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.
FEDERALLY QUALIFIED HEALTH CENTERS

TABLE OF CONTENTS

SUBJECT SECTION

OVERVIEW SECTION 22.0

COVERED SERVICES SECTION 22.1

Physician Services
Services and Supplies Incident to a Physician’s Professional Services
Physician Assistant Services
Nurse Practitioner and Nurse Midwife Services
Services and Supplies Incident to Physician Assistant, Nurse Practitioner and Nurse Midwife Services
Visiting Nurse Services to the Homebound
Plan of Treatment
Clinical Psychologist
Clinical Social Worker Services
Services and Supplies Incident to the Services of Clinical Psychologists and Clinical Social Workers
Other Ambulatory Services
Diabetes Self-Management Training
Fluoride Varnish Applications
Services Not Covered
Encounter
Service Limits
Request for Emergent or Life Threatening Conditions
Exclusions
Service Delivery

PROVIDER REQUIREMENTS SECTION 22.2

Location
Shortage Area Designation
Staffing
Medicaid Enrollment Criteria
Services
Billing
Diabetes Self-Management Training
Satellite Clinics
Mobile Clinics
Out of State FQHCs in Trade Areas
Changes
  Change in Ownership
Cost Reports

RECORD KEEPING

Record Maintenance and Availability
Protection of Record Information
Adequacy of Records
Retention of Records

REIMBURSEMENT

Rates
  Determination of Rate
  Adjustment of Rate
Out of State/Trade Area FQHC
Notice of Rate Setting
Appeals
Cost Report Submission
  Audits
Encounter Visits
  Payment for Adjunct Services
Billing
  Medical/Behavioral Encounters
  Behavioral Health/Psychiatric Services
    Physicians with a Psychiatric Specialty
    Nurse Practitioners or Clinical Nurse Specialists with a Psychiatric Specialty
    Licensed Clinical Social Workers
    Clinical Psychologist
  Adjunct Services
  Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening Services
Dental Encounters
Medicare/Medicaid Dual Eligible Billing
Outpatient Services
Inpatient Services

CONTACT INFORMATION
FORMS
GLOSSARY
CLAIMS FILING

APPENDIX A
APPENDIX B
APPENDIX C
APPENDIX D
OVERVIEW

The Omnibus Budget Reconciliation Acts of 1989, 1990, and 1993 amended Section 1905 of the Social Security Act to create a new category of entities under Medicaid and Medicare known as Federally Qualified Health Centers (FQHC). The Social Security Act §1905(l)(2))B) defines an FQHC for Medicaid purposes as an entity which:

- Is receiving a grant under Section 330 of the Public Health Service (PHS) Act,
- Is receiving funding from such grant under a contract with the recipient of the grant and meets the requirements to receive a grant under 330 of the PHS Act,
- Based on the recommendation of the Health Resources and Services Administration 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, and
- 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 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 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 recipients. The Department of Health and Hospitals, 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:

- Physician services;
- Services and supplies incident to physician’s services;
- Physician assistant services;
- Nurse practitioners and certified nurse midwife services;
- Services and supplies incident to the services of nurse practitioners, physician assistants, and certified nurse midwives;
- Visiting nurse services to the homebound;
- Clinical psychologist services;
- Clinical social worker services; and
- 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 recipient 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 his/her 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:

- In a physician’s office;
- Either without charge or included in the center’s bill;
- As an incidental, although integral, part of a physician’s professional services;
- Under the direct, personal supervision of a physician; and
- 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 (PA) 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. PA services are covered if:

- Furnished by a licensed PA who is employed by or receives compensation from the center and is enrolled in the Louisiana Medicaid Program;
- Identified by placing his/her provider number in the attending licensed physician space on the CMS 1500;
- 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;
- Furnished in accordance with medical orders for the care and treatment of a recipient prepared by a licensed physician
- Consistent with the type of service the PA is legally permitted to perform; and
Nurse Practitioner and Certified Nurse Midwife Services

Services are covered if:

- Furnished by a licensed nurse practitioner or certified nurse midwife who is employed by or receiving compensation from the center;
- Enrolled in Louisiana Medicaid;
- Identified by placing his/her provider number in the attending physician space on the CMS 1500;
- 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;
- Furnished in accordance with any medical orders for the care and treatment of a recipient prepared by a licensed physician;
- Performed by a licensed nurse practitioner or certified mid-wife, who is legally permitted to provide this type of service; and
- Services are covered by Medicaid.

Nurse practitioners 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 Midwife Services

Services and supplies incident to a nurse practitioner, nurse midwife or physician assistant services are covered if:

- Furnished in a licensed medical provider’s office;
- Rendered either without charge or included in the center’s bill;
• Furnished as an incidental, although integral part of professional services furnished by nurse practitioner, PA or certified nurse midwife;

• Furnished under his/her 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

• 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:

• The center is located in an area designated by CMS as a home health agency shortage area;

• The services are rendered to a homebound individual. For purposes of visiting nurse services, “homebound” means a Medicaid recipient who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, “place of residence” does not include a hospital or skilled nursing facility;

• The services are furnished by a licensed registered nurse or licensed practical nurse or a licensed vocational nurse, who is employed by or received compensation for the services from the center; and

• 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, nurse practitioner, physician assistant or certified nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician. The plan must be signed by the nurse practitioner, physician assistant, certified nurse midwife or the supervising physician of the center.
The plan of treatment must relate visiting nurse services to the recipient’s condition. The plan must specify the following:

- Types of services required and prognosis for changes in the recipient’s condition;
- Diagnosis and a description of the recipient’s functional limitations resulting from the illness or injury;
- Type and frequency of nursing services needed;
- Special diets;
- Activities permitted;
- Rehabilitation and therapy services;
- Medical social services;
- Home health aide services; and
- Necessary medical supplies.

