LOUISIANA DEPARTMENT OF HEALTH

FEDERALLY QUALIFIED HEALTH CENTERS

Chapter Twenty-Two of the Medicaid Services Manual

Issued December 1, 2010

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

State of Louisiana
Bureau of Health Services Financing

FEDERALLY QUALIFIED HEALTH CENTERS

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OVERVIEW

The Social Security Act §1905(l) (2)(B) defines a Federally Qualified Health Centers (FQHCs) for Medicaid purposes as an entity which:

1. Is receiving a grant under Section 330 of the Public Health Service (PHS) Act;

2. Is receiving funding from such grant under a contract with the beneficiary of such a grant;

3. Meets the requirements to receive a grant under 330 of such Act;

4. Based on the recommendation of the Health Resources and Services Administration (HRSA) within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled or operated by another entity; or

5. Was treated by the Secretary, for the purposes of Part B of Title XVIII, as a comprehensive federally funded health center as of January 1, 1990; and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

FQHCs must be located to make services accessible to residents of a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). Location in a Health Professional Shortage Area (HPSA) or government designated shortage area does not meet the shortage area requirements for the FQHC program. FQHC look-alikes may serve a whole or partial MUA/MUP so long as it demonstrates that it serves the neediest population in the service area or addresses gaps in services and or health disparities.

An FQHC provider must be a non-profit organization. All FQHC services provided by qualified individuals employed by or under contract with an FQHC are billed using the organization's provider number (e.g., FQHC's National Provider Identifier (NPI), FQHC's Medicaid identification (ID) number for each location) and Tax Identification Number (TIN).

The purpose of this chapter is to set forth the conditions and requirements that FQHCs must meet in order to qualify for reimbursement under the Louisiana Medicaid program. The manual chapter is intended to make available to Medicaid providers of FQHC services a ready reference for information and procedural material needed for the prompt and accurate filing of claims for services furnished to Medicaid beneficiaries. The Louisiana Department of Health (LDH), Bureau

of Health Services Financing (BHSF) is responsible for assuring provider compliance with these regulations.

COVERED SERVICES

A Federally Qualified Health Center (FQHC) agrees to provide those primary care services typically included as part of a physician's medical practice. Services and supplies that are furnished by FQHC staff and are incident to the FQHC professional service are considered part of the FQHC service. An FQHC can also provide services related to the diagnosis and treatment of mental illness, and, in certain instances, visiting nurse services.

The following FQHC reimbursable services are referred to as core services:

1. Physician services;
2. Services and supplies incident to physician's services;
3. Physician assistant services;
4. Nurse practitioners (NPs) and certified nurse mid-wife services;
5. Services and supplies incident to the services of NPs, physician assistants, and certified nurse mid-wives;
6. Visiting nurse services to the homebound;
7. Clinical psychologist services;
8. Clinical social worker services; and
9. Services and supplies incident to the services of clinical psychologists and clinical social workers.

NOTE: For reimbursement purposes, a service visit must be provided in order for a provider to be paid a Prospective Payment System (PPS) rate. (See Section 22.4 for more information about reimbursement).

Physician Services

Physician services are the professional services performed by a licensed physician for a beneficiary including diagnosis, therapy, surgery, and consultation.

Physician services are covered if they are professional services performed by a licensed physician at the center, or performed away from the center if the physician has an agreement with the center

to be paid for the services. The services must be within the scope of their profession under Louisiana law.

Services and Supplies Incident to a Physician's Services

Services and supplies incident to a licensed physician's professional service are covered if the service or supply is furnished:

1. In a physician's office;
2. Either without charge or included in the center's bill;
3. As an incidental, although integral, part of a physician's professional services;
4. Under the direct, personal supervision of a physician; and
5. By a member of the center's health care staff who is an employee of the center.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

Physician Assistant Services

A physician assistant is eligible to enroll in Medicaid and must obtain a provider number and use it on the billing form when performing services or prescribing drugs. Physician assistant services are covered if:

1. Furnished by a licensed physician assistant who is employed by or receives compensation from the center and is enrolled in the Louisiana Medicaid Program;
2. Identified by placing their provider number in the attending licensed physician space on the CMS-1500;
3. Furnished under the medical supervision of a licensed physician. The licensed physician supervision requirements are met if the conditions specified and any pertinent requirements of state law are satisfied;
4. Furnished in accordance with medical orders for the care and treatment of a beneficiary prepared by a licensed physician;
5. Consistent with the type of service the physician assistant is legally permitted to perform; and

6. Services are covered by Medicaid.

Nurse Practitioner and Certified Nurse Mid-wife Services

Services are covered if:

1. Furnished by a licensed NP or certified nurse mid-wife who is employed by or receiving compensation from the center;

2. Enrolled in Louisiana Medicaid;

3. Identified by placing their provider number in the attending physician space on the CMS-1500;

4. Furnished in collaborative practice with a physician. The physician supervision requirement is met if the conditions specified and any pertinent requirements of State law are satisfied;

5. Furnished in accordance with any medical orders for the care and treatment of a beneficiary prepared by a licensed physician;

6. Performed by a licensed NP or certified nurse mid-wife, who is legally permitted to provide this type of service; and

7. Services are covered by Medicaid.

NPs and certified nurse mid-wives are eligible to enroll in Medicaid and must obtain a provider number and use it on the billing form when performing services or prescribing medications.

Services and Supplies Incident to Physician Assistant, Nurse Practitioner and Nurse Mid-wife Services

Services and supplies incident to a NP, nurse mid-wife or physician assistant services are covered if:

1. Furnished in a licensed medical provider's office;

2. Rendered either without charge or included in the center's bill;

3. Furnished as an incidental, although integral part of professional services furnished by NP, physician assistant or certified nurse mid-wife;

4. Furnished under their direct, personal supervision. The direct personal supervision requirement is met only if the person is permitted to supervise these services under the written policies governing the center; and

5. Furnished by a member of the center's health care staff who is an employee of the center.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

Visiting Nurse Services to the Homebound

Part time or intermittent visiting nurse care and related supplies are covered if:

1. The center is located in an area designated by the Centers for Medicare and Medicaid Services (CMS) as a home health agency shortage area;

2. The services are rendered to a homebound individual. For purposes of visiting nurse services, "homebound" means a Medicaid beneficiary who is permanently or temporarily confined to their place of residence because of a medical or health condition. The individual may be considered homebound if they leave the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or skilled nursing facility;

3. The services are furnished by a licensed registered nurse (RN) or licensed practical nurse (LPN) or a licensed vocational nurse, who is employed by or received compensation for the services from the center; and

4. The services are furnished under a written plan of treatment.

Plan of Treatment

The plan of treatment must be established and reviewed at least every 60 days by a supervising physician of the center or established by a physician, NP, physician assistant or certified nurse mid-wife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician. The plan must be signed by the NP, physician assistant, certified nurse mid-wife or the supervising physician of the center.

The plan of treatment must relate visiting nurse services to the beneficiary's condition. The plan must specify the following:

1. Types of services required and prognosis for changes in the beneficiary's condition;
2. Diagnosis and a description of the beneficiary's functional limitations resulting from the illness or injury;
3. Type and frequency of nursing services needed;
4. Special diets;
5. Activities permitted;
6. Rehabilitation and therapy services;
7. Medical social services;
8. Home health aide services; and
9. Necessary medical supplies.

All changes in orders for controlled substance drugs must be signed by the physician.

Clinical Psychologist

Clinical psychologist services refer to services performed by a licensed clinical psychologist for diagnosis and treatment of mental illness which the clinical psychologist is legally authorized to perform under State licensure as would otherwise be covered if furnished by a licensed physician or as an incident to a physician's services.

Clinical Social Worker Services

Clinical social worker services refer to services performed by a licensed clinical social worker (LCSW) for diagnosis and treatment of mental illness which the clinical social worker is legally authorized to perform under state licensure and such services as would otherwise be covered if furnished by a physician or as an incident to a physician 's professional service.

Services and Supplies Incident to the Services of Clinical Psychologists and Clinical Social Workers

Services are covered if furnished as follows:

1. In a physician's office;

2. Either without charge or included in the center's bill;

3. As an incidental, although integral part of professional services furnished by a Clinical Psychologist or Clinical Social Worker;

4. Under their direct, personal supervision. The direct personal supervision requirement is met only if the person is permitted to supervise these services under the written policies governing the center; and

5. By a member of the center's health care staff who is an employee of the center.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

Other Ambulatory Services

FQHCs may provide other non-primary care ambulatory services covered by the Louisiana Medicaid State plan that are not included in the listing of FQHC services. These other ambulatory services may be provided by the FQHC if the FQHC meets the same standards as other enrolled providers of those services. Examples include:

1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for beneficiary's under the age of 21;

2. Vision care services (for beneficiaries under the age of 21);

3. Speech and language services (for beneficiaries under the age of 21);

4. Hearing services (for beneficiaries under the age of 21);

5. Dental services;

6. Podiatry services;

7. Pregnancy-related services;

8. Perinatal case management;

9. Chiropractic services;

10. Nutrition counseling as part of an encounter;

11. Family planning services (FPSs);

12. Physical and occupational therapy services;

13. Behavioral health services provided by licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs); and

14. Community Health Worker (CHW) services.

The above services are governed by Medicaid policies and procedures specific to each program. The policies and procedures for the FQHC services program do not apply to these "other" ambulatory services. Billing must be submitted according to the policies and procedures for each program. With the exception of CHW services, all other service visits will be reimbursed at the all-inclusive PPS rate per visit. CHW services are reimbursed at the rate on file for the date of service, in addition to the PPS rate per visit. (See Section 22.4 for more information about reimbursement).

Diabetes Self-Management Training

Diabetes self-management training (DSMT) is provided to beneficiaries diagnosed with diabetes. These services are comprised of one hour of individual instruction and nine hours of group instruction on diabetes self-management. Beneficiaries shall receive up to 10 hours of services during the first 12-month period beginning with the initial training date. After the first 12-month period has ended, beneficiaries shall only be eligible for two hours of individual instruction on diabetes self-management per calendar year.

Fluoride Varnish Applications

Coverage shall be provided for fluoride varnish applications performed in the FQHC to beneficiaries under 21 years of age based on medical necessity. Fluoride varnish applications will be reimbursed when performed in the FQHC by:

1. The appropriate dental providers;

2. Physicians;

3. Physician assistants;

4. NPs;

5. RNs;

6. LPNs; or

7. Certified medical assistants.

All participating staff must review the Smiles for Life training module for fluoride varnish and successfully pass the post assessment. All staff involved in the varnish application must be deemed as competent to perform the service by the FQHC and be practicing within the licensed practitioner's scope of practice.

Fluoride varnish applications shall only be reimbursed to the FQHC when performed on the same date of service as an office visit or preventative screening. Separate encounters for fluoride varnish services are not permitted and the application of fluoride varnish does not constitute an encounter visit

Services Not Covered

1. Injections ordered incident to a previous face-to-face encounter (these injections would be incident to the initial encounter and part of the PPS reimbursement of the initial encounter which warranted the injection);

2. Medications provided by a pharmacy that is not part of the FQHC;

3. Weight or blood pressure check only;

4. Services for which medical necessity is not clearly established;

5. Information provided to a patient over the telephone;

6. Cosmetic surgery;

7. A visit for the sole purpose of a patient obtaining a prescription when the need for the prescription has already been determined;

8. Canceled visits or for appointments not kept;

9. Foot care such as routine soaking and application of topical medication;

10. Transsexual surgery or a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis; and

11. Tattoo removal.

Encounter

Medical (inclusive of DSMT services) encounters are defined as face-to-face visits with a physician, physician assistant, NP, certified nurse mid-wife, or visiting nurse during which a FQHC service is rendered. Behavioral health encounters are defined as face-to-face visits with a physician with a psychiatric specialty, NP with a psychiatric specialty, clinical nurse specialist with a psychiatric specialty, licensed clinical psychologist, LCSW, LPC, LMFT, respectively, during which behavioral health service is rendered. A behavioral health specific service must be rendered in order to bill a behavioral health encounter. The submission of an evaluation and management code only will not suffice, with the exception of certain provider/specialty combinations identified in Section 22.1 of this manual under "Service Limits." A medical and a behavioral health encounter are allowed on the same day of service.

