UNISYS

KIDMED PROVIDER TRAINING

Fall 2007

LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

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

This packet does not present general Medicaid policy such as recipient eligibility and ID cards, and third party liability. The 2006 Basic Training packet may be obtained by downloading it from the Louisiana Medicaid website, www.lamedicaid.com.

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS
FOR CHILDREN AND YOUTH

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES.
TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.
(See listing of numbers on attachment)

MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.** Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828.

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED.
TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955
(or TTY 1-877-544-9544)

MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive Mental Health Rehabilitation Services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by mental health prior authorization unit.

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES
Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. Personal Care Services do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS must be ordered by a physician. The PCS provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES
Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT
If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. *EARLYSTEPS* CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

MEDICAL EQUIPMENT AND SUPPLIES
Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical Equipment and Supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

TRANSPORTATION
Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544).
IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED,
CALL 1-888-758-2220 FOR ASSISTANCE.

OTHER MEDICAID COVERED SERVICES

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

Services Available to Medicaid Eligible Children Under 21

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

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

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

If you need a service that is not listed above call the referral assistance coordinator at KIDMED (toll free) 1-877-455-9955 (or TTY 1-877-544-9544). If they cannot refer you to a provider of the service you need call 225-342-5774.

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

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

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

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

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

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

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CSRAs

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

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

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

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

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

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

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

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

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

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

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STANDARDS FOR PARTICIPATION

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

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

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

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

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

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

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

Picking and Choosing Services

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

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

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

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

Statutorily Mandated Revisions to All Provider Agreements

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

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

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

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

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

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

Surveillance Utilization Review

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

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

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

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

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

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

Fraud and Abuse Hotline

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

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

Deficit Reduction Act of 2005

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

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

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

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

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

KIDMED SCREENINGS

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

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

KIDMED Linkage

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

Medical Screening

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

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

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

Louisiana Medicaid reimbursement for a completed medical screening is $58.65. **

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

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

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

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

** Note: Reimbursement fees as of September 1, 2007 are current and subject to change.

Vision Screening

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

Subjective Vision Screening

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

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

Objective Vision Screening

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

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

- visual acuity (Snellen Test or Allen Cards for preschoolers and equivalent tests such as Titmus, HOTV or Good Light, or Keystone Telebinocular for older children);

- color perception (must be performed at least once after the child reaches the age of 6 using polychromatic plates by Ishihara, Stilling, or Hardy-Rand-Ritter); and

- muscle balance (including convergence, eye alignment, tracking, and a cover-uncover test).

Louisiana Medicaid reimbursement for a completed objective vision screening is $4.00. **

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

99173 with **EP** modifier	Vision Screening

** Note: Reimbursement fees as of September 1, 2007 are current and subject to change.

Hearing Screening

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

Subjective Hearing Screening

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

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

Objective Hearing Screening

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

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

Louisiana Medicaid reimbursement for a completed objective hearing screening is $3.60. **

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

92551	Hearing Screening

** Note: Reimbursement fees as of September 1, 2007 are current and subject to change.

Immunizations

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

Laboratory

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

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

Neonatal Screenings

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

Billing Information

Only KIDMED medical, vision, and hearing screenings should be billed on the KM-3 hard copy KIDMED claim form. If billing electronically, KIDMED medical, vision, and hearing screenings must be billed on the 837P with the K-3 (KIDMED) segment completed (see pages 33-35 for further details).

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

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

SCREENING PERIODICITY POLICY

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

Initial Screening

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

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

Periodicity Restrictions

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

Off-Schedule Screenings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INTERPERIODIC SCREENINGS

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

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

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

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

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

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

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

These codes are billed hard copy on the CMS-1500 form or electronically using the 837P claim transaction and are listed on the following page. Completed hard copy examples are on pages 56 & 57.

Louisiana Medicaid reimbursement for a completed interperiodic medical screen is $58.65. **

** Note: Reimbursement fees as of September 1, 2007 are current and subject to change.

Registered Nurse interperiodic screening codes:

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

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

Physician interperiodic screening codes:

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

TS: To be used to report interperiodic screening

DIAGNOSIS AND TREATMENT

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

Diagnosis

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

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

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

Initial Treatment

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

Providing or Referring Recipients for Services

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

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

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

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

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

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

KIDMED Hotlines:

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

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

In-House Referral

If a suspected condition is identified and referred in-house (when a suspected condition is identified during the screening and is diagnosed/treated by the screening provider during the same visit), no office visit of a higher level than CPT code 99212 is reimbursable.

If any other level of office visit is billed by the same attending provider on the same day, the claim processed first (either the screening or the office visit) will pay, and the second claim will deny.

If an office visit higher than 99212 is billed in error on the same date of a screening (same recipient, same attending provider) and is paid, it will cause the screening claim to deny. The provider may adjust the office visit claim to procedure code 99211 or 99212 and then re-bill the screening claim.

Consultation Codes

Medical, vision, or hearing screening findings may indicate the need for counseling, consultation, or other intervention by ancillary personnel, including registered nurses, physician assistants, licensed social workers, and registered dietitians, beyond the basic health education and anticipatory guidance components of the medical screening. Services provided by these professionals are to be billed by an enrolled KIDMED provider certified to bill medical screenings. These services may be reimbursed by Medicaid if provided to prevent a specific health or mental health problem or condition, or to treat or alleviate an actual medical or mental health problem or condition.

- ☞ The child must have received an age-appropriate KIDMED screening in order for these services to be reimbursable.

Consultation codes are short term codes not designed with episodic or continuous therapy in mind. These codes allow payment for a service identified through the KIDMED screener, who continues to see and have access to the patient in an environment which is conducive to rendering the service, such as in a school, early intervention setting or in a physician's office where the physician serves as a continuing care provider.

KIDMED consult codes are to be specific to an individual child's needs. Documentation should be present justifying the need for each consult for that particular child. **Consult codes are not to be used for ongoing treatment.** Outcomes for the consults are to be documented as well as referrals to appropriate resources for those conditions that might require further attention.

- ☞ Consults are to be face-to-face contact in one-on-one sessions. Group sessions are not allowed. Multiple units of service may not be billed for the same consult.

KIDMED clinics which assume the role primarily as a screener should bill these codes infrequently. One screening provider should never refer to another screening provider for the provision of these services.

The following table identifies consultation procedure codes:

Procedure Code	Description	Fee
T1001	Nursing Assessment/Evaluation	$13.71**
S9470	Nutritional Counseling, Dietitian Visit	$13.71**
99211-AJ	Office or other Outpatient Visit for Evaluation and Management of an Established Patient, Minimal Problem(s)	$13.71**

AJ = Social Worker

**** Note: Reimbursement fees as of September 1, 2007 are current and subject to change.**

Consultation Policy Reminders

- Procedure codes T1001, S9470, 99211-AJ **may not** be billed for preventive counseling, anticipatory guidance, or health education provided on the date of the medical screening by the same provider since these services are a component of the screening.

- Procedure codes T1001, S9470, 99211-AJ **may not** be billed on the same date that the same provider bills a physician's evaluation and management visit.

- The social worker (LCSW) consult code (99211-AJ) is not for treatment of mental illness or emotional disturbances. Ongoing therapy is payable by Louisiana Medicaid under the Mental Health Rehabilitation Program and appropriate referrals should be made.

- The KIDMED consultation codes are billed on the CMS 1500/837P.

WIC REFERRALS

WIC referrals and forms completion are a part of the KIDMED program. This is a federal requirement. Recipients should never be billed for these services. WIC referrals and forms completion occurring within 60 days of a KIDMED screening are considered part of the medical screening and should not be billed separately.

WIC referrals and forms completion occurring more that 60 days after a KIDMED screening may be billed as a nurse consult (T1001). This is because medical information to complete the form must be determined again since the information on the WIC referral form cannot be over 60 days old.

KM-3 INFORMATION

KM3 Form

The KM-3 form should be used when filing for Medicaid reimbursement of screening services provided under the Medicaid EPSDT KIDMED Program. **The screening services include the medical, vision, and hearing screening only.** KM-3 claim forms undergo preliminary processing before the adjudication cycle that results in claim denial or approval on the remittance advice. Once the claims have been entered into the KIDMED system, they are processed to check for errors and missing information. Certain claim errors cause a Resubmittal Turnaround Document (RTD) to be generated to the provider so that corrections may be made directly to the RTD and mailed back to Unisys. More information regarding RTDs can be found on pages 78-82.

Form Completion Reminders

- CPT codes 99381 – 99385 or 99391 – 99395 should be used for medical screenings. Please use the appropriate code to reflect the age of the child and whether or not the screening is an initial or periodic screening.
- Modifier TD should be used in conjunction with the appropriate CPT code to report that a screening was performed by a registered nurse.
- Vision screenings should be billed with CPT code 99173, with modifier -EP.
- Hearing screenings should be billed with CPT code 92551.
- The “Date of Screening” and the amount of the “Billed Charge” must be completed. Providers are to indicate their usual and customary fee as the “Billed Charge” amount. Claims will be reimbursed at the fee on file or the billed charge, whichever is lower.
- **ONLY** Rural Health Clinics/Federally Qualified Health Centers should complete the “Encounter” block on the KM3 form.
- Item 29 (completeness of immunizations) must always be completed. If the answer is “no”, then item 30 must also be completed (please see claim example on page 27).
- Item 31 (suspected conditions) must always be completed. If the answer is “yes”, then item 32 must also be completed. If item 32 indicates anything other than undercare, then item 33 must be completed. There must be a referral for each suspected condition which is not undercare (see claim examples on pages 27 and 28).
- If the recipient is linked to a CommunityCARE PCP that is not the KIDMED provider performing the screening, it will be necessary to indicate the CommunityCARE provider that the recipient is linked to in item 9. This should only happen if the KIDMED provider performing the screening has a contractual arrangement with the CommunityCARE PCP. An example is shown on page 28.

If the KIDMED provider that the recipient is linked to for KIDMED services is unable to perform the screening and requests that another KIDMED provider perform the screening services for them, the KIDMED provider that has the recipient's KIDMED linkage must forward a referral to the screening KIDMED provider.

REMINDER: Information on the claim form may be handwritten or computer generated. All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

KM3 Form Completion Instructions

Item No. **Description and Details**

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

- Check "original" if this is the original screening claim for this recipient for the service date indicated in item 25. If submitting an "original," skip directly to item 4.
- Check "adjustment" if this claim adjusts a previously submitted claim for this recipient for the service date indicated in item 25.
- Check "void" if this claim voids a claim already submitted for this recipient for the service date indicated in item 25.

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

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

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

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

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

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

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

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

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

9. **Refer Provider No.** – Complete this item only if the recipient is linked to another KIDMED provider. Enter the CommunityCARE PCP's, or the KIDMED provider's, 7-digit Medicaid provider number.

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

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

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

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

14. **Sex** - This item is optional. Enter "M" for male or "F" for female.

15. **Race** - This item is optional. Enter one of the following codes:

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

16. **Medical Record No.** - This item is optional. It may be used to cross-reference a patient's medical record number. Enter up to 18 alphabetical and/or numerical characters that have been assigned as the patient's medical record number.

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

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

19. **State** - This item is optional. Enter the commonly accepted postal abbreviation for the state ("LA" for Louisiana).

20. **Zip Code**- This item is optional. Enter the zip code for the recipient's address.

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

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

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

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

The next part of the claim form documents what type of provider performed the screening. It also documents the screening fee. In addition, it records information about future screenings scheduled.

Providers may bill for four types of screenings:

- **Medical Screening Nurse (99381-99385 and 99391-99395)** This is a medical screening where a registered nurse conducted the **complete unclothed physical exam** and other required age-appropriate medical screening components, including age-appropriate immunizations.

  REMINDER: The above codes **MUST BE** billed with **modifier TD**, indicating that a registered nurse performed the screening.

- **Medical Screening Physician (99381-99385 and 99391-99395)** - This is a medical screening where a licensed physician conducted the **complete unclothed physical exam** and other required age appropriate medical screening components, including age-appropriate immunizations.

  ☞ Providers must enter one or the other for a single medical screening, but not both. If both a physician and a registered nurse conducted the screening, the individual performing the physical exam or assessment should be entered.

- **Vision (99173-EP)** - This is an objective vision screening conducted by a licensed physician, physician assistant, registered nurse, licensed optometrist, or trained office staff under the supervision of one of the above listed licensed professionals. **Claims inappropriately paid are subject to post payment review and recoupment.**

- **Hearing (92551)** - This is an objective hearing screening conducted by a licensed physician, physician assistant, registered nurse, licensed and ASHA-certified

audiologist, licensed and ASHA-certified speech pathologist, or trained office staff under the supervision of one of the above listed licensed professionals. **Claims inappropriately paid are subject to post payment review and recoupment.**

*** Only Rural Health Clinics and Federally Qualified Health Centers should complete the block marked "Encounter". ALL other KIDMED providers should leave blank.**

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

NOTE - Providers are to enter the Carrier Code (column 25) and the TPL Amount (columns 27 & 28) if recipients have private insurance. Please remember to attach the EOB from the private insurance in order for your claim to process. (see example on page 29)

Providers may bill for appropriately performed medical, objective vision, and/or objective hearing screenings on the same screening claim form in any combination.

25. **Date of Screening** - For **each** applicable line, enter the date of the screening. For proper reimbursement, providers must date **each** screening type for which they are billing.

26. **Billed Charge** - For **each** line completed in item 25, enter the usual and customary charges for services rendered, using four digits for dollars and cents. For example, $75.00 would be entered as "7500".

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

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

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

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

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

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

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

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

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

33-35. Referrals for Suspected Conditions - Providers must complete at least one of these items if any suspected conditions are listed in item 32 as being referred in-house or offsite. The number of items completed will depend on how many conditions were found in the screening and on the referrals made. If more than four suspected conditions are found, providers must fill out at least items 33 and 34. If more than eight suspected conditions are found, providers must fill out items 33 through 35. Also, one item must be completed for each referral made. If there are more referrals than blocks 33-35 will accommodate, such referrals should be documented in the recipient's chart and would not be listed on the claim form.

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

33B. Referral Assist Needed - Check "no," as this block is no longer used to obtain referral assistance. If assistance is needed from the Louisiana KIDMED office on finding a referral resource, contact ACS at (877) 455-9955.

33C. Appointment Date - If the recipient is referred either in-house or offsite, enter the date of the appointment. The appointment date should be estimated if it is not known at the time the claim form is completed.

33D. Appointment Time - If the recipient is referred either in-house or offsite, enter the time of the appointment. The appointment time should be estimated if it is not known at the time the claim form is completed.

33E. Reason for Referral - Enter the reason for the referral, using up to 40 letters and/or the ICD-9 diagnostic codes. In addition, if referral assistance is needed because the referred-to provider requires direct contact with the recipient, indicate so here.

33F. Referred To - If an in-house or offsite referral is made, enter up to 20 letters of the name of the specific provider to whom the recipient was referred, starting with the last name first. Be as specific as possible. For example, if the recipient was referred to a large facility, give the name and department onsite. If self-referred, enter "self" for this item. Skip to item 36 if there is no other referral information to report.

33G. (Blank) - Do not enter any data here. This item is reserved for future use by KIDMED.

33H. Phone No. - If an in-house or offsite referral has been made, enter the area code and seven-digit phone number of the referred-to provider. If a self-referral has been made, leave this item blank.

33I. Transportation Assistance Needed - Check “no,” as this block is no longer used to obtain transportation assistance. The recipient (or the recipient’s parent) should contact the Medical Dispatch Office in his region. These telephone numbers are listed in the Medicaid Services Chart.

36. Providers must read and sign the certification statement at the bottom of the screening claim form in order to be paid. Providers may use a signature stamp if it is initialed by the individual completing the form. If a claim form is received without a signature on it the claim form will not be processed and will be returned to the billing provider. A signature certifies that all components of the screening have been provided.

KM-3 claim forms should be mailed to:

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

Completed KM-3 Examples

Example of a 7 year old child receiving a medical screening by a nurse, vision, and hearing screening. Immunizations are current and no suspected conditions identified.

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

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

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

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Kids R Us				

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Susie	02 01 2000		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
( ) —	( ) —	Smith	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99383	TD	02 14 07	75 00		
MEDICAL SCREENING PHYSICIAN						
VISION	99173	EP	02 14 07	400		
HEARING	92551		02 14 07	360		
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				82 60		

IMMUNIZATIONS

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

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

SUSPECTED CONDITIONS

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

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

32.

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

REFERRALS FOR SUSPECTED CONDITIONS

33.

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

E. REASON FOR REFERRAL

F. REFERRED TO	G.

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

34.

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

E. REASON FOR REFERRAL

F. REFERRED TO	G.

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

35.

