UNISYS

HOME AND COMMUNITY BASED WAIVER SERVICES 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 OF PARTICIPATION

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

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

PICKING AND CHOOSING SERVICES

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

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

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

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

STATUTORILY MANDATED REVISIONS TO ALL PROVIDER AGREEMENTS

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

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

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

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

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

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

SURVEILLANCE UTILIZATION REVIEW

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

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

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

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

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

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

FRAUD AND ABUSE HOTLINE

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

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

DEFICIT REDUCTION ACT OF 2005

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

- Effective July 1, 2007, the Louisiana Medicaid Program requires all new enrollment packets to have a signature on the PE-50 which will contain the above language.

- The above message was posted on LAMedicaid website, (https://www.lamedicaid.com/sprovweb1/default.htm), RA messages, and in the June/July 2007 Louisiana Provider Update

- Effective November 1, 2007, enrolled Medicaid providers will be monitored for compliance through already established monitoring processes.

- All providers who do $5 million or more in Medicaid payments annually, must comply with this provision of the DRA.

PROGRAMMATIC AND LICENSING/CERTIFICATION CHANGES PURSUANT TO GOVERNOR'S HEALTH CARE REFORM INITIATIVES

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

PROGRAMMATIC CHANGES

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

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

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

- Waiver issues pertaining to the elderly and disabled adults (e.g., Elderly and Disabled Adult Waiver and Adult Day Health Care Waiver populations) are now administered by the Division of Long Term Supports and Services (OAAS).

- The Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) Waiver Compliance Section is now responsible for administering the programs of Support Coordination for Early Periodic Screening Diagnosis and Treatment (EPSDT) and Nurse Family Partnership. The Waiver Compliance Section is also responsible for oversight of the actions of the Program Offices (OCDD and OAAS) in administering the Medicaid Waiver Program.

- Support Coordination for the HIV targeted population is now administered by the Office of Aging and Adult Services (OAAS).

- The Long Term-Personal Care Services program (LT-PCS) is now administered by OAAS.

- The Nursing Facility Admissions Review process is now administered by OAAS.

LICENSING & CERTIFICATION CHANGES

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

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

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

We appreciate your continued support and commitment to making a positive difference in the lives of individual recipients of home and community-based services. If you have any questions concerning these changes, please contact the OAAS by calling (225) 219-0200, OCDD-WSS by calling (225) 342-0095, or HSS by calling (225) 342-0415.

ELDERLY AND DISABLED ADULT (EDA) WAIVER

SERVICES PROCEDURE CODES/RATES

The following procedure codes represent current information.

Provider Type	HCBS/EDA Waiver Service Description	Proc. Code	HIPAA Service Description	Units
08	Transition Service	T2038	Community Transition, Waiver	$1,500.00 One time fee
08	Transition Intensive Support Coordination	Z0178	EDA High Risk Case Management	Monthly $157.00
08	Support Coordination	Z0195	EDA Case Management	Monthly $140.00
15	Environmental Accessibility Adaptation - Ramp	Z0060	Environmental Modifications – Ramp	3,000.00 Lifetime Cap- Based on Comprehensive Plan of Care
15	Environmental Accessibility Adaptation – Lift	Z0061	Environmental Modifications - Lift	
15	Environmental Accessibility Adaptation – Bathroom	Z0062	Environmental Modifications - Bathroom	
15	Environmental Accessibility Adaptation – Other Adaptations	Z0063	Environmental Modifications- Adaptations	
16	Personal Emergency Response System (PERS) – Installation	Z0058	Personal Emergency Response System (PERS) - Installation	Initial Installation $30.00
16	Personal Emergency Response System (PERS) – Monthly Maintenance Fee	Z0059	Personal Emergency Response System (PERS) – Monthly Fee	Monthly $27.00
82	Companion Service	S5135	Companion Care (Adult)	15 minutes $2.50

Modifiers: Certain procedure codes will require a modifier in order to distinguish services.
The following modifiers are applicable to Elderly and Disabled Adult Waiver provider:
U1 = Day
UJ = Night

Reissued February 9, 2007 BCSS-PC-04-002
Replaces Marc 29, 2004 Issuance

Waiver Eligibility Segment Code 00257

ELDERLY & DISABLED ADULT (EDA) WAIVER FACT SHEET

What is the Elderly and Disabled Adult (EDA) Waiver program?
It is a special program that provides certain services in the home or community to elderly or disabled adults who qualify.

What services do people get?
For people who qualify, the program provides for these services:

- Support coordination (formerly known as case management)
- Transition intensive support coordination
- Companion service (day or night)
- Environmental accessibility adaptation (home modifications)
- Personal Emergency Response System
- Transitional services (for people going from nursing facilities to the community)

The program pays for services within an established daily cost cap set by DHH. People who qualify can choose their own providers.

Who qualifies for services?

- Individuals age 65 or older can qualify if they meet Medicaid financial eligibility; meet the requirements for admission to a nursing facility (nursing facility level of care); **and** meet the imminent risk criteria; **or**
- Individuals age 21-64 who are disabled according to Medicaid standards or SSI disability criteria; meet Medicaid financial eligibility; meet the requirements for admission to a nursing facility (nursing facility level of care); **and** meet the imminent risk criteria.

What are the 2007 income limits?

- The income limits are $1,869 for an individual and $3,738 for a couple (when both spouses need long-term care.)

What are the 2007 resource limits?
Resources are the things people own. When we count resources for this program, we do not count the person's home, the car they drive to medical appointments, or other basic resources.

- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources when both spouses need long-term care.
- Married couples can have up to $101,640 in resources, as long as one spouse at home does not get long-term care.

How can people get Elderly and Disabled Adult Waiver services?

- The Department keeps an EDA Request for Services Registry (formerly known as the "waiting list") of people who have asked for these services, along with the date of the request.
- Based on date of first request for services, the Department first offers EDA Waiver opportunities to people from the EDA Request for Services Registry who are in nursing facilities but can return to their homes if they get services and/or people who might go into nursing facilities in the next 120 days unless they get services.
- All other EDA Waiver opportunities, if available, are offered on a first-come, first-served basis based on date of first request for services.
- To add your name to the EDA Request for Services Registry, call the Louisiana Options in Long Term Care Help Line at 1-877-456-1146, Mondays - Fridays, 8 a.m. – 5 p.m.

Questions? Call Louisiana Options in Long Term Care Help Line at 1-877-456-1146 (TDD: 1-877-544-9544). The call is free.

Reissued May 16, 2007

OAAS-RC-06-001

Replaces February 28, 2007 version

ADULT DAY HEALTH CARE

SERVICES PROCEDURE CODES/RATES

The following code represents current information.

Provider Type	HCBS Waiver Service Description	Revenue Code	HIPAA Service Description	Units
85	Adult Day Health Care	932	Medical Rehabilitation Day Program-Sub.Category 2-Full Day	$64.34 (perdiem)

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ADULT DAY HEALTH CARE (ADHC) WAIVER FACT SHEET

What is the Adult Day Health Care (ADHC) Waiver program?
It is a special program that provides certain services for five (5) or more hours per day in a licensed and Medicaid enrolled Adult Day Health Care Facility to people who qualify.

What services do people get?
Services include assistance with activities of daily living (toileting, grooming, etc), health & nutrition counseling, social services, exercise programs, health education classes, a hot meal & two snacks, transportation, and some health/nursing services.

Who can qualify for services?
- Individuals age 65 or older can qualify if they meet Medicaid financial eligibility; meet the requirements for admission to a nursing facility (nursing facility level of care) **and** meet the imminent risk criteria; **or**
- Individuals age 22-64 who are disabled according Medicaid standards or SSI disability criteria; meet Medicaid financial eligibility; meet the requirements for admission to a nursing facility (nursing facility level of care); **and** meet the imminent risk criteria.

What are the 2007 income limits?
- The income limits are $1,869 for an individual and $3,738 for a couple (when both spouses need long-term care.)

What are the 2007 resource limits?
Resources are the things people own. When we count resources for this program, we do not count the person's home, the car they drive to medical appointments, or other basic resources.
- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources when both spouses need long-term care.
- Married couples can have up to $101,640 in resources, as long as one spouse at home does not get long-term care.

How can people get Adult Day Health Care Waiver services?
- The Department keeps an ADHC Request for Services Registry (formerly known as the "waiting list") of people who have asked for these services, along with the date of the request.
- Based on date of first request for services, the Department first offers ADHC Waiver opportunities to people from the ADHC Request for Services Registry who are in nursing facilities but can return to their homes if they get services and/or people who might go into nursing facilities in the next 120 days unless they get services.
- All other ADHC Waiver opportunities, if available, are offered on a first-come, first-served basis based on date of first request for services.
- To add your name to the ADHC Request for Services Registry, call the Louisiana Options in Long Term Care Help Line at 1-877-456-1146, Mondays - Fridays, 8 a.m. – 5 p.m.

Questions? Call Louisiana Options in Long Term Care Help Line at 1-877-456-1146 (TDD: 1-877-544-9544). The call is free.