Multiple medical and/or behavioral health encounters, however, with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit, except for cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. When the beneficiary suffers illness or injury requiring additional diagnosis or treatment unrelated to the initial encounter visit an additional medical and/or behavioral health encounter may be billed.

A dental encounter is defined as a face-to-face visit with a dentist where dental services are rendered. Multiple dental encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit except for cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Multiple Same-day Visits

Only one medical encounter (inclusive DSMT encounters) per day per beneficiary, one behavioral health encounter per day per beneficiary, and one dental encounter per day per beneficiary may be

billed except in cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services shall not be arbitrarily delayed or split in order to bill additional encounters.

Service Limits

There is no annual limit placed on the number of FQHC visits (encounters) payable by the Medicaid Program for eligible beneficiaries.

Services not defined as an FQHC service or other ambulatory service rendered to Louisiana Medicaid beneficiaries are not permitted to be billed to the Louisiana Medicaid program.

Separate encounters for DSMT services are not permitted and the delivery of DSMT services alone does not constitute an encounter visit.

Exclusions

Medicaid policy does not provide for payment of follow-up visits occurring on the same date as a previously billed visit, consultation, emergency room (ER) care or hospital admission date.

Any services "incident to" an encounter code **ARE NOT** billable. These include, but are not limited to the following:

1. Injections (allergy, antibiotic, steroids, etc.);
2. Laboratory tests performed on site, Peak Flow and Spirometry, Respiratory Flow Volume Loop, electrocardiogram (EKG) testing and interpretation, and x-rays;
3. Immunizations;
4. Hearing/Vision screenings; and
5. Filling and/or obtaining prescriptions.

Service Delivery

Upon presentation at the clinic, a full mental, physical and dental assessment shall be performed and include a written plan for each identified problem noted in the history and physical exam. Any health problems identified must be addressed to the highest degree possible. Encounters for beneficiaries under the age of 21 shall include all the aspects of a well-child screening visit unless:

1. The provider determines that the child's medical condition at the time of the visit contraindicates the well-child screening as inadvisable; or

2. The child's medical record reflects that they are up to date on the well-child screenings in accordance with the Medicaid periodicity schedule.

NOTE: Service delivery for beneficiaries under the age of 21 includes the administration of required immunizations.

The medical encounter level of service must include **at a minimum**:

1. An expanded, problem-focused history (chief complaint, brief history of present illness, problem pertinent system review); or

2. An expanded, problem-focused exam (limited exam of the affected body area or organ system and other symptomatic or related organ systems).

This would be low-level complexity of medical decision making (limited number of diagnoses, limited complexity of data to review, the risk of complications and management options- low).

A new patient medical encounter level of service is to include the following:

1. A detailed history (chief complaint, history of present illness, problem pertinent system review, pertinent past, family, social history); and

2. A detailed exam with low-to moderate complexity decision making.

The dental encounter level of service must include **at a minimum**:

1. Comprehensive oral healthcare. Comprehensive oral healthcare is defined as all of the covered restorative and therapeutic services described in the Medicaid Dental Services Manual.

NOTE: Dental health preventive services should be rendered on the same day unless otherwise indicated due to identified medical issues preventing completion of all preventive services.

The behavioral health encounter level of service shall include **at a minimum**:

1. Face-to-face visits with a physician with a psychiatric specialty, NP with a psychiatric specialty, clinical nurse specialist with a psychiatric specialty, licensed clinical psychologist, or LCSW; (exclusive of medication management only);

2. Face–to-face visit with a LPC or LMFT (exclusive of medication management only); and

3. A qualified service for the assessment, diagnosis and/or treatment of a behavioral health disorder to include services such as psychotherapy, mental health assessment, psychiatric evaluation, psychological testing and medication management. These services may be provided in combination with medication management as well.

Behavioral Health Specific Service Delivery Limits

The below provider type/specialty combinations are the only behavioral health providers allowed to be reimbursed for claims including an evaluation and management Healthcare Common Procedure Coding System (HCPCS) code as the only detailed line:

Provider Type	Provider Specialty	Description
20	26	Psychiatrist
20	2W	Psychiatrist – Addictionologist
78	26	NP – Advanced Practice Registered Nurse (APRN)
93	26	Clinical Nurse Specialist - APRN
94	26	Physician's Assistant
31	6G	Medical Psychologist

All other behavioral health provider type/specialty combinations require at least one qualified psychiatric service included as a detailed line on the claim.

PROVIDER REQUIREMENTS

Location

Each Federally Qualified Health Center (FQHC) that receives Public Health Service (PHS) 330 grant funding must be located, as appropriate, to make services accessible to the residents of a designated medically underserved area (MUA) or medically underserved population (MUP).

Shortage Area Designation

In order for FQHCs to be eligible for a Health Professional Shortage Area (HPSA) facility designation, the center shall:

1. Not deny requested health care services, and shall not discriminate in the provision of services to an individual who is unable to pay for services or whose services are paid by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP);

2. Prepare a schedule of fees consistent with locally prevailing rates or charges;

3. Prepare a corresponding schedule of discounts (including waivers) to be applied to such fees or payments, with adjustments made on the basis of the patient's ability to pay;

4. Make every reasonable effort to secure from patients the fees and payments for services, and fees should be sufficiently discounted in accordance with the established schedule of discounts;

5. Enter into agreements with the State Medicaid agency to ensure coverage of beneficiaries; and

6. Take reasonable and appropriate steps to collect all payments due for services.

NOTE: Location in an HPSA alone or government designated shortage area does not meet the shortage area requirement for the FQHC program.

Staffing

FQHC primary care services are to be provided by licensed physicians, licensed physician assistants, nurse practitioners (NPs), or nurse-midwives operating under the direct supervision of the FQHC physician and within the scope of the physician extender's licensure or certification.

Direct supervision does not mean that the physician must be in the same room when services are rendered: however, the physician must be immediately available (at least by telephone) to provide direction or assistance when necessary.

Services of licensed clinical psychologists and clinical social workers are not required, but can be considered an FQHC service when these personnel provide diagnosis and treatment of mental illness. These services must be included in the Health Resources and Services Administration (HRSA) scope of service in order to receive reimbursement.

Commingling

Commingling refers to the sharing of FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service (FFS) practice operated by the same FQHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

1. Duplicate Medicare or Medicaid reimbursement (including situations where the FQHC is unable to distinguish its actual costs from those that are reimbursed on a FFS basis); or

2. Selectively choosing a higher or lower reimbursement rate for the services.

FQHC practitioners may not furnish FQHC-covered professional services as a Part B provider while in the FQHC or in an area outside of the certified FQHC space, such as a treatment room adjacent to the FQHC, during FQHC hours of operation.

If an FQHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and laboratory facility, dental clinic, emergency room (ER), etc., the FQHC space must be clearly defined. If the FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the FQHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between FQHC and non-FQHC usage to avoid duplicate reimbursement.

This commingling policy does not prohibit a provider-based FQHC from sharing its health care practitioners with the hospital emergency department (ED) in an emergency, or prohibit an FQHC physician from providing on-call services for an emergency room, as long as the FQHC would continue to meet the FQHC conditions for coverage even if the practitioner were absent from the facility. The FQHC must be able to allocate appropriately the practitioner's salary between FQHC

and non-FQHC time. It is expected that the sharing of the physician with the hospital ED would not be a common occurrence.

The fiscal intermediary (FI) has the authority to determine acceptable accounting methods for allocation of costs between the FQHC and another entity. In some situations, the practitioner's employment agreement will provide a useful tool to help determine appropriate accounting.

Medicaid Enrollment Criteria

To be eligible for enrollment in the Louisiana Medicaid Program, the FQHC must be an entity receiving a PHS grant under the following:

1. The Consolidated Health Center Programs (Community Health Center (CHC), Migrant Health Center (MHC), Health Care for the Homeless (HCH), Public Housing Primary Care (PHPC) and Healthy Schools, Healthy Communities (HSHC) programs authorized under Section 330 of the PHS Act as amended; or

2. Designated by the U.S. Department of Health and Human Services (DHHS) to meet the requirements to be receiving such a grant as a "look-a-like" entity.

The entity must provide a copy of the HRSA Notice Grant Award designating the center as a grantee under the applicable section of the PHS Act or the Centers for Medicare and Medicaid Services (CMS) notification letter designating the FQHC look-a-like with its enrollment packet. Only the entity designated as the grantee on the Notice of Grant Award/CMS notification letter may enroll in Louisiana Medicaid as a FQHC. The FI will verify CMS enrollment via the Provider Enrollment, Chain, and Ownership System (PECOS).

The FQHC must provide to the FI's provider enrollment unit a list of the names of all physicians and other practitioners who will be providing medical services at the center and include the practitioners':

1. National Provider Identifier (NPI); and

2. Assigned Medicaid provider number, if they are enrolled in Medicaid.

All enrollments of any practitioner in any Medicaid category of service, other than the FQHC program, must be submitted to the FI's provider enrollment unit.

NOTE: The FI's provider enrollment unit must be notified immediately of any change in the above. Failure to maintain current information with the provider enrollment unit may result in a loss of reimbursement for services provided by those practitioners not identified as FQHC staff.

All practitioners providing patient services must be enrolled with the FI's provider enrollment unit and be linked to the FQHC at the time of enrollment in order for the facility to receive reimbursement.

Since the grant awards are time-limited by budget years, the Medicaid provider agreement is time-limited, depending on the approval periods.

After enrollment, the FQHC must provide a copy of the current Notice of Grant Award each year to the Bureau of Health Services Financing (BHSF). Failure to supply the notice within 30 calendar days from the effective date of the renewal of the grant will result in termination of the center's enrollment as a provider of Medicaid services. (See Appendix A for contact information)

NOTE: The effective date of enrollment shall not be prior to the date of receipt of the completed enrollment packet and the PECOS enrollment effective date.

Services

The FQHC agrees to provide those primary care services typically included as part of a physician's medical practice. The FQHC must provide, either directly or by referral, a full range of primary diagnostic and therapeutic services and supplies which include:

1. Medical history
2. Physical examination;
3. Assessment of health status and treatment of a variety of conditions amendable to medical management on an ambulatory basis by a physician or a physician extender;
4. Evaluation and diagnostic services to include:
    a. Radiological services; and
    b. Laboratory and pathology services.
5. Services and supplies incident to a physician's or a physician extender's services such as:
    a. Pharmaceuticals; and
    b. Supplies.

In addition, an FQHC can provide services related to the diagnosis and treatment of mental illness, and in certain instances, visiting nurse services.

Billing

The FQHC agrees to bill its usual and customary charge for each FQHC-related service using applicable diagnoses and procedure codes. FQHC services must be billed using the FQHC's NPI and Medicaid provider number assigned to the specific FQHC location and Tax Identification Number (TIN) of the specific FQHC location where the services were provided and/or the rendering provider is based, as required by each health plan and/or the FI.

