



EPSDT HEALTH AND IDEA – RELATED SERVICES

Chapter Twenty of the Medicaid Services Manual

Issued March 01, 2013

**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

The Louisiana Medicaid program provides, in the school setting, coverage to all Medicaid eligible beneficiaries age 3 through age 20 for all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) health services and medically necessary health services to correct or ameliorate a child's disability or chronic health condition pursuant to §1905(a) of the Social Security Act. All Medicaid services must be provided by local education agencies (LEAs) to children who attend public school and private schools in Louisiana in order to be eligible for reimbursement. EPSDT health services and medically necessary health services must be performed by, or under the direction of, a licensed provider within the scope of their practice under state law and authorized by the student's written plan of service: individualized education plan (IEP), a section 504 accommodation plan pursuant to 34 Code of Federal Regulations (CFR) § 104.36, individualized health care plan (IHP) or other written plans of care (POC) as long as it is ordered and performed by individuals licensed to authorize the services included. Louisiana Medicaid services provided in schools is effective March 20, 2019, with the Centers for Medicare and Medicaid Services (CMS) approval of Louisiana Medicaid State Plan amendment LA SPA TN 19-0005.

Service Exclusions

1. These services are not covered if they are performed for educational purposes (e.g. academic testing), or, if as the result of the assessment and evaluation, it is determined the service is not reflected in a written plan of service or not determined to be medically necessary; and
2. Medicaid does not reimburse for social or educational needs.

Early and Periodic Screening, Diagnostic and Treatment

EPSDT is the component of the Louisiana Medicaid Program that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

Definitions

Early: Assessing and identifying problems early.

Periodic: Checking children's health at periodic, age-appropriate intervals.

Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.

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Diagnostic: Performing diagnostic tests to follow up when a risk is identified.

Treatment: Control, correct or reduce health problems found.

Medically Necessary Health Services

1. Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine; and
2. Authorization must be ordered and performed by individuals acting within the scope of their license.

Reimbursement Methodology

Medicaid services provided in schools allows claiming for LEAs using certified public expenditures to provide for the State match to federal funds. LEA employees are able to claim their salaries, benefits, taxes and vendor cost for the time spent providing services to students. In order to calculate the claimable amount of the employees' salaries, the LEA must participate in the quarterly statewide time study. A cost report provided by the Louisiana Department of Health (LDH) is used to calculate Medicaid eligible reimbursement due to LEAs on an annual basis. Participating LEAs are subject to periodic audits or reviews of the information submitted in the annual cost report.

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COVERED SERVICES**School-Based Medicaid Program Expansion**

Effective for dates of service on or after March 20, 2019, Louisiana Medicaid has expanded the covered services provided by a local education agency (LEA) in the School-Based Medicaid Program (SBMP) to include the following:

1. Health services provided by an LEA and licensed practitioner employed by the LEA; and
2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) health services on the Medicaid approved Periodicity Table may be reimbursed when provided by a licensed practitioner within the scope of their practice. All other health services must be included in a completed authorizing document pursuant to 34 Code of Federal Regulations (CFR) § 104.36, as follows:
 - a. Individualized Education Plan (IEP);
 - b. Section 504 Accommodation Plan;
 - c. Individualized Health Care Plan (IHCP); or
 - d. Included in otherwise medically necessary documentation, and include medical services that are provided to students pursuant to an IHCP, and/or services that are otherwise medically necessary.

NOTE: Payment for services provided pursuant to an IEP will continue to be provided under the expanded program.

Services provided in a school setting will only be reimbursed for beneficiaries who have been determined eligible for Title XIX and the Individuals with Disabilities Education Act (IDEA), Part B services with a written service plan which contains medically necessary services ordered and rendered by a physician or other licensed qualified practitioner who provides these services as part of their respective area and within the scope of their licensure under Louisiana state law. Licensed, qualified practitioners shall also be responsible for supervising their respective assistants in the same manner. LEAs are required to keep a copy of Louisiana licenses showing full name and dates

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of licensure reflecting the period services were provided onsite.

Service Exclusions

1. These services are not covered if they are performed solely for educational purposes (e.g. academic testing) or as the result of the assessment and evaluation it is determined the service is not reflected in a service plan or not determined to be medically necessary; and
2. Medicaid does not reimburse for social or educational needs.

Covered Services Provided by Local Education Agencies

1. Audiology Services;
2. Occupational Therapy (OT) Services;
3. Physical Therapy (PT) Services;
4. Speech-Language Services;
5. Nursing Services - Medically necessary services that are directly related to an individualized health plan (IHP) and/or a physician's written order, when required. The following school-based nursing services are covered:
 - a. Implementation of physician's orders;
 - b. Chronic Medical Condition Management and Care Coordination;
 - c. Medication administration;
 - d. EPSDT Nursing Assessment/Evaluation Services (IHP not required); and
 - e. EPSDT Program Periodicity Schedule for Screenings (vision and hearing) (IHP not required).
6. Behavioral Health Services: The professional requirements for Licensed Master Social Workers (LMSWs) or Certified Master Social Workers (CMSWs) and Certified School Psychologists include the following:

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- a. LMSWs or CMSWs practicing under the supervision of a Licensed Clinical Social Worker (LCSW); and
- b. Certified School Psychologists practicing under the supervision of a licensed psychologist.

NOTE: This is not an inclusive list of Behavioral Health professionals.

7. Special Transportation Services services include:

- a. Travel to and from school and between schools or school buildings on a day when a covered service is to be rendered on school premises and special transportation is included as a separate service;
- b. Travel to and from off-site premises the same day when the beneficiary is receiving a covered service that is on the child's IEP to be rendered off-site and special transportation is included in the IEP as a separate service; and
- c. Use of a specially adapted vehicle (such as a specially adapted bus, van or other vehicle such as a wheelchair lift, special harness, safety vest or special car seat).

8. Documentation for Transportation Services:

- a. Trip logs must be completed for all students who ride LEA designated specialized/adapted vehicles each day; and
- b. This information must be cross-referenced with attendance records and the documentation of receipt of a covered IDEA Health Service that is included in the student's service plan, on the same day as transportation.

New Covered Services Provided by Local Education Agencies

The following are new covered services provided by LEAs (effective as of March 20, 2019):

- 1. Optometry Services;
- 2. Physician Services;

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3. Respiratory Therapy; and
4. Applied Behavior Analysis (ABA)-based therapy:
 - a. Medicaid covered ABA-based therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior;
 - b. ABA-based therapy services teach skills through the use of behavioral observation and reinforcement, or prompting, to teach each step of targeted behavior. ABA-based therapy services are based on reliable evidence and are not experimental; and
 - c. Medicaid covered ABA-based therapy must be medically necessary and delivered in accordance with the beneficiary's IEP, section 504 accomodation plan, or IHCP.

Professional Requirements

1. Services shall be provided by, or under the supervision of a:
 - a. Behavior analyst who is currently licensed by the Louisiana Behavior Analyst Board;
 - b. Licensed psychologist, or by a licensed medical psychologist, working within the schope of their license; and/or
 - c. Licensed behavior analysts.

NOTE: Licensed psychologists, and licensed medical psychologists shall be reimbursed for Medicaid covered therapy services that are medically necessary, prior authorized by the Medicaid Program or its designee, and delivered in accordance with the beneficiary's treatment plan.

2. Licensed behavior analysts shall meet the following criteria:
 - a. Be licensed by the Louisiana Behavior Analyst Board;
 - b. Be covered by professional liability insurance in the amount designated by

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- the State;
- c. Have no sanctions or disciplinary actions on their Board Certified Behavior Analyst or Board Certified Behavior Analyst-Doctoral certification and/or state licensure;
 - d. Shall not have Medicare/Medicaid sanctions or be excluded from participation in federally-funded programs; and
 - e. Have a completed criminal background check according to the State's requirements.
3. Certified assistant behavior analysts shall meet the following criteria:
- a. Be certified by the Louisiana Behavior Analyst Board;
 - b. Work under the supervision of a licensed psychologists, licensed medical psychologists, and licensed behavior analyst, with the supervisory relationship documented in writing;
 - c. Have no sanctions or disciplinary actions, if State-certified or Board-certified;
 - d. Not have Medicare/Medicaid sanctions or be excluded from participation in federally-funded programs; and
 - e. Have a completed criminal background check according to the State's requirements.
4. Registered line technicians shall meet the following criteria:
- a. Be registered by the Louisiana Behavior Analyst Board;
 - b. Work under the supervision of a licensed psychologists, licensed medical psychologists, and licensed behavior analyst, with the supervisory relationship documented in writing;
 - c. Have no sanctions or disciplinary actions, if State-certified or Board-certified;

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- d. Not have Medicare/Medicaid sanctions or be excluded from participation in federally-funded programs; and
- e. Have a completed criminal background check according to the State's requirements.

Supervisory Requirements

- 1. Licensed behavior analysts shall provide supervision to certified assistant behavior analysts and registered line technicians;
- 2. Supervision is included in the State's Scope of Practice Act for licensed behavior analysts and they shall assume professional responsibility for the services rendered by an unlicensed practitioner; and
- 3. Licensed psychologists and licensed medical psychologists are authorized to provide supervision to non-licensed practitioners.

