Emergency Billing Policy and Procedures for Hurricane Evacuees

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Emergency Period Only

LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

Prepared by: Unisys Technical Communications Group
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EMERGENCY BILLING POLICY AND PROCEDURES

PURPOSE
This packet is designed to furnish providers with billing policies and procedures for services rendered during the hurricane emergency period. While some policies have been waived or altered for hurricane evacuees, others are current Louisiana Medicaid policy and remain unchanged.

**As of the date of publication, the Louisiana Department of Health and Hospitals defines those individuals considered Hurricane evacuees as recipients residing in the following Louisiana parishes:**

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<tr>
<td>Orleans</td>
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<td>26/65</td>
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<tr>
<td>St. Bernard</td>
<td>44</td>
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<tr>
<td>St. Tammany</td>
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<tr>
<td>St. Charles</td>
<td>45</td>
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<tr>
<td>St. John</td>
<td>48</td>
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<td>LaFourche</td>
<td>29</td>
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<tr>
<td>Terrebonne</td>
<td>55</td>
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<tr>
<td>Tangipahoa</td>
<td>53</td>
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<tr>
<td>Plaquemines</td>
<td>38</td>
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<tr>
<td>Washington</td>
<td>59</td>
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<tr>
<td>St. James</td>
<td>47</td>
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PROVIDER ENROLLMENT
All providers rendering services for Louisiana Medicaid recipients must enroll with Louisiana Medicaid in order to receive reimbursement from the Louisiana Medicaid Program. Providers must complete and submit a Louisiana provider enrollment application. A link to the Hurricane Emergency Provider Enrollment Packets may be found on the home page for Louisiana Medicaid’s website at www.lamedicaid.com. Once approved, providers will receive a Louisiana Medicaid 7-digit provider number assigned on a temporary basis. This number is to be used when verifying recipient eligibility and when submitting claims. While going through the enrollment process, providers may contact Provider Relations at 1-800-473-2783 to obtain temporary access codes necessary to verify eligibility. Once each provider receives a provider number, that number should be registered on the Louisiana Medicaid website at www.lamedicaid.com and used for any future eligibility inquiries.

RECIPIENT ELIGIBILITY VERIFICATION
The Department of Health and Hospitals (DHH) offers several options to assist providers with verification of current recipient eligibility. The following eligibility verification options are available: (1) Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system; (2) e-MEVS, a web application accessed through www.lamedicaid.com; and (3) Pharmacy Point of Sale (POS) for pharmacy providers only.
Before accessing the REVS and e-MEVS eligibility verification systems, providers should be aware of the following:

- In order to verify recipient eligibility through REVS and e-MEVS, inquiring providers must supply the systems with two (2) identifying pieces of recipient information.
- Specific dates of service must be requested. A date range in the date of service field on an inquiry transaction is not acceptable, and Provider Relations will not supply eligibility information for date ranges.

**Recipient Eligibility Verification System (REVS)**

The Recipient Eligibility Verification System (REVS) is a toll-free telephonic eligibility hotline that is used to verify Medicaid eligibility and is accessed through touch-tone telephone equipment using the Unisys toll-free telephone number (800) 776-6323 or the local Baton Rouge area number (225) 216-REVS (7387).

**e-MEVS**

Providers can verify eligibility for a Medicaid recipient using a web application accessed through [www.lamedicaid.com](http://www.lamedicaid.com).

Note: Providers must establish an online account to access eligibility information.

**Pharmacy Point of Sale (POS)**

For pharmacy claims being submitted through the POS system, eligibility is automatically verified as a part of the claims processing edits.

**BILLING**

- Medicaid is accepting only hard copy billing claim forms from all providers enrolled as “emergency” providers. Electronic claims submission will not be accepted from providers enrolled on this emergency basis.
- Claims must be submitted using the assigned 7-digit provider number received from Louisiana Medicaid.
- Some policies have been waived for evacuees only; however, other claims processing edits remain in place such as eligibility edits, procedure and diagnosis code edits, coverage edits, primary insurance edits, etc.
- More complete policy information can be found on the Louisiana Medicaid Website at [www.lamedicaid.com](http://www.lamedicaid.com).

The following emergency packet contains information on billing form completion instructions and sample forms, post office boxes for submitting claims, general policy information, and helpful phone numbers.
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STANDARDS FOR PARTICIPATION

Provider participation in Medicaid of Louisiana is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. These standards are listed as follows:

- Provider agreement and enrollment with the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH);
- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;
- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services;
- **NOTE:** Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, or the state Attorney General’s Medicaid Fraud Control Unit.
- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1978*, and, where applicable, Title VII of the *1964 Civil Rights Act*.

Picking and Choosing Services

On March 20, 1991, Medicaid of Louisiana adopted the following rule:

*Practitioners who participate as providers of medical services shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by the provider as a Medicaid patient.*

This rule prohibits Medicaid providers from "picking and choosing" the services for which they agree to accept a client's Medicaid payment as payment in full for services rendered. Providers must bill Medicaid for all Medicaid covered services that they provide to their clients.

Providers continue to have the option of picking and choosing from which patients they will accept Medicaid. Providers are not required to accept every Medicaid patient requiring treatment.
Statutorily Mandated Revisions to All Provider Agreements

The 1997 Regular Session of the Legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437.14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

- comply with all federal and state laws and regulations;
- provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- have all necessary and required licenses or certificates;
- maintain and retain all records for a period of five (5) years;
- allow for inspection of all records by governmental authorities;
- safeguard against disclosure of information in patient medical records;
- bill other insurers and third parties prior to billing Medicaid;
- report and refund any and all overpayments;
- accept payment in full for Medicaid recipients providing allowances for copayments authorized by Medicaid;
- agree to be subject to claims review;
- the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- notification prior to any change in ownership;
- inspection of facilities; and,
- posting of bond or letter of credit when required.

MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive. The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify Provider Enrollment immediately that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.
Surveillance Utilization Review

The Department of Health and Hospitals’ Office of Program Integrity, in partnership with Unisys, has expanded the Surveillance Utilization Review function of the Louisiana Medicaid Management Information System (LMMIS). Historically, this function has been a combination of computer runs, along with skilled Medical staff to review providers after claims are paid. Providers are profiled according to billing activity and are selected for review using computer-generated reports. The Program Integrity Unit of DHH reviews oral and written complaints sent from various sources throughout the state, including the fraud hotline.

As of July 1, 1998, the surveillance and utilization review capability of the LMMIS has been greatly expanded to review more providers than ever in the history of the Louisiana Medicaid Program. Additional controls in fraud and abuse measures have been added to include a personal computer-based Surveillance Utilization Review System with the full capability to provide:

- A powerful review tool at the desk-top level
- The ability to monitor more providers than ever under the previous system
- Enhanced exception processing
- Episode of care profiling
- A four-fold increase in review capability
- Significant expansion of field reviews and audits
- Higher focus on policy conformance issues.

If audited, providers should cooperate with the representatives of DHH, which includes Unisys representatives, in accordance with their provider agreement signed upon enrollment. Failure to cooperate could result in mild to severe administrative sanctions. The sanctions include, but are not limited to:

- Withholding of Medicaid payments
- Referral to the Attorney General’s Office for investigation
- Termination of Provider Agreement

The members of the Surveillance Utilization Review team and Program Integrity would once again like to issue a reminder that a service undocumented is considered a service not rendered. Providers should ensure their documentation is accurate and complete. All undocumented services are subject to recoupment. Other services subject to recoupment are:

- Upcoding on level of care
- Maximizing payments for services rendered
- Billing components of lab tests, rather than the appropriate lab panel
- Billing for medically unnecessary services
- Billing for services not rendered
- Inappropriate use of provider number (allowing someone who cannot bill the program to bill using your provider number).
- Consults performed by the patient’s primary care, treating, or attending physicians.

This expansion also brings together the largest group of surveillance professionals in the state to combat fraud and abuse within this Medicaid program, along with the advanced technology to accomplish the goal.
Provider Warning

Entities not enrolled as Medicaid providers are prohibited from using enrolled physicians’ Medicaid numbers in order to submit billing for their services. Physicians have unknowingly become involved in this fraudulent billing practice and risk being drawn into a long, complicated fraud investigation, and the unenrolled entities risk criminal prosecution.

Program Integrity and SURS Teams would also like to remind all providers that they are bound by the conditions of their provider agreement which includes but is not limited to those things set out in Medical Assistance Program Integrity Law (MAPIL) R.S. 46:437.1 through 440.3, The Surveillance and Utilization Review Systems Regulation (SURS Rule) Louisiana Register Vol. 29, No. 4, April 20, 2003, and all other applicable federal and state laws and regulations, as well as Departmental and Medicaid policies. Failure to adhere to these could result in administrative, civil and/or criminal actions.

Fraud and Abuse Hotline

The state has a hotline for reporting possible fraud and abuse in the Medicaid Program. Anyone can report concerns at (800) 488-2917.

Providers are encouraged to give this phone number to any individuals or providers who want to report possible cases of fraud or abuse.
IDENTIFICATION OF ELIGIBLE RECIPIENTS

Recipients enrolled in Louisiana’s Medicaid Program are issued Plastic Identification Cards; however, some hurricane evacuees may be issued a Temporary Letter. These permanent identification cards and temporary letters are issued as proof of Medicaid eligibility. Use of these cards and letters will require provider verification. The Department of Health and Hospitals (DHH) offers several options to assist providers with verification of current recipient eligibility. The following eligibility verification options are available: (1) Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system. (2) e-MEVS, a web application accessed through www.lamedicaid.com. (3) Pharmacy Point of Sale (POS).

These eligibility verification systems provide confirmation of the following:

- Recipient eligibility
- Third Party (Insurance) Resources
- Service limits and restrictions

Before accessing the REVS and e-MEVS eligibility verification systems, providers should be aware of the following:

- In order to verify recipient eligibility through REVS and e-MEVS inquiring providers must supply the system with two (2) identifying pieces of information about the recipient.
- Specific dates of service must be requested. A date range in the date of service field on an inquiry transaction is not acceptable, and Provider Relations will not supply eligibility information for date ranges.

Recipient Eligibility Verification System (REVS)

The Recipient Eligibility Verification System (REVS) is a toll-free telephonic eligibility hotline that is used to verify Medicaid eligibility and is provided at no additional cost to enrolled providers. REVS can be accessed through touch-tone telephone equipment using the Unisys toll-free telephone number (800) 776-6323 or the local Baton Rouge area number (225) 216-REVS (7387).

Accessing REVS

Enrolled providers may access recipient eligibility by using two (2) pieces of the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Medicaid ID number (valid during the last 12 months) and recipient birth date
- Medicaid ID number (valid during the last 12 months) and social security number
- Social Security number and recipient birth date
The 7-digit Louisiana Medicaid provider number must be entered to begin the eligibility verification process.
e-MEVSS

Providers can verify eligibility and service limits for a Medicaid recipient using a web application accessed through www.lamedicaid.com. An eligibility request can be entered via the web for a single recipient and the eligibility and service limits data for that individual will be returned on a web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Accessing e-MEVSS

Enrolled providers may access recipient eligibility by using the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Social security number and recipient birth date
- Recipient ID number and recipient birth date
- Recipient ID number and social security number
- Recipient ID number and recipient name
- Recipient name and recipient birth date
- Recipient name and social security number

Pharmacy Point of Sale (POS)

For pharmacy claims being submitted through the POS system, eligibility is automatically verified. Checking eligibility through REVS and e-MEVSS is not necessary except in an instance of recipient retroactive eligibility.
This card is for identification purposes. It is not proof of current eligibility.

EMERGENCIES - For emergencies, go to the nearest health care facility or hospital emergency room. Please notify your Primary Care Physician (PCP) of emergency care as soon as possible.

For questions about this Medicaid card or the Medicaid program, call 1-800-834-3333 for help.

PROVIDERS - To verify eligibility, swipe the card or call the Recipient Eligibility Verification System (REVS) at 1-800-776-6323.

To report possible Medicaid fraud or abuse call 1-800-488-2917.
Date: ____________________________

To Whom It May Concern:

This will serve as the Medicaid Eligibility Card for the persons listed below. These persons have been affected by Hurricane Katrina.

Claims for medical services covered by Louisiana Medicaid provided to these individuals will be processed and paid. For the period September 1, 2005 and ending midnight December 31, 2005, these eligibles are exempt from hospital pre-certification and prescription limits.

Medicaid providers should maintain a copy of this letter in order to guarantee Medicaid payment.

Medical providers should contact 1-800-473-2783 for questions regarding claims submission.

**ATTENTION Medicaid Eligibles:** As soon as you get a permanent address, report it to Medicaid. At that time if you are still eligible, we can send you a plastic Medicaid card.

<table>
<thead>
<tr>
<th>Name of Eligible Person</th>
<th>Medicaid ID Billing Number</th>
<th>Date of Birth</th>
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Sincerely,

Ben A Bearden
Medicaid Director

By: ____________________________

Louisiana Medicaid Eligibility Representative

MEDICAL VENDOR ADMINISTRATION
1201 CAPITOL ACCESS ROAD • P.O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9130
PHONE #: 225/342-3991 • FAX #: 225/342-9638
"AN EQUAL OPPORTUNITY EMPLOYER"
Federal regulations and applicable state laws require that third-party resources be used before Medicaid is billed. Third-party refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, which can be applied toward the Medicaid recipient's medical and health expenses. Providers should check the recipient's TPL segment to verify that the third-party liability (TPL) codes are accurate according to the TPL listing and the name of the third-party insurance carrier. (TPL carrier code listings can be found on the Medicaid website at www.lamedicaid.com under “Forms/Files” or by contacting Unisys Provider Relations at (800)473-2783 or (225)924-5040). If the TPL code is not correct, the provider should instruct the recipient to contact his/her parish worker to correct the file, especially if the insurance has been canceled. Claims submitted for payment will deny unless the insurance coverage is noted on the claim with the appropriate TPL code or unless a letter explaining the cancellation of the insurance from the carrier is attached to the claim.

NOTE: The lack of a third-party TPL code segment does not negate the provider's responsibility for asking the recipient if he/she has insurance coverage.

In most cases it is the provider's responsibility to bill the third-party carrier prior to billing Medicaid. In those situations where the insurance payment is received after Medicaid has been billed and has made payment, the provider must reimburse Medicaid, not the recipient. Reimbursement must be made immediately to comply with federal regulations.

TPL Billing Procedures

When billing Medicaid after receiving an Explanation of Benefits (EOB) from a TPL, the provider must bill a hard copy claim and:

- Attach a copy of the EOB/EOMB, making sure any remarks/comments from the other insurance company are legible and attached.
- Enter the amount the other insurance company paid in the appropriate block on the claim form (except for Medicare).
- Enter the six-digit carrier code assigned by Medicaid in the correct block on the claim form (except Medicare).

