EPSDT HEALTH SERVICES FOR CHILDREN WITH DISABILITIES

Chapter Twenty of the Medicaid Services Manual

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State of Louisiana
Bureau of Health Services Financing

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT HEALTH SERVICES FOR CHILDREN WITH DISABILITIES

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OVERVIEW

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

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 services are designed to provide a framework for routine health, mental health and developmental screening of children from birth to age 20 plus evaluation and treatment for illnesses, conditions or disabilities.

IDEA

The coordination of Medicaid with state special education and early intervention programs dates from the enactment of the Individuals with Disabilities Education Act (IDEA) Public Law 101-476. This legislation was originally passed in 1975 as Public Law 94-142, the Education of the Handicapped Act.

Part B and Part C of IDEA and EPSDT programs have a set of goals in common: to improve health and provide related services for children as selected in the legislative history. These programs together create an excellent opportunity to improve coverage and the range of services for children with disabilities.

Part B of IDEA

Part B of IDEA mandates that all children three through 20 years of age with disabilities receive a free, appropriate public education within the least restrictive environment.

- The law mandates that public school systems must prepare an Individualized Education Program (IEP) for each child eligible under Part B specifying all special education and appropriate health-related services needed by the child.
- Related services provided in the educational system must be directly related to the educational goals and objectives identified in the IEP.
- The law specifically prohibited states using Part B funds to pay for services that should be paid for by other federal, state, and local agencies including Medicaid.

Congress added that while the state education agencies are financially responsible for educational services for a Medicaid eligible disabled child, state Medicaid agencies remained responsible for the "related services" identified in the child's IEP if they are covered in the state's Medicaid plan, such as speech pathology and audiology, psychological services, physical and occupational therapy.

The Louisiana Medicaid Program expanded its EPSDT discretionary services in 1988. EPSDT Health Services for Children with Disabilities, hereafter referred to as EPSDT Health Services, are services for children with developmental delays and disabilities that are provided by a Local Education Agency (LEA) or local school board under Part B of the Individuals with Disabilities Education Act (IDEA) for children ages three through 20 years. All EPSDT Health Services must be included on the child's individualized education program (IEP) developed by the LEA. Medicaid coverage of these services has provided a valuable revenue source allowing local school boards to expand health services to low-income children.

OBRA '89

The Omnibus Budget Reconciliation Act (OBRA) changes in Sections 1902 and 1905 of the Medicaid statute greatly expanded EPSDT's role as a financing mechanism of health services for Medicaid eligible children. OBRA '89 added a new required EPSDT services component of "other necessary health, diagnostic, treatment, and other measures needed to ameliorate defects, physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state Medicaid plan." These EPSDT changes mean that health related services identified in an IEP or IFSP may be reimbursable for a Medicaid enrolled child.

Effective May 1, 2012, KIDMED which was the screening component of EPSDT that provided for medical, vision, and hearing and screening services is no longer in operation. Services previously offered through this program will now be provided through Bayou Health, the new health care delivery model in Louisiana. For children exempt from enrollment in Bayou Health these services shall be provided by their primary care physician.

COVERED SERVICES

Local Education Agencies

Local education agencies (LEAs) may provide the following services for children ages three to twenty:

- Audiology services;
- Occupational therapy evaluations and treatment services;
- Physical therapy evaluations and treatment services;
- Psychological evaluations and therapy (individual and group); and
- Speech and language evaluations and therapy (individual and group).

The Direct Service Model

The direct service model consists of individual treatment provided to a student. Although this model is the most restrictive, it is analogous to the "medical model" of service delivery billable under Medicaid.

- Tracking/monitoring consists of directly observing the student, talking with his parents and school staff, conducting any needed assessments and occasional hands-on interaction between the therapist and the student.

- Only direct observation and hands-on intervention is Medicaid billable as therapy. Case colleague or system consultation cannot be billed as a therapy service.

- Intervention on an indirect nature that does not directly involve the student and therapist is not billable as a Medicaid health service.

EarlySteps

EarlySteps provides services to families with infants and toddlers aged birth to three years who have a medical condition likely to result in a developmental delay, or who have developmental delays. Children with delays in cognitive, motor, vision, hearing, communication, social-emotional or adaptive development may be eligible for services. EarlySteps services are designed to improve the family's capacity to enhance their child's development. These services are provided in the child's natural environment, such as the child's home, child care or any other community setting typical for children aged birth to three years

Services the EarlySteps program provides include:

- Assistive technology;
- Audiology services;
- Family service coordination;
- Health services;
- Medical services;
- Nursing services;
- Nutrition services;
- Occupational therapy;
- Physical therapy;
- Psychological services;
- Social work services;
- Special education services;
- Special instructions;
- Speech/language therapy;
- Transportation services; and
- Vision services.

Medicaid reimburses only for direct, one-on-one patient contact services, billed as units of time, in physical and occupational therapy. **Group therapy and co-treating are not covered under physical and occupational therapy.**

Speech, Hearing, and Language Disorders

Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist.

Audiology Services

Audiology services are for the identification of children with auditory impairment, using at risk criteria and appropriate audiologic screening techniques. These services include:

- Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures in appropriate sound treated setting as necessary;
- Referral for medical and other services **necessary for the** rehabilitation of children with auditory impairment; and
- Provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services.

Professional Requirements

Audiology services must be provided by or under the direction of a qualified, licensed audiologist or a physician in Louisiana in accordance with the licensing standards of the State Examining Board for Audiologists or Physicians. A 'qualified audiologist' means an individual with a master's or doctoral degree in audiology and maintains documentation to demonstrate licensure by the state as an audiologist.

The audiologist or physician must be licensed in Louisiana to provide these services. Federal regulations also require that the audiologist have one of the following:

- A certificate of clinical competence from the American Speech and Hearing Association (ASHA);
- Completion of the equivalent educational **requirements** and work experience necessary for the certification; or
- Completion of the academic program and is acquiring supervised work experience to qualify for **the certificate.**

A referral must be made by the child's physician, preferably the primary care physician, at least annually in accordance to federal Medicaid regulations.

Audiologic Evaluation

Audiologic evaluation is the determination of the range, nature, and degree of a child's hearing loss and communication functions for modifying communicative behavior.

Occupational Therapy Services

Occupational therapy services 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 services include:

- Identification, assessment, and intervention;
- Adaptation of the environment;
- Selection, design, and fabrication to assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
- Prevention or reducing the impact of initial or future impairment, delays in development, or loss of functional ability.

Medicaid reimburses only for direct, one-to-one patient contact services, billed as units of time, in physical and occupational therapy. **Group therapy and co-treating are not covered under Physical and Occupational Therapy.**

Professional Requirements

Occupational therapy must be provided to a child by or under the direction of a qualified occupational therapist licensed in Louisiana to provide these services in accordance with the licensing standards of the Louisiana State Board of Medical Examiners (Board for Occupational Therapists).

Federal regulations also require that the occupational therapist must be:

- Registered by the American Occupational Therapy Association, Inc. (AOTA); or
- A graduate of a program approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the AOTA.

Services provided by an occupational therapy assistant certified by the AOTA who is licensed to assist in the practice of occupational therapy must be provided under the direction and supervision of an occupational therapist licensed in Louisiana. Supervision of assistants must be in accordance with the supervisory requirements of the Louisiana State Board of Medical Examiners.

Occupational therapy treatment services require a written referral or prescription by a physician licensed in Louisiana on at least an annual basis. An initial evaluation may be done without such a referral or prescription.

Occupational Therapy Evaluation

Occupational therapy evaluations determine the Medicaid-eligible student's level of functioning and competencies through professionally accepted techniques. Evaluations must include assessment of the functional abilities and deficits as related to the child's needs in the following areas:

- Muscle tone, movement patterns; reflexes, and fine motor/perceptual motor development;
- Daily living skills; including self-feeding, dressing, and toileting (Informal assessment tools may be used);
- Sensory integration;
- Prosthetic evaluation, when appropriate;
- Orthotic (splint) evaluation, when appropriate; and

- Need for positioning/seating equipment and other adaptive equipment.

All evaluation methods must be appropriate to the child's age, education, cultural, and ethnic background, medical status, and functional ability. The evaluation method may include observation, interview, record review, and the use of appropriate nationally approved evaluation techniques or tools.

Evaluation data must be analyzed and documented in summary form to document the child's status. The specific evaluation tools and methods used must also be documented.

The evaluation must be conducted by a licensed occupational therapist. An occupational therapy assistant may not perform an evaluation.

Physical Therapy Services

Physical Therapy Services are designed to improve the child's movement dysfunction. Includes:

- Screening of infants and toddlers to identify movement dysfunction;
- Obtaining, interpreting and integrating information appropriate to program planning; and
- Services to prevent or alleviate movement dysfunction and related functional problems.

Professional Requirements

Physical therapy services must be provided by or under the directions of a qualified physical therapist in accordance with the state licensing standards of the State Examiners Board for Physical Therapist. Federal regulations also require that the individual must be a graduate of a program of physical therapy approved by both the Council in Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent.

Physical therapy treatment requires a written referral or prescription by a physician licensed in Louisiana on at least an annual basis. An initial evaluation does not require such a referral or prescription.

Physical Therapy Evaluation

Physical therapy (PT) evaluation includes testing of gross motor skills and orthotic and/or prosthetic, neuromuscular, musculoskeletal, cardiovascular, respiratory, and sensorimotor functions. These services must include the following:

- Muscle, manual, extremity, or trunk testing, with report;
- Total physical therapy evaluation;
- Range-of-motion measurements and report on each extremity excluding hand; and
- Range of motion measurements and report.

Information methods, including observation of behavior during the evaluation and supplemental testing, may be used. Standard assessment tools listed below must be used when appropriate:

- Pediatric Screening: A Tool for Occupational and Physical Therapist;
- Joint Range of Motion Test;
- Berry Development Test if Visual-Motor Integration (VMI);
- The Macquarrie Test Mechanical Ability;
- Early Intervention Development Profile (EIDP);
- Preschool Development Profile (PDP);
- Motor Free Visual Perception Test;
- Denver Development Screening Test;
- Manual Muscle Tests;
- Southern California Sensory Integration Test (SCSIT);
- The Miller Assessment for Preschoolers (MAP);
- The Developmental Test of Visual Perception (Frostig);
- Test of Visual Perceptual Skills (TVPS);
- Bruininks-Oseretsky Test of Motor of Motor Proficiency;
- Bayley Developmental Scales;
- Callier-Azusa Scale;
- Bender Visual Motor Integration Test;
- Erhardt Developmental Test of Visual Perception;
- Frostig Developmental Test of Visual Perception;
- Gesell Developmental Schedules;
- McCarthy Scales of Children's Abilities;
- Milani-Comparetti;
- North Carolina Curriculum;
- Perceptual Motor Screening;
- Purdue Perceptual Motor Survey; or
- Reflex Testing Methods of Evaluation Central Nervous System Development.