Services Provided by Local Education Agencies

Applied Behavior Analysis services rendered in school-based settings must be provided by, or under the supervision of a behavior analyst currently licensed by the Louisiana Behavior Analyst Board, a licensed psychologist or licensed medical psychologist.

NOTE: Payment for services must be billed by the licensed professional.

School-Based Medicaid Program – Personal Care Services**Overview**

In the expansion of covered service provided by a LEA in the Louisiana SBMP, Personal Care Services (PCS) will be covered when ordered by a licensed practitioner within the scope of their practice. PCS is defined as services necessary for a student with disabilities to participate in the daily activities of a school setting. To be eligible for PCS in school, the student must be dependent in, and need assistance, for one or more of the activities of daily living (ADL).

Dependent in an ADL means the student requires cuing and stand-by supervision or hands-on assistance from a PCS worker to begin and complete an ADL. ADLs include the following:

- 1. **Grooming:** Assistance with basic hair care, ensuring clothes are clean and

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- properly fastened; and care of eyeglasses and hearing aids (confirming batteries work, positioning aids);
2. **Eating:** Assistance with hand washing and applying orthotics required for eating, as well as transfers and feeding, excluding enteral tube feeding;
 3. **Transfers:** Assistance with transferring the student from one seating or reclining area to another;
 4. **Mobility:** Assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a student;
 5. **Positioning:** Assistance with positioning or turning a student for necessary care and comfort;
 6. **Toileting:** Assistance with bowel or bladder elimination and care, including transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin and adjusting clothing, excluding catheterization; and
 7. **Behavioral Cuing:** Assistance and support for behavioral management, maintain and sustain on task behavior and assist in completion of tasks by offering behavioral prompts.

Other Health-Related Procedures and Tasks

Health-related procedures and tasks may be delegated by a **licensed qualified health care professional** to be performed by a PCS worker. Students must have a plan of care (POC) with interventions, tasks and health related procedures listed and authorized by a licensed provider within their scope of practice. Documentation of training and qualifications must be included in the employee file of the PCS worker. Documentation of qualifications and skill competency must be in the PCS personnel file.

Non-covered Services

PCS are not covered by the Louisiana School-Based Medicaid Program under the following circumstances:

1. ADL assistance provided to a student by a PCS worker who does not meet minimum qualifications for PCS role or worker and whose skills have not been

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documented and verified by a licensed, qualified practitioner;

2. Services provided by substitutes who have not received the required training and supervision;
3. Services provided by a parent, sibling, grandparent, stepparent, legal guardian or foster parent;
4. Services provided to a student that are age appropriate and would reasonably require assistance for a student of that age;
5. Academic assistance and support, for example:
 - a. Helping a student with school assignments, projects or activities.
6. Extracurricular support provided to a student for participation in activities before and after school including sports, clubs, class projects, tutoring, music lessons, etc.

Service Plans

A PCS POC is a document that contains the description of the medically necessary services a student will need during the school day with specific instruction on how the services should be provided, including frequency and duration. All PCS that are covered by Medicaid must be listed in an approved POC and authorized by a licensed provider within their scope of practice.

The PCS POC must be completed within the first week of starting the personal care assistance services and must be reviewed semi-annually (rolling sixth months). All health care POCs must be updated when there is a change in the student's condition or need for PCS. A copy of the most current PCS health care plan must be immediately available to the person who is providing the PCS services.

POC documents utilized in the state of Louisiana include but are not limited to the following:

1. IEP;
2. Section 504 Accommodation Plan;
3. IHCP; and

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4. Other written plans for health services that are deemed medically necessary.

Required Components of the Personal Care Service Plan

Components of a PCS POC must include the following:

1. Start and end date of the POC;
2. Student's name, date of birth (DOB), demographic information including name of parent, guardian or responsible party, and emergency contact information;
3. List of special instructions and /or procedures required to meet the student's specific needs;
4. A clear summary including the diagnosis and Current Procedural Technology (CPT) code, condition, sign, or symptom that is creating the need for the service, and the International Classification of Diseases (ICD) 10 codes as applicable; and
5. Number of days that services are required per week. Total time requested to complete each activity each week.

Service Limits

PCS is not subject to service limits. Services provided shall be based on the individual health requirements of the student and medical necessity for the covered services. The CPT code is T1019, modifier EP, unit of service 15 min. Please see EPDST Health and IDEA – Related Services fee schedule at https://www.lamedicaid.com/Provweb1/fee_schedules/EPDST_Fee.htm for details.

Record Keeping

The school must maintain required written or electronic documentation for five years from date of service. Required documentation includes the following:

1. Student name and DOB;
2. Authorizing/prescribing provider name, credentials, and NPI number;

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3. POC start date, reassessment date and time;
4. List of services required/authorized, and time required to complete services;
5. Documentation of services provided including signature of provider;
6. Records must be complete, accurately documented, timely, and organized; and
7. LEAs must make PCS direct care worker records available to the Louisiana Department of Health (LDH) and/or its designee upon request. The provider LEA shall be responsible for incurring the cost of copying records for LDH or its designee.

Personal Care Services Worker Qualifications

To be eligible to provide PCS, the person must meet all of the following requirements:

1. Be a resident of the state of Louisiana;
2. Be at least 18 years of age;
3. Have completed a General Educational Development (GED) program or high school equivalent;
4. Hold current Pediatric cardiopulmonary resuscitation (CPR) and First Aid certification;
5. Be someone other than a parent, grandparent, stepparent, paid legal guardian or foster parent;
6. Completed the required skills and procedure training and supervision provided by a licensed healthcare professional within their scope of practice under Louisiana state law;
7. Demonstrate the ability to effectively communicate with the student, supervising and ordering licensed, qualified practitioner, school healthcare personnel, and parents of the minor students;
8. Be able to appropriately respond to the student's needs and immediately report significant changes in the student's condition to the supervising licensed

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practitioner;

9. Be able to maintain required documentation daily including, but not limited to, PCS activity checklists or logs, student's response to procedures and activities when appropriate, and communication with the licensed practitioner and emergency contacts; and
10. Be employed by the school district to provide PCS or be under contract with school district or agency that has a PCS service agreement with the district.

Personal Care Services Worker Supervision

A licensed, qualified practitioner must supervise anyone providing personal care assistance using direct training, observation, and return demonstrations. These qualifications should be based on the service provided, the license, scope of practice, professional responsibilities, and professional experience. For example, ADLs such as positioning, transfers or toileting may be taught and supervised by a physical therapist or professional nurse. This ADL example of positioning, etc., would not be taught or supervised by a speech pathologist, audiologist, school psychologist, social worker or special education teacher because it is not within the scope of practice of those professionals. LEAs are required to keep a copy of the Louisiana licenses showing full name and dates of licensure reflecting the period services were provided onsite.

Supervision of the services requires the following:

1. Confirming that the PCS worker meets the qualifications to provide the services;
2. Appropriately assigning tasks to the PCS worker;
3. Providing training and ensuring competency of the PCS worker in meeting the individual needs of the student before services are provided;
4. Verifying that the PCS service plan, is completed and signed by authorizing provider within the first week after the start of services and updated as needed;
5. Reviewing the PCS worker's documentation of services provided; and
6. Documenting training, communications, initial and periodic evaluations of the PCS worker provided.

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Personal Care Services Worker Training and Responsibilities

To provide PCS, the PCS worker must complete the following training activities:

1. Current pediatric CPR and pediatric First Aid certification;
2. Complete an annual skills checklist, signed off by licensed, qualified practitioner practicing within their scope of practice;
3. Complete training and an orientation checklist given by the licensed, qualified practitioner on the specific needs of the individual student as identified in the written PCS service plan;
4. Be aware of the other support services provided for this student;
5. Be knowledgeable about the PCS service plan and emergency procedures before performing services;
6. Display competency in providing the required service according to the student's service plan;
7. Follows school / district policies for communication to report changes in the student's condition or behaviors to the appropriate person; and
8. Understand the documentation requirements for the services provided.

Individuals who provide coverage in the PCS worker's absence must meet all staffing requirements for the PCS worker; and including training.

Continuing Education

Annually thereafter, the provider shall ensure each PCS worker either contracted or employed, satisfactorily demonstrates the required skills and proficiencies to ensure continuing competence.

NOTE: Initial orientation and ongoing supervision shall not be considered for meeting this requirement.

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Personal Care Services Worker Evaluations**Initial Evaluation**

The licensed, qualified practitioner must complete an initial evaluation of the PCS worker through direct observation of the PCS worker's skills within the first 14 days of starting to provide regularly scheduled services to the student. After the initial evaluation, subsequent student assignments do not require direct observation of each PCS worker providing services unless determined by the licensed, qualified practitioner based on the needs of the student and the PCS worker's ability to meet those needs.

At the initial supervisory visit, the licensed, qualified practitioner must evaluate services provided by PCS worker for the following:

1. Adequacy of the tasks and activities in the PCS service plan to meet the needs of the student;
2. The PCS worker's understanding of the student's needs, including the following:
 - a. Knowledge of the POC;
 - b. When to notify the licensed practitioner of concerns or changes in the condition or behavior of the student; and
 - c. When emergency actions and contacts are required.
3. The PCS worker's demonstrated ability to competently carry out the tasks and activities, as trained; and
4. Changes in the needs of the student requiring revision of the PCS care plan or additional training of the person providing PCS services.

