



**PROVIDER TYPE SPECIFIC  
PACKET/CHECKLIST**

**(Louisiana Medicaid Program)**

**EPSDT  
Health Services**

(Enrollment packet is subject to change without notice)

# EPSDT Health Services

## CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Medicaid Solutions Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an EPSDT Health Services provider:

Completed	Document Name
<input type="checkbox"/> *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
<input type="checkbox"/> *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
<input type="checkbox"/> *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/> *	4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. <b>(Only the Disclosure of Ownership portion of this enrollment packet can be done by choosing Option 1.)</b>  <b>Option 1</b> (preferred): Provider Ownership Enrollment Web Application. Go to <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist. <p style="text-align: center;">-or-</p> <b>Option 2</b> (not recommended): If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.
<input type="checkbox"/> *	5. <b>(If submitting claims electronically)</b> Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form and Power of Attorney Form (if applicable).
<input type="checkbox"/>	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited <b>(deposit slips are not accepted)</b> .
<input type="checkbox"/>	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records <b>(W-9 forms are not accepted)</b> .
<input type="checkbox"/>	8. To report "Specialty" for this provider type on Section A of the PE-50 in the Basic Enrollment Packet, please use Code 44 (Public Health).
<input type="checkbox"/> **	9. Completed PE-50 EPSDT Health Services For Children With Disabilities Provider Enrollment Supplement Agreement
<input type="checkbox"/> **	10. Completed PE-50 EPSDT Provider Supplement Agreement B
<input type="checkbox"/> **	11. Completed PE-50 EPSDT Provider Supplement Agreement C - School Board Certification of Understanding (if applicable)
<input type="checkbox"/> **	12. <b>Only for Parish School Boards:</b> Completed Amendment to the Provider Agreement Between DHH-BHSF and the appropriate Parish School Board (4 pages).
<input type="checkbox"/> **	13. Completed Individual Therapist Form.
<input type="checkbox"/>	14. Printout of online medical license verification from the governing license board for each therapist identified in the list specified in item 13 above. This verification must contain the license number, the effective date of issuance, and the current status of the license.
<input type="checkbox"/>	15. Copy of the Early Intervention license from the Department of Social Services for providers serving the 0 to 3 year old population

\* Forms are included in the Basic Enrollment Packet

\*\* Forms are included here

**PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT. FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS) – DO NOT SUBMIT COPIES OF THE ATTACHED FORMS.**

Please submit all required documentation to:  
**Molina Medicaid Solutions Provider Enrollment Unit**  
**PO Box 80159**  
**Baton Rouge, LA 70898-0159**

**PE-50 EPSDT HEALTH SERVICES FOR CHILDREN WITH  
DISABILITIES PROVIDER ENROLLMENT SUPPLEMENT AGREEMENT**

In order to facilitate your enrollment as an EPSDT Health Services provider in Medicaid of Louisiana, you must provide the information that is requested below.

Name of Provider: \_\_\_\_\_

Medicaid Provider Number: \_\_\_\_\_

Address (Mailing and Street): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Address and Telephone Number if Other Sites (if applicable): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check the EPSDT health service(s) you wish to provide, list any restrictions related to the age or the number of children, geographical areas, or other factors, or enter "none." Attach documentation of applicable licensing and certification for staff providing these services.

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SERVICE RESTRICTIONS  
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- \_\_\_\_\_ Audiologic Evaluation
- \_\_\_\_\_ Speech and Language Evaluation
- \_\_\_\_\_ Speech, Language or Hearing Therapy
- \_\_\_\_\_ Occupational Therapy Evaluation
- \_\_\_\_\_ Occupational Therapy
- \_\_\_\_\_ Physical Therapy Evaluation
- \_\_\_\_\_ Physical Therapy
- \_\_\_\_\_ Psychological Therapy

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\* All services must be provided as part of or in the interest of establishing an Individual Service Plan (ISP) or an individual Family Service Plan (IFSP).

The Agreement, made by and between Medicaid of Louisiana and \_\_\_\_\_  
\_\_\_\_\_(Provider), sets forth the terms of participation in Early Periodic Screening and Diagnostic Treatment (EPSDT) health services to children with disabilities. The parties, intending to be legally bound, agree as follows.

