enrollment packet by contacting the Office of Public Health's (OPH) Immunization Section at (504) 838-5300.

Louisiana Immunization Network For Kids Statewide (LINKS)

LINKS is a computer-based system designed to keep track of immunization records for providers and their patients.

The purpose of LINKS is to consolidate immunization information among health care providers to assure adequate immunization levels and to avoid unnecessary immunizations.

LINKS can be accessed through the OPH website:
https://linksweb.oph.dhh.louisiana.gov

LINKS will assist providers within their medical practice by offering:

- Immediate records for new patients
- Decrease staff time spent retrieving immunization records
- Avoid missed opportunities to administer needed vaccines
- Fewer missed appointments (if the "reminder cards and letter" option is used)

LINKS will assist patients by offering:

- Easy access to records needed for school and child care
- Automatic reminders to help in keeping children's immunizations on schedule
- Reduced cost (and discomfort to child) of unnecessary immunizations

Providers can obtain an enrollment packet, or learn more about LINKS by calling the Louisiana Department of Health and Hospitals, Office of Public Health Immunization Program at (504) 838-5300.

The following chart lists vaccines for immunization services.

Vaccine Codes

* indicates the vaccine is available from the Vaccines For Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

Vaccine Code	Description
90476^	Adenovirus vaccine, type 4, live, for oral use
90477^	Adenovirus vaccine, type 7, live, for oral use
90581^	Anthrax vaccine, for subcutaneous use
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633*	Hepatitis A vaccine pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
90634*	Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646	Hemophilus Influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647*	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648*	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90649*	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
90655*	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656*	Influenza virus vaccine, split virus, preservative free, when administered to 3 years and older, for intramuscular use
90657*	Influenza Virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658*	Influenza Virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use
90660*	Influenza Virus vaccine, live, for intranasal use
90665^	Lyme Disease vaccine, adult dosage, for intramuscular use
90669*	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use
90675^	Rabies vaccine, for intramuscular use
90676^	Rabies vaccine, for intradermal use
90680*	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
90690^	Typhoid vaccine, live, oral
90691^	Typhoid vaccine, Vi capsular polysaccharide (ViCPS), for intramuscular use
90692^	Typhoid vaccine, heat-and phenol-inactivated (H-P) for subcutaneous or intradermal use

Vaccine Codes

* indicates the vaccine is available from the Vaccines For Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

Vaccine Code	Description
90693	Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (US Military)
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated, (DTaP-Hib-IPV), for intramuscular use
90700 *	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to younger than 7 years, for intramuscular use
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702*	Diphtheria and tetanus toxoids (DT) absorbed when administered to younger than 7 years, for intramuscular use
90703	Tetanus toxoid adsorbed, for intramuscular use
90704	Mumps virus vaccine, live, for subcutaneous use
90705	Measles virus vaccine, live, for subcutaneous use
90706	Rubella virus vaccine, live, for subcutaneous use
90707*	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous
90708	Measles and rubella virus vaccine, live, for subcutaneous use
90710*	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
90713*	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714*	Tetanus and diphtheria toxoids, (Td) absorbed, preservative free, when administered to 7 years or older, for intramuscular use
90715*	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to 7 years or older, for intramuscular use
90716*	Varicella virus vaccine, live, for subcutaneous use
90717	Yellow fever vaccine, live, for subcutaneous use
90718*	Tetanus and diphtheria toxoids (Td) adsorbed when administered to7 years or older, for intramuscular use
90719	Diphtheria toxoid, for intramuscular use
90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721*	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use
90723*	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use
90725	Cholera vaccine for injectable use
90727	Plague vaccine, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
90734*	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735	Japanese Encephalitis Virus vaccine, for subcutaneous use
90736	Zoster (shingles) vaccine, live, for subcutaneous injection

Vaccine Codes

* indicates the vaccine is available from the Vaccines For Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

Vaccine Code	Description
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744*	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
90746*	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
90748*	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use

COMMUNITY CARE IMMUNIZATION PAY-FOR-PERFORMANCE (P4P) INITIATIVE

Louisiana Medicaid implemented an immunization pay-for-performance initiative which includes supplemental payments to providers. This initiative was implemented to promote up-to-date immunizations of Louisiana Medicaid eligible children and to increase the number of providers utilizing the Louisiana Immunization Network for Kids Statewide (LINKS) immunization registry.

Requirements to participate in this pay-for-performance initiative and receive supplemental payments include:

- the provider must be enrolled in Louisiana Medicaid as a CommunityCARE PCP;

- the provider must be enrolled in and **utilizing** the Vaccines for Children (VFC) Program (*If KIDMED services including immunizations for recipients aged 19-35 months are contracted out, then the subcontractor must to be enrolled in and utilizing VFC)*;

- the provider must be enrolled in and **utilizing** LINKS. Utilizing LINKS is defined as input of recipient immunization data into LINKS in the past 30 days. (*If KIDMED services including immunizations for recipients aged 19-35 months are contracted out, then the subcontractor must to be enrolled in and utilizing LINKS);*

- Providers must enter the social security number of Medicaid eligible children linked to them for CommunityCARE into the LINKS record to ensure the child is correctly identified and included in the data for payment calculations.

CommunityCARE PCPs interested in participating in the immunization pay-for-performance initiative and receiving the supplemental payments will be required to register on a secure web page at www.lamedicaid.com.

Information required to complete this registration includes:

- CommunityCARE PCP Medicaid Billing Provider ID Number
- National Provider Identifier (NPI)
- VFC PIN Number
- LINKS Provider ID (IRMS Number)
- LINKS Facility Name

❖ All of the above information will also be required for any subcontractor of KIDMED services that provide immunizations (including the subcontractors Medicaid Billing Provider ID number). The PCP will be responsible for obtaining this information from the subcontractor and completing the information required on the secure web page mentioned earlier. This information is to be completed at the time the PCP registers to participate in the pay-for-performance supplemental payments.

- Note: The enrollment and utilization status of VFC and LINKS will be validated monthly with the Office of Public Health Immunization Program for all CommunityCARE PCPs registered to participate in the immunization pay-for-performance initiative.

Supplemental payments will be dependent on:

- the CommunityCARE PCP (or subcontractor of KIDMED services) being enrolled in and utilizing VFC and LINKS;

- the percentage of 24 month old Medicaid enrolled children linked to the PCP practice that are up-to-date with all childhood immunizations in the 4:3:1:3:3:1* vaccine series and these immunizations must be entered into LINKS; and

- the number of CommunityCARE linkages to the PCP for recipients under 21 years of age.

Payment calculations will be done on a monthly basis and payments of these monthly calculations will be made on a quarterly basis to the registered CommunityCARE PCPs. **Only** data that is in the LINKS immunization registry at the time of the monthly calculation for payments will be used.

The supplemental payment tiers or levels for payment are as follows:

- $0.25 per Medicaid recipient under the age of 21 linked to the CommunityCARE PCP **if** the PCP or subcontractor of KIDMED services is enrolled in and utilizing VFC and LINKS **AND** < 75% † of the recipients aged 24 months old with CommunityCARE linkages to the PCP are up-to-date with the vaccine series 4:3:1:3:3:1* **or**;

- $0.50 per Medicaid recipient under the age of 21 linked to the CommunityCARE PCP **if** the PCP or subcontractor of KIDMED services is enrolled in and utilizing VFC and LINKS **AND** 75%† to 89%† of the recipients aged 24 months old with CommunityCARE linkages to the PCP are-up to-date with vaccine series 4:3:1:3:3:1∗, **or**:

- $1.00 per Medicaid recipient under the age of 21 linked to the CommunityCARE PCP **if** the PCP or subcontractor of KIDMED services is enrolled in and utilizing VFC and LINKS **AND** 90% † or more of the recipients aged 24 months old with CommunityCARE linkages to the PCP are up-to-date with vaccine series 4:3:1:3:3:1∗

NOTE: Providers participating in this initiative will only qualify for a single level of payment (e.g. Providers with an immunization rate of 82% will only qualify for the second level or tier payment - not both the first and second tier).

For more information regarding the VFC Program or LINKS, contact the Office of Public Health Immunization Program at (504)838-5300.

For more information on the Immunization Pay-for-Performance Initiative, contact Unisys Provider Relations at (800)473-2783.

* ≥ 4 doses of DTaP; ≥ 3 doses of poliovirus vaccine; ≥ 1 dose of MMR vaccine; ≥ 3 doses of *Haemophilus infuenzae* type b vaccine; ≥ 3 doses of hepatitis B vaccine; and ≥ 1 dose of varicella vaccine.

† Percentages of up-to-date 24 month old recipients are determined solely by data from the LINKS immunization registry and the use of CoCASA software.

RHC/FQHC KM-3 CLAIMS FILING INSTRUCTIONS

- Initial and Periodic KIDMED screening services are billed on the revised KM3 form. It is necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on appropriate lines.
- Providers must also indicate encounter code T1015, with modifier EP, on the KM3 form
- If immunizations are given at the time of the screening, then those vaccine codes are listed on the CMS 1500, along with encounter T1015 and modifier EP. All claims billed with encounter T1015 and modifier EP must include all supporting detail procedures. Claims without an encounter code AND detail procedure will deny.
- If, on the same date of service, a recipient is referred in-house for treatment of a problem identified during the screening, encounter code T1015 is billed on the CMS1500 along with the appropriate CPT code indicating the level of care.
- When encounter code T1015 is billed on a CMS 1500, along with supporting detail, on the same date of service that a KIDMED screening is billed on the KM3, one encounter rate will pay and the other will deny with error code 715.
- Only 1 encounter code (T1015) will be paid per day.
- If the encounter code is missing, the detail line item(s) will deny.
- If the encounter code is denied, the detail line item(s) will deny.
- If the encounter code is present and passes all edits but the detail line item(s) is/are missing, the encounter code will deny.
- If the encounter code is present and passes all edits, it will deny if all detail line items deny.
- If the encounter code and detail line items are present, correct, and pass all edits, the encounter code will pay at the provider's encounter rate and the detail line item(s) will be approved at zero ($0).
- KIDMED screenings performed by a registered nurse should be billed using encounter code T1015 with modifier EP and the appropriate KIDMED medical screening code and the modifier TD to signify a registered nurse.
- Only a physician doing a screening should bill with no modifier.

KM-3 claim forms should be mailed to the following address for processing:

Unisys
P.O. Box 14849
Baton Rouge, LA 70821

NOTE: When a provider bills an encounter code, supporting detail, and modifier on one claim form, the claims processing sub-system keeps all lines together for processing purposes.

Following are instructions for completing the items of the KM-3 claim form:

Item No. **Description and details**

1. **Type of claim** - There are three choices in this box. You may choose only one, entering a checkmark as appropriate.

   - Check "original" if this is the original screening claim for this recipient for the service date indicated in item 25. If you check "original," skip directly to item 4.

   - Check "adjustment" if this claim adjusts a previously paid claim for this recipient for the service date indicated in item 25.

   - Check "void" if you are voiding a claim already submitted for this recipient for the service date indicated in item 25.

   If there is no checkmark in this block, it is considered to be an original claim

2. **Reason** If "adjustment" or "void" is indicated in item 1, providers must complete item 2 by entering the applicable two-digit code:

	Code	Explanation
Adjustments	02	Adjustment due to provider error
	03	Adjustment not due to provider error
Voids	10	Void due to claim paid for wrong recipient
	11	Void due to claim paid to the wrong provider

3. **Adjustment ICN** - Complete this item only if item 2 was completed. Enter the 13-digit Internal Control Number (ICN) as listed on the remittance advice for the original claim being adjusted or voided.

4. **Billing Provider No.** - Enter the provider's seven-digit KIDMED Medicaid Provider ID Number.

5. **Billing Provider Name** - Enter up to 17 letters of the billing provider's name, starting with the last name first and leaving a space between the last and first names. For example, William Sutherland, M.D., would be entered as "Sutherland (space) Willia." If the billing provider is a facility or agency (such as a school board, health unit, or clinic) rather than an individual, enter the name of the facility or agency.

6. **Site Number** - Enter the valid three-digit site code at which the screening was conducted. If the site code has less than three digits, fill the empty spaces to the left with zeros. For example, if the site code is 1, enter "001". **Please communicate these requirements to your VBC (Software Vendor, Billing Agent or Clearing House) for updating billing software in preparation for future Medicaid program requirements.**

7. **Attend Provider No.** – **Complete** this item only when the screening is provided by someone other than the billing provider. Enter the seven-digit Medicaid Provider I.D. Number of the provider who conducted the screening.

8. **Attend Provider Name** – **Complete** this item only if you completed item 7, entering up to 17 letters of the attending provider's name, starting with the last name first and using the same format that you used in item 5 above.

9. **Refer Provider No. –** Complete this item if the recipient is not linked to you but you are screening the recipient under a contractual agreement with the recipient's CommunityCARE PCP. If you have contracted with a CommunityCARE physician to conduct some of his KIDMED screenings, enter that CommunityCARE PCP's 7-digit Medicaid provider ID number here.

10. **Medicaid No.** - Enter the recipient's 13-digit Medicaid number as verified through the REVS, MEVS or e-MEVS eligibility systems. This should also be the 13-digit Medicaid number that appears on the RS-0-07 for that month.

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

11. **Patient Last Name** - Enter the first 17 letters of the recipient's last name, starting at the left of the block, as verified through the REVS, MEVS or e-MEVS eligibility systems. If the name has less than 17 letters, leave the remaining spaces blank.

12. **Patient First Name** - Enter up to 12 letters of the recipient's first name, starting at the left of the block, as verified through the REVS, MEVS or e-MEVS eligibility systems. If the name has less than 12 letters, leave the remaining spaces blank.

13. **Date of Birth** - Enter the six-digit date of birth for the recipient, using the MMDDYY format so that all spaces. The recipient must be under age 21 on the date of the screening. Do not leave any of the spaces blank.

14. **Sex** - Optional. Enter "M" for male or "F" for female.

15. **Race** - Optional. Enter one of the following codes:

Unknown	0
White	1
Black or African American	2
American Indian or Alaskan Native	3
Asian	4
Hispanic or Latino	5
Native Hawaiian or Other Pacific Islander	6
Hispanic or Latino and one or more races	7
More than one race (Hispanic or Latino not indicated)	8
Unknown	9

16. **Medical Record No.** - Optional. This number may be used to cross-reference your patient's medical record number. Enter up to 18 alphabetical and/or numerical characters assigned by your office as the patient's medical record number.

17. **Patient Address** - Optional. Enter the recipient's street address or P.O. box number, starting at the left of the block. Leave any unused spaces blank.

18. **City** - Optional. Enter up to nine letters of the city in which the recipient lives, starting at the left of the block. Leave any unused spaces blank.

19. **State** - Optional. Enter the commonly accepted postal abbreviation for the state ("LA" for Louisiana).

20. **Zip Code** - Optional. Enter the zip code for the recipient's address. If you do not know the full nine-digit zip code, enter the first five digits, and leave the remaining four spaces blank.

21. **Patient Home Phone** - Complete this item if the recipient has a home phone number or a contact phone number. Enter the three-digit area code and seven-digit home or contact phone number.

22. **Patient Work Phone** – Complete this item if the recipient has a work phone number. Enter the three-digit area code and seven-digit work phone number.

23. **Parent/Guardian Last Name** - This item must be completed for all recipients living with a parent or guardian. A foster parent or adoptive parent is considered a guardian. Enter up to 17 letters of the parent or guardian's last name, starting at the left of the block. Leave any unused spaces blank. If the recipient is not living with a parent or guardian, leave this item blank and skip to item 25.

24. **Parent/Guardian First Name** - Complete only if item 23 is completed. Enter up to 12 letters of the parent or guardian's first name, starting at the left of the block. Leave any unused spaces blank.

The next part of the claim form documents the “all inclusive” encounter, as well as the screening services performed which are being submitted on the claim. It also documents the encounter rate and screening fees. In addition, it records information about future screenings scheduled.

> **NOTE: You must bill the RHC/FQHC encounter procedure code T1015 with modifier EP on the appropriate claim line.**

In addition to the encounter code it is necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on appropriate lines.

Providers may bill for four (4) types of screenings:

- **Medical Screening Nurse (99381-99385 and 99391-99395 plus modifier TD)-** This is a medical screening where a registered nurse, nurse practitioner, or certified physician assistant conducted the **complete unclothed physical assessment** and other required age-appropriate medical screening components, including age-appropriate immunizations.

- **Medical Screening Physician (99381-99385 and 99391-99395 with no modifier) -** This is a medical screening where a licensed physician conducted the **complete unclothed physical exam** and other required age appropriate medical screening components, including age appropriate immunizations.

  ☞ Providers must enter one or the other for a single medical screening, but not both. If both a physician and a registered nurse conduct the screening, **the procedure code must be entered in the field by the person performing the physical exam or assessment.**

- **Vision (99173-EP)** - This is an objective vision screening conducted by a licensed physician, physician assistant, registered nurse, licensed optometrist or a trained office staff under the supervision of one of the above listed licensed professionals. (The interpretive conference with the family or recipient concerning the results of the test must be done by the RN, PA, or physician.) **No claim will be paid on a child under age four.**

- **Hearing (92551)** - This is an objective hearing screening conducted by a licensed physician, physician assistant, registered nurse, licensed and ASHA-certified audiologist, licensed and ASHA-certified speech pathologist, or a trained office staff under the supervision of one of the above listed licensed professionals. (The interpretive conference with the family or recipient concerning the results of the test must be done by the RN, PA, or physician.) **No claim will be paid on a child under age four.**

  NOTE - A vision and/or hearing screening will be approved only if there is an age appropriate medical screening listed for the same date of service.

- **Encounter** - RHC/FQHC providers must enter encounter code T1015 with EP modifier in the Encounter field.

- **Total Billed Amount -** Enter the total of all charges listed on the claim.

  NOTE - Providers are to enter the Carrier Code (column 25) and the TPL Amount (columns 27 & 28) if the recipients have private insurance. Please remember to attach the EOB from the private insurance in order for your claim to process.

25. **Date of Screening** - For **each** applicable line, enter the date of each service (Including the encounter and the screening(s)). For proper reimbursement, you must date **each** service line for which you are billing.

26. **Billed Charge** – All detail lines may be billed with $0 or a specific dollar amount. The facility encounter rate must be entered on the “Encounter” line.

27. **Next Screening Appointment Date** - If a future screening appointment has been scheduled, enter the six-digit appointment date for each applicable screening line. If no future appointments have been made at the time you submit the claim, leave this item blank and skip to item 29.

28. **Time** - If a future screening appointment has been scheduled, enter the appointment time.

29. **Immunization Status** - This item is **required** and must be completed for **medical** screenings only. Providers must certify with each claim whether or not the recipient's immunizations are complete and current for his or her age. Check "Yes" if immunizations are complete and current for this age recipient. Check "No" if they are not. If you check "Yes," skip to item 31.

30. **Reason** - If you indicate in item 29 that immunizations are not current and complete, you must check the appropriate box explaining why. Check "A" in the case of medical contraindication. Check "B" if the parents or guardians refuse to permit the immunization. Check "C" if immunizations are off schedule. For example, check "C" if the recipient received an immunization at this visit but is still due one for his or her age. Do not check "C" if immunizations are off schedule and you did not immunize.

31. **Presence or absence of suspected conditions** - This item is **required** and relates to screening findings. If you find no suspected conditions, check "no" and skip to item 36. If you do find one or more suspected conditions, check "yes" and proceed to item 32.

32. **Nature of suspected conditions and referral strategy -** This item documents the general types of suspected conditions identified during the screening and whether or not:

    - the recipient is already receiving care for the identified condition from any provider (**undercare**);
    - a referral was made **in-house** (when a suspected condition is identified during the screening and is diagnosed/treated by the screening provider during the same visit if possible or at a follow-up scheduled appointment to the screening provider for this suspected condition; includes self-referrals); or
    - a referral was made **offsite** (to a provider other than the screening provider).

    Complete this item by checking the appropriate boxes. For example, if a suspected medical condition was found for which the recipient is already under care by any provider, check the far left box on the first line. If a suspected nutritional condition is found and has been referred in-house/self-referred, check the far right column on the fifth line (E). If a suspected psychological/social condition is found and an outside referral is made, check the middle column on the eighth line (H). Be sure to enter information about all suspected conditions found. Do not make any entries on lines J through L.

    ☞ Note that each of these items may require that up to eight different kinds of information are entered in the spaces marked A, B, C, D, E, F, H, and I.

33 – 35. **Referrals for Suspected Conditions** - Providers must complete at least one of these items if any suspected conditions are listed in item 32 as being referred in-house or offsite. The number of items you complete will depend on how many conditions were found in the screening and on the referrals made. If more than four suspected conditions are found, providers must fill out at least items 33 and 34. If more than eight suspected conditions are found, Providers must fill out items 33 through 35. Also, one item must be completed for each referral made. If there are more referrals than blocks

33-35 will accommodate, such referrals should be documented in the recipient's chart and would not be listed on the claim form.