NOTE: The six-digit carrier code for traditional Medicare (060100) is not needed to process Medicare crossover claims. In fact, including the Medicare carrier code on these claims may cause processing errors. The Medicare EOB should be attached to each claim form. In addition, providers should not indicate the amount paid by Medicare on their claim forms.

Additionally, the dates of service, procedure codes and total charges must match, or the claim will deny. All Medicaid requirements such as precertification or prior authorization must be met before payment will be considered.

NOTE: Claims submitted where the billing information does not match the EOB should be sent to the Provider Relations Correspondence Unit with a cover letter explaining the discrepancy. Such instances would include payment for dates not precertified by Medicaid and privately assigned procedure codes not recognized by Medicaid.
Requests to Add or Remove Recipient TPL/Medicare Coverage

A request to add or remove TPL or Medicare coverage must include a cover letter indicating the action requested, the claim, and the EOB or proof of coverage termination and should be mailed to:

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

Payment Methodology When TPL is Involved

Medicaid payment is calculated by using cost comparison methodology after reimbursement is made from the TPL. The total payment to the provider from all resources will not be more than Medicaid allows for the service.

Example: A provider submits a claim to the private insurance company for procedure 99213 in the amount of $70.00. The private insurance allows $50.00 for this procedure, $10.00 is applied to the patient’s deductible and the insurance payment to the provider is $40.00. When the claim and EOB are sent to Medicaid, the payment will be zero. Currently, Medicaid allows $36.13 for this procedure. The $40.00 insurance payment to the provider is more than the Medicaid allowable, thus the zero payment. This zero payment is considered an approved claim and is payment in full. The provider may not bill the recipient any remaining balance including co-payments and/or deductibles.

TPL carrier code listings can be found on the Louisiana Medicaid Website at www.lamedicaid.com under “Forms/Files” or by contacting Unisys Provider Relations at (800) 473-2783 or (225) 924-5040.

Prenatal and Preventive Pediatric Care Pay and Chase

Louisiana Medicaid uses the “pay and chase” method of payment for prenatal and preventive care for individuals with health insurance coverage. This means that most providers are not required to file health insurance claims with private carriers when the service meets the pay and chase criteria. The Bureau of Health Services Financing seeks recovery of insurance benefits from the carrier within 60 days after claim adjudication when the provider chooses not to pursue health insurance payments.

Service classes which do not require private health insurance claim filing by most providers are:
1. Primary prenatal diagnoses confined to those listed below. All recipients qualify. **Hospitals are not included and must continue to file claims with the health insurance carriers**;

   - V22.0  640.0 - 648.9
   - V22.1  651.0 - 658.9
   - V22.2  671.0 - 671.9
   - V23.0 - V23.9  673.0 - 673.8
   - V28.0 - V28.9  675.0 - 676.9

2. Primary preventive pediatric diagnoses confined to those listed below. Individuals under age 21 qualify. **Hospitals are not included and must continue to file claims with the health insurance carriers**;

   - V01.0 - V05.0  V77.0 - V77.7
   - V07.0 - V07.9  V78.2 - V78.3
   - V20.0 - V20.2  V79.2 - V79.3
   - V70.0  V79.8
   - V72.0 - V72.3  V82.3 - V82.4
   - V73.0 - V75.9

3. EPSDT medical, vision, and hearing screening services (KIDMED screening services);

4. EPSDT dental services;

5. EPSDT services to children with special needs (formerly referred to as school health services) which result from screening and are rendered by school boards;

6. Services which are a result of an EPSDT referral, indicated by entering “Y” in block 24H of the CMS-1500 claim form or “1” as a condition code on the UB-92 (form locators 24 - 30).

7. Services for Medicaid eligibles whose health insurance is provided by an absent parent who is under the jurisdiction of the State Child Support Enforcement Agency. All providers and all services (regardless of diagnosis) qualify.

**Voiding Accident-Related Claims for Profit**

A provider who accepts Medicaid payment for an accident-related service or illness may not later void the Medicaid claim in order to pursue payment from an award or settlement with a liable third party. Federal regulations prohibit this practice. All providers enrolled in Louisiana’s Medicaid Program are required to accept Medicaid payment as payment in full and are not to seek additional payment for any unpaid portion of the bill.

**Outgoing Medical Records Stamp**
Providers who furnish medical information to attorneys, insurers, or anyone else must obtain a 3"x3" ANNOTATION STAMP and must assure that all outgoing medical information bears the stamp, which notifies the receiver that services have been provided under Louisiana's Medicaid Program (see example below).

![Example of Annotation Stamp]

**Medicaid Provider No. (7 digits)
(Optional Control Number)**

Services have been provided under Louisiana’s Medicaid Program and are payable under R.S. 46:446:1 to:

DHH Bureau of Health Services Financing
P. O. Box 91030
Baton Rouge, LA 70821-9030
ATTN: Third Party Liability Unit

Any additional authorization needed may be obtained from DHH/BHSF’s TPL Unit at (225) 342-9250.

**Trauma Diagnosis Codes**

Providers are reminded to include the appropriate trauma diagnosis code when billing for accident-related injuries or illnesses. Provider cooperation is vital as trauma codes are used to help uncover instances of unreported third party liability.

**Third Party Liability Recovery Unit**

Providers with questions about medical services to Medicaid recipients involved in accidents with liable third parties, and providers wishing to refer information about Medicaid recipients involved in accidents with liable third parties may contact the DHH Third Party Liability, Trauma/Health Recovery Unit at (225) 342-9250 or fax information to (225) 342-1376.

**HMO TPL Codes**

Providers must determine, prior to providing a service, to which HMO the recipient belongs and if the provider himself is approved through that particular HMO. (If the provider is not HMO approved, the recipient should be advised that he/she will be responsible for the bill and be given the option of seeking treatment elsewhere.)

Questions regarding HMOs should be referred to the DHH Third Party Liability/Medicaid Recovery Unit at (225) 342-3855. The fax number is (225) 342-2703.
HMO and Medicaid Coverage

Louisiana Medicaid has adopted the following policy concerning HMO/Medicaid coverage based on CMS (Centers for Medicare and Medicaid Services) clarification.

- **The recipient must use the services of the HMO that they freely choose to join.**
  These claims must be submitted hard copy with a copy of the HMO EOB from the carrier that is on file with the state.

- **If the HMO denies the service because the service is not a covered service offered under the plan, the claim will be handled as a straight Medicaid claim and processed based on Medicaid policy and pricing.**

- **If the HMO denies the claim because the recipient sought medical care outside of the HMO network and without the HMO’s authorization, Medicaid will deny the claim with a message that HMO services must be utilized.**

- **If the recipient uses out of network providers for emergency services and the HMO does not approve the claim, Medicaid will deny the claim with a similar edit.**

If the provider of the service plans to file a claim with Medicaid, copayments or any other payment cannot be accepted from the Medicaid recipient.

Qualified Medicare Beneficiaries (QMBs)

QMBs are covered under the *Medicare Catastrophic Coverage Act of 1988*. This act expands Medicaid coverage and benefits for certain persons aged 65 years and older as well as disabled persons who are eligible for Medicare Hospital Insurance (Part A) benefits and who:

- Have incomes less than 90 percent of the Federal poverty level,

- Have countable resources worth less than twice the level allowed for Supplemental Security Income (SSI) applicants,

- Have the general nonfinancial requirements or conditions of eligibility for Medical Assistance, i.e., application filing, residency, citizenship, and assignments of rights.
Individuals under this program are referred to as Qualified Medicare Beneficiaries (QMBs). The three groups of recipients under this category are: QMB Only, QMB Plus and Non QMB.

<table>
<thead>
<tr>
<th>QMBs</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB Only (Formerly Pure QMB)</td>
<td>Identified through the REVS and e-MEVS systems and are eligible only for Medicaid payment of deductibles and coinsurance for all Medicare covered services.</td>
</tr>
<tr>
<td>QMB Plus (Formerly Dual QMB)</td>
<td>Individuals who are eligible for both Medicare and traditional types of Medicaid coverage (SSI, etc). QMB Plus is identified by the REVS and e-MEVS systems and are eligible for Medicaid payment of deductibles and coinsurance for all Medicare covered services as well as for Medicaid covered services.</td>
</tr>
<tr>
<td>Non QMBs</td>
<td>Identified in the TPL segment of REVS and e-MEVS. Non QMBs are eligible for only Medicaid covered services.</td>
</tr>
</tbody>
</table>

In addition, for those persons who are eligible for Part A premium, but must pay for their own premiums, the State will now pay for their Part A premium, if they qualify as a QMB. The State will continue to also "buy-in" for Part B (Medical Insurance) benefits under Medicare for this segment of the population.

**Medicare Crossover Claims**

If problems occur with Medicare claims crossing over electronically, please follow the steps listed below:

- If your Medicare claims are not crossing electronically, please call Unisys Provider Relations at (800) 473-2783 or (225) 924-5040. Be very specific with your inquiry. You should indicate whether all of your claims are not crossing over or only claims for certain recipients. Were the claims crossing over previously and suddenly stopped crossing, or is this an ongoing problem? The more information you can give, the better. The Unisys representative will check certain pieces of information against the provider and/or recipient files to determine if an identifiable file error exists. If a file update is required, the Unisys representative will route this information to the Unisys Provider Enrollment or Third Party Liability Unit to correct the Medicaid file. If a problem cannot be identified, you may be referred to the Third Party Liability Unit for further assistance.

- If you are not certain that you have supplied your Medicare provider number(s) to Unisys Provider Enrollment, please write to this unit to have your number(s) loaded correctly on your Medicaid provider file. Many Medicare providers have a primary provider number and one or more secondary provider numbers linked to this primary number. **Claims will cross electronically ONLY if the Medicare provider number(s) is cross-referenced to the Medicaid provider number.** If any or all of your Medicare provider numbers have not been reported to Unisys Provider Enrollment, please do so immediately.

Medicare adjusted claims **DO NOT** crossover. Providers must submit Medicaid adjustments with the Medicare adjustment EOB attached for corrected payment.
Providers are responsible for verifying on the Medicaid Remittance Advice that all Medicare payments have successfully crossed over. If Medicare makes a payment which is not adjudicated by Medicaid within 30 days of the Medicare EOB date, you should submit your crossover claim hard copy with the Medicare EOB attached. All timely filing requirements must be met even if a claim fails to cross over.

**Also, if you are submitting a claim which Medicare has denied, the EOMB attached must include a complete description of the denial code.**

**Medicare Advantage**

All recipients participating in Medicare Advantage must have both Medicare Part A and Medicare Part B.

The Managed Care Plans currently participating in this program are: Humana Gold Plus, Tenet (Tenet 65 and Tenet PPO) and Sterling (Sterling Option One). These plans have been added to the Medicaid Third Party Resource File for the appropriate recipients with six-digit alpha-numeric carrier codes that begin with the letter “H”.

When possible these plans will cross the Medicare claims directly to Medicaid electronically, just as Medicare carriers electronically transmit Medicare crossover claims. These claims will be processed just as claims crossing directly from a Medicare carrier. If claims do not cross electronically from the carriers within 30-45 days from the Medicare plan EOB date, providers must submit paper claims with the Medicare plan EOB attached to each claim.

**NOTE:** Sterling Option One will not electronically transmit claims to Unisys. Providers in the Sterling Option One network should submit claims hard copy to Unisys.

When it is necessary for providers to submit claims hard copy, the appropriate carrier code must be entered on each hard copy claim form in order for the claim to process correctly. The carrier codes follow:

- Humana Gold Plus • H19510
- Tenet PPO • H19010
- Tenet 65 • H19610
- Tenet PPO • H19010
- Sterling Option One • H50060

Hard copy claims submitted without the plan EOB and without a six-digit carrier code beginning with an “H” will deny 275 (Medicare eligible). Both the EOB and the correct carrier code are required for these claims to process properly.

Providers may not submit these claims electronically. Electronic submissions directly from providers will deny 966 (submit hard copy claim).

When it is necessary to submit these claims hardcopy, a Medicare Advantage institutional or professional cover sheet **MUST** be completed for each claim and attached to the top of the claim and EOB. Once finalized, these cover sheets will be available on the Louisiana Medicaid website for easy download. Claims received without this cover sheet will be rejected.
The calculated reimbursement methodology currently used for pricing Medicare claims will be used to price these claims. Thus, claims may price and pay a zero payment if the plan payment exceeds the Medicaid allowable for the service.

Timely filing guidelines applicable for Medicare crossover claims apply for Medicare Advantage claims.

**CLAIMS PROCESSING REMINDERS**

Unisys Louisiana Medicaid images and stores all Louisiana Medicaid paper claims on-line. This process allows the Unisys Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

Prepare paper claim forms according to the following instructions to ensure appropriate and timely processing:

- Submit an original claim form whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.

- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.

- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. DO NOT use a highlighter to draw attention to specific information.

- Paper claims must be legible and in good condition for scanning into our document imaging system.

- Sign and date your claim form. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.

- Continuous feed forms must be torn apart before submission.

- Use high quality printer ribbons or cartridges - black ink only.

- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.

- Do not use italic, bold, or underline features.

- Do not submit two-sided documents.

- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).
• The recipient’s 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic card is NOT acceptable.
Rejected Claims

Unisys currently returns illegible claims. These claims have not been processed and are returned along with a cover letter stating what is incorrect.

The criteria for legible claims are:

1. all claim forms are clear and in good condition,
2. all information is readable to the normal eye,
3. all information is centered in the appropriate block, and
4. all essential information is complete.

Attachments

All claim attachments should be standard 8½ x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper. If it is necessary to attach documentation to a claim, the documents must be placed directly behind each claim that requires this documentation. Therefore, it may be necessary to make multiple copies of the documents if they must be placed with multiple claims.

Changes to Claim Forms

Louisiana Medicaid policy prohibits Unisys staff from changing any information on a provider’s claim form. Make all changes to the claims prior to submission. Please do not ask Unisys staff to make any changes on your behalf.

Data Entry

Data entry clerks do not interpret information on claim forms-data is keyed as it appears on the claim form. If the data is incorrect, or IS NOT IN THE CORRECT LOCATION, the claim will not process correctly.
TIMELY FILING GUIDELINES

In order to be reimbursed for services rendered, all providers must comply with the following filing limits set by Medicaid of Louisiana:

- Straight Medicaid claims must be filed within 12 months of the date of service.

- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations.

- Claims which fail to cross over via tape and have to be filed hard copy MUST be adjudicated within six months from the date on the Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.

- Claims with third-party payment must be filed to Medicaid within 12 months of the date of service.

Dates of Service Past Initial Filing Limit

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

- A Remittance Advice indicating that the claim was processed earlier (within the specified time frame)

  OR

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

To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible. Proof of timely filing documentation must reference the individual recipient and date of service.

