Louisiana Medicaid School-Based Health Center Presentation December 2011

Services Available

- **Professional Services**, think of a SBHC as a physician clinic *dropped* into the school setting.

- **KIDMED Services**, screening component of EPSDT and includes Medical, Vision, and Hearing screening services.
  - SBHC's must be enrolled as KIDMED providers.
    - Subjective vision and hearing screenings are part of the comprehensive history and physical exam or assessment component of the medical screening.
    - Objective vision and hearing screenings begin at **age 4.**

- **Dental Services** are only covered for FQHC's that are also SBHC's.

Rendering Services

SBHCs must have a Medicaid enrolled physician or NP linked to clinic to supervise services & be available to provide services.

- The doctor/NP may not be on-site at all times but are responsible for the supervision of all services.
- SBHCs can only provide services for which they have appropriate staff on-site.

If a doctor/NP is not physically present on-site	If a doctor/NP is physically present on-site
Services that can be provided: • **All KIDMED Services:** **KIDMED Screenings** **KIDMED Nurse Consults** **KIDMED Social Worker consults** **(99211-AJ - only billable by a social worker)** **KIDMED Dietitian Consults** **(S9470 – only billable by a dietitian)** **(Code 99211 may not be billed)**	**Services that can be provided:** • **All medically necessary physician clinic services (including 99211 by RN)** • **KIDMED services**

SBHC vs. School Nurses

- Services provided by RN's in SBHC are distinct and separate from services provided by "school nurses" employed by the Local Education Agency (LEA) or local school/school board and should be billed with the SBHC's provider ID.
- Services provided by "school nurses" are NOT billed as SBHC services but under the LEA's KIDMED provider number(if enrolled)
- School Nurses/RN's must follow the policies of the provider ID that is being worked under at that time of service and should not bill these services under both the SBHC & the LEA
- SBHC's follow current Professional Services and KIDMED policies as they are considered physician clinic's by Medicaid.

CommunityCARE

- The state's comprehensive health plan is based on a primary care case management model.
- In most cases the recipient is linked to a PCP.

CommunityCARE/KIDMED Referrals

- OPH certified SBHC's are excluded from the CommunityCARE /KIDMED referral requirement for children 10 yrs and older **BUT** they **MUST** coordinate services with the PCP.
- A CommunityCARE/KIDMED referral **IS** required for children less than 10 years old.

Becoming a CommunityCARE Provider

- SBHCs may be considered for and become a CommunityCARE PCP if they are willing to meet and abide by all requirements for PCPs.
- Some standards for participation in the CommunityCARE program follow:
  - Be open year round – 365 days a year
  - Have patient access to care 24/7
  - Have back up coverage
  - Have hospital admitting privileges
  - Physician coverage a minimum of 20 hours a week
- For additional requirements, you may contact Automated Health Systems (AHS) , 800-259-4444.

Billing Policy

- SBHC services must be provided on-site and be billed using the SBHC number.
- SBHC's must be enrolled as KIDMED providers.
- SBHC's physicians/NPs, must be enrolled in Medicaid, their individual numbers must be linked to the SBHC number and used on the claim form as the attending provider.

KIDMED Consultation Services

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

- Consultation codes are not to be used for ongoing treatment.
- Outcomes for the consultations are to be documented, as well as referrals to appropriate resources for those conditions that might require further attention.
- Consultations are to be face-to-face contact in one-on-one sessions. Group sessions are not allowed.
- Multiple units of service may not be billed for the same consult.

KIDMED Consultation Services Cont. .

- The child must have received an age-appropriate KIDMED screening in order for these services to be reimbursable.
- Procedure codes T1001, S9470, 99211-AJ **may not be billed for preventive counseling,** anticipatory guidance, or health education provided on the date of the medical screening by the same provider since these services are a component of the screening.
- • Procedure codes T1001, S9470, 99211-AJ **may not be billed on the same date that the** same provider bills a physician's evaluation and management visit.
- • The social worker (LCSW) consult code (99211-AJ) is not for treatment of mental illness or emotional disturbances. Ongoing therapy is payable by Louisiana Medicaid under the Mental Health Rehabilitation Program and appropriate referrals should be made.

KIDMED Consultation Services Cont. .