Telemedicine/Telehealth

Telemedicine/telehealth is not a covered service, but is a service delivery method. Louisiana Medicaid encourages the use of this delivery method, when appropriate, for any and all healthcare services (i.e., not just those related to COVID-19 symptoms). Louisiana Medicaid allows for the telemedicine/telehealth mode of delivery for many common healthcare services.

1. Permissible Telecommunications Systems:

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- a. All services eligible for telemedicine/telehealth may be delivered via an interactive audio/video telecommunications system;
- b. A secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant platform is preferred, if available. However, for the duration of the COVID-19 event, if a HIPAA-compliant system is not immediately available at the time it is needed, providers may use everyday communications technologies such as cellular phones with widely available audio/video communication platforms;
- c. Providers should follow guidance from the Office for Civil Rights at the Department of Health and Human Services (DHHS) for software deemed appropriate for use during this event;
- d. For the duration of the COVID-19 event, in cases where an interactive audio/video system is not immediately available at the time it is needed, an interactive audio-only system (e.g., telephone) without the requirement of video may be employed, unless noted otherwise;
- e. For use of an audio-only system, the same standard of care must be met, and the need and rationale for employing an audio-only system must be documented in the clinical record; and
- f. Please note, some telemedicine/telehealth services described below require delivery through an audio/video system due to the clinical nature of these services. Where applicable, this requirement is noted explicitly.

Telemedicine/Telehealth Site Criteria

- 1. **Originating Site:** The originating site refers to where the patient is located. There is currently no formal limitation on the originating site and this can include, but is not limited to, the patient's home; and
- 2. **Distant Site:** The distant site refers to where the provider is located. The preferred location of a distant site provider is in a healthcare facility. However, if there is disruption to a healthcare facility or a risk to the personal health and safety of a provider, there is no formal limitation as to where the distant site provider can be located, as long as the same standard of care can be met.

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Other Requirements

As always, providers must maintain the usual medical documentation to support reimbursement of the visit. In addition, providers must adhere to all telemedicine/telehealth-related requirements of their respective professional licensing boards.

Reimbursement

Reimbursement for services delivered through telemedicine/telehealth is at the same level as reimbursement for in-person services.

Providers must indicate place of service 02 and must append modifier -95.

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SECTION 20.2: ELIGIBILITY CRITERIA**PAGE(S) 1**

ELIGIBILITY CRITERIA

All Medicaid eligible children, birth through 21st birthday, are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

1. Medicaid eligible children ages birth up to third birthday are eligible for EPSDT services through the EarlySteps program. Please see the EarlySteps program manual for more information;
2. Medicaid eligible children ages 3 through age 20 are eligible for EPSDT services through a participating local education agency (LEA). The LEA must be an approved EPSDT provider (type 70) with Louisiana Medicaid;
3. Health services must be provided by an LEA and licensed practitioner employed by the LEA. EPSDT services on the Medicaid approved periodicity table may be reimbursed when provided by a licensed practitioner within the scope of their practice. All other health services, such as the following, must be included in a completed authorizing written plan of care (POC) pursuant to 34 Code of Federal Regulations (CFR) § 104.36:
 - a. Individualized Education Plan (IEP);
 - b. 504 accommodation plan;
 - c. Individualized Health Care Plan (IHCP); or
 - d. A medically necessary written POC, including medical services.

Medically necessary services must be prescribed by a licensed practitioner practicing within their scope of practice and performed by practitioners with a license or certification under the direction and supervision of a licensed practitioner. Unlicensed/certified practitioners practicing under the direction and supervision of a licensed practitioner must have received education and demonstrated competency for each health care service provided. The LEA must substantiate that all requirements are met and maintain documentation of education and demonstrated competency for unlicensed/certified practitioners. Licensed practitioners assume professional liability for unlicensed/certified practitioners under their direction and supervision and within their scope of practice.

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PROVIDER REQUIREMENTS

To receive Medicaid reimbursement for medically necessary health services provided to children ages 3 through the age of 20, a local education agency (LEA) must be enrolled and in good standing as a provider of Medicaid services in schools, provider type 70. All Medicaid providers are enrolled in accordance with applicable requirements for the provider's designated type and specialty. Medicaid provider enrollment is facilitated by Medicaid's fiscal intermediary (FI).

The enrollment packet can be found at:

https://www.lamedicaid.com/provweb1/Provider_Enrollment/PT70_EPSDTHHealthServices.pdf

As part of the documents required for enrollment in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) health services, the LEA (school board) must certify and assure that it does have the state and/or local match funds available to draw down the federal share of the EPSDT health services reimbursements for services provided to children with special needs. The LEA must also certify and assure that by participating in this program and qualifying for matching funds, no federal funds received by or available to the LEA will be used for matching or recapturing federal funds for reimbursement for provision of Medicaid covered services.

Local Education Agency Responsibilities

The LEA shall ensure the following:

1. Practitioners who provide EPSDT services are employed or contracted by the LEA (Medicaid provider);
2. Licensed practitioners who provide services to children meet professional requirements of the state licensing board for their specialty and practice within the scope of practice defined by the professional licensure board;
3. All practitioners and staff who provide EPSDT services or other authorized health services to students must operate within their professional licensure and scope of practice or certification under the supervision of a licensed practitioner; and
4. Licensed practitioners must assume professional liability for unlicensed/certified staff who provide health services to children under their supervision and within their scope of practice. The provider (LEA) shall maintain documentation of current licensure, training, and skill verification for all practitioners and staff who provide health services to children.

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Additional Information required for Claims Submission – National Provider Identifier

Effective with dates of service on or after **May 31, 2022**, a physician or non-physician practitioner within their defined scope of practice must authorize all LEA medical services prior to submitting claims to Medicaid¹. The only exceptions to this authorization include evaluations, assessments, screenings, and psychotherapy.

Effective for claims with dates of service on and after **May 31, 2022**, LEA billing providers will be required to enter the name and national provider identifier (NPI) number of the “ordering provider” in the ordering fields of the hard copy (CMS-1500) and electronic (837P) claims²- **with qualifier DK**.

The ordering provider NPI number must be:

1. For an individual (NPI type 1) and not an organization or practice;
2. Enrolled in legacy Medicaid also known as “fee-for-service (FFS),” as a fully participating provider for the date of service; and
3. Have licensing authority to order services within their defined scope of practice.

The ordering provider may be for an individual physician or other licensed practitioner associated with the student’s authorizing plan of care (POC) (i.e. individual education plan (IEP), 504 Accommodation plan, individualized health care plan (IHCP), or included in otherwise medically necessary documentation) or may be the actual provider performing the service (rendering provider) if they have licensing authority to order the service.

Phase 1: Educational messaging with edit 047 will begin for claims with dates of services on and after **May 31, 2022**, to alert LEA billing providers that the identification of the ordering provider is missing, incomplete, not enrolled in FFS Medicaid for the date of service, or does not have licensing authority to order the service.

Phase 2: Effective with dates of services on and after **September 30, 2022**, Medicaid will turn edit 047 to deny LEA billing provider claims that fail to meet the ordering provider requirements.

The following is a list of specific health professionals who are qualified ordering, prescribing, and referring (OPR) practitioners for services within their defined scope of practice:

¹ Including medication management administration and chronic disease management.

² 42 CFR 455.440

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1. Audiologist;
2. Speech language pathologist;
3. Certified nurse midwife;
4. Clinical nurse specialist;
5. Nurse practitioner (NP);
6. Optometrist;
7. Oral surgeon;
8. Physician;
9. Physician assistant;
10. Podiatrist;
11. Psychologist; and
12. Physical therapist.

Please refer to the following links for more information:

1. Process for registering with Medicaid as a provider:
 - a. Instructions for getting an NPI number: <https://nppes.cms.hhs.gov/#/>; and
 - b. Instructions for enrolling in FFS Medicaid: To be announced.
2. Instructions for billing Medicaid for services provided:
 - a. Instructions for billing with an ordering provider on hard copy claims (CMS-1500):
https://www.lamedicaid.com/provweb1/billing_information/CMS_1500_Professional-Instructions.pdf; and

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- b. Instructions for billing with ordering provider on electronic claims (837P):
https://www.lamedicaid.com/provweb1/HIPAABilling/837_Health_Care_Claim_Professional.pdf.

Random Moment Time Study - Failing to Respond

LEAs must make every effort to ensure all time study moments are completed and submitted by all participants. Participants have 48 hours from the time of the moment to complete each moment. Reminder emails are sent to the participant and the Medicaid coordinator each morning until the moment expires. When a time study moment has expired, it can no longer be completed and is deemed not returned. Any LEA that fails to return at least 85 percent of their moments from the time study for two quarters in a cost report year for any program will be suspended from that program for the entire cost report year.

The time study percentage used for cost reimbursement calculation is an average of the four quarterly statewide time study results for each school based Medicaid program. LEAs must participate in all four time study quarters to be reimbursed all cost for the fiscal year (FY). Any LEA that does not submit a cost report for any program for which any billings were submitted will be required to pay back any billing dollars received for that cost report year. This will be handled in the school based claiming cost settlement process.