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

E. REASON FOR REFERRAL

F. REFERRED TO	G.

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

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

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

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

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

02/03

KM-3

Ima Biller
36. SIGNATURE OF PROVIDER

02/20/07
37. DATE

FISCAL AGENT COPY

Example of a 7 year old child receiving a medical screening by a nurse, vision and hearing screenings. Immunizations are not current (indicating reason why). Suspected medical condition and referral information included.

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

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

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

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Kids R Us				

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Susie	02 01 2000		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 - 1212	( ) -	Smith	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99383	TD	02 14 07	75 00		
MEDICAL SCREENING PHYSICIAN						
VISION	99173	EP	02 14 07	4 00		
HEARING	92551		02 14 07	3 60		
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				82 60		

IMMUNIZATIONS

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

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

SUSPECTED CONDITIONS

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

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

32.

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

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
A	[ ] Yes [X] No	2 18 07	9 00

E. REASON FOR REFERRAL: GERD

F. REFERRED TO: Dr. Tim Smith | G.

H. PHONE NO.: (225) 555 - 2111 | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [X] NO

34.

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

E. REASON FOR REFERRAL

F. REFERRED TO | G.

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

35.

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

E. REASON FOR REFERRAL

F. REFERRED TO | G.

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

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

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

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

Ima Biller — 36. SIGNATURE OF PROVIDER

02/20/07 — 37. DATE

02/03
KM-3

FISCAL AGENT COPY

Example of a 2 year old child receiving medical screening by a physician. Immunizations are current. Suspected developmental condition identified and offsite referral information included.

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

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

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

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Kids R Us				1111111

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Tara	03 11 2005		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 - 1212	( ) -	Smith	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE						
MEDICAL SCREENING PHYSICIAN	99392		03 14 07	75 00		
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				75 00		

IMMUNIZATIONS

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

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

SUSPECTED CONDITIONS

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

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

32.

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

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
F	[ ] Yes [X] No	03 21 07	10 00

E. REASON FOR REFERRAL: Speech delay

F. REFERRED TO: ABC Therapy — G.

H. PHONE NO.: (225) 555 - 8255 — I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [X] NO

34.

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

E. REASON FOR REFERRAL

F. REFERRED TO — G.

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

35.

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

E. REASON FOR REFERRAL

F. REFERRED TO — G.

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

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

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

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

02/03

Ina Biller — 36. SIGNATURE OF PROVIDER

02/20/07 — 37. DATE

KM-3

FISCAL AGENT COPY

Example of a 5 year old child receiving a medical screening by a registered nurse. Recipient has private insurance, immunizations are current, and no suspected conditions

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

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

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

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

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

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Martin	Caleb	01 23 02		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
( ) —	( ) —	Martin	Betty

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99393	TD	03 11 07	75 00		
MEDICAL SCREENING PHYSICIAN						
VISION	99173	EP	03 11 07	4 00		
HEARING	92551		03 11 07	3 60		
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT			0 5 4 6 0 0	82 60	25 00	

IMMUNIZATIONS

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

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

SUSPECTED CONDITIONS

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

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

32.

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

REFERRALS FOR SUSPECTED CONDITIONS

33.

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

E. REASON FOR REFERRAL

F. REFERRED TO | G.

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

34.

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

E. REASON FOR REFERRAL

F. REFERRED TO | G.

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

35.

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

E. REASON FOR REFERRAL

F. REFERRED TO | G.

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

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

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

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

Ima Biller — 36. SIGNATURE OF PROVIDER

3/21/07 — 37. DATE

02/03
KM-3

FISCAL AGENT COPY

ADJUSTMENTS AND VOIDS ON THE KM-3 FORM

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

ADJUSTING/VOIDING CLAIMS

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

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

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

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

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

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

1. A claim is approved on the remittance advice dated 07/17/2007, ICN 7266156789000.
2. The claim is adjusted on the remittance advice dated 12/11/2007, ICN 7035126742100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (7035126742100) and RA date (12/11/2007) must be used.

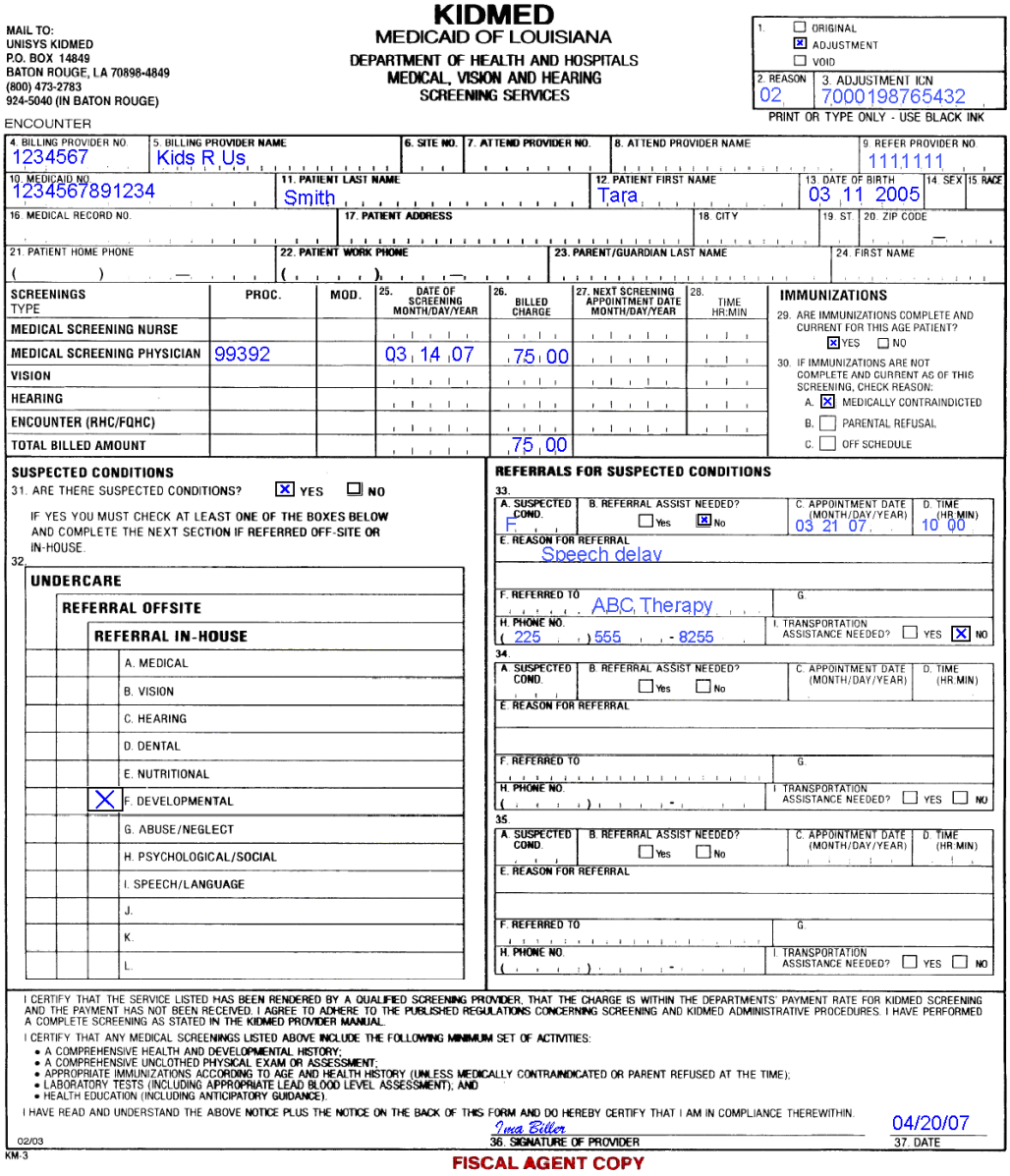
Adjustments: To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, **changing the item that was in error to show the way the claim should have been billed.** The approved adjustment will replace the approved original and will be listed under the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

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

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

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

Completed KM-3 Example: Adjustment



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

ENCOUNTER

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

1. ☐ ORIGINAL ☒ ADJUSTMENT ☐ VOID
2. REASON: 02
3. ADJUSTMENT ICN: 7000198765432

PRINT OR TYPE ONLY - USE BLACK INK

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Kids R Us				1111111

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Tara	03 11 2005		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

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

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE						
MEDICAL SCREENING PHYSICIAN	99392		03 14 07	75 00		
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				75 00		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? ☒ YES ☐ NO

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

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☒ YES ☐ NO

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

32.

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

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
F	☐ Yes ☒ No	03 21 07	10 00

E. REASON FOR REFERRAL: Speech delay

F. REFERRED TO: ABC Therapy — G.

H. PHONE NO.: (225) 555 - 8255 — I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☒ NO

34.

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

E. REASON FOR REFERRAL

F. REFERRED TO — G.

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

35.

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

E. REASON FOR REFERRAL

F. REFERRED TO — G.

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

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

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

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

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

Ima Biller — 36. SIGNATURE OF PROVIDER

04/20/07 — 37. DATE

02/03

KM-3

FISCAL AGENT COPY

KM-3 FORM TIMELY FILING GUIDELINES

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

Proof of Timely Filing

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

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

The following reports can suffice as proof of timely filing only if **detailed** information is indicated on the report. Refer to page 61 for additional information.

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

KIDMED/PREVENTIVE MEDICINE ELECTRONIC DATA INTERCHANGE (EDI) CLAIMS

HIPAA COMPLIANT TRANSACTIONS

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

DHH Rule Requirements Regarding KIDMED Claims

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

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

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

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

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

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

KIDMED DETAIL INFORMATION WITHIN THE 837P TRANSACTION

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

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

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

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

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

Field qualifier SC (Suspected Conditions)

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

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

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

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

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

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

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

Referral Information (Suspected Conditions)

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

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

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

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

The referral outcome should be indicated as follows:

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

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.

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

Vaccines for Children (VFC)

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

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

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

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

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

Louisiana Immunization Network for Kids Statewide (LINKS)

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

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

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

LINKS will assist providers within their medical practice by offering:

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

LINKS will assist patients by offering:

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

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

IMMUNIZATIONS

☞ **COMBINATION VACCINES ARE ENCOURAGED IN ORDER TO MAXIMIZE THE OPPORTUNITY TO IMMUNIZE AND TO REDUCE THE NUMBER OF INJECTIONS A CHILD RECEIVES IN ONE DAY.**

A rule published in the Louisiana Register states: The Bureau of Health Services Financing does not reimburse providers for a single-antigen vaccine and its administration if a combined-antigen vaccine is medically appropriate and the combined vaccine is approved by the Secretary of the United States Department of Health and Human Services. *(Louisiana Register, Volume 20, Number 3)*

Reimbursement

In order for providers to receive reimbursement for the administration of appropriate immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) in the current Immunization Schedule, providers must indicate the CPT code for the specific vaccine in addition to the appropriate administration CPT code(s). The listing of the vaccine on the claim form is required for federal reporting purposes.

For recipients' age birth through 18 years, vaccine CPT codes will be paid at zero ($0) because the provider obtains the vaccine from the Vaccines for Children Program at no cost.

For recipients age 19 through 20 years, providers should submit claims with their usual and customary charge for the vaccine and the claims will be reimbursed at the fee on file or the billed charge, whichever is lower.

Billing For a Single Administration

Providers should bill the appropriate CPT immunization administration code(s) 90465, 90467, 90471, or 90473 (Immunization administration…first injection/first administration/one vaccine) when administering one immunization. The next line on the claim form must contain the specific CPT code for the vaccine, with $0.00 in the "billed charges" column (see pg. 58 for an example).

- Do not report CPT codes 90465 and 90467 on the same date of service
- Do not report CPT codes 90471 and 90473 on the same date of service

Billing for Multiple Administrations

When administering more than one immunization, providers should bill as described above for a single administration. The appropriate procedure code(s) 90466, 90468, 90472, and 90474 (Immunization administration…each additional injection/administration/vaccine) should then be listed with the appropriate number of units for the additional vaccines placed in the "units" column. The specific vaccines should then be listed on subsequent lines. The number of specific vaccines listed after CPT administration codes should match the number of units listed in the 'units' column. Examples of this scenario are on pages 59-63.

- Use CPT codes 90466 and/or 90468 with 90465 OR 90467 to report more than one vaccine administered. Do NOT use 90466 and/or 90468 with 90471 or 90473.
- Use CPT codes 90472 and/or 90474 with 90471 OR 90473 to report more than one vaccine administered. Do NOT use 90472 and/or 90474 with 90465 or 90467.

Hard Copy Claim Filing for Greater Than Four Administrations

When billing hard copy claims for more than four immunizations and the six-line claim form limit is exceeded, providers should bill on two CMS-1500 claim forms. The first claim should follow the instructions above for billing the single administration. A second CMS-1500 claim form should be used to bill the remaining immunizations as described above for billing multiple administrations. An example is shown on pages 60 & 61.

Coverage of Vaccines for Recipients Age 19 through 20 Years

Louisiana Medicaid is in the process of updating programming for immunizations including the ACIP recommended vaccines for recipients aged 19 through 20 years of age (e.g. Human Papilloma Virus, Influenza). Providers will be notified when these changes have been implemented.

For recipients age19 through 20 years, providers should submit claims reporting the appropriate immunization administration CPT code along with the specific CPT code and their usual and customary charge for the vaccine administered. The claims will be reimbursed at the fee on file or the billed charge, whichever is lower for the vaccine and administration.

Pediatric Flu Vaccine: Special Situations

In the event a Medicaid provider does not have VFC pediatric influenza vaccine on hand to vaccinate a high priority VFC eligible Medicaid enrolled child, the provider should use pediatric influenza vaccine from private stock, if available. If a provider does use vaccine from private stock for a high priority VFC eligible Medicaid enrolled child, the provider would then replace dose(s) used from private stock with replacement dose(s) from VFC stock when VFC vaccine becomes available. The provider should not turn away, refer or reschedule a high priority VFC eligible Medicaid enrolled child for a later date if vaccine is available. Louisiana Medicaid will update Medicaid enrolled providers through Remittance Advices and Provider Updates regarding availability of vaccine through the VFC program and any billing issues. Please contact the Louisiana VFC Program office at (504)838-5300 for vaccine availability information.

Vaccine Codes

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

Vaccine Code	Description
90476^	Adenovirus vaccine, type 4, live, for oral use
90477^	Adenovirus vaccine, type 7, live, for oral use
90581^	Anthrax vaccine, for subcutaneous use
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633*	Hepatitis A vaccine pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
90634*	Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646	Hemophilus Influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647*	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648*	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90649*	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
90655*	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656*	Influenza virus vaccine, split virus, preservative free, when administered to 3 years and older, for intramuscular use
90657*	Influenza Virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658*	Influenza Virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use
90660*	Influenza Virus vaccine, live, for intranasal use
90665^	Lyme Disease vaccine, adult dosage, for intramuscular use
90669*	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use
90675^	Rabies vaccine, for intramuscular use
90676^	Rabies vaccine, for intradermal use
90680*	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
90690^	Typhoid vaccine, live, oral
90691^	Typhoid vaccine, Vi capsular polysaccharide (ViCPS), for intramuscular use
90692^	Typhoid vaccine, heat-and phenol-inactivated (H-P) for subcutaneous or intradermal use
90693	Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (US Military)

Vaccine Codes

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

Vaccine Code	Description
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated, (DTaP-Hib-IPV), for intramuscular use
90700 *	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to younger than 7 years, for intramuscular use
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702*	Diphtheria and tetanus toxoids (DT) absorbed when administered to younger than 7 years, for intramuscular use
90703	Tetanus toxoid adsorbed, for intramuscular use
90704	Mumps virus vaccine, live, for subcutaneous use
90705	Measles virus vaccine, live, for subcutaneous use
90706	Rubella virus vaccine, live, for subcutaneous use
90707*	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous
90708	Measles and rubella virus vaccine, live, for subcutaneous use
90710*	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
90713*	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714*	Tetanus and diphtheria toxoids, (Td) absorbed, preservative free, when administered to 7 years or older, for intramuscular use
90715*	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to 7 years or older, for intramuscular use
90716*	Varicella virus vaccine, live, for subcutaneous use
90717	Yellow fever vaccine, live, for subcutaneous use
90718*	Tetanus and diphtheria toxoids (Td) adsorbed when administered to7 years or older, for intramuscular use
90719	Diphtheria toxoid, for intramuscular use
90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721*	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use
90723*	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use
90725	Cholera vaccine for injectable use
90727	Plague vaccine, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
90734*	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735	Japanese Encephalitis Virus vaccine, for subcutaneous use
90736	Zoster (shingles) vaccine, live, for subcutaneous injection
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose

Vaccine Codes

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

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

REMINDERS:

- Procedure code 90703 (Tetanus toxoid - for trauma) will be payable at the rate of $2.42, and it is not available through the VFC program.