Reissued May 16, 2007 OAAS-RC-06-002
Replaces February 28, 2007 Version

CHILDREN'S CHOICE WAIVER

SERVICE PROCEDURE CODES/RATES

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

Modifiers

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

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

CHILDREN'S CHOICE WAIVER FACT SHEET

Description	• Began February 21, 2001 to offer supplemental support to children with developmental disabilities who currently live at home with their families, or who will leave an institution to return home. • Children's Choice is an option offered to children on the NOW Request for Services Registry as funding permits. • Families choose to either apply for Children's Choice or remain on the NOW Request for Services Registry. • Participants are eligible for all medically necessary Medicaid services, including EPSDT screenings and extended services, and will also receive up to $17,000 per year in Children's Choice services (including required Support Coordination (case management). • Service package is designed for maximum flexibility. • Children who "age out" (reach their 19th birthday) will transfer with their slot to an appropriate waiver as long as they remain eligible for waiver services. • There are 5 waiver services not available to other Medicaid recipients which are provided in lieu of institutional care: 1. Case Management - services that assist the families in life planning for the child including gaining access to needed waiver and State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the service to which access is gained. Home visits are required. 2. Family Support - services provided directly to the child that enable a family to keep the child at home and that enhance family functioning. 3. Center-Based Respite - services provided on a short-term basis to children unable to care for themselves due to the absence or need for relief of the parents or to others who normally provide care and supervision. 4. Environmental Accessibility Adaptations - physical adaptations to the home or vehicle necessary to ensure health, welfare, and safety of the child, or which enable the child to function with greater independence in the home, and without which additional supports institutionalization would be required. Excluded are adaptations of general use or those that add to the total square footage of the home. Excluded are fire alarms, smoke detectors, and fire extinguishers. 5. Family Training - training and education services for the families of recipients that is provided by professional organizations or practitioners appropriate to the needs of the child and approved by BCSS. • A family that chooses Children's Choice may later experience a crisis that increases the need for paid supports to a level that would be more than the $17,000 cap on Children's Choice expenditures. During an initial one-year trial period, special provisions have been made to provide additional supports during the crisis period until other arrangements can be made. • A family may also experience a temporary Anon-crisis@ that could increase the need for additional supports beyond the $17,000 cap and allow the participant's name to be restored to NOW Request For Services Registry. Current Children's Choice Waiver services will not be terminated as a result of restoring the name to the registry. Special provisions have been made to allow someone to be restored to the registry until a NOW waiver opportunity becomes available.
Level of Care	Recipients must meet ICF/MR level of care for medical and/or psychological criteria. Procedure and requirements for admission to the waiver are the same as for ICF/MR determination.
Population	Age - Birth through age 18 Disability - Meets the federal definition for mental retardation or a developmental disability.
Eligibility	Income - Up to 3 times SSI amount. Income of other family members is not considered. Needs Allowance - Three times the SSI amount. Resources - Less than $2,000 Non-financial - meets all Medicaid non-financial requirements (citizenship, residence, Social Security number, etc.) Other - Same resource, disability, parental deeming, etc. as ICF/MR.

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

Updated 7/25/07
Replaces February 1, 2005 Issuance

NEW OPPORTUNITIES WAIVER SERVICES

SERVICE PROCEDURE CODES/RATES

Proc. Code	MOD	Service Description	Units
Z0637		Case Management	Monthly
Z0177		Case Management	Monthly
S5136		Companion Care	Day $20.00
S5140		Foster Care, adult	Day $20.00
S5160		PER (Install & Test)	Initial installation $30.00
S5161		PER (Maintenance)	Monthly $27.00
T1002		RN Services	15 minutes $6.13
T1002	UN	RN Services, 2 persons	15 minutes $4.59
T1002	UP	RN Services 3 persons	15 minutes $4.04
T1003		LPN/LVN Services	15 minutes $6.13
T1003	UN	LPN/LVN Services	15 minutes $4.59
T1003	UP	LPN/LVN Services	15 minutes $4.03
S5125	U1	Attendant Care Services	15 minutes $4.00
S5125	UJ	Attendant Care Services	15 minutes $2.25
S5125	U1 AND UN	Attendant Care Services	15 minutes $3.13
S5125	U1 AND UP	Attendant Care Services	15 minutes $2.83
T2025		Community Integration & Dev	15 minutes $3.50
T2025	UN	Community Integration & Dev	15 minutes $2.00
H2017	U7	Psychosocial Rehabilitation Services	15 minutes $31.25
H2017	TD	Psychosocial Rehabilitation Services	15 minutes $6.13
H2017	AJ	Psychosocial Rehabilitation Services	15 minutes $9.38
H2014	U7	Skilled Training and Development	15 minutes $18.75
H2014	AJ	Skilled Training and Development	15 minutes $9.38

Proc. Code	MOD	Service Description	Units
Z0616		Environmental Access. (Ramp)	$7,000.00 per recipient; once the recipient reaches 90% or greater of the cap and the account has been dormant for 3 years, the recipient may access another $7,000.00
Z0617		Environmental Access. (Lift)	
Z0618		Environmental Access. (Bathroom)	
Z0620		Environmental Access. (Other)	
Z0621		Medical Equip. & Supplies (lifts)	$1,000.00 per recipient; once the recipient reaches 90% or greater of the cap and the account has been dormant for 3 years, the recipient may access another $1,000.00
Z0622		Medical Equip. & Supplies (switches)	
Z0623		Medical Equip. & Supplies (controls)	
Z0624		Medical Equip. & Supplies (other)	
T1005	HQ	Respite Care	15 minutes $2.87
H2023		Supported Employment	15 minutes $6.54
H2026		Ongoing Support to Maintain Employment	Day $50.00
H2025	TT	Ongoing Support to Maintain Employment	15 minutes $2.00
T2003		Non-Emergency Transportation	Day (One Way) $6.00
A0130		Non-Emergency Transportation (wheelchair)	Day (One Way) $10.00
T2019		Habilitation, Supported Employment	15 minutes $1.63
T2021		Day Habilitation Waiver	15 minutes $1.63
T2003	U6	Non-Emergency Transportation	Day (One Way) $6.00
A0130	U6	Non-Emergency Transportation wheelchair	Day (One Way) $10.00
T2038		Community Transition, Waiver	Lifetime $3,000.00
S5125	UN AND UJ	Attendant Care Services	15 minutes $1.82
S5125	UP AND UJ	Attendant Care Services	15 minutes $1.67

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

Modifiers

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

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

NEW OPPORTUNITIES WAIVER (NOW) FACT SHEET

Description	Home and Community-Based Services Waiver programs are based on federal criteria which allow services to be provided in a home or community-based setting for the recipient who would otherwise require institutional care. Due to the demand for these services, there is a Developmental Disability (DD) Request for Services Registry (RFSR) that lists individuals who meet the Louisiana definition for developmental disability and their request date. This waiver is offered on a first-come, first-served basis. Persons interested in being added to the Developmental Disability Request for Services Registry for this waiver should contact their local OCDD Regional Office/District/Authority. The application process does not begin until a waiver opportunity is available. At that time, medical and financial determinations are completed simultaneously to validate that the individual has a developmental disability and meets the financial and medical/psychological requirements for institutional care in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD). Through freedom of choice, requestors choose their support coordinator and direct service provider(s). The New Opportunities Waiver (NOW) is only appropriate for those individuals whose health and welfare can be assured via an Individual Support Plan and for whom home and community-based waiver services represent a least restrictive treatment alternative. The NOW is intended to provide specific, activity focused services rather than continuous custodial care. The following are the services provided under the NOW: Individualized and Family Support (IFS) Service-Day-Night; Center-Based Respite; Community Integration and Development; Environmental Accessibilities Adaptations; Specialized Medical Equipment and Supplies as an Extended State Plan Service; Supported Living; Substitute Family Care; Day Habilitation and Transportation for Day Habilitation; Supported Employment and Transportation for Supported Employment; Employment Related Training; Professional Services; Personal Emergency Response System; Skilled Nursing Services; and One-Time Transitional Services.
Level of Care	Requestors **must meet ICF/DD level of care** for medical and/or psychological criteria. Procedure and requirements are the same as ICF/DD facility determination for admission.
Population	Age 3 years and older and have a developmental disability which manifested prior to age 22. Must meet the Louisiana definition for developmental disability.
Financial	• Income - Up to 3 times the SSI amount. For children, income of other family members is not considered if the child receives SSI. Parental income is counted toward minor children for the month of admission only. The income of the minor and the income of the parent(s) with whom the child lived during that month are counted together. • Resources – Countable resources cannot be worth more than $2,000 for an individual or $3,000 for a couple who needs ICF/DD Level of Care. • The resources limits are subject to change each year.

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

Updated 03/01/07
Replaces 12/22/06 Issuance

SUPPORTS WAIVER

PROCEDURE CODES AND RATES

Effective May 20, 2007

HIPAA CODE NAME	SERVICE DESCRIPTION	CODE	MODIFIER	RATE	UNIT OF SERVICE	HOURS PER UNIT	ANNUAL SERVICE LIMITS
Supported Employment	Individual Job, Self-Employment or Microenterprise, Discovery and Development	H2024	UK	$104.00	1 day	6 or more hours	120
Supported Employment	Group Employment Job Assessment, Discovery and Development	H2024	No Modifier	$87.00	1 day	6 or more hours	20
Supported Employment	Individual Job, Self-Employment or Microenterprise Initial Job Support and Retention	H2026	TS	$52.00	1 day	1 or more hours	240+
Supported Employment	Group Employment Initial Job Support and Retention On staff to one-two participant ratio	H2026	TT	$77.00	1 day	1 or more hours	240+
Supported Employment	Group Employment Initial Job Support and Retention One staff to three-four participant ratio	H2026	UQ	$62.67	1 day	1 or more hours	240+
Supported Employment	Group Employment Initial Job Support and Retention One staff to five-eight participant ratio	H2026	No Modifier	$46.90	1 day	1 or more hours	240+
Day Habilitation	Day Habilitation One staff to one participant ratio	T2020	TT	$82.50	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240-254
Day Habilitation	Day Habilitation One staff to two-four participant ratio	T2020	UQ	$65.00	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240-254
Day Habilitation	Day Habilitation One staff to five to eight participant ratio	T2020	No modifier	$47.00	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240-254

HIPAA CODE NAME	SERVICE DESCRIPTION	CODE	MODIFIER	RATE	STANDARD UNIT OF SERVICE	HOURS PER UNIT	ANNUAL SERVICE LIMITS
Prevocational Habilitation	Prevocational services One staff to one participant ratio	T2014	TT	$82.50	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240
Prevocational Habilitation	Prevocational services One staff to two to four participant ratio	T2014	UQ	$55.00	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240
Prevocational Habilitation	Prevocational services One staff to five to eight participant ratio	T2014	No modifier	$37.00	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240
Respite	Center-based respite	T1005	HQ				
Attendant Care Services	In-Home respite	S5125	No modifier	$4.00	15 minutes	N/A	428
Habilitative Supported Employment	Habilitation	T2019	No modifier	$4.00	15 minutes	N/A	285
Personal Emergency Response System	PERS Installation	Z0058	No modifier	$30.00	One time	N/A	1 in current residence and 1 each time participant moves to new residence
Personal Emergency Response System	PERS monthly maintenance	Z00059	No modifier	$28.00	Monthly	N/A	12

