MENTAL HEALTH CLINICS PROVIDER MANUAL

Chapter Thirteen of the Medicaid Services Manual

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State of Louisiana
Bureau of Health Services Financing

MENTAL HEALTH CLINICS

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OVERVIEW

Mental Health Clinics (MHCs) are licensed by the Department of Health and Hospitals (DHH), Bureau of Health Standards. The regulations that govern MHCs are located in Louisiana Revised Statutes 28:567. Currently there is a moratorium on licensing new clinics until the publication and promulgation of new rules and regulations governing operations and reimbursement. (Refer to Executive Order BJ 08-24 –July 9, 2008). Additionally, all mental health clinics must be enrolled in both Medicare and Medicaid.

The fundamental purpose of a MHC is to assist adults with mental illness and children with emotional/behavioral disorders through outpatient services. Such services must be medically necessary to reduce the disability resulting from mental illness and assist in the recovery and resiliency of the recipient. The intent of MHC services is to minimize the disabling effects on the individual's capacity for independent living and to prevent or limit the periods of inpatient treatment. Services must include, at a minimum, outpatient services to residents of an assigned geographic area.

MHC services are expected to achieve the following outcomes:

- Assist recipients in the stabilization of acute symptoms of mental illness
- Assist recipients in coping with the chronic symptoms of their mental illness
- Minimize the aspects of mental illness that make it difficult for a recipient to live independently
- Reduce or prevent psychiatric hospitalizations; and
- Minimize the amount of time spent in out-of-home placement and disruptions in school for children

SERVICES

The clinic services covered under the program are defined as those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to an outpatient by or under the direction of a physician in a facility which is not a part of a hospital but which is organized and operated to provide medical care to outpatients.

The following services are also covered under the program:

- Psychological Evaluation
- Psychological Testing
- Psychosocial Evaluation
- Psychiatric Evaluation
- Medical Evaluation
- Mental Health Assessment
- Collateral Counseling
- Individual Therapy/Counseling
- Group Therapy/Counseling
- Family/Couple Therapy/Counseling
- Couple Therapy/Counseling
- Medication Management/Medication injection

Evaluation and Assessment Services

Evaluation and assessment services are as described below.

Psychological Evaluation - Clinical examination of an individual by face-to-face interview which includes but is not limited to collecting information about history, mental status, disposition, and may include communication with family or other sources. In certain circumstances, other informants will be seen in lieu of the individual. The outcome of the examination is a diagnosis of mental and/or substance use disorder according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) nosology and the formulation of an initial plan of care.

Psychological Testing – The evaluation of the cognitive processes, emotions, and problems of adjustment through the administration of tests of mental abilities, aptitudes, interests, attitudes, motivations and personality characteristics. Psychological testing explicitly includes the following three areas: intellectual, personality and emotional, and neuropsychological.

Psychosocial Evaluation - The determination and examination of the social situation of the individual as it relates to family background, family interaction, living arrangements, psycho-economic problems, or socioeconomic problems.

Psychiatric Evaluation - The psycho diagnostic process includes a medical history and a mental status which notes the attitudes and behavior; an estimate of intellectual functioning; orientation; an inventory of the patient's assets in a descriptive fashion; impressions; and recommendations.

Medical Evaluation - A medical evaluation is an examination of the body's functional processes, noting observations and findings, supplemented by diagnosis, if indicated.

Mental Health Assessment – Face to face therapeutic contact between identified persons served and assessor for the purposes of confirming eligibility as a member of targeted population; engaging client in therapeutic process; gathering pertinent assessment data; and integrating assessment information from diagnostic, clinical, psychosocial screenings/evaluation to determine risk; functional status and impairments; diagnoses; and client preference and desires for care delivery and services. For all clients who meet targeted population eligibility, the integrated screening/evaluation information is used in active partnership with client for development of the initial service plan (ISP) including selection of treatment services and modalities.

Therapy and Counseling Services

Therapy and counseling services include those services which are intended to change favorably the recipient or recipient's situation through the reduction or remedy of disability or discomfort, the amelioration of signs and symptoms, and the attainment of change in specific physical, mental, or social functioning. These services are usually formal and scheduled, but may be provided on an emergency basis. Therapy and counseling services are described below.

Collateral Counseling – Counseling or consultation provided to a family member or significant other of the client in accordance with the client's treatment plan. Client is not present.

Individual Therapy or Counseling – The treatment by individual interviews, the intent of which is to aid the recipient in meeting his/her needs by eliminating psychosocial barriers that may impede the development of skills. These services maximize strengths, reduce behavior problems or change behavior of the at risk client.

Group Counseling or Therapy – The treatment by use of group dynamics or group interaction. Services are provided simultaneously to two or more recipients who are grouped together for the purpose of achieving the goals in their respective treatment plans. Group counseling or therapy includes psychotherapy, psychoanalysis, play therapy, psychodrama, behavior modification, etc.

Family/Couple Counseling or Therapy – The treatment applied to couples, the family as a unit, or other significant family members which includes treatment of a child by working with the parents, treatment of an elder family member by working with other family members, etc.