"Usual and customary" is defined as the fee charged to private paying patients for the same procedure during the same period of time. Records on both Medicaid eligible and private paying patients must be maintained for a minimum of five years in order to verify compliance with this policy. The FQHC shall also furnish its authorized representative or contractual agents, with all information that may be requested regarding "usual and customary" fees.

The FQHC must ensure that no staff or contract provider will seek separate reimbursement from Medicaid for specific services that are ordered and/or performed in the FQHC and are billable under the FQHC program. Laboratory, pathology, radiological and other services ordered by the FQHC staff, but provided by an organization independent of the FQHC, must be billed by the provider of the service and not the FQHC.

Diabetes Self-Management Training

In order to receive Medicaid reimbursement for diabetes self-management training (DSMT) services, a FQHC must have a DSMT program that meets the quality standards of one of the following accreditation organizations:

1. The American Diabetes Association;

2. The American Association of Diabetes Educators; or

3. The Indian Health Service.

All DSMT programs must adhere to the national standards for diabetes self-management education. Each member of the instructional team must:

1. Be a certified diabetes educator (CDE) certified by the National Certification Board for Diabetes Educator; or

2. Have recent didactic and experiential preparation in education and diabetes management.

At a minimum, the instructional team must consist of one of the following professionals who is a CDE:

1. A registered dietician;

2. A registered nurse (RN); or

3. A pharmacist.

All members of the instructional team must obtain the nationally recommended annual continuing education units (CEUs) for diabetes management.

Satellite Clinics

A satellite clinic must enter into a separate provider agreement from the parent center and obtain its own provider number for billing and reimbursement purposes.

Mobile Clinics

An FQHC is prohibited from enrolling a mobile clinic in the Louisiana Medicaid program. Services rendered at the mobile clinic must be billed using the main center's provider number.

Out of State FQHCs in Trade Areas

An FQHC located in the trade areas designated by the Department that wishes to enroll in the Louisiana Medicaid program, must meet all the provider enrollment requirements of an FQHC located in Louisiana and include a letter from the FQHCs home state verifying its reimbursement rate.

Changes

FQHCs are required to notify Medicaid in writing within seven working days of any of the following changes:

1. Loss of FQHC status;

2. Changes in dates of the FQHC grant budget period;

3. Opening(s) and/or closing(s) of any satellite center(s); or

4. Addition or termination of providers.

Change in Ownership

When there is a change in ownership, Medicaid must be notified within 30 calendar days of the date of the FQHC ownership change. The new owner is required to enter into a new provider agreement with the Louisiana Medicaid program. Failure to enter into a new provider agreement following a change in ownership will result the center's termination as a Louisiana Medicaid provider.

Change of Address

FQHCs are required to report address changes. Providers must complete a file update form to submit to Provider Enrollment along with documentation from HRSA of the address change.

Cost Reports

FQHCs are required to submit cost reports with all requests for change in scope. Cost reports will not be accepted for rate changes without a change in scope of service. (See Section 22.4 for more information on reimbursement).

Medicare Certification

FQHCs are required to submit proof on an annual basis of Medicare certification as an FQHC. Failure to submit the annual certification may result in disenrollment or payments being suspended.

RECORD KEEPING

The Federally Qualified Health Center (FQHC) must maintain all clinical and fiscal records in accordance with written policies and procedures. The records must readily distinguish one type of service from another that is provided.

A designated member of the professional staff must be responsible for maintaining the records to ensure that they are complete, accurately documented, readily accessible, and systematically organized.

For each beneficiary receiving health care services, the center must maintain a record that includes the following as applicable:

1. Identification and social data, consent forms, pertinent medical history, assessment of the health status and health care needs of the beneficiary, and a brief summary of the episode, disposition, and instructions to the beneficiary; and

2. Reports of physical examinations, diagnostic and laboratory test results, consultative findings, physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the beneficiary's progress, as well, as the physician's or health care professional's signature.

Record Maintenance and Availability

The FQHC is responsible for:

1. Maintaining adequate financial and statistical records in the form that contains the data required by the Bureau of Health Services Financing (BHSF) and fiscal intermediary (FI) that supports the payment and distinguishes the type of service provided to the beneficiary;

2. Making the records available for verification and audit by BHSF or its contracted auditing agent; and

3. Maintaining financial data on an accrual basis, unless it is part of a governmental institution that uses a cash basis of accounting. In the latter case, depreciation on capital assets in accordance with the Health Insurance Manual-15 (HIM-15) is required. (See Appendix A for information about the HIM-15).

Protection of Record Information

The FQHC must maintain the confidentiality of records, provide safeguards against loss, destruction or unauthorized use, govern removal of records from the center and the conditions for release of information. The beneficiary's written consent must be obtained before the release of information not authorized by law.

Adequacy of Records

Reimbursement may be suspended if the center does not maintain records that provide an adequate basis to support payments. The suspension will continue until the center demonstrates to the satisfaction of the BHSF it does, and will continue to, maintain adequate records.

Retention of Records

Records must be retained for at least six years from the date of service or longer as required by state statute.

REIMBURSEMENT

Reimbursement for Federally Qualified Health Center (FQHC) services is made for those primary care services provided to Medicaid beneficiaries by enrolled FQHC providers. These services are described in Section 22.1 – Covered Services of this manual chapter. FQHCs are reimbursed for Medicaid covered services under an all-inclusive Prospective Payment System (PPS) as specified under Section 1902(bb) of the Social Security Act.

Payments specified as the PPS rates are all inclusive of professional, technical and facility charges, including evaluation and management, routine surgical and therapeutic procedures and diagnostic testing (including laboratory/pathology and radiology) capable of being performed on site at the FQHC and must be billed by utilizing the facilities' provider identification (ID) number and Tax Identification Number (TIN).

1. Laboratory/pathology, radiology and medications administered are not separately reimbursable. To the extent that the provider has the capabilities to provide these services and has historically provided these services, the FQHC shall continue to provide such services; and

2. The bundling of therapeutic and diagnostic testing services in the PPS rate is not meant to imply that the FQHC shall vend or refer out such ancillary services to other providers merely for the purpose of maximizing reimbursement.

Services and supplies incidental to a service visit include those services commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications, and supplies used in a patient service visit. Section 22.1 - Covered Services of this manual chapter has a list of "incident to" services. Services provided incidental to a service visit must be furnished by an employee and must be furnished under the direct supervision of an FQHC health care practitioner, meaning the health care practitioner must be immediately available when necessary, even if by telephone.

NOTE: Professional services performed in the FQHC will be subject to recoupment if billed under a physician/practitioner's individual Medicaid ID number.

Rates

Determination of Rate

Payments for Medicaid covered services will be made under a PPS and paid on a per visit basis.

For an FQHC which enrolls and receives approval to operate, the facility's initial PPS per visit rate will be the weighted average cost payment rate per encounter for all FQHCs.

Adjustment of Rate

PPS rates for primary care services are adjusted effective July 1 of the state fiscal year (SFY) by the published Medicare Economic Index (MEI) as prescribed in Section 1902(bb)(3)(A) of the Social Security Act.

PPS rates are adjusted to take into account any change (increase or decrease) in the scope of services furnished by the FQHC. A change in scope is an addition, removal or relocation of service sites and the addition or deletion of specialty and non-primary services that were not included in the base line rate calculation. The relocation of a site that does not impact the budget, the services provided and the number of patients served, or the number and type of providers available does not require a change in scope request for such relocation.

The FQHC is responsible for notifying the Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF), in writing, of any increases or decreases in the scope.

If the change is for the inclusion of an additional service or deletion of an existing service/site, the FQHC shall include the following in the notification:

1. The current approved organization budget and a budget for the addition or deletion of services/sites;

2. A detailed request for change in scope;

3. A cost report for the years preceding the change in scope; and

4. An assessment of the impact on total visits and Medicaid visits.

A new interim rate will be established based upon the reasonable allowed cost contained in the budget information. The final PPS rate will be calculated using the first two years of audited Medicaid cost reports which include the change in scope.

Out of State/Trade Area FQHC

An out of state FQHC in the trade area will be reimbursed the lesser of the Louisiana state-wide average or the PPS rate assigned to that FQHC in its state's location.

Notice of Rate Setting

BHSF will send written notice to the center notifying the center of the reimbursement rate per encounter and the methodology used to establish the rate.

BHSF, or its contracted auditing agency, will reconcile the initial PPS rates to the final audited PPS rates and inform the center of the rate determination and any reconciling amounts owed to the center or due from the center.

Appeals

FQHCs requesting to appeal the established PPS rate must submit their request in writing. (See Appendix A for contact information).

Cost Report Submission

To receive a PPS rate adjustment, FQHCs must submit cost reports for Health Resources and Services Administration (HRSA) approved changes in scope of service. **A cost report must be submitted prior to the consideration for PPS rate adjustments.** A HRSA approved change in scope can include: addition, removal or relocation of services sites, or the addition or deletion of specialty and non-primary services that were not included in the baseline rate calculation.

An interim rate will be set based on the initial cost report and effective the next SFY. The final PPS rate will be determined using the first two years of audited Medicaid cost reports, which must include documentation of the change in scope. **Cost reports will not be accepted for rate changes without a HRSA approved change in scope of service**.

NOTE: All HRSA approved changes in scope of service must be reported to the Department using the completed Services Facility Survey. (See Appendix B of this manual chapter).

Audits

All cost reports are subject to audit, including desk audits and field audits.

Encounter Visits

An FQHC provider can be reimbursed for only one medical, one behavioral health, and one dental encounter per day. Core service encounters with more than one health professional, and multiple encounters with the same health profession, that take place on the same date of service, at a single

location, constitute a single visit, and are limited to one encounter per day except when one of the following conditions exists:

1. After the first encounter, the beneficiary suffers illness or injury requiring additional diagnosis or treatment; and

2. The beneficiary has a medical visit or dental visit on the same day. Behavioral health benefits are subject to the requirements outlined in Section 22:1 Covered Services, of this provider manual chapter.

Services and supplies that are furnished by FQHC staff and incidental to an FQHC professional service as commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications and supplies used in a patient service visit are considered part of the FQHC service.

Fluoride varnish applications shall only be reimbursed to the FQHC when performed on the same date of service as an office visit or preventative screening. Separate encounters for fluoride varnish services are not permitted and the application of fluoride varnish does not constitute an encounter visit.

Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician**.**

Alternative Payment Methodology

Louisiana Medicaid has established several alternative payment methodologies (APM) for services provided within a FQHC. Reimbursement for these services are made in addition to the PPS rate, as an add-on payment, on the same day as another all-inclusive rate reimbursement. The FQHC APMs include payment for adjunct services.

Payment for Adjunct Services

Reimbursement will be made for adjunct services in addition to the encounter rate paid for professional services when these services are rendered during the evening, weekend or holiday hours as outlined in the *Current Procedural Terminology* (CPT) manual under "Special Services, Procedures and Reports".

To facilitate beneficiary access to services during non-typical hours and to reduce the inappropriate use of the hospital emergency department (ED), the reimbursement provided by use of the adjunct

codes is intended to assist with covering the additional administrative costs associated with staffing during these times. Providers are not to alter their existing business hours for the purpose of maximizing reimbursement.

The reimbursement is a flat fee in addition to the reimbursement for the associated encounter. Reimbursement for adjunct services are only billable for services rendered on weekends, state legal holidays, and between the hours of 5 p.m. and 8 a.m., Monday through Friday. Documentation must include the time the services were rendered.