1A. **Suspected Condition** - Referring back to item 32, enter in item 33A up to four letters (A through I), identifying the type of condition(s) identified. Remember, the referral may cover up to four conditions, but only one referral provider. Start at the left of the block, and leave any unused spaces blank. **DO NOT enter an ICD-9 diagnosis code or diagnosis abbreviation (e.g., "URI") here—that information should be entered in 33E.**

1B. **Referral Assist Needed** - Check "no," as this block is no longer used to obtain referral assistance. If assistance is needed from the Louisiana KIDMED office on finding a referral resource, contact the Specialty Care Resource Line (ACS) at (877) 455-9955

1C. **Appointment Date** - If the recipient is referred either in-house or offsite, enter the date of the appointment. The appointment date should be estimated if it is not known at the time the claim form is completed.

1D. **Appointment Time** - If the recipient is referred either in-house or offsite, enter the time of the appointment. The appointment time should be estimated if it is not known at the time the claim form is completed.

1E. **Reason for Referral** - Enter the reason for the referral, using up to 40 letters and/or the ICD-9 diagnostic codes. In addition, if referral assistance is needed because the referred-to provider requires direct contact with the recipient, indicate so here.

1F. **Referred To** - If an in-house or offsite referral is made, enter up to 20 letters of the name of the specific provider to whom the recipient was referred, starting with the last name first. Be as specific as possible. For example, if the recipient was referred to a large facility, give the name and department onsite. If you self-referred, enter "self" for this item. Skip to item 36 if there is no other referral information to report.

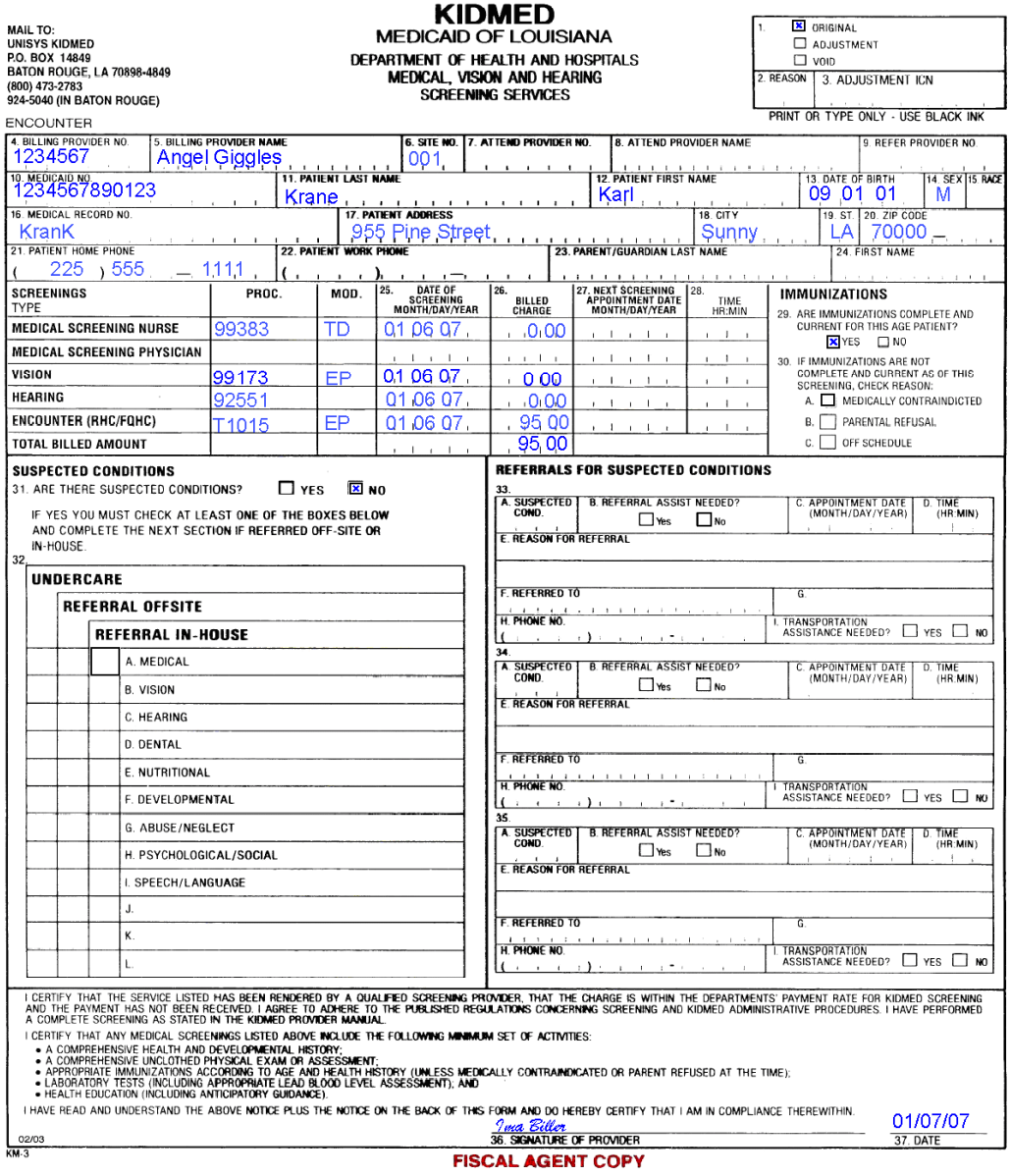
1G. **(Blank)** - Do not enter any data here. This item is reserved for future use by KIDMED.

1H. **Phone No.** - If an in-house or offsite referral has been made, enter the area code and six-digit phone number of the referred-to provider. If a self-referral has been made, leave this item blank.

1I. **Transportation Assistance Needed** - Check "no," as this block is no longer used to obtain transportation assistance. The recipient (or the recipient's parent) should contact the Medical Dispatch Office in this region. These telephone numbers are listed in the Medicaid Services Chart.

36. Providers must read and sign the certification statement at the bottom of the screening claim form in order to be paid. Providers may use a signature stamp if it is initialed by the individual completing the form. A signature certifies that the provider has provided all components of the screening, including appropriate immunizations when the medical screening is billed. The claim form will be returned unprocessed if no signature is present.

Example of a 5 year old child receiving a periodic screening by a nurse as well as vision and hearing screenings.



KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

1. [X] ORIGINAL [ ] ADJUSTMENT [ ] VOID
2. REASON 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Angel Giggles	001			

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567890123	Krane	Karl	09 01 01	M	

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE
KrankK	955 Pine Street	Sunny	LA	70000

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 — 1111	( ) —		

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99383	TD	01 06 07	0.00		
MEDICAL SCREENING PHYSICIAN						
VISION	99173	EP	01 06 07	0.00		
HEARING	92551		01 06 07	0.00		
ENCOUNTER (RHC/FQHC)	T1015	EP	01 06 07	95.00		
TOTAL BILLED AMOUNT				95.00		

IMMUNIZATIONS
29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? [X] YES [ ] NO
30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. [ ] MEDICALLY CONTRAINDICTED
B. [ ] PARENTAL REFUSAL
C. [ ] OFF SCHEDULE

SUSPECTED CONDITIONS
31. ARE THERE SUSPECTED CONDITIONS? [ ] YES [X] NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
		[ ]	A. MEDICAL
		[ ]	B. VISION
		[ ]	C. HEARING
		[ ]	D. DENTAL
		[ ]	E. NUTRITIONAL
		[ ]	F. DEVELOPMENTAL
		[ ]	G. ABUSE/NEGLECT
		[ ]	H. PSYCHOLOGICAL/SOCIAL
		[ ]	I. SPEECH/LANGUAGE
		[ ]	J.
		[ ]	K.
		[ ]	L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [ ] No		

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [ ] No		

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [ ] No		

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:

- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

Ima Biller — 36. SIGNATURE OF PROVIDER
01/07/07 — 37. DATE

02/03
KM-3

FISCAL AGENT COPY

Example of a 2 year old child receiving periodic screening by a physician. Immunizations are not current (indicating reason why). Suspected medical condition and referral information included.

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. [X] ORIGINAL [ ] ADJUSTMENT [ ] VOID
2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Angel Giggles	001			

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567890123	Jacobs	Jane	05 10 05	F	

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE
JacobJ	808 Cypress Blvd	Pine	LA	70661

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 — 1111	( ) —	Jacobs	Camille

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE						
MEDICAL SCREENING PHYSICIAN	99382		05 10 07	0 00		
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)	T1015	EP	05 10 07	88 00		
TOTAL BILLED AMOUNT				88 00		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? [ ] YES [X] NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
- A. [X] MEDICALLY CONTRAINDICTED
- B. [ ] PARENTAL REFUSAL
- C. [ ] OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? [X] YES [ ] NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
		[X]	A. MEDICAL
		[ ]	B. VISION
		[ ]	C. HEARING
		[ ]	D. DENTAL
		[ ]	E. NUTRITIONAL
		[ ]	F. DEVELOPMENTAL
		[ ]	G. ABUSE/NEGLECT
		[ ]	H. PSYCHOLOGICAL/SOCIAL
		[ ]	I. SPEECH/LANGUAGE
		[ ]	J.
		[ ]	K.
		[ ]	L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [X] No	05 11 07	09:45

E. REASON FOR REFERRAL: UTI

F. REFERRED TO: Dr. Mann | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [ ] No		

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [ ] No		

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:
- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

Fray Rider — 36. SIGNATURE OF PROVIDER

07/11/07 — 37. DATE

02/03
KM-3

FISCAL AGENT COPY

ADJUSTMENTS AND VOIDS ON THE KM-3 FORM

The KM-3 form can be used to adjust or void incorrect payments made on medical, vision or hearing screenings. Electronic submitters may electronically submit adjustment/void claims. An example of a correctly completed adjustment is shown on the following page.

ADJUSTING/VOIDING CLAIMS

The appropriate block for **adjustment** or **void** must be checked at the top of the KM-3. One of the following reason codes must be listed in Block 2 of the KM-3:

	Code	**Explanation**
Adjustments	02	Adjustment due to provider error
	03	Adjustment not due to provider error
Voids	10	Void due to claim paid to wrong recipient
	11	Void due to claim paid to wrong provider

The most recently approved control number must be listed in Block 3 of the KM-3 form.

Only **one** (1) control number can be adjusted or voided on each KM-3 form.

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

Block 3 must contain the claim's most recently approved control number. For example:

1. A claim is approved on the remittance advice dated 10/04/2007, ICN 7266156789000.
2. The claim is adjusted on the remittance advice dated 02/07/2008, ICN 8035126742100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number, 8035126742100, must be used.

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

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

KM-3 adjustment/voids should be mailed to the following address for processing:

Unisys
P.O. Box 14849
Baton Rouge, LA 70898

Example of an adjustment

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. ☐ ORIGINAL ☒ ADJUSTMENT ☐ VOID
2. REASON: 02 — 3. ADJUSTMENT ICN: 7135432132160
PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Angel Giggles	001			

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567890123	Jacobs	Jane	05 10 05	F	

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE
JacobJ	808 Cypress Blvd	Pine	LA	70661

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 — 1111	( ) —	Jacobs	Camille

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE						
MEDICAL SCREENING PHYSICIAN	99392		05 10 07	0 00		
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)	T1015	EP	05 10 07	88 00		
TOTAL BILLED AMOUNT				88 00		

IMMUNIZATIONS
29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? ☐ YES ☒ NO
30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. ☒ MEDICALLY CONTRAINDICTED
B. ☐ PARENTAL REFUSAL
C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS
31. ARE THERE SUSPECTED CONDITIONS? ☒ YES ☐ NO
IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.
32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
		☒	A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	☐ Yes ☒ No	05 11 07	09:45

E. REASON FOR REFERRAL: UTI

F. REFERRED TO: Dr. Mann — G.

H. PHONE NO. ( ) - — I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	☐ Yes ☐ No		

E. REASON FOR REFERRAL

F. REFERRED TO — G.

H. PHONE NO. ( ) - — I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	☐ Yes ☐ No		

E. REASON FOR REFERRAL

F. REFERRED TO — G.

H. PHONE NO. ( ) - — I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

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- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

Fran Rider — 36. SIGNATURE OF PROVIDER — 07/11/07 — 37. DATE

02/03
KM-3

FISCAL AGENT COPY

KM-3 FORM TIMELY FILING GUIDELINES

Unisys must receive initial KM-3 claim forms for screening services within 60 days from the date of service. Resubmissions must be received within 1 year and 60 days from the date of service and must be accompanied by proof of timely filing.

Proof Of Timely Filing

Acceptable forms of proof of timely filing are limited to the following:

- A remittance advice or a Claim Status Inquiry (CSI) screen print indicating that the claim was processed within 60 days from the date of service.

The following reports can suffice as proof of timely filing only if **detailed** information is indicated on the report.

- KIDMED report CP-0-115 (Recycled Claims Listing)
- KIDMED report CP-0-50 (Denied Claims List)
- KIDMED report CP-0-50 (Resubmittal Turnaround Document)
- KIDMED report CP-0-51A (Electronic Media Claim Proof List)
- Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the recipient.

KIDMED/PREVENTIVE MEDICINE ELECTRONIC DATA INTERCHANGE (EDI) CLAIMS

HIPAA COMPLIANT TRANSACTIONS

HIPAA mandates that providers billing electronically utilize HIPAA standardized EDI specifications. The electronic HIPAA transaction accepted for billing KIDMED/preventive medicine claims is the 837P Professional format, including the K3 (KIDMED) segment. **Please communicate these requirements to your Vendor, Billing Agent, Clearinghouse (VBC), and let them know that the "file extension" on the electronic file MUST be KID, not PHY.**

DHH Rule Requirements Regarding KIDMED Claims

As stated in the promulgated rule published in the *Louisiana Register, Volume 30, No. 8, August 20, 2004;*

- "All providers of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) preventative screening services shall be required to submit information to the Medicaid Program regarding recipient immunizations, referrals and health status."

The information submitted on the KIDMED/preventative medicine claim, including the information regarding recipient immunization services provided, immunization status, suspected conditions and referral information related to suspected conditions is a federal reporting requirement.

Accurate data submission on KIDMED/preventative medicine claims, whether it is submitted by paper claim on the KM-3 or electronically using the 837P with the K-3 segment is imperative. The services provided during a KIDMED/preventative medical screen should be reflected on the claim. It is a misrepresentation of services provided when immunizations are provided, referrals are made and health status information is obtained, recorded in the patient record and not communicated on the KM-3 or K3 segment. **Misrepresentation of the services provided, specifically, immunizations, referrals for suspected conditions and health status, is considered a direct violation of the promulgated rule. All Medicaid claims are subject to post-payment review.**

KIDMED denial edit 517 (KIDMED Format Required – Claim must be submitted in KIDMED format) will be set if the KIDMED service provided was not billed hard copy on a KM-3 claim form or submitted electronically on the 837P with the K-3 segment and the KID file extension.

KIDMED denial edit 518 (KIDMED information missing – immunization and suspected condition information required) will be set if the required KIDMED claim detail information (including immunization status, suspected conditions, and referral information) is NOT provided on the claim.

KIDMED DETAIL INFORMATION WITHIN THE 837P TRANSACTION

The following information may be helpful in communicating these new requirements to your VBC.

Within the 837P transaction is the K3 claim segment which contains detailed information specifically related to the KIDMED screening services provided. Louisiana Medicaid uses the K3 segment to collect the information related to immunization status, suspected conditions and referral information. This segment mirrors what is currently collected on the KM-3 paper claim. As with previous electronic and paper submissions, providers must certify with each claim whether or not the recipient's immunizations are complete and current for his/her age.

The following information is required for each KIDMED claim and appears in the K3 segment once the claim is submitted to Louisiana Medicaid:

Immunization Status (Required Information)
Values in this segment are answered with Y (Yes) or N (No). If the status is N (No) then the following information is also required:
A - if the immunizations are not complete due to medical contraindication;
B - if the parent(s) or guardian(s) refuse to permit the immunization;
C - if the patient is off schedule, having received an immunization at this visit but is still due one.

Screening Finding (Required Information) - Screening results must be reported as follows:

Field qualifier SC (Suspected Conditions)
Initially, this segment is answered with Y (Yes) or N (No). If the value is Y (Yes), additional information or type of suspected condition is required as follows:

A=Medical	D= Dental	G=Abuse/Neglect
B=Vision	E=Nutritional	H=Psychological/Social
C=Hearing	F=Developmental	I=Speech/Language

After each suspected condition is identified, the referral type is also required:

U (if already under care)
O (if referred offsite)
I (if being treated in-house.)

At least one referral type must be entered. Up to three types of referrals may be entered for each condition if applicable.

NOTE 1: No more than four (4) suspected conditions may be entered. If more than four apply, enter the most significant based on medical judgment.

NOTE 2: Any of the nine (9) types of suspected conditions may be entered.

Referral Information (Suspected Conditions)

If a referral is indicated, referral information must be provided using appropriate values and data including:

Referral Number (R1)
Appointment Date
Referral Reason
Provider name
Referral Phone Number

If additional referrals have been given, give the required information for each additional referral, identifying the second referral with a qualifier R2 and the third referral with R3 if needed.

If the referral was made as a result of the EPSDT screening service, a Y (Yes) indicator is also required in the loop. If no suspected health conditions were identified and no referral resulted from the EPSDT screening service, enter N (No).

The referral outcome should be indicated as follows:

AV Patient refused the referral.
S2 Patient is currently under care for the referred condition
ST Patient was referred to another provider as a result of at least one suspected condition identified during the screening. (If several conditions apply as a result of a screening service, this value should take precedence.)

RHC/FQHC AND KIDMED ERROR CODES

Error Code	Message	Reason for Denial
092	Invalid procedure modifier	When procedure T1015 is billed without the EP modifier on the KM3 claim form
136	No eligible service paid, encounter denied	Several different types of errors can cause this denial: • When encounter code T1015, mod. EP, is billed without an approved corresponding detail line item(s) • When line item detail is billed without the corresponding encounter code T1015 with modifier EP • When immunizations, vision and/or hearing screenings are billed without a physician or nurse screening
210	Provider/Procedure Conflict	Billing a code after May 1, 2003 that has been put in a non payable, non billable status will trigger this denial
517	KIDMED Format Required	The claim was not submitted in the KIDMED format.
518	KIDMED information missing	The immunization and suspected condition information was not indicated on the claim form
715	Duplicate edit	In situations where a medical screening is billed with T1015 EP on the KM3 and immunizations are listed on the CMS 1500 with T1015 EP for the same day of service one of the encounters will pay at the providers established rate and the others will deny

REMINDER: An encounter code of T1015, modifier (if applicable) and supporting detail must be entered on <u>each claim form.</u> If the claims are completed correctly, the first claim that is processed will pay, while the other claim(s) will deny "715" (Duplicate edit). Even though Louisiana Medicaid will pay only one T1015 per day, per recipient, per provider, policy still requires providers to submit claims indicating all services rendered. The information from these denied claims will be used for the collection of data by DHH.

RHC/FQHC EPSDT DENTAL, ADULT DENTURE SERVICES AND EXPANDED DENTAL SERVICES FOR PREGNANT WOMEN (EDSPW)

Dental Encounter Code Usage

The all inclusive dental encounter code (D0999) is required for billing RHC/FQHC dental services. When billing for EPSDT Dental, Adult Dental services or EDSPW, this code must appear on the first line of the 'Record of Services Provided' section of the claim form. The encounter code and other required information (date of service, procedure code, procedure description, and fee) must also be entered on the 1st line of the claim form. In addition to the encounter code (D0999), it is necessary to indicate on subsequent lines of the claim form the specific dental services provided and other required information for each service rendered.

Claims must pass all processing edits for payment to be approved.

- If the encounter code is missing, the detail line item(s) will deny.
- If the encounter code is denied, the detail line item(s) will deny.
- If the encounter code is present and passes all edits but the detail line item(s) is/are missing, the encounter code will deny.
- If the encounter code is present and passes all edits, it will deny if all detail line items deny.
- If the encounter code and detail line items are present, correct, and pass all edits, the encounter code will pay at the provider's encounter rate and the detail line item(s) will be approved at zero ($0).

REMINDER: Dental services should not be separated or performed on different dates of service solely to enhance reimbursement. If no restorative or other treatment services are necessary, all sealants must be performed on a single date of service. If restorative or other treatment services are necessary, sealants may be performed on the same day of service as the restorative or other treatment services. Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there are circumstances that would not allow restorative treatment in this manner, the contraindication (s) must be documented in the patient's dental record. A lead apron and thyroid shield must be used when taking any radiographs reimbursed by the Medicaid program. When taking radiographs, the use of a lead apron and thyroid shield is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene. Should you have any questions regarding this information, you may contact the Dental Medicaid Unit by calling 504-619-8589.