Psychological Services

Psychological services are for obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development. These services include:

- Administering psychological and developmental tests and other assessment procedures;
- Interpreting assessment results; and
- Planning and managing a program of psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

Professional Requirements

- Only services provided by a psychologist licensed under the Louisiana Licensing Law for Psychologists (R.S. 37, Chapter 28) are reimbursable by Louisiana Medicaid.
- Services provided by a school psychologist certified by the Department of Education not meeting the minimum criteria as outlined by the Louisiana Licensing Law for Psychologists are not billable to Medicaid.

Psychological Evaluation

The psychological evaluation includes a battery of tests, interviews, and behavioral evaluations that appraise cognitive, emotional, social, and behavioral functioning and self-concept. These services must be provided by a Louisiana licensed physician, psychiatrist, or licensed psychologist to be reimbursable by Louisiana Medicaid.

Psychological Therapy

Psychological therapy includes diagnosis and psychological counseling for children and their families. These services must be provided by a Louisiana licensed physician, psychiatrist, or licensed psychologist.

Speech Pathology Services

Speech pathology services are for 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. These services include:

- Referral for medical or other professional services necessary for the rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills; and
- Provision of services for the rehabilitation or prevention of communicative or

oropharyngeal disorders and delays in development of communication skills.

Professional Requirements

Speech pathology services must be provided by or under the direction of a licensed speech pathologist or audiologist in accordance with the licensing standards of the State Examiners Board for Speech Pathologists or Audiologists.

The speech pathologist or audiologist must be licensed in Louisiana to provide these services. Federal regulations also require that the speech pathologist or audiologist have one of the following:

- A certification of clinical competence from the American Speech and Hearing Association;
- Completion of the equivalent educational requirements and work experience necessary for the certification; or
- Completion of the academic program and is acquiring supervised work experience to qualify for the certificate.

Licensed speech-language pathology assistants may also provide services under the supervision of a certified licensed speech-language pathologist. Supervision of assistants must be in accordance with the supervisory requirements of the Louisiana Board of Examiners for Speech Language Pathology and Audiology.

NOTE: A written referral or prescription is no longer required from a licensed physician to provide speech pathology services. However, speech pathology services must still be included in a student's IEP in order to be reimbursed by Medicaid.

Speech/Language Evaluation

A speech/language evaluation includes tests used to determine a child's ability to understand and use appropriate verbal communication, identify communication impairments, and assess:

- Phonology and language;
- Voice and fluency;
- Oral structure; and
- Mechanism and functioning.

These services must include the following:

- Oral motor examination/consultation;

- Velopharyngeal examination/consultation;
- Child language consultation; and
- Observations of feeding dysphagia, when appropriate.

The evaluation procedure may only be reimbursed once in a 180-day period by the same provider.

Speech/Language and Hearing Therapy

Speech/language therapy services include the provision of services for the prevention of or rehabilitation of communicative oral pharyngeal disorders, dysphagia disorders, and delays in development of communication. Speech, language, and hearing therapy include the following services, as appropriate and medically necessary:

- Speech/language or hearing therapy (individual or group);
- Stuttering therapy;
- Speech reading/oral rehabilitation;
- Voice therapy;
- Feeding/dysphagia training;
- Esophageal speech training therapy; and
- Speech defect training therapy.

Other EPSDT Covered Services

Medicaid covers all medically necessary diagnosis and treatment services in addition to EPSDT Health Services for Children with Disabilities for recipients under age 21. The Louisiana Medicaid Program may require determination of medical necessity of the services.

Durable Medical Equipment

Medicaid-covered services include purchase of medical supplies or rental/purchase of durable medical equipment (DME) and appliances for children with disabilities. These services are only covered if authorized in advance by the Prior Authorization Unit (PAU) at the fiscal intermediary. A licensed physician must recommend the item in writing. It must be medically necessary and not a convenience item. Nor can it be investigational or experimental. A Medicaid enrolled vendor must make the request for payment of the item. The request is submitted to the PAU at the fiscal intermediary on a form PA-01 (see Appendix D) with appropriate medical documentation attached. The request must be acted upon within 25 days for a non-emergent request or the item is automatically approved.

The DME Provider Manual contains detailed information on items covered, requirements for

approval, and request procedures.

Transportation

Medicaid provides necessary transportation and scheduling assistance for health related services excluding transportation to pharmacy services. Medicaid does not provide transportation to school settings where both instructional and health services are provided. Transportation services will not be paid by Medicaid if other transportation sources are available at no cost to the recipient. These sources include friends, family members, neighbors, private insurance, free community resources, Title XIX providers, and other personal means.

ELIGIBILITY CRITERIA

All Medicaid eligible children under age 21 are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, and Medicaid eligible children from three years through 20 years of age are eligible for EPSDT Health Services through the Local Education Authority (LEA) or local school board. All EPSDT Health Services must be furnished in the interest of establishing or modifying a child's Individualized Education Program (IEP) or the services furnished must already be included in the current IEP. Non-IEP or non-Individualized Family Service Plan (IFSP) services may not be billed to Medicaid under the EPSDT Health Services program.

If a Medicaid eligible child does not meet the LEA or local school board's eligibility requirements for the EPSDT Health Services, these medically necessary Medicaid covered services are available from Medicaid. Medically necessary services must be prescribed by a physician and prior authorization is required.

PROVIDER REQUIREMENTS

To receive Medicaid reimbursement, a local education agency (LEA) must be enrolled as a Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Health Services provider (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 performed by Medicaid's fiscal intermediary.

In Louisiana, for Medicaid covered IDEA Part B services, LEAs must enroll as an EPSDT Health and IDEA-Related Services provider, which is Provider Type 70 (EPSDT Health and IDEA-Related Services). Medicaid provider enrollment of LEAs is performed by Medicaid's fiscal intermediary.

Effective May 1, 2012, KIDMED which was the screening component of EPSDT that provided for medical, vision, and hearing and screening services is no longer in operation. Services previously offered through this program will now be provided through Bayou Health, the new health care delivery model in Louisiana. For children exempt from enrollment in Bayou Health these services shall be provided by their primary care physician.

As part of the documents required for enrollment in 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 in 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.

Rendering Provider

The rendering provider must meet Medicaid-qualified provider criteria if the LEA bills Medicaid for the services performed. These criteria include state licensure, and in some cases, certification, registration or other professional or academic credentials. In addition, the rendering provider must provide services within the scope of their professional licensure or certification and, if applicable, be supervised as required by professional practice acts. Practitioners providing IEP services must not appear on the Department of Health and Human Services Office of Inspector General's "List of Excluded Individuals and Entities," which is available online. (Refer to Appendix E for contact information)

The rendering provider is an employee or contractor of the LEA. The individual practitioner/rendering provider need not be enrolled in the Medicaid program in order for the LEA to bill for covered IEP services performed by that practitioner; however, the practitioner must meet all applicable Medicaid provider qualifications. It is the responsibility of the LEA to ensure that

the rendering provider satisfies the Medicaid provider qualifications as well as applicable state licensure and certification requirements for his or her discipline.

Even if the rendering provider is enrolled in Medicaid and has a provider number, the LEA provider number must be used in both the "rendering provider" and "billing provider" fields on the Medicaid claim form or electronic claim transaction when billing for Medicaid-covered IEP or health-related services.

PROGRAM REQUIREMENTS

The Department of Health and Hospitals requires that all EPSDT Health Services for Children with Disabilities providers enrolled in Medicaid give the following statement in writing to each Medicaid-eligible recipient and/or caregiver at the time the individualized education program (IEP) or individualized family services plan (IFSP) is developed.

If your child is Medicaid eligible and is eligible to receive the following:

- **Audiological services,**
- **Occupational therapy evaluations and treatment services,**
- **Physical therapy evaluations and therapy (individual and group),**
- **Psychological evaluations and therapy (individual and group), and**
- **Speech and language evaluations and therapy (individual and group),**

You may choose to obtain them either through your school, an early intervention center, or another Medicaid enrolled provider of those services.

Children who do not qualify for these services for educational purposes may still be eligible for them through Medicaid. Services outside of the school, at school or in an early intervention center must be ordered by a physician. Once the services are ordered by a physician, the service provider must request approval from Medicaid. To locate a provider other than the school or early intervention center, please contact your case manager, physician, or call the Bayou Health Hotline (see Appendix E).

EPSDT Health Services program requirements for reimbursement are:

- All services must be furnished in the interest of establishing or modifying a child's IEP or an infant or toddler's IFSP or the services furnished must already be included in the current IEP or IFSP. Non-IEP or non-IFSP services may not be billed to Medicaid under the EPSDT Health and IDEA-Related Services program.

- If providing early intervention services to infants and toddlers, use one of the model IFSP forms found in Appendix D. Medicaid must approve any other IFSP forms before they may be used for reimbursement for these services.

- Only local education agencies (school boards) are eligible to enroll for children ages three and above.

- Both public and private early intervention centers may enroll directly with Medicaid as providers of these services for infants and toddlers under age three. These services must be coordinated with other age appropriate preventive health services, including screenings and immunizations with Bayou Health.

- These EPSDT services must also be coordinated with the Supplemental Food Program for Women, Infants, and Children (WIC) and Head Start. Make age-appropriate referrals for these services.

- Employ or contract with professional staff qualified to provide the services that meet state and Medicaid practitioner standards regarding certification, licensure, and supervision. Documentation of staff qualifications must be provided to Medicaid as part of the enrollment and monitoring process. Refer to Section 20.3 for applicable qualifications.

- A written referral or prescription must be obtained from a licensed physician to furnish occupational therapy, physical therapy, audiology or speech/language services. This must be done at least annually. The written referral or prescription is not required to conduct an initial evaluation.

- Agree to bill electronically.

- Medicaid collections from these services should be spent on the provision of health related services to children regardless of their Medicaid status.

    - 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.

    - Medicaid funds should not be used for strictly educational or non-medical purposes.

RECORD KEEPING

Providers must make available to the Bureau of Health Services Financing (BHSF) all records of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services provided to children with special health needs. The following documentation must be maintained for at least **five years** from the date of payment on all children for whom claims have been submitted.

- Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying an IEP, including the specific tests performed and copies of evaluation and diagnostic assessment reports signed by the individual and supervisor, if appropriate, that administered the test or did the assessment.

- Copies of the IEP documenting the need for the specific therapy or treatment services, the time and frequency required.

- Documentation of the provision of treatment services by individual physicians, therapist, and other qualified professionals including dates and times of services, billing forms, log books, reports on services provided, and the child's record(s) signed by the individual providing the services and signature of supervisor, if appropriate.

- Written referral or prescription from a licensed physician for any occupational therapy, physical therapy, or audiology services for the current school year (must be dated within the last 365 days).

- Documentation of dates and results of the most recent medical, vision, and/or hearing screening(s) or dates contacted to determine screening status.

Documentation Components

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

- Student's name;
- Date of service;
- Type of service;
- If a group session, the number of students in the group;
- Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with student);
- Description of therapy activity or method used;
- Student's progress toward established goals; and
- Signature of service provider, title and date.

All documentation must be signed, titled and dated by the 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 requirements above.

All documentation must be signed, titled and dated by the provider of the services and by the supervising certified licensed pathologist if supervision is required.

REIMBURSEMENT

EPSDT Health Services for Children with Disabilities program requirements for reimbursement are:

- All services must be furnished in the interest of establishing or modifying a child's individualized education program (IEP) or the services furnished must already be included in the current IEP. Non-IEP or non-Individualized Family Service Plan (IFSP) services may not be billed to Medicaid under this program.

- Only local education agencies (school boards) are eligible to enroll as a provider for children ages three through twenty years.

- Fee for service payments resulting from claims submitted by providers are considered interim payments as providers must submit cost reporting documentation annually as part of their Certified Public Expenditure cost settlement.

- These services must be coordinated with other age appropriate preventive health services, including screenings and immunizations with Bayou Health.

    - Contact Bayou Health or the primary care physician for recipients not linked to Bayou Health to determine the screening and immunization status of the child.
    - EPSDT Health and IDEA-Related Services must also be coordinated with the Supplemental Food Program for Women, Infants, and Children (WIC) and Head Start. Make age-appropriate referrals for these services.

- Employ or contract with professional staff qualified to provide the services that meet state and Medicaid practitioner standards regarding certification, licensure, and supervision. Documentation of staff qualifications must be provided to Medicaid as part of the enrollment and monitoring process.

- A written referral or prescription is no longer required from a licensed physician to provide speech pathology services. However, speech pathology services must still be included in a student's IEP in order to be reimbursed by Medicaid. A written referral or prescription must be obtained from a licensed physician to furnish occupational therapy, physical therapy, and audiology services. This must be done at least annually. The written referral or prescription is not required to conduct an initial evaluation.

- Agree to bill electronically.

- Medicaid collections from these services must be spent on the provision of health related services to children regardless of their Medicaid status.

- 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.

- Medicaid funds may not be used for strictly educational or non-medical purposes.

PROCEDURE CODES AND REIMBURSEMENT RATES

Louisiana Medicaid follows the current American Medical Association'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.

The following chart lists the codes most commonly billed by EPSDT Health and IDEA-Related Services providers:

Procedure Code	Description	Fee
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility; approximately 20 – 30 minutes face-to-face with the patient	$22.50
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45-50 minutes face-to-face with the patient	$45.00
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient	$22.50
90812	Individual psychotherapy, interactive, using play equipment, physical device, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, approximately 45-50 minutes face-to-face with the patient	$45.00
90846	Family psychotherapy (w/o Patient)	$22.50
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	$22.50
90853	Group psychotherapy (other than of a multiple family group)	$22.50
90857	Interactive group psychotherapy	$22.50
92506	Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation status	$45.00
92507	Treatment of speech, language, voice, communication and/or auditory processing disorder (includes aural rehabilitation); individual	$7.50
92508	Treatment of speech, language, voice, communication and/or auditory processing disorder (includes aural rehabilitation); group, 2 or more individuals	$7.50
92551	Screening test, pure tone, air only	$3.60
92552	Pure tone audiometry (threshold), air only.	$22.50

Procedure Code	Description	Fee
92553	Pure tone audiometry (threshold), air and bone.	$45.00
92555	Speech audiometry threshold	$9.00
92556	Speech audiometry threshold ; with speech recognition	$22.50
92557	Comprehensive audiometry, threshold evaluation and speech recognition	$54.00
92563	Tone decay test	$10.00
92564	Short increment sensitivity index (SISI)	$20.00
92565	Stenger test, pure tone	$15.00
92567	Tympanometry (impedance testing)	$22.50
92568	Acoustic reflex testing; threshold	$22.50
92569	Acoustic reflex decay test; decay	$36.00
92571	Filtered speech test	$25.00
92572	Staggered spondaic word test	$75.00
92575	Sensorineural acuity level test	$20.00
92576	Synthetic sentence identification test	$25.00
92577	Stenger test, speech	$13.50
92582	Conditioning play audiometry	$45.00
92583	Select picture audiometry	$22.50
92584	Electrocochleography	$200.00
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	$180.00
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the CNS; limited	$50.00
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	$25.00
92588	Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	$50.00
92590	Hearing aid exam and selection, monaural	$65.00
92591	Hearing aid exam and selection, binaural	$65.00
92592	Hearing aid check, monaural	$22.50
92593	Hearing aid check, binaural	$45.00
92594	Electroacoustic evaluation for hearing aid, monaural	$22.50
92595	Electroacoustic evaluation for hearing aid, binaural	$45.00

Procedure Code	Description	Fee
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	$76.50
97001	Physical Therapy evaluation	$54.00
97003	Occupational Therapy Evaluation	$51.00
97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes	$10.00
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	$10.00
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities	$10.00
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	$20.00
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion, etc.)	$10.00
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance); each 15 minutes	$8.00
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes	$8.00
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s), lower extremity(s) and/or trunk, each 15 minutes	$8.00

Reimbursement fees are current as of June 2012 and are subject to change.

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 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 (the 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 procedure performed on the same day by the same provider (LEA).

DEFINITIONS AND ACRONYMS

Abuse – the inappropriate use of public funds by either a provider or recipient.

AOTA - American Occupational Therapy Association, Inc.

ASHA - American Speech and Hearing Association.

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

Bureau of Health Services Financing (BHSF) – the Bureau within the Department of Health and Hospitals responsible for the administration of the Louisiana Medicaid Program.

Case Management/Support Coordination - services provided to eligible recipients 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.

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

COTA - Certified Occupational Therapy Assistant

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

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 him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

Early Intervention Services - services provided to children, birth through age two, 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.

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

Evaluation (Part H) - the process of collecting and interpreting data obtained through observation, interview, record review, or testing.

EMC - Electronic Media Claim.

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 evaluate resources and services to meet needs.

Federal Poverty Level - 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 - the private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. 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 for further information.

ICN - Internal Claim Number.

Individual Education Program (IEP) - Program that meets all the requirements of 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 H.

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

Early Steps (Infants and Toddlers with Disabilities) - individuals from birth through age two 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.

Local Education Agency (LEA) - the organization in charge of public schools in a particular geographic area. The LEA has a school board and a superintendent.

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

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, the Bureau of Health Services Financing within the Louisiana Department of Health and Hospitals 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 recipients.

OBRA '89 - Omnibus Budget Reconciliation Act of 1989 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.

OTA - Occupational Therapy Assistant.

OTR - Registered Occupational Therapist.

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

PCA - Personal Care Attendant.

PCCM - Primary Care Case Management.

Primary Care Physician (PCP) - the physician that serves as the recipient'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 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 recipients. .

Psychological Services - obtaining, integrating, and interpreting 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.

Recipient - a Medicaid eligible individual.

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 interpreter services, orientation and mobility training, audiological services, health services, speech therapy, counseling, and occupational or physical therapy.

REOMB - Recipient's Explanation of Medical Benefits.

Screening Services - the use of standardized tests given under medical direction in 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.

Speech/Language Pathology - identifies 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 - documents submitted by a state setting forth how it will use federal funds and conform to federal regulations. The plan must be approved by federal officials.

SURS - Surveillance Utilization Review System.

Title XIX - see Medicaid.

TPL - Third-Party Liability.

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

CLAIMS FILING

EPSDT Health and IDEA-Related Services are billed electronically on the 837P transaction or hardcopy on the CMS-1500 claim form.

Items to be completed are either required or situational. 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:

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

CMS-1500 Claim Form and Instructions

*1. Enter an "X" in the box marked Medicaid (Medicaid #)

*1a. Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid swipe card (MEVS), e-MEVS, or through REVS

NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable.

Note: If the 13-digit Medicaid ID number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.

*2. Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through MEVS, e-MEVS or REVS

3. SITUATIONAL Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, e-MEVS or REVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.

4. SITUATIONAL Complete correctly if appropriate or leave blank

5. SITUATIONAL Print the recipient's permanent address

6. SITUATIONAL Complete if appropriate or leave blank

7. SITUATIONAL Complete if appropriate or leave blank

8. SITUATIONAL Leave blank

9. SITUATIONAL Complete if appropriate or leave blank

9a. SITUATIONAL If recipient has no other coverage, leave blank. If there is other coverage, put the state assigned 6-digit TPL carrier code in this block - make sure the EOB is attached to the claim.

9b. SITUATIONAL Complete if appropriate or leave blank

9c. SITUATIONAL Complete if appropriate or leave blank

9d. SITUATIONAL Complete if appropriate or leave blank

10. SITUATIONAL Leave blank

11. SITUATIONAL Complete if appropriate or leave blank

11a. SITUATIONAL Complete if appropriate or leave blank

11b. SITUATIONAL Complete if appropriate or leave blank

11c. SITUATIONAL Complete if appropriate or leave blank

12. SITUATIONAL Complete if appropriate or leave blank

13. SITUATIONAL Obtain signature if appropriate or leave blank

14. SITUATIONAL Leave blank

15. SITUATIONAL Leave blank

16. SITUATIONAL Leave blank

17. SITUATIONAL If services are performed by a CRNA, enter the name of the directing physician.

If services are performed by an independent laboratory, enter the name of the referring physician.

If services are performed by a nurse practitioner or clinical nurse specialist, enter the name of the directing physician.

If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.

17a. SITUATIONAL If the recipient is linked to a PCP, the Primary Care Physician referral authorization number must be entered here.

18. SITUATIONAL Leave blank

19. SITUATIONAL Leave blank

20. SITUATIONAL Leave blank

*21. Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.

