UNISYS

PERSONAL CARE SERVICES PROVIDER TRAINING

Fall 2007

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

ABOUT THIS DOCUMENT

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

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

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

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

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

MR/DD MEDICAID WAIVER SERVICES

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

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

SUPPORT COORDINATION

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

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

MENTAL HEALTH REHABILITATION SERVICES

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

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

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

EPSDT/KIDMED EXAMS AND CHECKUPS

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

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

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

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

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

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

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

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

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

OTHER MEDICAID COVERED SERVICES

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

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

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

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

Services Available to Medicaid Eligible Children Under 21

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

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

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

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

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

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

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

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

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

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

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CSRAs

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

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

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

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

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

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

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

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

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

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

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STANDARDS OF PARTICIPATION

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

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

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

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

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

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

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

Picking and Choosing Services

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

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

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

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

Statutorily Mandated Revisions to All Provider Agreements

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

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

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

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

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

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

Surveillance Utilization Review

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

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

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

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

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

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

Fraud and Abuse Hotline

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

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

Deficit Reduction Act of 2005

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

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

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

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

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

EPSDT - PERSONAL CARE SERVICES

EPSDT Personal Care Services are available to EPSDT eligibles (recipients up to age 21 years) that meet the medical necessity criteria for these services. Providers must obtain a Personal Care Services provider number (provider type 24) in order to provide these services.

These services are not intended to provide respite. In addition, EPSDT PCS may not be provided to an EPSDT eligible receiving Individual and Family Support services through the New Opportunities Waiver (NOW) program until the waiver limit has been exhausted.

EPSDT Personal Care Services are defined as:

- Tasks that are medically necessary as they pertain to an EPSDT eligible's physical requirements when physical limitations are due to illness or injury and necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements.

- Those services which prevent institutionalization and enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.

As part of establishing medical necessity, **the recipient must be of an age at which the tasks to be performed by the recipient would ordinarily be performed by the individual, if he/she was not disabled due to illness or injury.**

EPSDT PCS does not include medical tasks, such as medication administration, tracheostomy care, feeding tubes, or catheters. The Home Health program covers these services.

EPSDT PCS providers may also provide Children's Choice services on the same date to the same recipient; however, it may not be performed at the same time. Only recipients in Children's Choice can receive these services on the same day.

If the recipient is receiving Home Health, Respite, and/or any other related services, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider.

Note: Both Long Term and EPSDT Personal Care Services are Medicaid State Plan Services and not waiver services; PCS recipients may not receive hospice services while receiving PCS.

PCS vs. PCA

Medicaid distinguishes between Personal Care Services (PCS) offered through the EPSDT Program and Personal Care Attendant (PCA) services offered through the Waiver Program by services covered, scope of service, and reimbursement rates. It is important that the provider clearly identify which service is being requested for Prior Authorization. When submitting requests for Prior Authorization of PCS, the provider must insure that the request is worded properly on all paperwork. This includes the PA-14 form, the Plan of Care and the physician's prescription. While many of our PCS providers refer to their workers as Personal Care Attendants, requests for PCS prior authorization phrased as "PCA" will be denied.

EPSDT Personal Care Services include:

- Basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with dressing

- Assistance with bladder and/or bowel requirements or problems, including helping the client to and from the bathroom or assisting the client with bedpan routines, but excluding catheterization

- Assistance with eating and food, nutrition and diet activities, including preparation of meals—for the recipient only

- Performance of incidental household services, for the recipient only, not the entire household, which are essential to the recipient's health and comfort in his/her home. Examples are:

    - Changing and washing the recipient's bed linens

    - Rearranging furniture to enable the client to move about more easily in his/her own room

    - Clean up of meal preparation—for the recipient only

- Accompanying, not transporting, the recipient to and from his/her physician and/or medical facility for necessary medical services.

Conditions for Provisions of EPSDT PCS:

- EPSDT PCS is not to be provided to meet childcare needs nor as a substitute for the parent/guardian when the parent/guardian is not present.

- If an EPSDT eligible is fourteen years of age or younger, childcare arrangements must be specified when requesting approval for EPSDT PCS.

- A parent or other adult caregiver must be in the home with an EPSDT eligible fourteen years of age or younger. Recipients over 14 years of age must be mentally and intellectually competent to direct their own care if they are to be left with the PCS worker without the presence of a parent or other adult caregiver.

- EPSDT PCS is not allowable for the purpose of providing respite care for the primary care giver. Respite services are only available through some of the waiver programs.

- EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or must be provided by the Department of Education.

- The recipient must be under 21 years of age.

- The recipient must meet medical criteria to be eligible for at least an Intermediate Care Facility 1 and be impaired in at least 2 daily living tasks, as determined by BHSF.

- The recipient must have a new prescription every 180 days, and when changes to the Plan of Care occur.

- The PCS provider must maintain a Plan of Care.

- PCS must be prior authorized.

- PCS cannot be provided to a recipient who resides in an institution.

- PCS must be provided through a licensed PCA Medicaid provider. Staff assigned to provide personal care services shall not be a member of the recipient's immediate family. Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the recipient.

A physician must sign all referrals. Signatures by nurse practitioners or registered nurses are not acceptable.

Physician's Responsibilities Regarding the Authorization of PCS

Medical necessity for personal care services must be certified by the ordering physician, who must complete and sign the following:

- Form 90-L

- Plan of Care

- Prescription (signed by the physician and specifying EPSDT Personal Care Services)

In signing these documents, the physician certifies that:

1. The recipient is under his/her care;
2. The recipient requires/would require institutional level of care equal to an Intermediate Care Facility 1;
3. A face-to-face medical assessment was done on the recipient within the last 90 days;
4. These Personal Care Services are medically necessary;
5. There is a written plan for care that is approved by him/her; and
6. The plan will be reviewed periodically (at least every 180 days) by him/her.

Penalties, which may be imposed on physicians for inappropriate certification, include:

1. Referral to the Office of the Inspector General;
2. Criminal penalties in the U.S. District Court, resulting in fines and/or a jail sentence;
3. Civil prosecution in a U.S. District Court, resulting in fines and/or settlements;

4. Civil monetary penalties with an administrative law judge resulting in fines ($2,000 per line item);
5. If fraud is proven under the False Claims Act, tripling of damages and fines;
6. Simple sanction (barred from Medicare and Medicaid programs) by the Washington Office of the Inspector General.

Plan of Care

All Plans of Care for EPSDT PCS with a physician's signature of September 1, 2007, or later must be submitted on the EPSDT PCS Standardized Plan of Care (Form EPSDT PCS POC – 1). This form needs to be completed in it entirety and should address each personal care task. Where assistance is being requested, the provider must include the goal, the days service is being requested, the amount of time to complete the task each day, and the total time requested to complete the task for the week. When assistance is not needed with a specific task, the provider shall indicate "no assistance required." A copy of this form with instructions can be downloaded from www.lamedicaid.com.

Instructions for Completing EPSDT PCS Plan of Care

Type of Plan of Care

Check the appropriate box to identify the Plan of Care:

- ***New*** – Used for agency's initial Plan of Care for recipient
- ***Renewal*** – Used for Plan of Care completed for each new authorization period
- ***Reconsideration*** – Used when the Plan of Care changes during the authorization period

Date Services Requested to Start

Complete with the date the provider agency is requesting to start providing services.

Identifying Information

- ***Name*** – Recipient's Name
- ***ID#*** - Medicaid Recipient Number
- ***DOB*** – Recipient's date of birth
- ***Address*** – Recipient's Address (street and city)

Provider Information

- ***Provider Agency Name*** – Name of the provider agency requesting authorization
- ***Provider Number*** – Provider agency's assigned Medicaid provider number
- ***Provider Phone Number*** – Phone number of provider agency
- ***Address*** – Provider agency's mailing address (street, city and ZIP Code)

- ***Contact person, e-mail and Phone #*** - Name of provider agency's representative and his/her e-mail address

Medical Reasons Supporting the Need for PCS

Summarize the recipient's medical condition. If the recipient's parent(s) or primary care giver(s) are disabled, summarize the parent(s) or primary care giver(s) medical condition and provide medical documentation from his/her physician that includes this individual's functional limitations how it affects the care of the recipient.

Other In-Home Services Requested or Currently Receiving

Identify all in-home services the recipient is currently receiving or has requested.

Personal Care Tasks

For each personal care task the recipient requires assistance, complete the following:

- ***Goal*** – include the goal for the personal care task
- ***Days Service Requested*** – circle the days assistance with the personal care task are required
- ***Time Required to Complete Activity*** – indicate the time required in minutes to complete the activity
- ***Total Time Requested for Week*** – indicate the total time requested for the week by multiplying the number of days the service is requested by the time required to complete the activity to obtain the total time needed each week to complete the task
- ***Total Weekly Hours Requested*** – add the **Total Time Requested for Week** for each individual activity to obtain the total time requested for the week to complete the covered personal care tasks

Child Care Arrangements

Child care arrangements must be indicated for children 14 years of age or younger, or 15 years of age or older if they are unable to self direct their own care. If service is requested for a recipient meeting this criteria whenever the parent(s) or primary care giver(s) are working or not in the home, indicate child care arrangements. *Note: child care provider must be 18 years of age or older.*

Signatures

A signature and date from the parent/guardian, the provider and the physician are required.

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing

EPSDT Personal Care Services – Plan of Care

☐ **New** ☐ **Renewal** ☐ **Reconsideration** **Date Services Requested to Start: _____**

Identifying Information		**Provider Information**	
Name		Provider Agency Name	
ID#	DOB	Provider Number	Phone #
Address		Address	
		Contact Person e-mail	

Medical Reasons Supporting the Need for PCS (Must be accompanied by appropriate medical documentation for recipient and parent/caregiver, if the parent/caregiver is disabled)

Other In-Home Services Requested or Currently Receiving		
☐ New Opportunities Waiver	☐ Home Health Nursing Services	☐ Home Bound Teacher
☐ Children's Choice Waiver	☐ Home Health Aide Services	☐ Mental Health Rehab
☐ OCDD Family Support/Respite	☐ Home Health Therapy	☐ Other:

Recipient Name:	Recipient ID#:

Personal Care Tasks Specify the personal care activities the parent/caregiver requires the assistance of the PCS provider due to an inability to perform these services alone.				
PCS Activity	Goal	Days Service Requested	Time Requested to Complete Activity	Total Time Requested for Week (# days x minutes)
Bathing		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Dressing		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Grooming		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Toileting		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Eating		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Meal Prep		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Incidental Household Services		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Accompanying to Medical Appointments		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes

Total Weekly Hours Requested: _____

Recipient Name:	Recipient ID#:

Child Care Arrangements
For children 14 years of age or younger, or for those 15 years of age or older and unable to self direct their own care, specify child care arrangements. *Note: For the children who meet this criteria, when the PCS worker is in the home, another adult must be present.*

Signatures		
Parent/guardian	Provider Representative	Physician
Date	Date	Date

PSDT PCS POC – 1 Issued 07/26/2007 Page 3 of 3 part form

CHRONIC NEEDS CASES

The Prior Authorization staff may designate some recipients as Chronic Needs Cases. Based on the recipient's medical condition, services are expected to be continuous and remain at the level currently approved. The Prior Authorization staff will notify both the provider and the recipient on the approval letter of this designation.

Once a recipient is deemed to be a Chronic Needs Case, providers shall only be required to submit a PA-14 form accompanied by a current statement from a physician verifying the recipient's condition has not improved and the services currently approved must be continued at the approved level. The provider must indicate "Chronic Needs Case" on the top of PA-14 form. This determination only applies to the services approved where requested services remain at the approved level. **Requests for an increase in these services will be treated as a traditional PA request and is subject to full review.**

PRIOR AUTHORIZATION LIAISON

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

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

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

While the support coordinator may assist with obtaining the additional information being requested, the provider maintains the responsibility for requesting prior authorization for the service and completing all necessary documentation. For all recipients under the age of 21 who have a support coordinator, the provider is also responsible for sending a copy of the "Request for Prior Authorization" form to the support coordinator.

PRIOR AUTHORIZATION FOR EPSDT- PCS

EPSDT- Personal Care Services require Prior Authorization (PA), which is obtained by completing the PA14 form or through the electronic Prior Authorization (ePA) process which is available on the Louisiana Medicaid website (www.lamedicaid.com). Requests for authorization are forwarded to the Prior Authorization Unit, and are submitted along with the following documents:

Form 90-L
Prescription, Physician's Orders, or Physician's referral that specifies the medical condition that necessitates EPSDT PCS
Plan of Care
Social Assessment
Any supporting documentation to support medical necessity
Daily Time Schedule Form

COPIES OF THESE FORMS ARE AVAILABLE IN THE APPENDIX

REMINDER: PCS prior authorization requests phrased as PCA will be denied

NOTE: The PA-14 form may be obtained on the www.lamedicaid.com website, or from the Prior Authorization Unit at (800) 488-6334. Instructions for completing the PA-14 form and an example of the form are included on pages 15-16. A blank PA-14 form is available on page 17.

The completed PA-14 Form, along with all necessary documentation to substantiate the medical necessity of the requested services, must be submitted to the Unisys Prior Authorization Unit (PAU) at the following address:

Unisys
P.O. Box 14919
Baton Rouge, LA 70898-4919
Attn: Prior Authorization (PCS)

The PA request may also be faxed to (225) 237-3342.

Once the PA-14 form is received at Unisys, it will be screened for pertinent information prior to entry into the PA system. If the PA-14 form is incomplete, or the required documentation is missing/incomplete, the form will be returned to the provider with a cover letter indicating what is needed.

After the PA-14 form is screened and entered into the PA system, a unique nine-digit prior authorization number is assigned. The system will perform a series of front-end edits. It will check for a valid seven-digit Medicaid provider number, a valid thirteen-digit recipient number, recipient eligibility, a valid ICD-9 diagnosis code, age restrictions, etc. If any of the submitted information does not clear the editing process, the system will deny the request automatically and generate a letter of denial to be sent to the provider **and** the recipient.

If the PA-14 form passes the above editing process, it will be reviewed by the Unisys review nurse and/or physician consultant(s) to determine medical necessity. Once the decision is made, the status of the review is entered into the prior authorization system and an approval or denial letter is sent to the provider and the recipient within the next two days. Once the notification of approval is received, the provider may begin to render services. Approvals may be authorized for a period not to exceed six months.