At this time Louisiana Medicaid does not accept printouts of Medicaid electronic remittance advice screens as proof of timely filing. Documentation must reference the individual recipient and date of service. Postal "certified" receipts and receipts from other delivery carriers are not acceptable proof of timely filing.
Submitting Claims for Two-Year Override Consideration

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

1) The recipient was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted.

2) The recipient won a Medicare or SSI appeal in which he or she was granted retroactive Medicaid Benefits.

3) The failure of the claim to pay was the fault of the Louisiana Medicaid Program rather than the provider’s each time the claim was adjudicated.

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

Unisys Provider Relations Correspondence Unit
P.O. Box 91024
Baton Rouge, LA 70821

The provider must submit the claim with a cover letter describing the criteria that has been met for consideration along with all supporting documentation. Supporting documentation includes but is not limited to proof of timely filing and evidence of the criteria met for consideration.

Claims submitted without a cover letter, proof of timely filing, and/or supporting documentation will be returned to the provider without consideration. Any request submitted to DHH staff will be routed to Unisys Provider Relations.
THE REMITTANCE ADVICE

The purpose of this section is to familiarize the provider with the design and content of the Remittance Advice (RA). This document plays an important communication role between the provider, the BHSF, and Unisys. Aside from providing a record of transactions, the Remittance Advice will assist providers in resolving and correcting possible errors and reconciling paid claims.

The Purpose of the Remittance Advice

The RA is the control document which informs the provider of the current status of submitted claims. It is sent out each week when the provider has adjudicated claims.

On the line immediately below each claim a code will be printed representing denial reasons, pended claim reasons, and payment reduction reasons. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. The only type of claim status which will not have a code is one which is paid as billed.

If the provider uses a medical record number (which may consist of up to 16 alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

At the end of each claim line is the 13-digit internal control number (ICN) assigned to that claim line. Each separate claim line is assigned a unique ICN for tracking and audit purposes. Following is a breakdown of the 13 digits of the ICN and what they represent:

| Position 1 | Last Digit of Current Year |
| Position 2-4 | Julian Date - ordinal day of 365-day year |
| Position 5 | Media Code - |
| | 0 = paper claim with no attachments |
| | 1 = electronic claim |
| | 2 = systems generated |
| | 3 = adjustment |
| | 4 = void |
| | 5 = paper claim with attachments |
| Positions 6-8 | Batch Number - for Unisys internal purposes |
| Positions 9-11 | Sequence Number - for Unisys internal purposes |
| Positions 12-13 | Number Of Line within Claim - |
| | • 00 = first line |
| | 01 = second line |
| | 02 = third line, etc. |

Unisys Provider Relations responds to inquiries concerning particular claims when the provider has reconciled the RA and determined that the claim has denied, pended, paid or been rejected prior to entry into the system. It is not possible for Unisys Provider Relations to take the place of the provider’s weekly RA by checking the status of numbers of claims on which providers, billers or collection agencies are checking.

In situations where providers choose to contract with outside billing or collection agencies to bill claims and reconcile accounts, it is the provider’s responsibility to provide the contracted
agency with copies of the RAs or other billing related information in order to bill the claims and reconcile the accounts.

**Electronic Remittance Advices (e-RAs)**

The EDI Department offers Electronic Remittance Advices (e-RAs). This allows providers to have their Remittance Advices transmitted from Unisys and posted to accounts electronically. There is a minimal fee for this service. Further information may be obtained by calling the Unisys EDI Department.

**Remittance Advice Breakdown**

Claims presented on the RA can appear under one of several headings: Approved Original Claims (paid claims); Denied Claims; Claims in Process; Adjustment Claims; Previously Paid Claims; and Voided Claims. When reviewing the RA, please look carefully at the heading under which the claims appear. This will assist with your reconciliation process.

Always remember that claims appear under the heading "Claims in Process" to let the provider know that the claim has been received by the Fiscal Intermediary, and should not be worked until they appear as either "Approved Original Claims" or "Denied Claims." "Claims in Process" are claims which are pending in the system for review. Once that review occurs, the claims will move to a paid or denied status on the RA. If claims pend for review, they will appear on an initial RA as "Claims in Process" as they enter the processing system. After that point, they will appear only once a month under that heading until they are reviewed.

**Remittance Summary**

"Approved Original Claims" may appear with zero (0 dollar) payments. These claims are still considered paid claims. Claims pay a zero amount legitimately, based on other insurance payments, maximum allowable payments, etc.

When providers choose to return checks to adjust or void a claim rather than completing an adjustment/void form, the checks will initially appear as a financial transaction on the front of the RA to acknowledge receipt of that check. The provider's check number and amount will be indicated, as well as an internal control number (ICN) which is assigned to the check. If claims associated with the check are processed immediately, they will appear on the same RA as the check financial transaction, under the heading of "adjustment or void" as appropriate, as well as the corresponding "previously paid claim." The amount of the check posted to the RA should offset the amount recouped from the RA as a result of the adjustment/void, and other payments should not be affected. However, if the adjustments/voids cannot be processed on the same RA, the check will be posted and appear on the financial page of the RA under "Suspense Balance Brought Forward" where it will be carried forward on forthcoming RAs until all adjustments/voids are processed. As the adjustments/voids are processed, they will appear on the RA and the amount of money being recouped will be deducted from the "Suspense Balance Brought Forward" until all claims payments returned are processed.

*It is the provider's responsibility to track these refund checks and corresponding claims until they are all processed.*

When providers choose to submit adjustment/void forms for refunds, the following is an important point to understand. As the claims are adjusted/voided on the RA, the monies recouped will appear on the RA appropriately as "Adjustment Claims" or "Voided Claims." A
corresponding "Previously Paid Claim" will also be indicated. The system calculates the difference between what has already been paid ("Previously Paid Claim") and the additional amount being paid or the amount being recouped through the adjustment/void. If additional money is being paid, it will be added to your check and the payment should be posted to the appropriate recipient's account. If money is being recouped, it will be deducted from your check amount. This process means that when recoupments appear on the RA, the paid claims must be posted as payments to the appropriate recipient accounts through the bookkeeping process and the recoupments must be deducted from the accounts of the recipients for which adjustment or voids appear. If the total voided exceeds the total original payment, a negative balance occurs, and money will be recouped out of future checks. This also includes state recoupments, SURS recoupments and cost settlements.

Below are the summary headings which may appear on the financial summary page and an explanation of each.

<table>
<thead>
<tr>
<th>Summary Heading</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspense Balance Brought Forward</td>
<td>A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed.</td>
</tr>
<tr>
<td>Approved Original Claim</td>
<td>Total of all approved (paid) claims appearing on this RA.</td>
</tr>
<tr>
<td>Adjustment Claims</td>
<td>Total of all claims being adjusted on this RA.</td>
</tr>
<tr>
<td>Previously Paid Claim</td>
<td>Total of all previously paid claims which correspond to an adjustment or void appearing on this RA.</td>
</tr>
<tr>
<td>Void Claims</td>
<td>Total of all claims being voided on this RA.</td>
</tr>
<tr>
<td>Net Current Claims Transactions</td>
<td>Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process).</td>
</tr>
<tr>
<td>Net Current Financial Transactions</td>
<td>Total number of all financial transactions appearing on the RA.</td>
</tr>
<tr>
<td>Prior Negative Balance</td>
<td>If a negative balance has been created through adjustments or voids processed, the negative balance is carried forward to the next RA. (This also includes state recoupments, SURS recoupments and cost settlements.)</td>
</tr>
<tr>
<td>Withheld for Future Recoveries</td>
<td>Difference between provider checks posted on the RA and the deduction from those checks when associated claims are processed on the same RA as the posting of the check. (This is added to Suspense Balance Brought Forward on the next RA.)</td>
</tr>
<tr>
<td>Total Payments This RA</td>
<td>Total of current check.</td>
</tr>
<tr>
<td>Total Copayment Deducted This RA</td>
<td>Total pharmacy co-payments deducted for this RA.</td>
</tr>
<tr>
<td>Suspense Balance Carried Forward</td>
<td>Total of Suspense Balance Brought Forward and withheld for future recoveries.</td>
</tr>
<tr>
<td>Y-T-D Amount Paid</td>
<td>Total amount paid for the calendar year.</td>
</tr>
<tr>
<td>Denied Claims</td>
<td>Total of all denied claims appearing on this RA.</td>
</tr>
<tr>
<td>Claims in Process</td>
<td>Total of all pending claims appearing on this RA.</td>
</tr>
</tbody>
</table>
Claims in Process

When the ICN of a claim appears on a remittance advice (RA), with a message of “Claim In Process,” the claim is in the process of being reviewed. The claim has not been approved for payment yet, and the claim has not had payment denied. During the next week, the claim will be reviewed and will appear as a “paid” or “denied” claim on the next RA unless additional review is required. The “Claim In Process” listing on the RA appears immediately following the “Denied Claims” listing and is often confused with “Denied Claims.”

Pended claims are those claims held for in-house review by Unisys. After the review is completed, the claim will be denied if a correction by the provider is required. The claim will be paid if the correction can be made by Unisys during the review.

Claims can pend for many reasons. The following are a few examples:

- Errors were made in entering data from the claim into the processing system.
- Errors were made in submitting the claim. These errors can be corrected only by the provider who submitted the claim.
- The claim must receive Medical Review.
- Critical information is missing or incomplete.

On the following pages are examples of remittance advice pages and a TPL denied claims notification list (this is normally printed at the end of the remittance advice).

Denied Claim Turnarounds (DTAs)

Denied claim turnarounds, also printed at the end of the remittance advice, are produced when certain errors are encountered in the processing of a claim. (Not all denial error codes produce denied claim turnarounds.) The denied claim turnaround document is printed to reflect the information submitted on the original claim. It is then mailed to the provider to allow him to change the incorrect items and sign and return the document to Unisys. Once the document is received at Unisys, the correction is entered into the claims processing system and adjudication resumes for the original claim. Note, however, that the turnaround document must be returned to Unisys with appropriate corrections as soon as possible, as they are only valid for 30 days from the date of processing of the original claim.

TPL Denied Claims Notification List

The TPL denied claims notification list is generated when claims for recipients with other insurance coverage are filed to Medicaid with no EOB from the other insurance and no indication of a TPL carrier code on the claim form. This list notifies the provider that third party coverage exists and gives the name and carrier code of the other insurance. Once the private insurance has been billed, the claim may be corrected and resubmitted to Unisys with the third party EOB.
## Professional Remittance Advice

**Louisiana Medical Assistance Program**

**Fiscal Agent - EMISYS**

**P.O. Box 3396**

<table>
<thead>
<tr>
<th>Recipient Number</th>
<th>Recipient Name</th>
<th>Date of Service</th>
<th>Service Code</th>
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<th>Amount Allowed</th>
<th>Amount Paid</th>
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**NOTE:**
- All services are Billing Code 015304.
- The amounts are in dollars.
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6 CLAIMS: 594400.00 00 00 00
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**TOTALS:**

| 31 CLAIMS  | 331905.00  | 331905.00  |
### Remittance Summary

**Louisiana Medicaid Assistance Program**

**Fiscal Agent - UNISYS**

**PO Box 3396**

**Baton Rouge, Louisiana 70821**

<table>
<thead>
<tr>
<th>Recipient Number</th>
<th>Recipient Name</th>
<th>Dates of Service</th>
<th>Units</th>
<th>Procedure-Add-On</th>
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<th>Amount Paid</th>
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<td></td>
<td></td>
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<td>To</td>
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#### Current Transactions

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- Denied Claims: 372 | 102,781.20
- Claims in Process: 45 | 31,177.00

Date: 08/09/2005
This section is designed to assist providers in resolving some of the more general claim denials appearing on the Louisiana Medicaid Remittance Advises. When claims deny and appear on a remittance advice, a three-digit error code is given with the claim information. At the end of the remittance advice, all error codes received are listed with a narrative description that gives an explanation of the error code. The purpose of this explanation is to aid providers in correcting errors and resubmitting their claim(s) for processing.

Some of the more common error codes are listed in this section, along with an explanation of the denials and suggestions on how to correct them. These error codes are grouped by category, and apply to most Medicaid programs.

**General Claim Form Completion Error Codes**

**ERROR CODE 003 – RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS**

**Cause:** The recipient ID number on the claim form was less than 13 digits in length or included letters or other non-numeric characters.

**Resolution:** Verify the correct 13-digit recipient ID number using REVS or e-MEVS and enter this number where required on the claim form.

**ERROR CODE 009 - SERVICE THRU DATE GREATER THAN DATE OF ENTRY**

**Cause:** The claim was received by Unisys prior to one or more dates of service billed.

**Resolution:** Correct the date span on the claim and rebill OR wait until all dates of service on the claim have passed and rebill.

**ERROR CODE 028 - INVALID OR MISSING PROCEDURE CODE**

**Cause:**
1. No procedure code was entered on the claim form, OR
2. The procedure code entered on the claim form is invalid (e.g., usually because it has fewer than five characters).

**Resolution:** Enter the correct procedure code on the claim form and resubmit.

**Recipient Eligibility Error Codes**

**ERROR CODE 215 - RECIPIENT NOT ON FILE**

**Cause:** The recipient ID number on the claim form is not in the State eligibility files.

**Resolution:** Verify the correct 13-digit recipient ID number using REVS or e-MEVS and enter this number where required on the claim form. If there is an e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.
### ERROR CODE 216 - RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE

**Cause:** The recipient ID number on the claim is in the State eligibility files, but the recipient’s eligibility does not cover the date of service filed on the claim.

**Resolution:** Verify the recipient’s eligibility using REVs or e-MEVS for all dates of service on the claim. If there is an e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter explaining the problem.

**Note:** Prior authorization does not override eligibility issues. Only dates of service during a recipient’s eligibility will be reimbursed.

### ERROR CODE 217 – NAME AND OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD

**Causes:**
1. The name on the claim form does not match the recipient ID number as recorded in the Unisys eligibility files. (This is sometimes caused when a recipient marries and changes her surname, or if several family members have similar ID numbers.) OR
2. The first and last names have been entered in reverse order on the claim form.

**Resolution:** Verify the correct spelling of the name via REVs or e-MEVS using the 13-digit recipient ID number. Ensure that the first and last names are entered in the correct order on the claim. Make corrections if necessary and resubmit.

### ERROR CODE 222 – RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE (S)

**Cause:** The recipient ID number on the claim is in the State eligibility files, but the recipient’s eligibility does not cover all dates of service filed on the claim.

**Resolution:**
1. Verify the recipient’s eligibility using REVs or e-MEVS for all dates of service on the claim. If there is an e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.
2. If there is no verification of eligibility for the date of service, resubmit the claim for covered dates of service only.

### ERROR CODE 223 – RECYCLED RECIPIENT NOT ON FILE

**Cause:** The recipient ID number on the claim form is not in the State eligibility files. The claim has been “recycled” a number of times looking for the ID number in the eligibility files.