NOTE: Payment is not allowed when the encounter is for dental services only.

Long Acting Reversible Contraceptives

FQHCs will receive reimbursement outside of their prospective payment system rate for long acting reversible contraceptives (LARCs). Reimbursement for LARCs will be the lesser of the Medicaid fee-for-service (FFS) rate on file or the actual acquisition cost (AAC), for entities participating in the 340B program. The rates for LARCs are located on the Durable Medical Equipment (DME) fee schedule on www.lamedicaid.com.

FQHC providers must submit the medical encounter and required detail line(s) for services provided to the beneficiary on the date of service according to current policy. The procedure code for the appropriate LARC and LARC insertion must be included in the detail lines of the claim. Detail lines for the LARC and LARC insertion cannot be the only detail lines on the claim or the claim will deny. The procedure code for the services listed will pay accordingly. All other detail lines on the claim will pay at zero.

Dental Services

FQHCs will receive an additional payment at the PPS rate for dental services that are provided on the same day as medical and behavioral health services.

Behavioral Health Services

FQHCs will receive an additional payment at the PPS rate for behavioral health services that are provided on the same day as medical and dental services.

Licensed Professional Counselors and Licensed Marriage and Family Therapist

Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) services are not core services. The services are other ambulatory services rendered in the FQHC.

These services follow the Medicaid policy in Chapter 2 of the Medicaid Services Manual, Behavioral Health Services Provider Manual for these providers. Reimbursement is at the all-inclusive reimbursement rate on file for the date of service.

Community Health Worker Services

FQHCs will receive the rate on file for community health worker (CHW) services in addition to the all-inclusive encounter rate payment on the same date of service. These services follow Medicaid policy in Chapter 5 of the Medicaid Services Manual, Professional Services Provider Manual for these providers.

Encounter Billing Guidelines

Reimbursement for medical, behavioral health and dental encounters include all services provided to the beneficiary on a specific date of service and any services on a subsequent day incidental to the original encounter visit. In addition to the appropriate encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and zero or usual/customary charges for each service provided on subsequent lines of the claim.

A visit to pick up a prescription or a referral is not considered a billable encounter. Laboratory or x-ray services with no "face-to-face" encounter with a covered FQHC provider do not constitute an FQHC visit and will not be reimbursed separately as they are part of the original encounter which warranted these additional services.

If a covered service is provided via an interactive audio and video telecommunications system (telemedicine), providers must refer to Chapter 5 of the Professional Services Provider Manual on www.lamedicaid.com for specific billing instructions.

Medical Encounters

Medical health services provided in FQHCs are reimbursed as encounters. These encounter visits must be billed on a CMS-1500 using procedure code T1015. The encounter reimbursement includes all services provided to the beneficiary on that date of service and any services on a subsequent day incidental to the original encounter visit. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and zero or usual/customary charges for each service provided on subsequent lines.

For obstetrical services, providers must bill the encounter code T1015 with modifier TH and all services performed on that date of service.

NOTE: Professional services not covered through the Professional Services Program are not covered through the FQHC Program.

Behavioral Health Encounters/Psychiatric Services

For behavioral health services provided during an encounter, and administered by a physician with a psychiatric specialty, a nurse practitioner (NP) or clinical nurse specialist with a psychiatric specialty, a licensed clinical social worker (LCSW), a licensed clinical psychologist, a LPC, or a LMFT, the FQHC provider ID number must be placed as the billing provider. The practitioner's provider ID number must be placed as the attending provider with the appropriate detail line procedure codes on the claim. These services should be billed on the CMS-1500 using procedure code H2020 as the first line of the claim. A behavioral health specific service must be rendered in order to bill a behavioral health encounter. The submission of an evaluation and management code alone is only allowed for specific provider types and specialty combinations. In addition, an FQHC cannot bill an encounter, and be paid the PPS rate, when only a group session is provided to a beneficiary.

Louisiana Medicaid reimburses professional service providers for select procedure codes specific to psychiatric services delivered in the office or other outpatient facility setting. This policy is applicable to physician services in the Professional Services program and mental health services provided in FQHCs. FQHC providers should enter the appropriate psychiatric procedure codes as encounter detail lines when submitting claims for the following services:

1. Psychiatric diagnostic or evaluative interview procedures;

NOTE: Procedure codes are reimbursable once per 365 days per attending provider.

2. Psychiatric therapeutic procedures; and

3. Psychological testing.

Psychological testing is reimbursable once per 365 days per attending provider. All applicable units of services related to this procedure code should be billed on one date of service and the units should not be divided among multiple dates of services or claim lines.

NOTE: Should nationally approved changes occur to Current Procedural Terminology (CPT) codes at a future date that relate to psychiatric services, providers are to follow the most accurate coding available for covered services for that particular date of service, unless otherwise directed.

In order to receive reimbursement from Louisiana Medicaid for behavioral health services, the FQHC's HRSA approval must include behavioral health services as a part of the clinic's scope of

service. In addition, the FQHC must notify LDH by completing a new Services Facility Survey and submitting it to the Department. (See Appendix B for Claims Related Information). The FQHC is not required to obtain a Behavioral Health Service Provider (BHSP) license from LDH Health Standards Section (HSS). A FQHC will be reimbursed the all-inclusive PPS rate for these services and must follow FQHC rules, policies, and manuals when billing. Practitioners who meet the above criteria can provide behavioral health services in the FQHC if they are one of the following:

1. Physicians with a Psychiatric Specialty;
2. NPs or Clinical Nurse Specialists with a Psychiatric Specialty;
3. LCSWs; or
4. Licensed Clinical Psychologists.

Physicians with a Psychiatric Specialty

The FQHC Medicaid ID number must be listed as the billing provider and the physician's individual Medicaid ID number must be listed as the attending provider on the claim for mental health services rendered by a physician with a psychiatric specialty.

Nurse Practitioners or Clinical Nurse Specialists with a Psychiatric Specialty

The FQHC Medicaid ID number must be listed as the billing provider and the NP or clinical nurse specialist's individual Medicaid ID number must be listed as the attending provider on the claim for mental health services rendered by a NP or clinical nurse specialist.

Licensed Clinical Social Workers

The FQHC Medicaid ID number is listed as the billing and attending provider on the claim for mental health services provided in an FQHC by a LCSW.

Licensed Clinical Psychologist

The FQHC Medicaid ID number must be listed as the billing and attending provider on the claim for mental health services provided in an FQHC by a clinical psychologist.

NOTE: Reimbursement for services for the above providers will be at the PPS rate on file on the date of service. Behavioral health services provided by a LPC or LMFT are considered other ambulatory services in the clinic and are reimbursed at the PPS rate on file.

Other Mental Health Providers Rendering Services in an FQHC

If the FQHC provides specialized mental health rehabilitation (MHR) services, i.e. community psychiatric support and treatment (CPST), crisis intervention (CI), and/or psychosocial rehabilitation (PSR) without the service being included in their HRSA scope of service approval or if services are delivered by an individual who is not a psychiatrist, an advanced practice registered nurse (APRN) with psychiatric specialty, a LCSW, a licensed clinical psychologist, LPC, or a LMFT, the entity is required to obtain a BHSP license issued by LDH HSS. The entity must enroll as an appropriate Specialized Behavioral Health Service (SBHS) provider, obtain a unique National Provider Identifier (NPI), have an active BHSP license issued by LDH HSS and meet qualifications and requirements established in the Medicaid BHSP Manual chapter, rules, laws and regulations. The entity must bill using its unique BHSP NPI in accordance with the SBHS Medicaid rules, policies and manuals.

NOTE: If Behavioral Health or MHR services outside of those addressed in this provider manual are delivered by an individual who is not a psychiatrist, an APRN with psychiatric specialty, a LCSW, a licensed clinical psychologist, LPC or a LMFT, the practitioner should review the Behavioral Health manual for Medicaid reimbursement.

Billing of an encounter on the same day as a residential treatment procedure code is not allowed in most cases. An exception would be if the beneficiary were seen on the day of admission to a treatment facility.

Dental Encounters

All dental services must be billed on the 2006 American Dental Association (ADA) claim form using the encounter code D0999. In addition to the encounter code, providers must list the specific dental services provided by entering the procedure code for each service rendered on subsequent lines. The provider should also include zero or usual/customary charges for each service provided.

Adjunct Services

FQHC adjunct services should be billed with the T1015 encounter code, the appropriate detail procedure, along with the adjunct service procedure code. The adjunct service procedure code may not be submitted as the only “detail line” for the encounter.

These adjunct codes are reimbursed in addition to the reimbursement for outpatient evaluation and management services when the services are rendered in settings other than hospital EDs:

1. Between the hours of 5 p.m. and 8 a.m. Monday through Friday;

2. On weekends between 12 a.m. Saturday through midnight on Sunday; and

3. State proclaimed legal holidays, 12 a.m. through midnight.

Providers are instructed to bill usual and customary charges. (See Appendix A for information on accessing the fee schedule).

Only one of the adjunct codes may be submitted by a billing provider per day. Providers are to select the code that most accurately reflects their situation. Adjunct codes are reported with another code or codes describing the service related to the beneficiary's visit or encounter. For example:

1. If the existing office hours are Monday-Friday 8 a.m. – 5 p.m. and the physician treats the beneficiary in the office at 7 p.m., then the provider may report the appropriate basic service (Evaluation/Management (E/M) visit code or encounter) and adjunct code; and

2. If a beneficiary is seen in the office on Saturday during existing office hours, the provider may report the appropriate basic service (E/M visit code or encounter) and adjunct code.

Documentation in the medical record relative to this reimbursement must include the time that the services were rendered. Should there be a post payment review of claims, providers may be asked to submit documentation regarding the existing office hours during the timeframe being reviewed.

FQHC providers will receive FFS reimbursement for the adjunct service codes separate from, but in addition to, the PPS reimbursement for the associated encounter (T1015).

1. For FQHC providers whose services meet the guidelines outlined in this policy:

    a. The encounter and required detail line(s) for services provided to the beneficiary on a date of service should be reported as directed in current FQHC policy;

    b. If appropriate, the adjunct services code may also be reported as a detail line, but it may not be submitted as the only "detail line" for an encounter; and

    c. The adjunct code will be reimbursed FFS in addition to the payment for the encounter.

2. The adjunct codes are not reimbursable for dental encounters.

Payments to all providers are subject to post payment review and recover of overpayments.

Early and Periodic Screening, Diagnostic and Treatment Services

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services must be billed using the CMS-1500/837P Professional format using encounter code T1015 with the EP modifier.

It is necessary to indicate the specific preventive screening services provided to support the T1015-EP encounter by entering the individual procedure code for each service rendered as the appropriate detail line. This includes but is not limited to immunizations, vision and hearing screening, developmental screening, and perinatal depression screening performed at the time of the EPSDT preventive visit. All claims billed using the T1015-EP must include the supporting detail procedure codes representing the services provided on the same date as the encounter.

The physician, APRN, or physician assistant listed as the rendering provider must be present and involved during a preventive visit. Any care provided by a registered nurse (RN), or other ancillary staff in a provider's office, is subject to Medicaid's 'Incident to' policy and must only be providing services within the scope of their license or certification.

In addition to the billing instructions above, providers must refer to and adhere to Medicaid Services Manual, Chapter 5, Professional Services Provider Manual on www.lamedicaid.com for all EPSDT screening policies.

NOTE: The dental encounter, D0999, may be billed on the same date of services as the encounter codes T1015, T1015 TH (OB encounter), T1015 EP (EPSDT screening) and/or H2020 (Behavioral Health encounter).