1. The provider agrees to adhere to all general enrollment conditions of Medicaid of Louisiana.
2. The provider agrees to comply with all applicable program requirements for services, timeliness standards, and reasonable standards of medical and other health professional practices set forth in the EPSDT Health Services Provider Manual.
3. The provider agrees to maintain sufficient staff, facilities, equipment, and supplies to provide the agreed upon services and notify Medicaid of Louisiana promptly, in writing, whenever he/she is not longer able to provide the services.
4. The provider agrees to ensure that recipients are allowed to choose providers freely.
5. The provider agrees to establish procedures through which eligible recipients and families may present grievances which may arise from EPSDT services provided under this agreement.
6. The provider agrees that the submission by or on behalf of the provider of any claim shall be certification that the specific services for which the payment is claimed were provided to the person identified as the recipient.
7. The provider agrees to keep records necessary to disclose the extent of EPSDT services provided to recipient for five years from the date of payment, to provide this information, as requested, to Medicaid of Louisiana or its authorized representative, and to cooperate with on-site reviews, and other monitoring and training activities.
8. The provider agrees to use Medicaid funds received for these services solely for the provision and/or enhancement of health services to children. These Medicaid funds may be used for the direct provision of these services and to defray the administrative cost of providing these services.
9. The provider agrees to submit claims within 1 year of the date of service and to submit these claims electronically.
10. The provider agrees to participate in KIDMED recipient outreach activities, including identifying and informing recipients of the benefits of preventive care, and how to access KIDMED screening services.
11. The provider agrees to provide age appropriate KIDMED medical, vision, and hearing screening services to Medicaid recipients under the age of 21 who are receiving EPSDT health services reimbursed by Medicaid or to contact KIDMED immediately to arrange for these screening services.

12. The provider agrees to refer any suspected child abuse, neglect, and/or sexual abuse of recipients under the age of 21 promptly to the Office of Community Services in the parish where the recipient resides.
13. Medicaid of Louisiana agrees to reimburse the provider for EPSDT health services covered by Medicaid in accordance with applicable regulations and the schedule of maximum Medicaid fees for these services.
14. The effective date of this agreement shall be the date on which it is signed by Medicaid of Louisiana unless otherwise stated.
15. This agreement may be terminated by either party upon 30 days after the receipt of a written notice by the other party.

I certify that the information provided on this form is true to the best of my knowledge.

\_\_\_\_\_  
Provider-Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medicaid Director or Designee

\_\_\_\_\_  
Date

## PE-50 EPSDT PROVIDER SUPPLEMENT AGREEMENT B

Provider Number: \_\_\_\_\_

The Agreement, made by and between the Bureau of Health Services Financing (“Bureau”) and \_\_\_\_\_ (“Provider”) sets forth the terms of participation in EPSDT medical, vision, and hearing services and/or health services to children with special needs. The parties, intending to be legally bound, agree as follows:

1. The Provider agrees to provide EPSDT services timely and efficiently and avoid duplicate and unnecessary services.
2. The Provider Agrees to adhere to all general Medicaid enrollment conditions.
3. The Provider agrees to comply with all applicable EPSDT requirements for services, timeliness, standards and reasonable standards of medical and other health professional practices set forth in the EPSDT Services Provider Manual.
4. The submission by or on behalf of the Provider of any claim shall be certification that the specific EPSDT services for which payment is claimed were provided to the person identified as the recipient.
5. The Provider agrees to keep records necessary to disclose the extend of EPSDT services provided to recipients for five years from the date of service and provide this information, as requested, to the Bureau or its authorized representative and cooperate with on-site reviews and other monitoring activities.
6. The Provider agrees to use Medicaid funds received from the Bureau solely for the provision and/or enhancement of health services to children. Medicaid funds may be used for the direct provision of these services and to defray the administrative cost of these services.
7. The Provider agrees to participate in EPSDT services provider training.
8. The Provider agrees to refer pregnant and postpartal recipients and children under age 5 to WIC and complete applicable WIC forms presented by the recipient.
9. The Provider agrees to participate in EPSDT recipient outreach activities including seeking out recipient and informing recipients of the benefits of EPSDT services, informing them of assistance, including transportation services, available and helping them use EPSDT services effectively.
10. The Provider agrees to promptly refer any suspected child abuse, neglect and/or sexual abuse of recipients under age 21 to the Office of Community Services in the parish where the recipient resides.

11. The Provider agrees to establish procedures through which eligible recipients and families may present grievances which may arise from EPSDT services provided under this agreement.
12. The Provider agrees to provide screening services to Medicaid recipients under age 21 receiving diagnosis, treatment and/or other health services reimbursed by Medicaid or refer to a screening provider for these services.
13. The Provider agrees to assure that recipients who are to be referred for services have freedom of choice providers.
14. The Provider agrees to maintain sufficient staff, facilities, equipment and supplies to provide the agreed upon services and agrees to notify the Bureau promptly, in writing, whenever it is unable to provide the required quality and quantity of services set forth in the EPSDT Services Provider Manual.
15. The Provider agrees to submit Medicaid claims within 90 days of the date of service for recipients under age 21.
16. The Bureau agrees to reimburse the Provider for EPSDT services covered by Medicaid in accordance with applicable statutes and regulations and schedule of maximum fees for EPSDT services.
17. The effective date of this Agreement shall be the date on which is it signed by the Department.
18. This Agreement may be terminated by either party upon thirty (30) days written notice to the other party.