22. SITUATIONAL Leave blank

23. SITUATIONAL Complete if required or leave blank

*24a. Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.

*24b. Enter the appropriate code from the approved Medicaid place of service code list.

24c. SITUATIONAL Leave blank

*24d. Enter the procedure code(s) for services rendered.

*24e. Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a "1", "2", etc. More than one diagnosis may be related to a procedure. Do not enter ICD-9-CM diagnosis code

*24f. Enter usual and customary charges for the service rendered

*24g. Enter the number of units billed for the procedure code entered on the same line in 24D

24h. SITUATIONAL Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral

24i. SITUATIONAL Leave blank

24j. SITUATIONAL Leave blank

24k. SITUATIONAL Enter the attending provider number if group number is indicated in block 33

25. SITUATIONAL Leave blank

26. SITUATIONAL Enter the provider specific information assigned to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.

27. SITUATIONAL Leave blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.

*28. Total of all charges listed on the claim

29. SITUATIONAL If block 9A is completed, indicate the amount paid; if no TPL, leave blank

30. SITUATIONAL If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from the billed charges

*31. The claim form MUST be signed. The practitioner is not required to sign the claim form. However, the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned unprocessed.

Date Enter the date of the signature

32. SITUATIONAL Complete as appropriate or leave blank

*33. Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid billing provider number must be entered in the space next to "Group (Grp) #."

Note: If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.

Marked (*) items must be completed or form will be returned.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567891234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Johnny

3. PATIENT'S BIRTH DATE MM DD YY: 01 18 97 SEX M [X] F [ ]

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

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

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

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

CITY: STATE:

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

CITY: STATE:

ZIP CODE: TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. 714.30
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	4	20	07	4	20	07			97003		1	56 00	1		NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 56 00

29. AMOUNT PAID $(TPL Amt)

30. BALANCE DUE $ 56 00

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

Ima Biller 5/15/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

ABC School Board
45 Oak Street
Sunny, LA 70000

a. 1111111111 b. 1111111

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

213 Adjustment/Void Form and Instructions

*1. ADJ/VOID—Check the appropriate block

*2. Patient's Name
   a. Adjust—Print the name exactly as it appears on the original claim if not adjusting this information
   b. Void—Print the name exactly as it appears on the original claim

3. Patient's Date of Birth
   a. Adjust—Print the date exactly as it appears on the original claim if not adjusting this information
   b. Void—Print the name exactly as it appears on the original claim

*4. Medicaid ID Number—Enter the 13 digit recipient ID number

5. Patient's Address and Telephone Number
   a. Adjust—Print the address exactly as it appears on the original claim
   b. Void—Print the address exactly as it appears on the original claim

6. Patient's Sex
   a. Adjust—Print this information exactly as it appears on the original claim if not adjusting this information
   b. Void—Print this information exactly as it appears on the original claim

7. Insured's Name— Leave blank

8. Patient's Relationship to Insured—Leave blank

9. Insured's Group No.—Complete if appropriate or blank

10. Other Health Insurance Coverage—Complete with 6-digit TPL carrier code if appropriate or leave blank

11. Was Condition Related to—Leave blank

12. Insured's Address—Leave blank

13. Date of—Leave blank

14. Date First Consulted You for This Condition—Leave blank

15. Has Patient Ever had Same or Similar Symptoms—Leave blank

16. Date Patient Able to Return to Work—Leave blank

17. Dates of Total Disability-Dates of Partial Disability—Leave blank

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

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

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

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

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

*22. Diagnosis of Nature of Illness
- a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information
- b. Void—Print the information exactly as it appears on the original claim

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

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

*25. A through F
- a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information
- b. Void—Print the information exactly as it appears on the original claim

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

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

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

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

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

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

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

Marked (*) items must be completed or form will be returned.

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

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

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

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

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

ADJUSTMENT

30 SIGNATURE OF PHYSICIAN OR SUPPLIER
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
32 YOUR PATIENT'S ACCOUNT NUMBER

FISCAL AGENT COPY

Molina - 213
5/97

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 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:

- All claim forms are clear and in good condition
- All information is readable to the normal eye
- All information is centered in the appropriate block
- All essential information is complete

Correct Claims Submission

We have learned that some providers are incorrectly submitting claims directly to DHH at P.O. Box 91030 rather than correctly submitting claims to the FI to the appropriate post office box for the program type. Unless specifically directed to submit claims directly to DHH, providers should cease this practice and submit claims to the appropriate 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 Medicaid of Louisiana:

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

Dates of Service Past Initial Filing Limit

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

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

OR

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

OR

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

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

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

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

Submitting Claims for Two-Year Override Consideration

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

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

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

Molina 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.

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

Any request submitted directly to DHH staff will be routed to Molina 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

The Louisiana Department of Health and Hospitals and Molina maintain a website to make information more accessible to LA Medicaid providers. At this online location, www.lamedicaid.com, providers can access information ranging from how to enroll as a Medicaid provider to directions for filling out a claim form.
Listed below are some of the most common topics found on the website:

New Medicaid Information
National Provider Identifier (NPI)
Disaster
Provider Training Materials
Provider Web Account Registration Instructions
Provider Support
Billing Information
Fee Schedules
Provider Update/Remittance Advice Index
Pharmacy
Prescribing Providers
Provider Enrollment
Current Newsletter and RA
Helpful Numbers
Useful Links
Forms/Files/User Guidelines

The website also contains a section for Frequently Asked Questions (FAQ) that provide answers to commonly asked questions received by Provider Relations.

Along with the website, the Molina Provider Relations Department is available to assist providers. This department consists of three units, (1) Telephone Inquiry, (2) Correspondence, and (3) Field Analysts. The following information addresses each unit and their responsibilities.

Molina Provider Relations Telephone Inquiry Unit

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification; ordering printed materials; billing denials/problems; requests for Field Analyst visits; etc. For more information see Appendix E.

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 Molina Provider Relations telephone inquiry phone numbers. Callers should have the 7-digit LA Medicaid provider number available to enter the system. Please listen to the menu options and press the appropriate key for assistance.

Press #2 - To order printed materials only**

Examples: Orders for provider manuals, Molina claim forms, and provider newsletter reprints.

To choose this option, press "2" on the telephone keypad. This option will allow providers to leave a message to request printed materials **only**. Please be sure to leave (1) the provider name, (2) provider number, (3) contact person, (4) complete mailing address, (5) phone number and (6) specific material requested.

- Only messages left in reference to printed materials will be processed when choosing this option. Please review the other options outlined in this section for assistance with other provider issues.
- Fee schedules, TPL carrier code lists, provider newsletters, provider workshop packets and enrollment packets may be found on the LA Medicaid website. Orders for these materials should be placed through this option **ONLY** if you do not have web access.
- An enrolled provider may also request a copy of the provider manual and training packet for the Medicaid program in which he is enrolled. A fee is charged for provider manuals and training packets ordered for non-providers (attorneys, billing agents, etc.) or by providers wanting a manual for a program for which they are not enrolled. All orders for provider manuals and training packets should be made by contacting the Provider Relations Telephone Inquiry Unit. Those requiring payment will be forwarded to the provider once payment is received.

Provider Relations cannot assist recipients. The telephone listing in Appendix E should be used to direct Medicaid recipient inquiries appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Molina. Recipients with a provider number may be able to obtain information regarding the provider (last

check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

Press #3 - To verify recipient or provider eligibility; Medicare or other insurance information; Primary Care Physician information; or service limits.

- Recipient eligibility
- Third Party (Insurance) Resources
- CommunityCARE
- Lock-In

NOTE: Providers should access eligibility information via the web-based application, e-MEVS (electronic-Medicaid Eligibility Verification System) on the Louisiana Medicaid website or MEVS vendor swipe card devices/software. Providers may also check eligibility via the Recipient Eligibility Verification System (REVS) (see Appendix E). Questions regarding an eligibility response may be directed to Provider Relations.

Press #4 - To resolve a claims problem

Provider Relations staff are available to assist with resolving claim denials, clarifying denial codes, or resolving billing issues.

NOTE: Providers must use e-CSI to check the status of claims and e-CSI in conjunction with remittance advices to reconcile accounts.

Press #5 – To obtain policy clarification, procedure code reimbursement verification, request a field analyst visit, or for other information.

Molina Provider Relations Correspondence Group

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims.

Providers, who wish to submit problem claims for research and want to receive a written response, **must submit a cover letter** explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). A copy of the claim form along with applicable corrections/and or attachments must accompany all resubmissions.

All requests to the Correspondence Unit should be submitted to the following address:

Provider Relations Correspondance 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 recipient files with correct eligibility. Staff in this unit does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

TPL File Updates: Requests to update Third Party Liability (TPL) should be directed to:

DHH-Third Party Liability
Medicaid Recovery Unit
P. O. Box 91030
Baton Rouge, LA 70821

"Clean" Claims: "Clean" claims should not be submitted to Provider Relations as this delays processing. Please submit "clean" claims to the appropriate P.O. Box. A complete list is available in Appendix E.

CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.

Claims Over Two Years Old: Providers are expected to resolve claims issues within two years from the date of service on the claims. The process through which claims over two years old will be considered for re-processing is discussed above in this section. In instances where the claim meets the DHH established criteria, a detailed letter of explanation, the hard copy claim, and required supporting documentation must be submitted **in writing** to the Provider Relations Correspondence Unit at the address above. **These claims may not be submitted to DHH**

personnel and will not be researched from a telephone call to DHH or the Provider Inquiry Unit.

Molina Provider Relations Field Analysts

Provider Relations Field Analysts are available to visit and train new providers and their office staff on site, upon request. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However**, **since the Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for material, or other policy documentation. These calls should not be directed to the Field Analysts but rather to the FI Provider Relations Telephone Inquiry (see Appendix E).**

A current listing of the FI Provider Relations Field Analysts assigned by parish can be found on the Medicaid website, www.lamedicaid.com and following the link for Provider Support and Field Analysts.

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:

- Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:
    - The correct 7-digit LA Medicaid provider number
    - The 13-digit Recipient's Medicaid ID number
    - The date of service
    - Any other information, such as procedure code and billed charge, that will help identify the claim in question
    - The Remittance Advice showing disposition of the specific claim in question
- Obtain the name of the phone representative you are speaking to in case further communication is necessary.
- Due of the large volume of incoming provider calls, Telephone Inquiry staff are not allowed to be put on hold after answering a call.
- Review and reconcile the remittance advice before calling Provider Relations concerning claims issues. Some providers call Provider Relations frequently, asking questions that

could be answered if the RA was reviewed thoroughly. However, providers are encouraged to call Provider Relations with questions concerning printed policy, procedures, and billing problems.