Care Coordination

Care coordination between the LEAs and the child's primary care provider (PCP) is required to reduce or avoid duplications of services whenever possible. Care coordination is a responsibility of all health care providers who participate in the care of a student and must be carried out in a manner that complies with privacy and confidentiality requirements in accordance with state and federal law and regulations including Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA). It is the expectation that LEAs, practitioners, and staff will participate in multidisciplinary team (MDT) and health conferences and other planning activities with other members of the student's health care team and parents when requested to ensure provision of coordinated health services to students.

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SECTION 20.4: PROGRAM REQUIREMENTS**PAGE(S) 2**

PROGRAM REQUIREMENTS

The Louisiana Department of Health (LDH) requires that all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) health services providers enrolled in Medicaid give the following statement, in writing, to each Medicaid-eligible beneficiary and/or caregiver at the time a written plan of care (POC) is developed:

“Your child is eligible to receive services to meet their needs. The services may be provided by the school system, or you may take your child to another provider that accepts Medicaid.”

EPSDT health services program requirements for reimbursement are as follows:

1. All services must be furnished through one of the following child-specific authorizing documents: individualized education plan (IEP), 504 plan, individual health plan (IHP) or medically necessary written POC. Only services provided through one of these care plans may be billed to Medicaid under the EPSDT’s Health and School-Based Services program;
2. Local education agencies (LEAs) are eligible to receive reimbursement for services provided to children ages 3 through age 20;
3. Healthcare practitioners and staff must be licensed and qualified to provide the services that meet state and Medicaid practitioner standards regarding professional licensure, certification, and supervision. Current documentation of practitioner and staff licensure, certification, education and skill verification must be provided to Medicaid as part of the enrollment and monitoring process. Refer to Section 20.1 of this manual chapter for applicable qualifications;
4. All Medicaid reimbursement from health services provided to students must be spent on the provision of health related services to children regardless of their Medicaid status;
5. Expenditures should be prioritized for expanding service delivery through additional employed or contracted staff before allocating funds for equipment and supplies, administrative support activities, capital improvements, or meeting the individual needs of children with disabilities; and
6. Medicaid funds shall not be used for strictly educational or non-medical purposes.

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Type One and Three Charter Schools in Orleans Parish

Upon enrollment, Orleans Parish Charters will be required to submit acceptable documentation (board minutes, letter from the school board, etc.) that authorizes the charter school to act as its own LEA. Likewise, in order to receive a cost settlement, confirmation that authorization is still in good standing with the school board will be required to accompany the submission of the cost report. Failure to provide this documentation at the time when the cost report is filed will cause the cost report to be non-compliant. LDH is currently exploring language to align the LDH school-based cost report procedures with rules that guide other providers that are required to submit cost reports.

Updated Contact Information

It is imperative that LDH is immediately notified of any contact changes such as name, email address, or phone number for the following positions:

1. Medicaid Coordinator;
2. Business Manager; and
3. Special Education Director.

Closing LEAs

LEAs that terminate business must notify the Louisiana Medicaid fiscal intermediary (FI), immediately, and provide instructions to LDH/Rate Setting and Audit and/or the Louisiana Department of Education (LDOE) as to the final disposition of cost settlements and previous dollars owed to or from Louisiana Medicaid. The following criteria must be met regarding LEAs:

1. For LEAs that transfer to new management companies and owe LDH, the new owners shall assume all obligations of repayment for the new LEA. Overpayments will be recouped from future earnings of the new management company; and
2. For separating LEAs that are owed reimbursements, LDH will issue a supplemental check to the LEA or the new management company; however, failure to provide instructions to LDH within 10 days of closure may result in forfeiture of payment.

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SECTION 20.5: RECORD KEEPING**PAGE(S) 3**

RECORD KEEPING

Providers must make all records of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services provided to Medicaid beneficiaries available to the Bureau of Health Services Financing (BHSF) upon request. This effort will require cooperation, coordination and communication between the **local education agencies (LEAs)** and the student's Medicaid **primary care provider**. **The following documentation must be maintained for at least six years from the date of payment on all children for whom claims have been submitted:**

1. Dates and results of all health services provided to students, including EPSDT services and evaluation/diagnosis provided in the interest of establishing or modifying an individualized education program (IEP), 504 Plan, individualized health plan (IHP) or other written plan of care (POC) for all health services, including documentation of the health service provided, student's response to the health service, and disposition of student after health service;
2. Any specific tests performed and copies of evaluation and diagnostic assessment reports signed by the individual practitioners and supervisors, if appropriate, that conducted the assessment;
3. Copies of the IEP, 504 Plan, IHP or POC for all health services documenting the need for the specific therapy or treatment services, including the time and frequency required when appropriate;
4. Documentation of the provision of health services by all practitioners, including:
 - a. Dates and times of services;
 - b. Health intervention/service provided;
 - c. Student's response to services;
 - d. Billing forms;
 - e. Log books;
 - f. Reports on services provided; and
 - g. The child's record(s) signed by the individual providing the services and signature of supervisor, if appropriate.

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NOTE: When electronic documentation system is utilized, electronic health record with confidential date/time stamp, logon of provider, and ability to log/track any changes to provider documentation is required;

5. All immunizations provided must be documented in Louisiana’s immunization database (LINKS);
6. A copy of the IEP, 504 Plan, IHP or POC authorizing documents for all health services provided. Documentation of notification to parents of any health services provided and their results; and
7. Documentation of care coordination efforts with other members of the student’s health care team, including primary care providers (PCPs).

Documentation Components

Documentation of each individual or group session must include the following information:

1. Eligible child’s full first and last name;
2. Date of service;
3. Type of service (Current Procedural Terminology (CPT) Code);
4. If a group session, the number of children in the group;
5. Time the service begins;
6. Length of time the service was performed (time may be recorded based on start and stop times or length of time spent with eligible child);
7. Description of service activity or method used;
8. Description of child’s response to the service;
9. Eligible child’s progress toward established goals; and
10. Signature of service provider, title, and date.

All documentation must be signed, titled, and dated by the licensed provider of the services at the time services are rendered. Late entries must be noted accordingly. Therapy session attendance forms alone do not constitute documentation, unless they meet all of the service documentation

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requirements outlined above.

Time must be documented by the provider of the services and by the supervising practitioner therapist if supervision is required. Services provided may also be documented electronically in a Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) compliant electronic health record. The electronic system must:

1. Include all information listed above;
2. Have the capability to produce reports for the provider of the services, the supervising therapist (if required) and for auditing purposes as needed; and
3. Have the capability to track all changes or modifications to a record including the time, date and author of the change.

Staff may be required to sign the reports to certify the services were provided as reported.

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REIMBURSEMENT

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) health services and Medicaid services provided in schools, are reimbursed according to the methodology detailed below.

Cost Reporting

Payroll/Vendor Cost - Total annual salaries and benefits, taxes and vendor cost paid based on payroll record from each local education agency's (LEA's) Payroll/Benefits or Accounts Payable System. These amounts will be reported on the Louisiana Department of Health's (LDH's) direct services cost report form for all direct service employees that participated in the random moment time study. Vendors and vendor costs are added to the cost report by each LEA.

Adjusted Payroll Cost – Total direct cost is reduced by funding percentage to remove any non-state or local amounts from reported salaries, benefits, taxes and vendor costs. The cost reported should not include any amounts for staff or vendor whose compensation is 100 percent reimbursed by a funding source other than state/local funds.

Allocation of Cost to Direct Services - A time study is used to determine the percentage of time EPSDT service providers spend providing EPSDT direct services as well as the percentage of time EPSDT service providers spend completing general and administrative services. Total general and administrative time is reallocated to the percentage of all other activities based on the percentage of time spent on each respective activity. This percentage is multiplied by total adjusted payroll cost as determined by the adjusted payroll cost base to allocate cost to Medicaid services provided in schools. The product represents direct service cost.

NOTE: Vendors do not participate in any EPSDT time study and therefore this percentage is not applied to vendor cost.

Indirect Cost - Indirect cost shall be determined by multiplying each LEA's indirect rate (percentage) assigned by the Department of Education by total direct cost. The sum of direct cost and indirect cost shall be the total employer direct service cost.

Medicaid Eligibility Rate – The Medicaid eligibility rate is calculated by dividing the number of Medicaid enrolled students in the LEA to all students in the LEA. To determine the amount of cost that may be attributed to Medicaid, the total direct service cost is multiplied by each LEA's Medicaid eligibility rate. This results in total cost that may be certified as Medicaid's portion of cost of Medicaid services provided in schools.

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Billing for Services

LEAs must bill for all EPSDT services performed within one year of the date of service. The dollars received from these claims represent an interim payment for services performed.

Centers for Medicare and Medicaid Services (CMS) requires each LEA to bill for all Medicaid services provided. CMS and the Office of Inspector General (OIG) rely on this billing data for documentation of the number of services provided by each LEA, and the billing data give them a mechanism to compare the cost reimbursed to the number of services being provided. If there are no claim submissions within an 18 month period, the State Medicaid Management Information System (MMIS) automatically terminates eligibility of a provider number making the LEA MEDICAID INELIGIBLE. Any LEA that is Medicaid ineligible will have all interim claims denied, and its cost report for all the programs in which the LEA participated will be rejected.