- T1001 – Nursing Assessment/ Evaluation
  - Nursing services also include the provision of services to protect the health status of children and correct health problems. These services may include health counseling and triage of childhood illnesses and conditions. KIDMED consultation codes are to be specific to an individual child's needs. Documentation should be present justifying the need for each consultation for that particular child.
  - To determine if a service is appropriate to be billed as a KIDMED consultation, ask the question: Is this something for which the parent would normally seek medical attention from a provider's office? And has this child received an age-appropriate KIDMED screening?
  - Administration of medication in the school setting is NOT billable, the entire service (assessment, intervention, evaluation) by the RN would be the billable service and the administration of any medications in an emergent situation would just be part of the 'intervention'.
  - If you are unsure of what can be billed as a consultation then you should contact the administrator.

Policy Updates

- Effective with dates of service January 1, 2011 and forward, procedure codes 90465, 90466, 90467, & 90468 to report immunization administration services have been deleted from the 2011 CPT manual.

- At this time the 2011 immunization administration CPT codes 90460 & 90461 will be in non-payable status.

- Continue to use procedure codes 90471, 90472, 90473, & 90474 per current Louisiana Medicaid Policy to report all Immunization administration services.

- If a suspected condition is identified during a comprehensive screening and referred in-house for treatment by the screening provider during the same visit, no office visit of a higher level than CPT code 99212 is reimbursable and must be billed with a 25 modifier

Policy Updates cont.

- **Preventive Pediatric Care Pay and Chase**
  - Louisiana Medicaid uses the "pay and chase" method of payment for Preventive care for individuals, under age 21, with health insurance coverage. This means that most providers are not required to file health insurance claims with private carriers when the service meets the pay and chase criteria. The Bureau of Health Services Financing seeks recovery of insurance benefits from the carrier within 60 days after claim adjudication when the provider chooses not to pursue health insurance payments.

    - Primary preventive pediatric diagnoses are confined to those listed below.

V01.0 - V06.9	V70.0	V77.0 - V77.7	V79.8
V07.0 - V07.9	V72.0 - V72.3	V78.2 - V78.3	V82.3 - V82.4
V20.0 - V20.2	V73.0 - V75.9	V79.2 - V79.3	

    - EPSDT medical, vision, and hearing screening services (KIDMED screening services);
    - Vaccines obtained from the Vaccines for Children (VFC) program used to immunize the child should billed to Medicaid directly.

Take Charge
Family Planning Waiver program

- TAKE CHARGE covers only family planning services and birth control.
- Take Charge services can not be provided through Schools or SBHC.
- Over the coming months, DHH will transition to the issuance of a white medical eligibility card for all Medicaid eligibility programs, regardless of the scope of the benefit package. Therefore, it is important that providers verify eligibility and coverage limitations or restrictions on the date of service on all Medicaid enrollees.

Behavioral Health Services

- Effective with date of service October 1, 2007, Louisiana Medicaid reimburses professional service providers for select procedure codes specific to psychiatric services (current codes 90801-90802, 90804-90815, 96101) delivered in the office or other outpatient facility setting as outlined by the *Current Procedural Terminology (CPT)* manual.

- This policy is currently applicable to physician services in the Professional Services program.

- Psychiatric Diagnostic or Evaluative Interview Procedures (either code 90801 or 90802) are reimbursable once per 365 days per attending provider. Psychological Testing (current code 96101) is reimbursable once per 365 days per attending provider. Providers should bill all applicable units of service related to this procedure code on one date of service and not divide the units amongst multiple dates of service or claim lines.

- Group Therapy is only covered for Medicare cross over claims in the Professional Services Program.

Louisiana Medicaid Website

WWW.LAMEDICAID.COM

- Provider login and password
- Provider Enrollment Applications
- Web applications
  - e-MEVS Medicaid Eligibility Verification System
  - e-CSI Claim Status Inquiry
  - e-CDI Clinical Data Inquiry

Timely Filing Guidelines

Professional & KIDMED

- Must be filed within 12 months of the date of service.
  - KIDMED claims that are not received for processing within the 60 day time period will receive the educational EOB edit 435 as a reminder to the provider that the claims should be submitted within 60 days of the date of service.
  - Providers should strive to submit KIDMED claims within 60 days in order for the claims to be adjudicated, and allow paid claims to be reflected on all reports.