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

**Clinical Psychologist**

Clinical psychologist services refers 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 refers to services performed by a licensed clinical social worker 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:

- In a physician’s office;
- Either without charge or included in the center’s bill;
- As an incidental, although integral part of professional services furnished by licensed nurse practitioner, licensed PA or certified nurse midwife,
- Under his/her 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
- 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:

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for recipients under the age of 21;
- Vision care services (for recipients under the age of 21);
- Speech and language services (for recipients under the age of 21);
- Hearing services (for recipients under the age of 21);
- Dental services;
- Podiatry services;
- Pregnancy-related services;
• Perinatal case management;
• Chiropractic services;
• Nutrition counseling as part of an encounter;
• Family planning services; and
• Physical and occupational therapy 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. Service visits will be reimbursed at the all-inclusive 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 recipients diagnosed with diabetes. These services are comprised of one hour of individual instruction and nine hours of group instruction on diabetes self-management. Recipients shall receive up to ten hours of services during the first 12-month period beginning with the initial training date. After the first 12-month period has ended, recipients 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 recipients under 21 years of age based on medical necessity. Fluoride varnish applications will be reimbursed when performed in the FQHC by:

• The appropriate dental providers;
• Physicians;
• Physician assistants;
• Nurse practitioners;
• Registered nurses;
Licensed practical nurses; or

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.

Services Not Covered

- 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);
- Medications provided by a pharmacy that is not part of the FQHC;
- Weight or blood pressure check only;
- Services for which medical necessity is not clearly established;
- Information provided to a patient over the telephone;
- Cosmetic surgery;
- A visit for the sole purpose of a patient obtaining a prescription when the need for the prescription has already been determined;
- Canceled visits or for appointments not kept;
- Foot care such as routine soaking and application of topical medication;
- 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
- Tattoo removal.

Encounter
A medical encounter (inclusive of mental health and DSMT services) is defined as a face-to-face visit with a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC 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 recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

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 recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

**Service Limits**

Only one medical encounter (inclusive of mental health and DSMT encounters) per day per recipient and one dental encounter per day may be billed per recipient except in cases in which the recipient, 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.

There is no annual limit placed on the number of federally qualified health center visits (encounters) payable by the Medicaid Program for eligible recipients.

Services not defined as an FQHC service or other ambulatory service rendered to Louisiana Medicaid recipients 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 care or hospital admission date.

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

- Injections (allergy, antibiotic, steroids, etc.);
• Laboratory tests performed on site, Peak Flow and Spirometry, Respiratory Flow Volume Loop, EKG testing and interpretation, and x-rays;

• Immunizations;

• Hearing/Vision screenings; and

• 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 recipients under the age of 21 shall include all the aspects of a well-child screening visit unless:

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

• The child’s medical record reflects that he or she is up to date on the well-child screenings in accordance with the Medicaid periodicity schedule.

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

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

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

• 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:

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

• A detailed exam with low-to moderate complexity decision making.
PROVIDER REQUIREMENTS

Location

Each 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 or medically underserved population.

Shortage Area Designation

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

- 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,
- Prepare a schedule of fees consistent with locally prevailing rates or charges,
- 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,
- 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,
- Enter into agreements with the State Medicaid agency to ensure coverage of beneficiaries, and
- 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, 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.

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 practice operated by the same FQHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the FQHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or
- 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 lab facility, dental clinic, emergency room, 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 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 emergency department would not be a common occurrence.

The fiscal intermediary 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 Public Health Service grant under the following:

- 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 Public Health Service (PHS) Act as amended.

OR

- Be 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 Health Resources and Services Administration (HRSA) Notice Grant Award designating the center as a grantee under the applicable section of the Public Health Services Act or the 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 FQHC must provide to the fiscal intermediary’s (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’:

- National Provider Identifier (NPI), and
- 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 fiscal intermediary’s (FI) 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. 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.

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:

- Medical history
- Physical examination,
- 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,
- Evaluation and diagnostic services to include:
  - Radiological services and
  - Laboratory and pathology services,
- Services and supplies incident to a physician’s or a physician extender’s services such as:
  - Pharmaceuticals,
• 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 fiscal intermediary.

“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:

• The American Diabetes Association,

• The American Association of Diabetes Educators, or

• 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:

• Be a certified diabetes educator (CDE) certified by the National Certification Board for Diabetes Educators, or
• 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:

• A registered dietician,
• A registered nurse, or
• A pharmacist.

All members of the instructional team must obtain the nationally recommended annual continuing education hours 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:

• Loss of FQHC status,
• Changes in dates of the FQHC grant budget period,
• Opening(s) and/or closing(s) of any satellite center(s), or
• 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.

