PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid)

HOME HEALTH AGENCY

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION REGARDING WAIVER ENROLLMENTS

- The effective date is the date of enrollment approval.
- Non active billing will result to deactivation of the Medicaid provider number. To be reinstated, a provider must meet all enrollment requirements.
- An updated license must be obtained and submitted to Provider Enrollment for physical address changes

GENERAL POLICY INFORMATION:

Waiver service providers are required to comply with both policy and program requirements located on the Louisiana Department of Health (LDH) Office for Citizens with Developmental Disabilities (OCDD) website, the LDH Office of Aging and Adult Services (OAAS) website, and the Louisiana Medicaid provider manuals linked below.

Louisiana Medicaid Provider Manuals located at:
https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

LDH/OCDD website:
https://www.ldh.la.gov/OCDD

LDH/OAAS website:
https://www.ldh.la.gov/OAAS

Please note Louisiana Medicaid will not reimburse you for waiver services provided to participants who are not enrolled in one of the waiver programs.

NOTICE

Home Health Agencies Billing DME Directly to Louisiana Medicaid

The Louisiana Department of Health mandates that Medicaid will adhere to the accreditation requirement under the Medicare Modernization Act of 2003 for Home Health Agency providers seeking reimbursement for DME.

Home Health providers wanting to bill DME directly through their Louisiana Medicaid Provider number must submit a written request to Gainwell Provider Enrollment and attach verification of their accreditation - from one of the following (10) national organizations authorized by Medicare:

- The Joint Commission (JC); website: http://www.jointcommission.org/
- National Association of Boards of Pharmacy (NABP); website: www.nabp.net
- Board of Orthotist/Prosthetist Certification (BOC); website: www.bocusa.org
- The Compliance Team, Inc; website: www.exemplaryprovider.com
- American Board for Certification in Orthotics & Prosthetics, Inc (ABC); website: www.abcop.org
- The National Board of Accreditation for Orthotic Suppliers (NBAOS); website: www.nbaos.org
- Commission on Accreditation of Rehabilitation Facilities (CARF); website: www.carf.org
- Community Health Accreditation Program (CHAP); website: www.chapinc.org
- HealthCare Quality Association on Accreditation (HQAA); website: www.hqaa.org/
- Accreditation Commission for Health Care, Inc; website: www.achc.org

Home Health Agency

REQUIRED DOCUMENTS FOR ENROLLMENT

The following checklist shows all required documents that MUST be submitted to enroll with Fee For Service (FFS) Louisiana Medicaid. Please make certain to complete each required form in its entirety to avoid processing delays.

*Form is included in the **Basic Enrollment Packet for Entities/Businesses**.

**Forms are included here.

Completed	Document Name
☐ *	1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. PE-50 Addendum – Provider Agreement Forms (three pages).
☐ *	3. Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	4. Louisiana Medicaid Ownership Disclosure Information Forms.
☐ *	5. **(If submitting claims electronically)** Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form **and** Power of Attorney Form (if applicable).
☐	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited **(deposit slips are not accepted**).
☐	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (**W-9 forms are not accepted**).
☐	8. Copy of Home Health Agency license issued by Health Standards Section (HSS).
☐	9. To bill for DME services directly: Submit a written request **AND** attach the DME accreditation certificate.
☐	10. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 87 (All Other).

FOR NOW/ROW SERVICES:

☐ **	11. To request NOW Skilled Nursing Services and/or ROW Nursing Services, complete the NOW/ROW Provider Verification Form.

FOR ROW SERVICES:

☐	12. To report "Sub-specialty" for this provider type to provide ROW Nursing Services, use Code 4W (Waiver Services) on Section A of the PE-50.