**Resolution:** Verify the correct 13-digit recipient ID number using REVs or e-MEVS and enter this number where required on the claim form. If there is an e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

### ERROR CODE 364 – RECIPIENT INELIGIBLE/DECEASED

**Cause:** The State eligibility files indicate the recipient was deceased prior to the billed date of service.

**Resolution:** Verify the recipient’s date of death with Unisys Provider Relations. If you have documentation proving the date of death on file is incorrect, submit the claim and your documentation, along with a cover letter explaining the problem, to Unisys Provider Relations Correspondence Unit.

### Timely Filing Error Codes
### ERROR CODE 272 – CLAIM EXCEEDS 1 YEAR FILING LIMIT

**Cause:** The date of service on the claim form is more than one year prior to the date the claim was received by Unisys. All such claims must be accompanied by proof of timely filing in order to be paid.

**Resolution:** Resubmit the claim with proof of timely filing attached. Proof of timely filing is usually a copy of an RA page that shows the claim was processed by Unisys within one year from the date of service. Such claims may be mailed with a cover letter requesting an override for proof of timely filing to the Unisys Correspondence Unit.

**Note:** When refiling claims over one year old, it is not enough for the provider to know or to believe that they have filed the claim to Unisys within one year from the date of service. The provider must attach proof of timely filing to the claim, or the claim will deny.

A history can be ordered to assist in determining if payment has been made or if a claim has been filed timely. The Field Analyst for your territory may also assist in placing such an order.

### ERROR CODE 030 – SERVICE “THRU” DATE MORE THAN TWO YEARS OLD

**Cause:** The date of service on the claim form is more than two years prior to the date the claim was received by Unisys.

**Resolution:** Timely filing guidelines dictate that, in general, claims with dates of service over two years old are not payable. Unisys staff does not have the authority to override such claims. In the case of retroactive eligibility, DHH must review the claim and approve any overrides for timely filing.

### ERROR CODE 371 – ATTACHMENT REQUIRES REVIEW/FILING DEADLINE

**Cause:** The date of service on the claim form is more than one year prior to the date the claim was received by Unisys. The claim has pended in the Unisys computer system so that it can be checked for attached proof of timely filing.

**Resolution:** If the claim was submitted with proof of timely filing attached, no further action is required. If no proof of timely filing was attached to the claim form, attach proof of timely filing to the claim and mail it with a cover letter requesting an override for proof of timely filing to the Unisys Correspondence Unit.

**Note:** Code 371 is not a true “error” code, as the claim has not been denied. The message is to notify the provider why the claim is in process.

### Duplicate Claim Error Code

### VARIOUS ERROR CODES SPECIFIC TO EACH PARTICULAR MEDICAID PROGRAM

**Cause:** The claim is a duplicate of one that has already been paid by Unisys.

**Resolution:** On the remittance advice, the denial refers the provider to the conflicting control number and adjudication date of the previously paid claim. Refer to the remittance advice date indicated to find the claim that has already been paid. Do not resubmit the claim if it has already been paid.

### Third Party Liability Error Codes

### ERROR CODE 273 - 3RD PARTY CARRIER CODE MISSING - REFER TO CARRIER CODE LIST
**Cause:** No carrier code was indicated on the claim for a recipient with other insurance coverage.

**Resolution:** Verify the recipient’s third party liability carrier code using REVS or e-MEVS. Resubmit the claim with the six-digit carrier code in the appropriate block and attach the EOB from the third party liability.

If you have verification that the recipient was not covered by other insurance for the date(s) of service, send a copy of the claim and the verification to the Unisys Correspondence Unit with a cover letter stating the problem.

---

**ERROR CODE 290 - NO EOB ATTACHED FOR RECIPIENT WITH OTHER RESOURCE INDICATED**

**Cause:** 1. No EOB from the other insurance was attached to the claim for a recipient with other insurance coverage, OR

2. There is a carrier code indicated on the claim form, but no EOB from the carrier is attached to the claim.

**Resolution:** Resubmit the claim with a copy of the EOB from the third party carrier.

If the carrier code was indicated on the claim form in error, remove it and resubmit the claim.

If you have verification that the recipient was not covered by other insurance for the date(s) of service, send a copy of the claim and the verification to the Unisys Correspondence Unit with a cover letter stating the problem.

---

**ERROR CODE 292 - NO TPL AMOUNT INDICATED ON CLAIM/REQUIRES REVIEW**

**Cause:** A carrier code was indicated on the claim form, but no TPL amount was entered on the claim.

**Resolution:** Indicate the amount paid by the third party carrier in the appropriate block on the claim form and resubmit the claim (including the third party carrier EOB).

If the carrier code was indicated on the claim form in error, remove it and resubmit the claim.

---

**ERROR CODE 032 - EOB(S) ATTACHED/CARRIER CODE DOES NOT MATCH**

**Cause:** The EOB attached to the claim does not appear to be from the third party carrier indicated on the State resource file for the recipient.

**Resolution:** Verify the recipient’s third party liability carrier code using REVS or e-MEVS. Correct the carrier code if necessary and resubmit the claim (including the third party carrier EOB).

If the carrier code on the claim is correct, ensure that the EOB submitted with the claim is from the correct third party carrier. If not, attach the correct EOB if necessary and resubmit the claim. If the EOB submitted with the claim is from the correct third party carrier, submit the claim and the EOB to Unisys Provider Relations Correspondence Unit along with a cover letter explaining the problem.

---

**ERROR CODE 918 – MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE**

**Cause:** The amount paid by third party liability (as indicated on the claim form) has been subtracted from the amount Medicaid would usually pay.

**Resolution:** Ensure that the amount shown in the “deductions” column of the remittance advice is the same as the other insurance payment on the claim form. If the claim form was completed incorrectly, indicating an incorrect amount paid by other insurance, an adjustment
must be filed to obtain correct payment.

**Note:** The message is to notify the provider why the payment is not the usual reimbursement amount.

### Medicare/Medicaid Error Codes

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<th>ERROR CODE 275 – RECIPIENT IS MEDICARE ELIGIBLE</th>
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<tbody>
<tr>
<td><strong>Cause:</strong> The state files indicate that the recipient is eligible for Medicare. Since Medicaid is always the payer of last resort, it will be necessary to bill Medicare first and then submit the claim to Medicaid along with the EOMB.</td>
</tr>
<tr>
<td><strong>Resolution:</strong> Submit the claim to Medicare. Once the Medicare EOB is received, attach it to the claim and send to Medicaid for adjudication.</td>
</tr>
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<table>
<thead>
<tr>
<th>ERROR CODE 330 - QMB NOT MEDICAID ELIGIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cause:</strong> The claim was filed for a recipient who is a QMB ONLY, meaning that Medicaid will only pay the co-insurance or deductible after Medicare has made payment. If the service is not a Medicare covered service or if Medicare did not make a payment on the claim (for whatever reason), Medicaid will not pay either. This type of recipient is not truly a Medicaid recipient. The recipient only has Medicaid coverage if Medicare has paid the claim and only co-insurance/deductible is owed.</td>
</tr>
<tr>
<td><strong>Resolution:</strong> In general, recipients may be billed for services considered non-covered by Medicaid.</td>
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<table>
<thead>
<tr>
<th>ERROR CODE 922 – MEDICARE EOMB INVALID/OR MISSING</th>
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</table>
| **Cause:** 1. The claim was received by Unisys with no Explanation of Medicare Benefits (EOMB) attached; OR  
2. The claim was received by Unisys with an EOMB which was invalid (missing date of service, recipient name, etc.). |
| **Resolution:** If no Medicare EOB was filed with the claim, resubmit the claim with the corresponding EOMB. If an invalid EOMB was attached to the claim, resubmit the claim with a corrected EOMB. |

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<tr>
<th>ERROR CODE 942 – DENIED BY MEDICARE, NOT COVERED BY MEDICAID</th>
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<tr>
<td><strong>Cause:</strong> The billed service was denied by Medicare and so is not payable by Medicaid.</td>
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<tr>
<td><strong>Resolution:</strong> Unless the recipient is a QMB plus, Medicaid is not required to make payment on services when Medicare denies payment. If the Medicare denial states the service was “not medically necessary,” the service is not payable by Medicaid, even for QMB PLUS recipients. If the service is for a QMB PLUS and the denial is for other than medical necessity, the claim and EOMB should be submitted to the Correspondence Unit with a cover letter explaining the problem.</td>
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<table>
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<th>ERROR CODE 996 – DEDUCTIBLE &amp; OR CO-INSURANCE REDUCED TO MAX ALLOWABLE</th>
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<td><strong>Cause:</strong> The Medicaid payment was reduced because of a Medicare payment.</td>
</tr>
<tr>
<td><strong>Resolution:</strong> This claim has been approved and is considered paid in full. The provider cannot bill the patient for any remaining balance. In determining the Medicaid payment, the computer system will calculate the amount Medicaid would pay if there were no Medicare. If Medicare has paid more than that amount, the claim is considered approved at $0.00. Otherwise, Medicaid will pay the difference between the Medicaid allowable and what Medicare paid, up to...</td>
</tr>
</tbody>
</table>
the coinsurance and deductible amount.

Adjustment/Void Error Codes

ERROR CODE 798 – HISTORY RECORD ALREADY ADJUSTED

**Cause:** An adjustment/void form has been submitted for an internal control number (ICN) that has already been adjusted or voided. Therefore, the ICN cannot be adjusted or voided again.

**Resolution:** Review previous RAs to determine all activity for the particular claim. Only the most recent paid claim (either original or adjustment) can be adjusted or voided. If an adjustment or void is still required, resubmit the adjustment/void form for the most recent paid ICN.

**Note:** Only paid claims can be adjusted or voided. It is impossible to process an adjustment or void of a denied claim.

ERROR CODE 799 – NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT

**Cause:** An adjustment/void form has been submitted for an internal control number (ICN) that is not in the Unisys claim history.

**Resolution:** Review previous RAs to determine the correct ICN to be adjusted. If the ICN submitted on the adjustment/void form is incorrect, submit a corrected adjustment or void. If the ICN on the claim is correct, send a copy of the adjustment/void form and all related documentation to Unisys Correspondence Unit with a cover letter explaining the problem.

**Note:** Adjustments and voids may only be processed if the adjudication date (RA date) of the last paid claim is under two years old.

Miscellaneous Error Codes

ERROR CODE 299 - PROCEDURE/DRUG NOT COVERED BY MEDICAID

**Cause:** The procedure code entered on the claim form is not a payable code.

**Resolution:** Review the claim that was filed, ensuring that the correct procedure code was entered on the claim form, including any modifiers that are appropriate. Make any necessary corrections and resubmit the claim.

ERROR CODE 232 - PROCEDURE/TYPe OF SERVICE NOT COVERED BY PROGRAM

**Cause:** Usually this is caused by an error in entering the procedure code on the claim form (e.g., inadvertently reversing two digits of the procedure code).

**Resolution:** Verify that the procedure code entered on the original claim form is correct. If not, correct the procedure code and resubmit the claim. In addition, verify that the procedure code is one covered for your provider type.

Please be reminded that you cannot always bill the recipient for a service on which you have received a 299 or 232 denial.

Some CPT codes are in a non-payable status on our files because their services as described in CPT are included in other codes, which are covered.

When the denied service is not payable on the file because it is a component of a payable service, it cannot be billed to the recipient. For example, Code 92015
(determination of refractive state) cannot be billed to the recipient because its fee is included in the fee for the office visit. Therefore, Code 92015 cannot be billed to the recipient if denied with a 299 or 232.

Provider Eligibility Error Codes

<table>
<thead>
<tr>
<th>ERROR CODE 201 – PROVIDER NOT ELIGIBLE ON DATES OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cause:</strong> The billing provider number entered on the claim form is on the State provider files, but the provider's enrollment was not effective on the claim date(s) of service.</td>
</tr>
<tr>
<td><strong>Resolution:</strong> Review the claim that was filed, ensuring that the correct Medicaid provider number was entered on the claim form. Make any necessary corrections and resubmit the claim.</td>
</tr>
<tr>
<td><strong>Note:</strong> Providers must be enrolled as Medicaid providers in order to be reimbursed by Medicaid.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ERROR CODE 206 – BILLING PROVIDER NOT ON FILE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cause:</strong> The billing provider number entered on the claim form is not on the State provider files.</td>
</tr>
<tr>
<td><strong>Resolution:</strong> Review the claim that was filed, ensuring that the correct Medicaid provider number was entered on the claim form. Make any necessary corrections and resubmit the claim.</td>
</tr>
<tr>
<td><strong>Note:</strong> Medicaid provider numbers are seven digits in length and begin with “1.” All seven digits of the Medicaid provider number must be correct in order for the claim to be paid.</td>
</tr>
</tbody>
</table>
The Louisiana Department of Health and Hospitals and Unisys maintain a website to make information more accessible to Medicaid providers. At this online location, www.lamedicaid.com, providers can access information ranging from how to enroll as a Medicaid provider to directions for filling out a claim form.

Below are some important links for Hurricane Katrina information found on the website:

- Emergency Billing Policy and Procedures for Hurricane Katrina Evacuees
- Emergency Provider Enrollment Packets
- Emergency Telephone Numbers
- Fee Schedules
- Forms/Files
- Hurricane Katrina Emergency Notices Provider Support
- Pharmacy
- Provider Update / Remittance Advice Index
- Provider Web Account Registration Instructions

Along with the website, the Unisys Provider Relations Department is available to assist providers.

**Unisys Provider Relations Telephone Inquiry Unit**

(800) 473-2783 or (225) 924-5040

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification.

**Unisys Provider Relations Correspondence Group**

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving claim denials and problems. Providers who wish to submit problem claims for research and want to receive a written response, **must submit a cover letter** explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, etc.) to the Correspondence Unit at the following address:

**Unisys Provider Relations Correspondence Unit**

P. O. Box 91024
Baton Rouge, LA 70821
## IMPORTANT UNISYS ADDRESSES

Please be aware that **separate post office boxes** are used for the various Medicaid programs. If you are submitting an original “clean” hard copy claim or adjustments/voids, please utilize the following post office boxes and zip codes.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>P.O. Box</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>91019</td>
<td>70821</td>
</tr>
<tr>
<td><strong>CMS-1500 Claims</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPSDT Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>91020</td>
<td>70821</td>
</tr>
<tr>
<td>Professional Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long Term Care</td>
<td>91021</td>
<td>70821</td>
</tr>
<tr>
<td>Dental, Home Health, Rehabilitation, Transportation (Ambulance and Non-ambulance)</td>
<td>91022</td>
<td>70821</td>
</tr>
<tr>
<td>ALL Medicare Crossovers and All Medicare Adjustments and Voids</td>
<td>91023</td>
<td>70821</td>
</tr>
<tr>
<td>KIDMED</td>
<td>14849</td>
<td>70898</td>
</tr>
</tbody>
</table>

**Unisys also has separate post office boxes for the various departments. They are as follows:**

<table>
<thead>
<tr>
<th>Department</th>
<th>P.O. Box</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMC, Unisys business &amp; Miscellaneous Correspondence</td>
<td>91025</td>
<td>70898</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>14919</td>
<td>70898</td>
</tr>
<tr>
<td>Provider Enrollment</td>
<td>80159</td>
<td>70898</td>
</tr>
</tbody>
</table>
In accordance with Section 1902(aa)/the provisions of the Benefits Improvement Act (BIPA) of 2000, effective January 1, 2001, payments to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Medicaid services will be made under a Prospective Payment System (PPS) and paid on a per visit basis.