ELECTRONIC PRIOR AUTHORIZATION

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

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

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

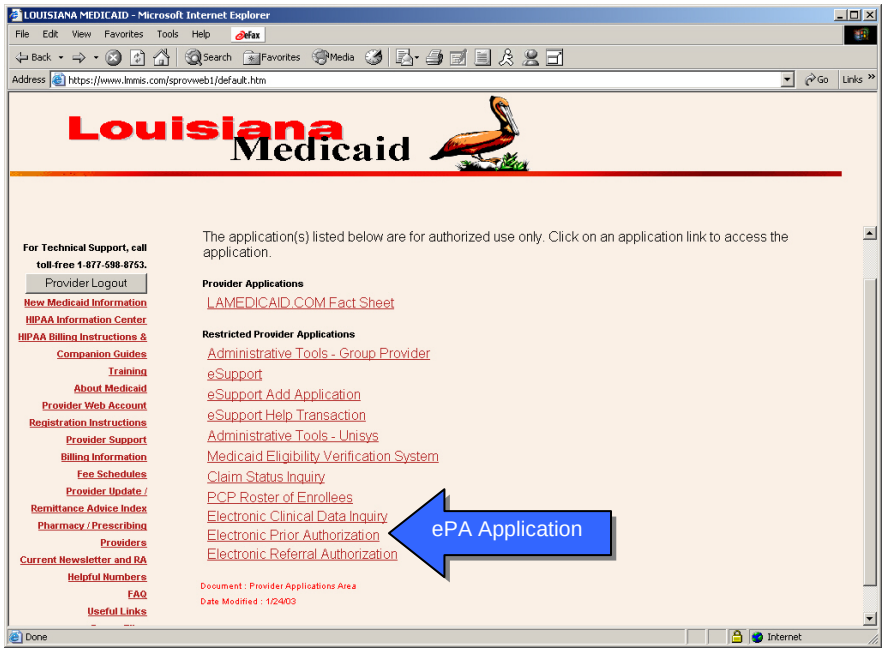
Reconsideration requests can be accepted via the e-PA web application.

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

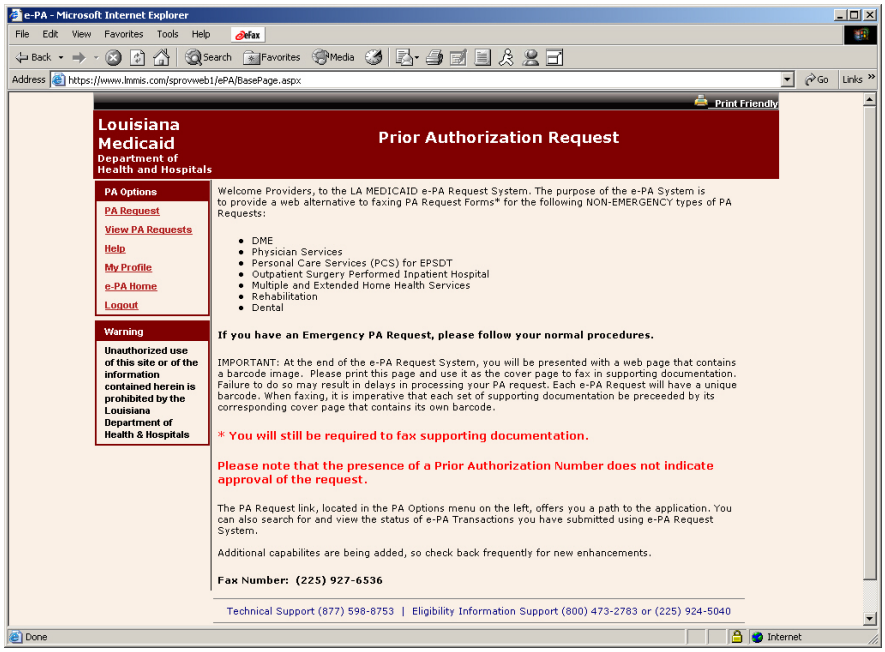
If the supporting documentation is not faxed to Unisys or the Request Response page is not used as a cover sheet or is un-readable, then the request will remain in a Pending Review status and will not be processed by the Unisys PA department. To identify whether or not the supporting documentation was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

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

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

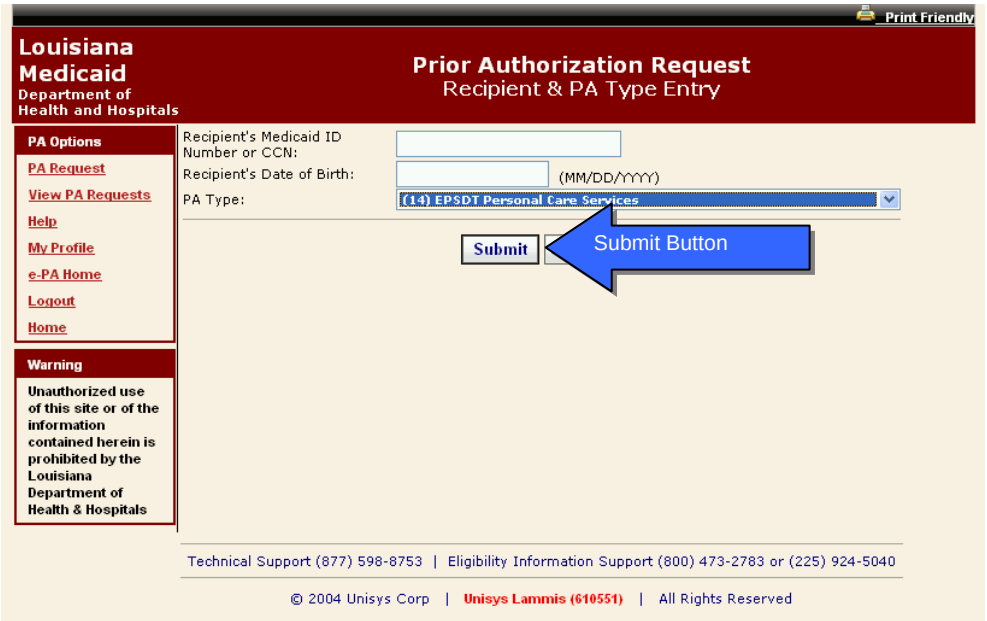


The **Louisiana Medicaid Prior Authorization Web Application** Home screen is displayed.

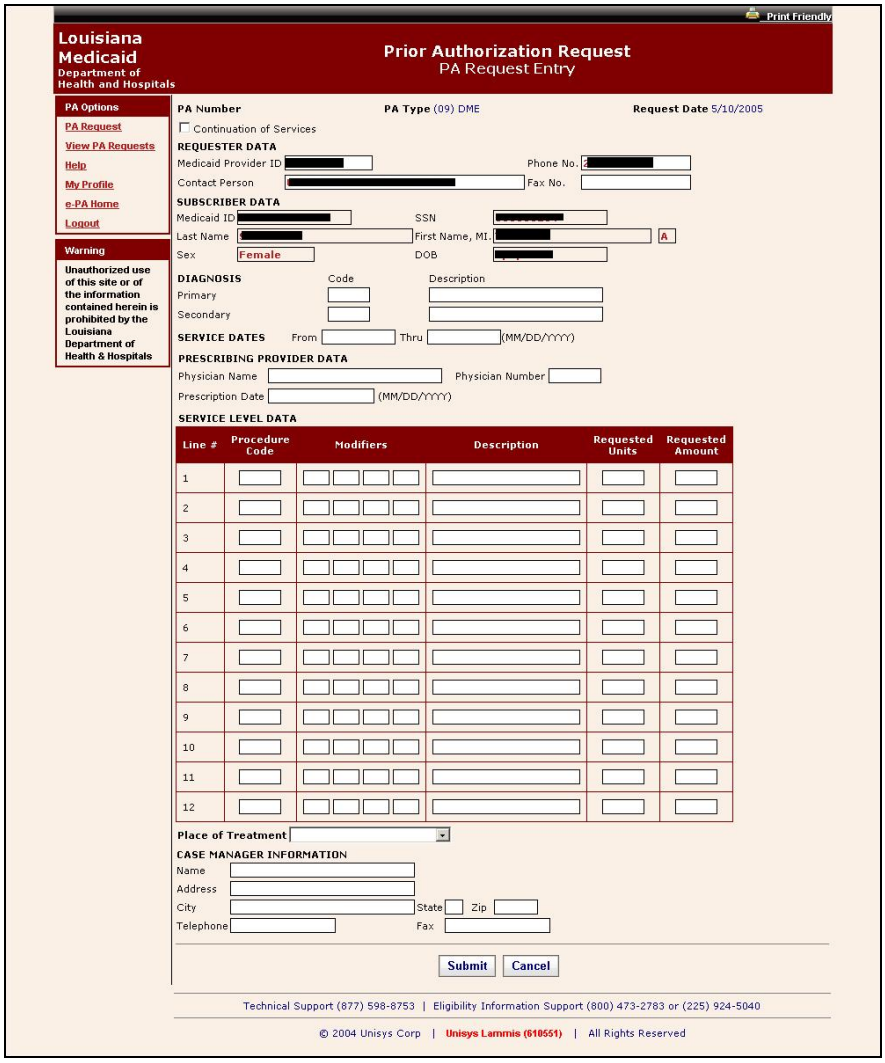


Select the PA Request link located in the upper left side of the main application page. The PA Type entry page will be displayed.

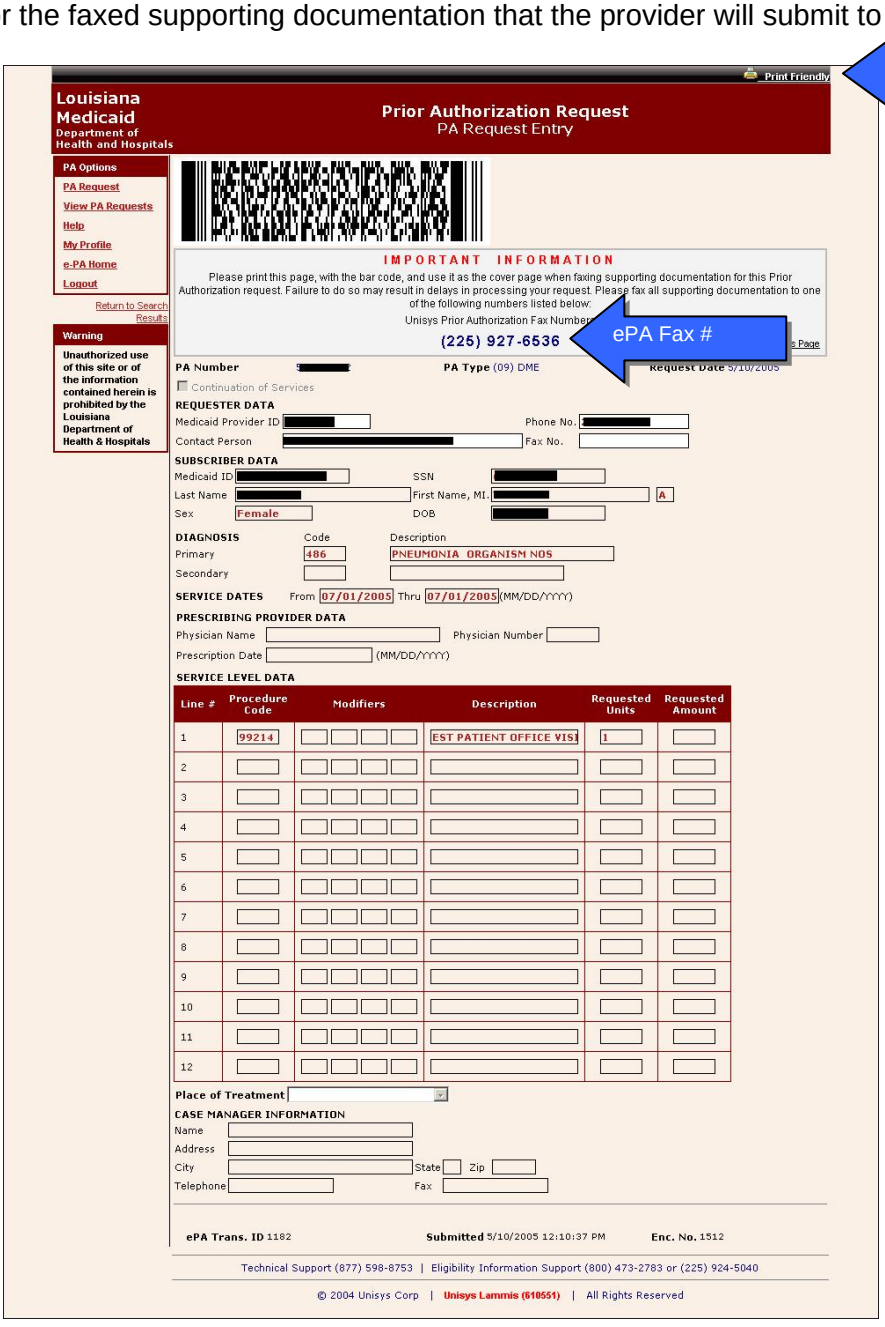
On the Recipient & PA Type Entry page, enter the recipient's Medicaid ID number or CCN and the date of birth in the appropriate boxes. In the PA Type drop-down list, select (14) EPSDT Personal Care Services as the type of PA request, then select the Submit button. The Prior Authorization Entry page will be displayed.



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



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



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

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

DATE 08/17/2005 RECIPIENT NAME DWAR M
PRIOR AUTH. NBR 5 259 RECIPIENT NUMBER 8: 096

*

. JT

702

PROVIDER NUMBER 1: 3

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW. IF ANY OF THE APPROVED ASTERISKED(*) SERVICES ARE REQUIRED BEYOND THE APPROVED DATES OF SERVICE, YOU MUST FILE A REQUEST FOR A CONTINUATION OF APPROVED SERVICES BY 02/02/2006 (25 DAYS BEFORE THE END OF THE APPROVED SERVICE DATE). IF YOU FAIL TO SUBMIT A CONTINUATION OF SERVICES REQUEST BY 02/02/2006, THESE SERVICES WILL NOT BE CONTINUED.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
*A4351 -INTERMITTENT URINARY CATH	$ 1,231.20	08/28/2005-02/27/2006	APPROVED
A4927 -GLOVES NON STERILE PER 10	6	08/28/2005-02/27/2006	APPROVED
*A4402 -OSTOMY LUBRICANT	$ 6.36	08/28/2005-02/27/2006	APPROVED

* RESUBMITTAL DATE: ____/____/_____

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

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

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

INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION FORM (PA-14)

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

FIELD 2* - Enter **either** the recipient's 13-digit Medicaid ID number **or** the 16-digit CCN number.

FIELD 3 - Enter the Social Security Number of the recipient.

FIELD 4 - Enter the recipient's last and first name as it appears on his/her Medicaid ID card.

FIELD 5 - Enter the recipient's date of birth in month, day, year format (MMDDYYYY).

FIELD 6* - Enter the 7-digit Medicaid provider number.

FIELD 7* - Enter in the "Begin" date of service block the first day the service is requested to start. Enter in the "End" date of service block the last day of service for that recipient's Treatment Plan.

FIELD 8 - Indicate whether the recipient is currently receiving Personal Care Services.

FIELD 9* - Enter **either** the numeric ICD-9 diagnosis code, both primary and secondary (if there is more than one diagnosis) **or** write out the description of the diagnosis.

FIELD 10 - Enter the day the prescription was written.

FIELD 11 - Enter the name of the physician prescribing the services.

FIELD 12A - Field is automatically populated with the procedure code.

FIELD 12B - Field is automatically populated with the required modifier.

FIELD 12C* - Enter the number of units being requested in order to fulfill the doctor's order during the Treatment Plan.

Calculate the total units requested (making sure that 1 unit is the equivalent of fifteen (15) minutes) by multiplying the number of units per day times the number of days per week times the number of weeks covered in the Treatment Plan. This will give the total units requested. For example:

If the physician requests five hours of service per day for seven days a week for six

months, the provider would indicate 3,640 units in this field because:

Twenty (four units per hour multiplied by five, which is the number of days that service is needed) multiplied by seven (number of days per week receiving service) equals 140; multiply that number (140) by twenty-six (number of weeks in six months). The correct answer would equal 3,640 units.