- Provider Relations WILL NOT reconcile provider accounts or work old accounts for providers. Calls to check claim status tie up phone lines and reduce the number of legitimate questions and inquiries that can be answered. It is each provider's responsibility to establish and maintain a system of tracking claim billing, payment, and denial. This includes thoroughly reviewing the weekly remittance advice, correcting claim errors as indicated by denial error codes, and resubmitting claims which do not appear on the remittance advice within 30 - 40 days for hard copy claims and three weeks for EDI claims.

- Providers can check claim status through the e-CSI (Claim Status Inquiry) web application found in the secure area of the Louisiana Medicaid website at www.lamedicaid.com. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on e-CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the e-CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to e-CSI or hard copy remittance advices for this purpose. This includes provider's direct staff and billing agents or vendors. A LA Medicaid/HIPAA Error Code Crosswalk is available on the website by accessing the link, Forms/Files.

- If a provider has a large number of claims to reconcile, it may be to the provider's advantage to order a provider history. Refer to the Ordering Information section for instructions on ordering a provider history.

- **Provider Relations cannot assist recipients.** The telephone listing in the "Recipient Assistance" section found in this packet should be used to direct Medicaid recipient inquires appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting FI. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

- Providers who wish to submit problem claims for a written response **must submit a cover letter** explaining the problem or question.

- Calls regarding eligibility, claim issues, requests for Molina claim forms, manuals, or other policy documentation should not be directed to the Field Analysts but rather to the FI Provider Relations Telephone Inquiry Unit.

DHH Program Manager Requests

Questions regarding the rationale for Medicaid policy, procedure coverage and reimbursement, medical justification, written clarification of policy that is not documented, etc. should be directed in writing to:

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

FORMS

1. **Individualized Family Service Plan (IFSP)**
2. **Individualized Education Program (IEP)**
3. **PA-01**

Individualized Family Service Plan

*Indicates information to be entered and stored electronically at the System Point of Entry

Section 1 Child Information

*Child's name: (Last/First/MI)	*Nickname:	*Gender: Circle one M or F
*Home address:	*Mailing address:	
*City/Town:	*Zip Code:	*Parish of Residence:
*Date of Birth:	*Current Age/Adjusted Age:	Today's date:

Child's Medicaid Number (if applicable): _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ICD-9 Code:_____

Section 1 A. General Contact Information

*Parent/Guardian:

*Relationship to child:

Telephone: Home: _____
Work: _____ Cell: _____
Other phone contact: _____
Best Time to Call: _____ Email: _____

Other Contact:	Telephone
Name:	Home:
Relationship:	Work:
	Cell

Additional contact information:

Section 1 B. IFSP History & Family Support Coordinator

*Name of FSC:

Telephone:

IFSP History

*Date of Initial IFSP	Projected Date of Annual IFSP

***Type of IFSP and Date**

☐ Interim	☐ 6 month Review
☐ Initial	☐ Transition
☐ Annual	☐ Review/Revision

Notes:

IFSP Documentation List:
Section 1: Child-Family Demographics
Section 2: Family Concerns Priorities and Resources
This section taken from page 8 of Family Assessment
Section 3a: Health History Form, page 2
Health Summary Updated: _____Yes _____No
Section 3b: Present Levels of Development and BDI-2 Evaluation Report Form (page 3)
Section 4: IFSP Outcomes
Section 5: Transition Outcomes
Section 6: EI Services
Section 7a: Assistive Technology
Section 7b: Transportation
Section 8: Other Services
Section 9: Team Participants
Section 10: Services outside Natural Environment Justification

IFSP 6 Month Review/Revision Section
IFSP page 1,
IFSP section 4 (if outcome added/revised)
IFSP section 5
IFSP Section 6 (updated, revised, or new if necessary)
IFSP Section 9
If outcome is added, additional outcome page(s) must be completed:

Indicate Concern and Rationale for Change:

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 2: Summary of Family Concerns, Priorities, and Resources to enhance the development of their child

This page is taken from page 8 of Family Assessment form and inserted in Section 2 of the IFSP **(Additional pages may be used if necessary)**

Date Completed: _____

Check appropriate box: ☐ Family assessment completed with family concurrence

☐ Family declined family assessment of concerns, priorities and resources (Parent signature)_____

Priority	Domain	Resource
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Othere	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	

Child Name:_____ Date Completed:_____

Section 3a: Present Levels of Health Functioning

Health History Form, page 2 **This page inserted as Section 3a of the IFSP**

Hearing Status:

Last Hearing Test Date:_____ Results:_____
Newborn Hearing Screen Results: ☐ Pass ☐ Fail ☐ Follow up: _____date
Hearing Aids: ☐ Yes ☐ No Ear Infections: ☐ Yes ☐ No Tubes: ☐ Yes ☐ No
Parent Concerns:_____
Risk factors from page 1 of Health History checked: ☐ Yes ☐ No

Hearing Screen Current within 3 months: ☐ **Yes** ☐ No
If no, Hearing Screen to be scheduled: ☐ **Yes** ☐ No

Vision Status:

Last Vision Test Date:_____ Results:_____
Glasses : ☐ Yes ☐ No
Parent Concerns:_____
Risk factors from page 1 of Health History checked: ☐ Yes ☐ No

Vision Screen Current within 3 months: ☐ **Yes** ☐ No
If no, Vision Screen to be scheduled: ☐ **Yes** ☐ No

Birth History and Physical Development/Health Status

Complete at Initial IFSP ONLY: Was your child's birth premature**?** ☐ No ☐ Yes How many weeks early was your child born?_____
Gestational age? _____ Birth weight? _____Birth Length**:**_____ Hospital Stay after Birth**:**_____

Update remaining section annually: Current Weight**:**_____
What medical diagnoses does your child have that you are aware of?_____
ICD – 9 Code:_____

Nutrition Status:

Diet: Bottle/Breast Feeding: ☐ Yes ☐ No **Formula/Oz/Day:**_____ **Special diet?** ☐ No ☐ Yes _____
WIC? ☐ Yes ☐ No Referral Needed: ☐ Yes ☐ No
Known allergies: ☐ Yes ☐ No If yes, specify type:_____
Other Health Information to Assist in Planning:_____

Adaptive Equipment	Medical Equipment
☐ Wheelchair ☐ Splints/AFOs/Braces ☐ Adaptive Seating ☐ Adaptive Bathing ☐ Feeding Aids ☐ Other: _____ ☐ No adaptive equipment	Special Equipment child came home from hospital with: **Hospital Discharge:** / **Current**: ☐ Apnea monitor / ☐ Apnea monitor ☐ Oxygen / ☐ Oxygen ☐ Feeding tube / ☐ Feeding tube ☐ Ventilator / ☐ Ventilator ☐ Trach / ☐ Trach ☐ Nebulizer / ☐ Nebulizer ☐ Other: _____ / ☐ Other: _____ ☐ No medical equipment / ☐ No medical equipment

Does your child receive any medications? (List type and purpose)

Medication:	Purpose:

Section 3b: IFSP Present Levels of Development and BDI-2 Evaluation Report

Page 3 of the BDI-2 Evaluation Report & IFSP and Program Planning Report

Child's Name: _____ DOB: _____ Chronological Age: _____

□ **Initial Eligibility** □ **Annual Eligibility** □ **Revision**

Give brief summary of development in each domain from BDI-2 or other assessment(s).

Domain	BDI-2 Scores	Other Assessment Results /Current Developmental Status
Adaptive	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Social-Emotional	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Communication	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Receptive	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Expressive	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Physical	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Gross Motor	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Fine Motor	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Cognition	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	

* Attach Original Assessment scoring booklet * Form to be completed at initial evaluation, annual evaluation, and exit evaluation. Vision and Hearing status in Health History

_____ _____ _____

Provider Signature & Credentials Provider Phone Number Date of Assessment

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Type of IFSP: □ Initial □ Review/Revision: □ New □ Revise □ Completed Outcome □ Annual

Section 4: Outcomes for child and family Complete a separate page for each outcome including at least one for FSC

Outcome Number ____: Description:	What's happening now?	Our team will be satisfied that we are finished with this outcome when (criteria for measuring progress):

What skills and behaviors do we want this child and family to accomplish in the next 3-6 months?

In 3 months:_____

_____

In 6 months:_____

_____

This outcome will include these strategies we will use to enhance this child's pre-literacy and language skills:

- ☐ Birth to three months – visual tracking, smiling and responding to social interaction
- ☐ Three to six months – responding to tones in voices, attending to others speaking
- ☐ Six to twelve months – babbling and imitating sounds
- ☐ Twelve to eighteen months – look at point to pictures in books, participate in songs with hand motions
- ☐ Eighteen to twenty four months - naming pictures in books and listening to stories
- ☐ Twenty four to thirty six months – singing songs, nursery rhymes, filling in words to familiar stories
- ☐ Other: _____

What strategies will the family/other caregivers use in their daily routines and activities to achieve the outcome?