The PPS per visit rate is provider specific. To establish the interim baseline rate for 2001, each RHC/FQHC’s 1999 and 2000 allowable costs as taken from the RHC/FQHC’s filed 1999 and 2000 Medicaid cost reports were totaled and divided by the total number of Medicaid patient visits for 1999 and 2000. The baseline calculation includes all Medicaid coverable services provided by the RHC/FQHC regardless of existing methods of reimbursement for said services. This includes, but is not to be limited to ambulatory, transportation, laboratory (where applicable), KidMed and dental services previously reimbursed on a fee-for-service or other non-encounter basis. **The per visit rate is all-inclusive. RHC/FQHC’s are not eligible to bill separately for any Medicaid covered services.** The final PPS rate will be based on audited final cost reports for 1999 and 2000.

For an RHC/FQHC which enrolls and receives approval to operate on or after January 1, 2001, the facility’s initial PPS per visit rate will be determined first through comparison to other RHCs/FQHCs in the same town/city/parish. Scope of services will be considered in determining which proximate provider most closely approximates the new provider.

**NOTE:** Effective October 21, 2004, newly enrolled FQHCs will be paid the statewide average rate.

**Reimbursement Adjustments**

The PPS per visit rate for each facility will be increased annually by percentage increase in the published Medicare Economic Index (MEI) for primary care services. The MEI will be applied on July 1 of each year.

**NOTE:** Please direct all cost reporting concerns to Carolyn Jones at (225) 342-2495.

**REMINDER:** RHCs/FQHCs must submit an annual cost report. The cost report must be sent to Trispan at the following address:

Trispan Health Services  
5420 Corporate Boulevard, Suite 201  
Baton Rouge, LA  70808  
Phone: 225/925-8115
RHC/FQHC PROGRAM OVERVIEW

There are 3 components that may be provided under the RHC/FQHC Program: Encounter Visits, KIDMED Screening Services, and EPSDT Dental, Adult Denture Services and Expanded Dental Services for Pregnant Women (EDSPW)

RHC/FQHC Encounter Visits

Encounter visits must be billed using procedure code T1015. In addition to the encounter code it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code, description, and total charges for each service rendered. If the encounter detail is not included the claim will deny.

For obstetrical (OB) services the RHC/FQHC providers must bill the encounter code T1015 with modifier TH and all services performed on that DOS.

RHC/FQHC KIDMED Screening Services

RHC/FQHC KIDMED screening services must be billed on the revised KM3 form using encounter code T1015 along with modifier EP. It will be necessary for providers 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, providers must enter the appropriate procedure code followed by the modifier TD next to ‘Screening Completed by a Nurse’. If immunizations are given at the time of the screening, then those codes continue to be billed on the CMS1500, along with encounter code T1015 and modifier EP. All claims billed using the T1015 and EP modifier must include supporting detail procedures.

RHC/FQHC EPSDT Dental, Adult Denture Services and Expanded Dental Services for Pregnant Women (EDSPW)

Dental services must be billed on the 2002 or 2002,2004 ADA claim form using the encounter code D0999. It will be necessary for providers to indicate on subsequent lines the specific dental services provided by entering the individual procedure code and description. All claims billed using D0999 must include supporting detail procedures.

NOTE: The dental encounter, D0999, may be billed on the same date of service as the encounter codes T1015(RHC/FQHC), T1015 TH(OB encounter), and/or T1015 EP (KIDMEDscreening).
RHC/FQHC ENCOUNTHER VISIT

RHC/FQHC Medical Encounter

A medical encounter is defined as receipt of services from a licensed practitioner and includes physicians, nurse practitioners and physicians’ assistants.

- Upon presentation at the clinic, a full mental, physical and dental assessment shall be done and any health problems identified must be addressed to the highest degree possible at that encounter.
- Encounter must include an assessment and written plan for each identified problem noted in the history and physical exam.
- Encounters for those recipients under the age of 21 must include all the aspects of a well-child screening visit.
- The documented Medical Encounter* level of service, at a minimum, is to include:
  - 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)
  - This would be low level complexity of medical decision making (limited number of diagnoses, limited complexity of data to review, the risk of complications and management options- low)

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

RHC/FQHC Clinical Social Worker Encounter

A clinical social worker encounter is defined as receipt of services from a clinical social worker.

- Problems identified at an encounter must be addressed to the highest degree possible at that encounter.
- The documented initial face-to-face clinical social worker encounter is to include, at a minimum:
  - The collection of current demographic data
  - Assessment/identification of current needs and make appropriate referrals with written contact information
  - Record any observable or reported deficits in function

- The documented subsequent face-to-face clinical social worker encounter should include, at a minimum:
  - The identification and coordination of referrals as indicated or requested
  - Discussion of services with the patient
  - Assessment of patient understanding of information discussed
  - Coordinate with facilities, physician, and others the completion of appropriate medical information as required to assist the patient
* These definitions are modeled after those found in the Current Procedural Terminology Manual – 2005 (CPT) currently used by the medical provider community to determine the level of medical care provided. These are minimal requirements from the Louisiana Department of Health and Hospitals, however providers are still required to comply with additional requirements outlined in the CPT book.

RHC/FQHC visits may be generated by the following licensed health care practitioners:

- Physicians
- Nurse Midwives (under a physician’s direction)
- Clinical Psychologists (under a physician’s direction)
- Physician Assistants (under a physician’s supervision)
- Specialized Nurse Practitioners (in accordance with an approved protocol and under a physician’s direction)
- Clinical Social Workers (under a physician’s direction)
- Nurse Practitioners (in accordance with an approved protocol and under a physician’s direction)
- Dentists

**NOTE:** Providers must obtain a Professional manual and training packet as a reference for policy regarding Professional services.

**RHC/FQHC Visit Codes**

RHC/FQHC encounter visits are billed using code T1015. Only one encounter visit should be billed per recipient per day. **All services performed at the visit should be included on the claim form.**

- Providers should list all services performed in addition to encounter code T1015.
- Providers should list the top 5 services performed in addition to encounter code T1015 if more than 5 services are rendered during an encounter.
- The attending provider number MUST BE included in block 24K to indicate the individual provider performing services if the physician, nurse practitioner, physician assistant or psychiatrist provides the service. If a MSW or psychologist provides the services, the number entered must be the RHC/FQHC group number.

**Obstetrical Care Billing**

Code **T1015, along with the modifier of TH**, is used by RHCs/FQHCs to bill for obstetrical (OB) services. This code is also reimbursable at the clinic’s encounter rate. All services performed at the encounter should be listed on the claim form along with the encounter code.
Billing Encounters on the CMS 1500

- **The encounter should be billed using T1015.** If the encounter is obstetrical, the modifier TH should be appended. If the encounter is for a KIDMED screening, the modifier EP should be appended.

- For all services rendered at the RHC/FQHC facility, in a nursing home, or home visits, the RHC/FQHC provider identification number must be used as the billing provider number in block 33 of the CMS 1500. Only inpatient hospital visits are billed using the individual physician’s provider identification number.

- **All detailed service procedure codes** provided to the patient on a DOS should be listed on the claim form following encounter code T1015, T1015–TH or T1015–EP, beginning with DOS 01/01/2005. These charges may be listed as the provider’s usual & customary charges or $0.

- For KIDMED providers: If immunizations are given at the time of the medical screening, the specific immunization codes are listed on the CMS 1500, along with encounter T1015 and modifier EP. The EP modifier signifies a screening of a recipient under age 21. All claims billed using the T1015 with modifier EP must include one or more supporting detail procedures.

**REMINDER: Only 1 T1015 procedure code will be paid per DOS.**

- If the encounter code is missing, the detail line item(s) will deny.
- If the encounter code is denied, the detail line item(s) will deny.
- If the encounter code is present and passes all edits but the detail line item(s) is/are missing, the encounter code will deny.
- If the encounter code is present and passes all edits, it will deny if all detail line items deny.
- If the encounter code and detail line items are present, correct, and pass all edits, the encounter code will pay at the provider’s encounter rate and the detail line item(s) will be approved at zero ($0).
Below are instructions for completing the claim form. Completed examples are shown following the instructions for completion.

**Certain items on the CMS-1500 are mandatory, as indicated below by an asterisk (*).**

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. Such claims cannot be processed until corrected and resubmitted by the provider.

1. Enter an “X” in the box marked Medicaid (Medicaid #).

*1A. **Insured’s ID Number** - enter the recipient’s 13 digit Medicaid ID number exactly as it appears in the recipient’s current Medicaid information obtained through REVS or e-MEVS.

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

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

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

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

4. **Insured’s Name** - Complete correctly if appropriate or leave this space blank.

5. **Patient’s Address** - Print the recipient’s permanent address.

6. **Patient Relationship to Insured** - Complete if appropriate or leave this space blank.

7. **Insured’s Address** - Complete if appropriate or leave this space blank.

8. **Patient Status** - Leave this space blank.

9. **Other Insured’s Name** - Complete if appropriate or leave this space blank.

9A. **Other Insured’s Policy or Population Number** - Complete using the recipient’s 6-digit TPL carrier code if the recipient has other insurance and the claim has been processed by the third party insurer. (If this is the case, the EOB from the other insurance should be attached to the claim.) If the recipient does not have other coverage, leave this space blank.

9B. **Other Insured’s Date of Birth** - Complete if appropriate or leave this space blank.
9C. **Employer’s Name or School Name** - Complete if appropriate or leave this space blank.

9D. **Insurance Plan Name or Program Name** - Complete if appropriate or leave this space blank.

10. **Was Condition Related To** - Leave this space blank.

11. **Insured Policy Population or FECA Number** - Complete if appropriate or leave this space blank.

11A. **Insured’s Date of Birth** - Complete if appropriate or leave this space blank.

11B. **Employer’s Name or School Name** - Complete if appropriate or leave this space blank.

11C. **Insurance Plan Name or Program Name** - Complete if appropriate or leave this space blank.

12. **Patient’s or Authorized Person’s Signature** - Complete if appropriate or leave this space blank.

13. **Insured’s or Authorized Person’s Signature** - Obtain signature if appropriate or leave this space blank.

14. **Date of Current Illness** - Leave this space blank.

15. **Date of Same or Similar Illness** - Leave this space blank.

16. **Dates Patient Unable to Work** - Leave this space blank.

*17. **Name of Referring Physician or Other Source** - If services are performed by a CRNA, the name of the directing physician must be entered here. If services are performed by an independent laboratory, the name of the referring physician must be entered in this field. If services are performed by a nurse practitioner, clinical nurse specialist or physician’s assistant, the name of the directing physician must be entered in this field.

17A. **ID Number of Referring Physician** – Leave this space blank.

18. **Hospitalization Dates Related to Current Services** - Leave this space blank.

19. **Reserved for Local Use** - Leave this space blank.

20. **Outside Lab** - Leave this space blank.

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

22. **Medical Resubmission Code** - Leave this space blank.

23. **Prior Authorization** - Complete if required or leave space blank.
*24A. **Date of Service** - Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.

*24B. **Place of Service** - Enter the appropriate code from the approved Medicaid place of service code list.

24C. **Type of Service** – Enter the appropriate code from the approved Place of Service listing.

*24D. **Procedure Code** - Enter the appropriate encounter procedure code on the first line.

**Encounter codes:**
- RHC/FQHC encounter visit: T1015
- RHC/FQHC obstetrical services: T1015 with modifier TH
- RHC/FQHC KIDMED services: T1015 with modifier EP

*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*

*24E. **Diagnosis Code** - Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a “1”, “2”, “3”, or “4”. More than one diagnosis may be related to a procedure. Do not enter an ICD-9-CM diagnosis code in this item.

*24F. **Charges** - Enter your encounter rate for the encounter code. You may enter $0 for the service procedure codes listed on subsequent lines.

*24G. **Days or Units** - Enter the number of units billed for the procedure code entered on the same line in 24D.

24H. **EPSDT** - Leave blank or Enter a “Y” if services were performed as a result of an EPSDT referral.

24I. **EMG** - Leave this space blank.

24J. **COB** - Leave this space blank.

*24K. **Attending Provider Number** - The attending provider number MUST BE included in block 24K to indicate the individual provider performing services if the physician, nurse practitioner, physician assistant, or psychiatrist provides the service. If a MSW or psychologist provides the services, the number entered must be the RHC/FQHC group number.

25. **Federal Tax ID Number** - Leave this space blank.

26. **Your Patient’s Account Number** - (Optional) Enter the recipient’s medical record number or other individual provider-assigned number to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.
27. **Accepts Assignment** - Leave this space blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.

*28. **Total Charge** - Total of all charges listed on the claim.

29. **Amount Paid** - Leave this space blank unless payment has been made by a third party insurer. If such payment has been made, indicate the amount paid.

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

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

**Date** - Enter the date of the signature.

32. **Name and Address Where Services Were Rendered** – Complete as appropriate or leave this space blank.

*33. **Physician’s or Medical Assistance Supplier’s Name, Address, Zip Code and Telephone Number and PIN** - Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid billing provider number must be entered in the space next to “Group (Grp) #.”

**Note:** If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.
**EXAMPLE OF A KIDMED ENCOUNTER WITH IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Service Description</th>
<th>Date of Service</th>
<th>Days of Service</th>
<th>Sequence</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015 EP</td>
<td>Immunization</td>
<td>10/01/05</td>
<td>1</td>
<td>1</td>
<td>9000</td>
</tr>
<tr>
<td>90700</td>
<td>Immunization</td>
<td>10/01/05</td>
<td>1</td>
<td>1</td>
<td>0000</td>
</tr>
<tr>
<td>90707</td>
<td>Immunization</td>
<td>10/01/05</td>
<td>1</td>
<td>1</td>
<td>0000</td>
</tr>
</tbody>
</table>

**RHC/FQHC CLINIC**

200 Healthy Ln Central, LA 70002

Ted Johnson

10/05/2005

*PLEASE PRINT OR TYPE*
UNISYS 213 ADJUSTMENT/VOID FORM

The Unisys 213 adjustment/void is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Unisys by calling Provider Relations at (800) 473-2783.

FORM COMPLETION

Only one (1) control number can be adjusted or voided on each 213 form.