I certify that the information provided on this form is true to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
BHSF Director

\_\_\_\_\_  
Date

**PE-50 EPSDT PROVIDER SUPPLEMENT AGREEMENT C  
SCHOOL BOARD CERTIFICATION OF UNDERSTANDING  
(APPLICABLE ONLY TO HEALTH SERVICES TO CHILDREN WITH SPECIAL NEEDS,  
FORMERLY REFERRED TO AS SCHOOL HEALTH SERVICES)**

The Provider School Board acknowledges that this Certification of Understanding is required by the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, as part of the Bureau of Health Services Financing's assurance in accordance with the Title XIX State Plan that local parish school board funds are available to the Medicaid Program to be matched with the federal share in the reimbursement of EPSDT services provided by the school board to children with special health care needs.

1. The Provider School Board understands, certifies and assures it does have the state and/or local match funds available to draw down the federal share for the EPSDT health services provided to children with special needs by the school board.
2. The Provider School Board understands, certifies, and assures that in participating in this program and qualifying for matching funds herein, no federal funds received by or available to the school board will be used in recapturing federal dollars.
3. The Provider School Board assures that adequate records and an audit trail to support the above assurances will be maintained for the individual checkwrites and will be made available to the U.S. Department of Health and Human Services and the Bureau of Health Services Financing and its designees for review.
4. The Provider School Board understands that this Certificate of Understanding is not applicable to EPSDT screening services.

\_\_\_\_\_  
BHSF Director

\_\_\_\_\_  
Superintendent

\_\_\_\_\_  
School Board

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**AMENDMENT to the PROVIDER AGREEMENT BETWEEN  
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS,  
BUREAU OF HEALTH SERVICES FINANCING  
AND  
\_\_\_\_\_ Parish School Board**

The Louisiana Department of Health, Bureau of Health Services Financing, hereinafter called BHSF, and the \_\_\_\_\_ Parish School Board, a government entity, hereinafter called Local School Board, hereby make this Amendment to the Provider Agreement in order to implement the Medicaid State Plan under Title XIX of the Social Security Act (Medicaid).

**I. GENERAL RESPONSIBILITY**

- A. BHSF recognizes the unique relationship that the Local School Board, and the affiliated entities operating under contract or memorandum of understanding with it, has with its Medicaid eligible clients and its unique abilities to provide IDEA School-Based Health Services to Medicaid eligible students. BHSF, in order to take advantage of this expertise and relationship and to promote objectives of the State Medicaid Plan, has entered into this Amendment to the Provider Agreement with Local School Board.
- B. BHSF and Local School Board makes this Amendment with full recognition of all Agreements that BHSF has developed for services to Title XIX eligible clients living in Louisiana and which are currently included in the Title XIX State Plan approved by the federal Centers for Medicare and Medicaid Services.

**II. IDEA SCHOOL-BASED DIRECT HEALTH SERVICES**

- A. BHSF agrees to:
  - 1. Claim for federal financial participation (FFP) under Title XIX the actual and reasonable expenditures of the Local School Board for IDEA School-Based Direct Health Services provided to Medicaid eligible children by its staff or by staff in agencies with which it has subcontracted for direct medical services under its Provider Agreement. Actual and reasonable expenditures by the Local School Board shall be determined by the same time accounting system which is utilized in Louisiana's Medicaid Allowable Costs approved Title XIX State Plan amendment which adhere to the provisions of OMB Circular A-87 and 45 CFR Parts 74 and 95. This system will allocate the expense and equipment costs necessary to collect data, disseminate information and carry out the staff functions outlined in this Agreement. BHSF agrees to reimburse the Local School Board no less than eighty-five percent of the FFP ("federal share") received for the expenditures so claimed and reserves the right to retain up to fifteen percent of the FFP for BHSF's own costs of administering the IDEA School-Based Health Services program, including

monitoring compliance and quality of the program and providing technical assistance to Local School Boards. Reimbursement will be claimed in accordance with State Plan documents as approved by the Centers for Medicare and Medicaid Services (CMS). Changes in any federal regulation affecting costs eligible for federal match, which become effective subsequent to the execution of this Agreement, will be applied herein as provided in such changes in applicable federal regulations.