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. For more information on adjustment of rate for a change in scope, refer to Section 22.4.
RECORD KEEPING

The center 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 recipient receiving health care services, the center must maintain a record that includes the following as applicable:

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

- 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 recipient’s progress, as well, as the physician’s or health care professional’s signature.

Record Maintenance and Availability

The center is responsible for:

- Maintaining adequate financial and statistical records in the form that contains the data required by the BHSF and fiscal intermediary that supports the payment and distinguishes the type of service provided to the recipient.

- Making the records available for verification and audit by BHSF or its contracted auditing agent, and

- 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 center 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 recipient’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 five 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 recipients 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 ID and Tax Identification Number (TIN).

- 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

- 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, supplies used in a patient service visit. 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 shall be determined through a comparison to other FQHCs in the same town/city/parish. The scope of services shall be considered in determining which proximate FQHC most closely approximates the new provider. If no FQHCs are available in the proximity, comparison shall be made to the nearest FQHC offering the same scope of service(s). The rate will be set to that of the FQHC comparative to the new provider.

Adjustment of Rate

PPS rates for primary care services are adjusted effective July 1 of the state fiscal year 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:

- The current approved organization budget and a budget for the addition or deletion of services/sites;
- A detailed request for change in scope;
- A cost report for the years preceding the change in scope; and
- 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

Federally qualified health centers are required to file a CMS-222-92 with appropriate addenda within five months of the clinics fiscal year end. Failure to submit a CMS-222-92 by the due date may result in a suspension of Medicaid payments. (See Appendix A for information on where to send cost reports.)

A written request for an extension on submission of the CMS-222-92 may be granted if received by the FQHC Program Manager within 30 or more days prior to the due date. No extension will be granted unless the FQHC provides evidence of extenuating circumstances, beyond its control, that have caused the report to be submitted late.

Audits

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

An FQHC provider will be reimbursed for only one medical (inclusive of mental health services) encounter and one dental encounter per day, when the visits take place with more than one health care practitioner, or with the same health care practitioner on the same day at a single location. This will constitute a single visit, except for cases in which the recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. 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.

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 recipient access to services during non-typical hours and to reduce the inappropriate use of the hospital emergency department, 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.
Billing

Medical/Behavioral Encounters

Medical/behavioral 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 recipient 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.

When behavioral health services are the only services provided during an encounter, and are administered by a licensed clinical social worker or a clinical psychologist, the FQHC provider identification number must be placed as both the billing and attending provider with the appropriate modifiers and detail line procedure codes on the claim.

A visit to pick up a prescription or a referral is not considered a billable encounter. Lab 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 medical encounter which warranted these additional services.

If a covered service is provided via an interactive audio and video telecommunications system (telemedicine), it must be identified on the claims form by appending the Health Insurance Portability and Accountability Act (HIPAA) 1996 complaint modifier “GT” to the appropriate procedure code.

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/Psychiatric Services

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:
• Psychiatric diagnostic or evaluative interview procedures;
  NOTE: Procedure codes are reimbursable once per 365 days per attending provider.

• Psychiatric therapeutic procedures; and

• 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 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.

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 nurse practitioner 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 nurse practitioner 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 licensed clinical social worker. If the service provided is one of the procedure codes listed above, the AJ modifier is appended to the procedure code in the detail line of the claim.

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. If the service
provided is one of the procedure codes listed above, the AH modifier is appended to the procedure code in the detail line of the claim.

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 emergency departments:

- Between the hours of 5 p.m. and 8 a.m. Monday through Friday;
- On weekends between 12 a.m. Saturday through midnight on Sunday; and
- 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 recipient’s visit or encounter. For example:

- If the existing office hours are Monday-Friday 8 a.m. – 5 p.m. and the physician treats the recipient 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.
- If a recipient 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 fee-for-service reimbursement for the adjunct service codes separate from, but in addition to, the PPS reimbursement for the associated encounter (T1015).

- For FQHC providers whose services meet the guidelines outlined in this policy:
  - The encounter and required detail line(s) for services provided to the recipient on a date of service should be reported as directed in current FQHC policy.
  - 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.
  - The adjunct code will be reimbursed fee-for-service in addition to the payment for the encounter.

- 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, Diagnosis and Treatment Screening Services**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services must be billed using the 837P Professional format using encounter code T1015 with modifier EP.

It will be necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on the appropriate line. If a registered nurse performs the screening, the appropriate procedure code must be entered followed by the modifier TD.

If immunizations are given at the time of the screening, those codes continue to be billed on the CMS-1500, along with encounter code T1015 and modifier EP. All claims billed using the T1015 and modifier EP must include supporting detail procedures. Only a physician doing a screening should bill with no modifier.

**Dental Encounters**

All dental services must be billed on the 2006 ADA claim form using the encounter code D0999. It will be necessary for providers to indicate the specific dental services provided by entering the procedure code for each service rendered on subsequent lines. All claims billed using D0999 must include supporting detail procedures.

The Recipient Eligibility Verification System (REVS) or the Medicaid Eligibility Verification System (MEVS) should be used to obtain recipient eligibility information. Providers should
keep hardcopy proof of eligibility from MEVS on file. Medicaid eligibility verification is also available on the web. (See Appendix A for web information.)