NOTE: Please refer to www.lamedicaid.com for the most updated Dental fee schedule. Please review website on a regular basis to ensure that you are using the most current fee schedule.

Dental Program Policy

Providers must obtain the following information to use as a policy reference for the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program, Expanded Dental Services for Pregnant Women (EDSPW) Program or Adult Denture Program:

- 2003 Dental Services Manual (available online at www.lamedicaid.com);
- 2006 Dental Provider Training Packet (available online at www.lamedicaid.com);
- New information and billing information related to dental which is included on the Medicaid provider website at www.lamedicaid.com;
- Other subsequent dental policy updates contained in the Medicaid Remittance Advice (RA) messages and/or Provider Updates.

EPSDT DENTAL PROGRAM POLICY REVISIONS AND POLICY AND GENERAL PROGRAM REMINDERS

The following pages contain specific policy revisions, policy reminders, and general program reminders made since the printing of the 2003 Dental Services Manual. With exception to the specific revisions identified below, existing EPSDT Dental Program policy still applies. The following information should be utilized when providing these services to EPSDT recipients as it is current policy. This information has been previously published in other provider resources such as the Medicaid Remittance Advice(s) (RA), Provider Update(s), and/or the Medicaid provider website at www.lamedicaid.com. Procedure codes marked with an asterisk (*) in the following policy revisions and in the attached EPSDT Fee Schedule indicate services that require prior authorization. Procedure codes marked with an underscored asterisk (*) in the following policy revisions and in the attached EPSDT Fee Schedule indicate services that require partial prior authorization. Prior authorization requirements for these procedures are based on tooth number or age of recipient. Please take notice that in the future the dental services manual will be revised to reflect this information.

Policy Revisions

For Medicaid purposes, local anesthesia, when applicable, is considered part of any procedure covered by Medicaid.

Diagnostic Services

D0150 Comprehensive Oral Evaluation (New Patient)

Medicaid recognizes this code for a new patient only. A new patient is described as a patient that has not been seen by this provider for at least three years. This procedure code is to be used by a general dentist and/or specialist when evaluating a patient comprehensively for the first time. This would include the examination and recording of the patient's dental and medical history and a general health assessment. The dental visit that includes the Comprehensive Oral Examination should include (but is not limited to) examination of the oral cavity and all of its structures, using a mirror and explorer, and periodontal probe (if required) and necessary diagnostic or vitality tests (considered part of the examination).

After the comprehensive oral examination, subsequent visits should be scheduled by the dentist to correct the dental defects that were identified. If no subsequent visit is required, the bitewing

radiographs, prophylaxis, and fluoride must be provided at the time of the initial comprehensive or periodic oral examination. If subsequent treatment is required, these services must be provided at the first treatment visit if they were not provided at the initial comprehensive or periodic oral examination.

The dental provider should maintain a recall of the patient for future examinations and treatment, (if required).

This procedure should not be billed to Medicaid unless it has been at least three years since the patient was seen by the specified provider or another provider in the same office. An initial comprehensive oral examination (D0150) is limited to once per three years when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider.

D0220 Intraoral – Periapical Radiograph, First Film
D0230 Intraoral – Periapical Radiographs, Each Additional Film

Payment for periapical radiographs (D0220 and D0230) taken in addition to bitewings is limited to a total of five and is payable when their purpose is to obtain information in regard to a specific pathological condition other than caries (ex. periapical pathology or serious doubt regarding the presence of the permanent dentition).

Under the following circumstances periapical radiographs must be taken, or written documentation as to why the radiograph(s) was (were) contraindicated must be in the patient's record:

- An anterior crown or crown buildup is anticipated; or
- Posterior root canal therapy is anticipated (root canal working and final fill films are included in the fees for endodontic treatment); or
- Anterior **initial** or **retreatment** root canal therapy is anticipated (both maxillary and mandibular anterior films) (root canal working and final fill films are included in the fees for endodontic treatment); or
- Prior to any tooth extraction.

These radiographs are reimbursable for and must be associated with a specific unextracted Tooth Number 1 through 32 or Letter A through T. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

D0350 Oral / Facial Photographic Images

This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be a part of the patient's clinical record.

Oral/Facial Photographic Images are required when dental radiographs do not adequately indicate the necessity for the requested treatment in the following situations: Buccal and lingual decalcification prior to crowning; prior to gingivectomy; prior to full mouth debridement; or with the presence of a fistula prior to retreatment of previous root canal therapy, anterior.

The provider should bill Medicaid for oral/facial photographic images ONLY when the photographs are taken under these circumstances. If post payment review discovers the billing of oral/facial images not in conjunction with these specific services, recoupment will be initiated. Oral/facial photographic images must be of good diagnostic quality and must indicate the necessity for the requested treatment.

This procedure is limited to two units per same date of service.

This procedure is reimbursable for oral cavity designators 01, 02, 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA claim form when requesting prior authorization or reimbursement for this procedure.

Preventive Services

D1110 Prophylaxis – Adult

Adult prophylaxis for children 12 through 20 years of age includes removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. Qualified dental personnel must perform any prophylaxis.

This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1110 (Adult Prophylaxis).

D1120 Prophylaxis – Child

Child prophylaxis for children under 12 years of age includes removal of plaque, calculus and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irritational factors. Qualified dental personnel must perform any prophylaxis.

This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

If, at the initial visit, it is determined that the Child Prophylaxis is the appropriate treatment and code D1120 (Child Prophylaxis) is billed to and reimbursed by Medicaid, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1120 (Child Prophylaxis).

D1203 Topical Fluoride Treatment (prophylaxis not included) – Child

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

Topical fluoride treatment should be provided to children less than 12 years of age. This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

D1204 Topical Fluoride Treatment (prophylaxis not included) – Adult

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

Topical fluoride treatment should be provided to children 12 through 15 years of age. This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

D1351 Sealants – per tooth

A sealant is a mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are limited to six- and twelve-year molars only. They are further limited to one application per tooth per lifetime by the same billing provider or another Medicaid provider located in the same office as the billing provider.

Six-year molar sealants will be paid only for those recipients under 10 years of age. Twelve-year molar sealants will be paid only for those recipients under 16 years of age.

If no restorations or other treatment services are necessary, all sealants must be performed on a single date of service. If restorative or other treatment services are necessary, sealants may be performed on the same date of service as the restorative or other treatment services.

This procedure is reimbursable for tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 only. The appropriate tooth number must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

In order for a tooth to be reimbursable for sealant services, it cannot have been previously sealed or restored on any surface and is caries-free on the date of service. Sealants are not reimbursable for teeth that have any previous restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana.

Restorative Services

D2930* Prefabricated Stainless Steel Crown, Primary Tooth

Stainless steel crowns (D2930) may be placed on primary teeth that exhibit any of the following indications, when failure of other available restorative materials is likely to occur prior to the natural shedding of the tooth:

- extensive caries;
- interproximal decay that extends into the dentin;
- significant observable cervical decalcification;
- significant observable developmental defects, such as hypoplasia and hypocalcification following pulpotomy or pulpectomy;
- restoring a primary tooth that is to be used as an abutment for a space maintainer; or,
- fractured tooth.

Additionally, a stainless steel crown may be authorized to restore an abscessed primary 2nd molar, in conjunction with a pulpectomy prior to the eruption of the permanent 1st molar in order to avoid placement of an indicated distal shoe space maintainer.

Stainless steel crowns are not medically indicated and reimbursement will not be paid in the following circumstances:

- primary teeth with abscess or bone resorption; or
- primary teeth where root resorption equals or exceeds 75% of the root; or
- primary teeth with insufficient tooth structure remaining so as to have a poor prognosis of success, i.e. unrestorable; or
- incipient carious lesions.

Endodontic Services

D3310* Root Canal, Anterior (excluding restoration)
D3320* Root Canal, Bicuspid (excluding restoration)
D3330* Root Canal, Molar (excluding restoration)

Complete root canal therapy (procedures D3310, D3320 and D3330) includes treatment plan, all appointments necessary to complete treatment, clinical procedures, all intra-operative radiographs (which must include a post operative radiograph) and follow-up care.

Prior authorization is required. Requests for prior authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographs, as applicable, to judge the general oral health status of the patient. Specific treatment plans for final restoration of the tooth must be submitted. If the radiographs do not indicate the need for a root canal, the provider must include a written statement as to why the root canal is necessary. Approval of any requested root canal will depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and the past history of recipient oral care.

Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider or if the radiographs do not adequately indicate the need for the root canal requested, the request for prior authorization will be returned to the provider requesting additional information.

A lifetime maximum of six root canals is allowed in the entire mouth and will be allowed as follows:

- A lifetime maximum of <u>two posterior root canals</u> (D3320 or D3330) is allowed per recipient with a limit of one (1) posterior root canal per covered tooth. Posterior root canals will be approved only when the tooth is in occlusion and will serve to stabilize the arch. Retreatment of previous root canal therapy is not a covered benefit for posterior teeth.
- A lifetime maximum of <u>four anterior root canals</u> (D3310) is allowed per recipient.

In cases where multiple root canals are requested or when teeth are missing or in need of endodontic therapy in the same arch, a partial denture may be indicated. Third molar root canals are not reimbursable.

The date of service on the payment request must reflect the final treatment date. Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the root canal and must be maintained in the patient treatment record.

D3310* Root Canal, Anterior (excluding restoration)

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D3320* Root Canal, Bicuspid (excluding restoration)

This procedure is reimbursable for Tooth Numbers 4, 5, 12, 13, 20, 21, 28 and 29. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D3330* Root Canal, Molar (excluding restoration)

This procedure is reimbursable for Tooth Numbers 2, 3, 14, 15, 18, 19, 30 and 31. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D3346* Retreatment of Previous Root Canal Therapy, Anterior

Effective September 1, 2004, procedure code D3346, Retreatment of Previous Root Canal Therapy – Anterior, became payable only to a different provider or provider group than originally performed the initial root canal therapy, and is reimbursable in the amount of $212.00 (with prior authorization) for Medicaid eligible recipients under 21 years of age.

The prior authorization request of procedure code D3346 by the same provider or provider group who performed the initial root canal therapy will be denied with a new denial code (452) which will state: "An anterior root canal retreatment is not payable to the same dentist or dental group who performed the initial root canal. Recipients may seek the service from a different dentist (dental group) who will submit for a new prior authorization."

Procedure D3346 may include the removal of post, pin(s), old root canal filling material, and the procedures necessary to prepare the canal and place the canal filling. This includes complete root canal therapy. The reimbursement for this procedure includes all appointments necessary to complete treatment and all intra-operative radiographs. The date of service on the payment request must reflect the final treatment date. Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the retreatment of the root canal and must be maintained in the patient treatment record.

Approval of any requested root canal retreatment will depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and the past history of recipient oral care.

Requests for prior authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographs, as applicable, to judge the general oral health status of the patient. Specific treatment plans for final restoration of the tooth must also be submitted.

If the radiographs do not indicate the need for a root canal, the provider must include a written statement as to why the root canal retreatment is necessary. If a fistula is present, a clear oral/facial image (photograph) is required and will be reimbursable in situations where dental radiographs do not adequately indicate the necessity for the requested retreatment of previous root canal therapy.

Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider or if the radiographs do not adequately indicate the need for the retreatment of a previous root canal, the request for prior authorization will be returned to the provider requesting additional information.

If the Dental Medicaid Unit consultant determines that Medicaid has reimbursed the initial root canal provider for an incomplete root canal, the matter will be referred to the Dental SURS Unit for further review and possible recoupment of the reimbursement for the initial root canal.

A lifetime maximum of four retreatment of root canal, anterior (D3346) are allowed per recipient with a limit of one (1) retreatment per covered tooth.

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

Periodontal Services

D4210* Gingivectomy or Gingivoplasty – Four or More Contiguous Teeth or Bounded Teeth Spaces per Quadrant

This procedure involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, and to restore normal architecture when gingival enlargements or asymmetrical or unesthetic topography is evident with normal bony configuration.

This procedure requires prior authorization. A gingivectomy may be approved by Medicaid only when the tissue growth interferes with mastication as sometimes occurs from Dilantin® therapy. Explanations or reasons for treatment should be entered in the “Remarks” section of the claim form and a photograph of the affected area(s) must be included with the request for authorization.

This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4341* Periodontal Scaling and Root Planing – Four or More Teeth per Quadrant

Radiographic evidence of large amounts of subgingival calculus, deep pocket formation, and bone loss must be submitted. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces as well as the removal of rough, calculus-contaminated cementum and dentin. It is therapeutic—not prophylactic—in nature, usually requiring local anesthesia.

This procedure requires prior authorization. Radiographic evidence of bone loss indicating a true periodontal disease state must be supplied with bitewings and/or posterior/anterior periapicals. This service is not approved for recipients who have not progressed beyond the mixed dentition stage of development.

Only two units of periodontal scaling and root planing may be reimbursed per day. For patients requiring hospitalization for dental treatment, a maximum of four units of procedure code D4341 may be paid on the same date of service if prior authorized. The claim form used to request prior authorization or reimbursement must identify the "Place of Treatment" (Block 38) and "Treatment Location" (Block 56) if the service was performed at a location other than the primary office.

This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4355* Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis

This procedure involves the gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

This service must be performed at the initial visit if this service is indicated.

No other dental services except examination, radiographs or oral/facial photographic images are reimbursable on the same date of service as full mouth debridement. When an exam is performed on the same date of service as a full mouth debridement, the exam must be performed after completion of the full mouth debridement.

Only one full mouth debridement is allowed in a 12 month period. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) or Child Prophylaxis (D1120) to the same billing provider or another Medicaid provider in the same office as the billing provider within a 12 month period.

This procedure requires prior or post authorization. When requesting prior or post authorization, bitewing radiographs that supply evidence of significant posterior supra and/or subgingival calculus in at least two quadrants must be submitted. In the occasional instance where the bitewing radiographs do not supply evidence of significant calculus in at least two quadrants, Oral/Facial Photographic Images that provide evidence of significant plaque and calculus are required.

Prior to requesting authorization for a D4355 (Full Mouth Debridement), providers must ask their new patients when they last received a Medicaid covered prophylaxis (D1110 or D1120) and

record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that it has been over 12 months since a D1110 or D1120 was reimbursed by Medicaid for this recipient. If it is determined that it has been less than 12 months, the recipient must reschedule for a later date which exceeds the 12 month period.

If the prior or post authorization request for D4355 is denied and it has been determined that Medicaid has not reimbursed a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis) within the preceding 12 months for this recipient, the provider may render and bill Medicaid for a D1110 (Adult Prophy) or D1120 (Child Prophylaxis), whichever is applicable based on the patient's age.

Removable Prosthodontic Services

D5211* Maxillary Partial Denture – Resin Base (including any conventional clasps, rests and teeth)
D5212* Mandibular Partial Denture – Resin Base (including any conventional clasps, rests and teeth)
D5213* Maxillary Cast Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)
D5214* Mandibular Cast Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth
D5820* Interim Partial Denture (Maxillary) – Includes any necessary clasps and rests
D5821* Interim Partial Denture (Mandibular – Includes any necessary clasps and rests

Only one prosthesis (excluding interim partial dentures) per recipient per arch is allowed in a five-year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana. Once the recipient becomes 21 years of age, the rules of the Adult Denture Program apply.

To receive consideration for approval for cast partial dentures, providers must submit periapical radiographs of the abutment teeth and bitewings with the treatment plan.

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. The provider should use the following symbols in Block 34 of the ADA claim form to indicate tooth status. "X" will be used to identify missing teeth and "/" will be used to identify teeth to be extracted.

The design of the prosthesis and materials used should be as simple as possible and consistent with basic principles of prosthodontics.

Only permanent teeth are eligible for replacement by an interim partial denture or a partial denture.

Opposing partial dentures are available if each arch independently fulfills the requirements.

Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch, and must serve to increase masticatory function and stability of the entire mouth.

The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries free or have been completely restored and have sound periodontal support. On those recipients requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographs may be requested prior to approval of a partial denture.

Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition stages in the following cases:

- Missing one or two maxillary permanent anterior tooth/teeth, or
- Missing two mandibular permanent anterior teeth, or
- Missing three or more permanent teeth in the same arch (of which at least one must be anterior)

Medicaid may provide a partial denture in cases where the recipient has matured beyond the mixed dentition stage in the following cases:

- Missing three or more maxillary anterior teeth, or
- Missing two or more mandibular anterior teeth, or
- Missing at least 3 adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or
- Missing at least 2 adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one quadrant (third molars not considered for replacement), or
- Missing a combination of two or more anterior and at least one posterior tooth (excluding wisdom teeth and the second molar) in the same arch.

Cast partials (D5213 and D5214) will be considered only for those recipients who are 18 years of age or older. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining teeth will dictate whether a cast or acrylic partial is approved. Radiographs should verify that all pre-prosthetic services have been successfully completed. On those recipients requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographs may be requested prior to approval of a cast partial denture.

D5510 Repair broken complete denture base
D5520 Replace missing or broken tooth – complete denture – per tooth
D5610 Repair resin partial denture base
D5630 Repair or replace broken clasp
D5640 Replace missing or broken tooth – partial denture – per tooth
D5650 Add tooth to existing partial denture – per tooth
D5660 Add clasp to existing partial denture

Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one year has elapsed since denture insertion by the same billing provider or another Medicaid provider located in the same office as the billing provider and the repair makes the denture fully serviceable and eliminates the need for a new denture.

If the same provider/provider group (or another Medicaid-enrolled provider located in the same office as the requesting provider) requests a complete or partial denture excluding interim partial

dentures) within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee. A repair is allowed in conjunction with a reline on the same recipient as long as the repair makes the denture fully serviceable.

A total of $125.00 in base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same recipient is allowed within a single one-year period for a single billing provider.

Procedure Codes D5510 and D5610 are reimbursable for Oral Cavity Designators 01 and 02. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting reimbursement for these procedures.

The request for payment for procedure codes D5510 and D5610 must include the location and description of the fracture in the "Remarks" section of the claim form.

The fee assigned for the first tooth billed using the codes D5520 or D5640 or D5650 will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. However, the fee assigned for the additional teeth will reflect the additional allowance per tooth as indicated in Appendix H.

Procedures D5520, D5640 and D5650 are reimbursable for Tooth Numbers 2 through 15 and 18 through 31. The appropriate tooth number must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

Procedure Codes D5630 and D5660 are reimbursable for Oral Cavity Designators 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting reimbursement for these procedures. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the "Remarks" section of the claim form.

Minimal procedural requirements for repair services include the following:

- The prosthesis should be processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the patient's treatment record.

- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion.

- The prosthesis must be finished in a workmanlike manner; be clean; exhibit a high gloss; and be free of voids, scratches, abrasions, and rough spots.

- The treatment record must specifically identify the location and extent of the breakage.

Failure to provide adequate documentation of services billed as repaired when requested by DHH or its authorized representative will result in recoupment of monies paid by the program for the repair.

Oral and Maxillofacial Surgery Services

D7140 Extraction, Erupted Tooth or Exposed Root (elevation and/or forceps removal)

This procedure includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.

D7210* Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

This procedure includes the cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone, and closure.

This procedure requires prior authorization. All requests for prior authorization of the surgical removal of erupted tooth require the submission of radiographs.

For pre-surgical prior authorization, the radiographic evidence must clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure.

If the radiographic evidence does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, the prior authorization request will be denied. After the tooth is removed, the provider may bill Medicaid for a D7140 or resubmit the prior authorization request for reconsideration (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications and the radiographs.

In the event a planned simple extraction becomes a surgical procedure, the provider may submit a “post” authorization request (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications along with the radiographs which will be used by the dental consultants in the authorization determination.

D7280* Surgical Access of an Unerupted Tooth

This procedure includes an incision, the reflection of tissue, and the removal of bone as necessary to expose the crown of an impacted tooth not intended to be extracted.

This procedure no longer includes the placement of orthodontic attachment. Refer to procedure code D7283 below for information related to the orthodontic attachment.

This procedure requires prior authorization.

Procedure Code D7280 is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. The appropriate tooth number must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D7283* Placement of Device to Facilitate Eruption of Impacted Tooth

This procedure involves the placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.

This procedure is only reimbursable in conjunction with a Medicaid-approved comprehensive orthodontic treatment plan.

This procedure requires prior authorization.

Procedure Code D7283 is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. The appropriate tooth number must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D7286* Biopsy of Oral Tissue – Soft

This procedure is for the surgical removal of an architecturally intact specimen only, and is not used at the same time as codes for apicoectomy/periradicular curettage.

This procedure requires post authorization. A copy of the pathology report should be submitted to the Dental Medicaid Unit when requesting post authorization.

This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for these procedures.

Policy Reminders

Radiographs (X-rays)

In order for the Dental Medicaid Unit to be able to make necessary authorization determination, radiographs and/or oral/facial images must be of good diagnostic quality. Those requests for prior authorization that contain radiographs and oral/facial images that are not of good diagnostic quality will be rejected.