FIELD 13* - Enter the name, mailing address, and telephone number of the service provider. As long as the name is present, the request will not be rejected.

FIELD 14 - Enter the name of the case management agency along with their address and telephone/fax numbers, if applicable.

FIELD 15* - Enter the signature of the Provider or an authorized representative. **IF USING A STAMPED SIGNATURE, AUTHORIZED PERSONNEL MUST INITIAL IT.**

FIELD 16* - Enter the date of request for the service

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

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

P.A. NUMBER

FAX TO: (225) 237-3342

CONTINUATION OF SERVICES ____YES ____ NO

(1) PRIOR AUTHORIZATION TYPE:	(2) RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY #
14 – EPSDT PERSONAL CARE SERVICES	7 7 7 7 6 6 6 6 5 5 5 5 4 4 4 4	
	(4) RECIPIENT LAST NAME: DOE — FIRST NAME: CAROLYN — MI:	(5) DATE OF BIRTH

(6) MEDICAID PROVIDER NUMBER (7- DIGIT)	(7) SERVICE TREATMENT PLAN BEGIN DATE (MMDDYYY)	END DATE (MMDDYYY)	(8) IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE
1 1 2 2 3 3 8	08 01 2007	02 01 2008	____ YES ____ NO	

(9) DIAGNOSIS:
PRIMARY CODE & DESCRIPTION: 343.9 Cerebral Palsy
SECONDARY CODE & DESCRIPTION:

(10) PRESCRIPTION DATE (MMDDYYYY)

STATUS CODES: 2 = APPROVED, 3 = DENIED

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

DESCRIPTION OF SERVICES — FOR INTERNAL USE ONLY

(12) PROCEDURE CODE	(12A) MODIFER	(12B) DESCRIPTION PERSONAL CARE SERVICE EACH 15 MINUTES	(12C) REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	
T1019	EP	EPSDT-Personal Care Service, each 15 minutes	2536				

(13)
PROVIDER NAME: A BETTER PCS AGENCY
ADDRESS: 111 Main Street
CITY: Velma STATE: LA ZIPCODE 00000
TELEPHONE: (___) ____ FAX NUMBER: (___) ____

(14) CASE MANAGER INFORMATION:
NAME:
ADDRESS:
CITY: STATE: ZIPCODE:
TELEPHONE: (___) ____ FAXNUMBER: (___) ____

(15) PROVIDER SIGNATURE: Cathryn Jester

(16) DATE OF REQUEST: 8/1/07

PA- 14 FORM

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

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

P.A. NUMBER

FAX TO: (225) 237-3342

CONTINUATION OF SERVICES ____YES ____ NO

(1) PRIOR AUTHORIZATION TYPE:	(2) RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY #
14 – EPSDT PERSONAL CARE SERVICES	(4) RECIPIENT LAST NAME FIRST NAME MI	(5) DATE OF BIRTH
(6) MEDICAID PROVIDER NUMBER (7- DIGIT)	(7) SERVICE TREATMENT PLAN BEGIN DATE (MMDDYYY) END DATE (MMDDYYY)	(8) IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES ____ YES ____ NO
		P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

(9) DIAGNOSIS:
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

(10) PRESCRIPTION DATE (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

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

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

(12) PROCEDURE CODE	(12A) MODIFER	(12B) DESCRIPTION PERSONAL CARE SERVICE EACH 15 MINUTES	(12C) REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

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

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

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA- 14 FORM

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

DATE 08/17/2005 RECIPIENT NAME NE H
PRIOR AUTH. NBR 5 951 RECIPIENT NUMBER / 068

E INC *

LA

PROVIDER NUMBER 1 8

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
T1019/EP/ -PERSONAL CARE SERVICE, EA	2536	08/16/2005-02/15/2006	APPROVED -666
T1019/EP/ -PERSONAL CARE SERVICE, EA		08/16/2005-02/15/2006	APPROVED -822
T1019/EP/ -PERSONAL CARE SERVICE, EA		08/16/2005-02/15/2006	APPROVED -823

666 - THIS REQUEST IS APPROVED FOR 4 HOURS PER DAY 7 DAYS A WEEK.
822 - THIS RECIPIENT HAS BEEN DEEMED AS A "CHRONIC NEEDS CASE". WRITE "CHRONIC NEEDS CASE " ON TOP OF NEXT P.A. REQUEST.
823 - SUBMIT ONLY P.A. FORM & DOCTORS STATEMENT STATING CONDITION OF PATIENT HAS NOT CHANGED.

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

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

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

Reconsideration Requests

If the request is denied, a notification letter with the PA number is generated giving the reason(s) for denial and is sent to the provider and the recipient. The recipient's letter will have a notice regarding his/her rights to appeal. A provider may then submit a reconsideration request to the Unisys Prior Authorization Unit and the physician consultant(s) will review the reconsideration request. To request a Reconsideration (RECON), providers should submit the following:

- A copy of the denial letter, with the word **RECON** written across the top of the denial letter, and the reason for requesting the reconsideration written at the bottom of the letter.

- Attach **all of the original documentation**, as well as any additional information or documentation, which supports medical necessity.

Mail the reconsideration letter and all documentation to the Prior Authorization Unit at Unisys.

Unisys physician consultant(s) will review the reconsideration request for medical necessity. When the reconsideration request is approved or denied, another notification letter (with the same prior authorization number) will be generated and mailed to the provider and the recipient.

Changing PCS Providers

If a recipient is changing PCS providers within an authorization period, the current agency must send a letter to the Unisys Prior Authorization Unit notifying them of the recipient's discharge so that a new PA can be issued to the new PCS provider that has been selected.

The new provider must submit an initial request for PA to the PA Unit using current documentation and must submit all required documentation necessary for an initial PA request.

Units approved for one provider CANNOT be transferred to another provider.

DEPAR **RECON** TALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 08/17/2005 RECIPIENT NAME :IN ENRY
PRIOR AUTH. NBR 5: 52 RECIPIENT NUMBER 4 53 O

RP *

LA

PROVIDER NUMBER 1 06

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
T1019/EP/ -PERSONAL CARE SERVICE, EA	1456	08/17/2005-02/17/2006	APPROVED -654
T1019/EP/ -PERSONAL CARE SERVICE, EA		08/17/2005-02/17/2006	APPROVED -046
T1019/EP/ -PERSONAL CARE SERVICE, EA	1456	08/17/2005-02/17/2006	DENIED -278

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW.
654 - THIS REQUEST IS APPROVED FOR 2 HOURS PER DAY 7 DAYS A WEEK.
046 - DOCUMENTATION DOES NOT WARRANT CHANGING ORIGINAL DECISION.
278 - THE TOTAL NUMBER OF HOURS REQUESTED / OR AN INCREASE IN PCS / OR HOME HEALTH SERVICES ARE NOT MEDICALLY NECESSARY.

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

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

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

Additional Documentation Attached to Justify 4 Hours Per Day

LONG TERM - PERSONAL CARE SERVICES (LT- PCS)

Louisiana Department of Health and Hospitals

General Information About Documentation Requirements

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

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

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

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

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

Care Plan / Service Plan

- Must clearly identify which of the recipient's needs will be served
- Must describe each routine or activity
- Must reflect the time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.
- Must also reflect whether the recipient is receiving services in more that one setting
- Units of service should be delivered in accordance with the Plan of Care
- Should not be more or less than the units specified in the care plan except in extenuating circumstances
- Where service delivery differs from the care plan, the provider should document the extenuating circumstances on the service log and the reason why
- During brief periods (less than 30days duration) the provider may deviate from Plan of Care

Required Documentation For Direct Service Providers

Direct Service providers will document progress as follows:

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

SCHEDULE OF DOCUMENTATION for DIRECT SERVICE PROVIDERS

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

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

Required Documentation For Support Coordinators

Support coordination providers will document progress as follows:

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

SCHEDULE OF DOCUMENTATION for SUPPORT COORDINATORS

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

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

SERVICE LOGS DOS AND DON'TS

LOUISIANA
Department of HEALTH and HOSPITALS

LT-PCS Dos & Don'ts

August 2007 **Service Logs** **Vol. 1 No.1**

Do

- Follow the care plan as written
- Provide specific tasks on the specified days in the time allotted
- Document the reason a task is not provided or the reason it is not provided as scheduled
- Subtract the time for a task not provided from the time billed
- Provide **only** the services listed on the care plan
- Ensure that service logs are filled out carefully and correctly
- Only bill for the tasks provided
- If a client receives more that one service (*e.g.*, EDA Waiver and LT-PCS) you must use a separate service log for each service
- Check service logs for accuracy and completeness
- Submit service logs that are in original, handwritten form

Don't

- Don't routinely move tasks or time to different days than are shown on the care plan
- Don't turn a 7 day care plan into a 5 day care plan or vice versa
- Don't fail to document differences from the care plan and the reason for the difference
- Don't bill for the time when a task is skipped (*e.g.*, if the client doesn't get a bath on a given day it is not allowable to bill for the time for that bath)
- Don't bill for tasks not on the care plan
- Don't submit service logs with numerous alterations. If errors are made, make corrections according to Medicaid policy
- Don't show tasks from more than one program on the same log
- Don't submit logs without required dates, times, signatures
- Don't photocopy prior filled out service logs and change the date

LT-PCS Dos and Don'ts is a Publication of the Department of Health and Hospitals,
Office of Aging and Adult Services, 628 North 4th Street, Bin 14, Baton Rouge, LA 70821 Fax 225-219-0202

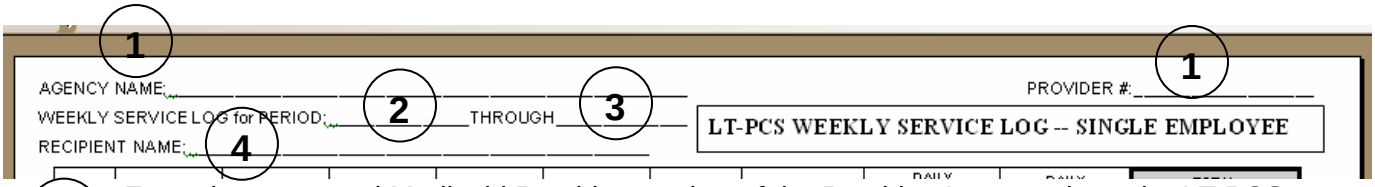
Instructions for Completion of LT-PCS Service Log

Effective 10/01/07, all LT PCS work must be documented on the standardized form, LT-PCS Weekly Service Log -- Single Employee.

<u>This Service Log is not a substitute for a Time Sheet. A separate Time Sheet is required for each LT PCS worker. Each Agency may design its own Time Sheet.</u>

<u>A separate official DHH Service Log is to be completed for each LT-PCS recipient.</u>

The following instructions should be used for completion of the Service Log.

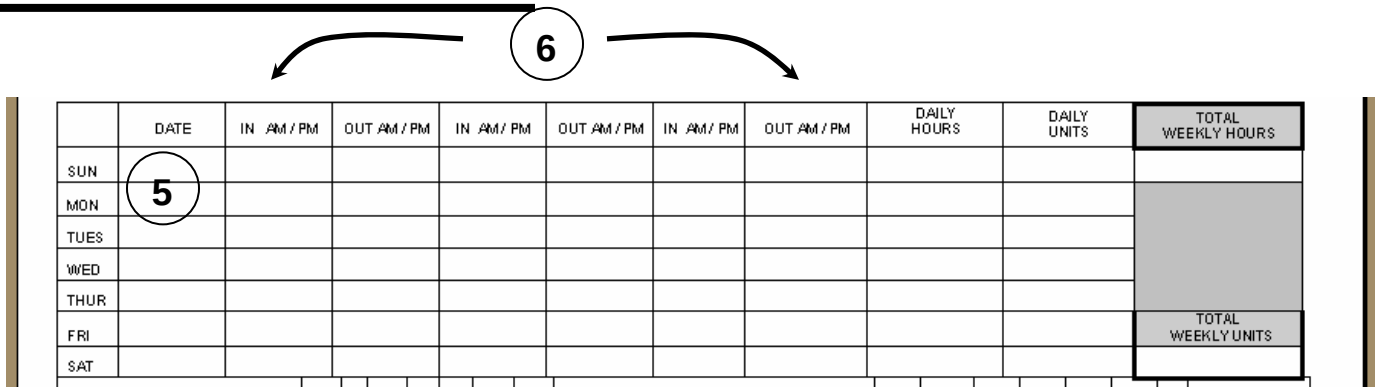


1 Enter the name and Medicaid Provider number of the Provider Agency where the LT PCS worker is employed.

2 Enter the beginning date of the week.

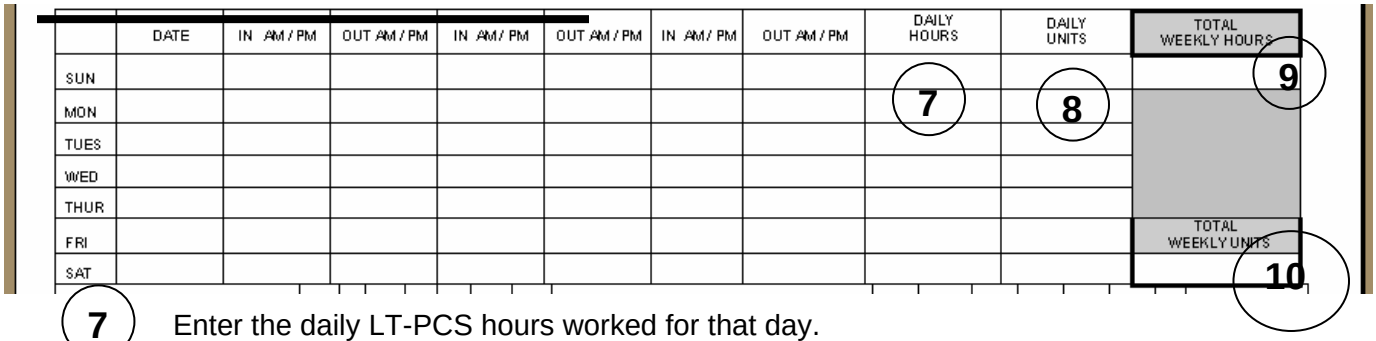
3 Enter the ending date of the week.

4 PRINT the recipient's name. NOTE: only one worker and one recipient may be documented on one Service Log.



5 Enter the date of each day in which LT-PCS services are performed.

6 Enter the time each period of LT-PCS service began during each day; enter the time each period of LT-PCS service ended each day. This form allows for documentation of up to three periods of time for each day LT-PCS services were performed.