☐ verbal prompting/ instructing	☐ with adaptive equipment ☐ with environmental modifications
☐ modeling (with verbal prompting)	**Strategies for Support Coordination Outcome**
☐ gesturing (with verbal prompting)	☐ Monthly telephone calls with family
☐ physically assisting/supporting/guiding (with verbal prompting)	☐ Communication with other service providers ☐ Other: _____
☐ Counseling for family	☐ Link family with community resources and monitor progress
☐ Classes/groups to attend	☐ Assist family with referral and application for services (IFSP Section 8 Other Services)
☐ Other	☐ Team Meetings (minimum quarterly)
With whom will these strategies be practiced? ☐ family members ☐ relatives ☐ child care staff ☐ service provider(s):_____ ☐ Service Coordinator **(if checked complete strategies for FSC outcome)** ☐ other:_____	Where can these strategies be practiced? ☐ special purpose facility ☐ special purpose facility with inclusive childcare ☐ community setting ☐ other:_____ ☐ home
We will measure progress towards the achievement of this outcome by: ☐ observation ☐ case notes/progress reports ☐ assessment/evaluation by team ☐ quarterly team meetings ☐ telephone calls ☐Other:_____ ☐ parent observation and report	Daily living routine addressed by this outcome: ☐ bathing ☐ dressing ☐ eating ☐ potty training ☐ playing indoors ☐ playing outdoors ☐ sleeping/napping ☐ other:_____

IFSP Review/Revision: □ Add outcome(add page) □ Change Outcome □ Revise Strategies □ No Changes in outcomes

Services: □Add □Drop □Frequency/Intensity Change □Change location □Change Provider (Supplement with Team Decision Process)

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 5: Transition Planning: Early Transition and Transition at Age Three

A. Plan for Transition **Must be discussed at each IFSP meeting.**		**Sign/Initial**	**Date of Discussion**
Procedures we will use to prepare the child for the upcoming transition: Procedures to prepare the child/family for changes in service delivery: _____ ☐ Discussed with parents future placements and other matters related to the child's transition. ☐ Discussed with parents community programs available following transition from Part C.	Program options identified by the team (check all that apply): ☐ Part B ☐ Head Start/ Early Head Start ☐ Child Care ☐ Other community resources ☐ OCDD/HSA/D ☐ Medicaid EPSDT services ☐ Other: _____	A plan for transition at Age 3 has been discussed: ☐ FSC: _____ ☐ Parent: _____	___/___/___

B. Early Transition Event and Issue *Check the appropriate box, if applicable*	**Early Transition Steps**	**Sign/Initial**	**Date of Discussion**
☐ Child is coming home from hospital; need to ensure no disruption of necessary services ☐ Family will be experiencing a change that may affect the delivery of an IFSP service (birth or adoption of sibling, medical needs of other family members, employment or loss of employment) ☐ Child will be experiencing a change that may affect the delivery of an IFSP service (i.e., hospitalization, placement in child care setting, medication changes, etc) ☐ Changes in IFSP services (i.e., termination/addition of service, change in location of service) ☐ Early Exit Before Age Three: Child is exiting EarlySteps, no longer eligible, parent declines participation in EarlySteps ☐ Plan for disposition of Assistive Device, if applicable: If box is checked above develop steps for transition in next column ☐ Schedule BDI-2 Exit; Date BDI-2 Requested:_____/_____/_____	☐ Early Transition Steps: ☐ Referral for Medicaid EPSDT services ☐ Assistance with referral to other community Resources: _____ ☐ Assistance with referral for Part C Services in other states: _____ ☐ SPOE to SPOE transfer in Louisiana ☐ Other: _____ ☐ Early Exit Steps ☐ Referral for Medicaid EPSDT case management ☐ Discuss OCDD/HSA/D entry requirements at age three with family ☐ Other: _____ ☐ Changes in Service Delivery Steps: ☐ Meet service providers ☐ Visit community service agencies ☐ Review written materials ☐ Other: _____	Early transition events and issues have been discussed: ☐ FSC: _____ ☐ Parent: _____	1. ___/___/___ 2. ___/___/___

C. Transition Conference at Age Three		
☐ Transition Notification Letter Sent to LEA at 2 years 2 months: _____ ☐ Child specific records were sent to the LEA ☐ Parent did not consent to record release : _____ (parent's initials) ☐ LEA was notified of child's upcoming transition conference: _____ ☐ Parent declined LEA attendance at transition conference: _____ (parent's initials) ☐ Schedule BDI-2 Exit; Date DBI-2 Exit Requested:_____/_____/_____	**Age three transition steps and services:** ☐ Family attends transition workshop ☐ Family and child visit LEA preschool sites ☐ Family and child visit /get information on Head Start centers ☐ Family visits other community agencies: preschool, child care, etc. ☐ Family contacts OCDD/HSA/D for entry ☐ LEA to schedule eligibility evaluation ☐ FSC to attend initial IEP meeting: ___/___/___ ☐ Part C Services End: ___/___/___ Discuss Program Options for remainder of school year ☐ Talk to other families ☐ Other: _____	Date of Transition Conference: ____/____/____

This child requires a referral for OCDD eligibility determination ☐ yes ☐ no If yes, date referral packet sent: _____/_____/_____

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 6: Early Intervention Services

*This entire page is part of the electronic record. **Attach Section 7A/B if Assistive Technology and/or Transportation are necessary to achieve the IFSP outcomes. Use codes as listed here for completion.**

Modification	Column A Early Intervention Service	B Outcome Number	C Location	D Frequency	E Intensity	F Start Date	G End Date	H Method	I Funding Source	J Provider's Name/Payee Type (including name of agency)
	Family Service Coordinator									☐ Independent ☐ Agency ☐ No Provider Available Name:
	Service: _____ ☐ Individual ☐ Group									☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):
	Service: ____ ☐ Individual ☐ Group									☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):
	Service: _____ ☐ Individual ☐ Group									☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):
	Service: _____ ☐ Individual ☐ Group									☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):

Services: □Add(+) □Frequency/Intensity Change □Change location □Change Provider (Supplement with Team Decision Process) □No Change (NC) □Drop (-) Service: _____ Date: _____

Section K: Primary Setting: What is the setting where the majority of services will be provided? Choose one from list below.

☐ Home ☐ Community Setting ☐ Special Purpose Center ☐ Hospital ☐ Residential Facility ☐ Service Provider Setting ☐ Other Setting

****LEGEND**

Column C - Location	Column H - Method	Column I - Funding
1= Home/community setting	1 =Early intervention service	A = Part C/State Funding
5=Special purpose center w/inclusive childcare	2= Family education/training	B = Medicaid C = MFP
6=Special purpose center or clinic	3=Assessment	

Parent Consent for Services: The contents of this IFSP have been fully explained to me. I give informed, written consent to implement the services described in Section 7 of the IFSP. I have received a written copy of our Parent's Rights in EarlySteps. **I understand that EarlySteps must wait at least 3 calendar days before taking any action.** I understand that I can revoke the consent for any service at any time.

_____
Parent Signature Date

Initial IFSP Date:_____ Type of IFSP: ☐ Initial ☐ Review/Revision _____ ☐ Annual _____

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 7A. Complete this page as needed

Assistive Technology Device

Child's Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __

IFSP Outcome Number	*Name of Device	*Vendor Providing Device	Where is device used?	When is device used? *indicate activities	*Start date for device use	*End date for device use	*HCPCs Code	*Price/Cost
	Is this covered by Medicaid? Yes No Did Medicaid provide? Yes No If no - attach copy of Medicaid denial letter.		☐ Home ☐ Child care ☐ Relative's home ☐ Community setting: _____ ☐ Other:					
	Is this covered by Medicaid? Yes No Did Medicaid provide? Yes No If no - attach copy of Medicaid denial letter.		☐ Home ☐ Child care ☐ Relative's home ☐ Community setting: _____ ☐ Other:					
Approval required for any item costing over $500.00 or if total of all items is more than $500.00							Total cost for all AT Devices listed: $	

I understand that any equipment provided by EarlySteps over $500.00 is the property of the state of Louisiana and I may be required to return this equipment upon my child's exit from EarlySteps.

Parent Signature: _____

Section 7B: Transportation Necessary to access Early Intervention Services

IFSP Outcome Number	*Start Date	*End Date	*Provider (Parent Name)	*Frequency	*Maximum miles per trip expressed as round trip

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 8: Other Services Needed to Enhance Child's Development

Service	Family or Child Service (circle)	Responsible Person Contact Information	Funding Source or Steps to secure service
Primary Medical Home or Physician	Child		
	Child Family		
	Child Family		
	Child Family		
	Child Family		

Section 9: IFSP Team

Printed Name	Position/Role	Agency (if applicable)	Telephone Number	Signature or Method of Participation
	Parent			Signature:
	IC (only at initial IFSP)			Signature:
	EIC (required for informed clinical opinion)			Signature:
	FSC			Signature:
	CDA Provider			☐ Telephone ☐ Report Signature:
	Provider			☐ Telephone ☐ Report Signature:
				☐ Telephone ☐ Report Signature:
				☐ Telephone ☐ Report Signature:
				☐ Telephone ☐ Report Signature:

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 10: Justification for Early Intervention Services Delivered Outside of the Natural Environment

Complete and attach to the IFSP only as required.

Early Intervention Service Not Provided in Natural Environment	Child specific reason why early intervention can not be satisfactorily achieved in a natural environment: Data to support this team decision:	How will services be incorporated into the Natural Environment? ☐ Provider will send a note home after each session for the family ☐ Provider will talk with the parent every 2 weeks regarding the child's progress ☐ Provider will send home information on the strategies the child is learning, so the parent can incorporate these strategies into the child's routine at home ☐ The parent will call the provider if he/she is unclear on how to implement a new strategy ☐ Parent or caregiver will participate in sessions when possible ☐ Other: _____
Early Intervention Service Not Provided in Natural Environment	Child specific reason why early intervention can not be satisfactorily achieved in a natural environment: Data to support this team decision:	How will services be incorporated into the Natural Environment? ☐ Provider will send a note home after each session for the family ☐ Provider will talk with the parent 2 weeks regarding the child's progress ☐ Provider will send home information on the strategies the child is learning, so the parent can incorporate these strategies into the child's routine at home ☐ The parent will call the provider if he/she is unclear on how to implement a new strategy ☐ Parent or caregiver will participate in sessions when possible ☐ Other: _____
Early Intervention Service Not Provided in Natural Environment	Child specific reason why early intervention can not be satisfactorily achieved in a natural environment: Data to support this team decision:	How will services be incorporated into the Natural Environment? ☐ Provider will send a note home after each session for the family ☐ Provider will talk with the parent 2 weeks regarding the child's progress ☐ Provider will send home information on the strategies the child is learning, so the parent can incorporate these strategies into the child's routine at home ☐ The parent will call the provider if he/she is unclear on how to implement a new strategy ☐ Parent or caregiver will participate in sessions when possible ☐ Other: _____

Initial IFSP Date:_____ Type of IFSP: ☐ Initial _____ ☐ Review/Revision _____ ☐ Annual _____

Transition Services

Date of Student Invitation: | Method of Student Invitation:

Measurable Postsecondary Goals (Outcomes that occur after the student has left high school.)

Training or Education Goal:
Employment Goal:
Independent Living Goal: (if applicable)

Transition Assessments List the multiple assessments used to address the student's career interests, vocational skills, employability, independent living skills, self advocacy and other preferences and interests. Assessment documentation must be included in IEP folder.

TRANSITION SERVICES	SCHOOL ACTION STEPS	STUDENT ACTION STEPS	FAMILY ACTION STEPS	AGENCY ACTION STEPS
INSTRUCTION/ RELATED SERVICES				
COMMUNITY EXPERIENCES				
EMPLOYMENT AND POSTSCHOOL ADULT LIVING				
FUNCTIONAL VOCATIONAL EVALUATION AND DAILY LIVING SKILLS				

WHEN NEEDED, IF A PARTICIPATING AGENCY DOES NOT ATTEND, DOCUMENT OTHER ACTIONS FOR AGENCY LINKAGES.