SUPPORTS WAIVER FACT SHEET

Description	Home and Community-Based Services Waiver programs are based on federal criteria that allow services to be provided in a home or community-based setting for the participant who would otherwise require institutional care. The Supports Waiver has reserved capacity for people who were receiving state general funded vocational and habilitation services through the Office for Citizens with Developmental Disabilities (OCDD) as of March 31, 2006, or who were listed as waiting for those services prior to May 31, 2006. This means that this population is the first served through this waiver. There is a Developmental Disability (DD) Request for Services Registry (RFSR) that includes individuals who meet the Louisiana definition for developmental disability and their request date, but do not have reserved capacity. Persons interested in being added to the Developmental Disability Request for Services Registry for the Supports Waiver should contact their local OCDD Regional Office/District/Authority. Once a request has been made, the person will be asked to participate in a determination process for system entry will only determine if the person meets the criteria for a developmental disability. The application process for the Supports Waiver will not begin until a waiver opportunity is available. At that time, medical and financial determinations will be completed simultaneously to validate that the individual has a developmental disability and meets the financial and medical/psychological requirements for institutional care in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD). Through freedom of choice, requestors will choose their support coordinator and direct service provider(s). The Supports Waiver will only be appropriate for those individuals whose health and welfare can be assured via the Individual Service Plan with a cost limit of $26,000 and for whom home and community-based waiver services represent a least restrictive treatment alternative. This waiver is intended to provide specific, activity focused services rather than continuous custodial care. The following are services offered through the Supports Waiver: Supported Employment, Day Habilitation, Prevocational Services, Respite, Habilitation, and Personal Emergency Response Systems.
Level of Care	Requestors **must meet ICF/DD level of care** for medical and/or psychological criteria. Procedure and requirements are the same as ICF/DD facility determination for admission.
Population	Age ≡Age 18 years and older with mental retardation or a developmental disability which manifested prior to age 22. Must meet the Louisiana definition for developmental disability.
Financial	* Income ≡ The monthly income limit is up to 3 times the SSI amount. * Resources ≡ For 2007, countable resources cannot be worth more than $2,000 for an individual or $3,000 for a couple who needs ICF/DD Level of Care. * These income and resources limits are subject to change each year.

For Information About Accessing Supports Waiver Services,
Please Contact Your OCDD Regional Office/District/Authority.

Updated 03/01/07
Replaces 07/11/06 Issuance

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

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

DIRECT SERVICE PROVIDER (DSP)

GENERAL INFORMATION/REQUIREMENTS

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

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

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

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

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

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

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

The Support Coordinator assists the individual in the coordination of all services needed by the individual. The Support Coordination Agency is responsible for developing an initial and subsequent annual, comprehensive plan of care (CPOC). The CPOC must reflect the

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

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

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

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

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

- All services are approved in the CPOC, and prior authorized (PA) before the DSP can receive reimbursement for providing those services. If services are provided without being listed in the approved CPOC, and/or prior to receiving prior approval (PA) – OAAS or OCDD CANNOT reimburse the DSP for services rendered. Retroactive PA is not permitted except in rare instances of emergencies as outlined in the manual. It is the responsibility of the provider to validate their correct provider number, the correct number of units and the correct procedure code is in the plan of care as well as in the electronic PA. It is the providers responsibility to take steps to correct this prior to the delivery of services.

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

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

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

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

- The DSP is required to report critical incidents to the appropriate waiver office (OAAS or OCDD) within 2 hours of first knowledge of the incident. Immediate jeopardy situations

shall be handled immediately and as outlined in the Provider Standards for Participation. Refer to the OAAS or OCDD website (www.dhh.la.gov/bcss) for the critical incident policy and reporting forms.

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

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

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

DIRECT SERVICE PROVIDER CHANGES

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

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

Waiver Service Provider Changes

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

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

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

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

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

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

INDIVIDUALIZED BACK-UP PLANS AND EMERGENCY EVACUATION RESPONSE PLANS

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

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

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

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

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

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

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

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

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

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

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

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

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

PRIOR AUTHORIZATION

All waiver services require prior authorization, which is transmitted through Statistical Resources, Incorporated (SRI). In order to obtain and process prior authorization, all providers must use the Louisiana Service Tracking System (LAST) for data tracking purposes. It is the responsibility of the provider to verify all data related to their provider number, procedure code and unit are correct prior to the delivery of services.

Louisiana Service Tracking Software System (LAST)

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

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

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

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

Computer Minimum Requirements

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

Issuance of Prior Authorized Waiver Services

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

Direct services may be billed anytime within the PA cycle.

Diapers may be billed anytime after the PA cycle ends.

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

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

DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION ABOUT DOCUMENTATION REQUIREMENTS

- It is the responsibility of the support coordination agency and direct service provider agency to provide adequate documentation of services offered to waiver participants for the purposes of continuity of care/support for the individual and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of activities undertaken on behalf of the participant.

- Progress notes must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be drawn from the content of the note, i.e., general terms such as “called the participant” or “supported participant” or “assisted participant” is not sufficient and does not reflect adequate content. Check lists alone are not adequate documentation.

- Service logs must support the activity that is billed and provide enough narrative documentation/information to clearly identify the activity and the participants. OAAS and OCDD allow the support coordinators and the direct service providers of waiver services to utilize the service log to document required “progress notes” and “progress summaries.”

- The Department of Health and Hospitals (DHH) offices, OAAS and OCDD, do not prescribe a format for waiver documentation, but must find all components outlined below. The schedule for documentation differs based on each waiver/service system. Please see table for documentation schedule.

- All notes, summaries and service log entries in a participant’s record should include:
  1. Name of author/person making entry
  2. Signature of author/person making entry
  3. Functional title of person making entry
  4. Full date of documentation
  5. Signature or Initials indicating review by supervisor if required
  6. Must be legible and if hand written, in ink
  7. Narrative that follows definition for the type of documentation used.

REQUIRED DOCUMENTATION FOR DIRECT SERVICE PROVIDERS

Direct Service providers will document progress as follows:

- **Payroll Sheets**
- **Progress Notes/Service Logs –** Narrative that reflects each entry into the payroll sheet and elaborates on the activity of the contact. *(**Note:** The service log may be used for this documentation.)*
- **Progress Summary -** Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress/lack of progress toward desired outcomes and changes that may impact the CPOC and the needs of the individual. This summary should be sufficient in detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other direct support staff or their supervisors, and allows for evaluation of activities by program monitors. *(**Note:** The service log may be used for this documentation.)*
- **Discharge Summary for Transfers and Closures** - All transfers/closures will require a summary of progress prior to final closure.

SCHEDULE OF DOCUMENTATION for DIRECT SERVICE PROVIDERS

REQUIRED DOCUMENTATION	**PROGRAM**					
	EDA Elderly & Disabled Adult Waiver	**EPSDT** Targeted Populations	**NOW** New Opportunities Waiver	**CCW** Children's Choice Waiver	**SW** Supports Waiver	**LTPCS** Long Term Personal Care Services
PAYROLL SHEET	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity
SERVICE LOG/PROGRESS NOTE * **	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity
PROGRESS SUMMARY *	YES at least every quarter	YES at least every quarter	YES at least every quarter	YES between 6th & 9th month at least; more frequently if indicated	YES at least every quarter	N.A.
DISCHARGE SUMMARY FOR CLOSURE/ TRANSFER	Within 14 days of discharge	Within 14 days of discharge	Within 14 days of discharge	Within 14 days of discharge	Within 14 days of discharge	N.A.

***OAAS and OCDD allow support coordinators to utilize the service log to document "Progress Notes" and "Progress Summary."*
*** See program manual for specific documentation requirements.*

REQUIRED DOCUMENTATION FOR SUPPORT COORDINATORS

Support coordination providers will document progress as follows:

- **Service Logs**: - Chronology of events and contacts which support justification of critical support coordination elements for Prior Authorization (PA) of services in the CMIS system. Each service contact is to be briefly defined (i.e., telephone call, face to face visit) with a narrative in the form of a progress note. See below. ***NOTE:*** *OAAS and OCDD allow support coordinators to utilize the service log to document "Progress Notes" and "Progress Summary.*"
- **Progress Notes** - Narrative that reflects each entry into the service log and elaborates on the substance of the contact. *(**Note:** The service log may be used for this documentation.)*
- **Progress Summary** - Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress/lack of progress toward desired outcomes and changes to the social history. This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other support coordinators or their supervisors, and allows for evaluation of activities by program monitors. *(**Note:** The service log may be used for this documentation.)*
- **Discharge Summary for Transfers and Closures** - All transfers/closures will require a summary of progress prior to final closure. *(**Note:** The service log may be used for this documentation; the CMIS Closure Summary MUST be completed.)*

SCHEDULE OF DOCUMENTATION for SUPPORT COORDINATORS

REQUIRED DOCUMENTATION	**PROGRAM**				
	EDA Elderly & Disabled Adult Waiver	**EPSDT, HIV, FTM** Targeted Populations	**NOW** New Opportunities Waiver	**CCW** Children's Choice Waiver	**SW** Supports Waiver
SERVICE LOG **	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity
PROGRESS NOTE * **	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity	YES at time of each activity
PROGRESS SUMMARY *	YES at least every quarter	YES at least every quarter	YES at least every quarter	YES between 6th & 9th month at least; more frequently if indicated	YES at least every quarter
DISCHARGE SUMMARY FOR CLOSURE/ TRANSFER	Within 14 days of discharge	Within 14 days of discharge	Within 14 days of discharge	Within 14 days of discharge	Within 14 days of discharge

OAAS and OCDD allow support coordinators to utilize the service log to document "Progress Notes" and "Progress Summary."
******** *See program manual for specific documentation requirements.*

QUALITY ASSURANCE/QUALITY IMPROVEMENT MONITORING

Quality Assurance /Quality Improvement (QA/QI) PLAN

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

Agency Self-Evaluation

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

Report Of Self-Evaluation Findings

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

DHH
Office of Aging and Adult Services
P.O. Box 2031
Baton Rouge, LA 70821
OR
OCDD Waiver Supports and Services
QA/QI Program Manager
PO Box 317
Baton Rouge, LA 70821-3117

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

CHANGE OF ADDRESS/ENROLLMENT STATUS

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

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

AND

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

Program Monitoring

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

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

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

IMPORTANT INFORMATION/REMINDERS

HOSPICE SERVICES

DHH is pleased to announce that this policy has been reversed. Effective May 1, 2007, recipients may receive both hospice and waiver services concurrently. However, both hospice and waiver provides must work together to ensure that no services are duplicated. To ensure the integrity of both programs, Medicaid and OAAS collaborated to craft policy designed to reduce the possibility of duplication. Both Hospice and Waiver providers must adhere to this policy when providing services to a Medicaid recipient that is receiving both services. This includes recipients who have both Medicare/private insurance and Medicaid.