Only an approved claim can be adjusted or voided.

Blocks 26 and 27 must contain the claim's most recently approved control number and R.A. date. For example:


2. The claim is adjusted on the R.A. dated 11/16/2005, ICN 5320890123456.

3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (5320890123456) and R.A. date (11/16/2005) must be used.

Provider numbers and recipient Medicaid ID numbers cannot be adjusted. They must be voided, then resubmitted.

Adjustments: To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the R.A. The original payment will be taken back on the same R.A. in the "previously paid" column.

voids: To file a void, the provider must enter all the information from the original claim exactly as it appeared on the original claim. When the void claim is approved, it will be listed under the "void" column of the R.A. and a corrected claim may be submitted (if applicable).

Only one (1) claim line can be adjusted or voided on each adjustment/void form.

213 Adjustment/void forms should be mailed to the following address for processing:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821
213 ADJUSTMENT/VOID INSTRUCTIONS

*1. ADJ/VOID—Check the appropriate block.

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

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

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

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

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

7. Insured’s Name—Leave this space blank.

8. Patient’s Relationship to Insured—Leave this space blank.

9. Insured’s Group No.—Complete if appropriate or leave space blank.

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

11. Was Condition Related to:—Leave this space blank.

12. Insured’s Address—Leave this space blank.

13. Date of:—Leave this space blank.

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

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

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

17. Dates of Total Disability-Dates of Partial Disability—Leave this space blank.
18. **Name of Referring Physician or Other Source**—Leave this space blank.

18A. **Referring ID Number**—Enter the CommunityCARE authorization number if applicable or leave blank.

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

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

21. **Was Laboratory Work Performed Outside of Office?**—Leave this space blank.

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

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

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

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

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

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

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

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

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

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

32. **Patient’s Account Number**—(Optional) Enter the patient’s correct provider-assigned account number.

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

KIDMED SCREENING POLICY

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is a Medicaid program that was established by the Federal government in 1967. The purpose of the program is to provide low-income children with comprehensive health care. Louisiana began EPSDT services in 1972. The screening component of EPSDT is called KIDMED and includes medical, vision, and hearing screening services.

KIDMED providers have the responsibility for coordinating medical, vision, and hearing screenings. Medical, vision, and hearing screenings should be performed on the same day to prevent the child from having to return at a later date. The following pages discuss the elements of KIDMED screenings. Additional information, including a description of each component and who may conduct each component, is found in the KIDMED provider manual.

MEDICAL SCREENING

Billing for these screenings should be completed hard copy on the KM-3 form. Billing may not be submitted for a medical screening unless all of the following components are administered:

<table>
<thead>
<tr>
<th>COMPONENTS OF THE MEDICAL SCREENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive health and developmental history (including assessment of both physical and mental health and development)</td>
</tr>
<tr>
<td>2. Comprehensive unclothed physical exam or assessment</td>
</tr>
<tr>
<td>3. Appropriate immunizations according to age and health history (unless medically contraindicated or parents or guardians refuse at the time)</td>
</tr>
<tr>
<td>4. Laboratory tests (including appropriate neonatal, iron deficiency anemia, urine, and blood lead screenings)</td>
</tr>
<tr>
<td>5. Health education (including anticipatory guidance)</td>
</tr>
</tbody>
</table>

NOTE: All components, including specimen collection, must be provided on-site during the same medical screening visit.

VISION SCREENING

The purpose of the vision screening is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malfunctions, eye diseases, strabismus, amblyopia, refractive errors, and color blindness.

Subjective vision screening

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of

- Any eye disorders of the child or his family
- any systemic diseases of the child or his family which involve the eyes or affect vision
- behavior on the part of the child that may indicate the presence or risk of eye problems
- medical treatment for any eye condition
Objective vision screening

Effective immediately, the KIDMED objective vision screenings may be performed by trained office staff under the supervision of a LICENSED Medicaid physician, physician assistant, registered nurse, or optometrist. The interpretive conference to discuss findings from the screenings must still be performed by a licensed physician, physician assistant, or registered nurse, as is currently the stated policy in the KIDMED manual.

Objective vision screenings begin at age 4. The objective vision screening must include the following tests:

- visual acuity (Snellen Test or Allen Cards for preschoolers and equivalent tests such as Titmus, HOTV or Good Light, or Keystone Telebinocular for older children);
- color perception (must be performed at least once after the child reaches the age of 6 using polychromatic plates by Ishihara, Stilling, or Hardy-Rand-Ritter); and
- muscle balance (including convergence, eye alignment, tracking, and a cover-uncover test).

The following procedure code is used to bill for vision screening:

| 99173 with EP modifier | Vision Screening |

HEARING SCREENING

The purpose of the hearing screening is to detect central auditory problems, sensorineural hearing loss, conductive hearing impairments, congenital abnormalities, or a history of conditions which may increase the risk of potential hearing loss.

Subjective hearing screening

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of

- the child’s response to voices and other auditory stimuli
- delayed speech development
- chronic or current otitis media
- other health problems that place the child at risk for hearing loss or impairment

Objective hearing screening

Effective immediately, the KIDMED objective hearing screenings may be performed by trained office staff under the supervision of a LICENSED Medicaid audiologist or speech pathologist, physician, physician assistant, or registered nurse. The interpretive conference to discuss findings from the screenings must still be performed by a licensed physician, physician assistant, or registered nurse, as is currently the stated policy in the KIDMED manual.

Objective hearing screenings begin at age 4. The objective hearing screening must test at 1000, 2000, and 4000 Hz at 20 decibels for each ear using the puretone audiometer, Welsh Allyn audioscope, or other approved instrument.

The following procedure code is used to bill for hearing screening:

| 92551 | Hearing Screening |
NOTE: Age appropriate hearing and vision screening should be performed in conjunction with an RHC/FQHC KIDMED medical screening. These services are not payable separately. If a hearing and/or vision screening is done separately from the KIDMED medical screening, an encounter may not be billed, and the services will not be paid.

LABORATORY

Age-appropriate laboratory tests are required at selected age intervals. Specimen collection must be performed in-house at the medical screening visit. A child cannot be sent to an outside laboratory to have blood drawn. Documented laboratory procedures provided less than six months prior to the medical screening should not be repeated unless medically necessary. Iron deficiency anemia screening and urine screening when required are included in the KIDMED medical screening fee and CANNOT be billed separately.

Providers should not bill Medicaid for lab services not performed in their own office.

IMMUNIZATIONS

Appropriate immunizations (unless medically contraindicated or the parents or guardians refuse at the time) are a federally required medical screening component. Failure to comply with or properly document the immunization requirement constitutes an incomplete screening and is subject to recoupment of the total medical screening fee.

⇒ The immunization administration fee is included in the KIDMED encounter reimbursement. Immunizations may not be reimbursed separately. If a recipient is too ill to receive immunizations at the time of a KIDMED medical screening the reason should be documented in the chart and they should be scheduled to return at a later date for immunization administration. An encounter visit cannot be charged for the return visit, because immunization administration was reimbursed in the original visit payment.

KIDMED follows the current Childhood Immunization Schedule recommended by the Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP) which is updated yearly. Providers are responsible for obtaining current copies of the schedule.

If an out-of-state provider or recipient/family member calls the local parish health units in Louisiana for immunization records, the health unit will search the LINKS (Louisiana Immunization Network for Kids Statewide) database for the records and fax the record, if available. The record will only be available on LINKS if the provider was connected to and used the LINKS system. If the immunization record was not in LINKS and the Louisiana provider is not able to provide the immunization record then the immunizations would most likely need to be given/restarted as if the recipient had not received the immunizations in the past.

All vaccine CPT codes will be paid at zero ($0) because the provider obtains the vaccine from the Vaccines for Children Program at no cost. The listing of the vaccine on the claim form is required for federal reporting purposes.
The Texas Department of State Health Services (DSHS) has opened a temporary call center to assist school personnel, physicians and parents in getting copies of immunization records for children who came to Texas from Alabama, Mississippi or Louisiana because of Hurricane Katrina.

DSHS has obtained direct access to the Louisiana Department of Health and Hospitals’ statewide immunization registry and will contact registries in Alabama and Mississippi on behalf of requestors.

School personnel, physicians and parents may call the DSHS center at (800) 252-9152 to request records. Hours of operation are 7 a.m. to 7 p.m. weekdays. The registries in the evacuees’ home states may not contain records for all children vaccinated. Copies of records found by DSHS will be faxed or mailed to requestors. Requestors also will be notified if records are not found.

The child’s full name, date of birth and gender and the full name of the parent or guardian will be needed to process requests. There is no charge for this service.

School personnel may download an online roster form allowing them to fax requests for records for all children enrolled in their schools. The form is available online at [www.ImunizeTexas.com](http://www.ImunizeTexas.com).
The following chart lists vaccines for immunization services.

<table>
<thead>
<tr>
<th>Vaccine Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90476^</td>
<td>Adenovirus vaccine, type 4, live, for oral use</td>
</tr>
<tr>
<td>90477^</td>
<td>Adenovirus vaccine, type 7, live, for oral use</td>
</tr>
<tr>
<td>90581^</td>
<td>Anthrax vaccine, for subcutaneous use</td>
</tr>
<tr>
<td>90585</td>
<td>Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use</td>
</tr>
<tr>
<td>90586</td>
<td>Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use</td>
</tr>
<tr>
<td>90632</td>
<td>Hepatitis A vaccine, adult dosage, for intramuscular use</td>
</tr>
<tr>
<td>90633^</td>
<td>Hepatitis A vaccine pediatric/adolescent dosage, 2-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90634^</td>
<td>Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90636</td>
<td>Hepatitis A and Hepatitis B vaccine (HEPA-HEPB), adult dosage, for intramuscular use</td>
</tr>
<tr>
<td>90645^</td>
<td>Hemophilus Influenza B vaccine (HIB), HBOC conjugate, 4-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90646^</td>
<td>Hemophilus Influenza B vaccine (HIB), PRP-D conjugate, for booster use only, intramuscular use</td>
</tr>
<tr>
<td>90647^</td>
<td>Hemophilus Influenza B vaccine (HIB) PRP-OMP conjugate, 3-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90648^</td>
<td>Hemophilus Influenza B vaccine (HIB), PRP-T conjugate, 4-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90655^</td>
<td>Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use</td>
</tr>
<tr>
<td>90656</td>
<td>Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use</td>
</tr>
<tr>
<td>90657^</td>
<td>Influenza Virus vaccine, split virus, 6-35 months dosage, for intramuscular use</td>
</tr>
<tr>
<td>90658^</td>
<td>Influenza Virus vaccine, split virus, 3 years and above dosage, for intramuscular use</td>
</tr>
<tr>
<td>90660^</td>
<td>Influenza Virus vaccine live, for intranasal use</td>
</tr>
<tr>
<td>90665^</td>
<td>Lyme Disease vaccine, adult dosage, for intramuscular use</td>
</tr>
<tr>
<td>90669^</td>
<td>Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use</td>
</tr>
<tr>
<td>90675^</td>
<td>Rabies vaccine, for intramuscular use</td>
</tr>
<tr>
<td>90676^</td>
<td>Rabies vaccine, for intradermal use</td>
</tr>
<tr>
<td>90680</td>
<td>Rotavirus vaccine, tetravalent, live, for oral use</td>
</tr>
<tr>
<td>90690^</td>
<td>Typhoid vaccine, live, oral use</td>
</tr>
<tr>
<td>90691^</td>
<td>Typhoid vaccine, VI capsular polysaccharide (VICPS), for intramuscular use</td>
</tr>
<tr>
<td>90692^</td>
<td>Typhoid vaccine, heat-and phenol-inactivated (H-P) for subcutaneous or intradermal use</td>
</tr>
<tr>
<td>90693</td>
<td>Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (US Military)</td>
</tr>
<tr>
<td>90698</td>
<td>Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Haemophilus influenza Type B, and Poliovirus vaccine, inactivated, (DT-aP-Hib-IPV) for intramuscular use</td>
</tr>
<tr>
<td>90700 *</td>
<td>Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP) for use in individuals younger than 7 years, for intramuscular use</td>
</tr>
<tr>
<td>90701</td>
<td>Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine (DTP), for intramuscular use</td>
</tr>
<tr>
<td>90702*</td>
<td>Diphtheria and Tetanus Toxoids (DT) absorbed for use in individuals younger than 7 years, for intramuscular use</td>
</tr>
<tr>
<td>90703</td>
<td>Tetanus Toxoids for trauma, for intramuscular use</td>
</tr>
<tr>
<td>90704</td>
<td>Mumps Virus vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90705</td>
<td>Measles Virus vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90706</td>
<td>Rubella Virus vaccine, live, for subcutaneous use</td>
</tr>
</tbody>
</table>
### BILLABLE VACCINE CODES

<table>
<thead>
<tr>
<th>Vaccine Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90707*</td>
<td>Measles, Mumps and Rubella Virus vaccine (MMR), live, for subcutaneous use</td>
</tr>
<tr>
<td>90708</td>
<td>Measles and Rubella Virus vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90710</td>
<td>Measles, Mumps, Rubella, and Varicella vaccine (MMRV), live, for subcutaneous use</td>
</tr>
<tr>
<td>90712</td>
<td>Poliovirus vaccine, any type(s), (OPV), live, for oral use</td>
</tr>
<tr>
<td>90713*</td>
<td>Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90714*</td>
<td>Tetanus and diphtheria toxoids, (Td) absorbed, preservative free, for use in individuals seven years or older, for intramuscular use</td>
</tr>
<tr>
<td>90715</td>
<td>Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use</td>
</tr>
<tr>
<td>90716*</td>
<td>Varicella Virus vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90717</td>
<td>Yellow Fever vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90718*</td>
<td>Tetanus and Diphtheria Toxoids (TD) adsorbed for use in individuals 7 years or older, for intramuscular use</td>
</tr>
<tr>
<td>90719</td>
<td>Diphtheria Toxoid, for intramuscular use</td>
</tr>
<tr>
<td>90720</td>
<td>Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine and Hemophilus Influenza B vaccine (DTP-HIB), for intramuscular use</td>
</tr>
<tr>
<td>90721*</td>
<td>Diphtheria, Tetanus Toxoids, and Acellular Pertussis vaccine and Hemophilus Influenza B vaccine (DTAP-HIB), for intramuscular use</td>
</tr>
<tr>
<td>90723*</td>
<td>Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Hepatitis B, and Poliovirus vaccine, inactivated (DTAP-HEPB-IPV), for intramuscular use</td>
</tr>
<tr>
<td>90725</td>
<td>Cholera vaccine for injectable use</td>
</tr>
<tr>
<td>90727</td>
<td>Plague vaccine, for intramuscular or jet injection use</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90733</td>
<td>Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use</td>
</tr>
<tr>
<td>90734*</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use</td>
</tr>
<tr>
<td>90735</td>
<td>Japanese Encephalitis Virus vaccine, for subcutaneous use</td>
</tr>
<tr>
<td>90740</td>
<td>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 3-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90743</td>
<td>Hepatitis B vaccine, adolescent, 2-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90744*</td>
<td>Hepatitis B vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90746*</td>
<td>Hepatitis B vaccine, adult dosage, for intramuscular use</td>
</tr>
<tr>
<td>90747</td>
<td>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 4-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90748*</td>
<td>Hepatitis B and Hemophilus Influenza B vaccine (HEP-HIB), for intramuscular use</td>
</tr>
</tbody>
</table>

* indicates the vaccine is available from the Vaccines For Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

**REMINDERS:**

- Procedure code 90703 (Tetanus Toxoid for Trauma) will be payable at the rate of $2.42, and it is not available through the VFC program.