- If the administration units for 90466, 90468, 90472 or 90474 are greater than the number of vaccines reported for the administration codes, the units will be cutback to reflect the number of vaccine codes being reported.

- If the administration units for 90466, 90468, 90472 or 90474 are less than the number of vaccines reported the claim will be processed based on the units listed for administration.

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

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

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

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

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

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

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

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

Information required to complete this registration includes:

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

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

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

Supplemental payments will be dependent on:

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

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

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

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

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

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

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

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

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

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

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

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

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

CMS-1500 CLAIM FORM

- **Immunizations, laboratory tests, interperiodic screenings, consultations, and low level visits in conjunction with a KIDMED screening are billed on the CMS-1500 claim form.**

CMS-1500 claim forms should be mailed to the following address for processing:

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

- **Certain items on the CMS-1500 are required.**

Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. Such claims cannot be processed until corrected and resubmitted by the provider.

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** – **Insured's ID Number** - Enter the recipient's 13-digit Medicaid number as verified through the REVS, MEVS, or e-MEVS eligibility systems. This should also be the 13-digit Medicaid number that appears on the RS-0-07 for that month. **Note: If the ID number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.**	
2	Patient's Name	**Required** – Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through the REVS, MEVS, or e-MEVS eligibility systems.	

Locator #	Description	Instructions	Alerts
3	Patient's Birth Date Sex	**Situational** – Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, REVS, or e-MEVS using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the 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, or leave blank.	
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	Leave blank.	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – Leave Blank; unless the recipient has other coverage. In that case, indicate the 6-digit TPL carrier code assigned by the state in this block (the carrier code list can be found at www.lamedicaid.com under the Forms/Files/User Guides link). Make sure to attach the EOB(s) from the other insurance(s) 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.	

Locator #	Description	Instructions	Alerts
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Leave blank.	
15	If Patient Has Had Same or Similar Illness Give First Date	Leave blank.	
16	Dates Patient Unable to Work in Current Occupation	Leave blank.	

Locator #	Description	Instructions	Alerts
17	Name of Referring Provider or Other Source	**Situational** – If the recipient is a lock-in recipient and has been referred to the billing provider for services, the lock-in physician's name is **required** here.	
17a	Unlabeled	**Situational** – If the recipient is linked to a PCP, the 7-digit Primary Care Physician referral authorization number is **required** to be entered. This information should be identical to item 9 on the KM3 form.	**The PCP's 7-digit referral authorization number must be entered in block 17a.**
17b	NPI	**Optional.** If the recipient is linked to a PCP, the 10-digit referring PCP's NPI number is entered here; however it is **not required**.	**The revised form accommodates the entry of the referring provider's NPI.**
18	Hospitalization Dates Related to Current Services	Leave blank.	
19	Reserved for Local Use	Leave blank.	**Usage to be determined.**
20	Outside Lab?	Leave blank.	
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.	
22	Medicaid Resubmission Code	Leave blank.	
23	Prior Authorization Number	Leave blank.	
24	Supplemental Information	**Situational** – Applies to the detail lines for drugs and biologicals only. In addition to the procedure code, the	**RHC/FQHCs who administer drugs and**

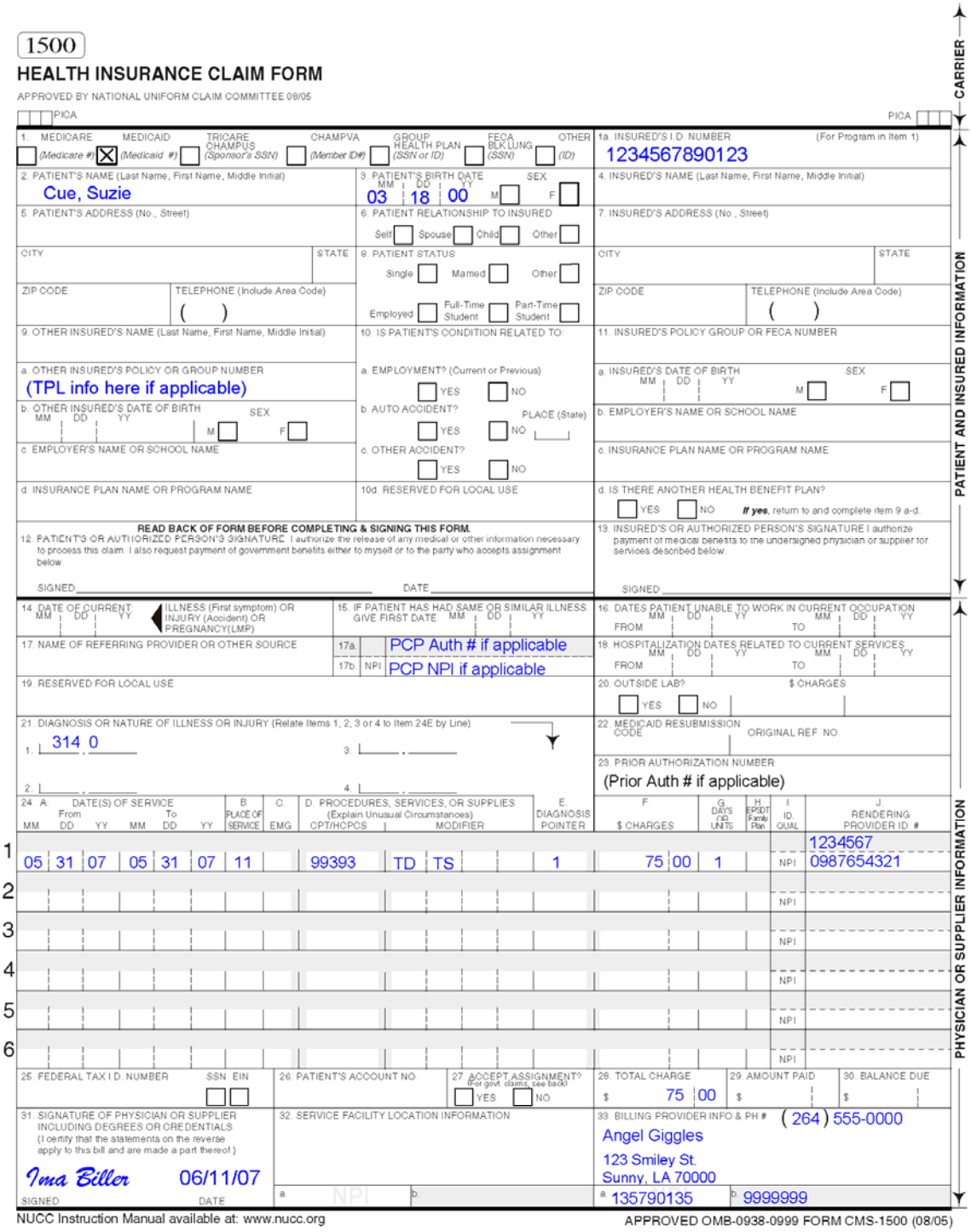
Locator #	Description	Instructions	Alerts
		National Drug Code (NDC) is required by the Deficit Reduction Act of 2005 for physician-administered drugs and shall be entered in the shaded section of 24A through 24G. Claims for these drugs shall include the NDC from the label of the product administered. 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 ad the NDC. Do not enter hyphens or spaces within the NDC. Providers should then leave one space then enter the appropriate Unit Qualifier (see below) and the actual units administered. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space. The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram UN Unit	**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).**
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code. Only 2 digit POS service codes are acceptable.	
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)	**If the detail line is for drugs or biologicals, entering the**

Locator #	Description	Instructions	Alerts
			appropriate information from Block 24 (above) is required.
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, “3”, or “4”). More than one diagnosis/reference number may be related to a single procedure. Do not enter an ICD-9-CM diagnosis code in this item.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D.	
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	Leave blank.	**The revised form accommodates the entry of I.D. Qual.**
24J	Rendering Provider I.D. #	**Situational** – Complete if appropriate, or leave blank. 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	Leave blank.	
26	Patient’s Account No.	**Optional** – Enter the recipient’s medical record number or other individual provider-assigned number to identify the patient. This number will appear on the Remittance	

Locator #	Description	Instructions	Alerts
		Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Leave blank.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – Leave this space blank unless payment has been made by a third party insurer. If such payment has been made, indicate the amount paid.	
30	Balance Due	**Situational** – If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from the billed charges.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Required** -- The claim form **MUST** be signed. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the physician, therapist or authorized representative. **If this item is left blank, or if the stamped or computer-generated signature does has not been initialed in handwriting, 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	Unlabeled	**Situational.** Complete if appropriate, or leave blank. When the billing provider is a CommunityCARE enrolled PCP, indicate the site number of the Service Location.	**Enter Medicaid ID number of the Service Facility**

Locator #	Description	Instructions	Alerts
		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.)	**Location.** **If PCP, enter Site Number and Qualifier of the service location.**
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Optional.** Enter the billing provider’s 10-digit NPI number.	**The revised form accommodates the entry of the Billing’s Provider’s NPI.**
33b	Unlabeled	**Required** – Enter the billing provider’s 7-digit Medicaid ID number.	**Format change with addition of 33a and 33b for provider numbers.**

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



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

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

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

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI PCP NPI if applicable

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 314.0

2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05 31 07	05 31 07	11		99393	TD TS	1	75 00	1		NPI 1234567 0987654321
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 75 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

Ima Biller 06/11/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

Angel Giggles

123 Smiley St.

Sunny, LA 70000

a. 135790135 b. 9999999

CARRIER

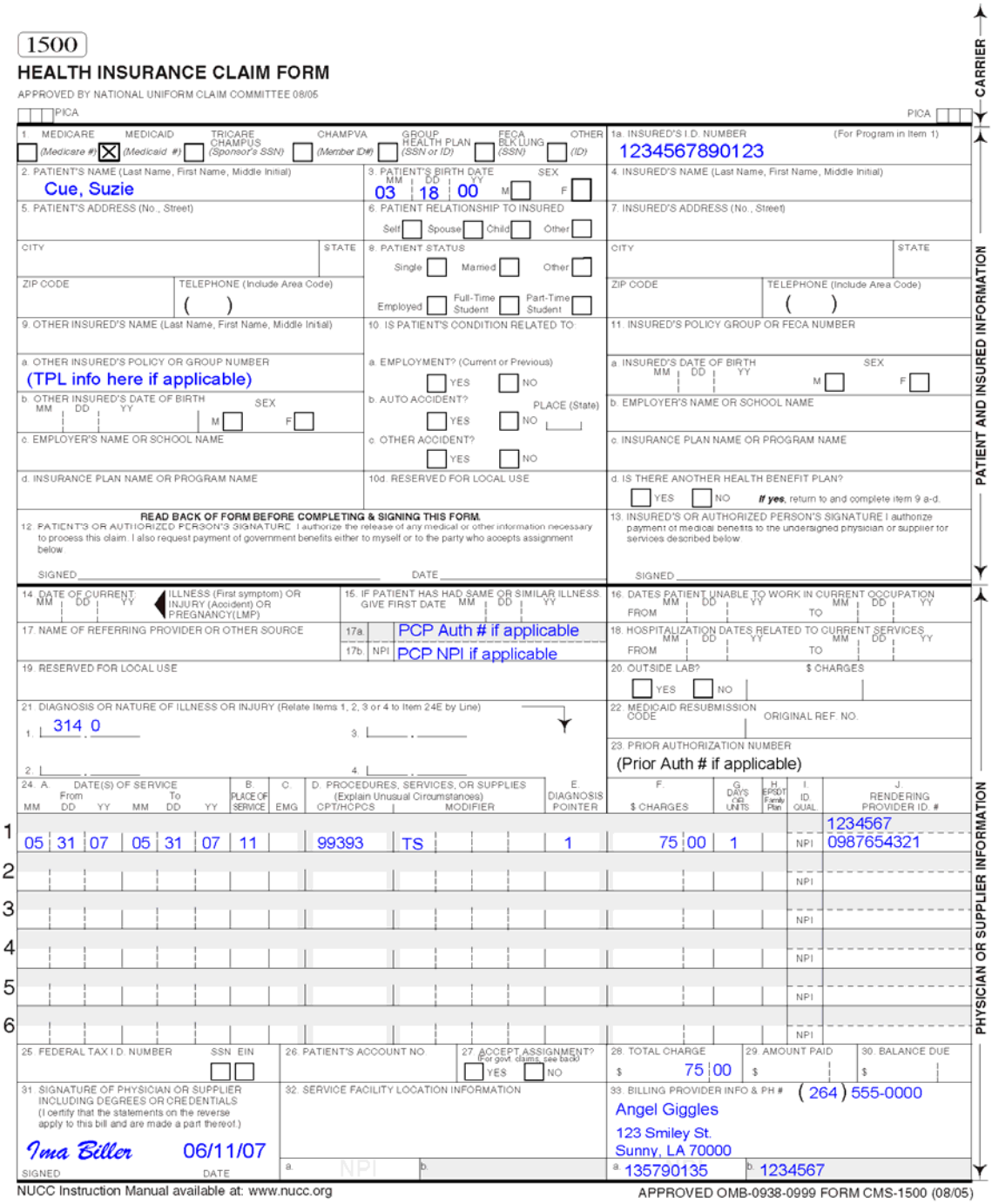
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

Example of: Interperiodic Screening Performed by a Physician on a 7 year old child



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

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

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

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI PCP NPI if applicable

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

19. RESERVED FOR LOCAL USE

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

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

1. 314.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

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

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05 31 07	05 31 07	11		99393	TS	1	75 00	1		NPI	1234567 0987654321
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 75 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

Ima Biller 06/11/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

Angel Giggles

123 Smiley St.

Sunny, LA 70000

a. 135790135 b. 1234567

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

Example of One Immunization Given

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9752432916523

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jenkins, Claire

3. PATIENT'S BIRTH DATE: 05 01 06 | SEX: M | F

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI PCP NPI # if applicable

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. V20.2 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

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

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05 01 07 | 05 01 07	11		90471		1	12 00	1		NPI	1122334 9988776655
2	05 01 07 | 05 01 07	11		90713		1	0 00	1		NPI	1122334 9988776655
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 12 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

Ima Biller 06/12/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

Angel Giggles

123 Smiley St.

Sunny, LA 70000

a. 1357901357 b. 1999999

CARRIER

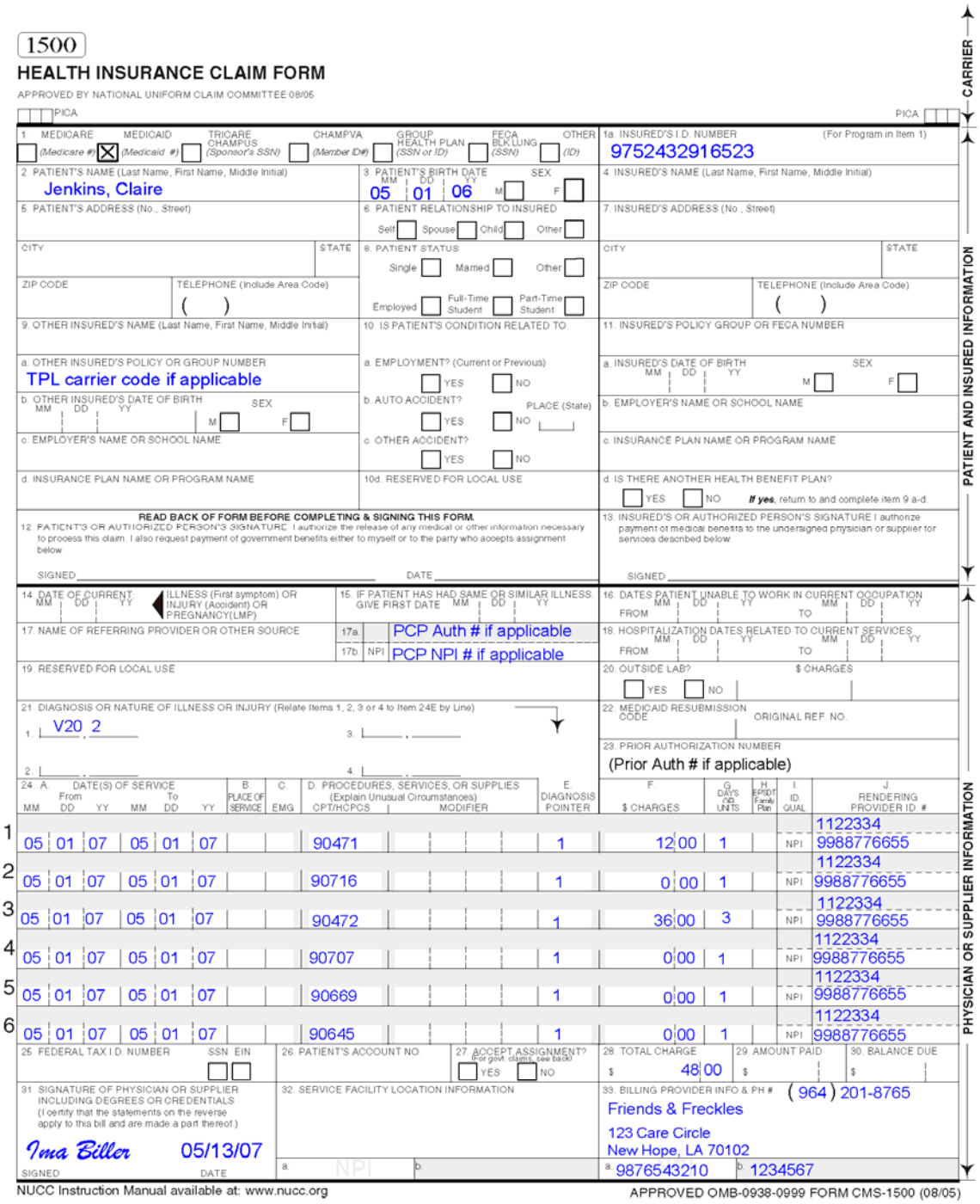
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