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

**Medicare/Medicaid Dual Eligible Billing**

Medicaid pays the Medicare co-insurance, up to the Medicaid established encounter rate, for recipients who are eligible for Medicare and Medicaid. Providers should first file claims with the regional Medicare fiscal intermediary/carrier, ensuring the recipient’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, 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 identification 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

<table>
<thead>
<tr>
<th>OFFICE NAME</th>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health and Hospitals</td>
<td>Receives annual notice of grant award from FQHC</td>
<td>Department of Health and Hospitals Bureau of Health Services Financing Medicaid Policy and Compliance P.O. Box 91030 Baton Rouge, LA 70821-9030</td>
</tr>
<tr>
<td>Molina – PA Unit</td>
<td>Receives prior authorization requests</td>
<td>Molina Medicaid Solutions Prior Authorization Unit P.O. Box 14919 Baton Rouge, LA 70898-4919</td>
</tr>
<tr>
<td>Molina – Provider Relations Unit</td>
<td>Provides assistance with questions regarding billing information</td>
<td>Molina Medicaid Solutions Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821</td>
</tr>
<tr>
<td>Molina – Claims Processing Unit</td>
<td>Processes Medicare crossover claims</td>
<td>Molina Medicaid Solutions P. O. Box 91023 Baton Rouge, LA 70821</td>
</tr>
<tr>
<td>MEVS/REVSS</td>
<td>Verifies recipient eligibility</td>
<td><a href="http://www.lamedicaid.com">www.lamedicaid.com</a></td>
</tr>
<tr>
<td>Bureau of Appeals</td>
<td>Receives appeal requests</td>
<td>Department of Health &amp; Hospitals Bureau of Appeals PO Box 4183 Baton Rouge, LA 70821-4183</td>
</tr>
<tr>
<td>LeBlanc, Robertson, Chisholm &amp; Associates, LLC (LRCA, LLC)</td>
<td>Receives annual cost reports</td>
<td><a href="http://lrcaudit.com">http://lrcaudit.com</a></td>
</tr>
<tr>
<td>Professional Services Fee Schedule</td>
<td>Reimbursement information relative to adjunct codes</td>
<td><a href="http://www.lamedicaid.com">www.lamedicaid.com</a> following “Fee Schedules” then “Professional Services” links</td>
</tr>
</tbody>
</table>

PHYSICIAN OUTPATIENT VISIT EXTENSION FORM

I. TREATING PHYSICIAN - Complete this Section:

Approval of additional EMERGENCY or LIFE-SUSTAINING physician outpatient visits is being requested for:

Patient's Name
DOB
Sex

Medicaid Identification Number
Social Security Number

Provide a specific DIAGNOSIS CODE for each EMERGENCY or LIFE-SUSTAINING visit extension request. Attach documentation of nature of emergency (Pathology report, clinical notes, etc.).

<table>
<thead>
<tr>
<th>Date of Vis</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician's Name, Address & Vendor No.

Signature of Treating Physician

II. Molina - Prior Authorization Unit Use Only

Extension of physician outpatient visits is approved for:

Date of Visit
Date of Visit
Date of Visit
Date of Visit

Extension(s) not approved for:
because

Date

Signature of Reviewing Physician

PHYSICIAN COPY
GLOSSARY

Adjunct Services – Services provided by the 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 Department of Health and Hospitals 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.

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

Department of Health and Hospitals (DHH) – 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 DHH.

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, 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 recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

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

Federally Qualified Health Center – An entity receiving a grant under Section 330 of the Public Health Service Act; is receiving funding from such grant under a contract with the recipients 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 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 – Is the private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. 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 – 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 the Department of Health and Human Services 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 – Areas designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population.

Medically Underserved Population – 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 recipients.

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 the Department of Health and Hospitals 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:

- Instructions for billing using the CMS-1500 Claim Form
- Samples of the CMS-1500 Claim Form
- Instructions for adjusting or voiding a CMS-1500 claim
- Samples of a CMS-1500 Claim Form Adjustment
- Instructions for billing using the ADA Dental Claim Form
- Sample of the ADA Dental Claim Form
- Instructions for adjusting or voiding an ADA claim using the 209 Adjustment/Void Form
- Sample of the 209 Adjustment/Void Form
- Instructions for adjusting or voiding an ADA claim using the 210 Adjustment/Void Form
- Sample of the 210 Adjustment/Void Form
CMS 1500 (02/12) Billing Instructions for FQHC Services

Hard copy billing of 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:

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

Services may be billed using:

- The rendering provider’s individual provider number as the billing provider number for independently practicing providers; or
- 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 EDI Specifications located on the Louisiana Medicaid website at www.lamedicaid.com, directory link “HIPAA Information Center, sub-link “5010v of the Electronic Transactions” – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.
### CMS 1500 (02/12) Billing Instructions for FQHC Services