Medication Management – The activities related to the dispersing, review, and regulation of a medication program for individuals or counseling/education related to the use of or effects of medication; and

Medication Injection – The injectable medication treatment, short or long term, for treating conditions requiring medication given by subcutaneous or intramuscular route (e.g., allergic reaction, side effects from medication, acute anxiety or agitation, or long action neuroleptic drugs).

Service Limits

DHH will reimburse enrolled MHCs for covered services for only one procedure per day per recipient. Occupational therapy, recreational therapy, music therapy, and art therapy are not reimbursable services for MHCs.
Medicaid eligible recipients ages six years and over are eligible for services covered in an MHC.

Recipients receiving Mental Health Rehabilitation (MHR) or Multi-Systemic Therapy (MST) services are not eligible to receive MHC services as this would result in duplicate services which are not billable. The only exception would be if MST recipients are evaluated at an MHC or currently receiving medication management from an MHC. Otherwise, all therapeutic counseling services are not billable through both providers simultaneously.

Non-Covered Services

- Occupational therapy
- Recreational therapy
- Music therapy
- Art therapy
- Inpatient services (in addition, covered services are not billable when a recipient is receiving inpatient care)
- Daycare for mental health services
- Partial Hospitalization

Admissions Criteria for Adults

A recipient who has a serious and persistent mental illness and meets the following criteria for *Age, Diagnosis, Disability*, and *Duration would be eligible for services as an adult under the program:*

Age: A recipient applying for MHC services as an adult must be 18 years of age or older.

Diagnosis: Severe non-organic mental illnesses including, but not limited to schizophrenia, schizo-affective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living such as self-care, household management, interpersonal relationships and work or school.

Disability: Impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas:

- Unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income.
- Employed in a sheltered setting.
- Requires public financial assistance for out-of-hospital maintenance (i.e., SSI) and/or is unable to procure such without help; does not apply to regular retirement benefits.
- Severely lacks social support systems in the natural environment (i.e., no close friends or group affiliations, lives alone, or is highly transient).
- Requires assistance in basic life skills (i.e., must be reminded to take medicine, must have transportation arranged for him/her, needs assistance in household management tasks).
- Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.

Duration: Must meet at least one of the following indicators of duration:

- Psychiatric hospitalizations of at least six months in the last five years (cumulative total).
- Two or more hospitalizations for mental disorders in the last 12 month period.
- A single episode of continuous structural supportive residential care other than hospitalization for duration of at least six months.
- A previous psychiatric evaluation or psychiatric documentation of treatment indicating a history of severe psychiatric disability of at least six months duration.

NOTE: Recipients who are between the ages of eighteen and twenty-one and who have been determined not to meet the adult medical necessity criteria for services, initial or continued care, shall be reassessed by the Bureau or its designee using the children/adolescent medical necessity criteria for services.

Admission Criteria for Youth

A recipient who has an emotional behavioral disorder and meets the following criteria for *Age, Diagnosis, Disability,* and *Duration would be eligible for services as a youth under the program:*

Age: The recipient must be under the age of 18 years and be at least 6 years of age.

Diagnosis: The recipient must have an emotional disturbance, a condition characterized by behavioral or emotional responses so different from appropriate age, cultural, or ethnic norms that they adversely affect performance. Performance includes academic, social, vocational or personal skills. Such disability is more than a temporary, expected response to stressful events in the environment; it is consistently exhibited in two different settings and persists despite individualized intervention within general education and other settings. Emotional disturbance can co-exist with other disabilities.

In order to meet the criteria of emotional disturbance, at least one of the following must be met:

- Exhibits seriously impaired contact with reality, and impaired social, academic, and self-care functioning, whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation; or

- Manifests long-term patterns of inappropriate behaviors, which may include, but are not limited to, aggressiveness (e.g. Intermittent Explosive Disorder), suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; or

- Experiences serious discomfort from anxiety, depression, or irrational fears and concerns whose symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive;

- Possesses a DSM- IV (or successor editions) diagnosis indicating a severe mental disorder, which requires 24-hour care and supervision, such as, but not limited to, psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive).

Children and youth who are socially maladjusted (e.g., severe conduct or oppositional disorders) qualify for services only if the disordered behavior is associated with a diagnosed emotional disturbance and/or another severe DSM disorder such as psychosis, mania, depression or anxiety.

Disorders that are the direct result of organic compromise of cognitive or behavioral functioning do not meet the diagnostic criteria. For example, children/youth with personality changes due to closed head injury are not eligible for services related to these disorders alone.

Disability: At least two of the following areas of impaired role functioning must be caused by the mental illness noted above and occur in at least two different settings: home, school or community:

- Inability to routinely exhibit appropriate behavior under normal circumstances;
- Tendency to develop physical symptoms or fears associated with personal or school problems;
- Inability to learn or work that cannot be explained by intellectual, sensory, or health factors;
- Inability to establish or maintain satisfactory interpersonal relationships with peers and adults;
- Exhibition of a general pervasive mood of unhappiness or depression;
- Conduct characterized by lack of behavioral control or adherence to social norms associated with a serious mental disorder (as defined in the diagnosis section).