A lead apron and thyroid shield must be used when taking any radiographs reimbursed by the Medicaid program. When taking radiographs, the use of a lead apron and thyroid shield is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.

Refer to the EPSDT Program policy revision section of this manual as well as the 2003 Dental Services Manual for additional policy information related to radiographs.

Restorative and Treatment Services

Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there are circumstances that would not allow restorative

treatment in this manner, the contraindication(s) must be documented in the patient's dental record.

Refer to the EPSDT Program policy revision section of this manual as well as the 2003 Dental Services Manual for additional policy information related to restorative and treatment services.

Crown Services

Crown services require radiographs, photographs, other imaging media or other documentation which depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by the Bureau or its designee upon request.
Refer to the EPSDT Program policy revision section of this manual as well as the 2003 Dental Services Manual for additional policy information related to crowns.

Extraction of Primary Teeth in the Advanced Stages of Natural Exfoliation

Post-payment reviews have shown that a number of providers are billing for the extraction of primary teeth in the advanced stages of natural exfoliation, with little or no therapeutic indication or benefit. Primary teeth that are being lost naturally should not be billed to Medicaid as an extraction. If a practice is noted during post-payment review of billing for the extraction of primary teeth that are shown radiographically to be in the advanced stages of root resorption (more than ¾ of the root resorbed), i.e., exfoliating naturally, there will be a recoupment of money paid for all such therapeutically unnecessary extractions.

If the extraction is warranted due to therapeutically indicated circumstances such as prolonged retention, blocking out of erupting permanent teeth, severe decay, abscess with bone loss, or other specifically identifiable indications, a preoperative periapical radiograph should be taken as a diagnostic aid and as means of documentation. This radiograph must be maintained in the recipient's record, and must be furnished to post-payment review if requested. Written documentation of the reason for the extraction must be noted in the dental treatment record.

Refer to the EPSDT Program policy revision section of this manual as well as the 2003 Dental Services Manual for additional policy information related to extractions.

General Program Reminders

- **Dental services should not be separated or performed on different dates of service solely to enhance reimbursement.**

- The date of service on a dental claim must reflect the actual date that the service was completed/delivered (please refer to page 16-11 of the Medicaid Dental Services Provider Manual). The Dental Surveillance and Utilization Department continues to identify dental providers who have billed and been paid for root canal therapy prior to the completion of the service. Dental claims shall not be filed prior to the completion/delivery of the service. This includes, but is not limited to, root canal therapy, a complete or partial denture and space maintainers. At a minimum, Medicaid will recover the payment for all claims billed when the date of service on the claim does not reflect the date the service was completed.

- A Medicaid dental provider cannot limit his practice to diagnostic and preventive services only. A dental provider who only offers diagnostic and preventive services in his practice does not meet the necessary criteria for participation in the Medicaid EPSDT Dental, Adult Denture or Expanded Dental Services for Pregnant Women (EDSPW) Programs. Medicaid covered dental services requiring treatment by a specialist may be referred to another provider who can address the specific treatment; however, the recipient or guardian, as appropriate, must be advised of the referral. The reimbursement made for the examination, prophylaxis, bitewing radiographs and/or fluoride to providers who routinely refer recipients for restorative, surgical and other treatment services is subject to recoupment.

- Providers must ask their new patients when they last received a Medicaid covered oral examination, prophylaxis, bitewing radiographs and fluoride and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that it has been over one year since the patient received these services. If it is determined that it has been less than one year, the recipient must schedule for a later date.

ADULT DENTURE PROGRAM POLICY AND GENERAL PROGRAM REMINDERS

The following information contains policy and general program reminders. It is intended to be used in conjunction with the 2003 Dental Services Manual, Adult Denture Program section. This information has been previously published in other provider resources such as the Medicaid Remittance Advice(s) (RA), Provider Update(s), and/or the Medicaid provider website at www.lamedicaid.com. Please take notice that in the future the dental services manual will be revised to reflect this information.

Policy Reminders

For Medicaid purposes, local anesthesia, when applicable, is considered part of any procedure covered by Medicaid.

Radiographs (X-Rays)

In order for the Dental Medicaid Unit to be able to make necessary authorization determination, radiographs must be of good diagnostic quality. Prior authorization requests that contain radiographs that are not of good diagnostic quality will be rejected.

A lead apron and thyroid shield must be used when taking any radiographs reimbursed by the Medicaid program. When taking radiographs, the use of a lead apron and thyroid shield is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.

Refer to the 2003 Dental Services Manual for additional policy information related to radiographs for the Adult Denture Program.

General Program Reminders

- **Dental services should not be separated or performed on different dates of service solely to enhance reimbursement.**

- The date of service on a dental claim must reflect the actual date that the service was completed/delivered. Dental claims shall not be filed prior to the completion/delivery of the service. At a minimum, Medicaid will recover the payment for all claims billed when the date of service on the claim does not reflect the date the service was completed.

- A Medicaid dental provider cannot limit his practice to diagnostic and preventive services only. A dental provider who only offers diagnostic and preventive services in his practice does not meet the necessary criteria for participation in the Medicaid EPSDT Dental, Adult Denture or Expanded Dental Services for Pregnant Women (EDSPW) Programs. Medicaid covered dental services requiring treatment by a specialist may be referred to another provider who can address the specific treatment; however, the recipient or guardian, as appropriate, must be advised of the referral. The reimbursement made for the examination, prophylaxis, bitewing radiographs and/or fluoride to providers who routinely refer recipients for restorative, surgical and other treatment services is subject to recoupment.

EXPANDED DENTAL SERVICES FOR PREGNANT WOMEN (EDSPW) PROGRAM POLICY AND POLICY REMINDERS

The following pages contain policy for the EDSPW Program. This information provides all EDSPW Program policy and includes policy revisions made since the implementation of the EDSPW Program. Several policy reminders are also included. This information has been previously published in other provider resources such as the Medicaid Remittance Advice(s) (RA), Provider Update(s), and/or the Medicaid provider website at www.lamedicaid.com. Procedure Codes marked with an asterisk (*) in the following policy revisions and in the attached EDSPW Program Fee Schedule indicate services that require prior authorization. Please take notice that in the future the dental services manual will be revised to reflect this information.

Program Information

Effective November 1, 2003, Medicaid implemented a new adult dental program for pregnant women, which is entitled the "Expanded Dental Services for Pregnant Women Program". This program provides coverage for certain designated dental services for Medicaid eligible pregnant women ages 21 through 59 years in order to address their periodontal needs during pregnancy. The services covered in this program are identified in the fee schedule which is located in Appendix J of this document.

It is the responsibility of the provider to verify recipient eligibility using the Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS) or Electronic Medicaid Eligibility Verification System (e-MEVS) which is available on the web at www.lamedicaid.com. The provider should keep hardcopy proof of eligibility from MEVS/e-MEVS.

Unisys provider relations staff can answer questions regarding claims processing. You may contact Unisys Provider Relations by calling (800) 473-2783 or (225) 924-5040. LSU Dental School, Dental Medicaid Unit can answer questions related to the Medicaid dental programs. You may contact the LSU Dental School, Dental Medicaid Unit by calling (225) 216-6470.

Eligibility Criteria

A Medicaid recipient is eligible for the Expanded Dental Services for Pregnant Women Program if she is 1) pregnant and has the original BHSF Form 9-M (Referral for Pregnancy Related Dental Services) which was completed and signed by the medical professional providing her pregnancy care; 2) Medicaid eligible; and 3) ages 21 through 59 years.

EDSPW Program services are available for recipients whose Medicaid coverage includes the full range of Medicaid benefits. Dental services are not covered for pregnant women certified in the following Medicaid categories:

Medically Needy - Pregnant women, who are certified for Medicaid in the "Medically Needy Program" (MNP), are **not** eligible for dental services. If the recipient is certified for Medicaid in the Medically Needy Program, the REVS/MEVS/e-MEVS message will specifically indicate that she is not eligible for dental services or dentures. If you receive this message and the recipient appears to meet the other program criteria, you should refer the pregnant woman to her local parish Medicaid office for a re-determination of her Medicaid eligibility.

Qualified Medicare Beneficiary Only - Pregnant women, who are certified as "Qualified Medicare Beneficiary Only" (QMB Only), are **not** eligible for dental services. If the recipient is certified for Medicaid as a QMB Only recipient, the REVS/MEVS/e-MEVS message will indicate that she is only eligible for Medicaid payment of deductibles and co-insurance for services covered by Medicare.

Eligibility Period

The recipient must be pregnant on each date of service in order to be eligible for services covered in this program. **Eligibility for the Expanded Dental Services for Pregnant Women Program ends at the conclusion of the pregnancy.**

Referral Requirement – BHSF Form 9-M (Mandatory)

The BHSF Form 9-M is the referral form that is used to verify pregnancy for the Expanded Dental Services for Pregnant Women (EDSPW) Program. This referral form also provides additional important information.

The recipient is required to obtain the original completed BHSF Form 9-M from the medical professional providing her pregnancy care and give it to the dentist prior to receiving dental services. Prior to rendering any services, the dental provider must have the original BHSF Form 9-M with the signature of the medical professional providing the pregnancy care. Facsimile copies are not acceptable. The original form must be kept in the recipient's dental record. A copy of this form must be submitted to the Dental Medicaid Unit when requesting prior authorization for any of the EDSPW Program services that require prior authorization.

The BHSF Form 9-M was revised with an issue date of 12/03. Effective April 1, 2004, the BHSF Form 9-M with the issue date of 12/03 became the only version excepted by Medicaid. A copy of the revised BHSF Form 9-M (Referral for Pregnancy Related Dental Services) with an issue date of 12/03 can be found in Appendix K. Blank forms may be photocopied for distribution as needed. Additional copies of this form may also be obtained from the LA Medicaid website (http://www.lamedicaid.com) or from Unisys Provider Relations by calling (800) 473-2783 or (225) 924-5040.

Prior Authorization

Services that require prior authorization are identified with an asterisk (*) in the EDSPW Program fee schedule located in Appendix J of this document. Medicaid requires the use of the American Dental Association (ADA) Claim Form for all dental prior authorization requests. The 2006 American Dental Association Claim Form is the only hardcopy dental claim form accepted for Medicaid prior authorization of services covered in the Medicaid EDSPW Program regardless of the date of service. Dental prior authorization requests received by LSU Dental School, Dental Medicaid Unit on the older versions of the ADA Claim Form will be returned to the provider.

When requesting prior authorization, two identical copies of the ADA form must be submitted with the appropriate mounted bitewing or periapical radiographs that support the clinical findings and justify the treatment requested.

Radiographs, unless contraindicated, should be attached to each request for authorization. If radiographs are contraindicated, the reason must be stated in the "Remarks" section of the claim forms and documented in the treatment record as well. Prior authorization requests that do not have adequate information or radiographs necessary to make the authorization determination will be returned.

When requesting prior authorization, the provider should list all services that are anticipated, even those not requiring authorization, so that the general dental health and condition of the recipient can be fully understood. Explanations or reasons for treatment, if not obvious from the radiographs, should also be entered in the "Remarks" section of the claim form. If the information required in the remarks section of the claim exceeds the space available, the provider should include a cover sheet which must include the date of the request, the recipient's name, the recipient's Medicaid ID#, the provider's name and the provider's Medicaid ID# and should outline the information required to document the requested service(s).

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the patient record and provide that information to the Dental Medicaid Unit. Additionally, it is the provider's responsibility to utilize the appropriate procedure code in a request for prior authorization.

Please remember to group services requiring authorization on a single claim form so that only one Prior Authorization Number is required to be issued per recipient. However, if a recipient requires services in two separate programs (e.g. Expanded Dental Services for Pregnant Women Program and the Adult Denture Program), a separate prior authorization request should be submitted for **each** program. If two separate requests are being submitted for a single individual, please note this in the "remarks" section of the dental claim form so that the dental consultants can review the entire treatment plan.

A copy of the BHSF Form 9-M **must** accompany each individual prior authorization request when requesting services covered under the Expanded Dental Services for Pregnant Women Program.

To ensure proper handling of the requests for prior authorization for services covered in the EDSPW Program, DHH asks that the BHSF Form 9-M be placed on <u>top</u> of the ADA claim form and other documents (i.e., radiographs) for each prior authorization request that is sent to the LSU Dental School, Dental Medicaid Unit.

All **<u>dental prior authorization requests</u>** should be sent to the following:

LSU Dental
Medicaid Unit
P.O. Box 19085
New Orleans, LA 70179-9085

If you have questions regarding dental prior authorization, you may contact the **LSU Dental Medicaid Unit** by calling **504-941-8206** or toll free **1-866-263-6534**.

Once prior authorization has been approved for a service, a copy of the claim form and the radiographs will be returned to the provider and the other copy will be retained by the Dental Medicaid Unit. A prior authorization letter will be sent to the provider and to the recipient detailing those services that have been prior authorized. The letter will also include a 9-digit

prior authorization number used when the provider submits a claim for payment of those prior authorized services.

Failure to receive the returned claim form and radiographs and/or a Prior Authorization Letter within 25 days from the date of submission should alert the provider that the documents might have been misdirected. In these instances, please contact the dental consultants at the Dental Medicaid Unit. If the claim form is returned, but the radiographs that were included with the claim are not returned, the provider must immediately contact the dental consultants at the Dental Medicaid Unit. Please document the contacts with the dental consultants in the patient's record. In general, EDSPW Program prior authorization decisions are rendered within two weeks from the date of receipt by the Dental Medicaid Unit.

To amend or request reconsideration of a prior authorization, the provider should submit a copy of the Prior Authorization Letter and copies of the original claim form and supporting documentation with a statement of what is requested. The services indicated on a single Prior Authorization Letter should match the services originally requested on a single page of the claim submitted for prior authorization. Requests for additional treatment must be submitted as a new claim for which a new prior authorization will be issued. For administrative changes only, e.g. provider number or recipient number corrections, date of service changes, etc., a copy of the Prior Authorization Letter with the requested changes noted may be sufficient.

- ☞ If the provider proceeds with treatment before receiving prior authorization, the provider should consider that the request may not be authorized for services rendered. However, providers may render and bill for services that do not require prior authorization while they are awaiting prior authorization of those services that do.

- ☞ Prior authorization of a requested service does not constitute approval of the fee indicated by the provider nor is it a guarantee of recipient Medicaid eligibility. When a recipient loses Medicaid eligibility, any authorization (approval) for services becomes void.

Notes: If a service is prior authorized and the pregnancy ends prior to receiving the service, the recipient is no longer eligible for the service.

It is the dental provider's responsibility to obtain a dental prior authorization on behalf of the patient. If a dental provider has not received a dental prior authorization decision (or other correspondence from the Dental Medicaid Unit) within 25 days from the date of submission, it is the provider's responsibility to contact the Dental Medicaid Unit at 225-216-6470. The provider should NEVER instruct the patient to contact Medicaid regarding the prior authorization request.

Refer to page 48 of this document for a prior authorization check list. This information is being provided as a tool to assist providers in avoiding common errors when requesting dental prior authorization.

Program Guidelines

Providers enrolled as a group or individual providers who are not linked to a group but are located in the same office as another provider are responsible for checking office records to assure that Medicaid established guidelines, limitations and/or policies are not exceeded.

Providers are not allowed to provide services to a Medicaid recipient beyond the intent of Medicaid guidelines, limitations and/or policies for the purpose of maximizing payments or circumventing Medicaid guidelines, limitations and/or policies. If this practice is detected, Medicaid will apply sanctions.

A Medicaid dental provider cannot limit his practice to diagnostic and preventive services only. A dental provider who only offers diagnostic and preventive services in his practice does not meet the necessary criteria for participation in the Medicaid EPSDT Dental, Adult Denture or Expanded Dental Services for Pregnant Women (EDSPW) Programs. Medicaid covered dental services requiring treatment by a specialist may be referred to another provider who can address the specific treatment; however, the recipient or guardian, as appropriate, must be advised of the referral. The reimbursement made for the examination, prophylaxis, bitewing radiographs and/or fluoride to providers who routinely refer recipients for restorative, surgical and other treatment services is subject to recoupment.

General Coding Information

A complete list of Medicaid covered services and procedure codes for the Expanded Dental Services for Pregnant Women Program, can be found in the fee schedule in Appendix J of this document. These codes conform to the American Dental Association (ADA) Code on Dental Procedures and Nomenclature. Fees for all procedures include local anesthesia and routine postoperative care. Providers cannot provide a service that has a defined CDT procedure code and bill a different service that has a defined CDT procedure code in order to receive reimbursement by Medicaid.

Tooth Numbering System and Oral Cavity Designators

Please refer to sections 16.2.4 of the 2003 Dental Services Manual for information regarding the tooth numbering system and oral cavity designator. Services requiring specific tooth numbers/letters and/or oral cavity designators are identified in the fee schedule.

Claims Filing

The 2006 American Dental Association Claim Form is the only hardcopy dental claim form accepted for the billing of services covered in the Medicaid EDSPW Program regardless of the date of service. Dental claims for payment received by Unisys on the older versions of the ADA Claim Form will be returned to the provider. Completed **claims for payment** should be mailed to:

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

Please refer to the ADA Claim Form Information and Instructions beginning on page 50 of this document and Chapter 7 (E) of the Dental Services Manual for other information related to claims filing.

Covered Services

The program is designed to address the periodontal needs of the recipients. Covered services are divided into five categories: Diagnostic Services; Preventive Services; Restorative Services; Periodontal Services; and Oral and Maxillofacial Surgery Services. **Services requiring prior authorization are identified by an asterisk (*). Dental services should not be separated or performed on different dates of service solely to enhance reimbursement.** The guidelines and policies related to each service should be reviewed carefully prior to rendering the service.

For Medicaid purposes, local anesthesia, when applicable, is considered part of any procedure covered by Medicaid.

Dental Visit (Initial)

The initial dental visit must include the following diagnostic and preventive services:

1. Comprehensive Periodontal Examination; and

2. Bitewing radiographs (unless contraindicated); and

3. Prophylaxis, including oral hygiene instructions (unless a Full Mouth Debridement [D4355] is required)

These services are limited to one each per pregnancy.

Providers must ask new patients when they last received a Medicaid covered comprehensive periodontal examination, bitewing radiographs, and/or prophylaxis and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that these services have not been rendered during the current pregnancy.

If it is determined that the recipient has already received a comprehensive periodontal examination, bitewing radiographs and/or prophylaxis during the current pregnancy, the recipient is ineligible for these services. If the recipient seeks additional eligible services from a second dental provider, the second dental provider should request a copy of the patient's treatment record and/or radiographs from the previous provider.

Diagnostic Services

Diagnostic services include a comprehensive periodontal examination and radiographs.

D0180	**Comprehensive Periodontal Examination - New or Established Patient**
D0220	**Intraoral – periapical first film**
D0230	**Intraoral – periapical each additional film (maximum of 4)**
D0240*	**Intraoral – occlusal film**
D0272	**Bitewings – two films**
D0330*	**Panoramic Film**

Examination

D0180 Comprehensive Periodontal Examination - New or Established Patient

A comprehensive periodontal examination is limited to one per pregnancy.

This procedure code is indicated for patients showing signs or symptoms of periodontal disease. It includes, but is not limited to, evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history, and general health assessment. It also includes the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, and oral cancer screening.

This visit should also include preparation and/or updating of the patient's records, development of a current treatment plan, and the completion of reporting forms.

After the comprehensive examination, subsequent visits should be scheduled by the dentist to correct the dental defects that were identified.

Radiographs (X-Rays)

D0220	**Intraoral – periapical first film**
D0230	**Intraoral – periapical each additional film (maximum of 4)**
D0240*	**Intraoral – occlusal film**
D0272	**Bitewings – two films**
D0330*	**Panoramic Film**

A lead apron and thyroid shield must be used when taking any radiographs reimbursed by the Medicaid program. When taking radiographs, the use of a lead apron and thyroid shield is a generally accepted standard of care practice and is part of normal, routine, radiographic hygiene.

Radiographs taken must be of **good diagnostic quality** and, when submitted for prior authorization or post payment review, must be properly mounted. Radiographic mounts and panographic-type radiographs must indicate the date taken, the name of the recipient, and the provider. Radiographic copies must also indicate the above as well as be marked to indicate the left and right sides of the recipient's mouth. Radiographs that are not of good diagnostic quality will be rejected.

Scanned radiographic images should be of an adequate resolution to be diagnostically acceptable and must indicate right and left side. Scanned images that are not diagnostic will be returned for new images.

According to the accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis should be taken.

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the dental treatment record and in the remarks section on any claims submitted for authorization:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the oral condition's effect on the periodontal health

Any prior authorization requests, which are not accompanied by the appropriate radiographs, must be accompanied by a copy of the recipient's treatment record as created on the Comprehensive Periodontal Examination appointment. The recipient's name and Medicaid number must be indicated on the copy of the treatment records submitted for review.