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung</td>
<td><strong>Required</strong> – Enter an “X” in the box marked Medicaid (Medicaid #).</td>
<td></td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s I.D. Number</td>
<td><strong>Required</strong> – Enter the recipient’s 13 digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS or REVS. <strong>NOTE:</strong> The recipients’ 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is <strong>NOT</strong> acceptable. The ID number must match the recipient’s name in Block 2.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td><strong>Required</strong> – Enter the recipient’s last name, first name, middle initial.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Date</td>
<td><strong>Situational</strong> – Enter the recipient’s date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example 01 02 07). Enter an “X” in the appropriate box to show the sex of the recipient.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td><strong>Situational</strong> – Complete correctly if the recipient has other insurance; otherwise, leave blank.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
<td><strong>Optional</strong> – Print the recipient’s permanent address.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship to Insured</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured's Policy or Group Number</td>
<td><strong>Situational</strong> – If recipient has no other coverage, leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is <strong>required</strong> in this block. This carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</td>
<td></td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is Patient’s Condition Related To:</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Insured's Policy Group or FECA Number</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td>Insured's Date of Birth</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan?</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient's or Authorized Person's Signature</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Release of Records)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Patient’s or Authorized Person’s Signature</td>
<td><strong>Situational</strong> – Obtain signature if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Payment)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------</td>
<td>-------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness / Injury / Pregnancy</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>OTHER DATE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Provider or Other Source</td>
<td>Situational – Complete if applicable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In the following circumstances, entering the name of the appropriate physician block is <strong>required</strong>:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>17a</td>
<td>Unlabeled</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab?</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>--------------</td>
<td>--------</td>
</tr>
</tbody>
</table>
| 21        | ICD Indicator | **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.  
|           |              | 9  ICD-9-CM  
|           |              | 0  ICD-10-CM |        |
| 22        | Diagnosis or Nature of Illness or Injury | **Required** – Enter the most current ICD diagnosis code.  
|           |              | **NOTE**: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.  
| 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 from the paid claim line as it appears on the remittance advice in the “Original Ref. No.” portion of this field.  
|           |              | Appropriate reason codes follow:  
|           |              | **Adjustments**  
|           |              | 01 = Third Party Liability Recovery  
|           |              | 02 = Provider Correction  
|           |              | 03 = Fiscal Agent Error  
|           |              | 90 = State Office Use Only – Recovery  
|           |              | 99 = Other  
|           |              | **Voids**  
|           |              | 10 = Claim Paid for Wrong Recipient  
|           |              | 11 = Claim Paid for Wrong Provider  
|           |              | 00 = Other |        |

**Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).**  

To adjust or void a claim, only the encounter line should be adjusted/voided since all payment is made on this line. The internal control number of the encounter line is used.
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Prior Authorization (PA) Number</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank. If the services being billed must be prior authorized, the 9 digit numeric PA number is <strong>required</strong> to be entered.</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Supplemental Information</td>
<td><strong>Situational</strong> – Applies to the detail lines for drugs and biologicals only.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>CURRENTLY, THIS IS NOT A REQUIREMENT FOR FQHC PROVIDERS.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In addition to the procedure code, the <strong>National Drug Code (NDC)</strong> is <strong>required</strong> by the Deficit Reduction Act of 2005 for <strong>physician-administered drugs</strong> and <strong>shall be entered</strong> in the <strong>shaded</strong> section of 24A through 24G. <strong>Claims for these drugs shall include the NDC from the label of the product administered.</strong></td>
<td>FQHCs who administer drugs and biologicals must enter drug-related information in the <strong>SHADED</strong> section of 24A – 24G of appropriate detail lines only. This information must be entered in addition to the procedure code(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the <strong>Qualifier N4</strong> followed by the <strong>11-digit NDC</strong>. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Providers should then leave one space then enter the appropriate <strong>Unit Qualifier</strong> (see below) and the <strong>actual units administered</strong>. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The following qualifiers are to be used when reporting NDC units:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>F2   International Unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ML   Milliliter</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>GR   Gram</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>UN   Unit</td>
<td></td>
</tr>
<tr>
<td>24A</td>
<td>Date(s) of Service</td>
<td><strong>Required</strong> -- Enter the date of service for each procedure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</td>
<td></td>
</tr>
<tr>
<td>24B</td>
<td>Place of Service</td>
<td><strong>Required</strong> -- Enter the appropriate place of service code for the services rendered.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------</td>
<td>---------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>24C</td>
<td>EMG</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, Services, or Supplies</td>
<td>Required – Enter the procedure code(s) for services rendered.</td>
<td>Enter the appropriate encounter procedure code on the first line.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Encounter Codes:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• FQHC encounter visit: T1015</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• FQHC obstetrical service: T1015 w/TH modifier.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• FQHC EPSDT service: T1015 w/EP modifier.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer</td>
<td>Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block.</td>
<td>More than one diagnosis/reference number may be related to a single procedure code.</td>
</tr>
<tr>
<td>24F</td>
<td>Amount Charged</td>
<td>Required – Enter usual and customary charges, or zero when appropriate, for the service rendered.</td>
<td></td>
</tr>
<tr>
<td>24G</td>
<td>Days or Units</td>
<td>Required – Enter the number of units billed for the procedure code entered on the same line in 24D</td>
<td></td>
</tr>
<tr>
<td>24H</td>
<td>EPSDT Family Plan</td>
<td>Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.</td>
<td></td>
</tr>
<tr>
<td>24I</td>
<td>I.D. Qual.</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider I.D. #</td>
<td>Situational – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is <strong>required.</strong></td>
<td>Entering the Rendering Provider’s NPI in the non-shaded portion of the block is <strong>optional.</strong></td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax I.D. Number</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>26</td>
<td>Patient's Account No.</td>
<td><strong>Situational</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment?</td>
<td><strong>Optional.</strong> Claim filing acknowledges acceptance of Medicaid assignment.</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td><strong>Required</strong> – Enter the total of all charges listed on the claim.</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td><strong>Situational</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Reserved for NUCC use</td>
<td><strong>Leave Blank.</strong></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier Including Degrees or Credentials Date</td>
<td><strong>Optional.</strong> – The practitioner or the practitioner’s authorized representative’s original signature is no longer required. <strong>Required</strong> -- Enter the date of the signature.</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Information</td>
<td><strong>Situational</strong> – Complete as appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>32a</td>
<td>NPI</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>32b</td>
<td>Unlabeled</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info &amp; Phone #</td>
<td><strong>Required</strong> – Enter the provider name, address including zip code and telephone number.</td>
<td></td>
</tr>
<tr>
<td>33a</td>
<td>NPI</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>33b</td>
<td>Unlabeled</td>
<td><strong>Required</strong> – Enter the billing provider’s 7-digit Medicaid ID number. <strong>ID Qualifier - Optional.</strong> If possible, leave blank for Louisiana Medicaid billing.</td>
<td></td>
</tr>
</tbody>
</table>