Duration: At least one of the following must be met:

- There is an impairment or pattern of inappropriate behavior(s) that has persisted for at least one year;
- There is substantial risk that without intervention the impairment or pattern of inappropriate behavior(s) will persist for an extended period;
- There is a pattern of inappropriate behavior that is severe and of short duration.

NOTE: Medication prescribed for Attention Deficit Hyperactive Disorder (ADHD) is insufficient to meet this criterion.

Acute: At least one of the criteria as described below must be met.

- Danger to self, as manifested by:
    - Recent suicide attempt;
    - Suicide plan, intent with means, or recurring suicidal ideation;
    - Other behavior that is seriously dangerous to self.
- Danger to others, as manifested by:
    - Dangerously aggressive behavior in the recent past that is due to a serious mental disorder (as defined in the diagnosis section);
    - Threats to kill or seriously harm another person with the means to carry out the threats, and the behaviors are due to a serious mental disorder (as defined in the diagnosis section);
    - Current homicidal plan, specific intent, or recurring ideas of harming others due to a serious mental disorder (as defined in the diagnosis section).
- Grave Disability refers to a serious impairment in functioning in one or more major life roles (school, job, family, interpersonal relationships, self-care) due to a serious mental disorder. Additionally, at least one of the following criteria must be met:
    - Inability to cooperate with caregivers unless active mental health intervention is instituted; e.g., the condition is severe enough that the consumer is unable to be treated by a primary care physician;
    - Acute onset or acute exacerbation of symptoms of a serious mental disorder such as hallucinations, delusions, disorganized thinking, other serious psychotic symptoms or other severe psychiatric symptoms such that the consumer's well being is seriously threatened - for example, panic attacks with a risk of suicide; depressive symptoms causing the consumer to be unable to sleep or eat; manic symptoms of such severity that physiological functioning is at risk; or an anxiety attack causing the consumer to be unable to leave his home;

In addition to the above criteria, other factors will also be considered which include:

- Do the symptoms occur in at least two settings?
- Have the symptoms been in evidence for at least three months?
- Is the behavior developmentally appropriate?
- Is there a history of previous hospitalizations?
- Has consideration been given to the child's age in relationship to the behavior? Would the behavior be amenable to treatment in a younger child but not in an adolescent (newly established behavior pattern vs. ingrained behavior pattern)?
- Has there been previous treatment in either an inpatient or outpatient facility?
- Was previous treatment effective?

NOTE: If an answer to these factors is "yes" and other criteria are met, then strong consideration should be given to admission.

- What was the family's level of participation in the treatment process? If involvement was minimal, consideration should be given to alternate referral.
- Are there accompanying disorders such as substance abuse, developmental disorders, legal issues, or academic issues? If "yes" consideration should be given to alternate referral in addition to admission.

STAFFING AND TRAINING

Staff Composition

The composition of clinical staff shall be determined by the facility based on an assessment of the needs of the community being served, the facility's goals, the programs provided, and applicable laws and regulations. The clinic must clearly describe the basis for decisions related to staff size and assignment.
The staff shall be interdisciplinary, including but not limited to at least one of the following:

- Physician (preferably a psychiatrist) who is responsible for directing and coordinating the medical care of patients;
- Social worker;
- Psychologist; and
- Registered nurse.

If the physician is not a psychiatrist, regular psychiatric consultation must be provided. Supervision must be provided by qualified licensed professional personnel for all non-licensed and paraprofessional clinical staff.

Staffing Requirements for Covered Services

The following professionals are authorized to record an established DSM diagnosis following a comprehensive evaluation:

- Licensed Physician – based on the Psychiatric Evaluation;
- Licensed Clinical Social Worker (LCSW) – based on the Psychosocial Evaluation; and
- Licensed Psychologist and Medical Psychologist (MP) – based on the Psychological Evaluation.

NOTE: All other Licensed Independent Practitioners (LIPs) may record a diagnostic impression pending concurrence/confirmation by one of the disciplines noted above.

The following professionals are authorized to administer, interpret and report the results of psychological testing as defined in R.S. 37:2352(5) and LAC 46, Part 63: Chapter 17:§1702:

- Licensed Psychologist and Medical Psychologist (MP);
- Unlicensed assistants as defined in LAC 46, Part 63, Chapter 11:§1101 or Act 251, §1360.61(G) only if directly supervised by a licensed psychologist or medical psychologist per regulations of the Louisiana State Board of Examiners (LSBE) or the Louisiana State Board of Medical Examiners (LSBME);
- Physicians who have competence in this area of practice

The following professionals are authorized to provide direct clinical treatment services that are within their defined scope of practice and for which they have competence and based on an established treatment plan which has been authorized by a physician:

- Physician;
- Advanced Practice Registered Nurse (APRN);
- Licensed Clinical Social Worker (LCSW);
- Licensed Psychologist or Medical Psychologist (MP);
- Licensed Professional Counselor (LPC);
- Licensed Marriage and Family Therapist (LMFT);
- Licensed Addiction Counselor (LAC).

All other staff providing direct care services must be directly supervised by the licensed professional within their discipline (for example Social Service Counselor supervised by LCSW; Registered Addiction Counselor by LAC; Licensed Professional Counselor Intern by LPC; Associate to a Psychologist (ATAP) by a Licensed Psychologist or MP; etc.). This form of supervision is in compliance with the regulations and standards established by the respective regulatory boards for that discipline.