2. Designate an employee to act as liaison with Local School Board for issues concerning this Agreement.

B. Local School Board agrees to:

1. Perform or coordinate its subcontractors' performance of IDEA School-Based Health Services activities on behalf of BHSF.
2. Account for the allowable activities of staff providing IDEA School-Based Health Services in accordance with the provisions of OMB Circular A-87 and 45 CFR Part 74 and 95, on forms issued by BHSF, according to Medicaid's written instructions.
3. Bill for IDEA School-Based Health Services based on the most current BHSF instructions for billing for these services.
4. Provide BHSF the expenditures information in the annual cost report it submits to BHSF, or its designee, in the manner prescribed by BHSF by no later than September 1<sup>st</sup> of each year and maintain related documentation for five years from date of payment.
5. Budget sufficient local and/or state funds, in an amount sufficient to equal anticipated total costs to provide IDEA health services to Medicaid eligible students which shall subsequently be certified as public expenditures eligible for Medicaid federal financial participation, in accordance with the provisions of this agreement.
6. Designate an employee to act as liaison with BHSF for issues concerning this Agreement.

### **III. FISCAL PROVISION**

Payment provisions under this Agreement shall be made in the following manner:

- A. Upon Local School Board's compliance with its responsibilities pursuant to Section II of this Agreement in a satisfactory manner and after BHSF has received federal financial participation for expenditures claimed, BHSF agrees to reimburse to Local School Board an equal amount equal to no less than 85 percent of the federal share of certified costs (as demonstrated by audit of actual cost incurred in Local School Board cost centers and appropriation accounts that are paid by non-federal funds).
- B. In addition, BHSF agrees to reimburse for IDEA School-Based Health Services provided by Local School Board only if Local School Board certifies that sufficient state/local funds are

available to support the total cost for IDEA School-Based Health Services claimed as Medicaid expenditures. This Agreement is also subject to any additional restrictions, limitations or conditions required by federal or state government which may affect the provisions, term or funding of this Agreement in any manner.

- C. Each year Local School Board agrees to provide BHSF with a certification of the estimate of non-federal public (local and/or state) funds to be expended for Medicaid IDEA School-Based Direct Health Services at the beginning of each state fiscal year, and a certification at the end of the fiscal year of the actual amount of non-federal public funds, (local and/or State General Revenue funds) used to reimburse for IDEA School-Based Direct Services for clients in an amount equal to the total Medicaid claimed expenditures for IDEA School-Based Direct Health Services. Said certification will be made on a form provided to the Local School Board by BHSF. If payments made during the fiscal year under the term of this agreement exceed the costs as reported on the cost report, the DHH will recoup those amounts determined to be overpayments to the Local School Board. If a fiscal year's cost report is not submitted by the date specified by DHH, then DHH may initiate recovery of all payments to the Local School Board made under this agreement and may suspend further payments until the required cost report is received and the provider is in compliance with this agreement. DHH may allow repayment plans for Local School Board if necessary.
- D. This Agreement will terminate at the end of any State or Federal fiscal year in the event funds are not appropriated by the Louisiana Legislature or the U.S. Congress for the next succeeding State or Federal fiscal year. If funds are appropriated for a portion of the fiscal year, this agreement will terminate at the end of the term for which funds are appropriated.
- E. BHSF's obligation to transfer these funds under this Agreement is contingent upon the availability of Federal Financial Participation for these services.
- F. Since State Fiscal Years (July - June) and Federal Fiscal Years (October - September) do not run concurrently, Federal financial Participation will be determined by weighed rates based on the state fiscal year (one quarter of the prior Federal Fiscal Year's FMAP plus three quarters of the current Federal Fiscal Year's FMAP based on federal fiscal years).
- G. Any audit exception, deferral or denial taken by CMS against payments covered under this Agreement will be the responsibility of Local School Board, unless said exception, deferral, or denial is the direct result of instructions given in writing by BHSF.

#### **IV. AMENDMENT**

This Agreement may be amended at any time by mutual written content of the parties of this Agreement. Either party may also terminate this Agreement without cause by delivery of written notice of termination to the other party at least thirty (30) days prior to the effective date of termination.

**V. TERM OF CONTRACT**

This Agreement is effective \_\_\_\_\_, and shall continue indefinitely. This Agreement is executed by the undersigned in their capacities as stated below.

\_\_\_\_\_ Parish School Board

\_\_\_\_\_  
Superintendent

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Medicaid Director or Designee

\_\_\_\_\_  
Date Signed