Reconciliation of Local Education Agency Certified Costs and Paid Claims

Each LEA must complete and submit an EPSDT Direct Services Cost Report for each program in which they are participating. The cost report(s) shall be received by LDH no later than five months after the fiscal year (FY) end.

The Department will reconcile the total expenditures (both state and federal share) for each LEA's services. The Medicaid certified cost expenditures from the cost report(s) will be reconciled against the interim claims paid by LDH's fiscal intermediary (FI) for each EPSDT program for each cost report year. The Department will issue a notice of final settlement, after all reviews that denotes the amount due to or from the LEA. This reconciliation is inclusive of all services provided by the LEA.

Cost Report Calculation:

State/Local Cost * Time Study % * (1+Indirect Cost Rate) * Medicaid Eligibility Rate = Certified Cost

Cost Settlement Calculation:

Certified Cost * Federal Medical Assistance Percentage = Federal Share of Certified Cost

Federal Share of Certified Cost – Interim Billing Claims – LDH Admin Fee = Fed. Share Due to (from) the LEA

Charter School Billing Under One Tax Identification Number (Parent Companies)

It is the responsibility of each charter school to ensure that its Medicaid provider numbers remains active. In the event that a charter school's provider number under the umbrella of the parent

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company becomes inactive, it may cause the cost report settlement for all of the schools under that tax identification number (TIN) to become ineligible for cost settlement.

All participating LEAs are required to maintain an active status with Medicaid. If an LEA's Medicaid provider number become inactive or if one LEA of a group that shares a single tax identification becomes inactive, it may cause the entire cost report to be denied and the cost settlement forfeited.

Cost reports must be submitted annually. The due date for filing annual cost reports is November 30. There shall be no automatic extension of the due date for filing of cost reports. If an LEA experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon written request submitted to the Department prior to the due date. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for situations beyond the LEA's control.

Cost reports that have NOT been received by the due date will be deemed non-compliant and may be subject to a non-refundable reduction of five percent of the total cost settlement. This reduction may be increased by an additional five percent each month until the completed cost report is submitted or the penalties total 100 percent. LEAs that have not filed their cost report by six months or more beyond the due date cannot bill for services until the cost report has been filed.

Change in School-Based Claiming Settlements

School-based claiming has always been separated by "program". Each program has its own time study and cost report based on the cost and billing data calculations.

The individual cost settlement amounts for each program (Therapy Services, Behavioral Health Services, Nursing Services, Personal Care Services (PCSs), and Other Medical Direct Services) will be combined into one cost settlement for the LEA. As has been done in prior years, settlement letters will be sent to the LEA with the individual final cost reports for record-keeping.

Medicaid Administrative Claiming (MAC) cost reports are derived by using the MAC-related time study results and costs related to each of the EPSDT programs. All costs will have been certified by the LEA with the EPSDT cost report, so no additional signatures or certifications are required for MAC; therefore, MAC cost reports shall remain separate.

Vendor Rate per Service for Providing EPSDT Services

Beginning with the 2021 cost report year, vendors will be reimbursed based on a **rate per service**. This rate includes all of a vendor's direct and indirect costs. The service rate should cover the time spent providing the direct service, administrative time, and any other time related to tasks related to that service. Vendors are not subject to the time study process. Vendors are only at a school to provide the direct services enumerated in the contract. Vendors are not expected to perform any additional general and administrative tasks for the LEA.

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Process Changes related to Recoupment of Overpayments to Local Education Agencies

Presently, the process of recouping overpayments from LEAs is restricted to offsetting payments with current or previous overpayments within the same type of service (Nursing, Therapy, Behavioral Health, etc.). In the future, recoupments will cross types of services. These proceeds will be applied to the earliest cost report year with an overpayment.

For example, if an LEA has an overpayment for nursing services and an amount due for therapy services, the payment for the therapy services will be applied to the LEA's overpayment for the nursing services. The net balance from this offset will be used to:

1. Offset overpayments in other periods (from oldest period moving toward the current period);
2. Create a net overpayment that will be carried forward and offset against future billings and/or or payments; and
3. Remit to the LEA.

Failing to Respond to the Random Moment Time Study

LEAs must make every effort to ensure all time study moments are completed and submitted by all participants. Participants have 48 hours from the time of the moment to complete each moment. Reminder emails are sent to the participant and the Medicaid Coordinator each morning until the moment expires. Once a time study moment has expired it can no longer be completed and is deemed not returned. Any LEA that fails to return at least 85 percent of its Moments from the time study for two quarters in a cost report year for any program will be suspended from that program for the entire cost report year.

The time study percentage used for cost reimbursement calculation is an average of the four quarterly statewide time study results for each Medicaid service provided in schools. LEAs must participate in all four time study quarters to be reimbursed all cost for the FY. Any LEA that does not submit a cost report for any program for which any billings were submitted will be required to pay back any billing dollars received for that cost report year. This will be handled in the school-based claiming cost settlement process.

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APPENDIX A: PROCEDURE CODES**PAGE(S) 2**

PROCEDURE CODES

Louisiana Medicaid follows the current American Medical Association's (AMA's) Current Procedural Terminology (CPT) coding and guidelines. If nationally approved changes occur to CPT codes at a future date, providers are to follow the most accurate coding available for covered services for that particular date of service, unless otherwise directed.

EarlySteps

Information on procedure codes and the current rates is available at:
https://www.lamedicaid.com/Provweb1/fee_schedules/OCDD_Fee.htm

EPSDT Health and IDEA-Related Services

Information on procedure codes and the current rates is available at:
https://www.lamedicaid.com/Provweb1/fee_schedules/EPSDT_Fee.htm

In addition to the procedure codes, EarlySteps providers must also add the appropriate procedure modifier. Both type of service (TOS) and place of service (POS) modifiers apply. Listed below is an explanation of the TOS found on this schedule. A combination of a POS code and a valid procedure modifier determine the type of service.

TOS 22 –For services rendered in the natural environment (home and community). “Communities” are environments where children of the same age with no disabilities or special needs participate. These can include childcare centers, agencies, libraries and other community settings.

POS/modifier combination must be one of the two following choices:

1. POS 12 Home and Procedure Modifier U8; or
2. POS 99 Other place of service and Procedure Modifier U8.

TOS 27 - For services rendered in a special purpose facility/inclusive childcare. These can include: childcare centers, nursery schools, or preschools in which at least 50 percent of students have no disabilities or developmental delays.

POS/modifier combination must be:

1. POS 99 and Procedure Modifier TJ.

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TOS 28 - For services rendered in a center-based special purpose facility. These are centers that serve only children with disabilities or developmental delays.

POS/modifier combination must be:

1. POS 99 and Procedure Modifier SE.

759 Denial Codes

The National Correct Coding Initiative (NCCI, also known as CCI) was implemented by Centers for Medicare and Medicaid Services (CMS) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for covered services by a single provider.

Because local education agencies (LEAs) are recognized as single providers and often provide multiple services to students with disabilities on a single day, claims are being denied with error code 759 (CCI: Incidental – History), one of the error codes related to the mandated NCCI edits. To resolve these NCCI edits, districts must begin using modifier 59 on all claims when two or more services are billed for a student on the same day that were performed by separate clinical staff.

Modifier 59 indicates that a procedure or service was distinct or independent from other services performed on the same day by the same provider (LEA). Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or student encounter, a different type of therapy, or a procedure performed on the same day by the same provider (LEA).

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APPENDIX B: DEFINITIONS/ACRONYMS

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DEFINITIONS/ACRONYMS

Abuse – The inappropriate use of public funds by either a provider or beneficiary.

American Occupational Therapy Association, Inc. (AOTA) – The national professional association established in 1917 to represent the interests and concerns of occupational therapy (OT) practitioners and students and improve the quality of OT services.

American Speech-Language-Hearing Association (ASHA) – A professional association for speech–language pathologists, audiologists, and speech, language, and hearing scientists in the United States and internationally.

Assessment - The collection and synthesis of information and activities to determine the state of a child’s health plus any delays or problems in the child’s cognitive, social, emotional, and physical development.

Assistive Technology Device - Any item, piece of equipment, or product system used to increase, maintain, or improve the functional capabilities of a child with a disability. This does not include convenience items but covers medically necessary assistance achieved through the use of assistive technology.

At Risk - Refers to children who are more likely to have substantial development delays if early intervention services are not provided.

Audiology Services – Services for the identification of children with auditory impairment using at risk criteria and appropriate screening techniques.

Beneficiary - A Medicaid eligible individual.

Bureau of Health Services Financing (BHSF) – The Bureau within the Louisiana Department of Health (LDH) responsible for the administration of the Louisiana Medicaid program.

Case Management/Support Coordination - Services provided to eligible beneficiaries to help them gain access to the full range of needed services including medical, social, educational, and other support services.

Centers for Medicare and Medicaid Services (CMS) – The federal agency charged with overseeing and approving states’ implementation and administration of the Medicaid and Medicare programs.

CMS-1500 - The universal claim form used to bill Medicaid services.

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Cost Avoidance - Term referring to avoiding the payment of Medicaid claims when other insurance resources are available to the Medicaid beneficiary.