Sample forms are on the following pages
Sample of FQHC CMS-1500 Claim Form with ICD-9 Diagnosis Code
(Dates BEFORE 10/1/15)

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>HCPCS Code</th>
<th>Modifier Code</th>
<th>Category Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td></td>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J0150</td>
<td></td>
<td>A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ICD-9 Code: 9
Sample of FQHC CMS-1500 Claim Form with ICD-10 Diagnosis Code
(Dates ON OR AFTER 10/1/15)
Sample of a Claim Form
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 Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided, thus:

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

If a paid claim must be adjusted, almost all data can be corrected through an adjustment, with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient 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 Remittance Advice 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 Remittance Advice.

Sample forms are on the following pages
### Sample of FQHC CMS-1500 Claim Form Adjustment with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

**HEALTH INSURANCE CLAIM FORM**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDicare</td>
<td></td>
</tr>
<tr>
<td>TRICARE</td>
<td></td>
</tr>
<tr>
<td>CHAMPVA</td>
<td></td>
</tr>
<tr>
<td>GROUP Health Plan</td>
<td></td>
</tr>
<tr>
<td>FECA FLILOKING</td>
<td></td>
</tr>
<tr>
<td>INSURED’S ID NUMBER</td>
<td>1234067890123</td>
</tr>
<tr>
<td>PATIENT’S NAME</td>
<td>LOU, JANNIE</td>
</tr>
<tr>
<td>PATIENT’S ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td></td>
</tr>
<tr>
<td>ZIP CODE</td>
<td></td>
</tr>
<tr>
<td>TELEPHONE (Include Area Code)</td>
<td></td>
</tr>
<tr>
<td>OTHER INSURED’S NAME</td>
<td></td>
</tr>
<tr>
<td>OTHER INSURED’S POLICY GROUP</td>
<td></td>
</tr>
<tr>
<td>TPL Code if applicable</td>
<td></td>
</tr>
<tr>
<td>INSURED’S POLICY GROUP OR FECA NUMBER</td>
<td></td>
</tr>
<tr>
<td>EMPLOYMENT (Current or Previous)</td>
<td></td>
</tr>
<tr>
<td>AUTO ACCIDENT PLACE (date)</td>
<td></td>
</tr>
<tr>
<td>OTHER ACCIDENT</td>
<td></td>
</tr>
<tr>
<td>INSURED’S PLNAME OR PROGRAM NAME</td>
<td></td>
</tr>
<tr>
<td>INSURED’S SOCIAL SECURITY #</td>
<td></td>
</tr>
<tr>
<td>INSURED’S DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>SEX</td>
<td></td>
</tr>
<tr>
<td>INSURED’S DATE OF DEATH</td>
<td></td>
</tr>
<tr>
<td>SEX</td>
<td></td>
</tr>
<tr>
<td>E. AUTO ACCIDENT PLACE (date)</td>
<td></td>
</tr>
<tr>
<td>OTHER ACCIDENT</td>
<td></td>
</tr>
<tr>
<td>INSURED’S PLNAME OR PROGRAM NAME</td>
<td></td>
</tr>
<tr>
<td>INSURED’S SOCIAL SECURITY #</td>
<td></td>
</tr>
<tr>
<td>INSURED’S DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>SEX</td>
<td></td>
</tr>
<tr>
<td>OTHER ACCIDENT</td>
<td></td>
</tr>
<tr>
<td>INSURED’S PLNAME OR PROGRAM NAME</td>
<td></td>
</tr>
<tr>
<td>INSURED’S SOCIAL SECURITY #</td>
<td></td>
</tr>
<tr>
<td>INSURED’S DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>SEX</td>
<td></td>
</tr>
<tr>
<td>OTHER ACCIDENT</td>
<td></td>
</tr>
</tbody>
</table>