Example of Four Immunizations Given



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | 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): 9752432916523

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jenkins, Claire

3. PATIENT'S BIRTH DATE MM DD YY: 05 01 06 SEX M F

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI PCP NPI # if applicable

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V20.2 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05 01 07	05 01 07			90471		1	12 00	1		NPI	1122334 9988776655
2	05 01 07	05 01 07			90716		1	0 00	1		NPI	1122334 9988776655
3	05 01 07	05 01 07			90472		1	36 00	3		NPI	1122334 9988776655
4	05 01 07	05 01 07			90707		1	0 00	1		NPI	1122334 9988776655
5	05 01 07	05 01 07			90669		1	0 00	1		NPI	1122334 9988776655
6	05 01 07	05 01 07			90645		1	0 00	1		NPI	1122334 9988776655

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 $ 48 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

Ima Biller 05/13/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (964) 201-8765

Friends & Freckles

123 Care Circle

New Hope, LA 70102

a. 9876543210 b. 1234567

CARRIER

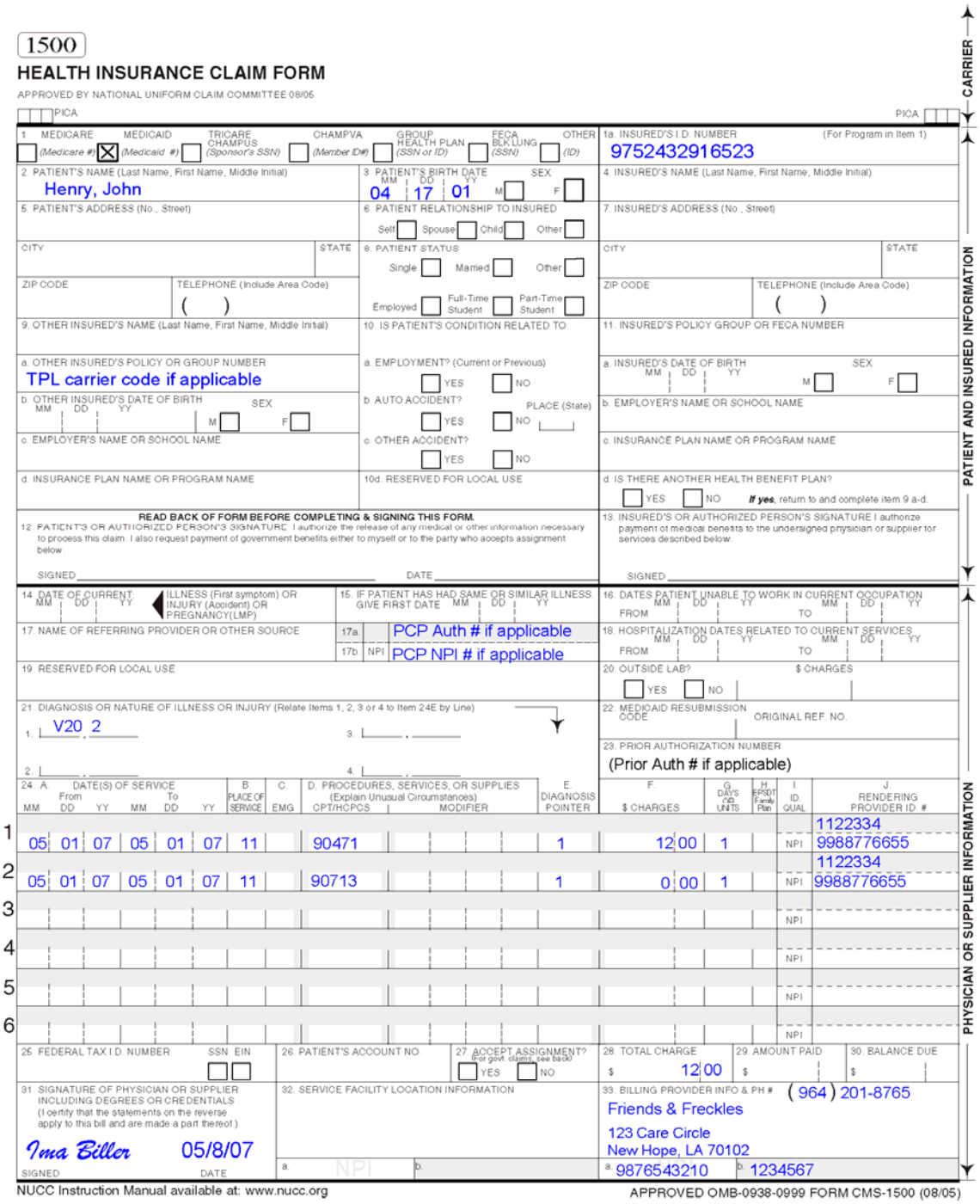
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

Example of Five Immunizations Given (Page 1 of 2)



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | 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): 9752432916523

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Henry, John

3. PATIENT'S BIRTH DATE MM DD YY: 04 17 01 SEX M F

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI PCP NPI # if applicable

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V20.2 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05 01 07	05 01 07	11		90471		1	12 00	1		NPI	1122334 9988776655
2	05 01 07	05 01 07	11		90713		1	0 00	1		NPI	1122334 9988776655
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 12 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

Ima Biller 05/8/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (964) 201-8765

Friends & Freckles

123 Care Circle

New Hope, LA 70102

a. 9876543210 b. 1234567

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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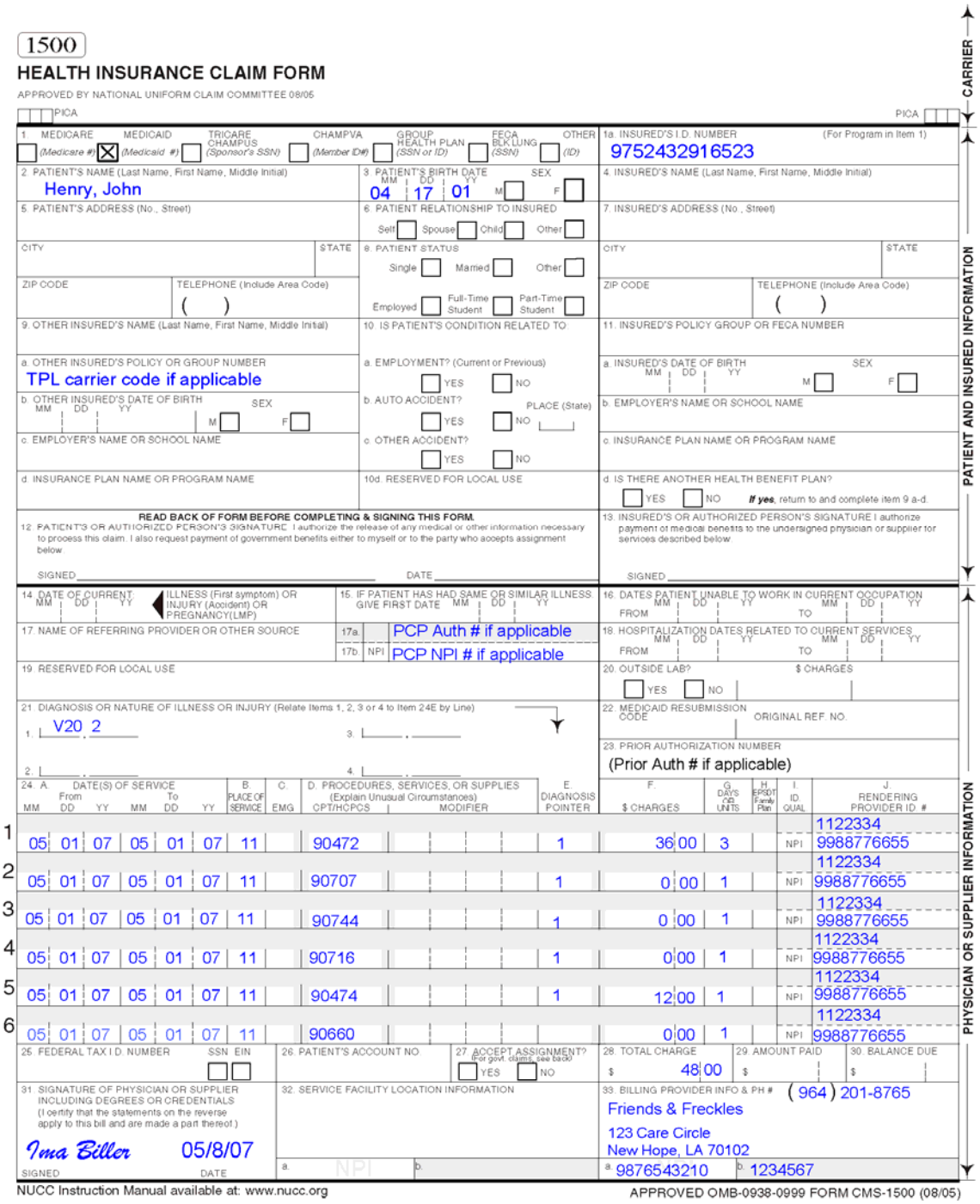
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Example of Five Immunizations Given (Page 2 of 2)



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | 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): 9752432916523

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Henry, John

3. PATIENT'S BIRTH DATE MM DD YY: 04 17 01 | SEX M [ ] F [ ]

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI PCP NPI # if applicable

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

19. RESERVED FOR LOCAL USE

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

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

1. V20.2 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

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

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05 01 07 | 05 01 07	11		90472		1	36 00	3		NPI	1122334 9988776655
2	05 01 07 | 05 01 07	11		90707		1	0 00	1		NPI	1122334 9988776655
3	05 01 07 | 05 01 07	11		90744		1	0 00	1		NPI	1122334 9988776655
4	05 01 07 | 05 01 07	11		90716		1	0 00	1		NPI	1122334 9988776655
5	05 01 07 | 05 01 07	11		90474		1	12 00	1		NPI	1122334 9988776655
6	05 01 07 | 05 01 07	11		90660		1	0 00	1		NPI	1122334 9988776655

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 $ 48 00 | 29. AMOUNT PAID $ | 30. BALANCE DUE $

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

Ima Biller 05/8/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (964) 201-8765

Friends & Freckles

123 Care Circle

New Hope, LA 70102

a. 9876543210 b. 1234567

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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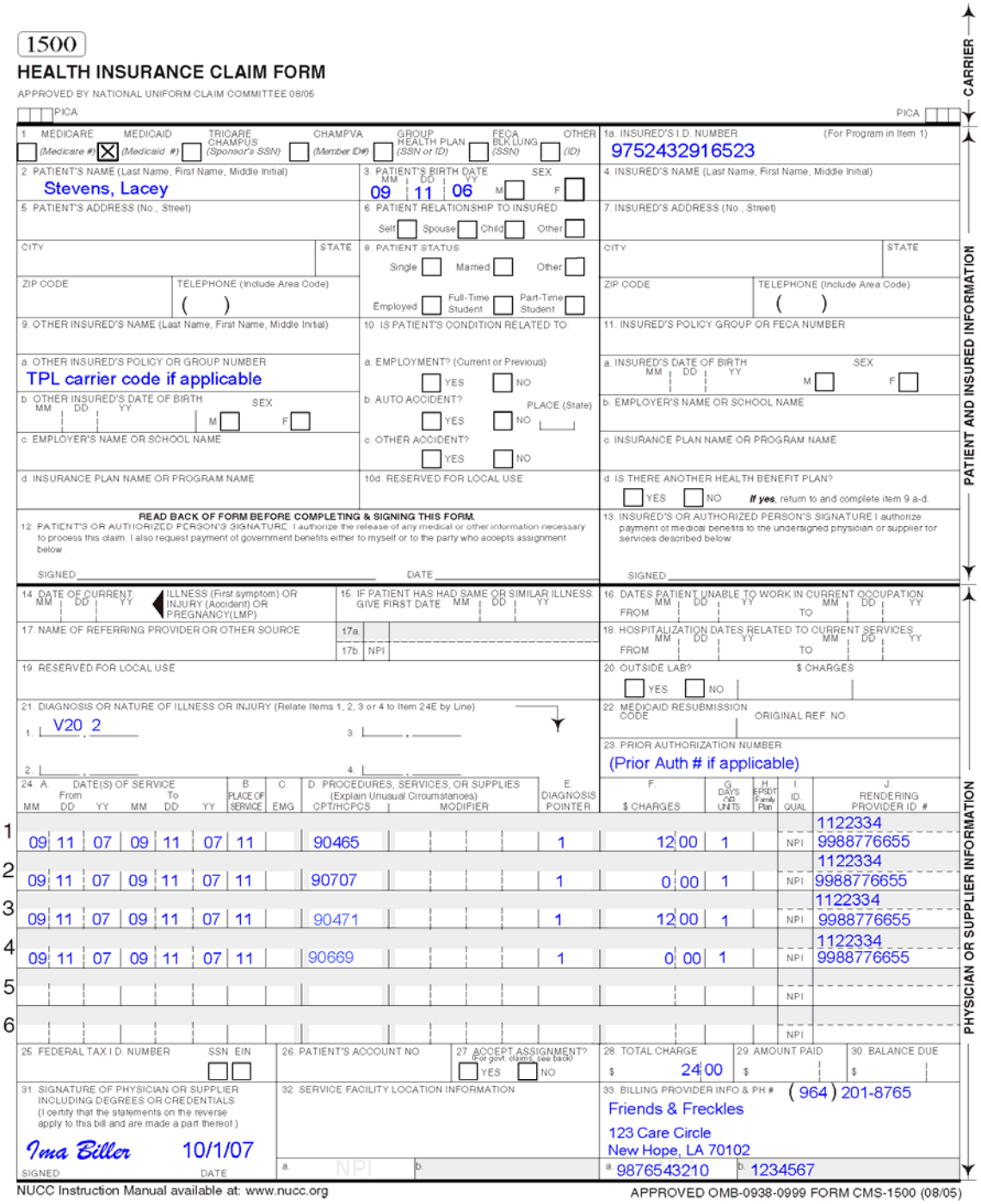
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Example of Two Immunizations Given for Recipient Younger than 8 Years Old: One Immunization with Physician Counsel and One without Physician Counsel.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | 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): 9752432916523

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Stevens, Lacey

3. PATIENT'S BIRTH DATE MM DD YY: 09 11 06 SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

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. V20.2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	09 11 07 09 11 07	11		90465		1	12 00	1		NPI	1122334 9988776655
2	09 11 07 09 11 07	11		90707		1	0 00	1		NPI	1122334 9988776655
3	09 11 07 09 11 07	11		90471		1	12 00	1		NPI	1122334 9988776655
4	09 11 07 09 11 07	11		90669		1	0 00	1		NPI	1122334 9988776655
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 24 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

Ima Biller 10/1/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (964) 201-8765