Certified Occupational Therapy Assistant (COTA) – A health care professional who works with occupational therapists to help patients recover from injuries and improve their physical health. COTAs help patients regain, develop, or master everyday skills so they can live independent, productive, and satisfying lives. They may also work in the area of wellness to promote optimal lifestyle performance.

Developmental Disability (DD) - A severe, chronic disability of a person attributed to a mental and/or physical disability that has an onset before age 22 and is likely to continue indefinitely and results in substantial functional limitation in three or more of the major life activities.

Diagnosis - The determination of the nature and cause of the condition requiring attention.

Diagnostic Services - Any medical procedures recommended by a physician or other licensed practitioner to enable them to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary.

Early Intervention Services- Services provided to children, birth through age 2, who are experiencing developmental delays or have diagnosed conditions that may lead to developmental delays designed to meet the developmental needs of each child and provided under public supervision by qualified personnel in conformity with an individualized family services plan (IFSP). In Louisiana, these services are provided through the EarlySteps program with LDH.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - A federally mandated cluster of preventive health, diagnosis, and treatment services for Medicaid eligible children age 0-21.

EarlySteps (Infants and Toddlers with Disabilities) - Individuals from birth through age 2 who need early intervention services because they are experiencing developmental delays or have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

Evaluation - The process of collecting and interpreting data obtained through observation, interview, record review, or testing.

Electronic Media Claim (EMC) – A paperless patient claim form that is created and submitted electronically to a health insurer or other third-party payer for processing and payment.

Family Service Coordination - An active process for implementing the IFSP that promotes and supports a family's capacities and competencies to identify, obtain, coordinate, monitor, and

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evaluate resources and services to meet needs. This service is provided through an enrolled agency and may also be called support coordination or case management.

Federal Poverty Level (FPL) - A measure used by the federal government to denote a survival level of family income. It varies by family size. The figures are revised annually. The poverty income guidelines are used for administrative purposes as a set standard to determine eligibility for public assistance.

Fiscal Intermediary (FI) - The private fiscal agent with which LDH contracts to operate the Medicaid Management Information System (MMIS). It processes the Title XIX (Medicaid) claims for services provided under the Medical Assistance Program and issues appropriate payment(s).

Fraud - An aspect of law. The definition that governs between citizens and agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.01. For further explanation, see Chapter 1 of the Medicaid Manual.

Internal Claim Number (ICN) – A unique identifier assigned to a medical claim by an insurance company to track and process payments for services provided to beneficiaries. ICNs can also be used by healthcare providers to track internal transactions, such as patient visits and surgical procedures.

Individual Education Program (IEP) - Program that meets all the requirements of the Individuals with Disabilities Education Act (IDEA) and Bulletin 1706 and includes all special educational and related services necessary to accomplish comparability of educational opportunity between exceptional children and children who are not exceptional.

Individualized Family Service Plan (IFSP) - A written plan for providing early intervention services to a child and the child's family who is eligible under IDEA Part C.

Individuals with Disabilities Education Act (IDEA) - Originally known as the Education of the Handicapped Act.

Local Education Agency (LEA) - The organization in charge of public schools in a particular geographic area.

Louisiana Department of Health (LDH) – The state agency responsible for administering the Medicaid program and other health-related services including public health, behavioral health and developmental disabilities.

Major Life Activities – Daily living activities that include self-care, receptive expressive language, mobility, self-direction, capacity for individual living and economic self-sufficiency.

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Medicaid - A federal-state medical assistance entitlement program provided under an approved State Plan authorized under Title XIX of the Social Security Act.

Medicaid Agency - The single state agency responsible for the administration of the Medical Assistance Program (Title XIX). In Louisiana, BHSF within LDH is the single state Medicaid agency. It is sometimes referred to as the Louisiana Medicaid Program.

Medicaid Management Information System (MMIS) - The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method for payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

Omnibus Budget Reconciliation Act of 1989 (OBRA '89) – Act that expanded Medicaid eligibility and EPSDT services.

Occupational Therapy (OT) Services - Services that address the functional needs of a child related to the performance of self-help skills, adaptive behavior, play and sensory, motor, and postural development.

Occupational Therapy Assistant (OTA) – Licensed health care providers who work with occupational therapists and other healthcare professionals to help clients regain, develop, or master everyday skills. OTAs may work with clients of all ages who have varying abilities due to physical injury, disease, aging, mental illness, or substance abuse. They may also work with clients who have developmental disabilities.

Registered Occupational Therapist (OTR) – An OT professional who has passed the National Board for Certification in Occupational Therapy (NBCOT) exam and has one of the following credentials:

1. OTR: Occupational Therapist Registered; or
2. COTA: Certified Occupational Therapy Assistant.

Pay and Chase - Method of payment where Medicaid pays the beneficiary's medical bills and then pursues reimbursement from liable health insurance company(s) and other liable third parties.

Personal Care Attendant (PCA) – Also known as a personal care aide or personal care assistant, helps people with mental or physical disabilities, chronic diseases, or aging-related needs perform daily activities. PCAs can work in many settings, including hospitals, nursing homes, patients' homes, and residential facilities.

Primary Care Case Management (PCCM) – A managed care system in the United States that

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connects Medicaid beneficiaries with primary care providers (PCPs). The PCPs are then paid a monthly fee to manage the care of the beneficiaries. PCCM originated in the 1980s and is one of the oldest types of Medicaid managed care.

Primary Care Physician (PCP) - The physician that serves as the beneficiary's family doctor, providing basic primary care, referral and after-hours coverage.

Physical Therapy (PT) Services - Services designed to improve the child's movement dysfunction.

Preventive Services - Services provided by a physician or other licensed practitioner to prevent disease, disability, and other health conditions or their progression, to prolong life. These services include screening and immunizations.

Prior Authorization (PA) - A request for approval for payment of service that must be made by the provider before rendering the service.

Provider - Health professionals enrolled in Medicaid who perform and/or deliver medically necessary services and/or supplies for eligible Medicaid beneficiaries.

Psychological Services – The obtaining, integrating, and interpreting of information about child behavior, and child and family conditions related to learning, mental health, and development and planning and managing a program of psychological counseling for children and family based on the results of the information.

Remittance Advice (RA) - A control document that informs the provider of the current status of submitted claims.

Related Services – Services provided in the education system only when it can be documented that the student needs or requires the services to benefit from the education program. These services include but are not limited to: interpreter services, orientation and mobility training, audiological services, health services, speech therapy, counseling, and OT or PT. Medicaid reimburses for speech therapy, OT, PT, audiology and psychology services through the EPSDT Health Services Program.

Screening Services – The use of standardized tests given under medical direction in an individual or the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

CHAPTER 20: EPSDT HEALTH AND IDEA – RELATED SERVICES

APPENDIX B: DEFINITIONS/ACRONYMS**PAGE(S) 6**

Speech/Language Pathology – The identification of children with communicative or oropharyngeal disorders and delays in development of communication skills including diagnosis and appraisal of specific disorders and delays in those skills.

State Plan – Comprehensive document setting forth how states will use federal funds and conform to federal regulations. The plan, and amendments thereto, must be approved by federal officials.

Surveillance Utilization Review System (SURS) – A subsystem of MMIS, which maintains and stores Medicaid claims data.

Title XIX - See Medicaid.

Third-Party Liability (TPL) – A legal obligation for individuals, entities, insurers, or programs to pay some or all of the costs for medical assistance under a state plan.

Treatment - The provision of services medically necessary to control or correct diagnosed conditions.

CLAIMS FILING

Hard copy billing of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Health and Individuals with Disabilities Education Act (IDEA)-Related Services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

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

Situational information may be required, but only in certain circumstances as detailed in the instructions below:

Paper claims should be submitted to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

1. The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
2. The group provider number as the billing provider number.

NOTE: Electronic claims submission is the preferred method for billing. (See the Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at <http://www.lamedicaid.com/>, directory link "Health Insurance Portability and Accountability Act (HIPAA) Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide).

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This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and a sample of a completed CMS-1500 claim form; and
2. Instructions for adjusting/voiding a claim and a sample of an adjusted CMS-1500 claim form.

CMS-1500 (02/12) INSTRUCTIONS FOR EPSDT AND IDEA-RELATED SERVICES

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 #).	You must write "EPSDT & IDEA" at the top center of the Louisiana Medicaid claim form.
1a	Insured's Identification (ID) Number	<p>Required – Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through the Medicaid Eligibility Verification System (MEVS), electronic Medicaid Eligibility Verification System (eMEVS), or Recipient Eligibility Verification System (REVS).</p> <p>NOTE: The beneficiary's 13-digit Medicaid ID number <u>must</u> be used to bill claims. The Medicaid provider number from the plastic ID card is NOT acceptable. The ID number must match the beneficiary's name in Block 2.</p>	
2	Patient's Name	Required – Enter the beneficiary's last name, first name, middle initial (MI).	
3	Patient's Date of Birth (DOB) Sex	<p>Situational – Enter the beneficiary's DOB using six-digits (MM DD YY). If there is only one-digit in this field, precede that digit with a zero (for example, 01 02 07).</p> <p>Enter an "X" in the appropriate box to show the sex of the beneficiary.</p>	

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APPENDIX C: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
4	Insured's Name	Situational – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the beneficiary'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	RESERVED FOR NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) USE		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<p>Situational – If beneficiary has no other coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the state assigned six-digit third-party liability (TPL) carrier code is required in this block. The carrier code is indicated on the MEVS response as the Network Provider Identification Number.</p> <p>Make sure the explanation of benefit (EOB) or EOBs from other insurance(s) are attached to the claim.</p>	Only the six-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or the Federal Employees' Compensation Act (FECA) Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's DOB Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	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	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional	
17	Name of Referring Provider or Other Source	Leave Blank.	