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

There will be no grandfathering in of participants.

Medicaid Waiver Recipients and Hospice Services

Recipients who receive home and community-based services through one of the waiver programs offered by OAAS or OCDD are also eligible for Medicaid hospice services. These waiver programs are:

Adult Day Health Care (ADHC) Waiver
Elderly and Disabled Adult (EDA) Waiver
New Opportunities Waiver (NOW)
Children's Choice Waiver (CCW)
Supports Waiver (SW)

Note: Long Term Personal Care Services (LT PCS) is a Medicaid State Plan Service and not a waiver service; LT PCS recipients may not receive hospice services while receiving LT PCS.

Service Coordination

Medicaid expects the hospice provider to interface with other non-hospice providers depending on the need of the recipient to ensure that the recipient's overall care is met and that non-hospice providers do not compromise or duplicate the hospice plan of care. This expectation applies to Medicaid hospice recipients and Medicare/Medicaid hospice recipients. The hospice provider must ensure that a thorough interview process is completed when enrolling a Medicaid or Medicare/Medicaid recipient to identify all other Medicaid or other state and/or federally funded program providers of care.

Medicaid waiver recipients who elect the hospice benefit do not have to disenroll from the waiver program, but they must be under the direct care of the Medicaid hospice provider for those services both programs have in common. The waiver member who elects the hospice benefit can still receive waiver services **that are not related to the terminal hospice condition and are not duplicative of hospice care**. The hospice provider and the waiver support coordinator must collaborate and communicate regularly to ensure the best possible overall care to the waiver/hospice member. These collaborative sessions must be documented in both

the hospice and waiver care manager/support coordinator progress notes. Failure to collaborate may result in administrative sanctions.

Guidelines for hospice and waiver providers include the following:

- The hospice provider, waiver provider and waiver case manager must meet to develop a coordinated plan of care.
    - The hospice provider must prepare the hospice plan of care to include all services that the hospice provider would have covered to treat the terminal illness and related conditions had the Medicaid recipient not been in the waiver program.
    - The waiver provider must prepare the waiver plan of care to include all services that the waiver provider would have covered had the Medicaid recipient not been in the hospice program.
    - The waiver providers must then modify the waiver plan of care to ensure there is no duplication of services by the waiver provider for those services held in common that would be necessary to treat the terminal illness and related conditions. For example, the waiver provider must modify or adjust hours in the waiver plan of care if the hospice agency must provide personal care , attendant care, or homemaker hours to treat the terminal condition that the waiver provider would otherwise provide if the recipient had not elected hospice services.
- Different diagnoses for the respective hospice and waiver plans of care are not sufficient to ensure that there is no duplication of services. Medical records of each provider may demonstrate that a patient's primary hospice diagnosis and patient's waiver diagnosis may intermingle to such a degree that it is not possible to differentiate between the waiver diagnoses and the hospice primary diagnoses.
- The fact the hospice provider and the waiver provider are in the member's home at different times is not sufficient to ensure that there is no duplication.
- Both providers must thoroughly document the required distinction between the services provided.
- The hospice provider shall be responsible for providing those services that intermingle between diagnoses. Approved waiver services shall be reduced by the appropriate level.

The hospice provider's failure to include all necessary hospice core services in the hospice plan of care for the waiver/hospice recipient subjects the hospice provider to recoupment when overpayment or duplication is identified.

SERVICE AREA/REGIONS

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

COMPREHENSIVE PLAN OF CARE

All CPOC planning must be person centered.

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

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

PROGRESS NOTES

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

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

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

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

CPOC IMPLEMENTATION DATES

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

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

MEDICAID ELIGIBILITY

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

MEDICAID WAIVER/INPATIENT SERVICES

Beginning, June 15, 2006, providers of Medicaid New Opportunity Waiver Services will no longer be reimbursed for providing waiver services to participants during inpatient hospital days. See the DHH website for further information.

MEDICAID WAIVER AND SUPPORT COORDINATION SERVICES POLICY AND REIMBURSEMENT

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

FREEDOM OF CHOICE

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

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

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

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

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

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

SERVICE LOGS/PROGRESS NOTES

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

Service Logs

1. Added to the list of service activities:
   17. Appeal Assistance
   18. EPSDT PA Tracking
   26. Annual Staffing (VACP only)
2. Added to the list of participants:
   12. Waiver Provider
   13. Medicaid Provider (non-waiver)
   14. Non-Medicaid Provider

15. PAL
16. Advocacy representative

3. Removed from the list of participants:
   06. Medicaid/Waiver Service Provider
4. For place of service, the following label changes were made:
   13. Case Management Agency became 13. Support Coordination Agency
   19. Waiver Service Provider's Place of Business became 19. Service Provider's Place of Business
5. End time of service is required for all services

Reports

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

Billing Updates

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

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

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

For questions regarding:	Contact:
Support Coordination policy and procedures	NOW Waiver, Children's Choice, and Supports Waiver: (225) 342--0095 OAAS (EDA): (225) 219-0200
Support Coordination software and data entry	Statistical Resources at (225) 767-0501
Verification of receipt of files	Statistical Resources at (225) 767-0501 (Statistical Resources will be able to verify the last file received and processed as of the prior business day.)
Prior authorization numbers (denial error codes 190 and 191)	Statistical Resources at (225) 767-0501
Denied claims or billing issues	Unisys Provider Relations at (800) 473-2783 or (225) 924-5040
Support Coordinator for EPSDT Targeted Population	Statistical Resources at (225) 767-0501

Job Assessment, Job Discovery, and Job Development Form

The Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, Waiver Supports and Services has issued a new form for the Supports Waiver Program effective March 27, 2007. The Job Assessment, Job Discovery, and Job Development Completion Form is to be used for all requests for job assessment, job discovery, and job development. This form is available via the website, www.lamedicaid.com, under the "New Medicaid Information" link. Providers are encouraged to visit the OCDD website at http://www.ocdd.dhh.louisiana.gov (Click on OCDD Waiver Unit link) for more information.

Note: See Appendix A for copy of forms.

BILLING

CESSATION OF SPAN DATE BILLING

Effective October 1, 2007, direct care providers (with the exception of support coordination agencies and personal emergency response providers) will no longer be allowed to use spanning service dates to bill claims for services. As of that date, when claims are submitted on the CMS 1500 claim form or electronically on the 837P, providers must line-item bill their services, indicating a single date of service and the number of service units provided on that particular day. In other words, providers will have to **bill one date of service per claim line**. Providers who bill claims using spanning dates after the effective date will receive denials with error code 351 – Span Date Not Allowed.

Prior authorizations (PAs) will remain unchanged and continue to span multiple days.

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

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

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

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

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

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

  Providers cannot bill for dates of services not yet performed
  Providers can only bill for one date of service per claim line. Span dates on billing will not be allowed after 10/1/07. All claims submitted with span dates will be denied.

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

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

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

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

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

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

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

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

CLAIMS FILING

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

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

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.	

Locator #	Description	Instructions	Alerts
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Patient Status	**Optional.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other coverage, the state assigned 6-digit TPL carrier code is **required** in this block (the carrier code list can be found at www.lamedicaid.com under the **Forms/Files** link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
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 block is **required**: If services are performed by a CRNA, enter the name of the directing physician. If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name. If services are performed by an independent laboratory, enter the name of the referring physician.	
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.**

Locator #	Description	Instructions	Alerts
17b	NPI	**Optional.**	**The revised form accommodates the entry of the referring provider's NPI.**
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	Reserved for Local Use	Reserved for future use. Do not use.	**Usage to be determined.**
20	Outside Lab?	**Optional.**	
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	
22	Medicaid Resubmission Code	**Optional**.	
23	Prior Authorization Number	**Situational** – Complete if appropriate or leave blank. If the services being billed must be Prior Authorized, the PA number is **required** to be entered.	
24	Supplemental Information	**Situational –** Applies to the detail lines for drugs and biologicals only. In addition to the procedure code, **the National Drug Code (NDC)** is **required** by the Deficit Reduction Act of 2005 for **physician-administered drugs** and **shall be entered** in the **shaded** section of 24A through 24G. **Claims for these drugs shall include the NDC from the label of the product administered.** 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	**Physicians and other provider types who administer drugs and biologicals must enter this new drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only.** **This information must be entered in addition to the procedure code(s).**