Exit Document: _____
Years to Graduate: _____
Anticipated Exit Date: _____

General Student Information

HOMEBASED SCHOOL: _____ OTHER SCHOOL: _____

IEP TYPE: _____ INDIVIDUAL EVALUATION / WAIVER DATE: _____

Primary / Other	Exceptionality	Detail(s)
Primary		
Other		
Other		
Other		
Other		

IEP Participants	Name	IEP Participants	Name

Include strengths; parental concerns; evaluation results; academic, developmental, and functional needs; statewide assessment results; progress or lack of expected progress in general education curriculum; and consideration of special factors: behavior, language needs for limited English proficient, instruction in and use of braille, communication needs, assistive technology devices and services, and health needs.

General Information about the Student:	
Strengths:	
Parent Concerns:	
Evaluation / Reevaluation Results:	
Academic, Developmental, and Functional Needs:	
Statewide Assessment Results:	
Progress or lack of expected progress in general education curriculum:	

General Student Information (continued)

Consideration of Special Factors

Behavior:	
Limited English Proficent:	
Communication Needs of Child:	
Instruction in and use of Braille:	
Assistive Technology Services / Devices - Please indicate AT devices used on the Accommodations Page	
Health needs - IHP needs to be attached to IEP	

☐ **After consideration by the IEP team, there are no special factors that need to be addressed at this time**

Transition Courses of Study - Attach plan to IEP: ☐ Individual Prescription for Instruction ☐ Individual Graduation Plan ☐ Educational / Career Plan for LAA1 Students

Educational Needs: ☐ Academic/Cognitive ☐ Behavior ☐ Communication ☐ Motor ☐ Self-Help ☐ Social

Accommodations

CHECK THE INDIVIDUAL ACCOMMODATIONS NEEDED

☐ **ESY Instruction**

ENVIRONMENT

☐ Assign preferential seating
☐ **Provide individual instruction**
☐ **Provide small group instruction**
☐ Assign peer tutors/work buddies/note takers
☐ Provide desktop list of tasks
☐ Alter physical room environment
☐ Modify student's schedule (describe)
☐ Other (specify)

INSTRUCTION/MATERIALS

☐ Modify assignments as needed (e.g., vary length, limit items)
☐ **Utilize oral responses to assignments/tests (answers recorded)**
☐ **Read class materials orally**
☐ Provide study outlines/guides
☐ Provide daily assignment list
☐ Provide homework lists
☐ Provide assistance/cues for transitions between activities
☐ Provide options for students to obtain information and demonstrate knowledge through use of ☐ alternative projects ☐ interviews ☐ oral reports
☐ Shorten assignments
☐ Modify/repeat/model directions
☐ Utilize multi-sensory modes to reinforce instruction
☐ **Transferred answers**
☐ Use text/workbooks/worksheets at a modified reading level
☐ Alter format of materials on page (type/highlight/spacing)
☐ **Utilize large print**
☐ **Utilize braille**
☐ Utilize audio/recorded books
☐ Utilize digital formats
☐ Other Instruction (specify)
☐ Utilize graphic/pictorial mode materials
☐ Utilize print with magnification
☐ Color code materials
☐ Other Materials (specify)

☐ **COMMUNICATION ASSISTANCE - related to hearing loss only (describe)**

TIME

☐ **Increase the amount of time allowed to complete assignments and tests**
☐ Limit amount of work required or length of tests
☐ **Allow breaks during work periods, between tasks, during testing**
☐ Provide assistance/cues for transitions betwen classes, lockers, and home
☐ Other (specify)

TESTS/QUIZZES/PROJECTS

☐ Prior notice of tests
☐ Limited multiple choice
☐ **Extra time – tests**
☐ Pace long term projects
☐ Preview test procedures
☐ Student writes on test
☐ Objective tests
☐ Extra time – projects
☐ Rephrase test questions/directions
☐ Test study guide
☐ Shortened tasks
☐ Modified tests (describe)
☐ Other (specify)
☐ Extra credit options
☐ Extra response time
☐ Simplify test wording
☐ Hands-on-projects
☐ **Extra time-written work**
☐ **Tests Read Aloud**
☐ **Individual testing**
☐ **Small group testing**
☐ **Transferred answers**
☐ **Answers recorded**

☐ **ASSISTIVE TECHNOLOGY**

☐ **Digital Recorders**
☐ Manipulatives
☐ Text-to-speech
☐ Colored reading filters
☐ Eye gaze communication system
☐ Adapted grips/utensils/pencils/drawing tools
☐ Other AT devices (specify)
☐ **Calculators**
☐ Organizers
☐ FM system
☐ **Word Processors**
☐ Adapted toys/games
☐ Communication board/system
☐ Voice output device
☐ Voice recognition software

☐ **NONE**

The accommodations bolded on this page match the LEAP test accommodations on the program/services page of the IEP.

Program / Services

LOUISIANA EDUCATIONAL ASSESSMENT PROGRAM

LEAP/iLEAP/GEE/EOC ☐

Alternate Assessment ☐ LAA 1 ☐ LAA 2 ☐ ELA ☐ Math ☐ Science ☐ Social Studies

Academic Skills Assessment (non-diploma exit pathway) ☐ ASA ☐ ASA LAA 2

None ☐

1) If alternate assessment is checked, explain why the student cannot participate in the regular assessment, and

2) why the particular alternate assessment selected is appropriate for student

ACCOMMODATION(S) NEEDED FOR STATEWIDE ASSESSMENT (CHECK ALL THAT APPLY.)

- ☐ **None**
- ☐ Answers Recorded
- ☐ Large Print
- ☐ Braille
- ☐ Individual
- ☐ Tests Read Aloud except Reading Comprehension*
- ☐ Transferred answers
- ☐ Extended Time
- ☐ Communication Assistance
- ☐ Small Group

☐ Assistive Technology: Identify the type of AT to be used

☐ Other

REGULAR CLASSES

- ☐ Reading
- ☐ Science
- ☐ Math
- ☐ Vocational
- ☐ Electives (list)
- ☐ Spelling
- ☐ Writing
- ☐ Art/Music
- ☐ English/Language Arts
- ☐ Physical Education
- ☐ Social Studies
- ☐ Foreign Language

If not in regular classes, explain

ACTIVITIES WITH NON-DISABLED PEERS (Check all activities with non-disabled peers)

- ☐ Assemblies
- ☐ Library
- ☐ Extracurricular/Nonacademic
- ☐ Other
- ☐ Buses
- ☐ Meals
- ☐ Field Trips
- ☐ Recess

☐ If not participating in activities with non-disabled peers,explain

EXTENDED SCHOOL YEAR SERVICES (ESYS)

Criteria For Consideration:

- ☐ Regression / Recoupment
- ☐ Critical Point of Instruction 1
- ☐ Critical Point of Instruction 2

Special Circumstances

- ☐ Employment
- ☐ Transition to Part B (Preschool)
- ☐ Transition to Post School Outcomes
- ☐ Excessive Absences
- ☐ Extenuating Circumstances

Supports Needed for School Personnel (Describe)

Services / Placement

STUDENTS TOTAL INSTRUCTIONAL DAY (Minutes): _____ Student attends school ☐ days per week.

			Individual /	Regular Class		Community		Special Class	
Service	Date to Begin	Duration	Group	Minutes	Sessions	Minutes	Sessions	Minutes	Sessions

Total Number of Minutes in Special Setting per Week: _____

PLACEMENT/SERVICE DETERMINATION CHECKLIST

Attends Regular Early Childhood Program at least 10 hours per week
- ☐ Receives majority of hours of special education and related services in the regular early childhood program
- ☐ Receives majority of hours of special education and related services in some other location

Attends Regular Early Childhood Program less than 10 hours per week
- ☐ Receives majority of hours of special education and related services in the regular early childhood program
- ☐ Receives majority of hours of special education and related services in some other location

Attends Special Education Program (not in any regular early childhood program)
- ☐ Separate Special Education Class ☐ Residential Facility
- ☐ Separate School

Attends neither a regular early childhood program nor a special education program
- ☐ Receives majority of special education and related services at home
- ☐ Receives majority of special education and related services at service provider or other location

COMMENTS

Placement

Special Transportation

☐ No ☐ Yes - Describe

SITE DETERMINATION

NOTE: The local education agency may choose to complete this section at this time. If the following assurances cannot be provided at this time, then a Site Determination Form assuring that the site selected is in accordance with least restrictive environment rules must be forwarded to the parent within ten (10) calendar days.

ASSURANCES:

1. This school is the one the student would attend if he or she were not identified exceptional.
2. This school and class are chronologically age appropriate for the student.
3. The school selected is accessible to the student for all school activities.
4. The classroom is comparable to and integrated with regular classes.

Site: Lafayette Parish-Charles M. Burke Elementary School (028047)

PROGRESS REPORT

The LEA assures that the program and services described in the IEP will be provided. The schedule for describing the progress towards achievement of the academic and functional annual goals will be every ☐ weeks, current with the issuance of report cards.

ASSESSMENT IMPLICATIONS (Check one)

☐ I understand my child (I) will participate in LEAP Alternate Assessment, Level 1 (LAA 1). Testing in LAA 1 means my child (I) will be progressing toward a Certificate of Achievement and not a High School Diploma. The implications of participating in LAA 1 have been explained to me and will be reviewed annually.

☐ I understand my child (I) will participate in LEAP Alternate Assessment, Level 2 (LAA 2), and by meeting all graduation requirements, my child (I) will receive a High School Diploma. However, if during my child's (my) exit year all graduation requirements have not been met, then my child (I) may be eligible to exit high school with a Certificate of Achievement. I understand that this certificate limits my child's (my) choices of post-secondary education and careers, including military services. The implications of participating in LAA 2 have been explained to me and will be reviewed annually.

☐ I understand my child (I) will be participating in the Academic Skills Assessment (ASA) or ASA LAA 2, if eligible. My child (I) is (am) leaving the high school diploma pathway and is (am) entering a non-diploma pathway. If successful, my child (I) will receive a Louisiana Equivalency Diploma (GED) with possibly an Industry-Based Certificate, or a State-Approved Skills Certificate but not a High School Diploma. The implications of participating in ASA or ASA LAA 2 have been explained to me and will be reviewed annually.