DHH allows certain unlicensed staff to provide services under the supervision of a licensed professional as required for clinical training leading to licensure. The supervising professional must review, approve and sign all legal medical documents related to diagnosis, assessment or evaluation and treatment plan.

The standard for supervision within specific disciplines may not be feasible under certain circumstances due to the human resource limitations within certain publicly operated programs. When such resource limitations exist, the Clinical/Medical Director of the facility/program shall establish a supervisory plan to oversee the clinical work of the employees who do not have access to supervision through their professional discipline.

The supervision provided shall not be considered as satisfying any requirements related to supervisory requirements for purposes of professional licensure, but only reflects the supervisory requirements of the public facility and its services which are delivered under a physician directed program within the Office of Behavioral Health (OBH) region.

Staff Organization

The clinic shall have an organizational chart which specifies the relationships among the governing body, the director, the administrative staff, the clinical staff, and supporting services; their respective areas of responsibility; the lines of authority involved; and the types of formal liaison between the administrative and clinical staff. The organizational chart must also reflect medical responsibility for the care of recipients.

The administrative and clinical staff shall be organized to carry out effectively the policies and programs of the facility. The organizational chart must reflect relationships with affiliate agencies which provide services by these standards.

The organizational chart must be reviewed and updated as necessary, at least annually.

Staff Development Including Orientation and Training

The provider must maintain records of participation in appropriate staff development programs for all administrative, clinical and support personnel. Staff development programs must reflect all programmatic changes in the facility and should contribute toward the preparation of personnel for greater responsibility and promotion. These programs should include intramural activities as well as educational opportunities available outside the facility. Facility based programs shall be planned and scheduled in advance and held on a continuing basis. The activities must be documented in order to evaluate their scope and effectiveness.

Providers must make appropriate orientation and training programs available to all new employees.

RECORD KEEPING

Provider records must be maintained in an organized and standardized format at the clinic site. The provider must have adequate space, facilities, and supplies to ensure effective record keeping. Providers must comply with all Louisiana Medicaid requirements regarding record keeping as further described in Chapter one (General Information and Administration).

Recipient Records

Clinical patient records shall be written and maintained in order to:

- Serve as a basis for planning for the patient;
- Provide a means of communication among all appropriate staff who contribute to the patient's treatment;
- Justify and substantiate the adequacy of the assessment process and to form the basis for the ongoing development of the treatment plan;
- Facilitate continuity of treatment and enable the staff to determine, at a future date, what the patient's condition was at a specific time and what procedures were used;
- Furnish documentary evidence of ordered and supervised treatments, observations of the patient's behavior, and responses to treatment;
- Serve as a basis for review, study and evaluation of the treatment rendered to the patient;
- Protect the legal rights of the patient, the facility, and clinical staff;
- Provide data, when appropriate, for use in research and education; and
- Serve as documentation to substantiate billing for services.

When parents or other family members are involved in the treatment program, appropriate documentation must exist for them although there may not have to be a separate record for each family member involved.

Content of Clinical Records

While form and detail of the clinical record may vary, all clinical records must contain all pertinent clinical information and each record must contain at least:

- Identification data and consent forms; when these are obtainable, reasons shall be noted;
- Source of referral;
- Reason for referral (e.g., chief complaint, presenting problem);
- Record of the complete assessment;

- Initial formulation and diagnosis based upon the assessment;
- Written treatment plan;
- Medication history and record of all medications prescribed;
- Record of all medications administered by facility staff, including type of medication, dosages, frequency of administration, and person who administered each dose;
- Record of adverse reactions and sensitivities to specific drugs; documentation of course of treatment and all evaluations and examinations;
- Periodic progress reports;
- All consultation reports;
- All other appropriate information obtained from outside sources pertaining to the patient
- Discharge of termination summary; and
- Plan for follow-up documentation of its implementation.

Identification data and consent forms shall include the patient's name, address, contact telephone numbers (e.g. home, mobile, etc.), date of birth, sex, next of kin, school and grade or employment information, date of initial contact and/or admission to the service, legal status and legal documents, and other identifying data as indicated.

Progress notes shall include regular notations by staff members, consultation reports and signed entries by authorized, identified staff. Notes and entries should contain all pertinent and meaningful observations and information.

Progress notes by the clinical staff must document:

- Dates of service, in chronological order;
- Begin and end time of service contact;
- Treatment rendered to the patient;
- Related goal/objective on the treatment plan;
- Each change in each of the patient's conditions;
- Patient’s response to and outcome of treatment; and
- Responses of the patient and the family or significant others to any important events
- Indicate if crisis-related.

The discharge summary shall reflect the general observations and understanding of the patient's condition initially, during treatment, and at the time of discharge, and shall include a final appraisal of the fundamental needs of the patient. All relevant discharge diagnoses must be recorded and coded in the standard nomenclature of the current revision International Classification of Diseases adapted for use in the United States. Referrals to other treatment resources shall be clearly documented.