If the treatment records do not adequately describe the conditions requiring treatment, the services requiring prior authorization will be denied.

Any periapical radiographs, occlusal radiographs or panoramic radiographs taken routinely at the time of a dental examination appointment for screening purposes are not covered. If a routine practice of taking such radiographs, without adequate diagnostic justification, is discovered during post payment review, all treatment records may be reviewed and recoupment of money paid for all radiographs will be initiated.

D0220 Intraoral – periapical first film
D0230 Intraoral – periapical each additional film

Payment for periapical radiographs taken in addition to bitewings is limited to a total of five and is payable when their purpose is to obtain information in regard to a specific pathological condition other than caries (e.g. periapical pathology or extensive periodontal conditions).

Periapical radiographs, unless contraindicated, must be taken prior to any tooth extraction.

For reimbursement by the Medicaid program, the radiographs must be associated with a specific unextracted Tooth Number 1 through 32 or Tooth A through T. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

D0240* Intraoral – occlusal film

A #2 size film taken in an occlusal orientation will be considered an anterior periapical radiograph for payment. The fee for an occlusal radiograph will be paid only when a true occlusal film (2" x 3") is used to evaluate the maxillary or mandibular arch. The actual occlusal radiograph must be sent with the prior authorization request for an occlusal film.

This radiograph is reimbursable for Oral Cavity designators 01 and 02. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D0272 Bitewings – two films

Bitewing radiographs are required (unless contraindicated) at the comprehensive periodontal examination and are limited to one set per pregnancy. In cases where the provider considers radiographs to be medically contraindicated, a narrative describing the contraindication must be documented in the recipient’s record.

D0330* Panoramic film

Panoramic radiographs are not indicated and will be considered insufficient for diagnosis in periodontics and restorative dentistry and will not be reimbursed. Panoramic radiographs are only reimbursable in conjunction with oral and maxillofacial surgery services. The dental consultants may request the actual panoramic radiograph before a prior authorization request can be completed.

Preventive Services

Adult Prophylaxis

D1110 Adult Prophylaxis

This procedure includes removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. Qualified dental personnel must perform any prophylaxis. This service is limited to one per pregnancy.

If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid, then procedure code D4355 (Full Mouth Debridement) will not be subsequently reimbursed during this pregnancy.

Restorative Services

Restorative services include: amalgam restorations, resin-based composite restorations, stainless steel crowns and resin crowns. Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there are circumstances that would not allow restorative treatment in this manner, the contraindication(s) must be documented in the patient's dental record. All restorative services require prior authorization.

D2140* Amalgam – one surface, primary or permanent
D2150* Amalgam – two surfaces, primary or permanent
D2160* Amalgam – three surfaces, primary or permanent
D2161* Amalgam – four or more surfaces, permanent
D2330* Resin-based composite, one surface, anterior

D2331* **Resin-based composite, two surfaces, anterior**
D2332* **Resin-based composite, three surfaces, anterior**
D2335* **Resin-based composite – four or more surfaces or involving incisal angle (anterior)**
D2390* **Resin-based composite crown, anterior**
D2931* **Prefabricated stainless steel crown – permanent tooth**
D2932* **Prefabricated resin crown, primary or permanent**
D2951* **Pin retention, per tooth, in addition to restoration**

Since this program is designed to address the periodontal needs during pregnancy, the location of the caries to be restored must be in an area that would impact the gingival integrity and affect the periodontal health of the woman. Radiograph(s), unless contraindicated, that support the need for the restoration to maintain the gingival integrity (e.g. significant subgingival decay, etc.) must be taken and submitted with the request for prior authorization. Restoration of dental caries not penetrating the dentin will be denied.

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the dental treatment record and in the remarks section on any claims submitted for authorization:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the oral condition's effect on the periodontal health

Any prior authorization requests, which are not accompanied by the appropriate radiographs, must be accompanied by a copy of the recipient's treatment record as created on the Comprehensive Periodontal Examination appointment. The recipient's name and Medicaid number must be indicated on the copy of the treatment records submitted for review.

If the treatment records do not adequately describe the conditions requiring treatment; the services requiring prior authorization will be denied.

Local anesthesia is considered to be part of restorative services. Tooth and soft tissue preparation, all adhesives (including amalgam bonding agents), liners and bases, are included as part of amalgam restorations. Tooth and soft tissue preparation, all adhesives (including resin bonding agents), liners and bases and curing are included as part of resin-based composite restorations. Pins should be reported separately.

The original billing provider is responsible for the replacement of the original restoration within the first twelve months after initial placement.

Laboratory processed crowns are not covered.

Amalgam Restorations (including polishing)

D2140* **Amalgam – one surface, primary or permanent**
D2150* **Amalgam – two surfaces, primary or permanent**
D2160* **Amalgam – three surfaces, primary or permanent**
D2161* **Amalgam – four or more surfaces, permanent**

Procedure codes D2140, D2150, D2160, and D2161 represent final restorations.

Procedure code D2140 is payable only for Class V type restorations on the buccal or lingual surface in direct contact with the periodontally affected gingival tissue. **Occlusal surfaces and buccal, lingual, and occlusal pits are specifically excluded from reimbursement for code D2140.**

Procedure codes D2150, D2160, and D2161 are payable only for restorations in which at least one of the involved surfaces is in direct contact with the periodontally affected gingival tissue.

In addition to the requirement of gingival contact, amalgam restorations must be placed in a preparation in which the entire preparation extends through the enamel and into dentin, and follows established dental protocol that the preparation and restoration include all grooves and fissures on the billed surface(s). If the restoration is a mesial occlusal or distal occlusal restoration, the preparation must extend down the mesial or distal surface far enough for the restoration to contact the periodontally affected gingival tissue.

Duplicate surfaces are not payable on the same tooth in amalgam restorations in a 12-month period.

If two or more restorations are placed on the same tooth, a maximum amalgam fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.

The fee for any additional restorative service(s) on the same tooth will be cutback to the maximum fee for the combined number of non-duplicated surfaces when performed within a 12-month period.

Procedure codes D2140, D2150 and D2160 are reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through C, H through M, and R through T.

Procedure code D2161 is reimbursable for Tooth Numbers 1 through 32 only. Code D2161 is not payable for primary teeth.

The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

Resin-Based Composite Restorations

D2330* Resin-based composite, one surface, anterior
D2331* Resin-based composite, two surfaces, anterior
D2332* Resin-based composite, three surfaces, anterior
D2335* Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390* Resin-based composite crown, anterior

Posterior composite restorations are not reimbursable under the guidelines of Louisiana Medicaid.

Procedure code D2330 is payable only for Class V type restorations on the buccal or lingual surface in direct contact with the periodontally affected gingival tissue. **Occlusal surfaces and buccal, lingual, and occlusal pits are specifically excluded from reimbursement for code D2330.**

Procedure codes D2331, D2332, D2335, and D2390 are payable only for restorations in which at least one of the involved surfaces is in direct contact with the periodontally affected gingival tissue.

In addition to the requirement of gingival contact, resin-based composite restorations must be placed in a preparation in which the entire preparation extends through the enamel and into dentin, and follows established dental protocol that the preparation and restoration include all grooves and fissures on the billed surface(s).

Procedure codes D2330, D2331, D2332, D2335, and D2390 represent final restorations. If two restorations are placed on the same tooth, a maximum fee for resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum fee for the combined number of surfaces when performed within a 12-month period.

Procedure D2335 is reimbursable only once per day, same tooth, any billing provider.

To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto the claimed surface. A Class V resin-based composite restoration is a one surface restoration.

The resin-based composite – four or more surfaces or involving incisal angle (D2335) is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four surfaces of an anterior tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least 1/3 of the clinical crown of the tooth.

The resin-based composite crown, anterior (D2390) is a single anterior restoration that involves full resin-based composite coverage of a tooth. Providers may request this procedure in cases where two D2332 restorations would not adequately restore the tooth or in cases where two D2335 would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment.

Crown services require radiographs (unless contraindicated) or other documentation which depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by the Bureau or its designee upon request.

Procedure codes D2330, D2331, D2332, D2335, and D2390 are reimbursable for Tooth Numbers 6 through 11, 22 through 27 and Tooth Letters C, H, M and R. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

Non-Laboratory Crowns

D2931* Prefabricated Stainless Steel Crown – permanent tooth
D2932* Prefabricated Resin Crown – primary or permanent tooth

Procedure codes D2931 and D2932 represent final restorations. These restorations must be in direct contact with the periodontally affected gingival tissue. Non-laboratory or chair-side full coverage restorations such as stainless steel and polycarbonate crowns are available but should only be considered when other conventional chair-side types of restorations such as complex amalgams and composite resins are unsuitable.

Crown services require radiographs (unless contraindicated).

Indications such as extensive caries, extensive cervical caries, fractured teeth, replacing a missing cusp, etc. must be radiographically evident and/or documented in the recipient's treatment records if radiographs are medically contraindicated. The documentation that supports the need for crown services must be available for review by the Bureau or its designee upon request.

D2931* Prefabricated Stainless Steel Crown – permanent tooth

This procedure is reimbursable for Tooth Numbers 1 through 32. The appropriate tooth number must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D2932* Prefabricated Resin Crown – primary or permanent tooth

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M and R. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

Other Restorative Services

D2951* Pin retention - per tooth, in addition to restoration

Reimbursement for pins is limited to one per tooth, per lifetime and may only be billed in conjunction with the complex restoration codes D2160 or D2161.

This procedure is reimbursable for Tooth Numbers 2 through 5; 12 through 15; 18 through 21; and 28 through 31. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

Periodontal Services

Periodontal services include periodontal scaling and root planing and full mouth debridement. Local anesthesia is considered to be part of periodontal procedures.

Prior authorization is required for all periodontal services.

D4341* Periodontal scaling and root planing – four or more teeth per quadrant
D4355* Full mouth debridement

Unless contraindicated, radiograph(s) that support the need for the periodontal services must be taken and submitted with the request for prior authorization.

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the dental treatment record and in the remarks section on any claims submitted for authorization:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the oral condition's effect on the periodontal health

Any prior authorization requests, which are not accompanied by the appropriate radiographs, must be accompanied by a copy of the recipient's treatment record as created on the Comprehensive Periodontal Examination appointment. The recipient's name and Medicaid number must be indicated on the copy of the treatment records submitted for review.

If the treatment records do not adequately describe the conditions requiring treatment, the services requiring prior authorization will be denied.

D4341* Periodontal scaling and root planing – <u>four or more teeth per quadrant</u>

Radiographic evidence of large amounts of subgingival calculus, deep pocket formation, and bone loss must be submitted. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces as well as the removal of rough, calculus-contaminated cementum and dentin. It is therapeutic not prophylactic in nature, usually requiring local anesthesia.

This procedure requires prior authorization. Radiographic evidence of bone loss indicating a true periodontal disease state must be supplied with bitewings and/or posterior/anterior periapicals. This service is not approved for recipients who have not progressed beyond the mixed dentition stage of development.

Only two units of periodontal scaling and root planing may be reimbursed per day.

This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4355* Full Mouth Debridement

This procedure involves the gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

<u>This service must be performed at the initial visit if the service is indicated.</u>

No other dental services except an examination and/or radiographs are reimbursable on the same date of service as full mouth debridement. When an exam is performed on the same date of service as a full mouth debridement, the exam must be performed after completion of the full mouth debridement.

Only one Full Mouth Debridement is allowed per pregnancy. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) to the same billing provider or another Medicaid provider in the same office as the billing provider during this pregnancy.

This procedure requires prior or post authorization. When requesting prior or post authorization, bitewing radiographs (unless contraindicated) that supply evidence of significant posterior supra and/or subgingival calculus in at least two quadrants must be submitted. In cases where radiographs are contraindicated or in which the radiographs do not visually satisfy the two quadrant minimum, the provider must include in the request for authorization a copy of the written patient record that provides narrative documentation that describes and supports the necessity for this procedure. Although not reimbursable in the EDSPW Program, intraoral photographs that clearly depict the extent of debris and need for D4355 can be submitted.

Prior to requesting authorization for a D4355 (Full Mouth Debridement), providers must ask their new patients if they have received a Medicaid covered prophylaxis (D1110) during this pregnancy and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that a D1110 has not been reimbursed by Medicaid for this recipient during this pregnancy. If it is determined that a D1110 has been reimbursed by Medicaid for this recipient during this pregnancy, the recipient is not eligible for a D4355.

If the prior or post authorization request for D4355 is denied and it has been determined that Medicaid has not reimbursed a D1110 (Adult Prophylaxis) for the recipient during this pregnancy, the provider may render and bill Medicaid for a D1110 (Adult Prophy).

Oral and Maxillofacial Surgery Services

Note: Dental providers who are qualified to bill for services using the Current Physician's Terminology (CPT) codes, may bill for certain medical oral surgery services using the CPT codes which are covered under the Physician's Program when those services are rendered to Medicaid recipients who are eligible for services provided in the Physician's Program. Refer to the Oral and Maxillofacial Surgery Program section of the 1995 Dental Services Manual for specific details.

The prophylactic removal of an asymptomatic impacted tooth is not covered.

Due to the potential risk of complications involved in the surgical removal of teeth, including the extraction of impacted teeth, minimal standards of care require that these procedures not be attempted without radiographic evaluation.

Requests for prior authorization for surgical extractions, including the extraction of impacted teeth, will not be considered without radiographs. The radiographic findings determine the necessity of surgical extraction and the degree of impaction and correspond to the CDT definitions of impactions. The prior authorization letter will list the tooth numbers and will

correspond to the CDT definitions. Therefore, it is suggested that prior authorization be used to resolve differences in interpretation prior to the day of surgery.

Procedure codes D7240 and D7241 are not reimbursable in this program.

Extractions

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210* Surgical removal of erupted tooth
D7220* Removal of impacted tooth – soft tissue
D7230* Removal of impacted tooth - partial bony

These codes include local anesthesia, suturing (if needed), and routine post-operative care.

Procedure codes D7140, D7210, D7220, and D7230 are reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T. ADA tooth numbering codes for Supernumerary Teeth 51 through 82 or AS through TS should be used when needed. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting reimbursement for this procedure.

Non-surgical Extractions

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

This procedure includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.

Radiograph(s), unless contraindicated, must be taken prior to this procedure (D7140).

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the recipient's treatment record:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the effect of the oral condition on the periodontal health

Surgical Extractions

D7210* Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

This procedure includes the cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone, and closure.

This procedure requires prior authorization. <u>All requests for prior authorization of the surgical removal of erupted tooth require the submission of radiographs.</u>

For pre-surgical prior authorization, the radiographic evidence must clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure.

If the radiographic evidence does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, the prior authorization request will be denied. After the tooth is removed, the provider may bill Medicaid for a D7140 or resubmit the prior authorization request for reconsideration (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications and the radiographs.

In the event a planned simple extraction becomes a surgical procedure, the provider may submit a "post" authorization request (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications along with the radiographs which will be used by the dental consultants in the authorization determination.

D7220* Removal of impacted tooth - soft tissue

The occlusal surface of the tooth is covered by soft tissue and removal of the tooth requires mucoperiosteal flap elevation.

All requests for prior authorization of the removal of impacted tooth - soft tissue (D7220) require the submission of radiographs.

D7230* Removal of impacted tooth – partial bony

Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

All requests for prior authorization of the removal of impacted tooth – partial bony (D7230) require the submission of radiographs.

Non-Covered Services

Non-covered services include but are not limited to the following:

- Procedure codes not included in the fee schedule located in Appendix J of this document
- Routine post-operative services (these services are covered as part of the fee for the initial treatment provided)
- Treatment of incipient or non-carious lesions
- Routine panoramic radiographs, occlusal radiographs, upper and lower anterior, or posterior periapical radiographs (when utilized as part of an initial examination or screening without a specific diagnostic reason why the radiograph(s) is necessary)
- General anesthesia
- Administration of in-office pre-medication

EDSPW Program Reminders

- The date of service on a dental claim must reflect the actual date that the service was completed/delivered. Dental claims shall not be filed prior to the completion/delivery of the service. At a minimum, Medicaid will recover the payment for all claims billed when the date of service on the claim does not reflect the date the service was completed.

- Providers must ask their new patients when they last received a Medicaid covered periodontal examination, prophylaxis, and bitewing radiographs, and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that the specified patient has not received these services during the current pregnancy. If it is determined that these services have been rendered during the current pregnancy, the patient is not eligible for the services.

PRIOR AUTHORIZATION INFORMATION AND REMINDERS

The 2006 American Dental Association Claim Form. The 2006 American Dental Association Claim Forms are the only hardcopy dental claim forms accepted for Medicaid prior authorization (PA) of services provided under the Medicaid EPSDT Dental Program, EDSPW Program or Adult Denture Program regardless of the date of service. Dental prior authorization requests received by LSU Dental School, Dental Medicaid Unit on the older versions of the ADA Claim Form will be returned to the provider.

Reminders

- If a claim is being submitted for prior authorization, you must mark "Request for Predetermination/Preauthorization" in Block 1 of the 2006 ADA Claim Form.
- Radiographs must be submitted with request for prior authorization when required.
- Providers are reminded that **dental prior authorization requests** are to be submitted to the following address:

LSU Dental School
Dental Medicaid Unit
P. O. Box 80159
Baton Rouge, LA 70898-0159

If you have questions regarding dental prior authorization, you may contact the **LSU Dental School, Dental Medicaid Unit** by calling **225-216-6470**.

Check List for Use Prior to Mailing a Medicaid Dental Prior Authorization Request
(Print or copy this page for your convenience)

The information provided below will help you prevent errors frequently made when completing a Medicaid dental prior authorization (PA) request. For complete dental prior authorization guidelines, refer to pages 16-6 through 16-9 of the Dental Services Manual dated May 1, 2003.

- ☐ Are you using the 2006 ADA Claim Form when submitting a request to Medicaid for dental prior authorization? (Only these versions are accepted.)
- ☐ Have you provided two identical copies of each ADA claim form being submitted?
- ☐ Has any information been placed in the upper right-hand corner of the claim (above the box labeled "Primary Subscriber Information")? (This area is for Medicaid use only and must be left blank.)
- ☐ Are you certain that the claim form is properly completed with provider name, group, and individual provider number, current provider address and phone number, recipient name and date of birth, etc.? (Each claim form submitted for dental prior authorization should be fully completed using the ADA Claim Form instructions on page 50 of this document. If a service has not been delivered at the time of the request, leave the date of service blank. If a service has already been delivered, enter the correct date of service on the claim form.
- ☐ Have you grouped together on the first lines of the claim form all services requiring prior authorization? (Procedures that will be rendered and do not require prior authorization should be listed on the ADA claim form after those services requiring prior authorization so that the reviewer understands the full treatment plan.)
- ☐ Have you provided an explanation or reason for treatment in the remarks section of the claim form if the reason is not obvious from the radiographs? (Be certain to include the remarks on the same ADA claim form in which the treatment is being requested.)
- ☐ Have you included bitewing radiographs and any other required radiographs?
- ☐ Are the radiographs mounted so that each individual film is readily viewable and does the doctor's name, patient's name, and the date of the films appear on the mounting? (Radiographs MUST be mounted and MUST contain the identified information.)
- ☐ Are the mounted radiographs on the top of the EPSDT Dental Program the Adult Denture Program claims? (The mounted radiographs MUST be on the top of the claim for prior authorization for these programs.)
- ☐ Is a single copy of the BHSF Form 9-M on top of the request, followed by the mounted radiographs and then the claim for the Expanded Dental Services for Pregnant Women (EDSPW) Program requests? (Placing the Form 9-M as the first page of an EDSPW request will help to identify it as related to an adult pregnant woman.)
- ☐ Have you submitted the panoramic radiograph, if one has been taken, along with the request for post-authorization of the radiograph and included any additional services requiring prior authorization on the same claim form?
- ☐ Have you stapled all pages (and the mounted radiographs) for a single recipient with a SINGLE staple in the upper left-hand corner? (Using a single staple will expedite the request. Paper clips should be not used.)
- ☐ Have you separated the dental prior authorization requests by program type (EPSDT Dental Program, Expanded Dental Services for Pregnant Women (EDSPW) Program, and Adult Denture Program and placed each program type in a separate package/envelope?
- ☐ **Are you mailing to LSU Dental School, Dental Medicaid Unit, P.O. Box 80159, B.R. LA 70898-0159?**

NOTE: It is the dental provider's responsibility to obtain a dental prior authorization on behalf of the patient. If a dental provider has not received a dental prior authorization decision (or other related correspondence from the Dental Medicaid Unit) within 25 days from the date of submission, it is the provider's responsibility to contact the Dental Medicaid Unit at 225-216-6470 to inquire on the status of the prior authorization request. The provider should NEVER instruct the patient to contact Medicaid regarding the dental prior authorization request.