Medicare/Medicaid Dual Eligible Billing

Medicaid pays the Medicare co-insurance, up to the Medicaid established encounter rate, for beneficiaries who are eligible for Medicare and Medicaid. Providers should first file claims with the regional Medicare fiscal intermediary (FI)/carrier, ensuring the beneficiary's Medicaid ID number is included on the Medicare claim form, before filing with Medicaid.

After the Medicare claim has been processed, then Medicaid should be billed. Providers must bill these claims on the UB92/UB04 and include the Medicare Explanation of Benefits (EOB), a copy

of the Medicare claims and put the Medicaid provider number and Medicaid ID number in the appropriate form locators. (See Appendix A for information on where to send the claim).

NOTE: This is the only instance where Louisiana Medicaid may be billed using the UB92/UB04 for FQHC services. Straight Medicaid claims must be processed on the CMS-1500 claim form.

Outpatient Services

For all services rendered at the FQHC, in a nursing home or during home visits, the FQHC provider ID number must be used as the billing provider number in the appropriate place on the CMS-1500 claim form.

Inpatient Services

Physician inpatient services are billed through the physician's individual provider number as the billing provider. Physicians are not allowed to bill through their FQHC group number for inpatient services.

CONTACT INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Louisiana Department of Health (LDH)	Receives annual notice of grant award from a Federally Qualified Health Center (FQHC)	LDH Bureau of Health Services Financing (BHSF) Medicaid Policy and Compliance P.O. Box 91030 Baton Rouge, LA 70821-9030
Gainwell Technologies – Prior Authorization Unit (PAU)	Receives prior authorization (PA) requests	Gainwell Technologies Medicaid Solutions PAU P.O. Box 14919 Baton Rouge, LA 70898-4919
Gainwell Technologies – Provider Relations Unit	Provides assistance with questions regarding billing information	Gainwell Technologies Medicaid Solutions Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821
Gainwell Technologies – Claims Processing Unit	Processes Medicare crossover claims	Gainwell Technologies Medicaid Solutions P. O. Box 91023 Baton Rouge, LA 70821
Medicaid Eligibility Verification System (MEVS)/Recipient Eligibility Verification System (REVS)	Verifies beneficiary eligibility	www.lamedicaid.com
Division of Administrative Law (DAL)	Receives appeal requests	DAL Health and Hospitals Section P.O. Box 4189 Baton Rouge, LA 70821-4189
LeBlanc, Robertson, Chisholm & Associates, LLC (LRCA, LLC)	Receives cost reports	http://lrcaudit.com
Professional Services Fee Schedule	Reimbursement information relative to adjunct codes	www.lamedicaid.com following “Fee Schedules” then “Professional Services” links

See http://www.cms.hhs.gov/Manuals/PBM/list.asp for information concerning the Health Insurance Manual-15 (HIM-15).

FORMS AND LINKS

Form Description	Link
Service Facility Survey	https://www.lamedicaid.com/provweb1/Forms/FQHC_Services_Facility_Survey.pdf
CMS-1500	https://www.lamedicaid.com/provweb1/billing_information/CMS_1500_RHC_FQHC.pdf

GLOSSARY

Adjunct Services – Services provided by the Federally Qualified Health Center (FQHC) on weekends, state legal holidays, and between the hours of 5 p.m. and 8 a.m. Monday through Friday.

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

Change in Scope – An addition, removal and relocation of service sites and the addition or deletion of specialty and non-primary services that were not included in the baseline rate calculation.

Center for Medicare and Medicaid Services (CMS) – CMS **(**formerly known as Health Care Financing Administration-HCFA) is the federal agency in the Department of Health and Human Services (DHHS) responsible for administering the Medicaid Program and overseeing and monitoring of the State's Medicaid Program.

Louisiana Department of Health (LDH) – The state agency responsible for administering the Medicaid Program and health and related services including public health, mental health, developmental disabilities, and alcohol and substance abuse services. In this manual the use of the word "department" will mean LDH.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and public health programs.

Encounter – A face-to-face visit with a physician, physician assistant, nurse practitioner (NP), nurse midwife, visiting nurse, clinical psychologist, clinical social worker, or any other State plan approved ambulatory provider during which an FQHC core or other ambulatory service is rendered. Multiple medical encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit, except for cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Enrollment – A determination made by LDH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other LDH-funded services. This is also referred to as provider enrollment.

Federally Qualified Health Center (FQHC) – An entity receiving a grant under Section 330 of the Public Health Service (PHS) Act; is receiving funding from such grant under a contract with the beneficiaries of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act; is not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of DHHS to meet the requirements for receiving a grant based on the recommendation of the

Health Resources and Services Administration (HRSA); is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Fiscal Intermediary (FI) – Is the private fiscal agent with which LDH contracts to operate the Medicaid Management Information System (MMIS). It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

Health Professional Shortage Area (HPSA) – An urban or rural area, population group, or public or nonprofit private medical facility which the Secretary of DHHS determines has a shortage of health professionals.

Health Resources Services Administration (HRSA) – An office within DHHS whose mission is to improve access to healthcare services for the uninsured, isolated, or medically vulnerable through leadership and financial support.

Medicaid – A federal-state financed entitlement program which provides medical services primarily to low-income individuals under a State Plan approved under Title XIX of the Social Security Act.

Medically Underserved Area (MUA) – Areas designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population.

Medically Underserved Population (MUP) – Areas designated by HRSA as having high infant mortality, high poverty, and/or high elderly population.

Medicare – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

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

Prospective Payment System (PPS) – Method of reimbursement in which payment is made on a predetermined, fixed amount. Section 1902(bb) of the Social Security Act describes the methodology used to determine the PPS for FQHCs.

Provider Enrollment – Another term for enrollment.

Secretary – The Secretary of LDH or any official to whom (s)he has delegated the pertinent authority.

Satellite Clinics – Separate clinics of the primary FQHC.

Service Site – Any center which provides primary health care services to a geographic service area or population.

Trade Areas – Counties in the states of Texas, Arkansas, and Mississippi that physically share a border with Louisiana.

CLAIMS FILING

This appendix contains the following information:

1. Instructions for billing using the CMS-1500 Claim Form;
2. Samples of the CMS-1500 Claim Form;
3. Instructions for adjusting or voiding a CMS-1500 claim;
4. Samples of a CMS-1500 Claim Form Adjustment;
5. Instructions for billing using the American Dental Association (ADA) Dental Claim Form;
6. Sample of the ADA Dental Claim Form;
7. Instructions for adjusting or voiding an ADA claim using the 209 Adjustment/Void Form;
8. Sample of the 209 Adjustment/Void Form;
9. Instructions for adjusting or voiding an ADA claim using the 210 Adjustment/Void Form; and
10. Sample of the 210 Adjustment/Void Form.

CMS-1500 (02/12) Billing Instructions for Federally Qualified Health Center Services

Hard copy billing of Federally Qualified Health Center (FQHC) services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required, situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned or will be denied through the system. 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 that follow.

Paper claims should be submitted to:

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

Services may be billed using:

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

2. The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

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

This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and samples of completed CMS-1500 claim forms; and

2. Instructions for adjusting/voiding a claim and samples of adjusted CMS-1500 claim forms.

CMS-1500 (02/12) Billing Instructions for Federally Qualified Health Center Services

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's Identification (ID) Number	**Required** – Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through the Medicaid Eligibility Verification System (MEVS), electronic Medicaid Eligibility Verification System (eMEVS) or Recipient Eligibility Verification System (REVS). **NOTE:** The beneficiary's' 13-digit Medicaid ID number must be used to bill claims. The card control number (CCN) from the plastic ID card is **NOT** acceptable. The ID number must match the beneficiary's name in Block #2.	
2	Patient's Name	**Required** – Enter the beneficiary's last name, first name, middle initial (MI).	
3	Patient's Date of Birth (DOB) Sex	**Situational** – Enter the beneficiary's DOB using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a 0 (for example 01 02 07). Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	**Situational** – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the beneficiary's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Reserved for the National Uniform Claim Committee (NUCC) Use	**Leave Blank.**	

Locator #	Description	Instructions	Alerts
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If beneficiary has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned six-digit Third Party Liability (TPL) carrier code is **required** in this block. This carrier code is indicated on the MEVS response as the Network Provider ID Number. Make sure the Explanation of Benefits (EOB) or EOBs from other insurance(s) are attached to the claim.	**ONLY the six-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.**
9b	Reserved for NUCC Use	**Leave Blank.**	
9c	Reserved for NUCC Use	**Leave Blank.**	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group Federal Employees' Compensation Act (FECA) Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's DOB Sex	**Situational** – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	**Leave Blank.**	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	**Optional.**	
15	OTHER DATE	**Leave Blank.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional.**	
17	Name of Referring Provider or Other Source	**Situational –** Complete if applicable. In the following circumstances, entering the name of the appropriate physician block is **required**: If the beneficiary is a lock-in beneficiary and has been referred to the billing provider for services, enter the lock-in physician's name.	
17a	Unlabeled	**Leave Blank.**	
17b	National Provider Identifier (NPI) Number	**Leave Blank.**	
18	Hospitalization Dates Related to Current Services	**Leave Blank.**	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab?	**Optional.**	

Locator #	Description	Instructions	Alerts
21	International Classification of Diseases (ICD) Indicator Diagnosis or Nature of Illness or Injury	**Required** – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM **Required** – Enter the most current ICD diagnosis code. **NOTE**: The ICD-10 External Cause of Injury Codes, the "V", "W", "X" and "Y" diagnosis series codes are allowable as non-primary diagnoses codes when completing claims to be submitted to Medicaid.	**The most specific diagnosis codes must be used. General codes are not acceptable.** **ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.** **Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).**

Locator #	Description	Instructions	Alerts
22	Resubmission Code	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number (ICN) from the paid claim line as it appears on the remittance advice (RA) in the "Original Ref. No." portion of this field. Appropriate reason codes follow: <u>Adjustments</u> 01 = TPL Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	**To adjust or void a claim, only the encounter line should be adjusted/voided since all payment is made on this line. The ICN of the encounter line is used.**
23	Prior Authorization (PA) Number	**Situational** – Complete if appropriate or leave blank. If the services being billed must be prior authorized, the nine digit numeric PA number is **required** to be entered.	