**EXAMPLE OF ICD 9**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
<td></td>
</tr>
<tr>
<td>V2501</td>
<td></td>
</tr>
<tr>
<td>V2501</td>
<td></td>
</tr>
<tr>
<td>V2501</td>
<td></td>
</tr>
<tr>
<td>V2501</td>
<td></td>
</tr>
</tbody>
</table>

**Sample Instruction Manual available at www.nucc.org**

**PLEASE PRINT OR TYPE**

Page 15 of 32 Appendix D
Sample of FQHC CMS-1500 Claim Form Adjustment with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)
ADA Claim Form Billing Instructions for FQHC Services

Medicaid EPSDT Dental and Adult Denture Program Services

The 2006 American Dental Association 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 American Dental Association 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:

Molina Medicaid Solutions
P. O. Box 91022
Baton Rouge, LA 70821
ADA Claim Form Billing Instructions for FQHC Services

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
</table>
| 1         | Type of Transaction                  | **Required** – Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization.  
**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 Molina Medicaid Solutions should never include radiographs. |
| 2         | Predetermination / Preauthorization Number | **Situational** – Enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization. |                                                                      |
| 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, Middle Initial, Suffix) | **Situational**. |                                                                      |
| 6         | Date of Birth (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 6-digit TPL carrier code is **required** in this block. This code is returned through MEVS recipient eligibility inquiries as the Network Plan Identifier. The MEVS application is located on the secure portal of the web site, [www.lamedicaid.com](http://www.lamedicaid.com). (The carrier code list can be found at [www.lamedicaid.com](http://www.lamedicaid.com) under the Forms/Files link)  
If the provider has chosen to bill the third party and Medicaid, an explanation of benefits must be attached to the claim filed with Medicaid. | |
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Patient's Relationship to Person Named in #5</td>
<td>Situational.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code</td>
<td>Situational.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code</td>
<td>Required -- Enter the recipient's last name, first name, and middle initial exactly as verified through REVS or MEVS. Recipient's address is optional.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Date of Birth (MM/DD/CCYY)</td>
<td>Required -- Enter the recipient’s 8-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Gender</td>
<td>Optional – Check appropriate block.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Policyholder/Subscriber ID</td>
<td>Required -- Enter the 13-digit Medicaid ID number as obtained from REVS or MEVS. Do not use the 16-digit Card Control Number (CCN) from the recipient's Medicaid card.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Plan / Group Number</td>
<td>Situational.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Employer Name</td>
<td>Situational.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Relationship to Policyholder/Subscriber in #12 above.</td>
<td>Situational.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Student Status</td>
<td>Situational.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code</td>
<td>Situational. This field should be used only when other private insurance is primary. Note: The Medicaid recipient's name is required to be entered in Block 12.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Date of Birth (MM/DD/CCYY)</td>
<td>Situational.</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Gender</td>
<td>Situational.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Patient ID / Account # (Assigned by Dentist)</td>
<td>Optional – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the Remittance Advice. The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20 characters.</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Procedure Date (MM/DD/CCYY)</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>25</td>
<td>Area of Oral Cavity</td>
<td><strong>Situational</strong> – Enter the oral cavity designator when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific <strong>requirements</strong> regarding oral cavity designator. If an oral cavity designator is <strong>required</strong> by Medicaid, do not enter a tooth number or letter in Block 27.</td>
<td>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.</td>
</tr>
<tr>
<td>26</td>
<td>Tooth System</td>
<td>Leave Blank</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Tooth Number(s) or Letter(s)</td>
<td><strong>Situational</strong> – Enter a tooth number or letter when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific <strong>requirements</strong> regarding tooth number or letter. If a tooth number or letter is <strong>required</strong> by Medicaid, do not enter an oral cavity designator in Block 25.</td>
<td>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.</td>
</tr>
<tr>
<td>28</td>
<td>Tooth Surface</td>
<td><strong>Situational</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td>29</td>
<td>Procedure Code</td>
<td><strong>Required</strong> – 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.</td>
<td>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.</td>
</tr>
<tr>
<td>30</td>
<td>Description</td>
<td><strong>Required</strong> – Enter the description of the service performed.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Fee</td>
<td><strong>Required</strong> – Enter the dentist’s full (usual and customary) fee for the dental procedure reported.</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Other Fee(s)</td>
<td>Leave Blank</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Total Fee</td>
<td><strong>Required</strong> – Total of all fees listed on the claim form.</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>(Place an ‘X’ on each missing tooth)</td>
<td><strong>Situational</strong> – 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 <strong>required</strong>: 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.</td>
<td></td>
</tr>
</tbody>
</table>
### Locator # Description