* Meningococcal conjugate vaccine will be available from the Vaccines For Children (VFC) Program in late fall 2005. Please check availability of this vaccine with the VFC Program.
NOTE: Providers must obtain a KIDMED manual and training packet as a reference for policy regarding KIDMED services.
VACCINES FOR CHILDREN & LOUISIANA IMMUNIZATION NETWORK FOR KIDS STATEWIDE

VACCINES FOR CHILDREN (VFC)

VFC is covered under Section 1928 of the Social Security Act. Implemented on October 1, 1994, it was an “unprecedented approach to improving vaccine availability nationwide by providing vaccines free of charge to VFC-eligible children through public and private providers.”

The goal of VFC is to ensure that no VFC-eligible child contracts a vaccine preventable disease because of his/her parent’s inability to pay for the vaccine or its administration.

Persons eligible for VFC vaccines are between the ages of birth through 18 who meet the following criteria:

- Eligible for Medicaid
- No insurance
- Have health insurance, but it does not offer immunization coverage and they receive their immunizations through a Federally Qualified Health Center
- Native American or Alaska native

Providers can obtain an enrollment packet by contacting the Office of Public Health’s (OPH) Immunization Section at (504) 838-5300.

LOUISIANA IMMUNIZATION NETWORK FOR KIDS STATEWIDE (LINKS)

LINKS is a computer-based system designed to keep track of immunization records for providers and their patients.

The purpose of LINKS is to consolidate immunization information among health care providers to assure adequate immunization levels and to avoid unnecessary immunizations.

LINKS can be accessed through the OPH website: WWW.OPH.DHH.STATE.LA.US.

LINKS will assist providers within their medical practice by offering:

- Immediate records for new patients
- Decrease staff time spent retrieving immunization records
- Avoid missed opportunities to administer needed vaccines
- Fewer missed appointments (if the “reminder cards and letter” option is used)

LINKS will assist patients by offering:

- Easy access to records needed for school and child care
- Automatic reminders to help in keeping children’s immunizations on schedule
- Reduced cost (and discomfort to child) of unnecessary immunizations

Providers can obtain an enrollment packet, or learn more about LINKS by calling the Louisiana Department of Health and Hospitals, Office of Public Health Immunization Program at (504) 838-5300.
SCREENING PERIODICITY POLICY

One important obligation of the KIDMED provider is to provide services according to the periodicity schedule. **KIDMED providers should follow the most current copy of the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP), and American Academy of Family Physicians (AAFP) Recommended Childhood Immunization Schedule. This schedule should be replaced by KIDMED providers each year as revisions are published.**

**Initial Screening**

Initial screenings must be scheduled within the time limits given below upon notification by the Louisiana KIDMED office:

- **Newborns** - immediately
- **Children one month to three years of age** - within 45 days
- **Children three to six years of age** - within 60 days
- **Children six to 21 years of age** - within 120 days

**Periodicity Restrictions**

Screenings must be performed on time at the ages shown on the Periodicity Chart which is found on the next page. For example, the screening due when the child is six months old must be performed after he or she has reached the age of six months, but before the seven-month birthday. The screening scheduled for three years of age must be performed between the child’s third and fourth birthdays. In addition, the periodic screenings performed on children under two must be performed at least 30 days apart. Screenings performed after the child’s second birthday must be at least six months apart. Claims submitted for KIDMED periodic screenings performed at an inappropriate time will not be paid.

**Off-Schedule Screenings**

If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring him or her up to date at the earliest possible time. **However, all screenings on children under two years of age must be at least 30 days apart, and those on children age two through six must be at least six months apart.**
### REQUIRED KIDMED MEDICAL, VISION, AND HEARING SCREENING COMPONENTS BY AGE OF RECIPIENT (EFFECTIVE APRIL 1, 1994)\(^1\)

<table>
<thead>
<tr>
<th>AGE</th>
<th>BIRTH(^2)</th>
<th>MEDICAL SCREENING</th>
<th>INITIAL/INTERVAL HISTORY</th>
<th>MEASUREMENTS</th>
<th>HEAD</th>
<th>CIRCUMFERENCE</th>
<th>BLOOD PRESSURE</th>
<th>DEVELOPMENTAL ASSESSMENT</th>
<th>UNCLOTHED PHYSICAL EXAM/ASSESSMENT</th>
<th>PROCEDURES</th>
<th>IMMUNIZATION (^4)</th>
<th>NEONATAL</th>
<th>SCREENING(^5)</th>
<th>ANEMIA SCREENING(^6)</th>
<th>URINE SCREENING(^7)</th>
<th>LEAD RISK ASSESSMENT(^8)</th>
<th>BLOOD LEAD SCREENING(^9)</th>
<th>NUTRITIONAL ASSESSMENT</th>
<th>HEALTH EDUCATION(^10)</th>
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</tr>
</tbody>
</table>

---

1. Baseline lab and developmental screening must be done at the initial medical screening on all children under age six.
2. The newborn screening examination at birth must occur prior to hospital discharge.
3. The physical examination/assessment must be unclothed or undraped and include all body systems.
4. The state health department immunization schedule must be followed per AAP recommendations.
5. If done less than 48 hours after birth, neonatal screening must be repeated.
6. Anemia screening is to be done once between 9 and 12 months or earlier if medically indicated, one year to four years, five years to 12 years, and between 13 and 20 years.
7. Urine testing (dipstick) is to be done once between one and four years (as soon as toilet trained), five to 12 years, and between 13 and 20 years.
8. Anticipatory guidance and verbal risk assessment for lead must be done at every medical screening.
9. Screening beginning at six months corresponds to CDC guidelines. The frequency of screening using blood lead test depends on the result of the verbal risk assessment.
<table>
<thead>
<tr>
<th>VISION SCREENING</th>
<th>S</th>
<th>S</th>
<th>S</th>
<th>S</th>
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<th>S</th>
<th>S</th>
<th>S</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEARING SCREENING</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
</tbody>
</table>

--- = One test must be entered during this time frame

X = Required at visit for this age
S = Subjective by history
O = Objective by Medicaid-approved standard testing method

10 Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 through 20, must receive more intensive health education which addresses psychological issues, emotional issues, substance usage, and reproductive health issues at each screening visit.
## RHC/FQHC KIDMED CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>99381</td>
<td><strong>Initial comprehensive preventative medicine by a physician</strong></td>
</tr>
<tr>
<td>99382</td>
<td>Infant (age under 1 year)</td>
</tr>
<tr>
<td>99383</td>
<td>Early Childhood (ages 1-4)</td>
</tr>
<tr>
<td>99384</td>
<td>Late Childhood (age 5-11)</td>
</tr>
<tr>
<td>99385</td>
<td>Adolescent (ages 12-17)</td>
</tr>
<tr>
<td>99386</td>
<td>Adult (ages 18-20)</td>
</tr>
<tr>
<td>99391</td>
<td><strong>Periodic comprehensive preventative medicine by a physician</strong></td>
</tr>
<tr>
<td>99392</td>
<td>Infant (age under 1 year)</td>
</tr>
<tr>
<td>99393</td>
<td>Early Childhood (ages 1-4)</td>
</tr>
<tr>
<td>99394</td>
<td>Late Childhood (age 5-11)</td>
</tr>
<tr>
<td>99395</td>
<td>Adolescent (ages 12-17)</td>
</tr>
<tr>
<td>99396</td>
<td>Adult (ages 18-20)</td>
</tr>
<tr>
<td>99381 -TD</td>
<td>Initial comprehensive preventative medicine by a nurse</td>
</tr>
<tr>
<td>99382 -TD</td>
<td>Infant (age under 1 year)</td>
</tr>
<tr>
<td>99383 -TD</td>
<td>Early Childhood (ages 1-4)</td>
</tr>
<tr>
<td>99384 -TD</td>
<td>Late Childhood (age 5-11)</td>
</tr>
<tr>
<td>99385 -TD</td>
<td>Adolescent (ages 12-17)</td>
</tr>
<tr>
<td>99396 -TD</td>
<td>Adult (ages 18-20)</td>
</tr>
<tr>
<td>99173 - EP</td>
<td>Periodic comprehensive preventative medicine by a nurse</td>
</tr>
<tr>
<td>92551</td>
<td>Screening test of visual acuity, quantitative and bilateral</td>
</tr>
</tbody>
</table>

- **Initial comprehensive preventative medicine by a nurse**
  - Infant (age under 1 year)
  - Early Childhood (ages 1-4)
  - Late Childhood (age 5-11)
  - Adolescent (ages 12-17)
  - Adult (ages 18-20)

- **Periodic comprehensive preventative medicine by a nurse**
  - Infant (age under 1 year)
  - Early Childhood (ages 1-4)
  - Late Childhood (age 5-11)
  - Adolescent (ages 12-17)
  - Adult (ages 18-20)
KM-3 CLAIMS FILING INSTRUCTIONS

- KIDMED screening services are billed on the revised KM3 form. **It is necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on appropriate lines.**
- Providers **must** also indicate encounter code T1015, with modifier EP, on the KM3 form.
- If immunizations are given at the time of the screening, then those codes are listed on the CMS 1500, along with encounter T1015 and modifier EP. All claims billed with encounter T1015 and modifier EP **must include** all supporting detail procedures. Claims without an encounter code AND detail procedure will deny.
- If, on the same date of service, a recipient is referred in-house for treatment of a problem identified during the screening, encounter code T1015 is billed on the CMS1500 along with the appropriate CPT code indicating the level of care.
- When encounter code T1015 is billed on a CMS 1500, along with supporting detail, on the same date of service that a KIDMED screening is billed on the KM3, one encounter rate will pay and the other will deny with error code 715.
- Only **1** encounter code (T1015) will be paid per day.
- If the encounter code is missing, the detail line item(s) will deny.
- If the encounter code is denied, the detail line item(s) will deny.
- If the encounter code is present and passes all edits but the detail line item(s) is/are missing, the encounter code will deny.
- If the encounter code is present and passes all edits, it will deny if all detail line items deny.
- If the encounter code and detail line items are present, correct, and pass all edits, the encounter code will pay at the provider’s encounter rate and the detail line item(s) will be approved at zero ($0).
- KIDMED screenings performed by a registered nurse should be billed using encounter code T1015 with modifier EP and the appropriate KIDMED medical screening code and the modifier TD to signify a registered nurse.
- Only a physician doing a screening should bill with no modifier.

KM-3 claim forms should be mailed to the following address for processing:

**Unisys**  
P.O. Box 14849  
Baton Rouge, LA 70821

**NOTE:** When a provider bills an encounter code, supporting detail and modifier on one claim form the claims processing sub-system keeps all lines together for processing purposes.
Following are instructions for completing the items of the KM-3 claim form:

**Item No. Description and details**

1. **Type of claim** - There are three choices in this box. You may choose only one, entering a checkmark as appropriate.
   
   Check "original" if this is the original screening claim for this beneficiary for the service date indicated later in item 25. If you check "original," skip directly to item 4.
   
   Check "adjustment" if this claim adjusts a previously paid claim for this beneficiary for the service date indicated later in item 25.
   
   Check "void" if you are voiding a claim already submitted for this beneficiary for the service date indicated later in item 25.

   **If there is no checkmark in this block, it is considered to be an original claim**

2. **Reason** - If you checked "adjustment" or "void" in item 1, you must complete item 2 by entering the applicable two-digit code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Adjustment due to provider error</td>
</tr>
<tr>
<td>03</td>
<td>Adjustment not due to provider error</td>
</tr>
<tr>
<td>10</td>
<td>Void due to claim paid for wrong beneficiary</td>
</tr>
<tr>
<td>11</td>
<td>Void due to claim paid to the wrong provider</td>
</tr>
</tbody>
</table>

3. **Adjustment ICN** - Complete this item only if you completed item 2. Enter the 13-digit Internal Control Number (ICN) as listed on the remittance advice for the original claim being adjusted or voided.

4. **Billing Provider No.** - Enter your valid seven-digit Medicaid Provider ID Number.

5. **Billing Provider Name** - Enter up to 17 letters of the billing provider’s name, starting with the last name first and leaving a space between the last and first names. For example, William Sutherland, M.D., would be entered as "Sutherland (space) Willia." If the billing provider is a facility or agency (such as a school board, health unit, or clinic) rather than an individual, enter the name of the facility or agency.

6. **Site Number** - This item applies only to providers who have more than one screening site. If you have only one site, skip to item 7. If you have more than one screening site, enter the valid three-digit site code at which the screening was conducted. If the site code has less than three digits, fill the empty spaces to the left with zeros. For example, if the site code is 1, enter "001."

7. **Attend Provider No.** – Leave blank

8. **Attend Provider Name** – Leave blank
9. **Refer Provider No.** – Leave blank.

10. **Medicaid No.** - Enter the beneficiary's 13-digit Medicaid number as verified through the REVS or e-MEVS eligibility systems. This should also be the 13-digit Medicaid number that appears on the RS-0-07 for that month.

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

11. **Patient Last Name** - Enter the first 17 letters of the beneficiary's last name, starting at the left of the block, as verified through the REVS, or e-MEVS eligibility systems. If the name has less than 17 letters, leave the remaining spaces blank.

12. **Patient First Name** - Enter up to 12 letters of the beneficiary's first name, starting at the left of the block, as verified through the REVS, or e-MEVS eligibility systems. If the name has less than 12 letters, leave the remaining spaces blank.

13. **Date of Birth** - Enter the six-digit date of birth for the beneficiary, using the MMDDYY format so that you fill up all the spaces. The beneficiary must be under age 21 on the date of the screening. Do not leave any of the spaces blank.

14. **Sex** - Optional. Enter "M" for male or "F" for female.

15. **Race** - Optional. Enter one of the following codes:

    - Unknown 0
    - White 1
    - Black or African American 2
    - American Indian or Alaskan Native 3
    - Asian 4
    - Hispanic or Latino 5
    - Native Hawaiian or Other Pacific Islander 6
    - Hispanic or Latino and one or more races 7
    - More than one race(Hispanic or Latino not indicated) 8
    - Unknown 9

16. **Medical Record No.** - Optional. This number may be used to cross-reference your patient's medical record number. Enter up to 18 alphabetical and/or numerical characters assigned by your office as the patient’s medical record number.