Claims Filing

Professional

- Electronically on the 837P format

- Hard-copy on the CMS 1500

KIDMED

- Electronically on the 837P w/ KIDMED segment

- Hard-Copy on the KM3
  - (The KM3 form is currently being revised)

ICD-9 vs. ICD 10 Diagnosis codes

- ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013

Structural Differences

ICD-9-CM Diagnoses Codes:

- **3-5 digits;**
- **First digit is alpha (E or V) or numeric;**
- **Digits 2-5 are numeric**

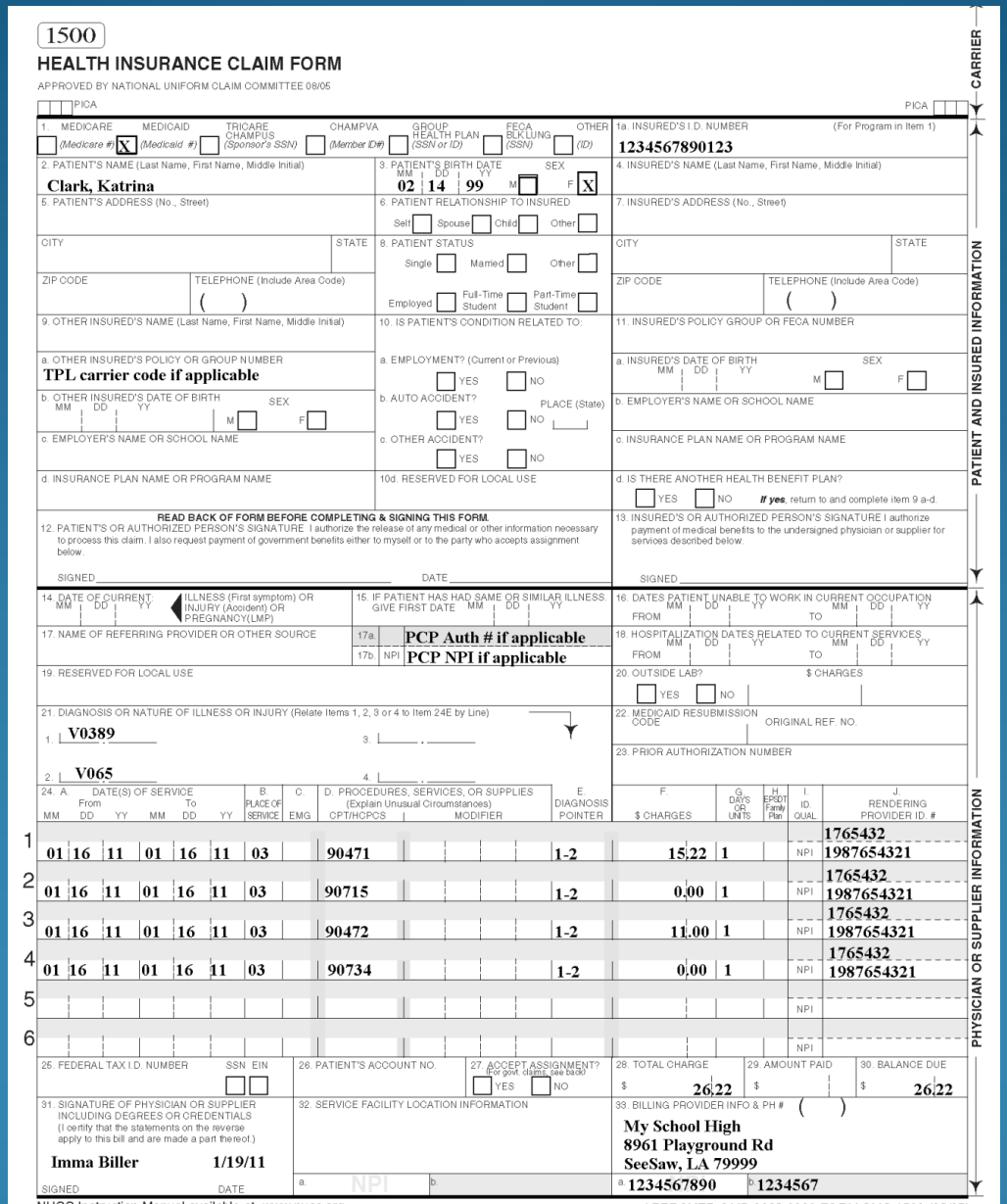
ICD-10-CM Diagnoses Codes:

- **3-7 digits;**
- **Digit 1 is alpha;**
- **Digits 2-3 are numeric;**
- **Digits 4-7 are alpha or numeric**

(alpha digits are not case sensitive)

- Additional information can be found on the following websites
  - http://www.cms.hhs.gov/icd10.
  - http://www.cdc.gov/nchs/icd.htm
  - www.lamedicaid.com

Billing for immunizations



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Clark, Katrina**

3. PATIENT'S BIRTH DATE: **02 14 99** SEX: M [ ] F [X]

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

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

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. **PCP Auth # if applicable**