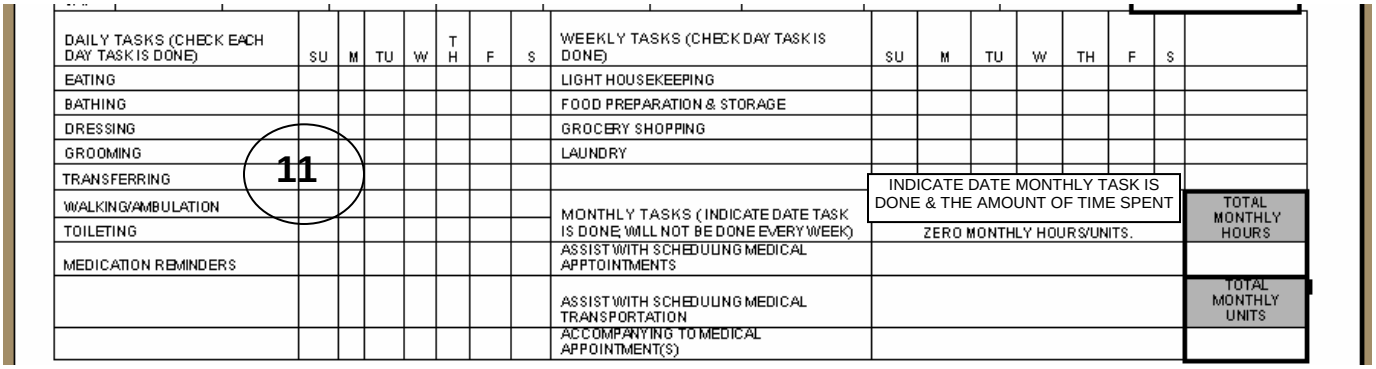
	DATE	IN AM / PM	OUT AM / PM	IN AM / PM	OUT AM / PM	IN AM / PM	OUT AM / PM	DAILY HOURS	DAILY UNITS	TOTAL WEEKLY HOURS
SUN										
MON										
TUES										
WED										
THUR										
FRI										TOTAL WEEKLY UNITS
SAT										

7 Enter the daily LT-PCS hours worked for that day.

8 Enter the daily LT-PCS units worked for that day.

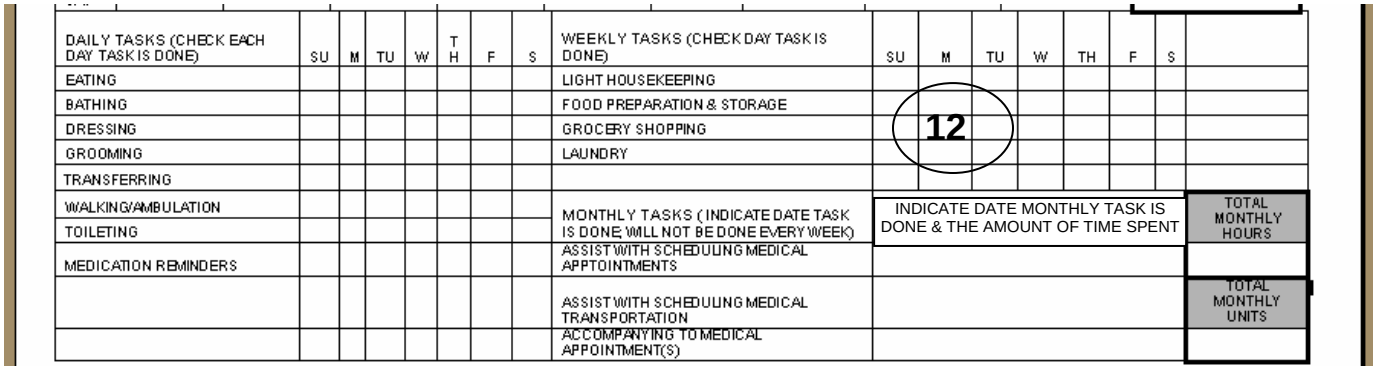
9 At the end of the week, total the number of LT-PCS hours worked for this recipient and enter the total here.

10 At the end of the week, total the number of LT-PCS units worked for this recipient and enter the total here.

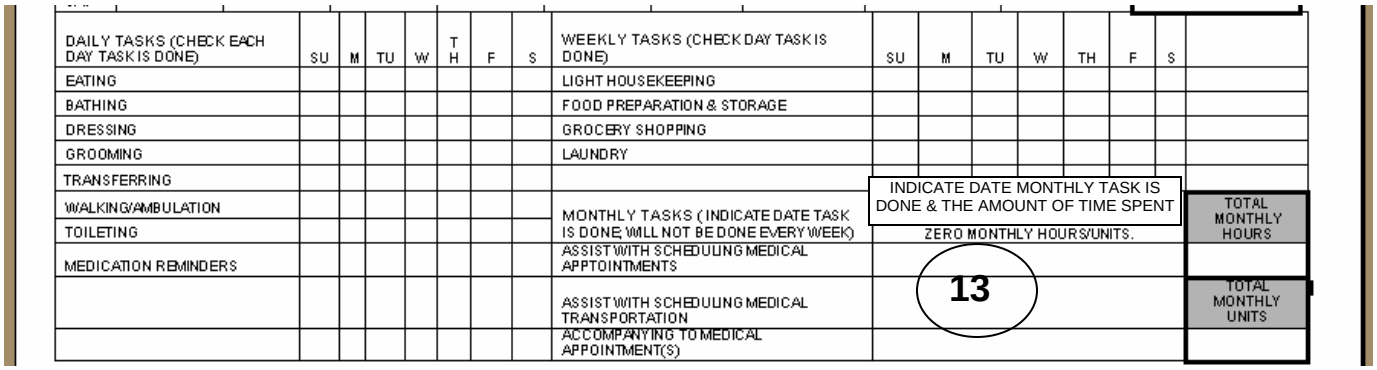


DAILY TASKS (CHECK EACH DAY TASK IS DONE)	SU	M	TU	W	TH	F	S	WEEKLY TASKS (CHECK DAY TASK IS DONE)	SU	M	TU	W	TH	F	S	
EATING								LIGHT HOUSEKEEPING								
BATHING								FOOD PREPARATION & STORAGE								
DRESSING								GROCERY SHOPPING								
GROOMING								LAUNDRY								
TRANSFERRING																
WALKING/AMBULATION								MONTHLY TASKS (INDICATE DATE TASK IS DONE; WILL NOT BE DONE EVERY WEEK)	INDICATE DATE MONTHLY TASK IS DONE & THE AMOUNT OF TIME SPENT							TOTAL MONTHLY HOURS
TOILETING									ZERO MONTHLY HOURS/UNITS.							
MEDICATION REMINDERS								ASSIST WITH SCHEDULING MEDICAL APPTOINTMENTS								
								ASSIST WITH SCHEDULING MEDICAL TRANSPORTATION								TOTAL MONTHLY UNITS
								ACCOMPANYING TO MEDICAL APPOINTMENT(S)								

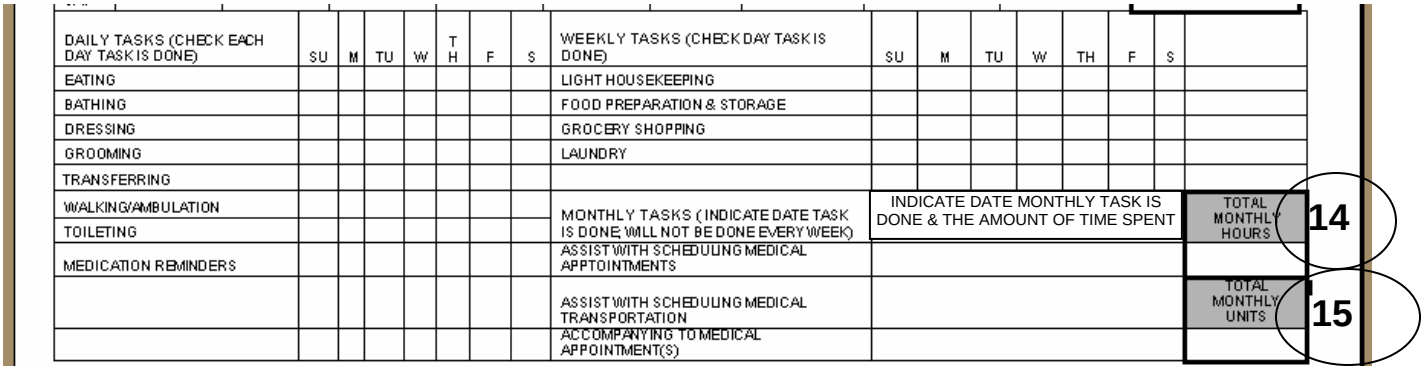
11 **Daily Tasks:** Place a check mark in each block to indicate which LT-PCS task(s) were done on which day of that week. Remember that all LT-PCS work must correspond to the approved Plan of Care. Only check LT-PCS tasks which have been completed on this day. A check mark in the appropriate block will indicate that the Activity was completed on that day.



12 **<u>Weekly Tasks</u>**: Place a check mark in the corresponding block to indicate any Weekly Tasks which were completed for this recipient during this week. Check mark the day of the week on which the individual Weekly Task was done. Remember that all LT-PCS work must correspond to the approved Plan of Care. Only check LT-PCS tasks which have been completed on this day. A check mark in the appropriate block will indicate that the Activity was completed on that day. If a weekly task was done on a different day from the day noted on the Plan of Care, a note will be needed in lower portion of this form. (See Item 16 below.)



13 **<u>Monthly Tasks:</u>** If a monthly task is done during this week, write the date (MM/DD) in the line provided by the description of the task. Also write the amount of time used in completion of this monthly task. Not all weeks will have a monthly task documented. Only write the date when the monthly task is done and the amount of time used. Remember that all LT-PCS work must correspond to the approved Plan of Care. A date in the appropriate line will indicate that the Activity was completed on that day.



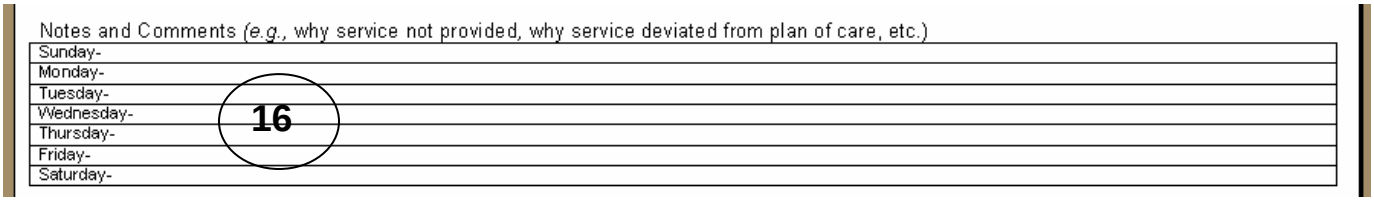
DAILY TASKS (CHECK EACH DAY TASK IS DONE)	SU	M	TU	W	TH	F	S	WEEKLY TASKS (CHECK DAY TASK IS DONE)	SU	M	TU	W	TH	F	S	
EATING								LIGHT HOUSEKEEPING								
BATHING								FOOD PREPARATION & STORAGE								
DRESSING								GROCERY SHOPPING								
GROOMING								LAUNDRY								
TRANSFERRING																
WALKING/AMBULATION								MONTHLY TASKS (INDICATE DATE TASK IS DONE; WILL NOT BE DONE EVERY WEEK)	INDICATE DATE MONTHLY TASK IS DONE & THE AMOUNT OF TIME SPENT							TOTAL MONTHLY HOURS
TOILETING																
MEDICATION REMINDERS								ASSIST WITH SCHEDULING MEDICAL APPTOINTMENTS								
								ASSIST WITH SCHEDULING MEDICAL TRANSPORTATION								TOTAL MONTHLY UNITS
								ACCOMPANYING TO MEDICAL APPOINTMENT(S)								

14

15

14 If any Monthly LT-PCS hours were worked during this week, enter the total Monthly LT-PCS Hours worked in this week. If no monthly tasks were completed in this week, enter "zero" for monthly hours.

15 If any Monthly LT-PCS units were worked during this week, enter the total Monthly LT-PCS units worked in this week. If no monthly tasks were completed in this week, enter "zero" for monthly units.



Notes and Comments *(e.g., why service not provided, why service deviated from plan of care, etc.)*

Sunday-
Monday-
Tuesday-
Wednesday-
Thursday-
Friday-
Saturday-

16

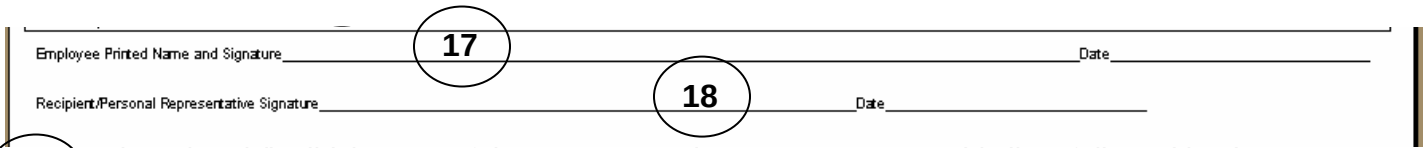
16 Use this area to document where the services were performed and any comments as to why a particular activity or service was not provided, or why the service or activity differed from the Plan of Care.

Examples:

Tuesday: "Plan of Care states shopping on Monday. Rained all day Monday. Shopping done today at Winn Dixie." (In this case, the checkmark for "shopping" in Weekly Tasks would be shown in Tuesday's block.)

Wednesday: "Ms. Jones refused her bath today." (In this case there would be no Daily Task checkmark for bathing shown in Wednesday's block.)

Friday: "All tasks done at Ms. Smith's home."



Employee Printed Name and Signature_____ Date_____

Recipient/Personal Representative Signature_____ Date_____

17

18

17 The printed (legible) name of the LT-PCS worker must appear on this line, followed by the signature of the worker. The date of the signature must also be entered.

18 The signature of the recipient or the recipient's personal representative and the date of that signature must appear on this line.

LT-PCS Weekly Service Log – Single Employee

AGENCY NAME:_____ PROVIDER #:_____

WEEKLY SERVICE LOG for PERIOD:_____THROUGH_____

RECIPIENT NAME:_____

LT-PCS WEEKLY SERVICE LOG -- SINGLE EMPLOYEE

	DATE	IN AM / PM	OUT AM / PM	IN AM / PM	OUT AM / PM	IN AM / PM	OUT AM / PM	DAILY HOURS	DAILY UNITS	TOTAL WEEKLY HOURS
SUN										
MON										
TUES										
WED										
THUR										
FRI										TOTAL WEEKLY UNITS
SAT										

DAILY TASKS (CHECK EACH DAY TASK IS DONE)	SU	M	TU	W	TH	F	S
EATING							
BATHING							
DRESSING							
GROOMING							
TRANSFERRING							
WALKING/AMBULATION							
TOILETING							
MEDICATION REMINDERS							

WEEKLY TASKS (CHECK DAY TASK IS DONE)	SU	M	TU	W	TH	F	S
LIGHT HOUSEKEEPING							
FOOD PREPARATION & STORAGE							
GROCERY SHOPPING							
LAUNDRY							

MONTHLY TASKS (INDICATE DATE TASK IS DONE; WILL NOT BE DONE EVERY WEEK)	ONLY INDICATE DATE WHEN THE MONTHLY TASK IS DONE & THE AMOUNT OF TIME SPENT ON THE MONTHLY TASK.	TOTAL MONTHLY HOURS
ASSIST WITH SCHEDULING MEDICAL APPTOINTMENTS		
ASSIST WITH SCHEDULING MEDICAL TRANSPORTATION		TOTAL MONTHLY UNITS
ACCOMPANYING TO MEDICAL APPOINTMENT(S)		

Notes and Comments (e.g. location of service provided, why service not provided, why service deviated from plan of care, etc.)