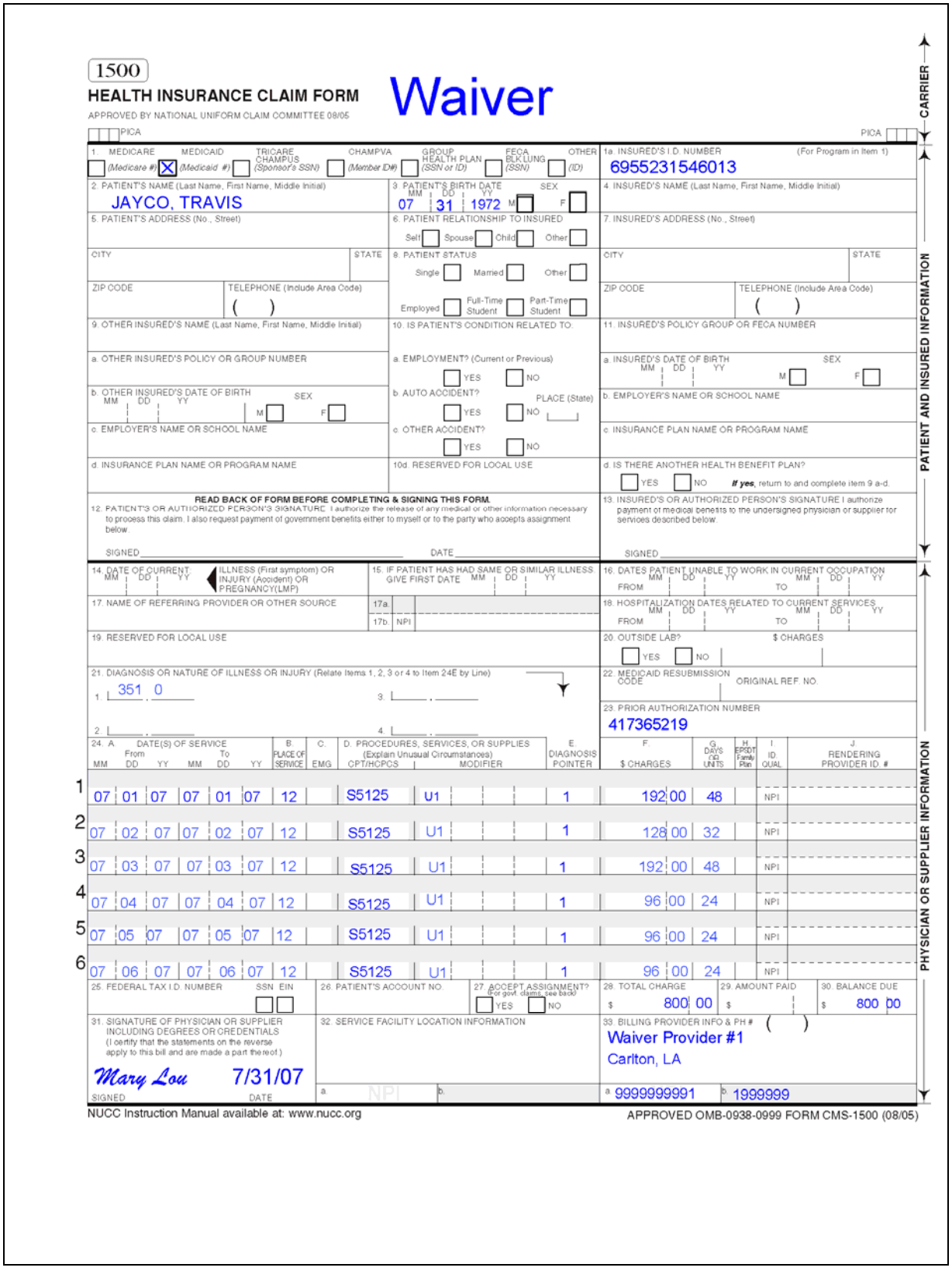
Locator #	Description	Instructions	Alerts
		space then enter the appropriate **Unit Qualifier** (see below) and the **actual units administered**. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space. The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram UN Unit	
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. No span dates accepted with DOS 10/1/07 Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	**Effective 10/1/07, no span dates will be accepted.**
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	**Situational** – Complete if appropriate or leave blank. When required, the appropriate CommunityCARE emergency indicator is to be entered in this field.	**This indicator was formerly entered in block 24I.**
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s).	
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	

Locator #	Description	Instructions	Alerts
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	**Optional.** If possible, leave blank for Louisiana Medicaid billing.	**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.	
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.	

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

Locator #	Description	Instructions	Alerts
33b	Unlabelled	**Required** – Enter the billing provider's 7-digit Medicaid ID number.	**Format change with addition of 33a and 33b for provider numbers.**

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



1500

HEALTH INSURANCE CLAIM FORM

Waiver

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): 6955231546013

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

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

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. 351 . 0

2. _____

3. _____

4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 417365219

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 01 07	07 01 07	12		S5125	U1		1	192 00	48		NPI	
2	07 02 07	07 02 07	12		S5125	U1		1	128 00	32		NPI	
3	07 03 07	07 03 07	12		S5125	U1		1	192 00	48		NPI	
4	07 04 07	07 04 07	12		S5125	U1		1	96 00	24		NPI	
5	07 05 07	07 05 07	12		S5125	U1		1	96 00	24		NPI	
6	07 06 07	07 06 07	12		S5125	U1		1	96 00	24		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 $ 800 00

29. AMOUNT PAID $

30. BALANCE DUE $ 800 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.)

Mary Lou 7/31/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Waiver Provider #1

Carlton, LA

a. 9999999991 b. 1999999

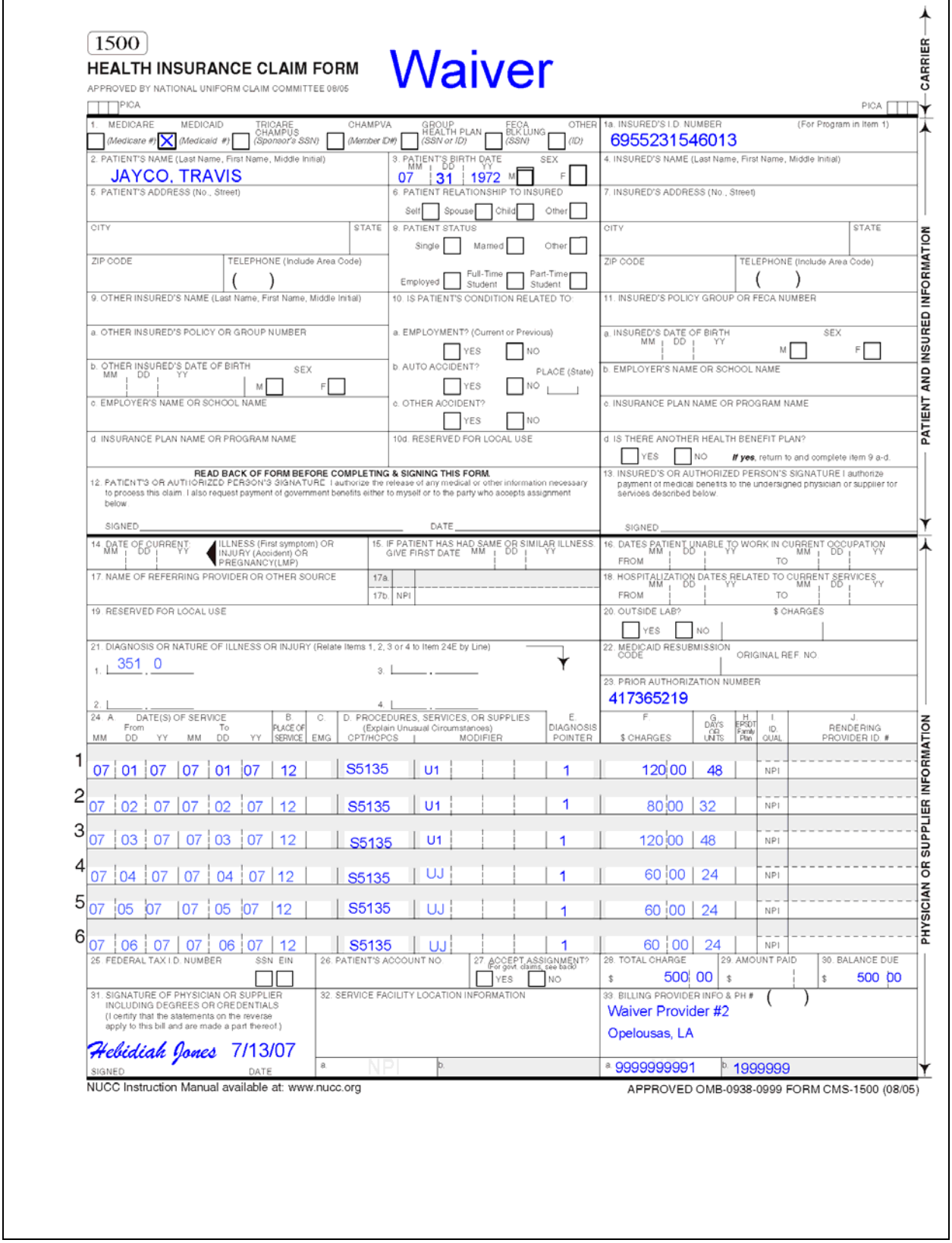
CARRIER

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)



1500

HEALTH INSURANCE CLAIM FORM

Waiver

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 6955231546013

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

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

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. 351.0 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 417365219

PHYSICIAN OR SUPPLIER INFORMATION

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 01 07	07 01 07	12		S5135	U1	1	120 00	48		NPI
2	07 02 07	07 02 07	12		S5135	U1	1	80 00	32		NPI
3	07 03 07	07 03 07	12		S5135	U1	1	120 00	48		NPI
4	07 04 07	07 04 07	12		S5135	UJ	1	60 00	24		NPI
5	07 05 07	07 05 07	12		S5135	UJ	1	60 00	24		NPI
6	07 06 07	07 06 07	12		S5135	UJ	1	60 00	24		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 $ 500 00

29. AMOUNT PAID $

30. BALANCE DUE $ 500 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.)

Hebidiah Jones 7/13/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Waiver Provider #2

Opelousas, LA

a. 9999999991 b. 1999999

NUCC Instruction Manual available at: www.nucc.org

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

FILING ADJUSTMENTS AND VOIDS

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

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

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

Electronic submitters may electronically submit adjustment/void claims.

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

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

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

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

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

INSTRUCTIONS FOR FILING ADJUSTMENT/VOID CLAIMS

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

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

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

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

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

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

7. **Insured's Name**— Leave blank.