Entries in the clinical records shall be made by all staff having pertinent information regarding the recipient. Authors shall clearly sign and date each entry. Signature shall include job title or discipline. When mental health trainees are involved in patient care, documented evidence shall be in the clinical record to substantiate the active participation of supervisory clinical staff. Symbols and abbreviations shall be used only when they have been approved by the clinical staff and when there is an explanatory legend. Final diagnoses (psychiatric, physical, and social) shall be recorded in full, and without the use of either symbols or abbreviations. Any error in a record must be corrected using the legal method, which is to draw a line through the incorrect information, write "error" by it and initial the correction.

NOTE: Correction fluid must never be used in a recipient's records.

Policies and Procedures for Clinical Records

The facility shall have written policies and procedures regarding clinical records which must provide that:

- The clinical records shall be confidential, current and accurate;
- The clinical record is the property of the facility and is maintained for the benefit of the patient, the staff and the facility;
- The facility is responsible for safeguarding the information in the record against loss, defacement, tampering or use of unauthorized persons;
- The facility shall protect the confidentiality of clinical information and communications among staff members and patients;
- Except as required by law, the written consent of the patient, family or other legally responsible parties is required for the release of clinical record information; and
- Records may be removed from the facility's jurisdiction and safekeeping only according to the policies of the facility or as required by law.

There shall be evidence that all staff have received training, as part of new staff orientation and with periodic update, regarding the effective maintenance of confidentiality of the clinical record. It shall be emphasized that confidentiality refers as well to discussions regarding patients inside and outside of the facility. Verbal confidentiality shall be discussed as part of employee training.

Maintenance of Clinical Records

Appropriate clinical records shall be directly and readily accessible to the clinical staff caring for the patient. The facility shall maintain a system of identification and filing to facilitate the prompt location of the patient's clinical record. There shall be written policies regarding the permanent storage, disposal and/or destruction of the clinical records of patients.

NOTE: Refer to Chapter one (General Information and Administration) for more information regarding record keeping requirements.

CLAIMS FILING AND REIMBURSEMENT

Claims Filing

Mental Health Clinic services are billed on the CMS-1500 claim or the electronic 837P which is the preferred method. Instructions for the CMS 1500 are included at the end of this section under CMS 1500 Instructions for MHCs. All claims must be submitted to the Fiscal Intermediary (FI) for processing (see Contact/Referral Information, appendix B).

Additionally, items to be completed are either required or situational. **Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted timely by the provider. **Situational** information may be required but only in certain circumstances as detailed in the instructions below.

When billing for dates of service the provider will use the standard procedure codes found in this document (appendix A).

General Provisions for Reimbursement

Mental Health Clinics (MHCs) are responsible for enrolling in both Medicare and Medicaid for crossover purposes and billing Medicare for dual eligible recipients.

A particular service must be excluded from coverage if it is determined to be the legal liability of any third party who is or may be liable to pay the expenditure for that service.

Services determined to be duplicate will not be reimbursed. Providers must not bill Medicaid for MHC services at the same time they bill another funding source for the same service. Duplicate claims will be denied and may be considered fraud and referred to the Program Integrity Section for further action.

When a recipient is admitted to an institution or hospital, the provider may bill for services provided up to the time of admission. The provider may resume billing for services after the recipient is discharged from the institution or hospital. No services can be billed while the recipient is in an inpatient facility.

The creation and transfer of information files and the submission of claims are related but separate processes. Providers are responsible for submitting claims to the FI in a timely manner. Any questions regarding a claim should be addressed to the FI Provider Relations Unit (see Contact/Referral Information, Appendix B).

CMS 1500 (08/05) Instructions for Professional Services (includes NDCs)

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	**Situational** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	**Situational** – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the recipient'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	Patient Status	**Optional.**	

9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other coverage, the state assigned 6-digit TPL carrier code is **required** in this block (the carrier code list can be found at www.lamedicaid.com under the **Forms/Files** link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	**Situational** – Complete if appropriate or 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 or FECA Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or	**Situational** – Complete if appropriate	

	Authorized Person's Signature (Release of Records)	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	If Patient Has Had Same or Similar Illness Give First Date	**Optional.**	
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 is **required**: If services are performed by a CRNA, enter the name of the directing physician. If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name. If services are performed by an independent laboratory, enter the name of the referring physician.	
17a	Unlabelled	**Situational** – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is **required** to be entered.	**The PCP's 7-digit referral authorization number must be entered in block 17a.**
17b	NPI	**Optional.**	**The revised form accommodates**

			the entry of the referring provider's NPI.
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	Reserved for Local Use	Reserved for future use. Do not use.	**Usage to be determined.**
20	Outside Lab?	**Optional.**	
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	
22	Medicaid Resubmission Code	**Optional**.	
23	Prior Authorization Number	**Situational** – Complete if appropriate or leave blank. If the services being billed must be Prior Authorized, the PA number is **required** to be entered.	
24	Supplemental Information	**Situational –** Applies to the detail lines for drugs and biologicals only. 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 HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the **Qualifier N4** followed by the **NDC.** Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.	**Physicians and other provider types who administer drugs and biologicals must enter this new 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**

		Providers should then leave one space then enter the appropriate **Unit Qualifier** (see below) and the **actual units administered in NDC UNITS**. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.	**code(s).** **Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units**
		The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram UN Unit	**versus service units.**
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	EMG	**Situational** – Complete if appropriate or leave blank. When required, the appropriate CommunityCARE emergency indicator is to be entered in this field.	**This indicator was formerly entered in block 24I.**
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s).	
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block.	