Sunday-
Monday-
Tuesday-
Wednesday-
Thursday-
Friday-
Saturday-

Employee Printed Name and Signature_____Date_____

Recipient/Personal Representative Signature_____Date_____

Long Term—Personal Care Services (LT-PCS) Fact Sheet

Who can qualify for Long Term-Personal Care Services (LT-PCS)?

People can qualify if they get Medicaid **AND**

- Are 65 years old or older, **OR**
- Are 21 years old or older with disabilities (Meeting the Social Security Administration definition of disability).

They must also:

- Meet Nursing Facility Level of Care, And
- Require at least limited assistance with one Activity of Daily Living, **AND**
- Be able to direct their care independently or through a responsible representative, **AND**
- Have no one available to help them on a regular basis, **AND**
- Meet <u>one</u> of the following:
  - Be in a nursing facility and be able to be discharged if community-based services were available; **OR**
  - Be likely to require nursing facility admission within the next 120 days; **OR**
  - Have a primary care-giver who has a disability or who is at least 70 years old.

What are Long Term-Personal Care Services? Long Term-Personal Care Services help with **activities of daily living**. Here are some examples:

Help with:	Other services:
• Eating • Bathing • Dressing • Grooming • Transferring • Walking • Toileting	• Light housekeeping; • Fixing and storing meals • Grocery shopping • Laundry • Reminders about medicines • Help with medical appointments and • Help finding transportation for medical appointments

What services are <u>not</u> Long Term-Personal Care Services?

This kind of help is <u>not</u> covered:	**These services are <u>not</u> covered:**
• Specialized or skilled nursing • Giving medicine • Rehabilitative services • Specialized aide services • **<u>Help that is already being given by family or others in the community or through another assistance program.</u>**	• Cleaning areas of the home that the applicant does not stay in • Food preparation or laundry for anyone other than the applicant • Companionship • Sitter services • Supervision not related to Activities of Daily Living • Respite for the caregiver

If you get Medicaid and want to find out more about
Long Term-Personal Care Services,
call Louisiana Options in Long Term Care at **1-877-456-1146.**
You can call Monday to Friday, 8 a.m. – 5 p.m. The call is free.

Purpose

The LT-PCS program began on January 19, 2004. The purpose of personal care services is to provide some degree of assistance with the activities of daily living and instrumental activities of daily living. It is not intended to be a substitute for available family or community supports.

These services must be prior authorized. Physician delegation of medical tasks or complex medical procedures is not a component of personal care services.

Recipients interested in receiving LT-PCS services must contact ACS at 1-877-456-1146. If the recipient is unable to contact ACS directly, his/her family may make the contact. However, **under no circumstance may the provider contact ACS to initiate services on behalf of the recipient.**

Recipient Criteria

In order to qualify for LT-PCS, a Medicaid recipient must have the following conditions met:

- Be age 65 or older, or 21 years of age or older with a disability. Disabled is defined as criteria established by the Social Security Administration;
- Meets nursing facility level of care criteria as determined by the Louisiana DHH Level of Care Eligibility Tool (LOCET) and/or the MDS-HC;
- Be able to participate in his/her care and self-direct the services of the personal care worker independently, or through a responsible representative;
- Is at imminent risk of nursing facility placement, which means that a person faces a substantial possibility of deterioration in mental or physical condition or functioning if either home and community-based services or nursing facility services are not provided in less than 120 days. This criterion is considered met if:
  - The recipient is in a nursing facility and could be discharged if community-based services were available; or
  - Is likely to require nursing facility admission within the next 120 days as determined by the LOCET and/or MDS-HC; or
  - Has a primary caregiver who has a disability or is age 70 or over;
  - Requires at least Limited Assistance (as defined by the MDS-HC) with one or more Activities of Daily Living:
    - The MDS-HC defines Limited Assistance for most Activities of Daily Living as the receipt of physical help or a combination of physical help

and weight-bearing assistance at specified frequencies during the period just prior to the MDS-HC assessment;

- Able to participate in his/her care and self-direct the services of the personal care worker independently or through a personal representative.

Note: Both Long Term and EPSDT Personal Care Services are Medicaid State Plan Services and not waiver services; PCS recipients may not receive hospice services while receiving PCS.

Covered Services

In order to qualify for LT-PCS, the recipient must require at least Limited Assistance with at least one ADLs (Activities of Daily Living). Once program requirements are met, assistance may be either the actual performance of the personal care task for the recipient, or supervising and prompting so the recipient performs the task.

ADLs are personal, functional activities required by an individual for continued well-being, health, and safety. These activities are usually performed on a daily basis and include:

- Bathing
- Grooming
- Dressing
- Ambulation
- Eating
- Transferring
- Toileting

IADLs (Instrumental Activities of Daily Living) are routine tasks that are essential for sustaining the individual's health and safety, but these tasks may not need to be performed every day. These tasks include:

- Laundry
- Meal preparation and storage
- Grocery Shopping
- Light Housekeeping tasks
- Assistance with scheduling medical appointments, if necessary
- Accompaniment to medical appointments, if necessary
- Assistance with accessing transportation, if necessary
- Medication *reminders*

LT-PCS is a task-oriented service. Time is approved for the performance of specific tasks, not for companionship and non-task related supervision. Documentation should reflect tasks performed within the parameters of time approved each day.

Medication Reminders

The personal care worker may only verbally remind the recipient to take his/her medicine, assist with opening the bottle or bubble pack, read the directions from the label, check the dosage chart from the label directions, and assist in ordering the medicine from the store.

The personal care worker cannot give the medicine to the recipient or set up pill organizers.

Physician delegation of medical tasks is not covered under personal care services.

Transportation

- Medicaid offers reimbursement for both emergency (ambulance) and non-emergency medical transportation if the recipient has no other means in which to obtain transportation to a Medicaid-covered service provider.

- If a provider opts to provide transportation services to their recipients, they must accept all liability for their employee transporting the recipient and ensure that the personal care worker has a current, valid driver's license as well as minimum liability coverage as designed by state law.

Excluded Services

Long-Term Personal Care Services do not include:

- Insertion and sterile irrigation of catheters (although changing and emptying the catheter bag is allowed)

- Irrigation of any body cavity, which requires sterile procedures

- Application of dressing, which involves prescription medication and aseptic techniques

- Skilled nursing services as defined in the State Nurse Practices Act, which include medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks

- Teaching a family member or other caregiver how to care for a recipient who requires frequent changes of clothing or linen due to partial/total incontinence for which no bowel or bladder training program is possible

- Teaching of signs/symptoms of disease process, diet and medications of any new or exacerbated disease process

- Specialized aide procedures, such as: rehabilitation of the recipient, measuring or recording of vital signs, measuring or recording of intake or output of fluids, specimen collection, special procedures such as non-sterile dressings, special skin care of decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight management, enemas
- Administration of medications
- Rehabilitative services, such as those performed by a licensed therapist
- Laundry, other than that incidental to the care of the recipient
- Food preparation or shopping for groceries or household items other than items required specifically for the health and maintenance of the recipient
- Housekeeping tasks in areas not used solely by the recipient
- Companionship
- Supervision
- Respite of primary caregiver

Delegation of Medical Tasks

The performance of complex and non-complex medical procedures is not a component of personal care services.

Assessments

Initial assessments and reassessments are the responsibility of ACS staff. These assessments enable staff members to gather medical and non-medical information in order to assist in the development of a Plan of Care. It is essential that the provider initiate approved services as soon as possible.

Service Location

LT-PCS may be provided in the recipient's home or in another location, outside of the home, if the provision of these services allows the recipient to participate in normal life activities as they pertain to the IADLs as cited in the Plan of Care.

A recipient's home is defined as:

- Recipient's place of residence, including his/her own house or apartment
- Boarding house
- House or apartment of a family member or unpaid primary caregiver

The place of service must be documented in the care plan.

Services performed outside of the recipient's home do not include travel outside of the state of Louisiana, unless the recipient lives in an area adjacent to the state's border and it is customary to seek medical and other services in the neighboring state.

These services cannot be performed in the personal care worker's home unless it can be satisfactorily assured that:

- The place of service is consistent with the recipient's choice
- The recipient's health and safety can be maintained when services are provided in the worker's home
- ***Services do not substitute for otherwise available family and community supports***

NOTE: PCS cannot be provided while the person is an inpatient in a hospital, an institution for mental disease, a nursing facility, or an intermediate care facility for the mentally retarded (ICF/MR)

Service Limitations

Hours are approved on an individual basis. The determination of hours is based on the recipient's assessment, Plan of Care, and supporting documentation.

- Maximum of 56 hours per week
- Must be prior Authorized in units of service
- One unit = 15 minutes
- Assistance shall not be provided for tasks that a recipient can complete without assistance.

Existing formal or informal Supports

LT-PCS will not replace existing formal or informal supports.

Existing Formal Supports

Community and other supports already in place which assist with some aspect of recipient's care.

Informal Supports

Adult family members or friends who are available and able to provide some aspect of care for the recipient and who may or may not live with the recipient.

Adults who reside in the same household with an LT-PCS recipient will generally be considered available to provide unpaid supports unless they are also disabled.

LT-PCS can provide supports during the time these households members are working or attending school.

Individuals who have been providing informal supports to a recipient will not be eligible to become the paid care giver for that recipient.

Changing Service Providers

A recipient may change providers without cause once after every 3 (three) month service authorization period. A recipient may change providers with good cause at any time during the service authorization period. Good cause is defined as the failure of the provider to furnish services in compliance with the service plan. DHH, or its designee, shall determine good cause. All requests for change in provider shall be submitted in writing to the contractor. Providers will receive written notification when approval has been given for the recipient to change providers.

When a provider becomes aware that a recipient is changing providers, it is crucial that the provider continue providing services as per the service plan. These services should not be altered until the agency receives notice from ACS that services have ended. Likewise, the provider that will receive the recipient should not begin to provide services until the appropriate notification from ACS has been received.

Termination of Services

According to Section 30.7.6 of the 05/01/2004 Revised Personal Care Services Manual, a provider must provide written notification to the recipient or the responsible representative when discontinuing services. The notice must be sent at least 30 days before the date on which the services are to be discontinued. In addition, the provider must notify the contractor within 24 hours of decision to discontinue services. This section of the manual also identifies those situations in which it is permissible to give a notice that is less than 30 days. Providers must be familiar with these regulations and ensure that they are being fulfilled.

Clarification of Service Provision Regions and Parish Borders

Personal Care Service providers must maintain an office in each region where services are provided. OAAS will consider an agency's request to provide services in one adjacent parish to its designated service region if that parish's border is within a 50 mile radius of the agency's office. Any provider who wishes to add a parish to its designated region should send a written request to OAAS. The letter should specify the parish which the provider desires to add, include the agency's Medicaid Provider Number, and be addressed to:

Office of Aging and Adult Services
628 North 4th Street
Bin 14
Baton Rouge, LA 70802

Attention: LT-PCS Program Manager

Reassessments

Reassessments are conducted annually to determine on-going qualification for services.

Recipients Currently in Nursing Homes

If a recipient residing in a long-term care facility requests LT-PCS, a provisional assessment must be performed to determine qualification for services. If the recipient is approved for services, a provisional approval notice will be issued for a 2-month certification period. A provisional prior authorization notice will be issued to the selected provider for a 2-month service authorization period.

Services will not begin until the recipient leaves the facility.

Once the recipient has left the nursing facility, an in-home assessment will be completed. Based on the results of the assessment, a new Plan of Care will be developed and the certification period will be issued for 12 months. A second prior authorization notice will be issued to the provider for the new service authorization period.

Solicitation

Medicaid providers are prohibited from offering material or financial gain directly or indirectly to Medicaid recipients in order to influence them in their choice of providers. In addition, no person shall solicit, receive, offer, or pay any remuneration, including but not limited to kickbacks, bribes, rebates, or bed hold payments, directly or indirectly, overtly or covertly, in cash or in kind, for the following:

- In return for referring an individual to a health care provider, or for referring an individual to another person for the purpose of referring an individual to a health care provider, for the furnishing or arranging to furnish any good, supply, or service for

which payment may be made, in whole or in part, under the medical assistance programs.

- In return for purchasing, leasing or ordering, any good, supply, or service, or facility for which payment may be made, in whole or in part, under the medical assistance program.
- To a recipient of goods, services, or supplies, or his representative, for which payment may be made, in whole or in part, under the medical assistance programs.
- To obtain a recipient list, number, name or any other identifying information.

PRIOR AUTHORIZATION FOR LT- PCS

All services for LT-PCS must be prior authorized. Payment will not be made for services provided prior to the authorization date.

If an EDA waiver recipient requests LT-PCS, ACS staff will complete the recipient intake form and forward it to the Office of Aging and Adult Services. The recipient's support coordinator (formerly known as the case manager) is responsible for contacting the recipient, scheduling and completing the in-home assessment and developing the Plan of Care. The support coordinator will then forward the information to the Office of Aging and Adult Services for approval. Upon approval, the Office of Aging and Adult Services will send ACS the prior authorization information. ACS will issue the prior authorization to the provider.

Non-waiver and ADHC recipients requesting LT-PCS will have a LOCET determination. If the LOCET determination indicates that Level of Care and Imminent Risk criteria are met, an ACS representative will schedule an appointment for an in-home assessment. The ACS staff will be responsible for completing the Plan of Care and forwarding all information to DHH for review. If approved for services, the recipient will receive a written notification of the approval, 2 copies of the Plan of Care and a list of enrolled Medicaid LT-PCS agencies in his/her region. The recipient will be instructed to contact his/her preferred agency. If the agency chooses to accept the recipient as a client, the agency will retain a copy of the Plan of Care for their records. The provider will need to forward the following documentation to ACS within 14 days so that a Prior Authorization Number can be established for these services. Please refer to the LT-PCS Provider manual Section 30.5 for the required documentation.