ADA CLAIM FORM INFORMATION/INSTRUCTIONS AND BILLING REMINDERS

Medicaid EPSDT Dental, EDSPW and Adult Denture Program Services

The 2006 American Dental Association Claim Form and the 2006 American Dental Association Claim Form are the only hardcopy dental claim forms accepted for Medicaid reimbursement of services provided under the Medicaid EPSDT Dental Program, EDSPW Program or Adult Denture Program regardless of the date of service. Dental claims received by Unisys on the older versions of the ADA Claim Form will be returned to the provider. These claim forms may be obtained by contacting the American Dental Association or your dental supply company.

Billing Reminders

- **If a claim is being submitted for payment, you must mark "Statement of Actual Services" in Block 1 of the 2006 American Dental Association (ADA) Claim Form.**

- **Claims for payment that are sent to Unisys should never include radiographs. Claims for payment that are submitted with radiograph attachments will cause a delay in payment.**

REMINDER: The all inclusive encounter code (D0999) and other required information regarding this code must be entered on the 1st line of the claim form; tooth number/letter, surface or oral cavity designator is not required for this line. In addition to the encounter information, it is necessary to indicate on subsequent lines of the claim form, the specific dental services provided by entering the individual procedures, including all appropriate line item information for each service rendered.

The following billing instructions correspond to the 2006 ADA Claim Form. Required information must be entered to ensure claims processing. Situational information may be required only in certain situations as detailed in each instruction item. Information on the claim form may be handwritten or computer generated and must be legible and completely contained in the designated area of the claim form. Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.

EPSDT Dental Program, EDSPW Program and Adult Denture Program claims should be submitted to:

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

Locator #	Description	Instructions	Alerts
1	Type of Transaction	**Required** -- Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization. **Situational** – Check box marked "EPSDT Title XIX" if patient is Medicaid eligible and under 21 years of age. If block is not checked, the claim will be processed as an adult claim.	
2	Predetermination / Preauthorization Number	**Situational** – Enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization.	
3	Company / Plan Name, Address, City, State, Zip Code	**Situational** – Enter the primary payer information if applicable.	
4	Other Dental or Medical Coverage?	**Situational** – If yes, complete Block 9.	
5	Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	**Situational.**	
6	Date of Birth (MM/DD/CCYY)	**Situational.**	
7	Gender	**Situational.**	
8	Policyholder/Subscriber ID	**Situational.**	
9	Plan/Group Number	**Situational** – Enter the third party's carrier code if a third party is involved. A list of codes identifying various carriers may be obtained from the Louisiana Medicaid website, www.lamedicaid.com under the link **Forms/Files**. If the provider has chosen to bill the third party and Medicaid, an explanation of benefits must be attached to the claim filed with Medicaid.	
10	Patient's Relationship to Person Named in #5	**Situational.**	

Locator #	Description	Instructions	Alerts
11	Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code	**Situational.**	
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	**Required** -- Enter the recipient's last name, first name, and middle initial exactly as verified through REVS or MEVS. Recipient's address is **optional**.	
13	Date of Birth (MM/DD/CCYY)	**Required** -- Enter the recipient's eight-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.	
14	Gender	**Optional** – Check appropriate block.	
15	Policyholder/Subscriber ID	**Required** -- Enter the thirteen-digit Medicaid ID number as obtained from REVS or MEVS. Do not use the sixteen-digit Card Control Number (CCN) from the recipient's Medicaid card.	
16	Plan / Group Number	**Situational.**	
17	Employer Name	**Situational.**	
18	Relationship to Policyholder/Subscriber in #12 above.	**Situational.**	
19	Student Status	**Situational.**	
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	**Situational.** This field should be used only when other private insurance is primary. **Note:** The Medicaid recipient's name is required to be entered in Block 12.	
21	Date of Birth (MM/DD/CCYY)	**Situational.**	
22	Gender	**Situational.**	

Locator #	Description	Instructions	Alerts
23	Patient ID / Account # (Assigned by Dentist)	**Optional** – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the Remittance Advice. The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20 characters.	
24	Procedure Date (MM/DD/CCYY)	**Required** -- Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero. A service must have been performed/delivered before billing Medicaid for payment.	
25	Area of Oral Cavity	**Situational** – Enter the oral cavity designator when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific **requirements** regarding oral cavity designator. If an oral cavity designator is **required** by Medicaid, do not enter a tooth number or letter in Block 27.	
26	Tooth System	**Leave Blank**	
27	Tooth Number(s) or Letter(s)	**Situational** – Enter a tooth number or letter when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific **requirements** regarding tooth number or letter. If a tooth number or letter is **required** by Medicaid, do not enter an oral cavity designator in Block 25.	
28	Tooth Surface	**Situational –** Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes: B = Buccal; D = Distal; F = Facial; I = Incisal; L = Lingual; M = Mesial; and O = Occlusal.	

Locator #	Description	Instructions	Alerts
28 cont.		Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.	
29	Procedure Code	**Required –** Enter the appropriate dental procedure code from the current version of Code on Dental Procedures and Nomenclature. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.	
30	Description	**Required –** Enter the description of the service performed.	
31	Fee	**Required** -- Enter the dentist's full (usual and customary) fee for the dental procedure reported.	
32	Other Fee(s)	**Leave Blank**	
33	Total Fee	**Required** – Total of all fees listed on the claim form.	
34	(Place an 'X' on each missing tooth)	**Situational** – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/". In the following circumstances, this information is **required**: If the claim is for the Adult Denture Program. If the claim is for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy.	
35	Remarks	**Situational** – Enter the amount paid by the primary payor if block 9 is completed. Write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [$0] payment) in this block. Enter any additional information **required** by Medicaid regarding requested services (including description of the	

Locator #	Description	Instructions	Alerts
35 cont.		patient management techniques used for which a patient management fee is billed; reason for hospitalization requests, or any additional information that the provider needs to include). For prior authorization requests, if the information **required** in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the recipient's name and Medicaid ID # and the provider's name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient's treatment record.	
36	Authorizations	**Optional.**	
37	Authorizations	**Optional.**	
38	Place of Treatment	**Situational** – Check the applicable box if services are to be or were provided at a location other than the address entered in Block 48. If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is **required**.	
39	Number of Enclosures	**Situational** – Enter 00 to 99 in applicable boxes. Claims submitted for prior authorization are **required** to contain the identified attachments. Claims submitted for payment should not contain any of the attachments listed in Block 39.	
40	Is Treatment for Orthodontics?	**Situational** – Complete if applicable. Claims requesting comprehensive orthodontic services are **required** to enter information in this block.	

Locator #	Description	Instructions	Alerts
40 cont.		Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.	
41	Date Appliance Placed	**Situational.**	
42	Months of Treatment Remaining.	**Situational.**	
43	Replacement of Prosthesis	**Situational** – Check appropriate box if applicable; if checked, complete Block 44 if known .	
44	Date Prior Placement	**Situational** – If Block 43 is checked and if known, enter the appropriate eight-digit date in month, day and year (MM/DD/CCYY).	
45	Treatment Resulting from	**Situational** – If the claim is the result of Occupational Illness / Injury, Auto Accident, or Other Accident, then this Block is **required**. Check the appropriate box.	
46	Date of Accident (MM/DD/CCYY).	**Situational**. If Block 45 is completed, then this block is **required**. Enter the eight-digit date in month, day and year (MM/DD/CCYY).	
47	Auto Accident State	**Situational**. If Auto Accident is checked in Block 45, this block is **required**. Enter the state in which the auto accident occurred.	
48	Billing Dentist Name, Address, City, State, Zip Code	**Required**. Enter the name of the individual dentist if the payment is being made to an individual dentist. Enter the group name if the payment is being made to a dental group. Enter the full address, including city, state and zip code, of the dentist or dental group to whom payment is being made.	
49	NPI	**Optional.**	**The 2006 ADA form accommodates entry of the NPI for the billing dental provider. This block was formerly**

Locator #	Description	Instructions	Alerts
49 cont.			**Medicaid Provider ID number, which is now Block 52A. Block 49 will become required when NPI becomes mandatory.**
50	License Number	**Optional.**	
51	SSN or TIN	**Optional.**	
52	Phone Number	**Required** -- Enter the phone number for the billing dental provider.	
52A	Additional Provider ID	**Required** – Enter the 7-digit Medicaid Provider ID of the billing dental provider.	**New block. The Medicaid ID was formerly entered in Block 49.**
53	Signature	**Required** – Enter the signature of treating (attending) dentist. Enter the date the claim was signed. Signature stamps and computer-generated signatures are acceptable if they are initialed. The signature may be initialed by the provider or the provider's assistant.	
54	NPI	**Optional.**	**The 2006 ADA form accommodates entry of the NPI for the treating (attending) dental provider. This block was formerly Medicaid Provider ID number of the treating (attending) provider, which is now Block 58.**

Locator #	Description	Instructions	Alerts
54 cont.			**Block 54 will become required when NPI becomes mandatory.**
55	License Number	**Required** – Enter the license number of the treating (attending) dental provider.	
56	Address, City, State, Zip Code	**Situational** – Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dental provider, if different from Block 48.	
56A	Provider Specialty Code	**Optional.**	**Formerly Block 58, "Treating Provider Specialty."**
57	Phone Number	**Situational** – Enter the phone number for the treating (attending) dental provider, if different from Block 52.	
58	Additional Provider ID	**Required** – Enter the 7-digit Medicaid ID of the treating (attending) dental provider.	**Formerly "Treating Provider Specialty." The Medicaid ID of the treating (attending) dental provider was formerly entered in Block 54.**

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ EPSDT /Title XIX

2. Predetermination/Preauthorization Number
9999999999

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Brown, Wade

13. Date of Birth (MM/DD/CCYY): 6/19/2000
14. Gender: ☒ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#): 1234567890123

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)
7. Gender: ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5: ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status: ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Patient ID/Account Number (Assigned by Dentist)
21. Date of Birth (MM/DD/CCYY)
22. Gender: ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	2/14/2007					D0999	Encounter All Inclusive	95 00
2	2/14/2007	10				D4341	Periodontal Scaling & Root Planing	101 00
3	2/14/2007			13		D2954	Post & Core	94 00
4	2/14/2007			15		D2931	Stainless Steel Crown	135 00
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an "X" on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	425 00

35. Remarks
If TPL involved: write the words "Carrier Paid" and enter the amount paid by TPL here

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99): Radiograph(s) ☐☐ Oral Image(s) ☐☐ Models ☐☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from: ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
XYZ Dental Group
123 Smiley St.
Anywhere, LA 70000

49. NPI: 9876543210
50. License Number
51. SSN or TIN
52. Phone Number: (225) 555 - 1212
52A. Additional Provider ID: 1800000

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Jane White, DDS — 05/04/07
Signed (Treating Dentist) — Date

54. NPI: 1234567890
55. License Number: 88888
56. Address, City, State, Zip Code
56A. Provider Specialty Code: 122300000X
57. Phone Number ( ) -
58. Additional Provider ID

EPSDT DENTAL SERVICES ADJUSTMENT/VOID (209) AND ADULT DENTAL SERVICES ADJUSTMENT/VOID (210) FORM CHANGES

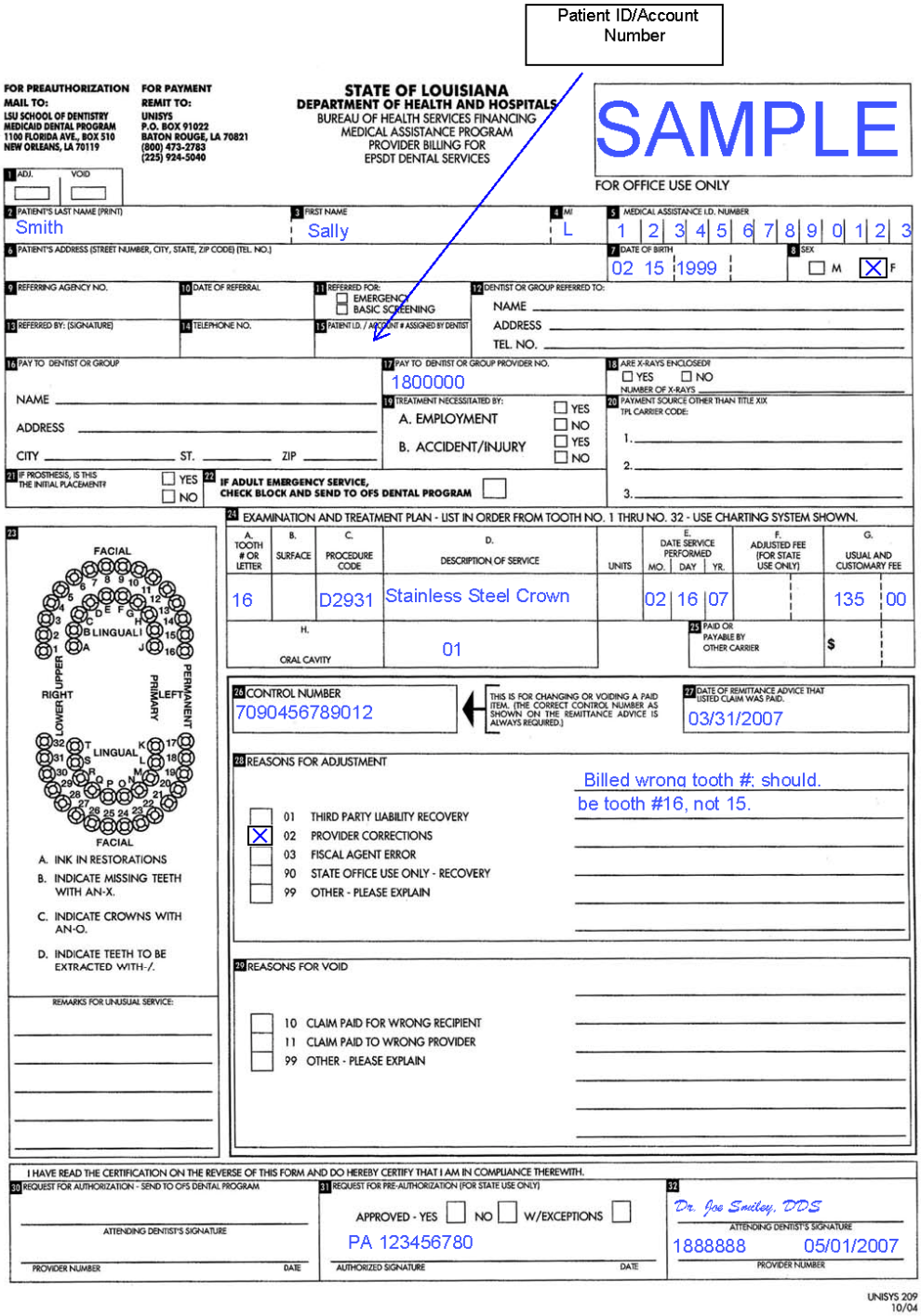
The EPSDT Dental Services 209 Adjustment/Void form (revision date 10/04) must be used when submitting adjustments/voids for EPSDT Dental Program services for all dates of service. Additionally, when submitting adjustments/voids for the Adult Denture Program or Expanded Dental Services for Pregnant Women Program for all dates of service, dental providers must use the Adult Dental Services 210 Adjustment/Void form (revision date 10/04). For both adjustment/void forms Form Locator 15 has been renamed as "Patient I.D./Account# Assigned by Dentist". If the patient's account (medical record) number is entered here, it will appear on the Medicaid Remittance Advice. It may consist of letters and/or numbers, and it may be a maximum of 20 positions. Providers can obtain these forms from Unisys or through the Louisiana Medicaid website at www.lamedicaid.com. Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

INSTRUCTIONS FOR COMPLETING 209 ADJUSTMENT/VOID FORM (EPSDT)

1	Adj/Void	Check the appropriate box.
2, 3, 4	Patient's Last Name,First Name, MI	**Adjust** - Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
5	Medical Assistance ID Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
6	Patient's Address	**Adjust** - Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
7	Date of Birth	**Adjust** - Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
8	Sex	**Adjust** - Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
A.		Not Required
15	Patient ID/Account Number (Assigned By Dentist)	**Adjust** – Enter the information exactly as it appeared on the original invoice **Void** – Enter the information exactly as it appeared on the original invoice
16	Pay to Dentist or Group	**Adjust** – Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
17	Pay to Dentist or Group Provider No.	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** – Enter the information exactly as it appeared on the original invoice
18	Are X-Rays Enclosed	Not required
19	Treatment Necessitated By	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
20	Payment Source Other Than Title XIX	**Adjust** - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. **Void** - Enter the information exactly as it appeared on the

		original invoice.
21, 22		Leave these spaces blank
23	Diagram	Not required
24	Examination and Treatment Plan	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted **Void** - Enter the information exactly as it appeared on the original invoice
25	Paid or Payable by Other Carrier	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0). **Void** - Enter the information exactly as it appeared on the original invoice
26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the paid or denied the claim.
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied claim
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.
30	Request for Authorization	Leave this space blank.
31	Request for Prior Authorization	Enter the 9 digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization
32	Attending Dentist's Signature - Provider Number	All adjustment forms must be signed, and the provider number must be entered.

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Unisys for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.


Patient ID/Account Number
FOR PREAUTHORIZATION MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119
FOR PAYMENT REMIT TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040
STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
EPSDT DENTAL SERVICES
SAMPLE
FOR OFFICE USE ONLY
1 ADJ. VOID
2 PATIENT'S LAST NAME (PRINT) Smith
3 FIRST NAME Sally
4 MI L
5 MEDICAL ASSISTANCE I.D. NUMBER 1 2 3 4 5 6 7 8 9 0 1 2 3
6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)
7 DATE OF BIRTH 02 15 1999
8 SEX M F
9 REFERRING AGENCY NO.
10 DATE OF REFERRAL
11 REFERRED FOR: EMERGENCY BASIC SCREENING
12 DENTIST OR GROUP REFERRED TO: NAME ADDRESS TEL. NO.
13 REFERRED BY: (SIGNATURE)
14 TELEPHONE NO.
15 PATIENT I.D. / ACCOUNT # ASSIGNED BY DENTIST
16 PAY TO DENTIST OR GROUP NAME ADDRESS CITY ST. ZIP
17 PAY TO DENTIST OR GROUP PROVIDER NO. 1800000
18 ARE X-RAYS ENCLOSED? YES NO NUMBER OF X-RAYS
19 TREATMENT NECESSITATED BY: A. EMPLOYMENT YES NO B. ACCIDENT/INJURY YES NO
20 PAYMENT SOURCE OTHER THAN TITLE XIX TPL CARRIER CODE: 1. 2. 3.
21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? YES NO
22 IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OFS DENTAL PROGRAM
24 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU NO. 32 - USE CHARTING SYSTEM SHOWN.
A. TOOTH # OR LETTER | B. SURFACE | C. PROCEDURE CODE | D. DESCRIPTION OF SERVICE | UNITS | E. DATE SERVICE PERFORMED MO. DAY YR. | F. ADJUSTED FEE (FOR STATE USE ONLY) | G. USUAL AND CUSTOMARY FEE
16 | | D2931 | Stainless Steel Crown | | 02 16 07 | | 135 00
H. ORAL CAVITY: 01
25 PAID OR PAYABLE BY OTHER CARRIER $
23
FACIAL
LINGUAL
RIGHT
LEFT
UPPER
LOWER
PRIMARY
PERMANENT
A. INK IN RESTORATIONS
B. INDICATE MISSING TEETH WITH AN-X.
C. INDICATE CROWNS WITH AN-O.
D. INDICATE TEETH TO BE EXTRACTED WITH-/.
REMARKS FOR UNUSUAL SERVICE:
26 CONTROL NUMBER 7090456789012
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. 03/31/2007
28 REASONS FOR ADJUSTMENT
Billed wrong tooth #: should be tooth #16, not 15.
01 THIRD PARTY LIABILITY RECOVERY
02 PROVIDER CORRECTIONS
03 FISCAL AGENT ERROR
90 STATE OFFICE USE ONLY - RECOVERY
99 OTHER - PLEASE EXPLAIN
29 REASONS FOR VOID
10 CLAIM PAID FOR WRONG RECIPIENT
11 CLAIM PAID TO WRONG PROVIDER
99 OTHER - PLEASE EXPLAIN
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.
30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER DATE
31 REQUEST FOR PRE-AUTHORIZATION (FOR STATE USE ONLY)
APPROVED - YES NO W/EXCEPTIONS
PA 123456780
AUTHORIZED SIGNATURE DATE
32 Dr. Joe Smiley, DDS
ATTENDING DENTIST'S SIGNATURE
1888888 05/01/2007
PROVIDER NUMBER
UNISYS 209 10/04

MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

INSTRUCTIONS FOR COMPLETING 210 ADJUSTMENT/VOID FORM (ADULT)