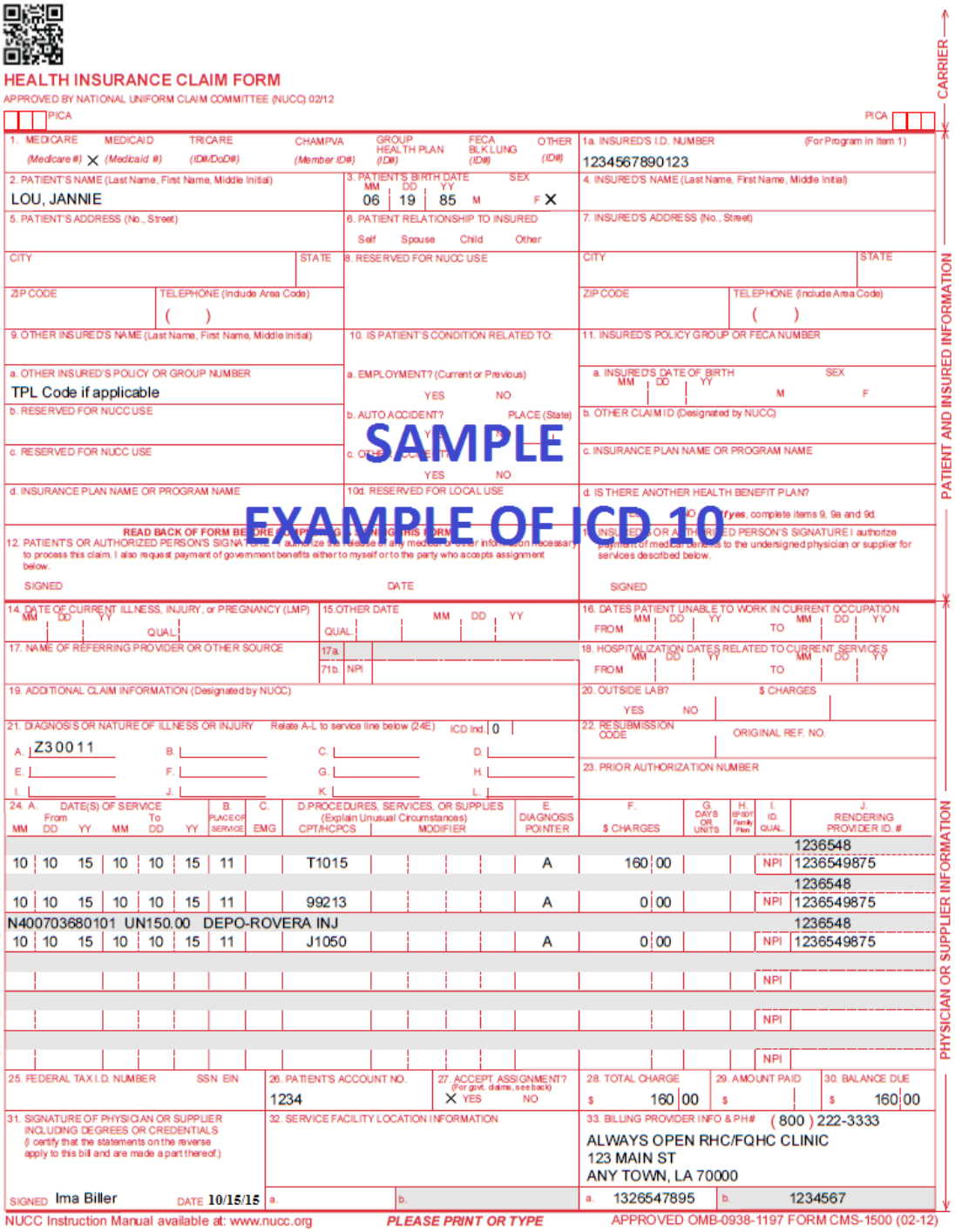
Locator #	Description	Instructions	Alerts
24	Supplemental Information	**Situational –** Applies to the detail lines for drugs and biologicals only. **CURRENTLY, THIS IS NOT A REQUIREMENT FOR FQHC PROVIDERS.** In addition to the procedure code, **the National Drug Code (NDC)** is **required** by the Deficit Reduction Act of 2005 for **physician-administered drugs** and **shall be entered** in the **shaded** section of 24A through 24G. **Claims for these drugs shall include the NDC from the label of the product administered.** To report additional information related to Healthcare Common Procedure Coding System (HCPCS) codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the **Qualifier N4** followed by the **11-digit NDC.** Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC. Providers should then leave one space then enter the appropriate **Unit Qualifier** (see below) and the **actual units administered**. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space. The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram UN Unit	**FQHCs who administer drugs and biologicals must enter drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only. This information must be entered in addition to the procedure code(s)**
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	Electromyography (EMG)	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered. Enter the appropriate encounter procedure code on the first line. **Encounter Codes:** 1. **FQHC medical encounter visit: T1015** 2. **FQHC obstetrical service: T1015 w/TH modifier.** 3. **FQHC Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service : T1015 w/EP modifier.** 4. **FQHC Behavioral Health encounter visit : H2020** **In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered.**	**If the detail line is for drugs or biologicals, entering the appropriate information from Block #24 (above) is required.** **For claims involving TPL, a claim line with the encounter code and the encounter rate must be added to the claim.**
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A” “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	**Required** -- Enter usual and customary charges, or zero when appropriate, for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D.	
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	ID Qualifier	**Optional.**	
24J	Rendering Provider ID	**Situational** – If appropriate, entering the Rendering Provider’s seven-digit Medicaid Provider Number in the shaded portion of the block is **required**. Entering the Rendering Provider’s NPI in the non-shaded portion of the block is **optional.**	

Locator #	Description	Instructions	Alerts
25	Federal Tax ID Number	**Optional.**	
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the RA. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – If TPL applies and block #9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Reserved for NUCC use	**Leave Blank.**	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional**. – The practitioner or the practitioner's authorized representative's original signature is no longer required. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI Number	**Optional.**	
32b	Unlabeled	**Optional.**	
33	Billing Provider Info & Phone Number	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI Number	**Optional**	
33b	Unlabeled	**Required** – Enter the billing provider's seven-digit Medicaid ID number. **ID Qualifier - Optional.** If possible, leave blank for Louisiana Medicaid billing.	**The seven-digit Medicaid Provider Number must appear on paper claims.**

Sample forms are on the following pages.

Sample of FQHC CMS-1500 Claim Form with ICD-10 Diagnosis Code



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOU, JANNIE

3. PATIENT'S BIRTH DATE MM DD YY: 06 19 85 | SEX: M | F X

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

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 Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER [illegible] 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? NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE SIGNING. [illegible] 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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z30011 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 10 15	10 10 15	11		T1015			A	160 00			NPI	1236548 / 1236549875
2	10 10 15	10 10 15	11		99213			A	0 00			NPI	1236548 / 1236549875
3	N400703680101 UN150.00 DEPO-ROVERA INJ												1236548
	10 10 15	10 10 15	11		J1050			A	0 00			NPI	1236549875
4												NPI	
5												NPI	
6												NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234

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

28. TOTAL CHARGE $ 160 00

29. AMOUNT PAID $

30. BALANCE DUE $ 160 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.)

SIGNED Ima Biller DATE 10/15/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH# (800) 222-3333

ALWAYS OPEN RHC/FQHC CLINIC
123 MAIN ST
ANY TOWN, LA 70000

a. 1326547895 b. 1234567

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

EXAMPLE OF ICD 10

Sample of a Claim Form

https://www.lamedicaid.com/provweb1/billing_information/CMS_1500_RHC_FQHC.pdf

Adjustments and Voids

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

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

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

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

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

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

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

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; and

2. If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

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

Adjustments/Voids Appearing on the Remittance Advice

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

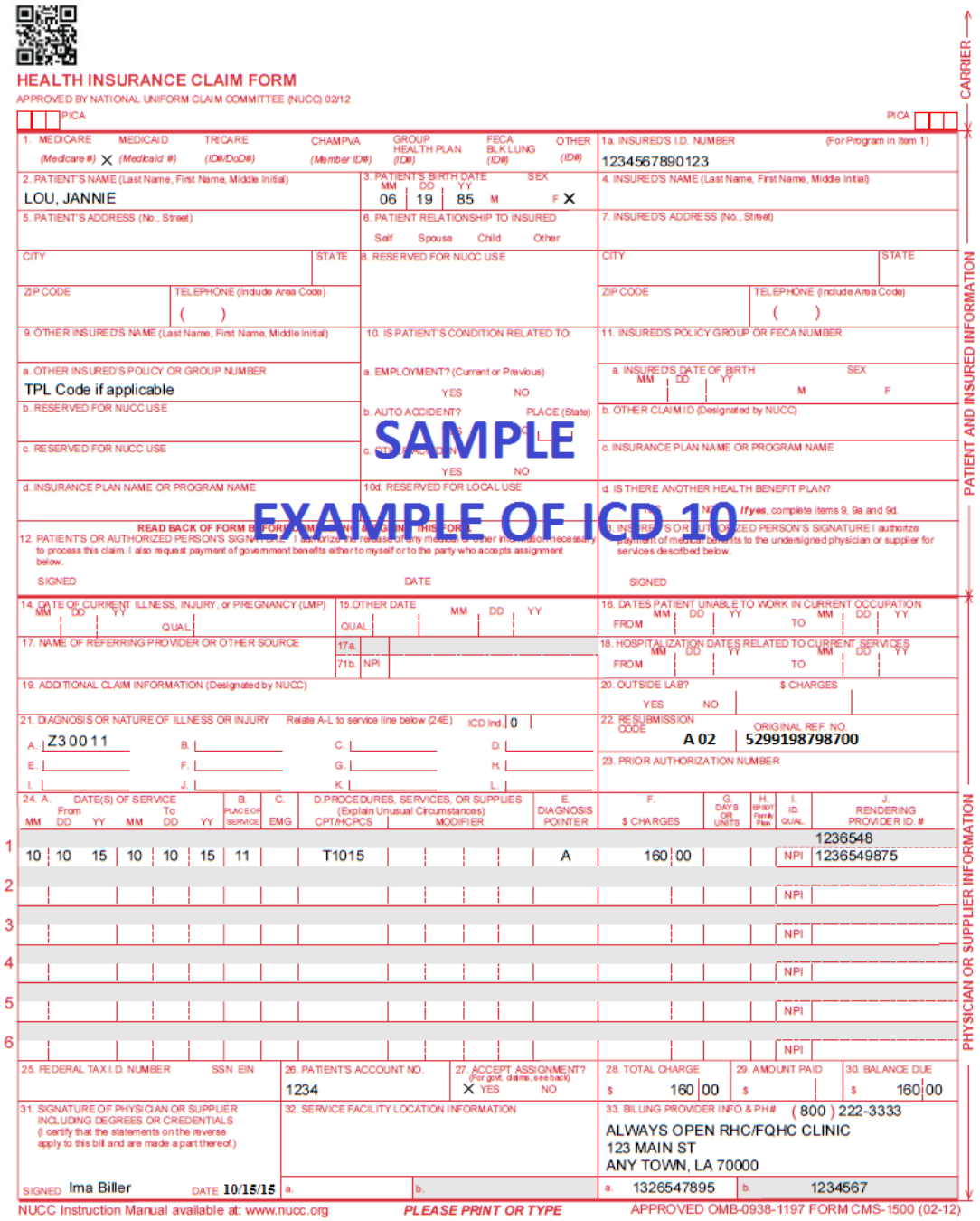
The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

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

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

Sample forms are on the following pages.

Sample of FQHC CMS-1500 Claim Form Adjustment with ICD-10 Diagnosis Code



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOU, JANNIE

3. PATIENT'S BIRTH DATE MM DD YY: 06 19 85 SEX M F X

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY | STATE

8. RESERVED FOR NUCC USE

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 Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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? NO If yes, complete items 9, 9a and 9d.

SAMPLE

EXAMPLE OF ICD 10

READ BACK OF FORM BEFORE SIGNING. 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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z30011 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: A 02 ORIGINAL REF. NO.: 5299198798700

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 10 15	10 10 15	11		T1015		A	160 00			NPI 1236548 1236549875
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234

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

28. TOTAL CHARGE: $ 160 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 160 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.)

SIGNED Ima Biller DATE 10/15/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH# (800) 222-3333

ALWAYS OPEN RHC/FQHC CLINIC
123 MAIN ST
ANY TOWN, LA 70000

a. 1326547895 b. 1234567

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

American Dental Association Claim Form Billing Instructions for Federally Qualified Health Center Services

Medicaid Early and Periodic Screening, Diagnostic, and Treatment Dental and Adult Denture Program Services

The 2006 ADA Claim Form is the only hardcopy dental claim form accepted for Medicaid reimbursement of services provided under the Medicaid EPSDT Dental Program or Adult Denture Program. These claim forms may be obtained by contacting the ADA or your dental supply company.