17b. NPI **PCP NPI if applicable**

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

19. RESERVED FOR LOCAL USE

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

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

1. **V0389** 3. _____

2. **V065** 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	01 16 11 | 01 16 11	03		90471		1-2	15,22	1		NPI	1765432 / 1987654321
2	01 16 11 | 01 16 11	03		90715		1-2	0,00	1		NPI	1765432 / 1987654321
3	01 16 11 | 01 16 11	03		90472		1-2	11,00	1		NPI	1765432 / 1987654321
4	01 16 11 | 01 16 11	03		90734		1-2	0,00	1		NPI	1765432 / 1987654321
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 26,22

29. AMOUNT PAID $

30. BALANCE DUE $ 26,22

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.)

Imma Biller **1/19/11**

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

My School High
8961 Playground Rd
SeeSaw, LA 79999

a. **1234567890** b. **1234567**

NUCC Instruction Manual available at: www.nucc.org

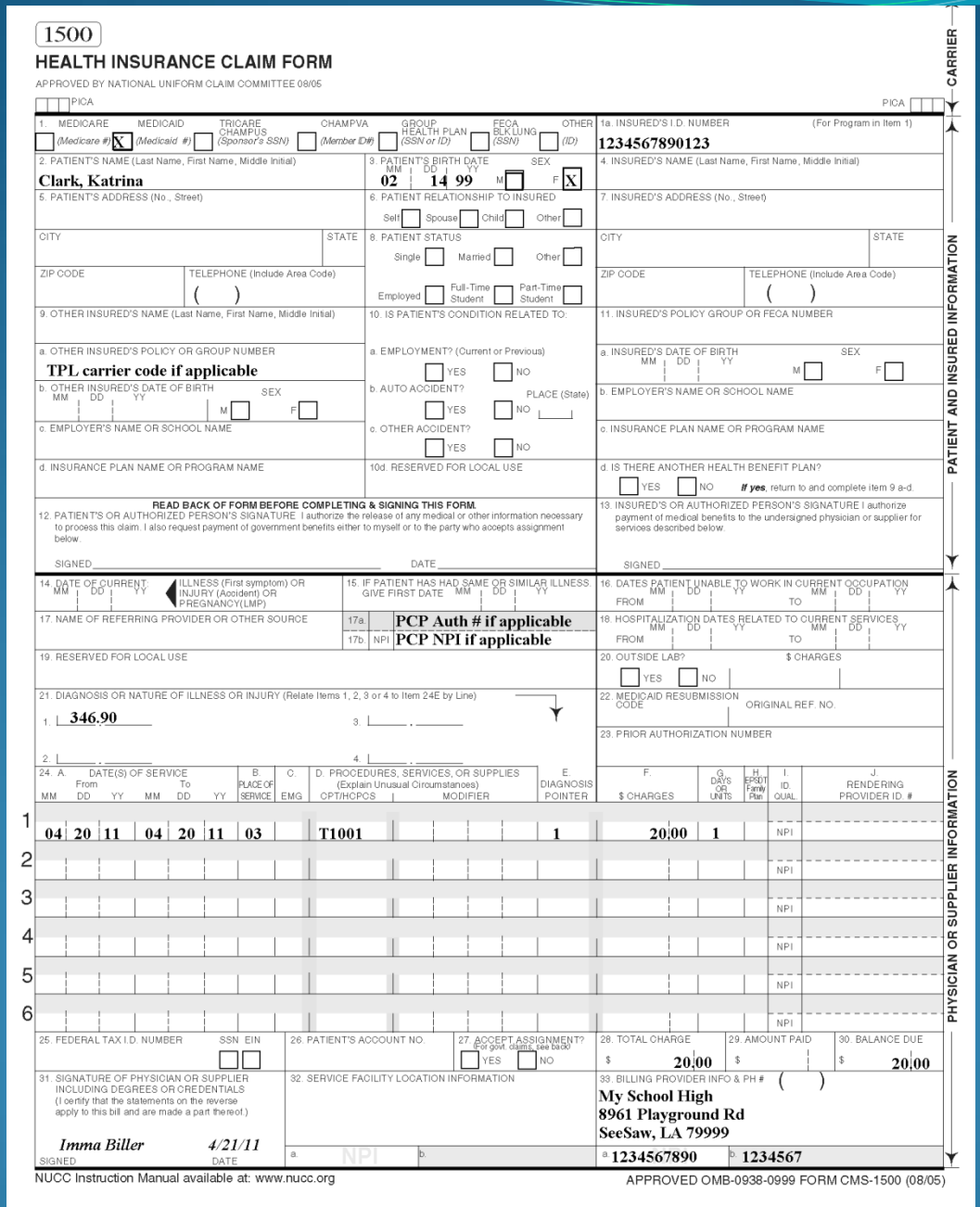
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Nursing Assessment/ Evaluation