		More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	**Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units.**
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	**Optional.** If possible, leave blank for Louisiana Medicaid billing.	**The revised form accommodates the entry of I.D. Qual.**
24J	Rendering Provider I.D. #	**Situational** – If appropriate, entering the Rendering Provider's 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**.	**The revised form accommodates the entry of NPIs for Rendering Providers**
25	Federal Tax I.D. #	**Optional.**	
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the	

		recipient. This number will appear on the Remittance Advice (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 (including any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Balance Due	**Situational** – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Required** -- The claim form **MUST** be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	

32a	NPI	**Optional.**	**The revised form accommodates entry of the Service Location NPI.**
32b	Unlabelled	**Situational –** Complete if appropriate or leave blank. When the billing provider is a CommunityCARE enrolled PCP, indicate the site number of the Service Location. The provider must enter the **Qualifier LU** followed by the **three digit site number**. Do not enter a space between the qualifier and site number (example "LU001", "LU002", etc.)	**If PCP, enter Site Number and Qualifier of the service location.**
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Optional.**	**The revised form accommodates the entry of the Billing Provider's NPI.**
33b	Unlabelled	**Required** – Enter the billing provider's 7-digit Medicaid ID number.	**Format change with addition of 33a and 33b for provider numbers.**

QUALITY ASSURANCE

The staff and administration shall work toward enhancing the quality of recipient care through specified documented, implemented, and ongoing processes of quality assurance mechanisms. The quality of care shall be the responsibility of each member of the clinical staff, the clinical supervisory and leadership personnel, and the administration. Formal quality assurance activities shall consist of three coordinated but distinct processes: individual case review procedures; clinical care evaluation studies; and utilization review. The organization of these review processes is dependent upon and varies with the goals, size, organizational structure, complexity, and resources of the facility.

Individual Case Review/Multidisciplinary Treatment Planning

Clinical case review meetings shall be held in regard to each patient frequently enough to ensure that each individual patient shall have a case review no later than one month after initiation of active treatment; subsequently at least every six months during the course of active treatment and prior to termination of treatment. Individual case reviews shall be reflected and documented in the individual case record.

Clinical Care Evaluation Studies

The facility should conduct studies of aggregate patterns of patient care in order to identify gaps and deficiencies in service and determine efficacy of treatment; to define standards of care consistent with the goals of the facility; to identify individual cases which deviate from the standards; and to establish new methods based upon knowledge gained from such studies. Written reports of such studies should be made to the MHC chief administrative officer and to appropriate clinical staff.

Utilization Review

Each facility shall have a plan for and carry out utilization review. The overall objective shall be to maintain a high quality of patient care, achieve cost efficiency, and increase the effective utilization of the facility's services through the peer group study of patterns of care, the development of empirical standards and the dissemination of the results of these studies to the staff. The facility shall choose and carry out a plan consistent with its own goals, size, organization and complexity. The plan shall be reviewed at least annually and signed and dated by the reviewer(s). The utilization review shall cover the appropriateness of admission to services, the provision of certain patterns of services, and duration of services. Criteria shall be set for: selection of the cases to be reviewed and the means of sampling; duration of treatment; and the process of active treatment. The reviews may be carried out as a special function or combined with other quality control reviews, but meetings including utilization reviews must be held at least monthly and records must be kept.

CODES AND MODIFIERS

MHC Billable and Non-Billable Procedure Codes

Service Ticket Service Code	Service Type	Authorized Disciplines (Codes)	CPT/HCCPS Code
001	Consultation	Psychiatrist (01); physician(02) Licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21); licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	Not Medicaid Billable
002	Individual Screening – (Evaluation and management of a new patient)	Psychiatrist (01); physician(02); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99201 <15 99202 >=15 and <30 min 99203 >=30 and <45 min 99204 >=45 and <60 min 99205 > = 60 min
	(Mental Health Assessment by non-physician)	Licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34; licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	H0031

Service Ticket Service Code	Service Type	Authorized Disciplines (Codes)	CPT/HCCPS Code
003	Group Screening	Psychiatrist (01); physician(02) Licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21); licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	Not Medicaid billable
004	Collateral Counseling/ Consult (Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons or advising them how to assist patient)	Psychiatrist (01); physician(02); licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21); licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	90887

Service Ticket Service Code	Service Type	Authorized Disciplines (Codes)	CPT/HCCPS Code
005	Psychosocial Evaluation	Psychiatrist (01); physician(02); licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21); licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	90801 90802 (interactive)*
006	Psychiatric Evaluation	Psychiatrist (01); physician (02)	90801 90802 (interactive)*
007	Psychological Testing (formerly Psychological Evaluation)	Licensed psychologist (03); associate to a psychologist (04)medical psychologist (16)	96101
008	Medical Evaluation (and Management of an established patient)	Psychiatrist (01); physician (02); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99212 <15 min 99213 >=15 and <30 min 99214 >=30 and <44 min 99215 >= 44 min
009	Other Evaluation/ Assessment		Not Medicaid billable
010	Psychological Evaluation	Licensed psychologist (03); associate to a psychologist (04); medical psychologist (16)	90801