The following billing instructions correspond to the 2006 ADA Claim Form.

Required information must be entered to ensure claims processing.

Situational information may be required only in certain situations as detailed in each instruction item.

Information on the claim form may be handwritten or computer generated and must be legible and completely contained in the designated area of the claim form.

EPSDT Dental Program and Adult Denture Program claims should be submitted to:

Gainwell Technologies
P. O. Box 91022
Baton Rouge, LA 70821

American Dental Association Claim Form Billing Instructions for Federally Qualified Health Center Services

Locator #	Description	Instructions	Alerts
1	Type of Transaction	**Required** -- Check applicable box to designate whether the claim is a statement of actual services or a request PA. **Situational** – Check box marked "EPSDT Title XIX" if patient is Medicaid eligible and under 21 years of age. If block is not checked, the claim will be processed as an adult claim.	If a claim is being submitted for payment, you must mark "Statement of Actual Services" in Block #1 of the claim form. Claims for payment that are sent to Gainwell Technologies should never include radiographs.
2	Predetermination / Preauthorization Number	**Situational** – Enter the PA number assigned by Medicaid when submitting a claim for services that require PA.	
3	Company / Plan Name, Address, City, State, Zip Code	**Situational** – Enter the primary payer information if applicable.	
4	Other Dental or Medical Coverage?	**Situational** – If yes, complete Block #9.	
5	Name of Policyholder/Subscriber in #4 (Last, First, MI, Suffix)	**Situational.**	
6	DOB (MM/DD/CCYY)	**Situational.**	
7	Gender	**Situational.**	
8	Policyholder/Subscriber ID	**Situational.**	

9	Plan/Group Number	**Situational** – Enter the third party's carrier code if a third party is involved. If there is other coverage, the state assigned six-digit TPL carrier code is **required** in this block. This code is returned through MEVS beneficiary eligibility inquiries as the Network Plan Identifier. The MEVS application is located on the secure portal of the web site, www.lamedicaid.com. (The carrier code list can be found at www.lamedicaid.com under the **Forms/Files** link). If the provider has chosen to bill the third party and Medicaid, an EOBs must be attached to the claim filed with Medicaid.	
Locator #	**Description**	**Instructions**	**Alerts**
10	Patient's Relationship to Person Named in #5	**Situational.**	
11	Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code	**Situational.**	
12	Policyholder/Subscriber Name (Last, First, MI, Suffix) Address, City, State, Zip Code	**Required** -- Enter the beneficiary's last name, first name, and MI exactly as verified through REVS or MEVS. Beneficiary's address is **optional**.	
13	DOB (MM/DD/CCYY)	**Required** -- Enter the beneficiary's eight-digit DOB in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.	
14	Gender	**Optional** – Check appropriate block.	
15	Policyholder/Subscriber ID	**Required** -- Enter the 13-digit Medicaid ID number as obtained from REVS or MEVS. Do not use the 16-digit CCN from the beneficiary's Medicaid card.	
16	Plan / Group Number	**Situational.**	
17	Employer Name	**Situational.**	
18	Relationship to Policyholder/Subscriber in #12 above.	**Situational.**	
19	Student Status	**Situational.**	
20	Name (Last, First, MI, Suffix) Address, City, State, Zip Code	**Situational.** This field should be used only when other private insurance is primary. **Note:** The Medicaid beneficiary's name is required to be entered in Block #12.	

21	DOB (MM/DD/CCYY)	**Situational.**	
22	Gender	**Situational.**	
23	Patient ID / Account Number (Assigned by Dentist)	**Optional** – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the RA. The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20 characters.	
24	Procedure Date (MM/DD/CCYY)	**Required** -- Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero. A service must have been performed/delivered before billing Medicaid for payment.	
Locator #	**Description**	**Instructions**	**Alerts**
25	Area of Oral Cavity	**Situational** – Enter the oral cavity designator when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific **requirements** regarding oral cavity designator. If an oral cavity designator is **required** by Medicaid, do not enter a tooth number or letter in Block #27.	Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.
26	Tooth System	**Leave Blank**	

27	Tooth Number(s) or Letter(s)	**Situational** – Enter a tooth number or letter when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific **requirements** regarding tooth number or letter. If a tooth number or letter is **required** by Medicaid, do not enter an oral cavity designator in Block #25.	Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.
28	Tooth Surface	**Situational –** Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes: B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial, and O = Occlusal Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.	
Locator #	**Description**	**Instructions**	**Alerts**
29	Procedure Code	**Required –** Enter the all-inclusive encounter code (D0999) on the first line then enter the appropriate dental procedure codes from the current version of Code on Dental Procedures and Nomenclature. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.	REMINDER: The all-inclusive encounter code (D0999) must be entered on the first line of the claim form. Tooth number/letter, surface or oral cavity designator is not required for this line. In addition to the

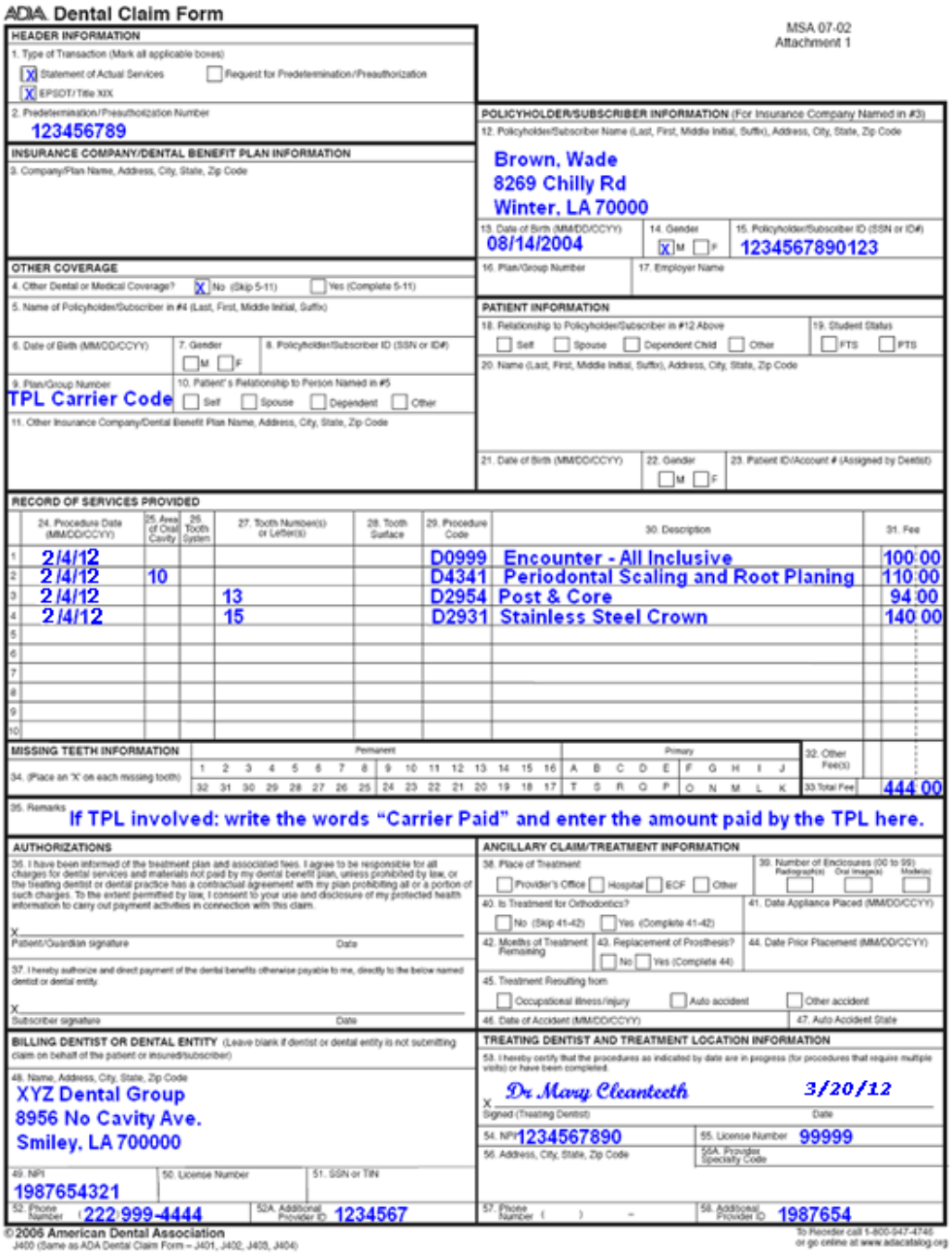
			encounter information, it is necessary to indicate on subsequent lines of the claim form, the specific dental services provided by entering the individual procedures, including all appropriate line item information for each service rendered.
30	Description	**Required –** Enter the description of the service performed.	
31	Fee	**Required** -- Enter the dentist's full (usual and customary) fee for the dental procedure reported.	
32	Other Fee(s)	**Leave Blank**	
33	Total Fee	**Required** – Total of all fees listed on the claim form.	
34	(Place an 'X' on each missing tooth)	**Situational** – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/". In the following circumstances, this information is **required**: If the claim is for the Adult Denture Program. If the claim is for the EPSDT Dental Program when requesting a prosthetic, space maintainer or root canal therapy.	

Locator #	Description	Instructions	Alerts
35	Remarks	**Situational** – Enter the amount paid by the primary payor if block #9 is completed. Write the words "Carrier Paid" and the amount that was paid by the carrier (including 0 [$0] payment) in this block. Enter any additional information **required** by Medicaid regarding requested services (including description of the patient management techniques used for which a patient management fee is billed; reason for hospitalization requests, or any additional information that the provider needs to include). For PA requests, if the information **required** in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the beneficiary's name and Medicaid ID number and the provider's name and Medicaid ID number. A copy of this cover sheet, along with a copy of the request for PA, should be kept in the patient's treatment record.	
36	Authorizations	**Optional.**	
37	Authorizations	**Optional.**	
38	Place of Treatment	**Situational** – Check the applicable box if services are to be or were provided at a location other than the address entered in Block #48. If services were provided at a location other than the address entered in Block #48, completion of this block and Block #56 is **required**.	
39	Number of Enclosures	**Situational** – Enter 00 to 99 in applicable boxes. Claims submitted for PA are **required** to contain the identified attachments. Claims submitted for payment should not contain any of the attachments listed in Block #39.	

Locator #	Description	Instructions	Alerts
40	Is Treatment for Orthodontics?	**Situational** – Complete if applicable. Claims requesting comprehensive orthodontic services are **required** to enter information in this block. Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.	
41	Date Appliance Placed	**Situational.**	
42	Months of Treatment Remaining.	**Situational.**	
43	Replacement of Prosthesis	**Situational** – Check appropriate box if applicable; if checked, complete Block #44 if known.	
44	Date Prior Placement	**Situational** – If Block #43 is checked and if known, enter the appropriate eight-digit date in month, day and year (MM/DD/CCYY).	
45	Treatment Resulting from	**Situational** – If the claim is the result of Occupational Illness / Injury, Auto Accident, or Other Accident, then this Block is **required**. Check the appropriate box.	
46	Date of Accident (MM/DD/CCYY).	**Situational**. If Block #45 is completed, then this block is **required**. Enter the eight-digit date in month, day and year (MM/DD/CCYY).	
47	Auto Accident State	**Situational**. If Auto Accident is checked in Block #45, this block is **required**. Enter the state in which the auto accident occurred.	
48	Billing Dentist Name, Address, City, State, Zip Code	**Required**. Enter the name of the individual dentist if the payment is being made to an individual dentist. Enter the group name if the payment is being made to a dental group. Enter the full address, including city, state and zip code, of the dentist or dental group to whom payment is being made.	
49	NPI	**Optional** – Enter the billing provider's 10-digit NPI number.	
50	License Number	**Optional.**	
51	Social Security Number (SSN) or Tax Identification Number (TIN)	**Optional.**	
52	Phone Number	**Required** -- Enter the phone number for the billing dental provider.	