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

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

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

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

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

13. **Date of**—Leave blank.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

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

ADJUSTMENT

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

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

UNISYS - 213
5/97

FISCAL AGENT COPY

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

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

WAIVER

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): JAYCO, TRAVIS
3 PATIENT'S DATE OF BIRTH: 07/31/1972
4 MEDICAID ID NUMBER: 6955231546013
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [ ]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

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

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
07	01	07	07	01	07	12	S5125	U1	1	385 00	110		

26 CONTROL NUMBER: 7360056789100
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: 07/24/07

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 UNIT AMOUNT

ADJUSTMENT

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
MARY LOU *07/05/07*
32 YOUR PATIENT'S ACCOUNT NUMBER
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Waiver Provider #1
Carlton, LA
1418230

UNISYS - 213
5/97

FISCAL AGENT COPY

MEDICAID STATE PLAN PERSONAL CARE SERVICES

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

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

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

Providers must first be licensed and Medicaid certified by the Department's Health Standards Section (HSS) as a Personal Care Attendant Agency and then obtain a provider type case 24 provider number in order to provide personal care services. The 2007 Personal Care Services Training Packet can offer more detailed information on this program.

COMMUNITYCARE

PROGRAM DESCRIPTION

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

RECIPIENTS

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

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

CommunityCARE enrollees are identified under the CommunityCARE segment of REVS, MEVS and the online verification system through the Unisys website – www.lamedicaid.com. This segment gives the name and telephone number of the linked PCP.

PRIMARY CARE PHYSICIAN

As part of the PCPs' care coordination responsibilities they are obligated to ensure that referral authorizations for medically necessary healthcare services which they can not/do no provide are furnished promptly and without compromise to quality of care. The PCP shall not unreasonably withhold or deny valid requests for referrals/authorizations that are made in accordance with CommunityCARE policy. The PCP also shall not require that the requesting provider complete the referral authorization form. The State encourages PCPs to issue appropriately requested referrals/authorizations as quickly as possible, taking into consideration the urgency of the enrollee's medical needs, not to exceed a period of 10 days. Although this time frame was designed to provide guidance for responding to requests for post-authorizations, we encourage PCPs to respond to requests sooner than 10 days if possible. Deliberately holding referral authorizations until the 10th day just because the PCP has 10 days is inappropriate.

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

The Medicaid covered services, which do not require authorization referrals from the CommunityCARE PCP, are "**exempt**." The current list of exempt services is as follows:

- Chiropractic service upon KIDMED referrals/authorizations, ages 0-21.
- Dental services for children, ages 0-21 (billed on the ADA claim form).
- Dental Services for Pregnant Women (ages 21-59), billed on the ADA claim form
- Dentures for adults.
- The three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but **do require POST authorization**. Refer to "Emergency Services" in the CommunityCARE Handbook.
- Inpatient Care that has been pre-certed (this also applies to public hospitals even without pre-certification for inpatient stays): hospital, physician, and ancillary services billed with inpatient place of service.
- EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program.
- Family planning services.
- Prenatal/Obstetrical services.
- Services provided through the Home and Community-Based Waiver programs.
- Targeted case management.
- Mental Health Rehabilitation(privately owned clinics).
- Mental Health Clinics (State facilities).
- Neonatology services while in the hospital.
- Ophthalmologist and Optometrist services (age 0-21).
- Pharmacy.
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists services.
- Transportation services.
- Hemodialysis.

- Hospice services.
- Specific outpatient laboratory/radiology services.
- Immunization for children under age 21 (Office of Public Health and their affiliated providers).
- WIC services (Office of Public Health WIC Clinics).
- Services provided by School Based Health Centers to recipients age 10 and over
- Tuberculosis clinic services (Office of Public Health).
- STD clinic services (Office of Public Health).
- Specific lab and radiology codes.

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

NON-PCP PROVIDERS AND EXEMPT SERVICES

Any provider other than the recipient's PCP must obtain a referral from the recipient's PCP, **prior to rendering services**, in order to receive payment from Medicaid. Any provider who provides a non-exempt, non-emergent (routine) service for a CommunityCARE enrollee, without obtaining the appropriate referral/authorization prior to the service being provided risks non-payment by Medicaid. **DHH and Unisys will not assist providers with obtaining referrals/authorizations for routine/non-urgent care not requested in accordance with CommunityCARE policy.** PCPs are not required to respond to requests for referrals/authorizations for non-emergent/routine care not made in accordance with CommunityCARE policy: i.e. requests made after the service has been rendered.
When a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the patient's PCP to obtain the appropriate referral/authorization for any follow-up services the patient may need after discharge (i.e. Durable Medical Equipment (DME) or home health). Neither the home health nor DME provider can receive reimbursement from Medicaid without the appropriate PCP referral/authorization. **The DME and home health provider must have the referral/authorization in hand prior to rendering the services.**

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

Providers:

Unisys - (800) 473-2783 or (225) 924-5040 - CommunityCARE Program policy, procedures, and problems, complaints concerning CommunityCARE

ACS - (800) 259-4444 PCP - assignment for CommunityCARE recipients, inquiries related to monitoring, certification

ACS - (877) 455-9955 – Specialty Care Resource Line - assistance with locating a specialist in their area who accepts Medicaid

Enrollees:

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

- CommunityCARE Enrollee Hotline (800) 259-4444: Provides assistance with questions or complaints about CommunityCARE or their PCP. It is also the number recipients call to select or change their PCP.
- Specialty Care Resource Line (877) 455-9955: Provides assistance with locating a specialist in their area who accepts Medicaid.
- 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

ELECTRONIC DATA INTERCHANGE (EDI)

CLAIMS SUBMISSION

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

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

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

CERTIFICATION FORMS

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

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

Required Certification forms may be obtained from lamedicaid.com. Under the Provider Enrollment link, click on Forms to Update Existing Provider Information.

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

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

ELECTRONIC DATA INTERCHANGE (EDI) GENERAL INFORMATION

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

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

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

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

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

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

Enrollment Requirements For EDI Submission

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

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

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

Enrollment Requirements For 835 Electronic Remittance Advices

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

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

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

ELECTRONIC ADJUSTMENTS/VOIDS

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

SUBMISSION DEADLINES
Regular Business Weeks

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

Thanksgiving Week

Magnetic Tape and Diskettes	4:30 P.M. Tuesday, 11/20/07
KIDMED Submissions	4:30 P.M. Tuesday, 11/20/07
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/21/07

Important Reminders For EDI Submission

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

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

HARD COPY REQUIREMENTS

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

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

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

CLAIMS PROCESSING REMINDERS

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

Electronic claims submission is the preferred method for submitting claims; however, if claims cannot be submitted electronically, prepare paper claim forms according to the following instructions to ensure appropriate and timely processing:

- Submit an original claim form whenever possible. Claim forms **must be two sided** documents and include the standard information on the back regarding fraud and abuse. If a copy is submitted, it should be legible, and not too light or too dark.

- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.

- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. **DO NOT use a highlighter to draw attention to specific information.**

- Paper claims must be legible and in good condition for scanning into our document imaging system.

- **Don't forget to sign and date your claim form <u>if the claim form requires a signature</u>. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.**

- Continuous feed forms must be torn apart before submission.

- Use high quality printer ribbons or cartridges-black ink only.

- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.

- Do not use italic, bold, or underline features.

- Claims submitted should be two-sided documents and include the standard information on the back regarding fraud and abuse.

- **Do not use white out or a marking pen to omit claim line entries. To correct an error, draw a line through the error and initial it. Use a black ballpoint pen (medium point).**

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

Attachments

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

Changes to Claim Forms

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

Data Entry

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

Rejected Claims

Each year, Unisys returns more than 250,000 claims that are illegible or incomplete. These claims are not processed and are returned along with a cover letter stating why the claim(s) is/are rejected. The most common reasons for rejection are listed as follows:

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

The criteria for legible claims are:

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

Correct Claims Submission

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

IMPORTANT UNISYS ADDRESSES

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

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

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

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

TIMELY FILING GUIDELINES

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

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

DATES OF SERVICE PAST INITIAL FILING LIMIT

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

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

OR

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

OR

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

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

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

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

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

SUBMITTING CLAIMS FOR TWO-YEAR OVERRIDE CONSIDERATION

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

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

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

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

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

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

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

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

PROVIDER ASSISTANCE

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

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

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

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

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

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

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

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

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

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

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

- ☞ Only messages left in reference to printed materials will be processed when choosing this option. Please review the other options outlined in this section for assistance with other provider issues.

- ☞ Fee schedules, TPL carrier code lists, provider newsletters, provider workshop packets and enrollment packets may be found on the LA Medicaid website. Orders for these materials should be placed through this option **ONLY** if you do not have web access.

- ☞ Provider Relations staff mail each new provider a current copy of the provider manual and training packet for his program type upon enrollment as a Medicaid provider. An enrolled provider may also request a copy of the provider manual and training packet for the Medicaid program in which he is enrolled. A fee is charged for provider manuals and training packets ordered for non-providers (attorneys, billing agents, etc.) or by providers wanting a manual for a program for which they are not enrolled. All orders for provider manuals and training packets should be made by contacting the Provider Relations Telephone Inquiry Unit. Those requiring payment will be forwarded to the provider once payment is received.

Provider Relations cannot assist recipients. The telephone listing in the "Recipient Assistance" section found on page 80 should be used to direct Medicaid recipient inquiries appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

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

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

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

Press #4 - To resolve a claims problem

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

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

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

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

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

Providers who wish to submit problem claims for research and want to receive a written response, **must submit a cover letter** explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). A copy of the claim form along with applicable corrections/and or attachments must accompany all resubmissions.