Service Ticket Service Code	Service Type	Authorized Disciplines (Codes)	CPT/HCCPS Code
015	Individual Therapy /Counseling	Psychiatrist (01); physician (02); licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21); licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	90804<31 min 90806>=31 and <61 min 90808>=61 min <u>Interactive*</u> 90810<31 min 90812>=31 and <61 min 90814>=61 min
016	Group Therapy /Counseling	Psychiatrist (01); physician (02); licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21); licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	90853 90857 (interactive)*
017	Family Counseling /Therapy (with client present)	Psychiatrist (01); physician (02); licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21); licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	90847

Service Ticket Service Code	Service Type	Authorized Disciplines (Codes)	CPT/HCCPS Code
018	Couple Therapy /Counseling	Psychiatrist (01); physician (02); licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21); licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	90847
019	Recreational Therapy	Recreational therapist (09)	Not Medicaid Billable
020	Occupational Therapy	Occupational therapist (18)	Not Medicaid Billable
021	Art Therapy	Art therapist (09)	Not Medicaid Billable
022	Music Therapy	Music therapist (09)	Not Medicaid Billable
027	Medical Management	Psychiatrist (01); physician (02); physician's assistant (19); medical resident (20); medical intern (21); medical psychologist (16); registered nurse (06); advanced practice registered nurse (17)	90862
028	Medication Injection	Psychiatrist (01); physician(02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211

Service Ticket Service Code	Service Type	Authorized Disciplines (Codes)	CPT/HCCPS Code
28A	Prolixin (up to 25 mg)	Psychiatrist (01); physician (02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211
28B	Haldol (up to 5 mg)	Psychiatrist (01); physician (02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211
28C	Congentin (up to 2 mg)	Psychiatrist (01); physician (02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211
28D	Vistaril (up to 50 mg)	Psychiatrist (01); physician (02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211
28E	Thorazine (up to 50 mg)	Psychiatrist (01); physician (02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211

Service Ticket Service Code	Service Type	Authorized Disciplines (Codes)	CPT/HCCPS Code
28F	Benadryl (up to 50 mg)	Psychiatrist (01); physician (02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211
28G	Unclassified drugs (for use with drugs not covered by other 28 codes)	Psychiatrist (01); physician (02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211
28H	Risperdal 25 mg injection	Psychiatrist (01);physician (02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211
28I	Risperdal 37.5 mg injection	Psychiatrist (01); physician(02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211
28J	Risperdal 50 mg injection	Psychiatrist (01); physician (02)	96372
		Registered nurse (06); licensed practical nurse (07); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21)	99211

Service Ticket Service Code	Service Type	Authorized Disciplines (Codes)	CPT/HCCPS Code
030	Court Group	Psychiatrist (01); physician (02); licensed psychologist (03); associate to a psychologist (04); medical psychologist (16); licensed clinical social worker (05); registered social worker (29); graduate social worker(30); licensed professional counselor (15); professional counselor (33); licensed professional counselor intern (34); advanced practice registered nurse (17); physician's assistant (19); medical resident (20); medical intern (21); licensed marriage and family therapist (35); licensed marriage and family therapist intern (36)	Not Medicaid billable
095	Adjuvant Service	All disciplines	Not Medicaid billable

*****Interactive CPT codes refer to a service "that involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication." Examples of interactive services would be use of dolls or puppets with young children and sign language with persons who are deaf.

All modifiers may be used where appropriate except for "GT" which may not be used for medication injections.

MODIFIERS

TELEMEDICINE – SITUATIONAL

Modifier	Qualification	Description
GT	Telemedicine	The service was provided through telemedicine. This may be used for all services EXCEPT medication injection.
Blank	Not telemedicine	The service was not provided through telemedicine.

EDUCATIONAL LEVEL OF TREATMENT STAFF - REQUIRED

Modifier	Educational Level	Description
HL	Intern	The rendering caregiver is a social work intern or psychologist intern. Social Work Intern: the individual is pursuing the LCSW credential and is participating in the required post-graduate social work experience with supervision by a Board Approved Clinical Supervisor. Psychologist Intern: the individual is pursuing a Louisiana license as a psychologist and is participating in the required supervised practice under supervision of a licensed psychologist.
HM	Less than Bachelor degree level	The rendering caregiver has an educational attainment less than a Bachelors degree.
HN	Bachelors degree Level	The rendering caregiver has a highest educational attainment of a Bachelors degree.
Modifier	**Educational Level**	**Description**

HO	Masters degree level	The rendering caregiver has a highest educational attainment of a Masters degree.
HP	Doctorate degree level	The rendering caregiver has a highest educational attainment of a Doctorate degree (MD, PhD, PharmD, etc.).