1	Adj/Void	Check the appropriate box
2, 3, 4	Patient's Last Name, First Name, MI	**Adjust** – Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
5	Medical Assistance ID Number	**Adjust** – Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim **Void** - Enter the information exactly as it appeared on the original invoice
6	Patient's Address	**Adjust** – Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
7	Date of Birth	**Adjust** – Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
8	Sex	**Adjust** – Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
A.		Not required
15	Patient ID/Account Number (Assigned By Dentist)	**Adjust** – Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
16	Pay to Dentist or Group	**Adjust** – Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
17	Pay to Dentist or Group Provider No.	**Adjust** – Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice
18	Are X-Rays Enclosed	Not required
19	Treatment Necessitated By	**Adjust** – Enter the information exactly as it appeared on the original invoice **Void** - Enter the information exactly as it appeared on the original invoice
20	Payment Source Other	**Adjust** – Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to

	Than Title XIX	indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. **Void** - Enter the information exactly as it appeared on the original invoice
21		Not required
22		Leave blank
23	A – G	**Adjust** – Enter the information exactly as it appeared on the original invoice unless this information is being adjusted. **Void** - Enter the information exactly as it appeared on the original invoice
24	Paid of Payable by Other Carrier	**Adjust** – Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0). **Void** - Enter the information exactly as it appeared on the original invoice
25	Other Information	Leave blank
26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the paid or denied claim
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied the claim
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable
30	Request for Authorization	Leave this space blank
31	Request for Prior Authorization	Enter the 9 digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization
32	Attending Dentist's Signature – Provider Number	All adjustment forms must be signed, and the provider number must be entered

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Unisys for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

Patient ID/Account Number

FOR PREAUTHORIZATION MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT REMIT TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
ADULT DENTAL SERVICES

SAMPLE

FOR OFFICE USE ONLY

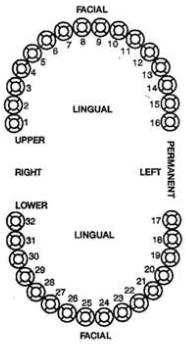
1 ADJ. [X] VOID [ ]

2 PATIENT'S LAST NAME (PRINT): Que
3 FIRST NAME: Susie
4 MI: L
5 MEDICAL ASSISTANCE I.D. NUMBER: 1 2 3 4 5 6 7 8 9 0 1 2 3
6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)
7 DATE OF BIRTH: 06 19 1935
8 SEX: [ ] M [X] F

9 REFERRING AGENCY NO.
10 DATE OF REFERRAL
11
12 DENTIST OR GROUP REFERRED TO:
NAME
ADDRESS
TEL. NO.
13 REFERRED BY: (SIGNATURE)
14 TELEPHONE NO.
15 PATIENT ID/ACCOUNT # ASSIGNED BY DENTIST

16 PAY TO DENTIST OR GROUP
NAME
ADDRESS
CITY ST. ZIP
17 PAY TO DENTIST OR GROUP PROVIDER NO.: 1800000
18 ARE X-RAYS ENCLOSED? [ ] YES [ ] NO
NUMBER OF X-RAYS
19 TREATMENT NECESSITATED BY:
A. EMPLOYMENT [ ] YES [ ] NO
B. ACCIDENT/INJURY [ ] YES [ ] NO
20 PAYMENT SOURCE OTHER THAN TITLE XIX
TPL CARRIER CODE:
1.
2.
3.
21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? [ ] YES [ ] NO

22



INDICATE TEETH TO BE EXTRACTED WITH A/.

INDICATE MISSING TEETH WITH AN X.

SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND TEETH TO BE CLASPED.

23 A. PROCEDURE CODE	B. DESCRIPTION OF SERVICE	C. DATE SERVICE PERFORMED MO. DAY YEAR	D. ADJUSTED FEE (FOR STATE USE ONLY)	E. USUAL AND CUSTOMARY FEE
D5510	Repair Full Denture Base	01 20 07		125 00

F. ORAL CAVITY	G. TOOTH #	24 PAID OR PAYABLE BY OTHER CARRIER	$
01			

25 (1) IS THE PATIENT EDENTULOUS?
MAXILLARY: NO [ ] YES [ ] DATE OF LAST EXTRACTIONS ___/___/___
MANDIBULAR: NO [ ] YES [ ] DATE OF LAST EXTRACTIONS ___/___/___

(2) DOES PATIENT PRESENTLY WEAR A DENTURE? DATE OF PLACEMENT.
MAXILLARY: NO [ ] YES [ ] FULL [ ] PARTIAL [ ] MO. _____ YR. _____
MANDIBULAR: NO [ ] YES [ ] FULL [ ] PARTIAL [ ] MO. _____ YR. _____

COMMENTS:

INFORMATION FROM PATIENT
(1) IN WHAT MONTH AND YEAR WAS YOUR LAST DENTURE MADE? UPPER _____ LOWER _____
(2) NAME AND ADDRESS OF DENTIST
(3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES [ ] NO [ ]

26 CONTROL NUMBER: 7117456789012
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.: 04/27/2007

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 wrong charge amount.
Initially billed $12.50 instead of
$125.00

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

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER DATE

31 REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY)
APPROVED YES [ ] NO [ ] W/EXCEPTIONS [ ]

32 Dr. Joe Smiley, DDS
ATTENDING DENTIST'S SIGNATURE
1888888 05/01/2007
PROVIDER NUMBER

UNISYS-210
10/04

MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

DENTAL CLAIM ERROR CODE INFORMATION

The Medicaid computer system compares information from claims against specific program requirements (i.e., reporting of tooth codes, prior authorization, service limitations, etc.) Claim error codes are used when the claim information does not match these program requirements. A discussion of the most common dental claim error codes follows. Please note that this is not a complete list of dental claim error codes. The remittance advice (RA) contains a brief description of each error code reported; however, if further explanation/information is required regarding an error code, the provider should contact Unisys Provider Relations by calling (800) 473-2783 or (225) 924-5040.

EDIT RESOLUTION		
Code	**Message**	**Resolution**
103	Invalid Tooth Code/Oral Cavity Designator	Either the data in the "Tooth # or letter" or oral cavity designator columns of the claim form is not recognized as a valid tooth code or oral cavity designator. Or The data in the "Tooth # or letter" column of the claim form is valid tooth code or oral cavity designator, but it is not valid for the service billed (e.g., billing a tooth number for a service requiring an oral cavity designator.). Or The claim does not indicate a tooth code or oral cavity designator for a procedure code that requires this information. Determine whether the procedure requires a tooth code or oral cavity designator. Correct the claim to reflect the appropriate and accurate data and resubmit the claim.
510	Only 1 of These Procedures in 7 Years Per Recipient/Provider	Only one of the procedures billed can be performed for the recipient, by the provider, within seven years. The system will deny the claim.
515	Override Required-Send To Dental PA Unit	The claim history for this recipient indicates this claim is the second restoration request for the same tooth within a year. The reason that the tooth requires a second or additional restoration must be well documented in the patient's record. For Medicaid to reconsider the claim, you must send the following to the LSU Dental School, Dental Medicaid Unit, P. O. Box 80159, Baton Rouge, Louisiana 70898-0159: • A cover letter requesting reconsideration of the 515 denial. • One original and one copy of the ADA claim form with the denied service(s) listed. NOTE: ADA claim form, Block 1, must be marked "Statement of Actual Services" and completed so that it is acceptable by Unisys for payment. • A copy of the Remittance Advice denying your request for payment (indicating the 515 denial). • A copy of the entire treatment record. • All pertinent radiographs taken. If radiographic copies are sent, they must be labeled right/left and be of good diagnostic quality.

EDIT RESOLUTION		
Code	**Message**	**Resolution**
598	PA Tooth/Oral Cavity Code Not Same as Claim	This claim was prior authorized. The tooth number/letter or oral cavity designator on the claim does not match the tooth number or oral cavity designator prior authorized. The system will deny the claim. Ensure that the correct prior authorization number, tooth number, and/or oral cavity designator were billed on the claim form. If not, correct the claim and resubmit.
603	Tooth Code/Oral Cavity Designator Required	The claim does not indicate a tooth code or oral cavity designator for a procedure code that requires this information. Ensure that the tooth code or oral cavity designator is on the claim form and in the correct column. Resubmit the claim.
613	Invalid Tooth Code/Oral Cavity Designator	Either the data in the "Tooth # or letter" or oral cavity designator columns of the claim form is not recognized as a valid tooth code or oral cavity designator. Or The data in the "Tooth # or letter" column of the claim form is valid tooth code or oral cavity designator, but it is not valid for the service billed (e.g., billing a tooth number for a service requiring an oral cavity designator.). Or The claim does not indicate a tooth code or oral cavity designator for a procedure code that requires this information. Determine whether the procedure requires a tooth code or oral cavity designator. Correct the claim to reflect the appropriate and accurate data and resubmit the claim.
742	Only 1 of These Procedures Allowed in 5 Years Per Recipient/Provider	Only one of the procedures billed can be performed for the recipient, by the provider, within five years. The system will deny the claim.
775	Payment Cutback Same Tooth	The claim history for this recipient indicates that Medicaid has already processed a claim or claims for this tooth, and the paid amounts have been applied toward the maximum amount allowed for the tooth. In payment of the current claim, only part of the billed amount could be reimbursed without exceeding the maximum allowed payment. Normally this occurs when more than one restoration is billed for the same tooth by the same provider within a certain period of time. Ensure the correct dates of service and procedure code were billed on the claim form. If not, correct the claim and resubmit. Otherwise, refer to the patient's chart and billing records, including RAs that reflect payment for services for the recipient.
779	Procedure on Extracted Tooth Not Payable	The claim history for this recipient indicates that Medicaid has already paid for the extraction of this tooth. Ensure that the correct date of service, procedure code and tooth letter/number were billed on the claim form. If not, correct and resubmit. Otherwise, contact the Dental Medicaid Unit by calling 225-216-6470.

ORAL AND MAXILLOFACIAL SURGERY PROGRAM (MEDICAL SERVICES)

Covered Services

Medicaid recipients, regardless of age, who are eligible for services that are covered under the Physician's Program are eligible for coverage of essentially medically necessary oral and maxillofacial medical procedures that are covered in the Medicaid Physician's Program when required in the treatment of injury or disease related to the head and neck. Procedures performed for cosmetic purposes are not allowed.

Providers are not allowed to bill unlisted/miscellaneous Current Procedural Terminology (CPT) codes for services that have specific codes published in the Current Dental Terminology (CDT) for that service even if the CDT procedure is a non-covered Medicaid service. For example, a provider cannot bill an unlisted/miscellaneous CPT code for a tooth extraction since there are specific CDT codes for this procedure. Please note: Tooth extractions are not covered by Medicaid for adults except for those extractions covered in the Expanded Dental Services for Pregnant Women (EDSPW) Program.

Recipient Eligibility

Providers should verify the recipient's eligibility on each date of service using the Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS). Electronic Medicaid Eligibility Verification System (E-MEVS) is also available on the web at www.lamedicaid.com. The provider should keep hardcopy proof of eligibility from MEVS and/or e-MEVS in the patient's record. (Payment is made for authorized services only if the recipient is eligible on the date the service is rendered.)

Reimbursement

Reimbursement to providers is determined by federal regulations and state policy. Reimbursement to dental providers for oral and maxillofacial surgery services covered under the Physician's Program is based upon the fee for service that has been established for physician providers for the procedure code billed on the claim form.

Claims Filing

The CMS-1500 Claim Form is the only claim form that can be processed for payment of claims for medical services (CPT codes) in the Oral and Maxillofacial Surgery Program.

Procedure Codes

The CPT (Physicians Current Procedural Terminology) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by qualified

providers. The purpose of the terminology is to provide a uniform language that will accurately designate medical, surgical, and diagnostic services and that will provide an effective means for reliable, nationwide communications among providers, patients, and third parties.

Diagnosis Codes

Providers should use the appropriate diagnosis codes listed in the ICD-9-CM Diagnosis Code Book when completing the CMS-1500 claim form.

Diagnosis codes are required entries. Omission will cause the claim to be denied. The diagnosis codes appropriate for all treatment rendered should be listed in Block 21.

NOTE: A diagnosis code beginning with an E or M is not covered.

Additional Program Information

Please refer to the 2007 Basic Services Training Packet and/or the 2007 Professional Services Training Packet for additional information regarding claims filing, prior authorization, third party liability, Medicare/Medicaid reimbursement, etc.

FAMILY PLANNING WAIVER (TAKE CHARGE)

Effective October 1, 2006, the Department of Health and Hospitals implemented a family planning waiver program entitled **TAKE CHARGE**. The target population is females between the ages of 19-44 who do not meet Medicaid certification criteria but who have family incomes up to 200% of the Federal Poverty Level (FPL). **TAKE CHARGE** enrollees are exempt from CommunityCARE – providers don't have to get referrals for family planning waiver services. However, they do not have Medicaid so only services approved for the **TAKE CHARGE** related to family planning services will be approved. **TAKE CHARGE** program enrollees receive a pink identification card similar to a regular Medicaid card in appearance. Enrollees will be identified when the program eligibility card is swiped using MEVS or eligibility is verified by telephone using REVS. All providers must verify the enrollee's eligibility through the automated systems, MEVS or REVS, each time a service is provided in order to confirm eligibility for family planning waiver services.

TAKE CHARGE benefits are a defined set of services. Services will include the following:

- Yearly physical examinations and necessary re-visits
- Laboratory tests
- Medications and supplies (such as birth control pills, condoms, patches, injections, IUD's, diaphragms, etc.)
- Some voluntary sterilization procedures are also covered.

NOTE: A limit of FOUR visits per calendar year (including initial visit and re-visits) has been established on services rendered by a physician, nurse practitioner, or physician assistant, based on the following procedure codes:

- 99201-99205
- 99211-99215
- 99241-99245

If a recipient becomes eligible for Medicaid and enrolls in Medicaid during or after enrolling in **TAKE CHARGE**, the number of annual visits that were credited against **TAKE CHARGE** will not be credited against the number of annual Medicaid visits. However, Office of Public Health (OPH) visits and revisits do count toward the **TAKE CHARGE** service limits.

Reimbursement for services covered under **TAKE CHARGE** will be based on the current Louisiana Medicaid fee-for service rate. **RHC/FQHC providers will receive fee-for services payments, not encounter payments.**

Additional information about **TAKE CHARGE** can also be found at: www.TAKECHARGE.DHH.Louisiana.gov.

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

Electronic Data Interchange (EDI) General Information

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

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 EMC 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 EMC Department at (225) 216-6000 ext. 2.

Electronic Adjustments/Voids

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

SUBMISSION DEADLINES
Regular Business Weeks

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

Thanksgiving Week

Magnetic Tape and Diskettes	4:30 P.M. Tuesday, 11/20/07
KIDMED Submissions	4:30 P.M. Tuesday, 11/20/07
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/21/07

Important Reminders For EMC Submission

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

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

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

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
Office Visits over limit – Form 158A for extension of office visits	Continue hardcopy billing
Modifiers 22, 47, 51, 52, 62, 66 – medical documentation	Continue hardcopy billing
Physician hospital visits to newborn – medical necessity, letter requesting precert edit override	Continue hardcopy billing
Physician claims for inpatient visits (not newborn) when no precert exists – Admit and discharge summary	Continue hardcopy billing
All unlisted procedures – medical documentation	Continue hardcopy billing
Consultation by Physician of same specialty – medical documentation	Continue hardcopy billing
Regular OV during pregnancy – medical documentation	Continue hardcopy billing
Norplant if earlier than 5 years – medical documentation	Continue hardcopy billing
Critical Care services – medical necessity	Continue hardcopy billing
Pathology Consultations (codes 80500, 80502) – medical necessity, list of tests, test results, consult narrative	Continue hardcopy billing
Sonograms (codes 76815, 76816) – medical necessity, dated notes	Continue hardcopy billing

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

CLAIMS PROCESSING REMINDERS

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

Electronic claims submission is the preferred method for submitting claims; however, if claims cannot be submitted electronically, prepare paper claim forms according to the following instructions to ensure appropriate and timely processing:

- Submit an original claim form whenever possible. In the future, copies of claim forms may not be accepted. 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 a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

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

Attachments

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

Changes to Claim Forms

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

Unisys currently returns claims that are illegible or incomplete. These claims are not processed and are returned along with a cover letter stating why the claim(s) is/are rejected. Unisys rejects hundreds of thousands of claims every year. 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

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

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. Staff in this unit also handles requests to update recipient files with correct eligibility. Provider Relations staff do not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence department, so these may take additional time for final resolution.

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 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 personel 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 on page 80 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. 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.
CommunityCARE Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - OCDD	(866) 327-5978	Providers and recipients may obtain information on EarlySteps Program and services offered.
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4149	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 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.
CommunityCARE Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program – OCDD	(866) 327-5978	Recipients may obtain information on 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 the Medicaid website, however, the following applications are the most commonly used:

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

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

e-MEVS:

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

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

e-CSI:

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

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

e-CDI:

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

The nine (9) clinical services information components are:

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

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

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

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

e-PA

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

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

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

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

Reminders:

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

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

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

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

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

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

RECONSIDERATION REQUESTS (RECONS) 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 (nursing home updates and cost report information, outpatient surgery fee schedule, updates to ambulatory surgery groups, contacts, FAQ)

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

PHARMACY SERVICES

Prior Authorization

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

Contact information for the Pharmacy Prior Authorization department:

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

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

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

Preferred Drug List (PDL)

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

Monthly Prescription Service Limit

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

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

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

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

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

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program

REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

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

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

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

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

Practitioner Signature:*

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

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

APPENDIX A

Codes used to bill for the **initial and periodic** medical screening:

99381*	Initial comprehensive preventive medicine; Infant (age under 1 year)
99382*	Initial comprehensive preventive medicine; Early Childhood (ages 1-4)
99383*	Initial comprehensive preventive medicine; Late Childhood (ages 5-11)
99384*	Initial comprehensive preventive medicine; Adolescent (ages 12-17)
99385*	Initial comprehensive preventive medicine; Adult (ages 18-20)
99391*	Periodic comprehensive preventive medicine; Infant (age under 1 year)
99392*	Periodic comprehensive preventive medicine; Early Childhood (ages 1-4)
99393*	Periodic comprehensive preventive medicine; Late Childhood (ages 5-11)
99394*	Periodic comprehensive preventive medicine; Adolescent (ages 12-17)
99395*	Periodic comprehensive preventive medicine; Adult (ages 18-20)

*****Providers should use the **TD Modifier** in conjunction with the appropriate CPT code to report a screening that was performed by a nurse.

Registered Nurse, Certified Nurse Practioner, Physician Assistant interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TD plus TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TD plus TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TD plus TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TD plus TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TD plus TS	Interperiodic Re-evaluation and Management (ages 18-21)

TD = RN, CNP, PA
TS = Interperiodic screening

Physician interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TS	Interperiodic Re-evaluation and Management (ages 18-21)

APPENDIX B

REQUIRED KIDMED MEDICAL, VISION, AND HEARING SCREENING COMPONENTS BY AGE OF RECIPIENT (EFFECTIVE APRIL 1, 1994)[11]

AGE	BIRTH [12]	BY 1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	2 YR	3 YR	4 YR	5 YR	6 YR	8 YR	10 YR	12 YR	14 YR	16 YR	18 YR	20 YR
MEDICAL SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
INITIAL/INTERVAL HISTORY	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS																					
Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X	X	X											
Blood Pressure											X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL ASSESSMENT	S	S	SO	S	S	S	SO	S	S	SO	SO	SO	SO	S	S	S	S	S	S	S	S
UNCLOTHED PHYSICAL EXAM/ASSESSMENT [13]	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PROCEDURES																					
Immunization [14]	X		X	X	X		X	X				---	X	---				X	---		
Neonatal Screening [15]	---	X																			
Anemia Screening [16]						---	X	(X	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Urine Screening [17]							(X	---	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Lead Risk Assessment [18]					X	X	X	X	X	X	X	X	X								
Blood Lead Screening [19]							X			X											
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEALTH EDUCATION [20]	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
VISION SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO
HEARING SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO

X = Required at visit for this age S = Subjective by history O = Objective by Medicaid – approved standard testing method
--- = One test must be administered during this time frame

[11] Baseline lab and developmental screening must be done at the initial medical screening on all children under age six.

[12] The newborn screening examination at birth must occur prior to hospital discharge.

[13] The physical examination/assessment must be unclothed or undraped and include all body systems.

[14] The state health department immunization schedule must be followed per AAP recommendations.

[15] If done less than 48 hours after birth, neonatal screening must be repeated.

[16] Anemia screening is to be done once between 9 and 12 months or earlier if medically indicated, one year to four years, five years to 12 years, and between 13 and 20 years.

[17] Urine testing (dipstick) is to be done once between one and four years, (as soon as toilet trained), five to 12 years, and between 13 and 20 years.

[18] Anticipatory guidance and verbal risk assessment for lead must be done at every medical screening.

[19] Screening beginning at six months corresponds to CDC guidelines. The frequency of screening using the blood lead test depends on the result of the verbal risk assessment.