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
</table>
| 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 zero [$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 prior authorization 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 recipient’s name and Medicaid ID # and the provider's name and Medicaid ID #.  A copy of this cover sheet, along with a copy of the request for prior authorization, 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 prior authorization 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 8-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 | SSN or TIN | Optional. |  
52 | Phone Number | **Required** – Enter the phone number for the billing dental provider. |  
52A | Additional Provider ID | **Required** – Enter the 7-digit Medicaid Provider ID of the billing dental provider. |  
53 | Signature | Optional. |
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>NPI</td>
<td>Optional – Enter the 10-digit NPI of the treating (attending) dental provider</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>License Number</td>
<td>Required – Enter the license number of the treating (attending) dental provider.</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Address, City, State, Zip Code</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>56A</td>
<td>Provider Specialty Code</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Signature</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>NPI</td>
<td>Optional – Enter the 10-digit NPI of the treating (attending) dental provider</td>
<td></td>
</tr>
</tbody>
</table>
Sample of ADA Claim Form

```plaintext
<table>
<thead>
<tr>
<th>Procedure/Date</th>
<th>Code</th>
<th>Description</th>
<th>D1 Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/4/12</td>
<td>D0999</td>
<td>Encounter - All Inclusive</td>
<td>100.00</td>
</tr>
<tr>
<td>2/4/12</td>
<td>D4341</td>
<td>Periodontal Scaling and Root Planing</td>
<td>10.00</td>
</tr>
<tr>
<td>2/4/12</td>
<td>D2954</td>
<td>Post &amp; Core</td>
<td>5.40</td>
</tr>
<tr>
<td>2/4/12</td>
<td>D2931</td>
<td>Stainless Steel Crown</td>
<td>140.00</td>
</tr>
</tbody>
</table>
```

**MISSING TEETH INFORMATION**

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

**AUTHORIZED**

If there 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 following dental a compliant with any plan policy at or in a portion of such charges. To the extent provided by law, I consent to full disclosure of any protected health information to carry out payment activities in connection with this claim.

**ANCILLARY CLAIM/TREATMENT INFORMATION**

**BILLING DENTIST OR DENTAL ENTITY**

(XYZ Dental Group)

8956 No Cavity Ave.

Smiley, LA 70000

**TREATING DENTIST/TREATMENT LOCATION INFORMATION**

Dr. Mary Cleanteeth

3/10/12

**SIGNATURES**

(XYZ Dental Group)

987654321

229994444

1234567

© 2005 American Dental Association
EPSDT 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 Remittance Advice. It may consist of letters and/or numbers, and it may be a maximum of 20 positions.

Providers can obtain these forms from Molina Medicaid Solutions 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 (EPSDT)

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adj/Void</td>
<td>Check the appropriate box.</td>
<td></td>
</tr>
</tbody>
</table>
| 2-4       | 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         | Date of Birth                        | **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 No. | **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. |        |
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Payment Source Other Than Title XIX</td>
<td><strong>Adjust</strong> - 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 6-digit TPL carrier code. <strong>Void</strong> - Enter the information exactly as it appeared on the original invoice.</td>
<td></td>
</tr>
<tr>
<td>21, 22</td>
<td>Leave these spaces blank.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Diagram</td>
<td><strong>Not required.</strong></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Examination and Treatment Plan</td>
<td><strong>Adjust</strong> - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted <strong>Void</strong> - Enter the information exactly as it appeared on the original invoice.</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Paid or Payable by Other Carrier</td>
<td><strong>Adjust</strong> - 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). <strong>Void</strong> - Enter the information exactly as it appeared on the original invoice.</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Control Number</td>
<td>Enter the control number assigned to the claim on the Remittance Advice that reported the claim as paid/approved.</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Date of Remittance Advice</td>
<td>Enter the date of the Remittance Advice that paid or denied claim.</td>
<td></td>
</tr>
<tr>
<td>28, 29</td>
<td>Reasons for Adjustment/Void</td>
<td>Check the appropriate box and give a written explanation, when applicable.</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Request for Authorization</td>
<td>Leave this space blank.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Request for Prior Authorization</td>
<td>Enter the 9-digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization.</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Attending Dentist's Signature - Provider Number</td>
<td>The attending provider number must be entered in this field.</td>
<td></td>
</tr>
</tbody>
</table>

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 Molina Medicaid Solutions for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.
Sample of 209 Adjustment/Void Form (EPSDT)
Instructions for Completing 210 Adjustment/Void Form (Adult)

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adj/Void</td>
<td>Check the appropriate box.</td>
<td></td>
</tr>
</tbody>
</table>
| 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.  
**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         | Date of Birth                                    | **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 No.             | **Adjust** - Enter the information exactly as it appeared on the original invoice.  
**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. |        |
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Payment Source Other Than Title XIX</td>
<td>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 6-digit TPL carrier code. Void - Enter the information exactly as it appeared on the original invoice.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td>Not required.</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>Leave blank.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>A-G</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Paid of Payable by Other Carrier</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Other Information</td>
<td>Leave blank.</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Control Number</td>
<td>Enter the control number assigned to the claim on the Remittance Advice that reported the claim as paid/approved.</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Date of Remittance Advice</td>
<td>Enter the date of the Remittance Advice that paid or denied claim.</td>
<td></td>
</tr>
<tr>
<td>28, 29</td>
<td>Reasons for Adjustment/Void</td>
<td>Check the appropriate box and give a written explanation, when applicable.</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Request for Authorization</td>
<td>Leave this space blank.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Request for Prior Authorization</td>
<td>Enter the 9- digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization.</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Attending Dentist's Signature - Provider Number</td>
<td>The attending provider number must be entered in this field.</td>
<td></td>
</tr>
</tbody>
</table>

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 Molina Medicaid Solutions for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.
Sample of 210 Adjustment/Void Form (Adult)