The information must be mailed or faxed to ACS:

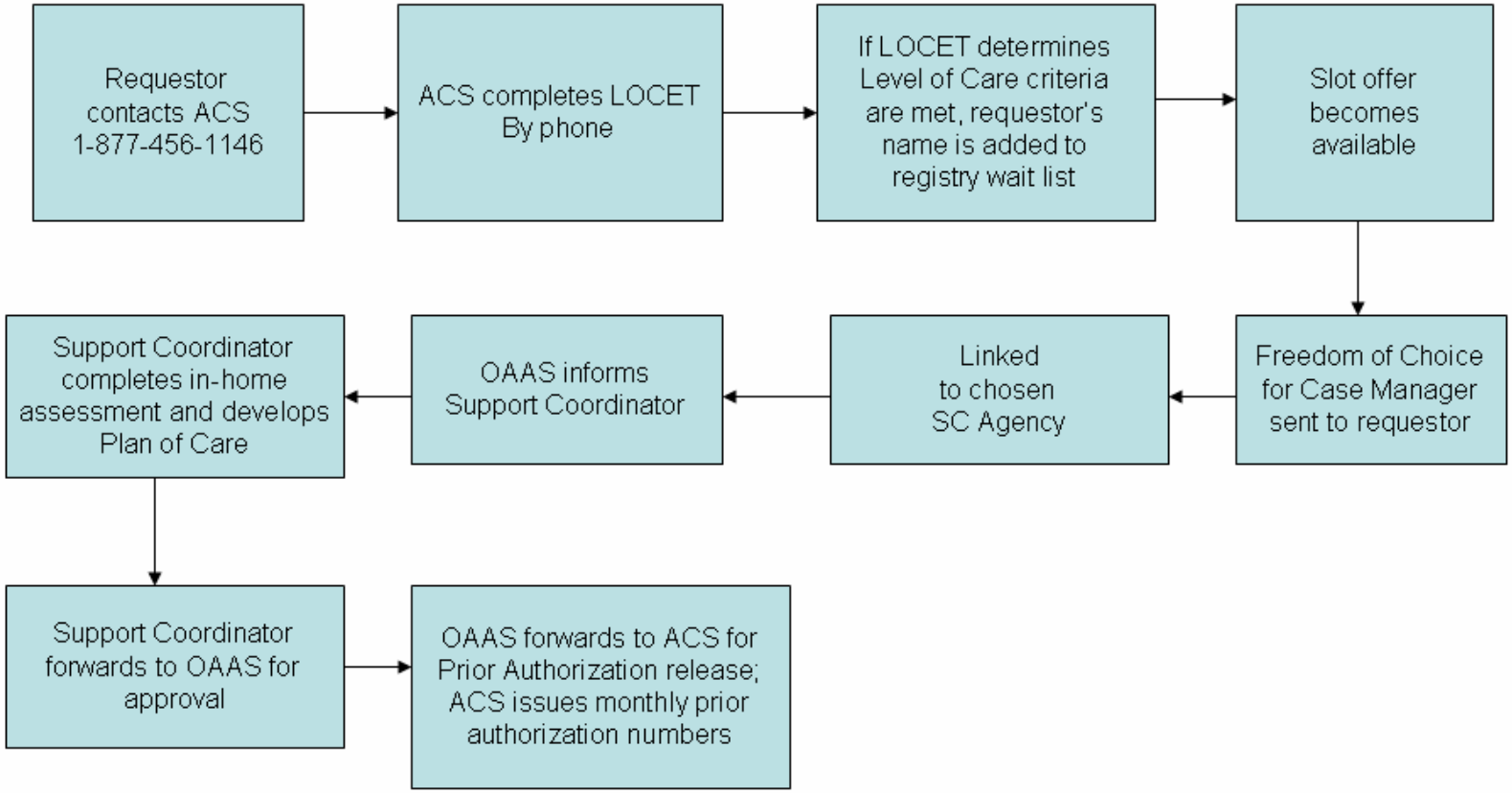
Affiliated Computer Services
5700 Florida Boulevard, 13th floor
Baton Rouge, LA 70806
Fax: (225) 231-8151
Attn: Long Term-Personal Care Services

An example of a Prior Authorization letter from ACS is located on page 38.

The recipient or his/her responsible representative must initiate all requests for changes in services and/or hours. An interim assessment will be conducted for all requests for changes in services and/or service hours.

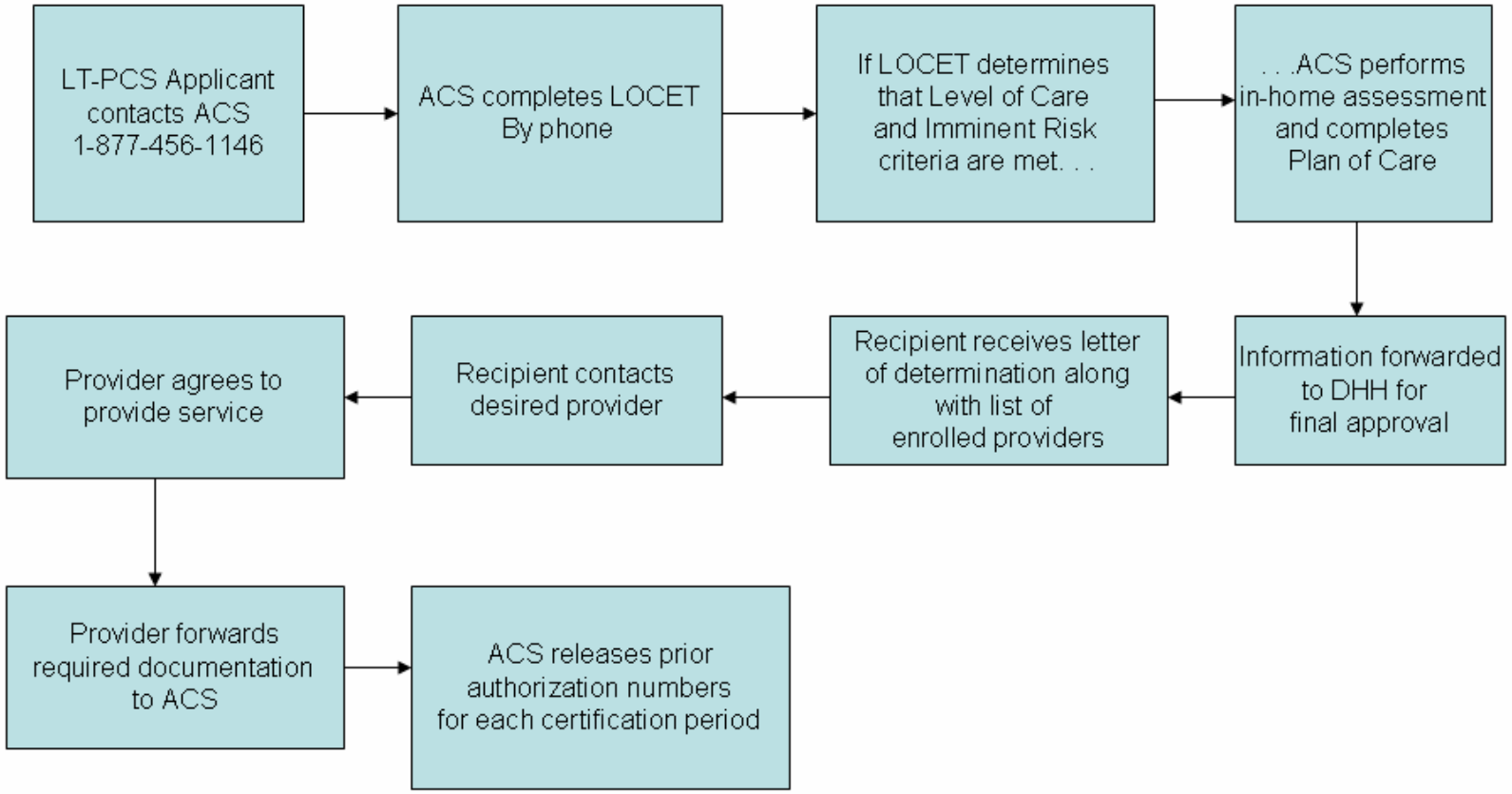
Prior Authorization:

Waiver Recipient



Prior Authorization:

Non-Waiver Recipient



DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

Provider Name
Street Address
City, LA Zip Code

Date

Recipient Name

Recipient Number

AUTHORIZATION NOTICE

This letter is to notify your agency of the following regarding Medicaid Long Term-Personal Care Services (LT-PCS):

☐ The above named recipient is authorized to receive services from _____to _____. Listed below are authorization numbers, approved units of service, and authorized dates of service for this certification period.

☐ The above named recipient is authorized to receive an increase in units of service from _____ to _____. For the current month of _____, the recipient is authorized to receive _____ additional units of service. Listed below are authorization numbers, approved units of service, and authorized dates of service for this change.

☐ The above named recipient has moved from a long-term care facility to reside in the community. A provisional authorization has been issued from _____ to _____. The recipient will be reassessed prior to the termination date, and a new authorization notice will be issued at that time. Listed below are authorization numbers, approved units of service, and authorized dates of service.

Authorization Numbers	Units of Service	Begin Date	End Date

☐ We have been notified that the above named recipient wishes to change LT-PCS providers. Effective _____ your authorization to provide these services to this recipient will end.

Agency Representative

Phone Number

LT-PCS 4 Provider Authorization
Reissued 06 06 05 Prior Issues Obsolete

BILLING FOR PCS

All personal care services are prior authorized and billed with the provider number associated with a type 24 provider number.

EPSDT Services:

Procedure Code	Modifier	Description	Unit Size	Reimbursement Rate
T1019	EP	EPSDT – Personal Care Services	15 min	$2.53

Long Term Services:

Procedure Code	Modifier	Description	Unit Size	Reimbursement Rate
T1019	UB	LT – Personal Care Services	15 min	$3.50

Cessation of Span Date Billing

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

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

Providers billing for Long Term PCS should be sure to closely follow the approved Service Plan. It is vital that all services are performed in 15 minute increments in order for full reimbursement to be received. Amounts of time which are not multiples of 15 minutes cannot be billed.

Providers should contact Provider Relations Inquiry Unit for assistance with all denied claims. For claims denied relative to the prior authorization number, the provider may be referred to the agency that issued the prior authorization for further assistance.

CLAIMS FILING

Personal Care Services are billed to Medicaid on the CMS-1500 claim form. The following pages explain the proper completion of the claim form.

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

Completed claim forms should be mailed to:

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

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

Locator #	Description	Instructions	Alerts
4	Insured's Name	**Situational** – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the recipient's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Patient Status	**Optional.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other coverage, the state assigned 6-digit TPL carrier code is **required** in this block (the carrier code list can be found at www.lamedicaid.com under the **Forms/Files** link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
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	**Optional.**	
15	If Patient Has Had Same or Similar Illness Give First Date	**Optional.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional.**	
17	Name of Referring Provider or Other Source	**Situational** – Complete if applicable. In the following circumstances, entering the name of the appropriate physician is **required**: If services are performed by a CRNA, enter the name of the directing physician. If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.	

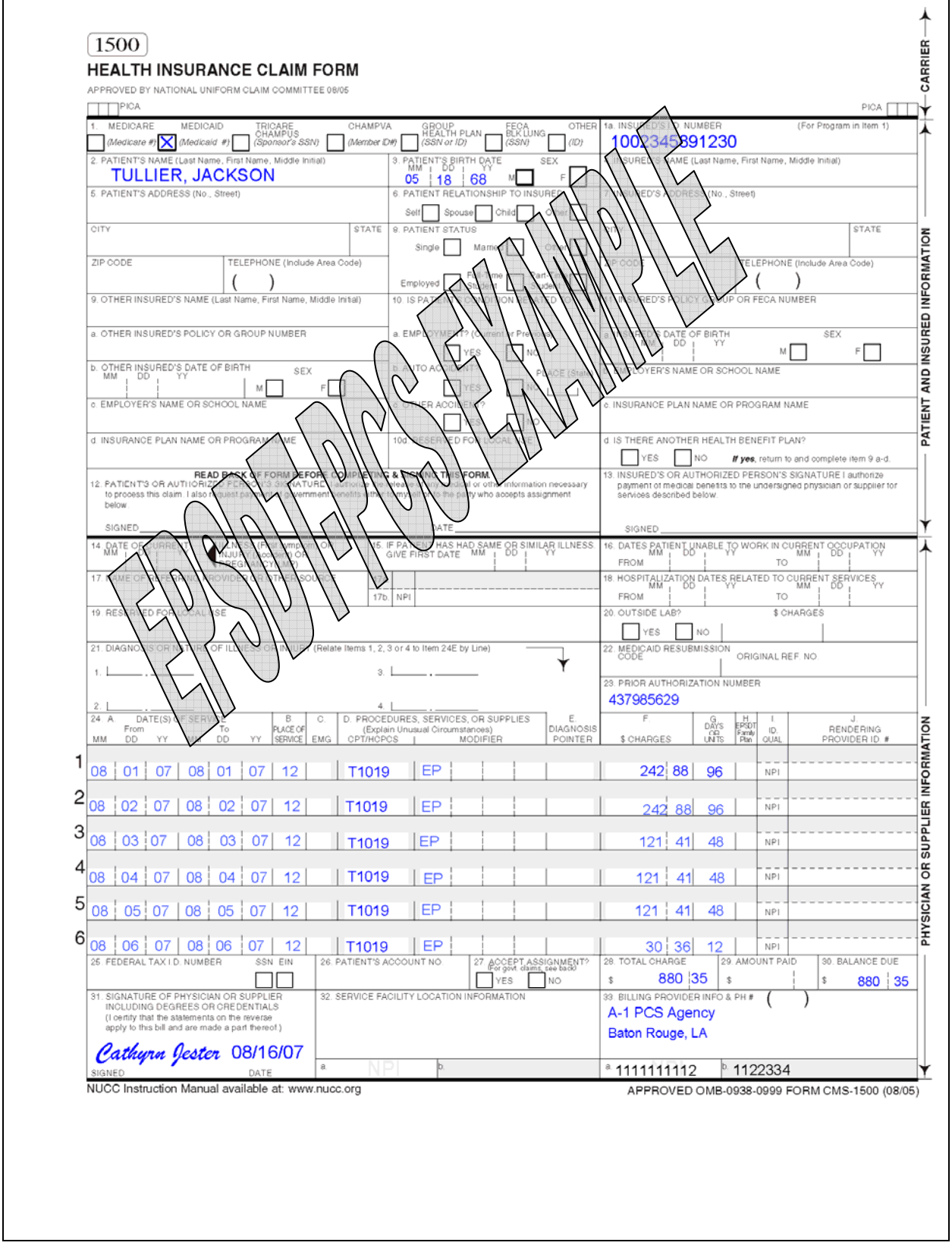
Locator #	Description	Instructions	Alerts
		If services are performed by an independent laboratory, enter the name of the referring physician.	
17a	Unlabelled	**Situational** – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is **required** to be entered.	**The PCP's 7-digit referral authorization number must be entered in block 17a.**
17b	NPI	**Optional.**	**The revised form accommodates the entry of the referring provider's NPI.**
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	Reserved for Local Use	Reserved for future use. Do not use.	**Usage to be determined.**
20	Outside Lab?	**Optional.**	
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	
22	Medicaid Resubmission Code	**Optional**.	
23	Prior Authorization Number	**Situational** – Complete if appropriate or leave blank. If the services being billed must be Prior Authorized, the PA number is **required** to be entered.	
24	Supplemental Information	**Situational –** Applies to the detail lines for drugs and biologicals only. In addition to the procedure code, **the National Drug Code (NDC)** is **required** by the Deficit Reduction Act of 2005 for **physician-administered drugs** and **shall be entered** in the **shaded** section of 24A through 24G. **Claims for these drugs shall include the NDC from the label of the product administered.**	**Physicians and other provider types who administer drugs and biologicals must enter this new drug-related information in the SHADED section of 24A – 24G of**

Locator #	Description	Instructions	Alerts
		To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the **Qualifier N4** followed by the **NDC.** Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC. Providers should then leave one space then enter the appropriate **Unit Qualifier** (see below) and the **actual units administered**. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space. The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram UN Unit	**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. No span dates accepted with date of service 10/01/07. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	**Effective with 10/01/07, no span dates will be accepted.**
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	**Situational** – Complete if appropriate or leave blank. When required, the appropriate CommunityCARE emergency indicator is to be entered in this field.	**This indicator was formerly entered in block 24I.**
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s).	

Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	**Optional.**	**The revised form accommodates the entry of I.D. Qual.**
24J	Rendering Provider I.D. #	**Situational** – If appropriate, entering the Rendering Provider’s Medicaid Provider Number in the shaded portion of the block is **required**. Entering the Rendering Provider’s NPI in the non-shaded portion of the block is **optional**.	**The revised form accommodates the entry of NPIs for Rendering Providers**
25	Federal Tax I.D. Number	**Optional.**	
26	Patient’s Account No.	**Situational** – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	

Locator #	Description	Instructions	Alerts
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Balance Due	**Situational** – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Required** -- The claim form **MUST** be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI	**Optional.**	**The revised form accommodates entry of the Service Location NPI.**
32b	Unlabelled	**Situational –** Complete if appropriate or leave blank. When the billing provider is a CommunityCARE enrolled PCP, indicate the site number of the Service Location. The provider must enter the **Qualifier LU** followed by the **three digit site number**. Do not enter a space between the qualifier and site number (example "LU001", "LU002", etc.)	**If PCP, enter Site Number and Qualifier of the service location.**

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



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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): 100234591230

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TULLIER, JACKSON

3. PATIENT'S BIRTH DATE: 05 | 18 | 68 SEX: M [X] F

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

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

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

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

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 437985629

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	08 01 07	08 01 07	12		T1019	EP		242 88	96		NPI
2	08 02 07	08 02 07	12		T1019	EP		242 88	96		NPI
3	08 03 07	08 03 07	12		T1019	EP		121 41	48		NPI
4	08 04 07	08 04 07	12		T1019	EP		121 41	48		NPI
5	08 05 07	08 05 07	12		T1019	EP		121 41	48		NPI
6	08 06 07	08 06 07	12		T1019	EP		30 36	12		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 $ 880 35

29. AMOUNT PAID $

30. BALANCE DUE $ 880 35

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.)

Cathyrn Jester 08/16/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

A-1 PCS Agency

Baton Rouge, LA

a. 1111111112 b. 1122334

NUCC Instruction Manual available at: www.nucc.org

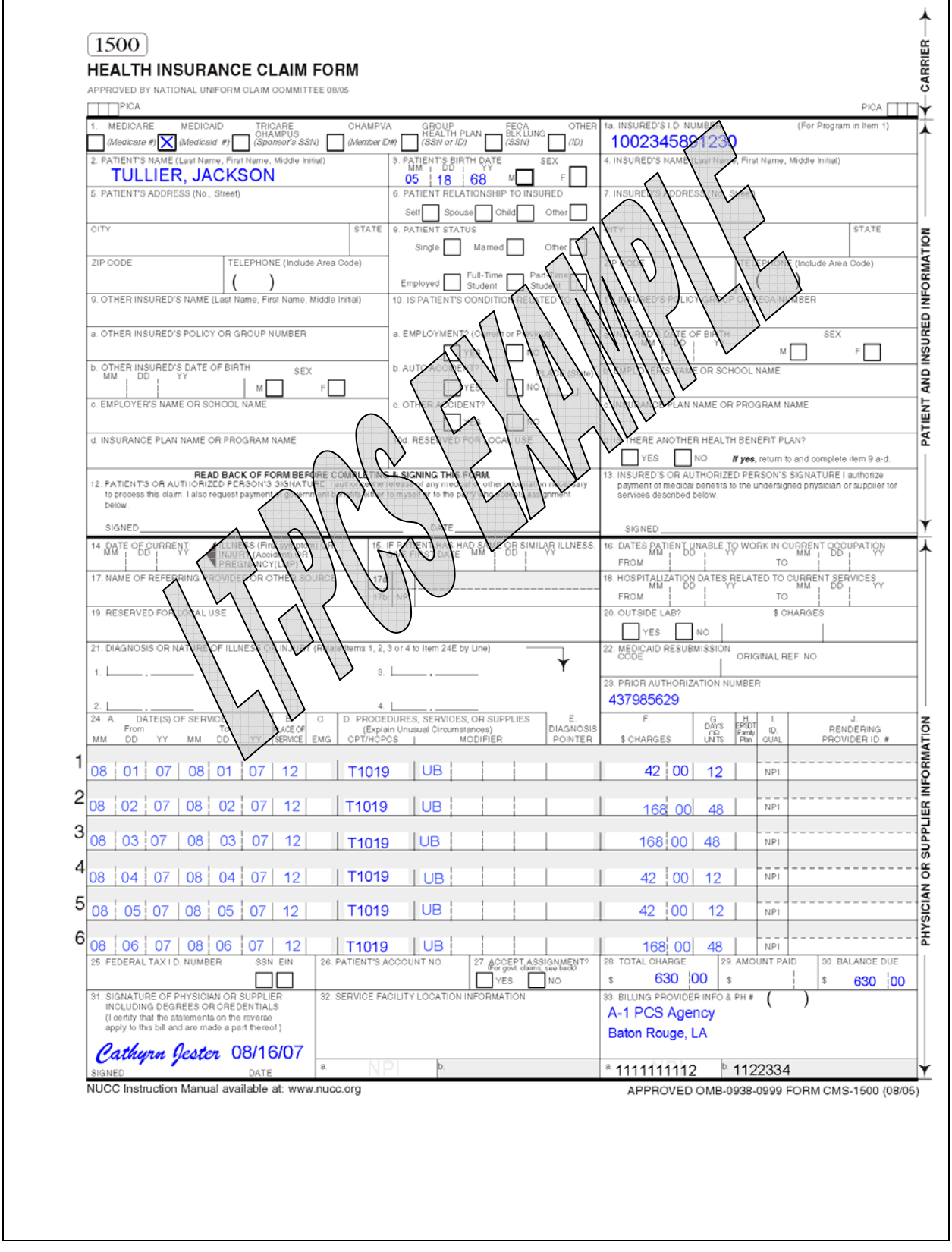
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EPSDT-PCS EXAMPLE



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): 10023458901230

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TULLIER, JACKSON

3. PATIENT'S BIRTH DATE: 05 18 68 | SEX: M

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

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 (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. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 437985629

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	08 01 07	08 01 07	12		T1019	UB			42 00	12		NPI
2	08 02 07	08 02 07	12		T1019	UB			168 00	48		NPI
3	08 03 07	08 03 07	12		T1019	UB			168 00	48		NPI
4	08 04 07	08 04 07	12		T1019	UB			42 00	12		NPI
5	08 05 07	08 05 07	12		T1019	UB			42 00	12		NPI
6	08 06 07	08 06 07	12		T1019	UB			168 00	48		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 $ 630 00

29. AMOUNT PAID $

30. BALANCE DUE $ 630 00

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

Cathyrn Jester 08/16/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI | b.

33. BILLING PROVIDER INFO & PH # ( )

A-1 PCS Agency

Baton Rouge, LA

a. 1111111112 | b. 1122334

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

A-1 PCS EXAMPLE

NUCC Instruction Manual available at: www.nucc.org

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

Unisys 213 Adjustment/Void Form

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

Form Completion

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

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

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

1. A claim is approved on the RA dated 11/23/2004, ICN 4295067890123.

2. The claim is adjusted on the RA dated 12/28/2004, ICN 4352090123456.

3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (4352090123456) and RA date (12/28/2004) must be used.

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

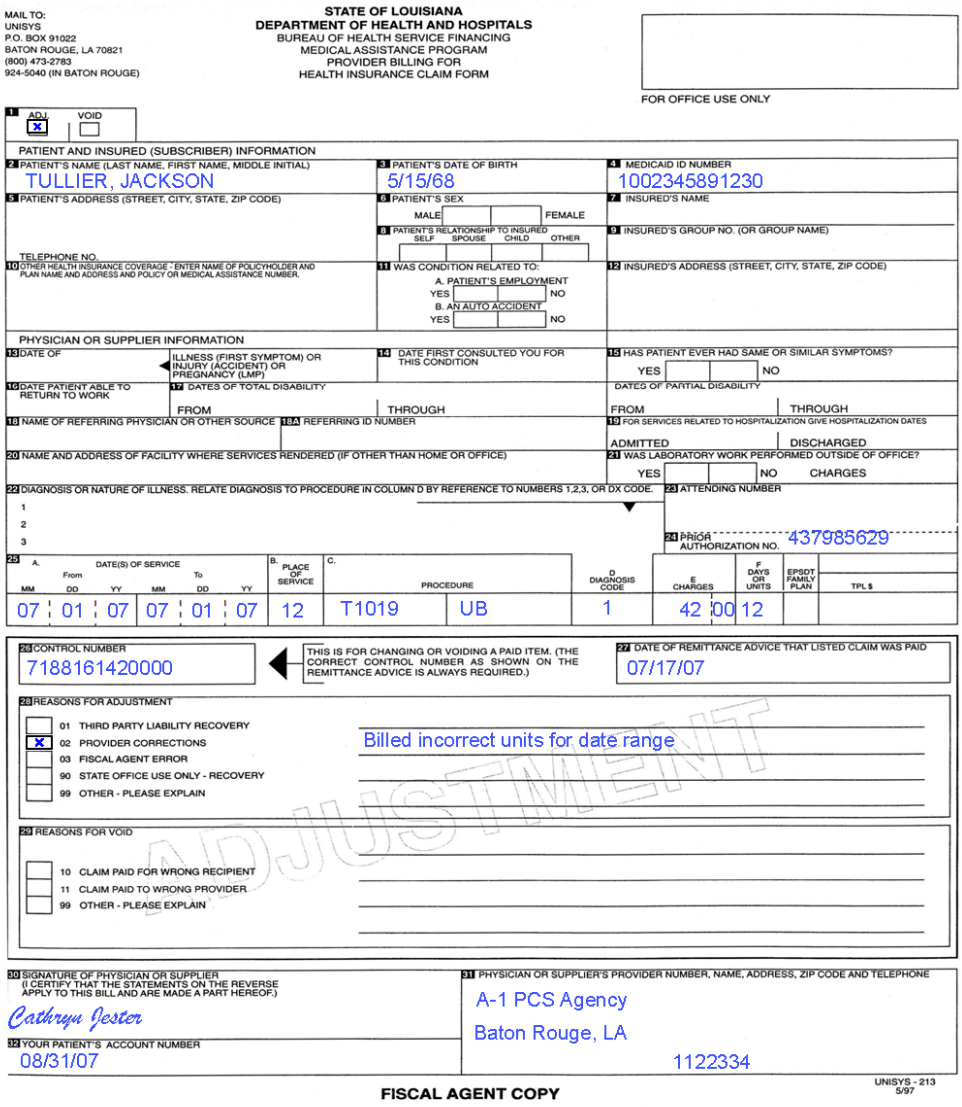
Adjustments: To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the 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 RA and a corrected claim may be submitted (if applicable).

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

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

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



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

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

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): TULLIER, JACKSON
3 PATIENT'S DATE OF BIRTH: 5/15/68
4 MEDICAID ID NUMBER: 1002345891230
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. 437985629

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
07	01	07	07	01	07	12	T1019	UB	1	42 00	12		

26 CONTROL NUMBER: 7188161420000
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 07/17/07

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

ADJUSTMENT

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Cathryn Jester
32 YOUR PATIENT'S ACCOUNT NUMBER
08/31/07

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
A-1 PCS Agency
Baton Rouge, LA
1122334

FISCAL AGENT COPY

UNISYS - 213
5/97

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION

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

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

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

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

ADJUSTMENT

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE

32 YOUR PATIENT'S ACCOUNT NUMBER

UNISYS - 213
5/97

FISCAL AGENT COPY

Instructions for Completing the 213 Adjustment/Void form

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

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

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

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

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

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

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

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

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

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

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

25. **REQUIRED** A through F

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

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

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

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

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

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

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

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

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

REQUIRED items must be completed or form will be returned.

CLAIM DENIAL RESOLUTION

This section is designed to assist providers in resolving claim denials. The most frequently encountered error codes are listed, along with an explanation of each denial and how to correct it.

Hardcopy Claim Denial Resolution

The following explanations assume that, if the claim was filed hardcopy, no data entry errors occurred. If the information on the Remittance Advice does not match the data on the claim (recipient ID number, date of service, procedure code, recipient name, charges, etc.), then a data entry error occurred. Providers may call Unisys Provider Relations department (see p. 54) to report the problem and request that the claim be reprocessed.

For Further Information

The topics of recipient eligibility verification (using REVS, MEVS, and e-MEVS), spend-down medically needy eligibility, third party liability, timely filing guidelines, SURS, and others are discussed in detail in the 2006 Basic Medicaid Provider Training packet. Providers may obtain a copy of this document by attending a 2006 Basic Medicaid Provider Training workshop or by requesting the packet from Provider Relations.

General Claim Form Completion Error Codes

ERROR CODE 003–RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS	
Cause:	The recipient ID number on the claim form was less than 13 digits in length or included letters or other non-numeric characters.
Resolution:	Verify the correct 13-digit recipient ID number using REVS or MEVS and enter this number where required on the claim form.

ERROR CODE 009-SERVICE THRU DATE GREATER THAN DATE OF ENTRY	
Cause:	The claim was received by Unisys prior to one or more dates of service billed.
Resolution:	Correct the date span on the claim and rebill **OR** wait until all dates of service on the claim have passed and rebill.

Duplicate Claim Error Codes

ERROR CODE 813 - EXACT DUPLICATE ERROR: IDENTICAL CLAIMS	
Cause:	The claim is a duplicate of one that has already been paid by Unisys.
Resolution:	On the Remittance Advice, the denial refers the provider to the conflicting control number and adjudication date of the previously paid claim. Refer to that Remittance Advice date indicated to find the paid claim. Do not resubmit the claim if it has already been paid.
	If the wrong number of units were paid for that date range, submit an adjustment in order to receive correct payment.

Recipient Eligibility Error Codes

ERROR CODE 215-RECIPIENT NOT ON FILE	
Cause:	The recipient ID number on the claim form is not in the Unisys eligibility files.
Resolution:	Verify the correct 13-digit recipient ID number using REVS, MEVS, or e-MEVS and enter this number where required on the claim form. If there is a printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 216-RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE	
Cause:	The recipient ID number on the claim is in the Unisys eligibility files, but the recipient's eligibility does not cover the date of service filed on the claim.
Resolution:	Verify the recipient's eligibility using REVS, MEVS, or e-MEVS for all dates of service on the claim. If there is a printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter explaining the problem.

ERROR CODE 217-NAME AND OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD	
Cause:	1. The name on the claim form does not match the recipient ID number as recorded in the Unisys eligibility files. This is sometimes caused when a recipient marries and changes her surname, or if several family members have similar ID numbers, **OR**
	2. The first and last names have been entered in reverse order on the claim form.
Resolution:	Verify the correct spelling of the name via REVS, MEVS, or e-MEVS using the 13-digit recipient ID number. Ensure that the first and last names are entered in the correct order on the claim. Make corrections if necessary and resubmit.
Occasionally a recipient's name may be changed on the Unisys eligibility files after PA is issued but before billing can occur. In such cases, the provider should contact Unisys Prior Authorization Unit to request that the name on the prior authorization record be changed to reflect the new name.	