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APPENDIX C: CLAIMS FILING**PAGE(S) 26**

Locator #	Description	Instructions	Alerts
17a	Unlabeled	Leave Blank.	
17b	National Provider Identifier (NPI)	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

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Locator #	Description	Instructions	Alerts				
21	<p>International Classification of Diseases (ICD) Indicator</p> <p>Diagnosis or Nature of Illness or Injury</p>	<p>Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.</p> <table><tr><td>9</td><td>ICD-9-CM</td></tr><tr><td>0</td><td>ICD-10-CM</td></tr></table> <p>Required – Enter the most current ICD diagnosis code.</p> <p>NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	9	ICD-9-CM	0	ICD-10-CM	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.</p> <p>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).</p>
9	ICD-9-CM						
0	ICD-10-CM						

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Locator #	Description	Instructions	Alerts
22	Resubmission Code	<p>Situational. If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the “Code” portion of this field.</p> <p>Enter the internal control number (ICN) from the paid claim line as it appears on the remittance advice (RA) in the “Original Ref. No.” portion of this field.</p> <p>Appropriate reason codes follow:</p> <p>Adjustments 01 = TPL Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p>Voids 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS-1500 (02/12).</p> <p>To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different ICN.</p>
23	Prior Authorization (PA) Number	<p>Situational – Complete if appropriate or leave blank.</p> <p>If the services being billed must be prior authorized, the PA number is required to be entered.</p>	
24	Supplemental Information	Leave Blank.	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered.	

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Locator #	Description	Instructions	Alerts
24C	Rlectromyogram (EMG)	Leave Blank.	
24D	Procedures, Services, or Supplies	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s). When a modifier(s) is required, enter the appropriate modifier in the correct field.	
24E	Diagnosis Pointer	Required -- Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	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	Leave Blank.	
24I	ID. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	

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Locator #	Description	Instructions	Alerts
24J	Rendering Provider ID Number	Situational – If appropriate, entering the Rendering Provider’s seven-digit Medicaid Provider Number in the shaded portion of the block is required. Optional: Enter the Rendering Provider’s NPI in the non-shaded portion of the block.	
25	Federal Tax ID Number	Optional.	
26	Patient’s Account No.	Situational – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the RA. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter ‘0’ if the third party did not pay. If TPL does not apply to the claim, leave blank. Do not report Medicare payments in this field.	
30	RESERVED FOR NUCC USE	Leave Blank.	

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Locator #	Description	Instructions	Alerts
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional. The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete as appropriate or leave blank.	
33	Billing Provider Info & Phone Number	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabeled	Required – Enter the billing provider's seven-digit Medicaid ID number. ID Qualifier – Optional – If possible, leave blank for Louisiana Medicaid billing.	The seven-digit Medicaid Provider Number <u>must</u> appear on paper claims.

REMINDER: MAKE SURE “VISION” IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM


Sample forms are on the following pages

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SAMPLE EPSDT AND IDEA-RELATED CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR BEFORE 10/01/15)

 **HEALTH INSURANCE CLAIM FORM**
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

☐ ☐ PICA PICA ☐ ☐

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (TRICARE #) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ADALAM, MARY		3. PATIENT'S BIRTH DATE MM DD YY 06 11 00 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) c. OTHER (Specify) 10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Print name and title below signature) SIGNED DATE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 06 11 00 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO <input checked="" type="checkbox"/> <input type="checkbox"/> If yes, complete items 9, 9a and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 08 15 QUAL 03		15. OTHER DATE MM DD YY 10 08 15 QUAL 03	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 97003 17b. NPI A		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 10 08 15 TO MM DD YY 10 08 15	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind 0) A. M0800 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 6500 ORIGINAL REF. NO. 1	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. ICD-10 Code (Print)		23. PRIOR AUTHORIZATION NUMBER (Prior Auth # if applicable)	
25. FEDERAL TAX I.D. NUMBER 1234 SSN EIN 1234		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 65.00		29. AMOUNT PAID \$ 65.00	
30. BALANCE DUE \$ 65.00		31. BILLING PROVIDER INFO & PH# (800) 222-3333	
32. SERVICE FACILITY LOCATION INFORMATION ABC SCHOOL BOARD 123 MAIN ST ANY TOWN, LA 70000		33. BILLING PROVIDER INFO & PH# (800) 222-3333	
SIGNED Ima Biller DATE 10/09/15		a. 1234567891 b. 1234567	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

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Adjustments and Voids

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

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

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

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.**

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the RA, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved ICN can be adjusted or voided, thus:

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; and
2. If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the RA under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the RA.

Sample forms are on the following pages.

LOUISIANA MEDICAID PROGRAM

ISSUED: 06/12/25
REPLACED: 11/27/24

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SAMPLE EPSDT AND IDEA-RELATED CLAIM FORM ADJUSTMENT WITH ICD-10
DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA ☐PICA ☐

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK/LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ADALAM, MARY		3. PATIENT'S BIRTH DATE MM DD YY 06 11 00 M F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? (State) c. OTHER (Specify) 10d. RESERVED FOR LOCAL USE	
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		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? e. IF YES, complete items 9, 9a and 9d. 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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10 Ind. 0 A. M0800 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. 5299198561200 23. PRIOR AUTHORIZATION NUMBER (Prior Auth # if applicable)	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. HOURS PER WEEK I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 10 08 15 10 08 15 03 97003 A 65.00 1 NPI			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 1234	
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.) SIGNED Ima Biller DATE 10/09/15		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 65.00 29. AMOUNT PAID \$ 65.00 30. BALANCE DUE \$ 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# (800) 222-3333 ABC SCHOOL BOARD 123 MAIN ST ANY TOWN, LA 70000 a. 1234567891 b. 1234567	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code)										CITY STATE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED DATE										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										b. OTHER CLAIM ID (Designated by NUCC)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete Items 9, 9a, and 9d.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
A. _____ B. _____ C. _____ D. _____										SIGNED									
E. _____ F. _____ G. _____ H. _____										18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
I. _____ J. _____ K. _____ L. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
24. A. DATE(S) OF SERVICE To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. PRIOR REF. NO. I. ID. QUAL J. RENDERING PROVIDER ID. #										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
1										22. RESUBMISSION CODE ORIGINAL REF. NO.									
2										23. PRIOR AUTHORIZATION NUMBER									
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN										28. TOTAL CHARGE 29. AMOUNT PAID 30. Reserved for NUCC Use									
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.)										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO									
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()									
SIGNED DATE										a. NPI b. NPI									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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Attachments

All claim attachments should be standard 8 ½ 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 the fiscal intermediary (FI) staff from changing any information on a provider's claim form. Any claims requiring changes must be made prior to submission. 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

Claims that are illegible or incomplete are not processed. These claims are returned with a cover letter stating why the claim(s) is/are rejected. The most common reasons for rejection are listed as follows:

The provider number was missing or incomplete.

The criteria for legible claims are as follows:

1. All claim forms are clear and in good condition;
2. All information is readable to the normal eye;
3. All information is centered in the appropriate block; and
4. All essential information is complete.

Correct Claims Submission

Unless specifically directed to submit claims directly to the Louisiana Department of Health (LDH), providers are to submit **ALL** claims to the appropriate FI post office box for processing. The correct post office boxes can be found on the following page of this packet and in Appendix E.

Timely Filing Guidelines

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

1. Straight Medicaid claims must be filed within 12 months of the date of service;
2. Claims for beneficiaries who have Medicare and Medicaid coverage must be filed with the Medicare FI within 12 months of the date of service in order to meet Medicaid's timely filing regulations;
3. 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 Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service; and
4. 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:

1. An electronic-Claims Status Inquiry (e-CSI) screen print indicating that the claim was processed within the specified time frame;
2. A RA indicating that the claim was processed within the specified time frame; or
3. Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the beneficiary.

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NOTE 1: All proof of timely filing documentation must reference the individual beneficiary and date of service. RA pages and e-CSI screen prints must contain the specific beneficiary 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 beneficiary 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:

1. The beneficiary was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted;
2. The beneficiary won a Medicare or Supplemental Security Income (SSI) appeal in which they were granted retroactive Medicaid Benefits; and
3. 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:

**Gainwell Technologies Provider Relations Correspondance Unit
P.O. Box 91024
Baton Rouge, Louisiana 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.

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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 LDH staff will be routed to Gainwell Technologies Provider Relations.

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

Provider Assistance

LDH and Gainwell Technologies maintain a website to make information more accessible to Louisiana 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.