Friends & Freckles

123 Care Circle

New Hope, LA 70102

a. 9876543210 b. 1234567

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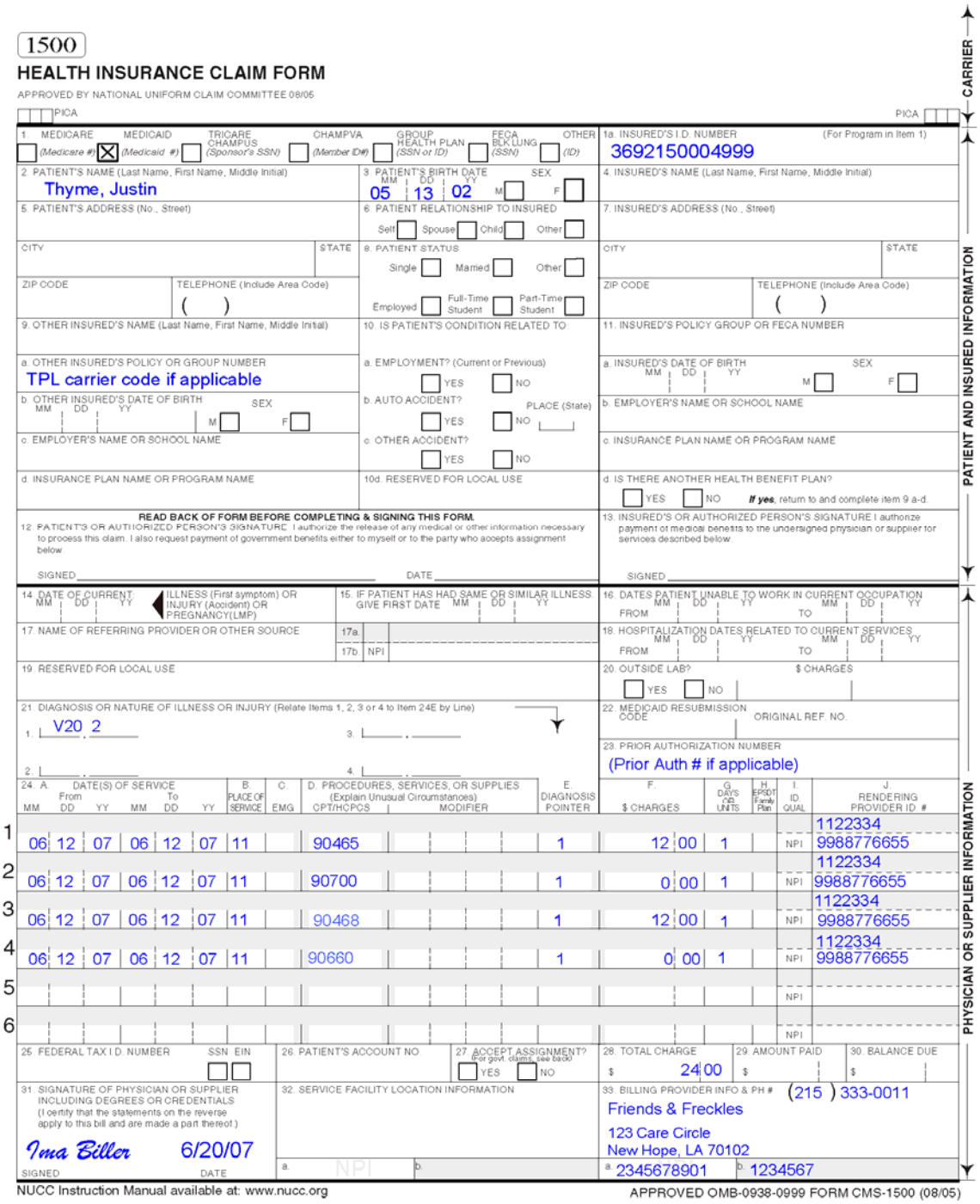
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Example of Two Immunizations Given for Recipient Younger than 8 Years old with Physician Counsel



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | 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): 3692150004999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Thyme, Justin

3. PATIENT'S BIRTH DATE MM DD YY: 05 13 02 SEX M F

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

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. V20.2

2.

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	06 12 07	06 12 07	11		90465		1	12 00	1		NPI 1122334 9988776655
2	06 12 07	06 12 07	11		90700		1	0 00	1		NPI 1122334 9988776655
3	06 12 07	06 12 07	11		90468		1	12 00	1		NPI 1122334 9988776655
4	06 12 07	06 12 07	11		90660		1	0 00	1		NPI 1122334 9988776655
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 24 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

Ima Biller 6/20/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (215) 333-0011

Friends & Freckles

123 Care Circle

New Hope, LA 70102

a. 2345678901 b. 1234567

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)

213 ADJUSTMENT/VOID FORM

The 213 adjustment/void is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Unisys by calling Provider Relations at (800) 473-2783 or at www.lamedicaid.com using the Forms/Files/User Guides link. An example of a correctly completed void form is shown on the following page.

Form Completion

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

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

Blocks 26 and 27 of the Unisys 213 form must be completed with the claim's most recently approved control number and RA date. For example:

1. A claim is approved on the remittance advice dated 07/17/2007, ICN 7266156789000.
2. The claim is adjusted on the remittance advice dated 12/11/2007, ICN 7035126742100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (7035126742100) and RA date (12/11/2007) must be used.

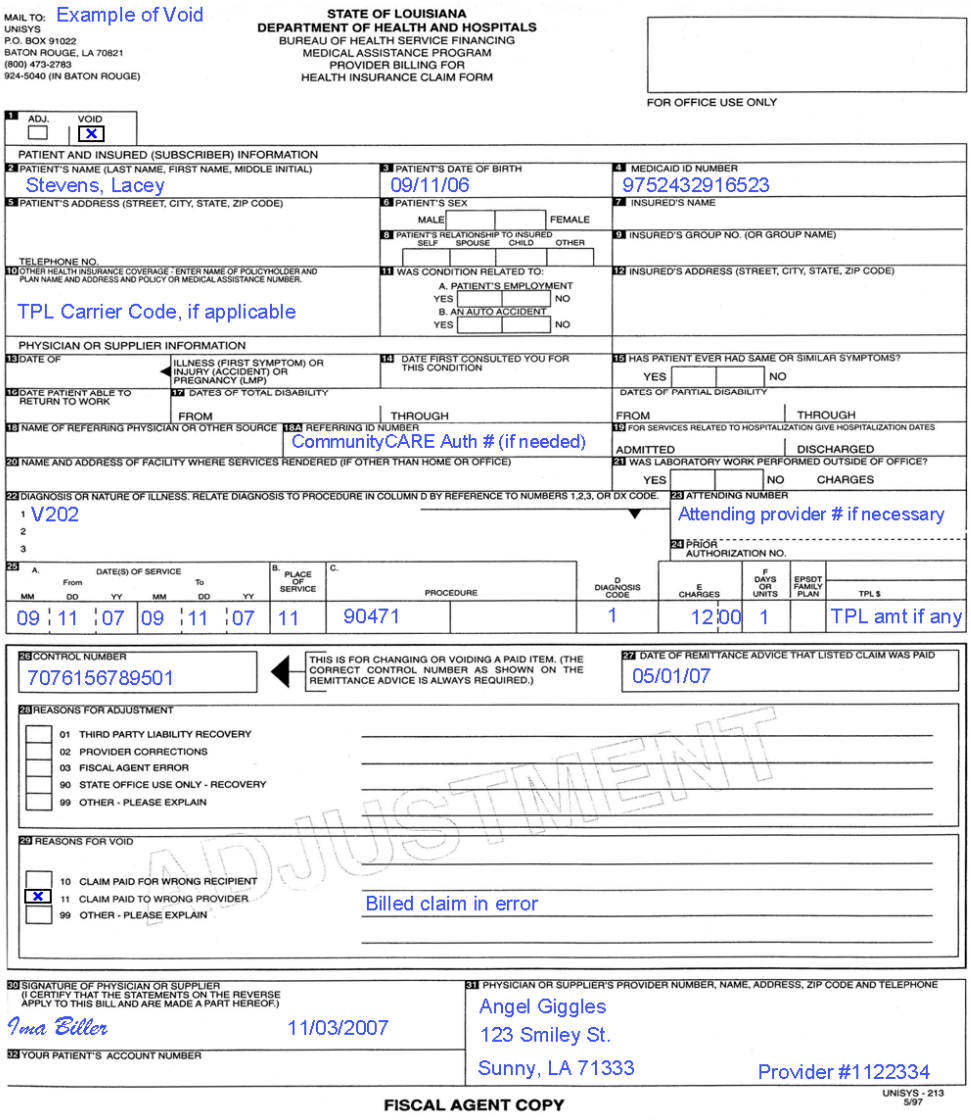
Claims paid to the wrong provider or for the wrong recipient cannot be adjusted. They must be voided and the correct claims submitted.

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

Voids: To file a void, the provider must enter all the information from the original claim **exactly as it appeared on the original claim.** When the void claim is approved, it will be listed under the "void" column of the R.A. and a corrected claim may be submitted (if applicable).
Only one (1) claim line can be adjusted or voided on each adjustment/void form.

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

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



MAIL TO: Example of Void
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 [X]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Stevens, Lacey
3 PATIENT'S DATE OF BIRTH: 09/11/06
4 MEDICAID ID NUMBER: 9752432916523
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [ ]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
TPL Carrier Code, if applicable
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER: CommunityCARE Auth # (if needed)
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 V202
2
3
23 ATTENDING NUMBER: Attending provider # if necessary
24 PRIOR AUTHORIZATION NO.

23 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 $
09	11	07	09	11	07	11	90471		1	12 00	1		TPL amt if any

25 CONTROL NUMBER: 7076156789501
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: 05/01/07

26 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

28 REASONS FOR VOID
[ ] 10 CLAIM PAID FOR WRONG RECIPIENT
[X] 11 CLAIM PAID TO WRONG PROVIDER
[ ] 99 OTHER - PLEASE EXPLAIN
Billed claim in error

29 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Ima Biller 11/03/2007
32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Angel Giggles
123 Smiley St.
Sunny, LA 71333
Provider #1122334

FISCAL AGENT COPY

UNISYS - 213
5/97

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.

KIDMED REPORTS

Linkage And Screening Reports

EP-0-10 - New Recipient and Missed Screen List

- Lists newly linked recipients and the last day on which an initial screening may be scheduled
- Indicates missed appointment dates (based on lack of paid claim for the appointment date)
- Allows providers to request that KIDMED remind recipients of screening appointments, if desired
- Mailed weekly by Unisys Corporation

EP-0-21 - Provider Schedule List

- Lists recipients who have appointments in the coming week and appointment date and time
- Allows providers to report whether screenings were actually performed, the reason why they were not kept, and the new appointment date and time if one has been rescheduled
- Mailed weekly by Unisys Corporation (based on information given by the provider)

RS-0-07 - Screening and Provider Beneficiary Report

- Lists all recipients linked to the provider along with the effective date of linkage
- Indicates last screening date for recipients based on paid screening claims on file
- Shows the next screening period, during which next screening should be scheduled, as well as recipients requiring initial screening
- Allows providers to request that KIDMED remind recipients of screening appointments, if desired
- Located on the website www.lamedicaid.com
    - **RS-0-07 reports are loaded monthly on the www.lamedicaid.com website. These reports remain on the site for 2 months to allow providers to access the current and the previous months' reports. Requests for reports to be reprinted hardcopy will not be honored. Please ensure that you have procedures in place to retrieve these reports as needed.**

If any of these reports are used as a turnaround document for scheduling appointments, they should be returned to the KIDMED office at:

ACS
5700 Florida Blvd., 13th Floor
Baton Rouge, LA 70806

EPW010
RUN: 08/05/07 06:34:10
CYCLE: 08/05/07

MEDICAID COMMUNITYCARE/KIDMED SUBSYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
NEW RECIPIENT AND MISSED SCREEN LIST

REPORT NO: EP-O-10
PAGE NO: 1

PROVIDER ID NO.

PROVIDER SITE NO. 001

PROVIDER

MEDICAID ID	BENEFICIARY NAME	MAILING ADDRESS	SEX	D.O.B. MM/DD/YY	TELEPHONE NUMBER(S)	LOCN	TYPE	NEW BENEFICIARY OR MISSED APPOINTMENT	INITIAL SCREENING DUE/MISSED APPT DATE MM/DD/YY	APPT. DATE AND TIME GIVEN BENEFICIARY DATE / TIME
67	72				337 788-	H	M V H	NEW BENEF	08/16/07	____/____/____
					337	T				_____:_____

TOTAL RECIPIENTS FOR ABOVE PROVIDER: 1

EPW0[illegible]
RUN: 08/05/07 03:19:19
CYCLE: 08/04/07

MEDICAID COMMUNITYCAR[illegible]KIDMED SUBSYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
PROVIDER SCHEDULE LIST

REPORT NO: [illegible]O-21
PAGE NO: 2

PROVIDER ID NO.

PROVIDER SITE NO. 001

PROVIDER

MEDICAID ID	BENEFICIARY NAME	MAILING ADDRESS	SEX	D.O.B. MM/DD/YY	TELEPHONE NUMBER(S)	LOCN	TYPE	APPOINTMENT DATE & TIME MM/DD/YY	SCREENING PERFORMED YES/NO IF NO, REASON	RESCHEDULED APPT. DATE AND TIME GIVEN BENEFICIARY DATE / TIME
50- -76		CASTOR LA 71016-0000	M			T	M V H	08/13/07 08:00	Y__N__R__	____/____/____ _____:_____
07- -03		SIBLEY LA 71073-2974	M			T	M V H	08/13/07 09:00	Y__N__R__	____/____/____ _____:_____
41- -05		COUSHATTA LA 71019-0000	F			R T	M V H	08/13/07 10:00	Y__N__R__	____/____/____ _____:_____
41- 03		COUSHATTA LA 71019-0000	F			T	M V H	08/13/07 10:00	Y__N__R__	____/____/____ _____:_____
65- -50		COUSHATTA LA 71019-0000	F			T	M V H	08/13/07 13:30	Y__N__R__	____/____/____ _____:_____
38- 80		COUSHATTA LA 71019-0000	M			T	M V H	08/13/07 13:30	Y__N__R__	____/____/____ _____:_____

REASON CODES: F=FORGOT APPT, R=REFUSED SERVICE, S=SICK, T=NO TRANSPORTATION, U=UNABLE TO FIND, X=FAILED TO SHOW, K=KEPT, O=MISSED OTHER

RSM018
RUN: 07/24/07 20:58:34
MONTH: AUGUST, 2007

MEDICAID COMMUNITYCARE/KIDMED SUBSYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
SCREENING PROVIDER BENEFICIARY REPORT
BASED ON SCREENING CLAIMS PAID

REPORT NO: RS-O-07
PAGE NO: 1

PROVIDER ID NO.

PROVIDER SITE NO.
001

PROVIDER

MEDICAID ID/ LINKAGE BEGIN DATE MM/DD/YY	BENEFICIARY NAME	MAILING ADDRESS	SEX	D.O.B. MM/DD/YY	TELEPHONE NUMBER(S)	LOCN	TYPE	LAST DATE SCREENED MM/DD/YY	NEXT SCREENING PERIOD MM/DD/YY MM/DD/YY	APPOINTMENT DATE AND TIME GIVEN BENEFICIARY DATE / TIME
							M	- INITIAL SCREEN REQUIRED -		___/___/___
							V	- INITIAL SCREEN REQUIRED -		
							H	- INITIAL SCREEN REQUIRED -		_____:_____
							M	- INITIAL SCREEN REQUIRED -		___/___/___
							V	- INITIAL SCREEN REQUIRED -		
							H	- INITIAL SCREEN REQUIRED -		_____:_____
							M	11/09/06	(05/09/07-04/04/09)	___/___/___
							V	11/09/06	(05/09/07-04/04/09)	
							H	11/09/06	(05/09/07-04/04/09)	_____:_____
							H M	07/20/98	(05/04/05-10/06/06)	___/___/___
							R V	10/22/01	(05/04/05-10/06/06)	
							H	10/22/01	(05/04/05-10/06/06)	_____:_____
							R M	08/02/94	(02/02/95-01/28/97)	___/___/___
							V	10/01/96	(04/01/97-01/28/99)	
							H	10/01/96	(04/01/97-01/28/99)	_____:_____
							H M	- INITIAL SCREEN REQUIRED -		___/___/___
							V	- INITIAL SCREEN REQUIRED -		
							H	- INITIAL SCREEN REQUIRED -		_____:_____
							H M	- INITIAL SCREEN REQUIRED -		___/___/___
							R V	11/13/97	(12/08/98-12/07/00)	
							X H	11/13/97	(12/08/98-12/07/00)	_____:_____
							M	- INITIAL SCREEN REQUIRED -		___/___/___
							V	- INITIAL SCREEN REQUIRED -		
							H	- INITIAL SCREEN REQUIRED -		_____:_____

* SIGNIFIES THAT THIS RECIPIENT IS ON THE REPORT FOR THE FIRST TIME THIS MONTH.
** SIGNIFIES THAT THIS RECIPIENT IS ON THE REPORT FOR THE LAST TIME THIS MONTH.