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Clark, Katrina

3. PATIENT'S BIRTH DATE MM DD YY: 02 14 99 SEX M [ ] F [X]

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

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

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

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

CITY | STATE

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI PCP NPI if applicable

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

19. RESERVED FOR LOCAL USE

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

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

1. 346.90 3. _____ 2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	04 20 11	04 20 11	03		T1001		1	20,00	1		NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 20,00

29. AMOUNT PAID $

30. BALANCE DUE $ 20,00

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.)

Imma Biller 4/21/11

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

My School High
8961 Playground Rd
SeeSaw, LA 79999

a 1234567890 b 1234567

CARRIER

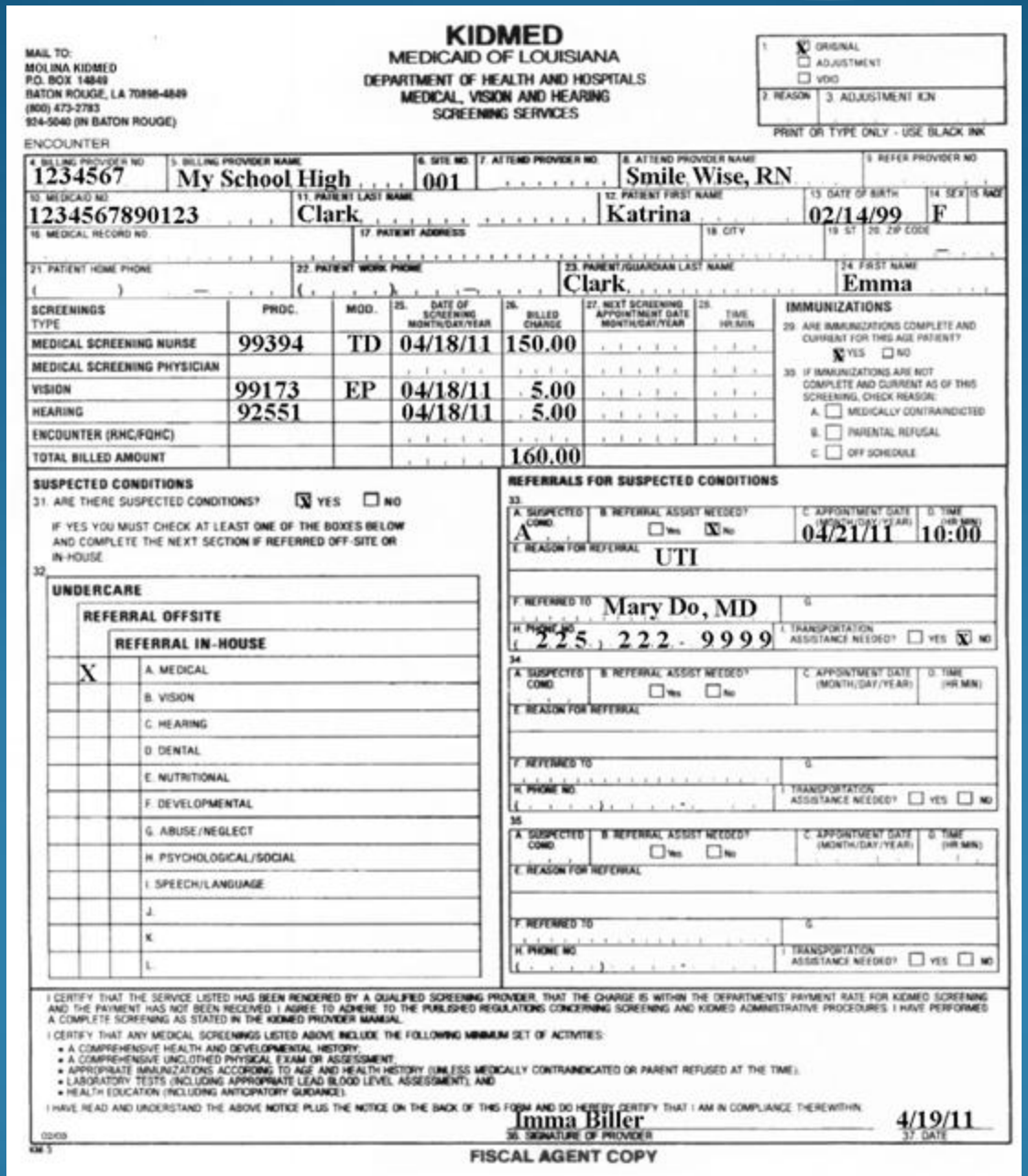
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