[20] Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 through 20, must receive more intensive health education which addresses psychological issues, emotional issues, substance usage, and reproductive health issues at each screening visit.

APPENDIX C

REFERRAL FOLLOW UP FORM

Patient Name	*Date of Birth*	*Date Referred*	*Reason for referral*	*Referred to*	*Appointment date*	*Follow up effort 1*	*Follow up effort 2*	*Follow up complete*

APPENDIX D

Vaccine Codes

* indicates the vaccine is available from the Vaccines For Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

Vaccine Code	Description
90476^	Adenovirus vaccine, type 4, live, for oral use
90477^	Adenovirus vaccine, type 7, live, for oral use
90581^	Anthrax vaccine, for subcutaneous use
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633*	Hepatitis A vaccine pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
90634*	Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646	Hemophilus Influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647*	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648*	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90649*	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
90655*	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656*	Influenza virus vaccine, split virus, preservative free, when administered to 3 years and older, for intramuscular use
90657*	Influenza Virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658*	Influenza Virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use
90660*	Influenza Virus vaccine, live, for intranasal use
90665^	Lyme Disease vaccine, adult dosage, for intramuscular use
90669*	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use
90675^	Rabies vaccine, for intramuscular use
90676^	Rabies vaccine, for intradermal use
90680*	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
90690^	Typhoid vaccine, live, oral
90691^	Typhoid vaccine, Vi capsular polysaccharide (ViCPS), for intramuscular use
90692^	Typhoid vaccine, heat-and phenol-inactivated (H-P) for subcutaneous or intradermal use

Vaccine Codes

* indicates the vaccine is available from the Vaccines For Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

Vaccine Code	Description
90693	Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (US Military)
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated, (DTaP-Hib-IPV), for intramuscular use
90700 *	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to younger than 7 years, for intramuscular use
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702*	Diphtheria and tetanus toxoids (DT) absorbed when administered to younger than 7 years, for intramuscular use
90703	Tetanus toxoid adsorbed, for intramuscular use
90704	Mumps virus vaccine, live, for subcutaneous use
90705	Measles virus vaccine, live, for subcutaneous use
90706	Rubella virus vaccine, live, for subcutaneous use
90707*	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous
90708	Measles and rubella virus vaccine, live, for subcutaneous use
90710*	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
90713*	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714*	Tetanus and diphtheria toxoids, (Td) absorbed, preservative free, when administered to 7 years or older, for intramuscular use
90715*	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to 7 years or older, for intramuscular use
90716*	Varicella virus vaccine, live, for subcutaneous use
90717	Yellow fever vaccine, live, for subcutaneous use
90718*	Tetanus and diphtheria toxoids (Td) adsorbed when administered to7 years or older, for intramuscular use
90719	Diphtheria toxoid, for intramuscular use
90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721*	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use
90723*	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use
90725	Cholera vaccine for injectable use
90727	Plague vaccine, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
90734*	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735	Japanese Encephalitis Virus vaccine, for subcutaneous use
90736	Zoster (shingles) vaccine, live, for subcutaneous injection

Vaccine Codes

* indicates the vaccine is available from the Vaccines For Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

Vaccine Code	Description
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744*	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
90746*	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
90748*	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use

APPENDIX E

Universal Screening Documentation Tools – Optional

A universal screening documentation tool is one that can be used at the screening provider's option. The tool is attached. This tool should be completed thoroughly and accurately to ensure all components of a screening are documented. Providers should be familiar with the program requirements of a screening as explained in the KIDMED provider manual. Any additional information necessary to support the screening should also be found in the patient's chart. This tool was designed to incorporate necessary items for a screening in a clear, concise manner. **We <u>are not</u> requiring this tool to be used; it is for your convenience, only.** However, any tool used must document that all five components of a medical screening as stated in the KIDMED manual, were completed. Program compliance reviews will look for such documentation. Furthermore, be aware that the same documentation applies to a "well-child" visit which must also conform to the requirements mandatory for a KIDMED screening. If you do not wish to use this documentation, you may develop your own.

INITIAL SCREENING
BIRTH THROUGH 5 YEARS

DATE:

ıtient Name: Age:

Family History

[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Sickle Cell _____
[ ] T.B. _____
[ ] Other: _____
_____
_____

(Please note family member's relation to patient)

Birth History

[ ] Term [ ] Premature [ ] Post-mature
[ ] Prenatal care [ ] Complications

[ ] NVD [ ] C-Section

[ ] Neonatal Complications _____

Neonatal Screen: WNL Repeated
Results requested: Yes No

Comments: _____

Past Medical History

Illness _____
_____
Hospitalization _____
_____
_____
_____
_____
Allergies _____
_____
_____

HT. WT. T P R Head Circ. (0-2yrs): Blood Pressure (3yrs and up):

Hct or Hgb: WNL UTD UTO Urine Dipstick: WNL UTD UTO Lead: Drawn UTD UTO
Value: Comments: [ ] Not required at this time

Vision Screening

Subjective: any eye disorder Yes No
F.H.O. eye disorder Yes No
Wear glasses Yes No

Objective: Visual acuity R20/ L20/
Muscle Balance pass fail
(Objective screening begins at age 4.)

Hearing Screen

Subjective: response to voices Yes No
Delayed speech development Yes No
Recurrent O.M Yes No
Hearing 20 db HL
1000Hz 2000 Hz 4000Hz
Right Ear _____ _____ _____
Left Ear _____ _____ _____

Lead Poisoning Risk Assessment

Peeling paint in house, daycare etc. Yes No
Relative with lead poison Yes No
House built before 19 Yes No
Renovation Yes No
Adult work in pottery or ceramics Yes No
Live near battery recycling plant or lead release industry Yes No
Live near highway or heavy traffic Yes No

Developmental Assessment

Subjective Assessment WNL Suspect Objective Assessment WNL Delayed
(Copy of screen must be in chart.)

Physical Exam **Normal** (✓) **Abnormal** (Describe)

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Nutritional Assessment

[ ]Breast fed [ ] Formula

Eating Problems _____
Vitamins Supplements Yes No
Growth Grid Normal Yes No
(Growth Grid must be in chart..)

Dental Assessment

Any Dental Disease Yes No
Dental Caries Yes No
Brush Teeth Regularly Yes No
Do You Have a Dentist? Yes No
Name of Dentist _____

Anticipatory Guidance
(mark those discussed)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____
Toilet Training _____

Environmental Assessment

Water supply: City Well None
Sewer system: City Septic None
[ ] Smokers in the home: _____
[ ] Pets in home: _____

Comments:

Immunization Status

[ ] Immunizations current
[ ] Off Schedule* [ ] Parental Refusal*
[ ] Medically Contraindicated*

Explain * _____
(Vaccine record must be in chart.)

Impressions:

ıan or Referral: [ ]Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

INITIAL SCREENING
AGES 6 TO 21 YEARS

DATE:

ıtient Name: Age:

Family History

[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Sickle Cell _____
[ ] T.B. _____
[ ] Other: _____

(Please note family member's relation to patient)

Birth History

[ ] Term [ ] Premature [ ] Post-mature

[ ] Prenatal care [ ] Complications

Note: _____

[ ] NVD [ ] C-Section

[ ] Neonatal Complications _____

Past Medical History

[ ] Major Illness _____

[ ] Hospitalizations _____

[ ] Allergies _____

HT. WGT. B.P. T. P. R.

Labs Hct or Hgb: WNL UTD UTO Value: _____ Urine Dipstick: WNL UTD UTO Comments:

Vision Screen

Subjective: any eye disorder	Yes	No
F.H.O. eye disorder	Yes	No
Wear glasses	Yes	No
Objective: Visual acuity	R 20/	L 20/
Muscle Balance	pass	fail
Color Perception	pass	fail

(6 years and up)

Hearing Screen

Subjective: response to voices	Yes	No
Delayed speech development	Yes	No
Recurrent O.M.	Yes	No

Hearing 20 db HL

	1000Hz	2000 Hz	4000Hz
Right Ear			
Left Ear			

Developmental Assessment

Appropriate verbal communication	Yes	No
Drugs/Alcohol/Tobacco	Yes	No
Hobbies & Sports	Yes	No
Family/Peer Relationship	WNL	Poor
School/Job Performance	WNL	Poor

Reproductive

Sexually active Yes Denies
Contraceptive used _____
Menarche age _____ LMP _____
Gravida _____ Para _____

Physical Exam **Normal (✓)** **Abnormal (Describe)**

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Nutritional Assessment

[ ] Special Diet _____
[ ] Vitamins/ Supplements _____
[ ] Growth Chart WNL See Grid
Comments: _____

Dental Assessment

Any Dental Disease	Yes	No
Dental Caries	Yes	No
Brush Teeth Regularly	Yes	No
Do You Have a Dentist?	Yes	No

Name of Dentist _____

Environmental Assessment

Water supply: City Well None

Sewer system: City Septic None

Smokers in the home? _____

Pets in home? List:

Immunization Status

[ ] Immunizations current [ ] Off Schedule*

[ ] Medically Contraindicated* [ ] Parental Refusal*

Explain * _____

Anticipatory Guidance
(Mark ones taught)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____
Health/Reproduction _____
High Risk activities _____

Impressions:

Plan or Referral:

[ ] Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

PERIODIC SCREENING
BIRTH THROUGH 5 YEARS

DATE:

Patient Name: Age:

Family History

[ ] No changes since last screen
[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Sickle Cell _____
[ ] T.B. _____
[ ] Other: _____

(Please note family member's relation to patient)

Recent Medical History

[ ] No changes since last screen
[ ] Major Illness _____
[ ] Hospitalizations _____
[ ] Allergies _____
[ ] Current Medications _____

Neonatal Screen: WNL Repeated
Results requested: Yes No

Comments: _____

Environmental Assessment

[ ] No changes since last screen

Water supply: City Well None
Sewer: City Septic None

Smokers in home: _____

Pets in home: _____

Developmental Assessment

Subjective Assessment WNL Suspect

Objective Assessment WNL Delayed

(Objective Assessment Must Be In Chart)

HT. WT. T P R
Head Circ. (0-2yrs): Blood Pressure (3yrs and up):

Hct or Hgb: WNL UTD UTO Urine Dipstick: WNL UTD UTO Lead: Drawn UTD UTO
Value: Comments: [ ] Not required at this time

Vision Screening

Subjective: any eye disorder	Yes	No
F.H.O. eye disorder	Yes	No
Wear glasses	Yes	No

Objective: Visual acuity R20/ L20/
Muscle Balance pass fail
(Objective screening begins at age 4)

Hearing Screen

Subjective: response to voices	Yes	No
Delayed speech development	Yes	No
Recurrent O.M.	Yes	No

Hearing 20 db HL

	1000Hz	2000 Hz	4000Hz
Right Ear	_____	_____	_____
Left Ear	_____	_____	_____

Lead Poisoning Risk Assessment

Peeling paint in house, daycare etc.	Yes	No
Relative with lead poison	Yes	No
House built before 1960	Yes	No
Renovation	Yes	No
Adult work in pottery or ceramics	Yes	No
Live near battery recycling plant or lead	Yes	No
Release industry	Yes	No
Live near highway or heavy traffic	Yes	No

Physical Exam **Normal (✓)** **Abnormal** (Describe)

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Nutritional Assessment

[ ] Breast fed [ ] Formula

Eating Problems _____

Vitamins Supplements	Yes	No
Growth Grid Normal	Yes	No

(Growth Grid must be in chart)

Dental Assessment

Any Dental Disease	Yes	No
Oral Car e Appropriate	Yes	No

Comments:

Name of Dentist _____
(Dental Visits are recommended by age 3)

Immunization Status

[ ] Immunizations current [ ]Off Schedule* [ ]Medically Contraindicated* [ ]Parental Refusal*

Explain * _____

(Vaccine record must be in chart.)

Anticipatory Guidance
(mark those discussed)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____

Impressions:

Plan or Referral:

[ ] Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

APPENDIX F

EarlySteps
Louisiana's Early Intervention System
System Point of Entry (SPOE's)

DHH Region	SPOE	Parishes	Contractor-Information
1	Jefferson Parish Human Service Authority	Orleans, St. Bernard, Jefferson , Plaquemines	**Lynne-Marie Ruckert, Program Supervisor** 201 Evans Road Bldg 1 Suite 100 Harahan, LA 70123 Phone (504) 888-7530 Toll Free 1-866-296-0718 Fax (504) 838-5284 E-mail: doguinn@fhfgno.org
2	Southeast Louisiana Area Health Education Center	East Baton Rouge, West Baton Rouge, East Feliciana, West Feliciana, Pointe Coupee, Iberville, Ascension	**Brian Jakes III, Program Manager** 3060 Teddy Drive Suite A Baton Rouge, LA 70809 Phone (225) 925-2626 Toll Free 1-866-925-2426 Fax (225) 925-1370 E-mail: ahecbpj@I-55.com
3	Southeast Louisiana Area Health Education Center	Assumption, St. John, St. Charles, St. James, Terrebonne, Lafourche, St. Mary	**Brian Jakes III, Program Manager** 602 Parish Road Thibodaux, LA 70301 Phone (985) 447-6550 Toll Free 1-866-891-9044 Fax (985) 447-6513 E-mail: ahecbpj@I-55.com
4	First Steps Referral and Consulting LLC	Lafayette, Iberia, St. Martin, Vermillion, St. Landry, Evangeline, Acadia	**Mary F. Hockless, CEO** 134 East Main Street, Suite 4 New Iberia, LA 70560 Phone (337) 359-8748 Toll Free 1-866-494-8900 Fax (337) 359-8747 E-mail: teamfsrc@bellsouth.net
5	First Steps Referral and Consulting LLC	Beauregard, Jefferson Davis, Allen, Cameron, Calcasieu	**Mary F. Hockless, CEO** 134 East Main Street, Suite 4 New Iberia, LA 70560 Phone (337) 359-8748 Toll Free 1-866-494-8900 Fax (337) 359-8747 E-mail: teamfsrc@bellsouth.net
6	Families Helping Families at the Crossroads of Louisiana	Vernon, Rapides, Winn, Grant, LaSalle, Catahoula, Concordia, Avoyelles	**Teresa Harmon, Program Supervisor** 2840 Military Highway Suite B Pineville, LA 71360 Phone (318) 640-7078 Toll Fee 1-866-445-7672 Fax (318) 640-5799 E-mail: tjharmon891@hotmail.com

7	Families Helping Families at the Crossroads of Louisiana	Caddo, Bossier, Webster, Claiborne, Bienville, Natchitoches, Sabine, DeSoto, Red River	**Rebecca Thornton, Program Supervisor** 2620 Centenary Blvd. Bldg. 2 Suite 249 Shreveport, LA 71104 Phone (318) 226-8038 Toll Free 1-866-676-1695 Fax (318) 425-8295 E-mail: jennifer@spoe.ntcmail.net
8	Easter Seals of Louisiana	Ouachita, Union, Jackson, Lincoln, Caldwell, Morehouse, West Carroll, East Carroll, Richland, Franklin, Tensas, Madison	**Peyton Fisher, Director** 1300 Hudson Lane, Suite B Monroe, LA 71201 Phone (318) 322-4788 Toll Free 1-877-322-4788 Fax (318) 322-1549 Email: pfisher@bayou.com
9	Southeast Louisiana Area Health Education Center	St. Tammany, Livingston, Tangipohoa, Washington, St. Helena	**Brian Jakes III, Program Manager** 1302 J.W. Davis Drive Hammond, LA 70403 Phone (985) 429- 1252 Toll Free 1-866-640-0238 Fax (985) 429-1613 Email: ahecbpj@I-55.com

APPENDIX G

Check List for Use Prior to Mailing a Medicaid Dental Prior Authorization Request
(Print or copy this page for your convenience)

The information provided below will help you prevent errors frequently made when completing a Medicaid dental prior authorization (PA) request. For complete dental prior authorization guidelines, refer to pages 16-6 through 16-9 of the Dental Services Manual dated May 1, 2003.

- ☐ Are you using the 2006 ADA Claim Form when submitting a request to Medicaid for dental prior authorization?
- ☐ Have you provided two identical copies of each ADA claim form being submitted?
- ☐ Has any information been placed in the upper right-hand corner of the claim (above the box labeled "Primary Subscriber Information")? (This area is for Medicaid use only and must be left blank.)
- ☐ Are you certain that the claim form is properly completed with provider name, group, and individual provider number, current provider address and phone number, recipient name and date of birth, etc.? (Each claim form submitted for dental prior authorization should be fully completed using the ADA Claim Form instructions on page 50 of this document. If a service has not been delivered at the time of the request, leave the date of service blank. If a service has already been delivered, enter the correct date of service on the claim form.
- ☐ Have you grouped together on the first lines of the claim form all services requiring prior authorization? (Procedures that will be rendered and do not require prior authorization should be listed on the ADA claim form after those services requiring prior authorization so that the reviewer understands the full treatment plan.)
- ☐ Have you provided an explanation or reason for treatment in the remarks section of the claim form if the reason is not obvious from the radiographs? (Be certain to include the remarks on the same ADA claim form in which the treatment is being requested.)
- ☐ Have you included bitewing radiographs and any other required radiographs?
- ☐ Are the radiographs mounted so that each individual film is readily viewable and does the doctor's name, patient's name, and the date of the films appear on the mounting? (Radiographs MUST be mounted and MUST contain the identified information.)
- ☐ Are the mounted radiographs on the top of the EPSDT Dental Program the Adult Denture Program claims? (The mounted radiographs MUST be on the top of the claim for prior authorization for these programs.)
- ☐ Is a single copy of the BHSF Form 9-M on top of the request, followed by the mounted radiographs and then the claim for the Expanded Dental Services for Pregnant Women (EDSPW) Program requests? (Placing the Form 9-M as the first page of an EDSPW request will help to identify it as related to an adult pregnant woman.)
- ☐ Have you submitted the panoramic radiograph, if one has been taken, along with the request for post-authorization of the radiograph and included any additional services requiring prior authorization on the same claim form?
- ☐ Have you stapled all pages (and the mounted radiographs) for a single recipient with a SINGLE staple in the upper left-hand corner? (Using a single staple will expedite the request. Paper clips should be not used.)
- ☐ Have you separated the dental prior authorization requests by program type (EPSDT Dental Program, Expanded Dental Services for Pregnant Women (EDSPW) Program, and Adult Denture Program and placed each program type in a separate package/envelope?
- ☐ **Are you mailing to LSU Dental School, Dental Medicaid Unit, P.O. Box 80159, B.R. LA 70898-0159?**

NOTE: It is the dental provider's responsibility to obtain a dental prior authorization on behalf of the patient. If a dental provider has not received a dental prior authorization decision (or other related correspondence from the Dental Medicaid Unit) within 25 days from the date of submission, it is the provider's responsibility to contact the Dental Medicaid Unit at 225-216-6470 to inquire on the status of the prior authorization request. The provider should NEVER instruct the patient to contact Medicaid regarding the dental prior authorization request.

APPENDIX H

BHSF Form 9-M
Issued 12/03

Medicaid Program

Referral for Pregnancy Related Dental Services

(Must Be Completed By the Medical Professional Providing Pregnancy Care)

Part I: All Items Must Be Complete

Name of Patient: _____

Street Address:_____ City:_____ Zip Code:_____

Medicaid Recipient ID #: _____

Estimated Date of Delivery (MM/DD/YYYY):_____

Part II: Check (☑) All Conditions That Apply

- ❑ Bleeding Gums
- ❑ Swollen, puffy gums
- ❑ Loose teeth
- ❑ Teeth with obvious decay
- ❑ Teeth that appear longer
- ❑ Pain associated with teeth or gums
- ❑ Bad breath odor that does not go away with normal brushing
- ❑ Spaces between the teeth that were not there before
- ❑ Inability to chew or swallow properly
- ❑ Tender gums that bleed when brushing

Are there any medical or perinatal complications that the dentist should be aware of prior to the delivery of dental services? ❑ YES ❑ NO If yes, please describe below:

_____

_____

Is pre-medication or other medication required prior to dental treatment? ❑ YES ❑ NO
(If yes, please attach a photocopy of the prescription.)

Part III: Check (☑) Any Services That Are Contraindicated

- ❑ Local Anesthetic
- ❑ Radiograph(s)
- ❑ Teeth Cleaning
- ❑ Restoration(s)
- ❑ Gum Treatment – Ultrasonic Cleaning and/or Scaling Below the Gum Line
- ❑ Extraction(s)

Part IV: Please include other comments and/or recommendations below:

_____

_____

I have confirmed the pregnancy with diagnostic testing for the above-named patient.

_____	_____	(___)_____	_____
Medical Professional Signature **(Required)**	Provider Type & License #	Office Telephone #	Date

To locate a Medicaid enrolled dentist, you may contact the Medicaid Referral Assistance Hotline toll-free at 1-877-455-9955.

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 provide constructive comments and suggestions:_____

_____

_____

_____

_____

_____

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