CLAIM RELATED REPORTS

CNTL-D012 - Direct Biller Process Summary

- Informs electronic biller whether or not input was accepted (in which case the range of CCNs assigned to individual claims will be displayed) or rejected (which requires the biller to resubmit input).
- **Cannot serve as proof of timely filing, as no specific claim data is displayed.**

CP-0-51A - Electronic Media Claim Proof List

- Displays in summary the CCN range assigned to individual claims which were accepted through electronic transmission.
- Displays in detail the CCN and specific claim data transmitted within each claim line of the transmission.
- **Can serve as proof of timely filing.**

CP-0-115 - Recycled Claims Listing

- Informs provider that certain claims have "pended" for errors encountered within the processing cycle and are being recycled in case recipient eligibility files are updated.
- **Can serve as proof of timely filing.**

CP-0-50 - Resubmittal Turnaround Document (RTD)

- Informs provider of errors encountered in processing KM-3 claim form.
- Allows provider to correct errors and return RTD by specified date.
- **Can serve as proof of timely filing if provider number, recipient name or number, procedure, and date of service are present and correct.**
- Instructions on proper completion of RTD are found on pages 78-80.

CP-0-50 - Denied Claims List

- Informs provider of KM-3 claim denial and errors encountered in processing.
- If errors are correctable, serves as prompt to resubmit corrected KM-3.
- **Can be used as proof of timely filing.**

Examples of the above reports are shown on the following pages.

cpd212
RUN: 08/08/07 16:19:21
CYCLE: 08/08/07

MEDICAID COMMUNITYCARE/KIDMED SUBSYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
DIRECT BILLER PROCESS SUMMARY

REPORT NO: CNTL-D012
PAGE NO: 1

SUBMITTER NAME: DATE OF DATA: 08/08/07 FORM OF DATA: 837P VOLSER:

BILLER ID:		FROM CCN: 7[illegible]		THRU CCN: 7[illegible]		BILLED CHARGES:	$10,433.80
PROVIDER ID:	SITE#:	FROM CCN: 7[illegible]	1	THRU CCN: 7[illegible]	1	BILLED CHARGES:	$387.40
PROVIDER ID:	SITE#:	FROM CCN: 7	1	THRU CCN: 7	1	BILLED CHARGES:	$6,888.40
PROVIDER ID:	SITE#:	FROM CCN: 7	1	THRU CCN: 7	4	BILLED CHARGES:	$258.00
PROVIDER ID:	SITE#:	FROM CCN: 7	1	THRU CCN: 7	1	BILLED CHARGES:	$2,696.00
PROVIDER ID:	SITE#: 001	FROM CCN: 7	1	THRU CCN: 7	1	BILLED CHARGES:	$204.00

RECORDS READ: 650
RECORDS WRITTEN: 162
DOCUMENTS WRITTEN: 156

***** END - OF - REPORT *****

CPDO12
RUN: 08/06/07 16:01:13
CYCLE: 08/06/07

MEDICAID COMMUNITYCARE/KIDMED SUBSYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
ELECTRONIC MEDIA CLAIM PROOF LIST

REPORT NO: CP-0-51A
PAGE NO: 1

SUBMITTER NAME:

DATE OF DATA: 08/06/07 FORM OF DATA: 837P VOLSER: 000070806

CCN	PROVIDER NUMBER	SITE NO	RECIPIENT MEDICAID ID	RECIP NAME	MEDICAL RECORD NUMBER	SCREENING TYPE	SCREEN DATE	BILLED CHARGE	PROC CODE	PROC MODS	IMMUN COMP CURR	SUSP COND
						MED - NURSE	08/03/2007	51.00	99394	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99394	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99384	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99394	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99393	TD	Y	N
						MED - NURSE	08/02/2007	51.00	99393	TD TS	Y	N
						MED - NURSE	08/02/2007	51.00	99393	TD TS	Y	N
						MED - NURSE	08/03/2007	51.00	99393	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99394	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99394	TD TS	Y	N
						MED - NURSE	08/03/2007	51.00	99394	TD	Y	N
						MED - NURSE	08/02/2007	51.00	99391	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99393	TD	Y	N
						MED - NURSE	08/02/2007	51.00	99381	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99392	TD	Y	N
						MED - NURSE	08/02/2007	51.00	99392	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99392	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99393	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99392	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99393	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99383	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99381	TD	Y	N
						MED - NURSE	08/02/2007	51.00	99391	TD	Y	N
						MED - NURSE	08/02/2007	51.00	99381	TD	Y	N
						MED - NURSE	08/03/2007	51.00	99382	TD	Y	N
						MED - PHYS	06/14/2007	134.00	99381		Y	N
						MED - PHYS	07/31/2007	120.00	99392		Y	Y
						VISION	07/31/2007	55.00	99173	EP	Y	N
						HEARING	07/31/2007	16.00	92551		Y	N
						MED - PHYS	07/31/2007	120.00	99392		Y	Y
						MED - NURSE	07/31/2007	150.00	99383	TD TS	Y	Y
						VISION	07/31/2007	55.00	99173	EP	Y	N
						HEARING	07/31/2007	16.00	92551		Y	N
						MED - NURSE	07/31/2007	120.00	99392	TD TS	Y	Y
						MED - PHYS	07/31/2007	120.00	99393		Y	Y
						VISION	07/31/2007	55.00	99173	EP	Y	N
						HEARING	07/31/2007	16.00	92551		Y	N

RUN: 08/06/07
CYCLE: 08/06/07

MEDICAID COMMUNITYCARE/KIDMED SUBSYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
RECYCLED CLAIMS LISTING

REPORT NO: CP-O-115 PAGE 1

O14 = MEDICAID NUMBER NOT ON FILE
O15 = RECIPIENT NOT ELIGIBLE ON DATE OF SEVICE
O17 = PATIENT LAST NAME/MEDICAID NUMBER MISMATCH
O19 = PATIENT FIRST NAME/MEDICAID NUMBER MISMATCH

BILLING PROV NO	SITE NO	CCN		MEDICAID NO	PATIENT NAME		DATE OF SCREENING	ERROR 1	ERROR 2	ERROR 3	ERROR 4	ERROR 5	FIRST PEND DATE	TOTAL
	001	7218	01	20	52	GEISE B	07/24/2007	017					08/06/2007	
		7218	01	28	53	MARTI C	07/23/2007	017	019				08/06/2007	
		7218	02	28	53	MARTI C	07/23/2007	017	019				08/06/2007	
		7218	03	28	53	MARTI C	07/23/2007	017	019				08/06/2007	
		7218	01	28	53	TAYLO J	07/16/2007	014					08/06/2007	
		7218	02	28	53	TAYLO J	07/16/2007	014					08/06/2007	
		7218	03	28	53	TAYLO J	07/16/2007	014					08/06/2007	
		72181	01	93	00	HAMIL A	07/19/2007	014					08/06/2007	
		72181	02	93	00	HAMIL A	07/19/2007	014					08/06/2007	
		72181	03	93	00	HAMIL A	07/19/2007	014					08/06/2007	
		72181	01	93	99	HARMO V	07/17/2007	014					08/06/2007	
														11
														11

CPW400
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CYCLE: 08/06/07

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
DENIED CLAIMS LIST

REPORT NO: CP-0-50
RPT PAGE NO: 2
PAGE NO: 2

PROVIDER:
SITE: 001

RECIPIENT MEDICAID ID	RECIPIENT LAST NAME	RECIPIENT FIRST NAME	MEDICAL RECORD NUMBER	SITE NO	CCN	CLAIM TYPE MODIFIER	SCREENING TYPE	SCREEN DATE	STATUS	ERROR CODE
				001		ORIGINAL	MED - PHYS	07/27/2007	DENIED	519

ERROR CODE	ERROR CODE DESCRIPTION	NUMBER OF OCCURRENCES
519	PROCEDURE CODE INAPPROPRIATE FOR RECIPIENT'S AGE.	1

CPW400
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CYCLE: 08/08/07

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
DENIED CLAIMS LIST

REPORT NO: CP-0-50
RPT PAGE NO: 10
PAGE NO: 2

PROVIDER:
SITE: 001

RECIPIENT MEDICAID ID	RECIPIENT LAST NAME	RECIPIENT FIRST NAME	MEDICAL RECORD NUMBER	SITE NO	CCN	CLAIM TYPE MODIFIER	SCREENING TYPE	SCREEN DATE	STATUS	ERROR CODE
17 3465	VER	R		001	72?	001	ORIGINAL	MED - PHYS	03/20/2007	DENIED	069
53? 7796	JIL	A		001	72?	801	ORIGINAL	MED - PHYS	08/03/2007	DENIED	027
68? 1831	EVE	M		001	72?	402	ORIGINAL	VISION	08/01/2007	DENIED	032

ERROR CODE	ERROR CODE DESCRIPTION	NUMBER OF OCCURRENCES
027	IMMUNIZATIONS NOT COMPLETE AND CURRENT REASON CODE MISSING	1
032	REFERRAL MISSING AND REQUIRED FOR VISION	1
069	CLAIM EXCEPTION FOR 60 DAY TIMELY FILING	1

CP-0-50 RESUBMITTAL TURNAROUND DOCUMENTS

When KM-3 claim forms are processed, errors that are detected may result in the claim denying. However, certain errors do not cause denial but rather cause the claim to pend, enabling the provider to correct it without having to resubmit a new KM-3. Generally in these cases the erroneous claim causes a resubmittal turnaround document (RTD) to be generated and mailed by Unisys to the provider. (see example on pages 81 and 82)

The RTD can be used to correct certain errors made in completing the KM-3 form. For providers who submit their claims hardcopy, it is normally much easier to make needed corrections on the RTDs and return them, as opposed to completing entirely new KM-3 claim forms containing the correct information. Providers who submit KIDMED claims electronically may either submit corrected RTDs or they may resubmit the corrected claim electronically. There is an expiration date shown on the RTD by which the RTD must be corrected and returned to Unisys. If the RTD is not returned by the deadline, the claim will be denied and would have to be resubmitted as a corrected claim.

Each RTD lists specific information regarding the error(s) made on the KM-3 submission. The information on the original KM-3 is reflected on the RTD, and the fields on the RTD correspond to those on the KM-3 claim form. Completion requirements for the RTD parallel those of the KM-3 (e.g., a particular response in one item may require that the next item must be completed). The RTD indicates the error or omission so that it can be corrected.

Most of the errors that result in RTDs are easily understood and corrected. If needed information is missing, it can be written in on the RTD. If information shown on the RTD is incorrect, it can be lined through to delete it, or it can be lined through and the correct information written below it to make the correction. Following are instructions for correcting the RTD for the errors that seem to be most common. In addition, this information can be used to determine the cause of denials and the steps to correcting them.

Eligibility Errors – Denial Codes 013 – 019

Items 10 – 12 of the KM-3 and the RTD must be completed and must match the information on the Medicaid recipient eligibility files. Normally the Medicaid recipient eligibility files match the information you receive on the RS-0-07 report. Occasionally providers will receive eligibility denials because they are using an old Medicaid number on their files instead of the recipient ID number on the RS-0-07. In addition, errors can be caused by incomplete Medicaid ID numbers, transposing numbers within the Medicaid ID number, using part of the card control number from the Medicaid ID card rather than the 13-digit Medicaid ID number, and using the ID number for one sibling with the name of another.

Items to look for on the RTD:

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

11. Patient Last Name - Enter the first 17 letters of the recipient's last name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility system. The name should also appear on the recipient's current Medicaid eligibility card. If the name has less than 17 letters, leave the remaining spaces blank.

12. Patient First Name - Enter up to 12 letters of the recipient's first name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility system. The name should also appear on the recipient's current Medicaid eligibility card. If the name has less than 12 letters, leave the remaining spaces blank.

Screening Date And Billed Charges – Denial Codes 023 – 024

Items 25 and 26 should reflect the date of the screening and the charge for it. If these items are inadvertently omitted or are only partially completed, the claim will deny. These items can easily be completed or corrected on the RTD.

Items to look for on the RTD:

25. Date of Screening - For **each** applicable line, enter the date of the screening. For proper reimbursement, the provider must date each screening type that is being billed.

26. Billed Charge - For **each** line completed in item 25, enter the appropriate charge for services rendered, using four digits for dollars and cents. For example, $75.00 would be entered as “7500."

Immunization Status – Denial Codes 025 – 027

Item 29 must contain a response. If the response is that immunizations are not complete and up-to-date, item 30 must be completed.

Items to look for on the RTD:

29. Immunization Status - Enter “Y” if immunizations are complete (items 30A – 30C should contain neither “Y” nor “N”). Enter “N” if they are not and enter Y in one of 30A – 30C (whichever is appropriate) to indicate why immunizations are not complete.

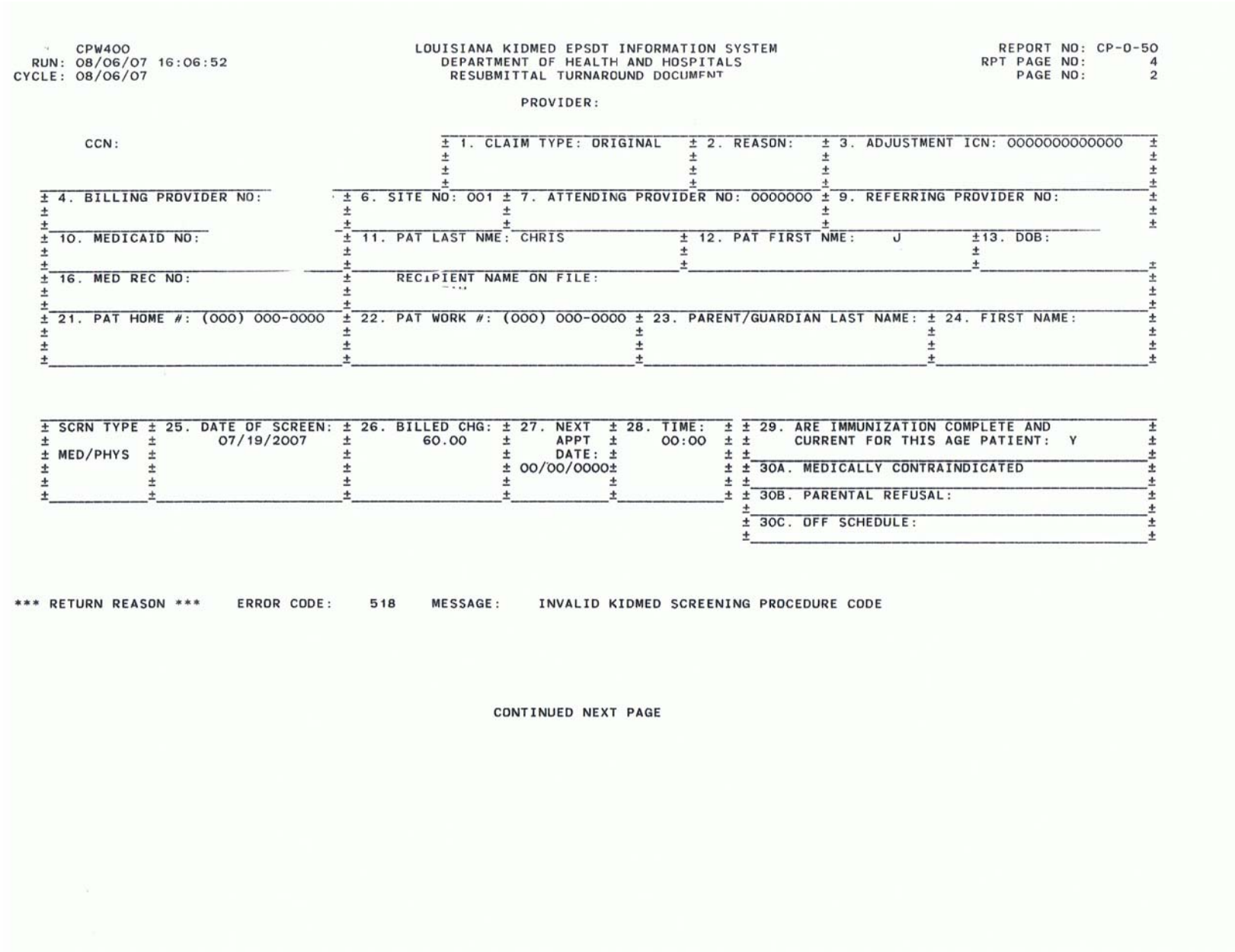
Suspected Conditions And Referrals – Denial Codes 028 – 066

Item 31 must contain a response. If the response is that there are suspected conditions, item 32 must be completed. If item 32 indicates any condition other than undercare, at least one referral must be entered in items 33-35.

Items to look for on the RTD:

31. Suspected Conditions - Enter N if there are no suspected conditions (make sure there are no suspected conditions indicated in 32). Enter “Y” if there are suspected conditions and specify them in 32. In item 32, suspected conditions are noted with “U” (undercare), “O” (off-site referral), or “I” (in-house referral). Mark an “X” in the corresponding blank to indicate the type of condition suspected.