AGE OF MAJORITY

☐ **Beginning at least one year before reaching the age of majority, I (my child) have been informed that my (his or her) rights under the act will transfer to me (my child) on my (his or her) reaching the age of majority**

PARENT/STUDENT* CONSENT FOR SERVICES

☐ I have received a copy of the Educational Rights of Exceptional Children, and was given an opportunity for an oral explanation. I have received a copy of my (child's) evaluation and documentation of determination of eligibility.

☐ I give consent for the provision of special education and related services. I understand that if I disagree with any services or the placement described on the IEP, I can pursue a solution to my complaint through the state's written dispute resolution options.

☐ Parent / Student did not attend the **Review** IEP Team meeting.

SUPPORTING DOCUMENTATION

Have the following documents been included in the IEP folder?

LEAP Alternate Assessment Participation Criteria, Level 1 (LAA 1)	☐ Yes	☐ N/A
LEAP Alternate Assessment Participation Criteria, Level 2 (LAA 2)	☐ Yes	☐ N/A
Individual Healthcare Plan	☐ Yes	☐ N/A
Individual Prescription for Instruction (get copy from advisor/school guidance counselor)	☐ Yes	☐ N/A
Individual Graduation Plan (get copy from school guidance counselor)	☐ Yes	☐ N/A
Parental Consent form for Connections for 8th graders (get signed copy from SBLC team)	☐ Yes	☐ N/A
Summary of Performance Criteria Form	☐ Yes	☐ N/A
Parental Consent form for Medicaid Billing	☐ Yes	☐ N/A
Educational / Career Plan for LAA 1 Students	☐ Yes	☐ N/A
Behavior Intervention Plan	☐ Yes	☐ N/A
Assistive Technology Consideration Checklist	☐ Yes	☐ N/A

SIGN: _____

PARENT/GUARDIAN/SURROGATE PARENT/COMPETENT MAJOR/STUDENT **Date**

PRINT:

*Signature is only required for the **initial** provision of services.
*Parents should initial and date in signature box if they attended an IEP team meeting where the IEP was amended.

SIGN: _____

OFFICIALLY DESIGNATED REPRESENTATIVE OF LOCAL EDUCATION AGENCY **Date**

PRINT:

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

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

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)

Social Security No. (3)

RECIPIENT LAST NAME FIRST MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	ENTER NDC CODE (11 DIGITS) THAT CORRESPONDS WITH HCPC FORMULA CODE OR ENTER THE DESCRIPTION OF EACH PROCEDURE CODE (11B)	REQUESTED UNITS (11C)	REQUESTED AMT (11D)	AUTHORIZED UNITS	AUTHORIZED AMT	PA CODE(S)

(12)
PLACE OF TREATMENT: ____ RECIPIENT'S HOME ___ NURSING HOME ____ ICF-MR FACILITY ____ OUTPATIENT HOSPITAL / CLINIC

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

(14) CASE MANAGER INFORMATION:
NAME: _____
ADDRESS: _____
CITY: _____ STATE; _____ ZIPCODE _____
TELEPHONE (____) ____ _____ FAX NUMBER: (____) ____ _____

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

Instructions For Completing Prior Authorization Form (PA-01)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT MOLINA MEDICAID SOLUTIONS.

FIELD NO. 1	**CHECK THE APPROPRIATE BLOCK TO INDICATE THE TYPE OF PRIOR AUTHORIZATION REQUESTED.**
FIELD NO. 2	**ENTER RECIPIENT'S 13-DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER.**
FIELD NO. 3	**ENTER THE RECIPIENT'S SOCIAL SECURITY NUMBER.**
FIELD NO. 4	**ENTER THE RECIPIENT'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON THEIR MEDICAID CARD.**
FIELD NO. 5	**ENTER THE RECIPIENT'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).**
FIELD NO. 6	**ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER. IF ASSOCIATED WITH A GROUP, ENTER THE ATTENDING PROVIDER NUMBER ONLY.**
FIELD NO. 7	**ENTER THE BEGINNING AND ENDING DATES OF SERVICE IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).**
FIELD NO. 8	**ENTER THE NUMERIC ICD9-DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION.**
FIELD NO. 9	**ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).**
FIELD NO. 10	**ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES.**
FIELD NO. 11	**ENTER THE HCPCS / PROCEDURE CODE.**
FIELD NO. 11A	**ENTER THE CORRESPONDING MODIFIERS (WHEN APPROPRIATE).**
FIELD NO. 11B	**ENTER THE 11 DIGIT NDC CODE THAT CORRESPONDS WITH THE HCPC FORMULA CODE, OR THE CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED.**
FIELD NO. 11C	**ENTER THE NUMBER OF UNITS REQUESTED FOR EACH INDIVIDUAL HCPC/ PROCEDURE.**
FIELD NO. 11D	**ENTER THE REQUESTED CHARGES FOR EACH INDIVIDUAL HCPC/ PROCEDURE WHEN APPROPRIATE FOR THE REQUESTED HCPC/ PROCEDURE.**
FIELD NO. 12	**ENTER THE LOCATION FOR ALL SERVICES RENDERED.**
FIELD NO. 13	**ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE.**
FIELD NO. 14	**ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE RECIPIENT'S CASE MANAGER , IF AVAILABLE**
FIELD NO. 15	**PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.**
FIELD NO. 16	**DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF FIELD IS NOT DATED.**

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT MOLINA:

PRIOR AUTHORIZATION TOLL-FREE NO. IS 1-800-488-6334

PRIOR AUTHORIZATION UNIT NO IS 1- 225-928-5263

PRIOR AUTHORIZATION FAX NO. IS 1-225-929-6803

CONTACT/REFERRAL INFORMATION

Important Molina Addresses for Billing

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

Type of Claim	Address/Telephone/Website
Fiscal Intermediary: Molina Medicaid Solutions *(formerly UNISYS Corporation)*	
Pharmacy	P.O. Box 91019 Baton Rouge, LA 70821
CMS-1500 Claims • Case Management • Chiropractic • Durable Medical Equipment • EPSDT Health and IDEA-Related Services • FQHC • Hemodialysis Professional Services Independent Lab • Mental Health Rehabilitation • PCS • Professional • Rural Health Clinic • Substance Abuse and Mental Health Clinic • Waiver	P.O. Box 91020 Baton Rouge, LA 70821
Inpatient and Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long Term Care	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

Name of Contact	Address/Telephone/Website
Fiscal Intermediary: Molina Medicaid Solutions *(formerly UNISYS Corporation)*	
Electronic Data Interchange (EDI) Electronic claims sign up and testing	P.O. Box 91025 Baton Rouge, LA 70898-0159 Phone: 225-216-6303 Fax: 225-216-6336
Prior Authorization Unit (PAU) Prior authorization issues, forms, etc. **See LSU School of Dentistry below in "Other Helpful Numbers" for more information.*	P.O. Box 14919 Baton Rouge, LA 70898-4919 Phone: 800-807-1320 ***(Home Health)*** Phone: 866-263-6534 ***(Dental)*** Phone: 800-488-6334 ***(DME & All Other)*** Phone 800-877-0666, Option 2 (***Hospice***) Fax: 225-216-6478

Name of Contact	Address/Telephone/Website
Fiscal Intermediary: Molina Medicaid Solutions ***(formerly UNISYS Corporation)***	
Provider Enrollment Unit (PEU) Provider Enrollment, direct deposit problems, reporting of changes and ownership, NPI	P.O. Box 80159 Baton Rouge, LA 70898 Phone: 225-216-6370 Fax: 225-216-6392
Provider Relations (PR) Billing and training questions	P.O. Box 91024 Baton Rouge, LA 70821 Phone: 225-924-5040 (Local) Phone: 800-473-2783 (Toll Free) Fax: 225-216-6334 http://www.lamedicaid.com
Recipient Eligibility Verification (REVS)	Phone: 225-216-7387 (Local) Phone: 800-776-6323 (Toll Free)
Web Technical Support	Phone: 877-598-8753 (Toll Free)

Name of Contact	Address/Telephone/Website
Department of Health and Hospitals (DHH)	
BAYOU HEALTH	Bayou Health Hotline Phone: 855-229-6848 (Toll Free) http://new.dhh.louisiana.gov/index.cfm/subhome/6/n/70
Division of Administrative Law (DAL) Formerly DHH Bureau of Appeals	P.O. Box 4189 Baton Rouge, LA 70821 Phone: 225-342-0263 Fax: 225-219-9823 http://www.adminlaw.state.la.us/
Durable Medical Equipment (DME)	628 N. Fourth Street Baton Rouge, LA 70802 Phone: 225-342-3935 Fax: 225-342-9462
Louisiana's Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) General Medicaid and card questions	General Medicaid Hotline Phone: 888-342-6207 (Toll Free) http://www.lamedicaid.com/provweb1/default.htm LaCHIP: 225-342-0555 (Local) LaCHIP: 877-252-2447 (Toll Free) http://bhsfweb.dhh.louisiana.gov/LaCHIP/
Louisiana Medicaid Website	www.lamedicaid.com
Medicaid Card Questions	Phone: 800-834-3333 (Toll Free)

Name of Contact	Address/Telephone/Website

Department of Health and Hospitals (DHH)	
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: 225-342-8823 E-mail: ocddinfo@la.gov http://www.dhh.louisiana.gov/offices/?ID=191
Office of Management and Finance (Bureau of Health Services Financing – MEDICAID	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: 225-342-5774 Fax: 225-342-3893 E-mail: medweb@la.gov http://www.medicaid.la.gov

Name of Contact	Address/Telephone/Website
Department of Health and Hospitals (DHH)	
Program Integrity (PI)	628 N. 4th Street; 6th Floor Baton Rouge, LA 70821 Phone: 225-219-4149 Fax: 225-219-4155 Fraud and Abuse Hotline: 800-488-2917 http://new.dhh.louisiana.gov/
Rate & Audit Review Nursing Facilities (Rates)	P.O. Box 546 Baton Rouge, LA 70821-0546 Phone: 225-342-6116 Fax: 225-342-1831 http://www.dhh.louisiana.gov/offices/?ID=111
Take Charge (Family Planning Waiver)	P.O. Box 91278 Baton Rouge, LA 70821 Phone: (888) 342-6207 Fax: (877) 523-2987 Email: medweb@la.gov http://new.dhh.louisiana.gov/index.cfm/page/232

Other Helpful Contact Information	
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 To obtain current CMS-1500, UB-04, ADA claim forms	P.O. Box 371954 Pittsburgh, PA 15250-7954 Phone: 205-512-1800
U.S. Department of Health & Human Services Sterilization and Consent Forms	www.hhs.gov/opa/familyplanning/toolsdocs/