FOR COMMUNITY CHOICES WAIVER SERVICES:

☐ **	13. To request CCW Skilled Maintenance Therapy and/or Nursing Services, Complete the *"Provider Attestation for the Community Choices Waiver Skilled Maintenance Therapy and Nursing Services"* form.
☐	14. To report "Sub-Specialty" for this provider type to provide one or more of the 4 Community Choices Waiver Skilled Maintenance Therapies on Section A of the PE-50, please **use one of the following codes**: 6T (Community Choices Waiver – Physical Therapy) 7H (Community Choices Waiver – Occupational Therapy) 7G (Community Choices Waiver – Speech/Language Therapy) 3E (Community Choices Waiver – Physical Therapy & Occupational Therapy) 3F (Community Choices Waiver – Physical Therapy & Speech/Language Therapy) 3H (Community Choices Waiver – Occupational Therapy & Speech/Language Therapy) 3L (Community Choices Waiver – Physical Therapy, Occupational Therapy & Speech/Language Therapy) 3R (Community Choices Waiver – All Skilled Maintenance Therapies)
☐	15. To report "Sub-Specialty" for this provider type to provide Nursing Services under the Community Choices Waiver on Section A of the PE-50, please use Code 8N.
☐	16. To report "Sub-Specialty for this provider type to provide Personal Assistance Services under the Community Choices Waiver on Section A of the PE-50, please use Code 5W.
☐	17. To report "Sub-Specialty" for this provider type to provide Nursing Services **AND** Personal Assistance Services under the Community Choices Waiver on Section A of the PE-50, please use Code 9A.

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:

Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Provider Verification for NOW/ROW Services

To Be Completed By the Home Health Agency

Provider Number:	**LA Medicaid Provider #** (leave blank if new applicant)	**National Provider Identifier (NPI)**
Provider Name:		
Physical Address:		
Nursing Services Being Requested:	NOW Skilled Nursing Service Service and ROW Nursing Service ☐ ROW Nursing Service ☐ NOW Skilled Nursing ☐	
Contact Person for questions regarding this form:		
Contact Person Phone Number:		

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct, and
- that I can receive reimbursement for services provided only to those persons within the New Opportunities Waiver (NOW) and/or Residential Options Waiver (ROW), and
- that all Professional Services provided to any NOW and/or ROW participants must be prior authorized before services are rendered, and
- that as a Professional providing services to ROW participants, I have one year paid experience working with people with developmental disabilities as outlined in the ROW Provider Manual, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____, State of _____

on the ____ day of _____, 20 ____.

_____ _____

Print Individual Provider's Name Notary Public Signature

_____

Individual Provider's Signature

Notary Seal or Notary Identification Number (required)

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Provider Attestation for the Community Choices Waiver

Skilled Maintenance Therapy and Nursing Services

PURPOSE

This form confirms that the provider specified below wishes to provide one or more of the Skilled Maintenance Therapy service s and/or nursing services under the Community Choices Waiver program, and attests that the provider will conform to prior approval and reimbursement regulations and policies and that licensed Occupational Therapist, Physical Therapist, and/or Speech Therapist, personnel (as applicable) used will have one full year of verifiable experience working with the elderly.

Provider Number:	**LA Medicaid Provider #** (leave blank if new applicant)	**National Provider Identifier (NPI)**
Provider Name:		
Physical Address:		
Professional Category (choose all that apply):	OT ☐ PT ☐ ST ☐ Nursing ☐	
Contact Person for questions regarding this form:		
Contact Person Phone Number:		

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct;
- That I can receive reimbursement for services provided only to those persons within the Community Choices Waiver;
- That Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare;
- That failure to exhaust these above referenced third party payer sources may subject this/my Medicaid enrolled agency to recoupment of funds previously paid by Medicaid;
- That all Professional Services provided to Community Choices Waiver participants must be prior authorized before services are rendered;
- That as a provider of services to Community Choices Waiver participants, any licensed therapist used will have one full year of verifiable experience working with the elderly; and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

Print Authorized Representative's Name _____ Signature of Authorized Representative _____ Date of Signature _____

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____, State of _____

on the ____ day of _____, 20 ____.

Print Individual Provider's Name _____ Notary Public Signature _____

Individual Provider's Signature _____

Notary Seal or Notary Identification Number (required)

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370