ERROR CODE 222 – RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE (S)	
Cause:	The recipient ID number on the claim is in the Unisys eligibility files, but the recipient's eligibility does not cover all dates of service filed on the claim.
Resolution:	Verify the recipient's eligibility using REVS, MEVS, or e-MEVS for all dates of service on the claim. If there is a MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

Timely Filing Error Codes

ERROR CODE 272-CLAIM EXCEEDS 1 YEAR FILING LIMIT	
Cause:	The date of service on the claim form is more than 1 year prior to the date the claim was received by Unisys and no proof of timely filing was attached.
Resolution:	Resubmit the claim with proof of timely filing attached. Proof of timely filing is usually a copy of a RA page that shows the claim was processed by Unisys within one year from the date of service. Such claims may be mailed with a cover letter requesting an override for proof of timely filing to the Unisys Correspondence Unit.
A history can be ordered to assist in determining if payment has been made or if a claim has been filed timely. This may be done by calling the Provider Relations Telephone Inquiry Unit. The Field Analyst for your territory may also assist in placing such an order.	

ERROR CODE 030-SERVICE "THRU" DATE MORE THAN TWO YEARS OLD	
Cause:	The date of service on the claim form is more than two years prior to the date the claim was received by Unisys.
Resolution:	Timely filing guidelines dictate that, in general, claims with dates of service over two years old are not payable. Unisys staff does not have the authority to override such claims. In the case of retroactive eligibility, DHH must review the claim and approve any overrides for timely filing.

Prior Authorization Error Codes

Providers must bill services exactly as they are authorized via the PA letter. The Medicaid computer system compares several items which must be the same on both the claim form and the prior authorization record: PA number, Medicaid recipient ID number, provider number, procedure code, and date of service. The Remittance Advice (RA) reflects the PA number entered on each processed claim. This is found on the left-hand side of the RA page, just below the recipient name.

Several error codes pertain to the process the computer uses in matching items on the claim to items on the prior authorization record:

ERROR CODE 190–PA NUMBER NOT ON FILE	
Cause:	The number entered in block 23 of the CMS 1500 claim form is not a recognized number.
Resolution:	Review the PA letter, paying special attention to the Prior Authorization number. Make sure the number listed on the PA letter is the same as the number entered in block 23. Make any necessary corrections and resubmit.

ERROR CODE 191-PROCEDURE REQUIRES PRIOR AUTHORIZATION	
Cause:	No PA number entered in block 23.
Resolution:	Review recipient records to ascertain whether or not authorization had been given. If the prior authorization letter shows an approval for that service, be sure to indicate that specific PA number in block 23.

ERROR CODE 193-DATE ON CLAIM NOT COVERED BY PA	
Cause:	The date of service indicated on the claim form is not a date covered by that PA number.
Resolution:	1. Review recipient records to ascertain whether the date entered on the claim form is correct.
	2. Review the PA letter to ensure that the correct PA number is given.

ERROR CODE 196-CLAIM RECIPIENT ID DOES NOT MATCH ID ON PA FILE	
Cause:	Recipient ID on PA file is not the same as the one entered on the claim.
Resolution:	Review the PA letter, being sure to pay special attention to the recipient ID. When submitting the claim, all information on the PA must match the claim. Therefore, if a recipient has a different ID number on date of service than the PA record shows, the claim will deny.

ERROR CODE 197-PA PROVIDER ID NOT SAME AS CLAIM PROVIDER ID	
Cause:	The provider information on the PA file does not match the information on the claim form.
Resolution:	**EPSDT-PCS Claims only:** Review the PA letter, paying special attention to the Provider ID number. If there was a keying error or the provider did not indicate the correct ID number, a **Reconsideration** will need to be done in order for payment to be made. **LT-PCS Claims only:** Review the PA letter, paying special attention to the Provider ID number. If the provider number indicated on the PA letter is not correct, contact Provider Relations for follow up. If the provider number indicated on the claim form is incorrect, resubmit the claim with the correct provider number.

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
Recipient eligibility Issues – copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing – letter/other proof i.e., RA page	Continue hardcopy billing
Spend Down Recipient – 110MNP Spend Down Form	Continue hardcopy billing
Third Party/Medicare Payment – EOBs. (Includes Medicare adjustment claims)	Continue hardcopy billing
Retroactive eligibility – copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing

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.**

IMPORTANT UNISYS ADDRESSES

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

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

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

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

TIMELY FILING GUIDELINES

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

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

Dates of Service Past Initial Filing Limit

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

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

OR

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

OR

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

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

NOTE 2: At this time Louisiana Medicaid **does not** accept printouts of Medicaid Electronic Remittance Advice (ERA) screens as proof of timely filing. Reject letters are not considered proof of timely filing as they do not reference a specific individual recipient or date of service. Postal "certified" receipts and receipts from other delivery carriers are not acceptable proof of timely filing.

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

Submitting Claims for Two-Year Override Consideration

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

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

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

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

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

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

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

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

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.

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:

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

Office of Aging and Adult Services
Long Term Personal Care Services
P.O. Box 2031
Baton Rouge, LA 70821

Attention: Program Manager

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE/

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

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

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

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

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

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

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

APPENDIX A – FORMS FOR EPSDT- PCS

BHSF Form 90-L
Rev. 11/00

REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION

I. RECIPIENT INFORMATION

A. Recipient's Name:		SS #:	Medicaid #:
B. Address (City, State, Zip Code, Parish):		C. Responsible Party/Curator:	
		Address (City, State, Zip Code, Parish):	
Telephone #:	Race: Sex:		
Medicare #:	Date of Birth:	Relationship:	Telephone #:
D. What are/were the living arrangements: • Own home • Relative's home • Other			
E. What previous institutional care (including nursing facilities) has this person received?			
Facility: Date:		Facility: Date:	
Facility: Date:		Facility: Date:	
F. What Home/Community-based services have been used/considered: • ADHC • MR/DD • CC • PCA • ELDERLY • HH			
G. Why were services not suitable?			
H. Requesting Nursing Home placement: • Temporarily • Permanently			
I. Applicant/Responsible Party Signature:_____ Date:_____			

II. LEVEL OF CARE DETERMINATION

Institutional care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. The attending physician must designate the required level of care by selecting the appropriate level below. This requirement also applies to applicants requesting home or community-based waiver services to allow for a determination of the level of institutional care that would otherwise be required. Please select one of the following levels of care:

A. • Intermediate Care II (minimum care required) - Includes some aid in activities of daily living, diversionary activities, protection from hazards and/or a minimum

B. • Intermediate Care I (medium care required) - Includes need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization.

C. • Skilled Care (maximum care required) - Indicate special level, if indicated: • TDC • ID • NRTP (• Complex; • Rehab) Includes professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

D. • ICF/MR - Requires active treatment of mental retardation or a developmental disability under supervision of a qualified mental retardation or developmental disability professional.

E. Is this person likely to need services in a medical facility (hospital, nursing facility, etc.) for at least thirty (30) consecutive days ? • Yes • No

F. Home/community based services are adequate to meet the needs of this patient. • Yes • No

G. COMMENTS:

Recipient's Name:

III. MEDICAL INFORMATION

A. Diagnosis: _____

B. Medications:(Specify dosage, frequency, and route) ALLERGIES _____

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

C. Recent Hospitalizations: (include psychiatric) _____

D. Mental Status/Behavior: check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always

• Yes (1, 2, 3) • No 1. Oriented	• Yes (1, 2, 3) • No 4. Comatose	• Yes (1, 2, 3) • No 7. Hostile
• Yes (1, 2, 3) • No 2. Forgetful	• Yes (1, 2, 3) • No 5. Confused	• Yes (1, 2, 3) • No 8. Combative
• Yes (1, 2, 3) • No 3. Depressed	• Yes (1, 2, 3) • No 6. Wanders	

E. Activities of Daily Living: (check appropriate box)

- 1. Verbal
- 2. Non-verbal
- 3. Bowel Incontinence
- 4. Dentures _____
- 5. Impaired vision _____ • Glasses
- 6. Impaired hearing _____ • Hearing Aid
- 7. Bladder Incontinence _____
- 8. Urinary Catheter _____

SELF	ASSIST	TOTAL	
•	•	•	10. Eating
•	•	•	11. Bathing
•	•	•	12. Personal
•	•	•	13. Oral Hygiene
•	•	•	14. Ambulation

F. SPECIAL CARE/PROCEDURES: (check appropriate box: when appropriate give type, frequency, size, stage and site)

- 1. Ostomy care _____
- 2. Glucose Monitoring _____
- 3. Restraints _____
- 4. IV's _____
- 5. Suctioning _____
- 6. Specialized Rehab _____
- 7. MRSA _____
- 8. Diet/Tube Feeding _____
- 9. Dialysis _____
- 10. Respiratory _____
- 11. Decubitus _____
- 12. Other _____

G. PHYSICAL EXAMINATION: Height _____ Weight _____ Pulse _____ Resp _____ Temp _____ B/P _____
Lab Results: HCT _____ HGB _____ U/A _____ Radiology _____

General _____ Head and CNS _____

Mouth and EENT _____ Chest _____

Heart and Circulation _____ Abdomen _____

Genitalia _____ Extremities _____

Skin _____ Other _____

H. Physician's Name (Type or Print) _____ PHONE _____
Address: _____
Physician's Signature _____ Date _____

EPSDT Personal Care Services—Social Assessment
Must Be Submitted In Addition to Form 90-L

RECIPIENT NAME:_____ MEDICAID #_____

1. HOUSEHOLD COMPOSITION:

Name	Age	Relationship	School/Work?

2. PRIMARY CAREGIVER ASSESSMENT:

Name: _____ Age_____ Relationship_____ Phone_____

Does Primary Caregiver have physical or mental limitations which would affect his/her ability to care for the recipient?
☐Yes ☐No If yes, explain and attach medical documentation of limitations:

_____

_____

Will the primary caregiver supervise the PCS worker? ☐Yes ☐No

3. CHILDCARE ARRANGEMENTS:

Age of the recipient: _____ If fourteen years or younger, explain childcare arrangements when the parent is gone from the home. (ie., when parent is at work, before/after school when parent works, or when parent is away on errands).

_____

_____

4. RECIPIENT ASSESSMENT:

Does recipient attend school or work? ☐Yes ☐No If yes, specify hours attended and name of school or work:_____

Is recipient ☐ Verbal ☐ Nonverbal?
Does recipient utilize adaptive equipment? ☐Yes ☐No
If yes, specify what type equipment:_____

_____

Can recipient direct his/her own care? ☐Yes ☐No
If no, is primary caregiver or other caregiver in home? ☐Yes ☐No

Is recipient on medication: ( ) Yes ( ) No
If yes, who gives medication?_____

5. DIETARY FACTORS:

Who prepares meals?_____

Type of meals and number per day:_____
Assistive devices for eating (feeding tube, other): ( ) Yes ( ) No
If yes, specify:_____

6. HOME ENVIRONMENT:

Access (describe stairs, doors, walks, etc): _____

_____

Living Space:_____

_____

Location (rural, urban, on bus line, etc.):_____

_____

7. **Family Interpersonal Relationships:** Which family members assume major responsibilities for caring for recipient and what tasks do they perform?

_____

_____

8. SOCIAL SUPPORT SYSTEM: Are there other friends or relatives that assist in caring for the recipient or in giving relief to the primary caregiver?

_____

_____

9. OTHER SERVICES: What other services is the recipient receiving at this time (home health, respite, etc.)?

_____

_____

10. PCS SERVICES: What is the name of the agency that will provide PCS services?

_____

Signature(s) of person(s) completing assessment:

_____ Date:_____

_____ Date:_____

8-18

EPSDT PCS DAILY SCHEDULE

Client Name_____ Medicaid #_____

Specify hours of all services recieved by recipient. This includes EPSDT PCS as well as other services such as home health aide or nurse, respite or PCA from waiver or contract, physical therapy, etc. Be certain to show times the recipient is in school.

TIME	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
NOON							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							
12:00 PM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
Comments							

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing

EPSDT Personal Care Services – Plan of Care

☐ **New** ☐ **Renewal** ☐ **Reconsideration** **Date Services Requested to Start: _____**

Identifying Information		**Provider Information**	
Name		Provider Agency Name	
ID#	DOB	Provider Number	Phone #
Address		Address	
		Contact Person e-mail	

Medical Reasons Supporting the Need for PCS (Must be accompanied by appropriate medical documentation for recipient and parent/caregiver, if the parent/caregiver is disabled)

Other In-Home Services Requested or Currently Receiving		
☐ New Opportunities Waiver	☐ Home Health Nursing Services	☐ Home Bound Teacher
☐ Children's Choice Waiver	☐ Home Health Aide Services	☐ Mental Health Rehab
☐ OCDD Family Support/Respite	☐ Home Health Therapy	☐ Other:

Recipient Name:	Recipient ID#:

Personal Care Tasks Specify the personal care activities the parent/caregiver requires the assistance of the PCS provider due to an inability to perform these services alone.				
PCS Activity	Goal	Days Service Requested	Time Requested to Complete Activity	Total Time Requested for Week (# days x minutes)
Bathing		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Dressing		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Grooming		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Toileting		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Eating		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Meal Prep		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Incidental Household Services		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes
Accompanying to Medical Appointments		Mon Tue Wed Thur Fri Sat Sun	minutes	_____Hours _____Minutes

Total Weekly Hours Requested: _____

Recipient Name:	Recipient ID#:

Child Care Arrangements
For children 14 years of age or younger, or for those 15 years of age or older and unable to self direct their own care, specify child care arrangements. *Note: For the children who meet this criteria, when the PCS worker is in the home, another adult must be present.*

Signatures		
Parent/guardian	Provider Representative	Physician
Date	Date	Date

APPENDIX B – FORMS FOR LT- PCS

Long Term – Personal Care Services
Provider Service Plan

Check box	Recipient Name:	Medicaid ID#
[ ] New	Address:	Responsible Representative:
[ ] Revision		Responsible Representative's Phone #
Date Service Plan Prepared	Phone #	Responsible Representative's Alternate Phone #

Provider Agency:	Name of Contact Person:
Provider #	Phone #
Address:	Fax #
	E-mail address:

I have participated in the development of this service plan, and I am aware of the services that are to be provided through the Long Term – Personal Care Service program.

Recipient's Signature _____ **Date** _____

Responsible Representative's Signature _____ **Date** _____

Agency Representative's Signature _____ **Date** _____

LT-PCS Form SP
Issued 2/10/05

- 1 -

Activities of Daily Living				
Activity	Approved POC Activity	Support LT-PCS Agency Will Provide *Describe in DETAIL---* (How, where and when the tasks will be performed)	List the Day(s) Support Will Be Provided	Daily Time Allotment (Minutes/hours)
Eating	[ ] YES [ ] NO			
Bathing	[ ] YES [ ] NO			
Dressing	[ ] YES [ ] NO			
Grooming	[ ] YES [ ] NO			
Transferring	[ ] YES [ ] NO			
Ambulation	[ ] YES [ ] NO			
Toileting	[ ] YES [ ] NO			

Instrumental Activities of Daily Living				
Activity	Approved POC Activity	Support LT-PCS Agency Will Provide *Describe in DETAIL---* (How, where and when the tasks will be performed)	List the Day(s) Support Will Be Provided	Time Allotment (Min. or hrs. per day/wk/month)
Light Housekeeping	[ ] YES [ ] NO			
Food Preparation	[ ] YES [ ] NO			
Grocery Shopping	[ ] YES [ ] NO			
Laundry	[ ] YES [ ] NO			
Scheduling Medical Appointments	[ ] YES [ ] NO			
Accompany to Medical Appointments	[ ] YES [ ] NO			
Arrange Medical Transportation	[ ] YES [ ] NO			
Medication Reminders	[ ] YES [ ] NO			

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**