DISCIPLINE OF PROVIDER – SITUATIONAL

Modifier	Discipline	Description
AH	Clinical Psychologist	The provider of service holds a current, active license from the LA State Board of Examiners of Psychologists.
AJ	Clinical Social Worker	The provider of service holds a current, active license from the LA State Board of Social Work Examiners
MP	Medical Psychologist	The provider of service holds a current, active license from the LA State Board of Examiners of Psychologists

TD	RN	The provider of the service holds a current, active license from the LA State Board of Nursing
TE	LPN	The provider of the service holds a current, active license from the LA State Board of Practical Nurse Examiners
Blank	None of the above	The provider of services meets none of the above requirements.

CONTACT/REFERRAL INFORMATION

Name of Contact	Address/Telephone/Website
Fiscal Intermediary: UNISYS Corporation	
Electronic Media Claims (EMC) Electronic claims sign up and testing	P.O. Box 91025 Baton Rouge, LA 70898 Phone: 225-216-6000 Fax: 225-216-6335
Pharmacy Point of Sale (POS)	P.O. Box 91019 Baton Rouge, LA 70821 Phone: 800-648-0790 (Toll Free) Phone: 225-216-6381 (Local)
Pre-Certification Unit (Hospital) Pre-certification issues and forms	P.O. Box 14849 Baton Rouge, LA 70809-4849 Phone: 800-877-0666 Fax: 800-717-4329
Prior Authorization Unit (PAU) Prior authorization issues, requests and forms	P.O. Box 14919 Baton Rouge, LA 70898 Phone: 800-807-1320 Fax: 225-216-6476
Provider Enrollment Unit (PEU) Provider Enrollment, direct deposit problems, reporting of changes and ownership, NPI	P.O. Box 80159 Baton Rouge, LA 70898 Phone: 225-216-6370 Fax: 225-216-6392
Provider Relations (PR) Billing and training questions	P.O. Box 91024 Baton Rouge, LA 70821 Phone: 225-924-5040 (Local) 800-473-2783 (Toll Free) Fax: 225-216-6334
Recipient Eligibility Verification (REVS)	Phone: 800-766-6326 (Toll Free) Phone: 225-216-7387 (Local)
Web Technical Support	Phone: 877-598-8753 (Toll Free)

Name of Contact	Address/Telephone/Website
Department of Health and Hospitals (DHH)	
Behavioral Health/Mental Health Rehabilitation (MHR) Program	628 N. 4th Street Baton Rouge, LA 70802 Phone: 225-342-1203 Fax: 225-389-8134
Bureau of Appeals	P.O. Box 4183 Baton Rouge, LA 70821-4182 Phone: 225-342-0443 Fax: 225-342-8773
Health Standards Section (HHS)	P.O. Box 3767 Baton Rouge, LA 70821 Phone: 342-0138 Fax: 342-5292
Louisiana Children's Health Insurance Program (LaCHIP) **Louisiana Medicaid**	LaCHIP: 225-342-0555 (Local) LaCHIP: 877-252-2447 (Toll Free) http://bhsfweb.dhh.louisiana.gov/LaCHIP/ General Medicaid Hotline: 888-342-6207
Medicaid Card Questions	800-834-3333 (Toll Free)
Office of Aging and Adult Services (OAAS)	P.O. Box 2031 Baton Rouge, LA 70821 Phone: 866-758-5038 Fax: 225-219-0202 E-mail: MedWeb@dhh.la.gov http://www.dhh.louisiana.gov/offices/?ID=105
Office for Citizens with Developmental Disabilities (OCDD)	628 N. Fourth Street Baton Rouge, LA 70802 Phone: 225-342-0095 (Local) Phone: 866-783-5553 (Toll Free) E-mail: ocddinfo@la.gov http://www.dhh.louisiana.gov/offices/?ID=191
Office of Management and Finance Bureau of Health Services Financing – MEDICAID	P.O. Box 91030 Baton Rouge, LA 70810 http://www.dhh.louisiana.gov/offices/?ID=92

Name of Contact	Address/Telephone/Website
Department of Health and Hospitals (DHH)	
Program Integrity (PI)	P.O. Box 91030 Baton Rouge, LA 70810 Fax: 225-219-4155 Fraud and Abuse Hotline: 800-488-2917 http://www.dhh.louisiana.gov
Rate & Audit Hospice, Nursing Facilities	628 N. Fourth Street Baton Rouge, LA 70802 www.dhh.la.gov/rar
Take Charge (Family Planning Waiver)	P.O. Box 91278 Baton Rouge, LA 70821 Phone: (888) 342-6207 Fax: (877) 523-2987 medweb@la.gov www.takecharge.dhh.louisiana.gov
Third Party Liability (TPL) TPL Recovery, Trauma	453 Spanish Town Road Baton Rouge, LA 70802 Phone: 342-1376 Fax: 342-5292
Other Helpful Contact Information	
Office of Population Affairs (OPA) Clearinghouse	P.O. Box 30686 Bethesda, MD 20824-0686 Phone: 866-640-7827 Fax: 866-592-3299 E-mail: Info@OPAclearinghouse.org
U.S. Department of Health & Human Services Sterilization and Consent Forms	www.hhs.gov/opa/familyplanning/toolsdocs/