Example of KIDMED Claim



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

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

1. [X] ORIGINAL [ ] ADJUSTMENT [ ] VOID
2. REASON 3. ADJUSTMENT ICN
PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO
1234567	My School High	001		Smile Wise, RN	

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. AGE
1234567890123	Clark	Katrina	02/14/99	F	

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

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

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR/MIN
MEDICAL SCREENING NURSE	99394	TD	04/18/11	150.00		
MEDICAL SCREENING PHYSICIAN						
VISION	99173	EP	04/18/11	5.00		
HEARING	92551		04/18/11	5.00		
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				160.00		

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

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

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

32.

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

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR MIN)
A	[ ] Yes [X] No	04/21/11	10:00

E. REASON FOR REFERRAL: UTI

F. REFERRED TO: Mary Do, MD G.

H. PHONE NO: (225) 222 - 9999 I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [X] NO

34.

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

E. REASON FOR REFERRAL

F. REFERRED TO G.

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

35.

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

E. REASON FOR REFERRAL

F. REFERRED TO G.

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

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

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

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

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

Imma Biller — 36. SIGNATURE OF PROVIDER
4/19/11 — 37. DATE

02/09
KM 1

FISCAL AGENT COPY

Adjusting/Voiding Claims

Professional Claims

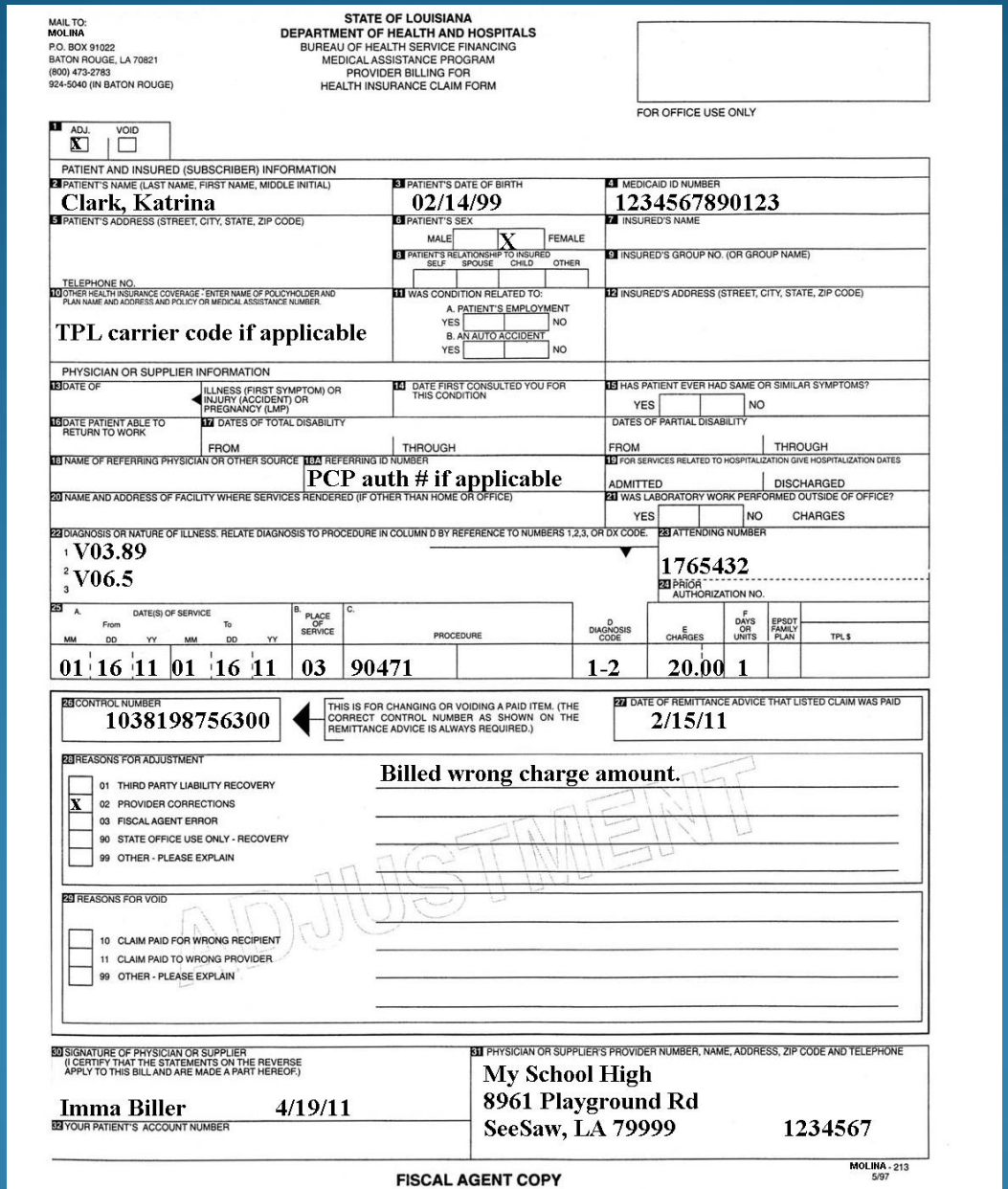
- Use Molina 213 adjustment/Void Form.
  - In the near future, providers of Professional Services and non screening KIDMED Services will use CMS 1500 Claim Forms to Adjust/Void Claims. The Molina 213 will no longer be used for adjustments/voids.