32. **Referrals** - If there are no suspected conditions, or if the conditions are all undercare, this section should have no information entered. Otherwise, items 33A, 34A, and 35A may be completed only with letters A – I signifying which suspected condition the referral is for. **DO NOT enter an ICD-9 diagnosis code or diagnosis abbreviation (e.g., "URI") here, that information should be entered in 33E, 34E, and 35E.** The other items in this section are self-explanatory.



CPW400
RUN: 08/06/07 16:06:52
CYCLE: 08/06/07

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
RESUBMITTAL TURNAROUND DOCUMENT

REPORT NO: CP-O-50
RPT PAGE NO: 4
PAGE NO: 2

PROVIDER:

CCN:

1. CLAIM TYPE: ORIGINAL
2. REASON:
3. ADJUSTMENT ICN: OOOOOOOOOOOO
4. BILLING PROVIDER NO:
6. SITE NO: 001
7. ATTENDING PROVIDER NO: OOOOOOO
9. REFERRING PROVIDER NO:
10. MEDICAID NO:
11. PAT LAST NME: CHRIS
12. PAT FIRST NME: J
13. DOB:
16. MED REC NO:
RECIPIENT NAME ON FILE:
21. PAT HOME #: (OOO) OOO-OOOO
22. PAT WORK #: (OOO) OOO-OOOO
23. PARENT/GUARDIAN LAST NAME:
24. FIRST NAME:

SCRN TYPE	25. DATE OF SCREEN:	26. BILLED CHG:	27. NEXT APPT DATE:	28. TIME:
MED/PHYS	07/19/2007	60.00	00/00/0000	00:00

29. ARE IMMUNIZATION COMPLETE AND CURRENT FOR THIS AGE PATIENT: Y
30A. MEDICALLY CONTRAINDICATED
30B. PARENTAL REFUSAL:
30C. OFF SCHEDULE:

*** RETURN REASON *** ERROR CODE: 518 MESSAGE: INVALID KIDMED SCREENING PROCEDURE CODE

CONTINUED NEXT PAGE

CPW400
RUN: 08/06/07 16:06:52
CYCLE: 08/06/07

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
RESUBMITTAL TURNAROUND DOCUMENT

REPORT NO: CP-0-50
RPT PAGE NO: 5
PAGE NO: 3

CCN: PROVIDER:

31. ARE THERE SUSP COND: N

32. SUSPECTED CONDITIONS:

U	O	I	DESCRIPTION
_	_	_	A. MEDICAL
_	_	_	B. VISION
_	_	_	C. HEARING
_	_	_	D. DENTAL
_	_	_	E. NUTRITIONAL
_	_	_	F. DEVELOPMENTAL
_	_	_	G. ABUSE/NEGLECT
_	_	_	H. PSYCHOLOGICAL
_	_	_	I. SPEECH/LANGUAGE
_	_	_	J.
_	_	_	K.
_	_	_	L.

CORRECT AND RESUBMIT THIS COPY

THIS CORRECTED COPY MUST BE RECEIVED BEFORE 10/05/2007 OR THIS CLAIM WILL BE DENIED.

33A. SUSP COND: | 33B. REF ASST NEED: | 33C. APPT DATE: 00/00/0000 | 33D. TIME: 00:00

33E. REASON FOR REFERRAL:

33F. REFERRED TO: | 33G.

33H. PHONE NO: (000) 000-0000 | 33I. TRANSPORTATION ASSISTANCE NEEDED:

34A. SUSP COND: | 34B. REF ASST NEED: | 34C. APPT DATE: 00/00/0000 | 34D. TIME: 00:00

34E. REASON FOR REFERRAL:

34F. REFERRED TO: | 34G.

34H. PHONE NO: (000) 000-0000 | 34I. TRANSPORTATION ASSISTANCE NEEDED:

35A. SUSP COND: | 35B. REF ASST NEED: | 35C. APPT DATE: 00/00/0000 | 35D. TIME: 00:00

35E. REASON FOR REFERRAL:

35F. REFERRED TO: | 35G.

35H. PHONE NO: (000) 000-0000 | 35I. TRANSPORTATION ASSISTANCE NEEDED:

I HEREBY AMEND/CORRECT, AS INDICATED ABOVE, THE MEDICAID CLAIM IDENTIFIED ON THIS SHEET AND REQUEST THE REPROCESSING OF THE SAID CLAIM BE MADE WITH THE INFORMATION PROVIDED ON THIS DOCUMENT. ALL INFORMATION ON THE CLAIM IDENTIFIED ABOVE AND NOT AMENDED SHALL REMAIN AS IS. I HEREBY CERTIFY THAT THE CLAIM FOR SERVICES AND INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS

PROVIDER SIGNATURE: _____ DATE OF SIGNATURE: _____

PLEASE RETURN TO: UNISYS-KIDMED
P.O. BOX 14849

BATON ROUGE, LA 70898-4849

COMMUNITYCARE BASICS FOR NON-PCPS

Program Description

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

Recipients

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

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

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

How to Identify CommunityCARE Enrollees

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

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

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

Primary Care Physician

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

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

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

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

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

Important CommunityCARE Referral/Authorization Information

- Any provider other than the recipient's PCP must obtain a referral from the recipient's PCP, **prior to rendering services**, in order to receive payment from Medicaid. Any provider who provides a non-exempt, non-emergent (routine) service for a CommunityCARE enrollee, without obtaining the appropriate referral/authorization prior to the service being provided risks non-payment by Medicaid. **DHH and Unisys will not assist providers with obtaining referrals/authorizations for care not requested in accordance with CommunityCARE policy.** PCPs are not required to respond to requests for referrals/authorizations for non-emergent/routine care not made in accordance with CommunityCARE policy: i.e. requests made after the service has been rendered.

- When ancillary services such as DME or Home Health are ordered by a provider other than the PCP, the ordering provider is responsible for obtaining the CommunityCARE referral/authorization. For example, when a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to

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

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

  Examples:

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

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

  - The PCP refers his CommunityCARE patient to a surgeon for an outpatient procedure and sends the surgeon a written referral/authorization. The surgeon must provide a copy of that written referral/authorization to any other provider whose services may be needed during that episode of care (i.e. DME, Home Health, and anesthesia).

- Recipients **may not** be held responsible for claims denied due to provider errors or failure to follow Medicaid policies/procedures, such as failure to obtain a PCP referral/authorization, prior authorization or pre-cert, failure to timely file, incorrect TPL carrier code, etc.

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

Providers:

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

Enrollees:

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

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

HARD COPY REQUIREMENTS

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

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

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

LOUISIANA MEDICAID WEBSITE APPLICATIONS

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

www.lamedicaid.com

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

Provider Login and Password

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

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

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

Web Applications

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

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

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

e-MEVS:

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

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

e-CSI:

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

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

e-CDI:

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

The nine (9) clinical services information components are:

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

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

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

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

e-PA

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

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

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

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

Reminders:

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

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

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

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

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

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

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

Additional DHH Available Websites

www.lamedicaid.com: Louisiana Medicaid Information Center which includes Field Analyst listing, RA messages, Provider Updates, Preferred Drug Listings, General Medicaid Information, Fee Schedules, and Program Training Packets

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

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

www.la-kidmed.com: KIDMED – Program Information, Frequently Asked Questions, Outreach Material ordering

www.la-communitycare.com: CommunityCARE – Program Information, PCP Listings, Frequently Asked Questions, Outreach Material ordering

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

www.ltss.dhh.louisiana.gov/offices/?ID=152: Division of Long Term Community Supports and Services (DLTSS)

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

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

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

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

PROVIDER ASSISTANCE

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

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

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

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

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

Unisys Provider Relations Telephone Inquiry Unit

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

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

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

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

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

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

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

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

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

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

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

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

Press #4 - To resolve a claims problem

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

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

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

Unisys Provider Relations Correspondence Group

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

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

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

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

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

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

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

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

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

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

Unisys Provider Relations Field Analysts

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

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

Provider Relations Reminders

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

- Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:
    - The correct 7-digit LA Medicaid provider number
    - The 13-digit Recipient's Medicaid ID number
    - The date of service
    - Any other information, such as procedure code and billed charge, that will help identify the claim in question
    - The Remittance Advice showing disposition of the specific claim in question

- Obtain the name of the phone representative you are speaking to in case further communication is necessary.

- Because of the large volume of incoming provider calls, Telephone Inquiry staff are not allowed to be put on hold after answering a call.

- PLEASE review and reconcile the remittance advice before calling Provider Relations concerning claims issues. Some providers call Provider Relations frequently, asking questions that could be answered if the RA was reviewed thoroughly. However, providers are encouraged to call Provider Relations with questions concerning printed policy, procedures, and billing problems.

- **Provider Relations WILL NOT reconcile provider accounts or work old accounts for providers. Calls to check claim status tie up phone lines and reduce the number of legitimate questions and inquiries that can be answered. It is each provider's responsibility to establish and maintain a system of tracking claim billing, payment, and denial. This includes thoroughly reviewing the weekly remittance advice, correcting claim errors as indicated by denial error codes, and resubmitting claims which do not appear on the remittance advice within 30 - 40 days for hard copy claims and three weeks for EDI claims**.

- **Providers can check claim status through the e-CSI (Claim Status Inquiry) web application found in the secure area of the Louisiana Medicaid website at www.lamedicaid.com. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on e-CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the e-CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to e-CSI or hard copy remittance advices for this purpose. This includes provider's direct staff and billing agents or vendors. A LA Medicaid/HIPAA Error Code Crosswalk is available on the website by accessing the link, Forms/Files.**

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

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

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

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

DHH PROGRAM MANAGER REQUESTS

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

Program Manager - (i.e. Professional, DME, Hospital, etc.)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

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

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

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

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

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

Department	Phone	Purpose
Fraud and Abuse Hotline	(800) 488-2917	Recipients may anonymously report any suspected fraud and/or abuse.
Regional Office – **DHH**	(800) 834-3333 (225) 925-6606	Recipients may request a new card or discuss eligibility issues.
Eligibility Operations – **BHSF**	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Specialty Care Resource Line - **ACS**	(877) 455-9955	Recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED.
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 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.

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

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.

APPENDIX

EarlySteps

(The following information was received from the EarlySteps Program. Please contact the EarlySteps Program for additional information.)

EarlySteps is Louisiana's Early Intervention System which provides services to families with infants and toddlers who have special needs. These services are delivered in the recipient's home or "natural setting".

Eligibility criteria for the EarlySteps program are for children ages birth to age 3 and in two areas, Developmental Delay and Established Medical Conditions as follows:

Developmental Delay
The recipient must have a developmental delay of at least 1.5 SD (standard deviations) in one of the following developmental areas or in a specified subdomain;

- Cognitive development
- Physical development (vision, hearing, fine and gross motor)
  --fine motor
  --gross motor
- Communication development
  --receptive language
  --expressive language
- Social or emotional development
- Adaptive skills development (also known as self-help or daily living skills)

A child may also qualify using *informed clinical opinion* in any area of development if a developmental assessment alone does not indicate a delay of 1.5 standard deviations from the mean. In this case, the provider should document that the area of concern is atypical for the child's age, interferes with normal functioning, and makes day-to-day care of the child difficult.

These developmental delay criteria are in effect as of July 1, 2007.

Established Medical Condition

EarlySteps utilizes the following medical conditions which have a high probability of resulting in developmental delay for eligibility.

Diagnosed Conditions List and ICD-9 Codes
If documented by a physician's signature (or that of an audiologist in the case of hearing impairment or a speech/language pathologist in the case of a child with developmental apraxia of speech) children with the following diagnoses are eligible for the EarlySteps System. These diagnoses have a high probability of resulting in developmental delay.

Genetic Disorders

A. Chromosomal Abnormality Syndromes
Down's syndrome (758.0), Trisomy 13 (758.1), Trisomy 18 (758.2)
Autosomal deletion syndromes (758.3_) (includes Cri-du-chat, velo-cardio-facial, others)
Other micro-deletion syndromes (758.5) (includes Miller Dieker syndrome, Smith-Magenis syndrome)
DiGeorge Syndrome (279.11)
Fragile X (759.83)
Prader-Willi (759.81)

Other conditions due to autosomal anomalies (758.5)
Conditions due to sex chromosome anomalies, (758.81) This does not include Klinefelter's Syndrome (XXY) or Turner's Syndrome (XO)
Conditions due to anomaly of unspecified chromosome (758.9) (includes Williams Syndrome)

B. Pre-natal exposures

Fetal alcohol syndrome (760.71)
Narcotics exposure (760.72)
Hallucinogenic agent exposure (760.73)
Cocaine exposure (760.75)
Anticonvulsant exposure (760.77)

C. Neurocutaneous Syndromes

Incontinentia pigmenti (757.33)
Neurofibromatosis (237.7)
Sturge-Weber syndrome (759.6)
Tuberous sclerosis (759.5)

D. Inborn Errors of Metabolism

Disorders of amino-acid transport (270--) (includes PKU, Maple Sugar Urine Disease, urea cycle defects, organic acidemias, others)
Disorders of Carbohydrate metabolism (only 271.0,271.1)
Disorders of Lipid Metabolism (only 272.7, 272.8)
Cerebral degenerations of the central nervous system (includes leukodystrophies (330-); cerebral lipidoses such as TaySach's (330.1); Fabry's, Gaucher's, Niemann Pick, sphingolipidoses (330.2), Hunter's and other mucopolysaccaridoses (277.5), other cerebral degenerations in childhood (330.8, 330.9)

E. Prenatal Infections

"TORCH infections" (771.0--771.2), including:
Congenital rubella (771.0)
Congenital cytomegalovirus infection (CMV) (771.1)
Congenital herpes simplex (771.2)
Congenital toxoplasmosis (771.2)

F. Other Syndromes

Chondrodystrophies (756.4)
Congenital anomalies of central nervous system (742.--)
Osteodystrophies (756.5)
Cerebral gigantism (253.0)
Other specified congenital anomalies affecting multiple systems (759.8-) (includes Beckwith Weiderman Syndrome, Cornelia de Lange's Syndrome, others 759.89)

Sensory Impairments

Impairment can be congenital or acquired
Profound impairment, both eyes (369.0-)
Moderate or severe impairment, better eye, profound impairment lesser eye (369.1-)
Moderate or severe impairment, both eyes (369.2-)
Legal blindness, as defined in USA (369.4)
Retinopathy of prematurity, (Grades 4 and 5) (362.21), bilateral
Cortical Blindness (377.75), bilateral
Hearing impairment (25dB loss or greater) (389.--), unilateral or bilateral
Auditory neuropathy (389.9)
Central hearing loss (389.14)

Orthopedic and Neurological Disorders

Anoxic brain damage (348.1)
Anterior horn cell disease (335.--)
Arthrogryposis (728.3)
Brachial plexus palsy, perinatal origin (767.6) and post-perinatal origin (953.4)
Cerebral cysts (348.0)
Cerebral palsy (all types) (343.--)
Cleft hand (755.58)
Congenital anomalies of the central nervous system (742.--)
Congenital anomalies of limbs (755.2-; 755.3-; 755.4-)
Congenital musculoskeletal anomalies (756.0; 756.13 & 756.51)
Degenerative progressive neurological conditions (330.--)
Developmental apraxia of speech (784.69)
Encephalopathy Not Otherwise Specified (348.30)
Fracture of vertebral column with spinal cord injury (806)
Hemiplegia and hemiparesis (342.--)
Hereditary and degenerative diseases of the central nervous system (331.3; 331.4; 331.7, & 335.--)
Hydrocephaly, congenital (742.3) and acquired (331.3-331.4)
Infantile spasms (345.6)
Intraventricular hemorrhage (IVH) - Grade 3 (772.13) & Grade 4 (773.14)
Meningomyelocele / Myelomeningocele / Spina Bifida / Neural Tube Defect (741.--)
Muscular dystrophies and other myopathies (359.0, 359.1 & 359.2)
Paralytic syndromes (344.0 – 344.5)
Spinal cord injury (952.--)
Stroke (434.--)
Traumatic Brain Injury (851.--)

Social Emotional Disorders

Childhood depression (311)
Reactive attachment disorder (313.89)

Pervasive Developmental Disorders (299.--) including:

Asperger's syndrome / disorder (299.8)
Autism (299.0)
Childhood disintegrative disorder (299.1)
Unspecified pervasive developmental disorder-NOS (299.9)
Rett's syndrome (330.8)

Medically Related Disorders

Congenital or infancy-onset hypothyroidism (243)
Cleft palate (prior to the operation to repair the cleft and up to one-year post-operative) (749.0 and 749.2)
Craniosynostosis (756.0)
Premature closure of the sutures (756.0)
Lead intoxication (>45 µg/dL) (984)
Very low birth weight (<1500 grams at birth) up to 12 months corrected age only (765.1, 765.2, 765.3, 765.4, 765.5)
Preterm infants 32 weeks or less gestational age up to 12 months corrected age only (765.21, 765.22, 765.23, 765.24, 765.25,765.26)
Non-organic failure to thrive (783.41)
Chronic respiratory failure or ventilatory dependent (518.83)
Bronchopulmonary dysplasia (770.7)

EarlySteps Supports and Services
EarlySteps provides the following Medicaid-covered services:

- Occupational Therapy
- Physical Therapy
- Speech/Language Therapy
- Audiology
- Psychology
- Support Coordination (Family Service Coordination)

EarlySteps also provides the following services not covered by Medicaid:

- Nursing Services/Health Services (Only to enable an eligible child/family to benefit from the other EarlySteps services)
- Medical Services for diagnostic and evaluation purposes only
- Special Instruction
- Vision Services
- Assistive Technology devices and services
- Social Work
- Counseling Services/Family Training
- Transportation
- Nutrition Services
- Sign language and cued language services

If providers identify recipients that may meet the qualifications noted above or for whom concerns are identified through developmental screening, they may refer them to the local System Point of Entry (SPOE) detailed on the following pages, or have them call EarlySteps at 1-866-earlysteps.