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

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

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

Eligiblity File Updates: Provider Relations staff also handles requests to update recipient files with correct eligibility. Staff in this unit does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

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

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

"Clean" Claims: "Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box. A complete list is available in this training packet under "Unisys Claims Filing Addresses". **CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.**

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

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

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

FIELD ANALYST	PARISHES SERVED	
Kellie Conforto (225) 216-6269	Jefferson Orleans Plaquemines	St. Bernard St. Tammany **(Slidell Only)**
Stacey Fairchild (225) 216-6267	Ascension Assumption Calcasieu Cameron Jeff Davis Lafourche St. Charles	St. James St. John St. Martin **(below Iberia)** St. Mary Terrebonne Vermillion Beaumont (TX)
Tracey Guidroz (225) 216-6201	West Baton Rouge Iberville Tangipahoa St. Tammany **(except Slidell**)	Washington Centerville (MS) McComb (MS) Woodville (MS)
Ursula Mercer (225) 216-6273	Bienville Bossier Caddo Caldwell Claiborne Catahoula Concordia East Carroll Franklin Jackson	LaSalle Lincoln Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Vicksburg (MS) Marshall (TX)
Kelli Nolan (225) 216-6260	East Baton Rouge East Feliciana Livingston	Pointe Coupee St. Helena West Feliciana
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin **(above Iberia)**
Sherry Wilkerson (225) 216-6306	Avoyelles Beauregard DeSoto Grant Natchitoches Rapides	Red River Sabine Vernon Winn Jasper (TX) Natchez (MS)

PROVIDER RELATIONS REMINDERS

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

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

- If a provider has a large number of claims to reconcile, it may be to the provider's advantage to order a provider history. Please see the Ordering Information section for instructions on ordering a provider history.

- **Provider Relations cannot assist recipients.** The telephone listing in the "Recipient Assistance" section found in this packet should be used to direct Medicaid recipient inquires appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

- Providers who wish to submit problem claims for a written response **must submit a cover letter** explaining the problem or question.

- Calls regarding eligibility, claim issues, requests for Unisys claim forms, manuals, or other policy documentation should not be directed to the Field Analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit.

DHH PROGRAM MANAGER REQUESTS

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

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

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

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

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – DHH	(800) 834-3333 (225) 925-6606	Providers may request verification of eligibility for presumptively eligible recipients; recipients may request a new card or discuss eligibility issues.
Eligibility Operations –BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information about the LaCHIP Program that expands Medicaid eligibility for children from birth to 19.
Office of Public Health - Vaccines for Children Program	(504) 838-5300	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Specialty Care Resource Line - ACS	(877) 455-9955	Providers and recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED. Providers may inquire about PCP assignment for CommunityCARE recipients and CommunityCARE monitoring/certification, and obtain information on KIDMED linkage, referrals, monitoring, and certification.
Louisiana Medicaid Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - OCDD	(866) 327-5978	Providers and recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4149	Providers may request termination as a recipient's lock-in provider.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (866) 758-5035	Providers and recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 342-0095 (866) 783-5553	Providers and recipients may request assistance regarding waiver services to waiver recipients.
Family Planning Waiver	(225) 219-4153	Providers may request assistance about the family planning waiver.
DHH Rate and Audit	(225) 342-6116	For LTC, Hospice, PACE, and ADHC providers to address rate setting and claims or audit issues.

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

Provider Relations cannot assist recipients. The telephone listing below should be used to direct recipient inquiries appropriately.

Department	Phone	Purpose
Fraud and Abuse Hotline	(800) 488-2917	Recipients may anonymously report any suspected fraud and/or abuse.
Regional Office – DHH	(800) 834-3333 (225) 925-6606	Recipients may request a new card or discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Specialty Care Resource Line - ACS	(877) 455-9955	Recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED.
Louisiana Medicaid Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program – OCDD	(866) 327-5978	Recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Recipients may obtain immunization information.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (800) 660-0488	Recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 342-0095 (866) 783-5553	Recipients may request assistance regarding waiver services.
Family Planning Waiver	(225) 219-4153	Recipients may request assistance regarding family planning waiver services.

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

LOUISIANA MEDICAID WEBSITE APPLICATIONS

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

www.lamedicaid.com

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

PROVIDER LOGIN AND PASSWORD

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

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

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

WEB APPLICATIONS

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

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

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

e-MEVS:

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

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

e-CSI:

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

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

e-CDI:

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

The nine (9) clinical services information components are:

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

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

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

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

e-PA

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

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

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

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

Reminders:

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

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

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

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

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

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

RECONSIDERATION REQUESTS (RECONS) CAN BE SUBMITTED USING e-PA AS LONG AS THE ORIGINAL REQUEST WAS SUBMITTED THROUGH e-PA.

ADDITIONAL DHH AVAILABLE WEBSITES

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

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

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

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

www.la-kidmed.com: KIDMED – program information, Frequently Asked Questions, outreach material ordering

www.la-communitycare.com: CommunityCARE – program information, PCP listings, Frequently Asked Questions, outreach material ordering

https://linksweb.oph.dhh.louisiana.gov: Louisiana Immunization Network for Kids Statewide (LINKS)

www.ltss.dhh.louisiana.gov: Division of Long Term Community Supports and Services (OAAS)

www.dhh.louisiana.gov/offices/?ID=77: Office of Citizens with Developmental Disabilities (OCDD)

www.dhh.louisiana.gov/offices/?ID=334: Early Steps Program

www.dhh.state.la.us/offices/?ID=111: DHH Rate and Audit Review (nursing home updates and cost report information, Outpatient Surgery Fee Schedule, Updates to Ambulatory Surgery Groups, contacts, FAQ)

www.doa.louisiana.gov/employ_holiday.htm: State of Louisiana Division of Administration site for Official State Holiday

APPENDIX A – OCDD FORM - SUPPORTS WAIVER PROGRAM

JOB ASSESSMENT, JOB DISCOVERY, AND JOB DEVELOPMENT COMPLETION FORM

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
SUPPORTS WAIVER (SW)

Job Assessment, Job Discovery, and Job Development Completion Form

Instructions: This form is to be used for all requests for Job Assessment, Job Discovery, and Job Development. The support coordinator will complete Section 1 and must submit with the ISP to the OCDD Regional Office. Section 2 will be completed by the OCDD Regional Office. When completed, OCDD Regional Office will send it to the support coordinator who will forward it to the provider. Section 3 will be completed by the enrolled service provider. If any adjustments are to be made to the services/timelines, the individual's support team members must submit the revised the ISP (i.e., objectives, time-lines), the revised ISP along with the support team signature sheet. Section 4 will be completed by the support coordinator and signed by the recipient/guardian. All documentation is to be forwarded to the OCDD Regional Office.
All signatures are mandatory.

SECTION 1: MUST BE COMPLETED BY THE SUPPORT COORDINATOR

RECIPIENT'S NAME: _____ MEDICAID ID #: _____

ADDRESS: _____ DIAGNOSIS: _____

SUPPORT COORDINATION AGENCY: _____ PHONE #: ( )

ADDRESS: _____ PROVIDER #: _____

PROVIDER OF SUPPORTED EMPLOYMENT ACTIVITIES: _____ PHONE #: ( )

ADDRESS: _____ PROVIDER #: _____

DESCRIPTION OF REQUESTED ACTIVITIES: (JOB ASSESSMENT, JOB DISCOVERY, AND/OR JOB DEVELOPMENT) _____ DATE SERVICE REQUESTED: _____ ANTICIPATED COMPLETION DATE: _____

REQUESTED UNITS: _____ ISP AND TIMELINE ATTACHED: YES/NO PROCEDURE CODE: _____

PROVIDER AGREEMENT SIGNATURE: _____ DATE: _____

SUPPORT COORDINATION AGENCY AGREEMENT SIGNATURE: _____ DATE: _____

RECIPIENT/FAMILY AGREEMENT SIGNATURE:: _____ DATE: _____

SECTION 2 – OCDD AGREEMENT DETAILS: MUST BE COMPLETED BY THE OCDD REGIONAL OFFICE

APPROVED ACTIVITY: (JOB ASSESSMENT, JOB DISCOVERY, AND/OR JOB DEVELOPMENT) _____

PROCEDURE CODE: _____ APPROVED UNITS: _____

OCDD SIGNATURE: _____ DATE OF APPROVAL: _____

APPROVAL AND SUBSEQUENT PRIOR AUTHORIZATION BY THE OCDD OFFICE DOES NOT OVERRIDE ANY LIMITS THE INDIVIDUAL HAS ALREADY MET.

SECTION 3 – PROVIDER VERIFICATION OF COMPLETION: MUST BE COMPLETED BY ENROLLED SERVICE PROVIDER

DESCRIPTION OF ACTIVITY: (JOB ASSESSMENT, JOB DISCOVERY, AND/OR JOB DEVELOPMENT) _____ NUMBER OF UNITS PROVIDED: _____

DATE ACTIVITY BEGAN: _____ DATE ACTIVITY COMPLETED: _____

PROVIDER'S SIGNATURE: _____ DATE: _____

RECIPIENT/FAMILY SIGNATURE: _____ DATE: _____

SECTION 4 – SUPPORT COORDINATOR'S POST AUTHORIZATION SUMMARY: MUST BE COMPLETED BY THE SUPPORT COORDINATOR

DATE COMPLETED ACTIVITY VERIFIED: _____ APPROVED UNITS: _____

COMMENTS: _____

SUPPORT COORDINATOR'S SIGNATURE: _____ DATE: _____

RECIPIENT/FAMILY ACCEPTANCE SIGNATURE: _____ DATE: _____

SUPPORT COORDINATION AGENCY SUBMITS TO OCDD OFFICE FOR MODIFIED PA RELEASE

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Job Assessment, Job Discovery, Job Development Form
Instructions
SUPPORTS WAIVER (SW)

SECTION 1

a. The support coordinator will complete information in Section 1 once the participant/participant's representative has chosen a direct service provider and an approved ISP is received.

b. The direct service provider will submit the portion of the ISP covering Job Assessment, Job Discovery and Job Development services to the support coordinator with measurable goals, objectives, and time-lines in order to receive prior-authorization. The direct service provider will ensure that the ISP is signed and dated by the participant/participant representatives and support team members indicating agreement with the goals, objectives and time lines.

c. The support coordinator will ensure that the service provider is aware of the activities involved in Job Assessment, Job Discovery, and Job Development. The service provider will bear the burden of liability with all applicable licensing requirements in effect for the area of the state in which the activity is being conducted.