KIDMED

- Use the KM3 (KIDMED) Claim Form.
  - The KM3 form is currently being revised

- Electronic Submitters may electronically submit adjustment/voids
- ONLY an approved claim can be adjusted or voided
- One line item per adjustment/void form
- Must contain the most recently approved ICN and RA date.
- Errors on provider numbers and recipient ID numbers must be voided – not adjusted

Adjustment on Form 213



MAIL TO:
MOLINA
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): Clark, Katrina
3 PATIENT'S DATE OF BIRTH: 02/14/99
4 MEDICAID ID NUMBER: 1234567890123
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [X]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER: TPL carrier code if applicable
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER: PCP auth # if applicable
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO [ ] CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 V03.89
2 V06.5
3
23 ATTENDING NUMBER: 1765432
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
01	16	11	01	16	11	03	90471	1-2	20.00	1		

26 CONTROL NUMBER: 1038198756300
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: 2/15/11

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

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

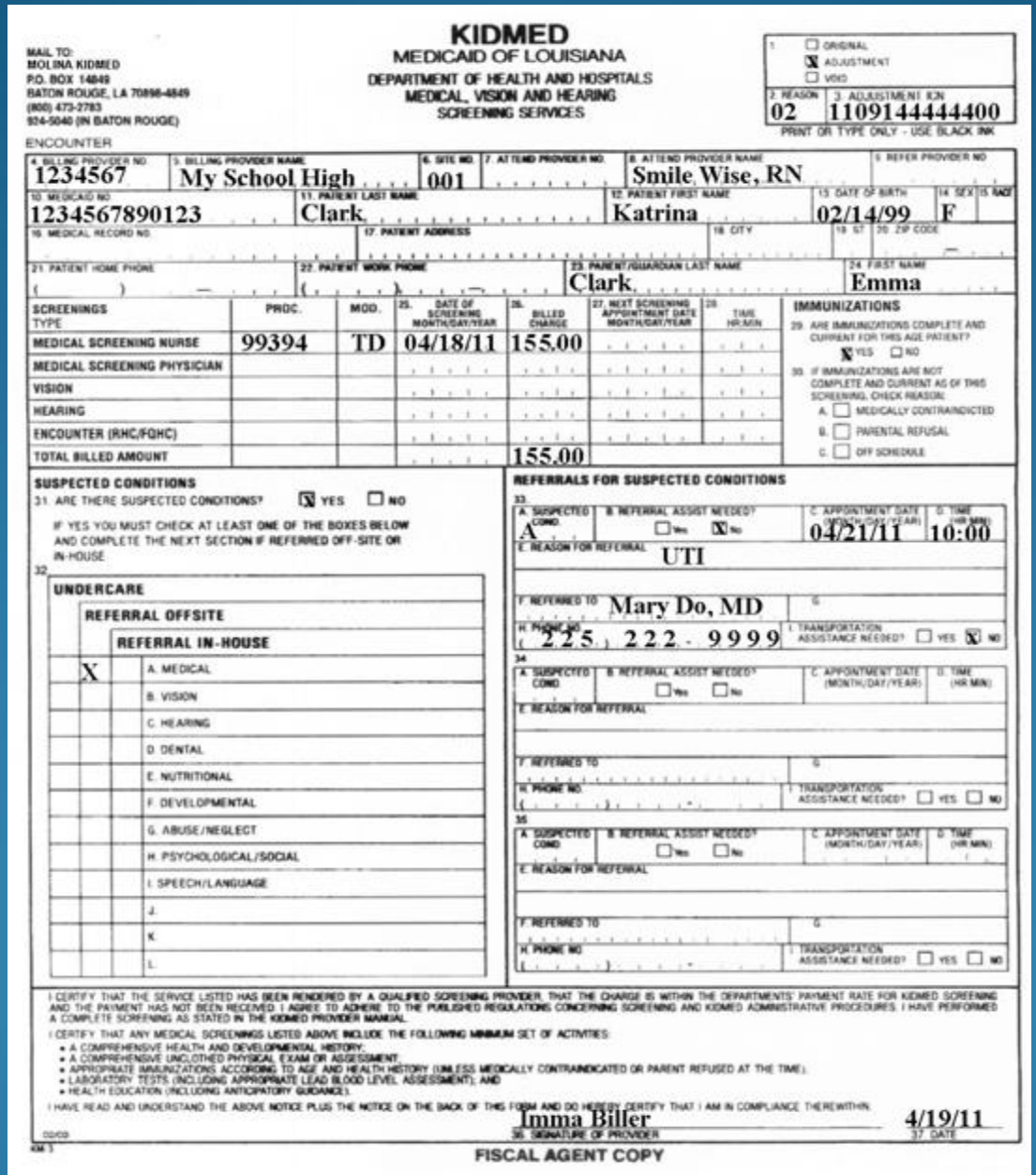
ADJUSTMENT

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Imma Biller 4/19/11
32 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
My School High
8961 Playground Rd
SeeSaw, LA 79999 1234567

FISCAL AGENT COPY
MOLINA - 213
5/97

Adjustment on KM3 Form



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

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

1. ☐ ORIGINAL ☒ ADJUSTMENT ☐ VOID
2. REASON: 02
3. ADJUSTMENT ICN: 1109144444400
PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO	5. BILLING PROVIDER NAME	6. SITE NO	7. ATTEND PROVIDER NO	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO
1234567	My School High	001		Smile Wise, RN	

10. MEDICAID NO	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567890123	Clark	Katrina	02/14/99	F	

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

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

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR/MIN
MEDICAL SCREENING NURSE	99394	TD	04/18/11	155.00		