All services are provided through a plan of care called the Individualized Family Service Plan (IFSP). Early intervention services are provided through EarlySteps in conformance with Part C of the Individuals with Disabilities Education Act.

The EPSDT Early Intervention Services (EarlySteps) Fee Schedule is available online at www.lamedicaid.com. This fee schedule lists the Louisiana Medicaid reimbursement for all direct services (occupational therapy, physical therapy, speech/language therapy, psychology, and audiology).

NOTE:
If a Medicaid eligible child under the age of 3 years does not meet the eligibility requirements for early intervention services under the EarlySteps program, medically necessary services are available through the Medicaid Infant and Toddler Support Coordination program and the EPSDT Program for direct services. Medically necessary services must be prescribed by a physician and prior authorization is required. Families may be referred to Medicaid providers directly for these services and/or may contact Statistical Resources, Inc. at 1-800-364-7828 for referrals.

EarlySteps
Louisiana's Early Intervention System
System Point of Entry (SPOE's)

DHH Region	SPOE	Parishes	Contractor-Information
1	Jefferson Parish Human Service Authority	Orleans, St. Bernard, Jefferson , Plaquemines	**Lynne-Marie Ruckert, Program Supervisor** 201 Evans Road Bldg 1 Suite 100 Harahan, LA 70123 Phone (504) 496-0165 Toll Free 1-866-296-0718 Fax (504) 838-5284 **E-mail: lruckert@fhfgno.org**
2	Southeast Louisiana Area Health Education Center	East Baton Rouge, West Baton Rouge, East Feliciana, West Feliciana, Pointe Coupee, Iberville, Ascension	**Brian Jakes III, Program Manager** 3060 Teddy Drive Suite A Baton Rouge, LA 70809 Phone (225) 925-2426 Toll Free 1-866-925-2426 Fax (225) 925-1370 **E-mail: ahecbpj@I-55.com**
3	Southeast Louisiana Area Health Education Center	Assumption, St. John, St. Charles, St. James, Terrebonne, Lafourche, St. Mary	**Brian Jakes III, Program Manager** 602 Parish Road Thibodaux, LA 70301 Phone (985) 447-6550 Toll Free 1-866-891-9044 Fax (985) 447-6513 **E-mail: ahecbpj@I-55.com**
4	First Steps Referral and Consulting LLC	Lafayette, Iberia, St. Martin, Vermillion, St. Landry, Evangeline, Acadia	**Mary F. Hockless, CEO** 134 East Main Street, Suite 4 New Iberia, LA 70560 Phone (337) 359-8748 Toll Free 1-866-494-8900 Fax (337) 359-8747 **E-mail: teamfsrc@bellsouth.net**
5	First Steps Referral and Consulting LLC	Beauregard, Jefferson Davis, Allen, Cameron, Calcasieu	**Mary F. Hockless, CEO** 134 East Main Street, Suite 4 New Iberia, LA 70560 Phone (337) 359-8748 Toll Free 1-866-494-8900 Fax (337) 359-8747 **E-mail: teamfsrc@bellsouth.net**
6	Families Helping Families at the Crossroads of Louisiana	Vernon, Rapides, Winn, Grant, LaSalle, Catahoula, Concordia, Avoyelles	**Teresa Harmon, Program Supervisor** 2840 Military Highway Suite B Pineville, LA 71360 Phone (318) 640-7078 Toll Fee 1-866-445-7672 Fax (318) 640-5799 **E-mail: tjharmon891@hotmail.com**

7	Families Helping Families at the Crossroads of Louisiana	Caddo, Bossier, Webster, Claiborne, Bienville, Natchitoches, Sabine, DeSoto, Red River	**Rebecca Thornton, Program Supervisor** 2620 Centenary Blvd. Bldg. 2 Suite 249 Shreveport, LA 71104 Phone (318) 226-8038 Toll Free 1-866-676-1695 Fax (318) 425-8295 **E-mail: spoereg7ps@bellsouth.net**
8	Easter Seals of Louisiana	Ouachita, Union, Jackson, Lincoln, Caldwell, Morehouse, West Carroll, East Carroll, Richland, Franklin, Tensas, Madison	**Peyton Fisher, Director** 1300 Hudson Lane, Suite B Monroe, LA 71201 Phone (318) 322-4788 Toll Free 1-877-322-4788 Fax (318) 322-1549 **Email: pfisher@bayou.com**
9	Southeast Louisiana Area Health Education Center	St. Tammany, Livingston, Tangipohoa, Washington, St. Helena	**Brian Jakes III, Program Manager** 1302 J.W. Davis Drive Hammond, LA 70403 Phone (985) 429- 1252 Toll Free 1-866-640-0238 Fax (985) 429-1613 **Email: ahecbpj@I-55.com**

REFERRAL FOLLOW UP FORM

Patient Name	*Date of Birth*	*Date Referred*	*Reason for referral*	*Referred to*	*Appointment date*	*Follow up effort 1*	*Follow up effort 2*	*Follow up complete*

REQUIRED KIDMED MEDICAL, VISION, AND HEARING SCREENING COMPONENTS BY AGE OF RECIPIENT (EFFECTIVE APRIL 1, 1994)[11]

AGE	BIRTH [12]	BY 1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	2 YR	3 YR	4 YR	5 YR	6 YR	8 YR	10 YR	12 YR	14 YR	16 YR	18 YR	20 YR
MEDICAL SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
INITIAL/INTERVAL HISTORY	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS																					
Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X	X	X											
Blood Pressure											X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL ASSESSMENT	S	S	SO	S	S	S	SO	S	S	SO	SO	SO	SO	S	S	S	S	S	S	S	S
UNCLOTHED PHYSICAL EXAM/ASSESSMENT [13]	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PROCEDURES																					
Immunization [14]	X		X	X	X		X	X				---	X	---				X	---		
Neonatal Screening [15]	---	X																			
Anemia Screening [16]						---	X	(X	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Urine Screening [17]							(X	---	---	---	---	X)	(X	---	---	---	X)	(X	---	---	X)
Lead Risk Assessment [18]					X	X	X	X	X	X	X	X	X								
Blood Lead Screening [19]							X			X											
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEALTH EDUCATION [20]	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
VISION SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO
HEARING SCREENING	S	S	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO

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

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

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

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

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

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

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

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

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

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

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

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

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

1. ☐ ORIGINAL ☐ ADJUSTMENT ☐ VOID
2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

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

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

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? ☐ YES ☐ NO

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

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☐ YES ☐ NO

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

32.

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

REFERRALS FOR SUSPECTED CONDITIONS

33.

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

E. REASON FOR REFERRAL

F. REFERRED TO | G.

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

34.

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

E. REASON FOR REFERRAL

F. REFERRED TO | G.

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

35.

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

E. REASON FOR REFERRAL

F. REFERRED TO | G.

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

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

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

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

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

02/03

36. SIGNATURE OF PROVIDER _____ 37. DATE _____

KM-3

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

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

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

ADJUSTMENT

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

Universal Screening Documentation Tools – Optional

A universal screening documentation tool is one that can be used at the screening provider's option. The tool is attached. This tool should be completed thoroughly and accurately to ensure all components of a screening are documented. Providers should be familiar with the program requirements of a screening as explained in the KIDMED provider manual. Any additional information necessary to support the screening should also be found in the patient's chart. This tool was designed to incorporate necessary items for a screening in a clear, concise manner. **We <u>are not</u> requiring this tool to be used; it is for your convenience, only.** However, any tool used must document that all five components of a medical screening as stated in the KIDMED manual, were completed. Program compliance reviews will look for such documentation. Furthermore, be aware that the same documentation applies to a "well-child" visit which must also conform to the requirements mandatory for a KIDMED screening. If you do not wish to use this documentation, you may develop your own.

INITIAL SCREENING
BIRTH THROUGH 5 YEARS

DATE:

ıtient Name: Age:

Family History

[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Sickle Cell _____
[ ] T.B. _____
[ ] Other: _____
_____
_____

(Please note family member's relation to patient)

Birth History

[ ] Term [ ] Premature [ ] Post-mature
[ ] Prenatal care [ ] Complications

[ ] NVD [ ] C-Section

[ ] Neonatal Complications _____

Neonatal Screen: WNL Repeated
Results requested: Yes No

Comments: _____

Past Medical History

Illness _____
_____
Hospitalization _____
_____
_____
_____
_____
Allergies _____
_____
_____

HT. WT. T P R (3yrs and up): Head Circ. (0-2yrs): Blood Pressure

Hct or Hgb: WNL UTD UTO Value: Urine Dipstick: WNL UTD UTO Comments: Lead: Drawn UTD UTO [ ] Not required at this time

Vision Screening

Subjective: any eye disorder Yes No
F.H.O. eye disorder Yes No
Wear glasses Yes No

Objective: Visual acuity R20/ L20/
Muscle Balance pass fail
(Objective screening begins at age 4.)

Hearing Screen

Subjective: response to voices Yes No
Delayed speech development Yes No
Recurrent O.M Yes No
Hearing 20 db HL
1000Hz 2000 Hz 4000Hz
Right Ear _____ _____ _____
Left Ear _____ _____ _____

Lead Poisoning Risk Assessment

Peeling paint in house, daycare etc. Yes No
Relative with lead poison Yes No
House built before 19 Yes No
Renovation Yes No
Adult work in pottery or ceramics Yes No
Live near battery recycling plant or lead release industry Yes No
Live near highway or heavy traffic Yes No

Developmental Assessment

Subjective Assessment WNL Suspect Objective Assessment WNL Delayed
(Copy of screen must be in chart.)

Physical Exam **Normal (✓)** **Abnormal** (Describe)

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Nutritional Assessment

[ ]Breast fed [ ] Formula

Eating Problems _____
Vitamins Supplements Yes No
Growth Grid Normal Yes No
(Growth Grid must be in chart..)

Dental Assessment

Any Dental Disease Yes No
Dental Caries Yes No
Brush Teeth Regularly Yes No
Do You Have a Dentist? Yes No
Name of Dentist _____

Environmental Assessment

Water supply: City Well None
Sewer system: City Septic None
[ ] Smokers in the home: _____
[ ] Pets in home: _____

Comments:

Immunization Status

[ ] Immunizations current
[ ] Off Schedule* [ ] Parental Refusal*
[ ] Medically Contraindicated*

Explain * _____
(Vaccine record must be in chart.)

Anticipatory Guidance
(mark those discussed)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____
Toilet Training _____

Impressions:

ıan or Referral: [ ]Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

INITIAL SCREENING
AGES 6 TO 21 YEARS

DATE:

ıtient Name: Age:

Family History

[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Sickle Cell _____
[ ] T.B. _____
[ ] Other: _____

(Please note family member's relation to patient)

Birth History

[ ] Term [ ] Premature [ ] Post-mature

[ ] Prenatal care [ ] Complications

Note: _____

[ ] NVD [ ] C-Section

[ ] Neonatal Complications _____

Past Medical History

[ ] Major Illness _____

[ ] Hospitalizations _____

[ ] Allergies _____

HT. WGT. B.P. T. P. R.

Labs Hct or Hgb: WNL UTD UTO Value: _____ Urine Dipstick: WNL UTD UTO Comments:

Vision Screen

Subjective: any eye disorder	Yes	No
F.H.O. eye disorder	Yes	No
Wear glasses	Yes	No
Objective: Visual acuity	R 20/	L 20/
Muscle Balance	pass	fail
Color Perception	pass	fail
(*6 years and up*)		

Hearing Screen

Subjective: response to voices	Yes	No	
Delayed speech development	Yes	No	
Recurrent O.M.	Yes	No	
Hearing 20 db HL			
	1000Hz	2000 Hz	4000Hz
Right Ear	_____	_____	_____
Left Ear	_____	_____	_____

Developmental Assessment

Appropriate verbal communication	Yes	No
Drugs/Alcohol/Tobacco	Yes	No
Hobbies & Sports	Yes	No
Family/Peer Relationship	WNL	Poor
School/Job Performance	WNL	Poor

Reproductive

Sexually active Yes Denies
Contraceptive used _____
Menarche age _____ LMP _____
Gravida _____ Para _____

Physical Exam **Normal (✓)** **Abnormal (Describe)**

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Nutritional Assessment

[ ] Special Diet _____
[ ] Vitamins/ Supplements _____
[ ] Growth Chart WNL See Grid
Comments: _____

Dental Assessment

Any Dental Disease	Yes	No
Dental Caries	Yes	No
Brush Teeth Regularly	Yes	No
Do You Have a Dentist?	Yes	No

Name of Dentist _____

Environmental Assessment

Water supply: City Well None

Sewer system: City Septic None

Smokers in the home? _____

Pets in home? List:

Immunization Status

[ ] Immunizations current [ ] Off Schedule*

[ ] Medically Contraindicated* [ ] Parental Refusal*

Explain * _____

Anticipatory Guidance
(Mark ones taught)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____
Health/Reproduction _____
High Risk activities _____

Impressions:

Plan or Referral:

[ ] Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

PERIODIC SCREENING
BIRTH THROUGH 5 YEARS

DATE:

Patient Name: Age:

Family History

[ ] No changes since last screen
[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Sickle Cell _____
[ ] T.B. _____
[ ] Other: _____

(Please note family member's relation to patient)

Recent Medical History

[ ] No changes since last screen
[ ] Major Illness _____
[ ] Hospitalizations _____
[ ] Allergies _____
[ ] Current Medications _____

Neonatal Screen: WNL Repeated
Results requested: Yes No

Comments: _____

Environmental Assessment

[ ] No changes since last screen

Water supply: City Well None
Sewer: City Septic None

Smokers in home: _____

Pets in home: _____

Developmental Assessment

Subjective Assessment WNL Suspect

Objective Assessment WNL Delayed

(Objective Assessment Must Be In Chart)

HT. WT. T P R
Head Circ. (0-2yrs): Blood Pressure (3yrs and up):

Hct or Hgb: WNL UTD UTO Urine Dipstick: WNL UTD UTO Lead: Drawn UTD UTO
Value: Comments: [ ] Not required at this time

Vision Screening

Subjective: any eye disorder Yes No
F.H.O. eye disorder Yes No
Wear glasses Yes No

Objective: Visual acuity R20/ L20/
Muscle Balance pass fail
(Objective screening begins at age 4)

Hearing Screen

Subjective: response to voices Yes No
Delayed speech development Yes No
Recurrent O.M. Yes No

Hearing 20 db HL

	1000Hz	2000 Hz	4000Hz
Right Ear			
Left Ear			

Lead Poisoning Risk Assessment

Peeling paint in house, daycare etc. Yes No
Relative with lead poison Yes No
House built before 1960 Yes No
Renovation Yes No
Adult work in pottery or ceramics Yes No
Live near battery recycling plant or lead Yes No
Release industry Yes No
Live near highway or heavy traffic Yes No

Physical Exam **Normal (✓)** **Abnormal (Describe)**

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Nutritional Assessment

[ ] Breast fed [ ] Formula

Eating Problems _____
Vitamins Supplements Yes No
Growth Grid Normal Yes No
(Growth Grid must be in chart)

Dental Assessment

Any Dental Disease Yes No
Oral Car e Appropriate Yes No
Comments:

Name of Dentist _____
(Dental Visits are recommended by age 3)

Immunization Status

[ ] Immunizations current [ ]Off Schedule* [ ]Medically Contraindicated* [ ]Parental Refusal*

Explain * _____
(Vaccine record must be in chart.)

Anticipatory Guidance
(mark those discussed)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____

Impressions:

Plan or Referral:

[ ] Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

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