Description of Requested Activity	Support coordinator will enter the Procedure Name: (Job Assessment, Job Discovery, and/or Job Development)
Date Service Requested	Support coordinator will enter the date that the service (Job Assessment, Job Discovery, and/or Job Development) was requested.
Anticipated Completion Date	Support coordinator will enter the anticipated completion date of the activity (Job Assessment, Job Discovery, Job Development) as indicated by service provider.
Requested Units	Support coordinator will enter the number of units requested for the activity. (Activities will be authorized for a maximum of 120 units in a service year for individual Job Assessment, Job Discovery and Job Development, and 20 units in a service year for group Job Assessment, Job Discovery and Job Development: A standard unit of service is 6 or more hours per day.)
ISP and Timeline Attached	Notes whether or not the ISP and time line are attached
Provider Agreement Signature	Presence of a signature of service provider indicates agreement to provide the activity and anticipated completion date.
Support Coordination Agency Agreement Signature	Presence of a signature of support coordination agency representative indicates agreement with the need of the activity, number of units, and anticipated completion date.
Recipient/Family Agreement Signature	Presence of a signature indicates approval of the recipient/family, and agreement with the number of units and anticipated completion date.

The support coordinator will forward the Job Assessment, Job Discovery, and Job Development Form along with the ISP to the OCDD Regional Office for review and completion of Section 2.

SECTION 2

a. The OCDD Regional Office will enter the approved activity, the procedure code of the approved activity and the number of units of the approved activity (only the amount approved shall be reimbursed).

b. A regional office staff signature in the section labeled "OCDD Agreement" indicates authorization of the requested activity and unit amount payable to the provider for the activity.

c. The OCDD Regional Office staff will enter the date of the approval for the activity.

d. The approval and subsequent prior authorization by the regional office does not override any limits the individual has already met.

Approved Activity	OCDD will list the type of activity approved (Job Assessment, Job Discovery and/or Job Development).
Approved Units	Number of standard service units approved (only the amount approved shall be reimbursed)
Procedure Code	Support coordinator will indicate appropriate procedure code for the activity.
OCDD Agreement Signature	Indicates authorization of the requested activity and unit amount payable to the provider for the activity. (However, the approval of the OCDD Office does not override any limits the individual has already met.)
Date Activity Approved	Actual date OCDD approved activities

The OCDD Regional Office will send the form and ISP (and any attachments) back to the support coordinator who will forward it to the provider.

SECTION 3

a. The selected service provider will complete this section of the form after the activity is completed.

b. The service provider will then forward the form, ISP, and any additional documentation to the support coordinator.

Job Assessment

To receive post-authorization for Job Assessment, one or more of the following documents must be submitted along with this form to the support coordinator:

- Completed vocational assessment
- Completed job analysis
- Notes from community-based/facility-based situational assessments
- Participant profile
- Placement plan

Approval of Job Assessment documents will be based on the following:

- The objectives and time lines outlined in the ISP were met timely.
- Identification in the document(s) of basic guidelines a job would need to meet.
  These guidelines must include but are not limited to:
  - Specific career interest(s) are identified.
  - Maximum hours per week participant will consider working.
  - Minimum rate of pay participant will accept.
  - Benefits participant receives that might impact earnings, in particular SSI and/or SSDI.
  - Times of day participant will consider working.
  - Areas of town, city or parish(s) participant will consider working.
  - Transportation currently available to participant.
  - Current work strengths/skills that will help participant obtain job of his/her choosing.
  - Current barriers to participant obtaining job of his/her choosing.
  - If group employment is the career outcome, the staff ratio needed to support the participant.

Job Assessment activities for individual/self-employment/microenterprise will be authorized for a maximum of 120 standard units in a service year (a standard unit of service is 6 or more hours per day). Job Assessment activities for group employment will be authorized for a maximum of 20 standard units in a service year. Utilization of Job Assessment units will be counted towards the total available units for Job Assessment, Discovery and Development for a service year. Therefore, if 120 (individual job/self-employment/microenterprise) or 20 (group employment) standard units are utilized in a service year, Job Discovery and Development could not begin until the next service year. If all available units in Job Assessment, Discovery and Development are used for Job Assessment for a participant in one service year, only Job Discovery and Development activities and not Job Assessment will be authorized for the next service year.

Job Discovery and Development

Job Discovery and Development consists of one or more of the following activities:

- Marketing agency services to employers that match the participant's interest in order to establish business relationships that could result in job opportunities for the participant.
- Assisting the participant to make use of all available job services through One-Stop career centers.
- Contacting specific employers whose business matches the participant's career interests, or who are advertising for open positions through newspaper advertisements, websites, or word of mouth.
- Assisting the participant in creating a resume.
- Assisting the participant in preparing for a job interview.
- Transporting the participant to a job interview.
- Accompanying the participant to a job interview if requested to do so.
- Referring participant to work incentives, planning and assistance representatives when necessary, or as requested.
- Reconfiguring an existing position to fit the employer and participant's needs, also know as job restructuring.
- Consulting and/or negotiating as needed and/or requested with employer on rate of pay, benefits, and employment contracts.
- Restructuring a work site to maximize a participant's ability to perform the job, also know as job accommodations.
- Travel training to enable a participant to independently travel from his/her home to place of employment.
- Providing employee education and training as requested by employer on disability issues.
- Providing employers with information on benefits available when hiring a person with a developmental disability, such as job training (OJT) or Work Opportunities Tax Credit (WOTC).
- Assisting with personal care activities of daily living.

- The following activities are included for self-employment/microenterprise:

    - Coordinating of access to grants and other resources needed to begin and/or sustain the enterprise.
    - Identifying equipment and supplies needed.
    - Facilitating consultation with groups able to offer guidance such as SCORE and the Small Business Administration.
    - Assisting with creation of a business plan.
    - Facilitating of interactions with required legal entities such as necessary business licensing agencies, fire marshals and building inspectors.
    - Assisting with hiring, training and retaining appropriate employees.

  The participant may or may not be present during Job Discovery and Development activities. If the participant is not present, a signed and dated confidentiality form must be in the participant's record in his/her native language indicating that the participant has approved contacts, meetings, education or training to occur in his/her absence.

Documentation Requirements for Job Discovery and Job Development

The following documents reflecting the participant's choice of occupation as documented on the ISP must be submitted to the participant's support coordinator for approval. These elements can be listed or contained in a narrative report.

- All objectives and time lines related to Job Discovery and Development outlined in the ISP were met timely. If changes were made, the revised ISP and the new signature page with dates must be attached.
- Date, time, names and addresses of companies contacted and method of contact (e.g., in-person, by phone, letter, e-mail or through employer's website).
- Job restructuring activities, including meetings specific to an identified job in a community business, including date, time, names, and job titles of community business staff in attendance. If meeting(s) occurred, meeting minutes must be submitted.
- Community business education and/or trainings specific to an identified job in a community business, including date, time, names and job titles of community business staff in attendance, and content of education and/or training session(s).
- Job accommodation, travel training, and any other employment related activities specific to an identified job in a community business.
- Amount of time spent in discovery and development per day.
- Confidentiality release forms in the participant's native language, if applicable, that he/she approved contacts, meetings, education or training to occur in his/her absence.

Rates for Job Discovery and Development are paid per participant, not per group. Job Discovery and Development may be provided on one staff to multiple participant ratios. Documentation of Job Discovery and Development must be specific to each participant regardless of staff to participant ratio.

(When individual Job Discovery and Development is billed on one staff to multiple participant ratio, post authorization documentation must show individual outcomes. For example, if an employment specialist bills for two participants on the same day for the same time period, post authorization documentation must show that job development efforts were made for each individual according to his/her identified specific career interests. If both participants identified career interests are restaurant work, then billing could reflect a visit to one restaurant on behalf of both participants. However, if one participant's identified career interest is restaurant work and the other participant wishes to work in a medical setting, documentation must show visits to the specific type of business for each participant.)

NOTE: All activities are to be performed in the year the current ISP is approved, or an ISP amendment must be completed. Specific documentation that reflects the goals, objectives and time lines on the ISP related to those activities have been met must be submitted to the participant's support coordinator for post-authorization.

If an objective or time line cannot be met timely, the provider must facilitate changes prior to the end date of the objectives and time lines on the ISP and obtain support team members' dated signatures indicating agreement with the changes. Partial completion of Job Assessment, Discovery and/or Development of ISP objectives and time lines will not qualify for post authorization of payment.

Description of Activity	Description of activity provided and completed (attach appropriate documentation)
Units Provided	Number of standard service units provided (only the amount approved shall be reimbursed)
Provider's Signature	Presence of a signature indicates the activity has been completed by service provider as agreed upon.
Date Activity Began	Actual date the activities began
Date Activity Completed	Actual date of completion
Recipient/Family Signature	Presence of a signature verifies that the activity was completed.

The service provider will then provide the form with the original signature(s), ISP (amended ISP if changed), and documentation to the support coordinator who will then review the activity with the family and complete Section 4. This form, ISP, and documentation can be faxed to the support coordinator and the original form mailed to expedite the process.

SECTION 4

a. The support coordinator will complete this section and obtain the signature of recipient/family member indicating approval/agreement, and send a copy of the form, the ISP and necessary documentation to the OCDD Regional Office via fax or mail within ten (10) working days of the date of the actual completion of the activity.

b. The OCDD Regional Office staff, upon receipt of required documentation, will forward the information to the state data contractor.

Date Completed Activity was Verified	Date form (and attachments) were verified as having been completed by OCDD
Approved Units	Indicates number of approved units (only the amount approved shall be reimbursed)
Comments	Documentation noting any additional comments and/or information
Support Coordinator's Signature	Presence of a signature verifies acceptance of documentation that the activity was completed.
Recipient/Family Signature	Presence of a signature verifies that the activity was completed.

HOW DID WE DO?

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

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

Provider Subspecialty (if applicable):_____

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

Do you have internet access in the workplace?_____

Do you use www.lamedicaid.com?_____

What topic was most beneficial to you?_____

Please provide us with your business email address:_____

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

Please provide constructive comments and suggestions:_____

_____

_____

_____

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