52A	Additional Provider ID	**Required** – Enter the seven-digit Medicaid Provider ID of the billing dental provider.	
53	Signature	**Optional**.	
Locator #	**Description**	**Instructions**	**Alerts**
54	NPI	**Optional** – Enter the 10-digit NPI of the treating (attending) dental provider	
55	License Number	**Required** – Enter the license number of the treating (attending) dental provider.	
56	Address, City, State, Zip Code	**Situational** – Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dental provider, if different from Block #48.	
56A	Provider Specialty Code	**Optional.**	
57	Signature	**Optional**.	
58	NPI	**Optional** – Enter the 10-digit NPI of the treating (attending) dental provider	

Sample of American Dental Association Claim Form



ADA Dental Claim Form

MSA 07-02
Attachment 1

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[X] EPSDT/Title XIX

2. Predetermination/Preauthorization Number: 123456789

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number: TPL Carrier Code | 10. Patient's Relationship to Person Named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:
Brown, Wade
8269 Chilly Rd
Winter, LA 70000
13. Date of Birth (MM/DD/CCYY): 08/14/2004 | 14. Gender [X] M [ ] F | 15. Policyholder/Subscriber ID (SSN or ID#): 1234567890123
16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Student Status [ ] FTS [ ] PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) | 22. Gender [ ] M [ ] F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	2/4/12					D0999	Encounter - All Inclusive	100 00
2	2/4/12	10				D4341	Periodontal Scaling and Root Planing	110 00
3	2/4/12			13		D2954	Post & Core	94 00
4	2/4/12			15		D2931	Stainless Steel Crown	140 00
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	444 00

35. Remarks: If TPL involved: write the words "Carrier Paid" and enter the amount paid by the TPL here.

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code:
XYZ Dental Group
8956 No Cavity Ave.
Smiley, LA 700000
49. NPI: 1987654321 | 50. License Number | 51. SSN or TIN
52. Phone Number: (222)999-4444 | 52A. Additional Provider ID: 1234567

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment [ ] Provider's Office [ ] Hospital [ ] ECF [ ] Other | 39. Number of Enclosures (00 to 99): Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining | 43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Dr Mary Cleanteeth 3/20/12
Signed (Treating Dentist) Date
54. NPI: 1234567890 | 55. License Number: 99999
56. Address, City, State, Zip Code | 56A. Provider Specialty Code
57. Phone Number ( ) - | 58. Additional Provider ID: 1987654

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)
To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

Early and Periodic Screening, Diagnostic, and Treatment Dental Services Adjustment/Void (209) and Adult Dental Services Adjustment/Void (210) Form

The EPSDT Dental Services 209 Adjustment/Void form (revision date 10/04) must be used when submitting adjustments/voids for EPSDT Dental Program services for all dates of service.

Additionally, when submitting adjustments/voids for the Adult Denture Program for all dates of service, dental providers must use the Adult Dental Services 210 Adjustment/Void form (revision date 10/04).

For both adjustment/void forms, the Form Locator 15 has been renamed as "Patient I.D./Account# Assigned by Dentist". If the patient's account (medical record) number is entered here, it will appear on the Medicaid RA. It may consist of letters and/or numbers, and it may be a maximum of 20 positions.

Providers can obtain these forms from Gainwell Technologies or through the Louisiana Medicaid website at www.lamedicaid.com. Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

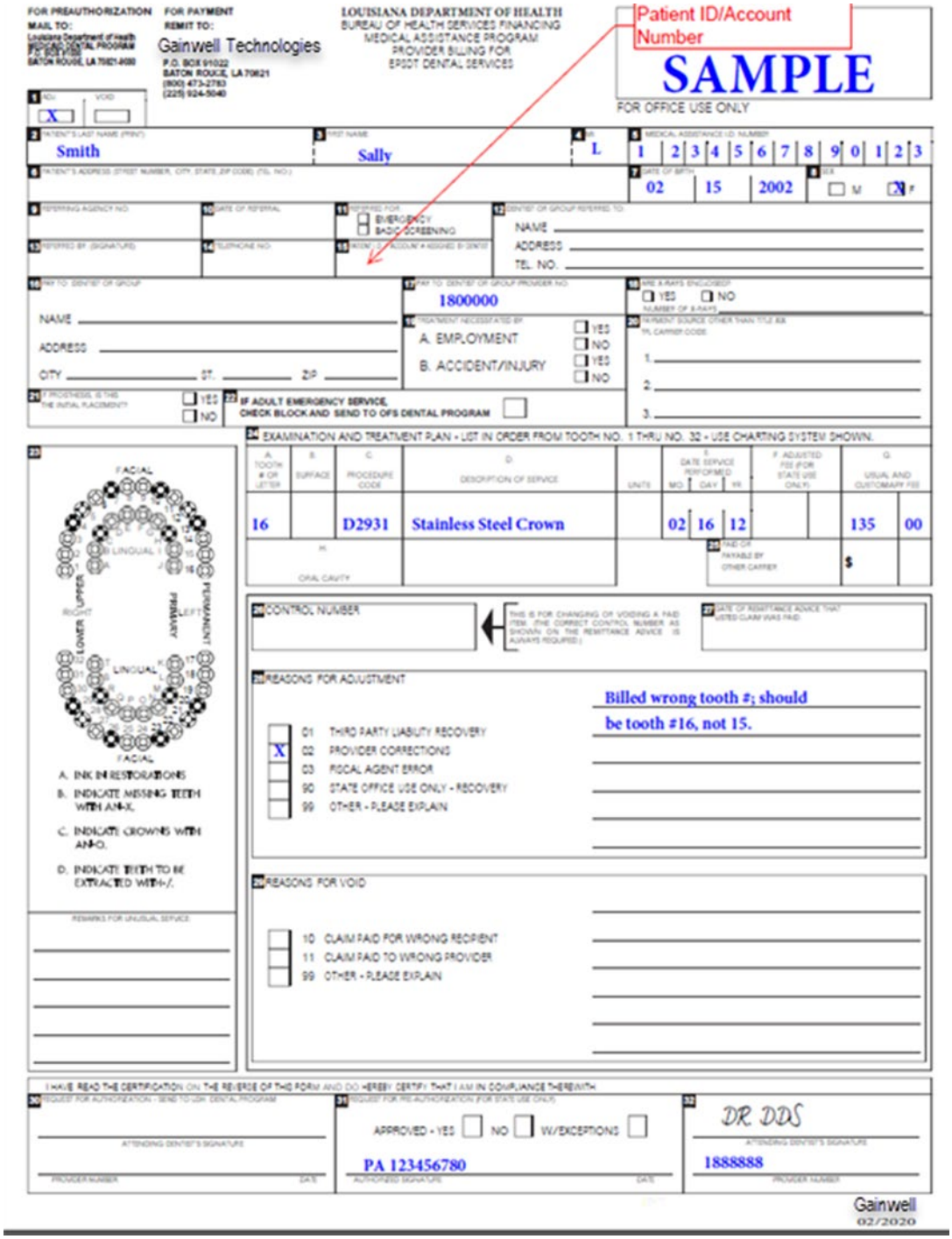
Instructions for Completing 209 Adjustment/Void Form (Early and Periodic Screening, Diagnostic, and Treatment)

Locator #	Description	Instructions	Alerts
1	Adjust/Void	Check the appropriate box.	
2 **3** **4**	Patient's Last Name First Name MI	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
5	Medical Assistance ID Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.	
6	Patient's Address	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
7	DOB	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
8	Sex	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
9-14		Not Required.	
15	Patient ID/Account Number (Assigned By Dentist)	**Adjust** – Enter the information exactly as it appeared on the original invoice. **Void** – Enter the information exactly as it appeared on the original invoice.	
16	Pay to Dentist or Group	**Adjust** – Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
17	Pay to Dentist or Group Provider Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** – Enter the information exactly as it appeared on the original invoice.	
18	Are X-Rays Enclosed	Not required	

19	Treatment Necessitated By	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
Locator #	**Description**	**Instructions**	**Alerts**
20	Payment Source Other Than Title XIX	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the six-digit TPL carrier code. **Void** - Enter the information exactly as it appeared on the original invoice.	
21, 22		Leave these spaces blank.	
23	Diagram	Not required.	
24	Examination and Treatment Plan	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted. **Void** - Enter the information exactly as it appeared on the original invoice.	
25	Paid or Payable by Other Carrier	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0). **Void** - Enter the information exactly as it appeared on the original invoice.	
26	Control Number	Enter the control number assigned to the claim on the RA that reported the claim as paid/approved.	
27	Date of RA	Enter the date of the RA that paid or denied claim.	
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.	
30	Request for Authorization	Leave this space blank.	
31	Request for PA	Enter the nine-digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires PA.	
32	Attending Dentist's Signature - Provider Number	The attending provider number must be entered in this field.	

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Gainwell Technologies for adjustment. If the code was submitted on the original invoice, and PA was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

Sample of 209 Adjustment/Void Form (Early and Periodic Screening, Diagnostic, and Treatment)



Instructions for Completing 210 Adjustment/Void Form (Adult)

Locator #	Description	Instructions	Alerts
1	Adjust/Void	Check the appropriate box.	
2 **3** **4**	Patient's Last Name First Name MI	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
5	Medical Assistance ID Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.	
6	Patient's Address	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
7	DOB	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
8	Sex	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
9-14		Not Required.	
15	Patient ID/Account Number (Assigned By Dentist)	**Adjust** – Enter the information exactly as it appeared on the original invoice. **Void** – Enter the information exactly as it appeared on the original invoice.	
16	Pay to Dentist or Group	**Adjust** – Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
17	Pay to Dentist or Group Provider Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** – Enter the information exactly as it appeared on the original invoice.	
18	Are X-Rays Enclosed	Not required.	

19	Treatment Necessitated By	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.	
Locator #	**Description**	**Instructions**	**Alerts**
20	Payment Source Other Than Title XIX	**Adjust** - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the six-digit TPL carrier code. **Void** - Enter the information exactly as it appeared on the original invoice.	
21		Not required.	
22		Leave blank.	
23	A-G	**Adjust** – Enter the information exactly as it appeared on the original invoice unless this information is being adjusted. **Void** - Enter the information exactly as it appeared on the original invoice.	
24	Paid of Payable by Other Carrier	**Adjust** – Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0). **Void** - Enter the information exactly as it appeared on the original invoice.	
25	Other Information	Leave blank.	
26	Control Number	Enter the control number assigned to the claim on the RA that reported the claim as paid/approved.	
27	Date of RA	Enter the date of the RA that paid or denied claim.	
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.	
30	Request for Authorization	Leave this space blank.	
31	Request for PA	Enter the nine- digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires PA.	
32	Attending Dentist's Signature - Provider Number	The attending provider number must be entered in this field.	

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Gainwell Technologies for adjustment. If the code was submitted on the original invoice, and PA was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

Sample of 210 Adjustment/Void Form (Adult)