Listed below are some of the most common topics found on the website:

1. New Medicaid Information;
2. NPI;
3. Disaster;
4. Provider Training Materials;
5. Provider Web Account Registration Instructions;
6. Provider Support;
7. Billing Information;
8. Fee Schedules;
9. Provider Update/RA Index;
10. Pharmacy;

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11. Prescribing Providers;
12. Provider Enrollment;
13. Current Newsletter and RA;
14. Helpful Numbers;
15. Useful Links; and
16. 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 Gainwell Technologies Provider Relations Department is available to assist providers. This department consists of three units:

1. Telephone Inquiry Unit;
2. Correspondence Unit; and
3. Reminders Unit.

The following information addresses each unit and their responsibilities.

Gainwell Technologies 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, etc. (See Appendix E for more information). 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 Gainwell Technologies Provider Relations telephone inquiry phone numbers. Callers should have the seven-digit LA Medicaid provider

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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, Gainwell Technologies 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 the following information:

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 Louisiana Medicaid website. Orders for these materials should be placed through this option **ONLY** if you do not have web access.

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 beneficiaries. The telephone listing in Appendix E should be used to direct Medicaid beneficiary inquiries appropriately. Providers should not give their

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Medicaid provider billing numbers to beneficiaries for the purpose of contacting Gainwell Technologies. Beneficiaries 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 beneficiary or provider eligibility, Medicare or other insurance information, primary care physician information, or service limits.

1. Beneficiary eligibility;
2. Third-Party (Insurance) Resources; and
3. Lock-In.

NOTE: Providers should access eligibility information via the web-based application, e-MEVS on the Louisiana Medicaid website or MEVS vendor swipe card devices/software. Providers may also check eligibility via REVS. (See Appendix E for more information). 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 for other information.

Gainwell Technologies Provider Relations Correspondence Unit

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, beneficiary chart notes,

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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:

**Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge, Louisiana 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.

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

TPL File Updates: Requests to update TPL should be directed to:

**LDH-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 Appendix E.

**CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED
“CLEAN” CLAIMS AND WILL NOT BE RESEARCHED.**

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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 above in this section. In instances where the claim meets the LDH 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 LDH personnel and will not be researched from a telephone call to LDH or the Provider Inquiry Unit.**

Gainwell Technologies Provider Relations

Provider Relations is available to visit and train new providers and their office staff on site, upon request. Providers are encouraged to request assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **These calls should be directed to the FI Provider Relations Telephone Inquiry (see Appendix E).**

Provider Relations Reminders

The FI 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:

1. Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:
 - a. The correct seven-digit Louisiana Medicaid provider number;
 - b. The 13-digit Beneficiary's Medicaid ID number ;
 - c. The date of service ;
 - d. Any other information, such as procedure code(s) and billed charge, that will help identify the claim in question;
 - e. The RA showing disposition of the specific claim in question; and

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- f. Obtain the name of the phone representative you are speaking to in case further communication is needed.
2. Due of the large volume of incoming provider calls, Telephone Inquiry staff are not allowed to be put on hold after answering a call;
3. Review and reconcile the RA 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;
4. 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 RA within 30 - 40 days for hard copy claims and three weeks for EDI claims;
5. Providers can check claim status through the e-CSI 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 RA. The date of the RA is displayed in the e-CSI response. The hard copy RA 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 RAs for this purpose. This includes provider's direct staff and billing agents or vendors. A Louisiana Medicaid/HIPAA Error Code Crosswalk is available on the website by accessing the link, Forms/Files;
6. If a provider has a large number of claims to reconcile, it may be to the provider's advantage to order a provider history. Refer to the Ordering Information section for instructions on ordering a provider history;

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7. **Provider Relations cannot assist beneficiaries.** The telephone listing in the “Beneficiary Assistance” section found in this packet should be used to direct Medicaid beneficiary inquiries appropriately. Providers should not give their Medicaid provider billing numbers to beneficiaries for the purpose of contacting FI. Beneficiaries 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;
8. Providers who wish to submit problem claims for a written response **must submit a cover letter** explaining the problem or question; and
9. Calls regarding eligibility, claim issues, requests for Gainwell Technologies claim forms, manuals, or other policy documentation should be directed to the FI Provider Relations Telephone Inquiry Unit.

Louisiana Department of Health 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:

Louisiana Department of Health
P.O. Box 91030
Baton Rouge, LA 70821

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APPENDIX D: RESERVED

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CHAPTER 20: EPSDT HEALTH AND IDEA-RELATED SERVICES**APPENDIX E: CONTACT/REFERRAL INFORMATION** **PAGE(S) 5****CONTACT/REFERRAL INFORMATION****Gainwell Technologies**

The Medicaid Program's fiscal intermediary (FI), Gainwell Technologies can be contacted for assistance with the following:

TYPE OF ASSISTANCE	CONTACT INFORMATION
<u>CMS-1500 Claims</u> <ol style="list-style-type: none"> 1. Case Management 2. Chiropractic 3. Durable Medical Equipment (DME) 4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Health and Individuals with Disabilities Education Act (IDEA)-Related Services 5. Federally Qualified Health Centers (FQHC) 6. Hemodialysis Professional Services 7. Independent Laboratory 8. Mental Health Rehabilitation (MHR) 9. Personal Care Services (PCS) 10. Professional Services 11. Rural Health Clinic (RHC) 12. Substance Use Disorders (SUDs) and Mental Health Clinic 13. Waiver 	P.O. Box 91020 Baton Rouge, LA 70821
Inpatient and Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long-Term Care (LTC)	P.O. Box 91021 Baton Rouge, LA 70821
Dental, Home Health, Rehabilitation, Transportation (Ambulance and Non-Ambulance)	P.O. Box 91022 Baton Rouge, LA 70821
All Medicare Crossovers and All Medicare Adjustments and Voids	P.O. Box 91023 Baton Rouge, LA 70821
e-CDI technical support <i>Web Technical Support</i>	Gainwell Technologies Medicaid Solutions (877) 598-8753

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TYPE OF ASSISTANCE	CONTACT INFORMATION
Electronic Data Interchange (EDI) <i>Electronic claims sign up and testing</i>	P.O. Box 91025 Baton Rouge, LA 70898-0159 Phone: (225) 216-6303 Fax: (225) 216-6335
Pharmacy	P.O. Box 91019 Baton Rouge, LA 70821
Prior Authorization Unit (PAU) <i>*See LSU School of Dentistry below in "Other Helpful Contact Information" for more information.</i>	Gainwell Technologies – PAU P.O. Box 14919 Baton Rouge, LA 70898-4919 (800) 263-6534 (<i>Dental</i>) (800) 488-6334 (<i>DME & All Other</i>) (800) 877-0666, <i>Option 2 (Hospice)</i> Fax: (225) 216-6476
Provider Enrollment Unit (PEU)	Gainwell Technologies – PEU P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 (225) 216-6392 Fax
Provider Relations Unit	Gainwell Technologies – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
Recipient Eligibility Verification (REVS)	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)

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The Louisiana Department of Health (LDH) can be contacted for assistance with the following:

TYPE OF ASSISTANCE	CONTACT INFORMATION
DME	628 N. Fourth Street Baton Rouge, LA 70802 Phone: 225-342-3935 Fax: 225-342-9462
EarlySteps	P.O. Box 3117 Baton Rouge, LA 70821-3117 Phone: 866-EarlySteps (Toll Free)
General Medicaid Hotline	(888) 342-6207 (Toll Free)
Louisiana Children's Health Insurance Program (LaCHIP)	(225) 342-0555 (Local) (877) 252-2447 (Toll Free) http://new.dhh.louisiana.gov/index.cfm/page/222
Louisiana Medicaid Website	www.lamedicaid.com
Medicaid Card Questions	Phone: 800-834-3333 (Toll Free) http://ldh.la.gov/index.cfm/faq/category/72

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Office of Behavioral Health (OBH)	P.O. Box 4049 Baton Rouge, LA 70821-4049 Phone: 225-342-2540 Fax: 225-342-5066 http://ldh.la.gov/index.cfm/subhome/10
Office for Citizens with Developmental Disabilities (OCDD)	P.O. Box 3117 Baton Rouge, LA 70821-3117 Phone: (225) 342-0095 (Local) Phone: (866) 783-5553 (Toll-free) Fax: 342-8823 E-mail: ocddinfo@la.gov
Office of Management and Finance – Bureau of Health Services Financing (BHSF) – MEDICAID	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: 225-342-5774 Fax: 225-342-3893 E-mail: medweb@la.gov http://ldh.la.gov/index.cfm/subhome/1
Rate Setting and Audit Hospital Services	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: 225-342-0127 225-342-9462
Third-Party Liability (TPL) TPL Recovery, Trauma	453 Spanish Town Road Baton Rouge, LA 70802 Phone: (225) 342-1376 Fax: (225) 342-5292

Fraud Hotline

TYPE OF ASSISTANCE	CONTACT INFORMATION
To report fraud	Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://ldh.la.gov/index.cfm/page/219

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Other Helpful Contact Information

TYPE OF ASSISTANCE	CONTACT INFORMATION
Centers for Medicare and Medicaid Services (CMS)	www.cms.hhs.gov
Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP)	http://www.gohsep.la.gov
Office of Population Affairs (OPA) Clearinghouse	P.O. Box 30686 Bethesda, MD 20824-0686 Phone: (866)-640-7827 Fax: (866)-592-3299 E-mail: Info@OPAClearinghouse.org
Superintendent of Documents Forms	http://www.gpo.gov/ Phone: (202) 512-1800