MEDICAL SCREENING PHYSICIAN						
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				155.00		

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

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

32.

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

REFERRALS FOR SUSPECTED CONDITIONS

33.
A. SUSPECTED COND: A
B. REFERRAL ASSIST NEEDED? ☐ Yes ☒ No
C. APPOINTMENT DATE (MONTH/DAY/YEAR): 04/21/11
D. TIME (HR/MIN): 10:00
E. REASON FOR REFERRAL: UTI
F. REFERRED TO: Mary Do, MD
G.
H. PHONE NO: (225) 222 - 9999
I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☒ NO

34.
A. SUSPECTED COND | B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR/MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

35.
A. SUSPECTED COND | B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR/MIN)
E. REASON FOR REFERRAL
F. REFERRED TO | G.
H. PHONE NO | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

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

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

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

Imma Biller — 36. SIGNATURE OF PROVIDER
4/19/11 — 37. DATE

02/03
KM 3

FISCAL AGENT COPY

Electronic Data Interchange (EDI)

- Preferred method of submitting Medicaid claims to Molina
- Methods of EDI submission:
  - telecommunications
- Advantages of submitting EDI
  - Increased cash flow
  - Improved claim control
  - Faster payment turnaround

5010v HIPAA Electronic Transactions

- Effective January 1, 2012.
- We anticipate being ready for provider testing early in Quarter 4 of this year.
- Providers should be working with their billing entities to ensure that they will be ready for testing with Molina at the appropriate time.
- Check for updates on www.Lamedicaid.com.

Other Helpful Websites

- Additional DHH available websites
  - WWW.LA-KIDMED.COM
  - WWW.LA-CommunityCARE.COM

- Louisiana Department of Education
  - http://www.doe.state.la.us/divisions/specialp/school_medicaid.html

Provider Assistance

Molina Provider Relations Department
Phone: (800) 473-2783
(225) 924-5040

Molina EDI Department
Phone: (225) 216-6303

Molina Provider Enrollment
Phone: (225) 216-6370

Molina Web Technical Support Help Desk
Phone: (877) 598-8753

Field Analyst Listing on Web Site
(www.LaMedicaid.com)

Questions