17. **Patient Address** - Optional. Enter the beneficiary's street address or P.O. box number, starting at the left of the block. Leave any unused spaces blank.

18. **City** - Optional. Enter up to nine letters of the city in which the beneficiary lives, starting at the left of the block. Leave any unused spaces blank.

19. **State** - Optional. Enter the commonly accepted postal abbreviation for the state ("LA" for Louisiana).

20. **Zip Code** - Optional. Enter the zip code for the beneficiary's address. If you do not know the full nine-digit zip code, enter the first five digits, and leave the remaining four spaces blank.
21. **Patient Home Phone** - If the beneficiary has a home phone number or a contact phone number, you must complete this item, including the area code. Enter the three-digit area code and seven-digit home or contact phone number.

22. **Patient Work Phone** - If the beneficiary has a work phone number, you must complete this item, including the area code. Enter the three-digit area code and seven-digit work phone number.

23. **Parent/Guardian Last Name** - This item must be completed for all beneficiaries living with a parent or guardian. A foster parent or adoptive parent is considered a guardian. Enter up to 17 letters of the parent or guardian’s last name, starting at the left of the block. Leave any unused spaces blank. If the beneficiary is not living with a parent or guardian, leave this item blank and skip to item 25.

24. **Parent/Guardian First Name** - If you complete item 23, you must complete item 24 also, entering up to 12 letters of the parent or guardian’s first name, starting at the left of the block. Leave any unused spaces blank.

The next part of the claim form documents the “all inclusive” encounter, as well as the screening services performed which are being submitted on the claim. It also documents the encounter rate and screening fees. In addition, it records information about future screenings scheduled.

**NOTE:** You must bill the RHC/FQHC encounter procedure code T1015 with modifier EP on the appropriate claim line.

In addition to the encounter code it is necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on appropriate lines.

Listed below are the four types of screenings to be indicated on the KM3:

- **Medical Screening Nurse (99381-99385 and 99391-99395 plus modifier TD)** - This is a medical screening where a registered nurse, nurse practitioner, or certified physician assistant conducted the complete unclothed physical assessment and other required age-appropriate medical screening components, including age-appropriate immunizations.

- **Medical Screening Physician (99381-99385 and 99391-99395 with no modifier)** - This is a medical screening where a licensed physician conducted the complete unclothed physical exam and other required age-appropriate medical screening components, including age-appropriate immunizations.

  You must enter one or the other for a single medical screening, but not both. If both a physician and a registered nurse conduct the screening, **the procedure code must be entered in the field by the person performing the physical exam or assessment.**

- **Vision (99173-EP)** - This is an objective vision screening conducted by a licensed physician, certified physician assistant, registered nurse, licensed optometrist or a...
trained office staff member. (The interpretive conference with the family or recipient concerning the results of the test must be done by the RN, PA, or physician.) **No claim will be paid on a child under age four.**

- **Hearing (92551)** - This is an objective hearing screening conducted by a licensed physician, certified physician assistant, registered nurse, licensed and ASHA-certified audiologist, licensed and ASHA-certified speech pathologist, or a trained office staff member. (The interpretive conference with the family or recipient concerning the results of the test must be done by the RN, PA, or physician.) **No claim will be paid on a child under age four.**

A vision and/or hearing screening will be approved only if there is an age appropriate medical screening listed.

25. **Date of Screening** - For each applicable line, enter the date of each service (including the encounter and the screening(s)). For proper reimbursement, you must date each service line for which you are billing.

26. **Billed Charge** - For each line you completed in item 25, enter the appropriate charge for services rendered, using up to five digits for dollars and cents.

27. **Next Screening Appointment Date** - If a future screening appointment has been scheduled, enter the six-digit appointment date for each applicable screening line. If no future appointments have been made at the time you submit the claim, leave this item blank and skip to item 29.

28. **Time** - If a future screening appointment has been scheduled, enter the appointment time.

29. **Immunization Status** - This item is required and should be completed for medical screenings only. You must certify with each claim whether or not the beneficiary's immunizations are complete and current for his or her age. Check "Yes" if immunizations are complete and current for this age beneficiary. Check "No" if they are not. If you check "Yes," skip to item 31.

30. **Reason** - If you indicate in item 29 that immunizations are not current and complete, you must check the appropriate box explaining why. Check "A" in the case of medical contraindication. Check "B" if the parents or guardians refuse to permit the immunization. Check "C" if immunizations are off schedule. For example, check "C" if the beneficiary received an immunization at this visit but is still due one for his or her age. Do not check "C" if immunizations are off schedule and you did not immunize.

31. **Presence or absence of suspected conditions** - This item relates to screening findings. If you find no suspected conditions, check "no" and skip to item 36. If you do find one or more suspected conditions, check "yes" and proceed to item 32.

32. **Nature of suspected conditions and referral strategy** - This item documents the general types of suspected conditions identified during the screening and whether or not a referral was made in-house (includes self-referrals) or offsite. Complete it by checking the appropriate boxes. For example, if you found a suspected medical condition for which the beneficiary is already under care by you or any other provider, check the far left box on the first line. If you found a suspected nutritional condition and you have self-referred, check the far right column on the fifth line (E). If you found a suspected psychological/social condition and have made a referral outside your practice, check the middle column on the
eighth line (H). Be sure to enter information about all suspected conditions found. Do not make any entries on lines J through L.

Note that each of these items may require you to enter up to eight different kinds of information in the spaces marked A, B, C, D, E, F, G, H, and I.

33-35. Referrals for Suspected Conditions - You must complete at least one of these items if any suspected conditions are listed in item 32 as being referred in-house or offsite. The number of items you complete will depend on how many conditions you found in the screening and on the referrals made. As you will see below, if more than four suspected conditions are found, you must fill out at least items 33 and 34. If more than eight suspected conditions are found, you must fill out items 33 through 35. Also, you must complete one item for each referral made. If there are more referrals than blocks 33-35 will accommodate, such referrals should be documented in the recipient's chart and would not be listed on the claim form.

33A. Suspected Condition - Referring back to item 32, enter in item 33A up to four letters (A through I), identifying the type of condition(s) identified. Remember, the referral may cover up to four conditions, but only one referral provider. Start at the left of the block, and leave any unused spaces blank. DO NOT enter an ICD-9 diagnosis code or diagnosis abbreviation (e.g., “URI”) here—that information should be entered in 33E.

33B. Referral Assist Needed - Check “no,” if there is a referral. If assistance is needed from the Louisiana KIDMED office on finding a referral resource, contact the Specialty Care Resource Line (ACS) at (877) 455-9955

33C. Appointment Date - If you referred the beneficiary either in-house or offsite, enter the date of the appointment. The appointment date should be estimated if it is not known at the time the claim form is completed.

33D. Appointment Time - If you referred the beneficiary either in-house or offsite, enter the time of the appointment. The appointment time should be estimated if it is not known at the time the claim form is completed.

33E. Reason for Referral - Enter the reason for the referral, using up to 40 letters and/or the ICD-9 diagnostic codes. In addition, if referral assistance is needed because the referred-to provider requires direct contact with the beneficiary, indicate so here.

33F. Referred To - If you made your own in-house or offsite referral, enter up to 20 letters of the name of the specific provider to whom the beneficiary was referred, starting with the last name first. Be as specific as possible. For example, if the beneficiary was referred to a large facility, give the name and department onsite. If you self-referred, enter "self" for this item. Skip to item 36 if you have no other referral information to report.

33G. (Blank) - Do not enter any data here. This item is reserved for future use by KIDMED.

33H. Phone No. - If you made your own in-house or offsite referral, enter the area code and six-digit phone number of the referred-to provider. If you self-referred, leave this item blank.

33I. Transportation Assistance Needed - Check “no,” as this block is no longer used to obtain transportation assistance. The recipient (or the recipient’s parent) should contact the Medical Dispatch Office at 1-866-272-5501.
34. Follow the instructions above for item 33.

35. Follow the instructions above for item 33.

36. Providers must read and sign the certification statement at the bottom of the screening claim form in order to be paid. Providers may use a signature stamp if it is initialed by the individual completing the form. A signature certifies that the provider has provided all components of the screening, including appropriate immunizations when the medical screening is billed. The claim form will be returned unprocessed if no signature is present.
**2005 Emergency Billing Policy and Procedures for Hurricane Evacuees**

**Louisiana Medicaid RHC/FQHC Provider Services**
EXAMPLE OF A KIDMED ENCOUNTER WITH A MEDICAL SCREENING DONE BY A PHYSICIAN

MAIL TO:
UNSYS KIRED
P.O. BOX 18440
BATCH ROUGE, LA 70898-4449
(800) 473-3763
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

144444 0
ABC RHC
012

1234567891234
Smith
James
09.01.99 M

225 555 1212
SmithJ
123 Oak Lane
Sunny
LA 70000

MEDICAL SCREENING NURSE
99383
10.15.05 $51.00

VISION

HEARING
T1015
10.15.05 $91.00

ENCOUNTER (RHC/FQHC)

TOTAL BILLED AMOUNT $142.00

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENT'S PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:
- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE COUCHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT; AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THERETWITH.

Ima Biller
10/17/05

REFFERALS FOR SUSPECTED CONDITIONS

REFERRAL OFFSITE

REFERRAL IN-HOUSE
A. MEDICAL
B. VISION
C. HEARING
D. DENTAL
E. NUTRITIONAL
F. DEVELOPMENTAL
G. ABUSE/NEGLECT
H. PSYCHOLOGICAL/SOCIAL
I. SPEECH/LANGUAGE
J.
K.
L.

1. ORIGINAL
   □ ADJUSTMENT
   □ VOID
2. REASON
   3. ADJUSTMENT RCN

PRINT OR TYPE ONLY - USE BLACK INK

2005 Emergency Billing Policy and Procedures for Hurricane Evacuees
Louisiana Medicaid RHC/FQHC Provider Services
EXAMPLE OF A KIDMED ENCOUNTER WITH A MEDICAL SCREENING DONE BY A NURSE

<table>
<thead>
<tr>
<th>SCREENINGS TYPE</th>
<th>PROC. MOD.</th>
<th>DATE OF SCREENING/MONTH/YEAR</th>
<th>BILLING CHARGED</th>
<th>NEXT SCREENING APPOINTMENT DATE/MONTH/YEAR</th>
<th>TIME/HR/MIN</th>
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</thead>
<tbody>
<tr>
<td>MEDICAL SCREENING NURSE</td>
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<td>MEDICAL SCREENING PHYSICIAN</td>
<td>99173 TD</td>
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</tbody>
</table>

31. ARE THERE SUSPECTED CONDITIONS?  ☑️ Yes  ❌ No

If Yes you must check at least one of the boxes below and complete the next section if referred off-site or in-house.

32. UNDERCARE

<table>
<thead>
<tr>
<th>REFERRAL OFFSITE</th>
<th>REFERRAL IN-HOUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. MEDICAL</td>
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</tr>
<tr>
<td>B. VISION</td>
<td></td>
</tr>
<tr>
<td>C. HEARING</td>
<td></td>
</tr>
<tr>
<td>D. DENTAL</td>
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<tr>
<td>E. NUTRITIONAL</td>
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<td>F. DEVELOPMENTAL</td>
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</tr>
<tr>
<td>G. ABUSE/NEGLECT</td>
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<tr>
<td>H. PSYCHOLOGICAL/SOCIAL</td>
<td></td>
</tr>
<tr>
<td>I. SPEECH/LANGUAGE</td>
<td></td>
</tr>
<tr>
<td>J.</td>
<td></td>
</tr>
<tr>
<td>K.</td>
<td></td>
</tr>
<tr>
<td>L.</td>
<td></td>
</tr>
</tbody>
</table>

I certify that the service listed has been rendered by a qualified screening provider, that the charge is within the department's payment rate for KIDMED screening and the payment has not been received. I agree to adhere to the published regulations concerning screening and KIDMED administrative procedures. I have performed a complete screening as stated in the KIDMED Provider Manual.

I certify that any medical screenings listed above include the following minimum set of activities:
- A comprehensive health and developmental history;
- A comprehensive unclotted physical exam or assessment;
- Appropriate immunizations according to age and health history (unless medically contraindicated or parent refused at the time);
- Laboratory tests (including appropriate lead blood level assessment); and
- Health education (including anticipatory guidance).

I have read and understand the above notice plus the notice on the back of this form and do hereby certify that I am in compliance therewith.

Ima Biller
10/17/05

Signature of Provider

2005 Emergency Billing Policy and Procedures for Hurricane Evacuees
Louisiana Medicaid RHC/FQHC Provider Services
### EXAMPLE OF A KIDMED ENCOUNTER WITH A MEDICAL SCREENING DONE BY A PHYSICIAN AND A REFERRAL IN-HOUSE

**Provider Information**
- **Billing Provider No.:** 1444440
- **Billing Provider Name:** ABC, RHC
- **Site No.:** 012
- **Attend Provider No.:** 1234567891234
- **Attend Provider Name:** Smith
  - **Patient Last Name:** Smith
  - **Patient First Name:** Susie
  - **Date of Birth:** 09/01/99
  - **Gender:** F
- **Medical Record No.:** 123 Oak Lane
- **Address Line 2:** Sunny
- **Zip Code:** LA 70000
- **Patient Home Phone:** (225) 555-1212
- **Patient Work Phone:** 123 456789
- **Patient Home Phone:** 225 555-1212
- **Provider Home Phone:** 225 555-1212
- **Provider Work Phone:** 225 555-1212
- **Provider Name:** Smith
  - **First Name:** Jonathon
- **Provider Phone:** 433-555

**Screenings**
- **Medical Screening Nurse:**
- **Medical Screening Physician:**
- **Vision:**
- **Hearing:**

**Encounter (RHC/FQHC):**
- **Screening Date:** 10/07/05
- **Billing Charge:** $51.00
- **Encounter Code:** T1015
- **Referral Date:** 10/07/05
- **Referral Payer:** $95.00
- **Total Billable Amount:** $46.00

**Referrals for Suspected Conditions**
- **Diagnosis:** UTI
- **Referring Provider:** Dr. Brown
  - **Date:** 10/10/05
  - **Time:** 9:45

**Suspected Conditions**
- **UPC:**
  - **Note:** If yes, you must check at least one of the boxes below and complete the next section if referred off-site or in-house.

**Undercare**
- **Referral Offsite**
- **Referral In-House**
  - **A. Medical**
  - **B. Vision**
  - **C. Hearing**
  - **D. Dental**
  - **E. Nutritional**
  - **F. Developmental**
  - **G. Abuse/Sexual**
  - **H. Psychological/Social**
  - **I. Speech/Language**
  - **J.**
  - **K.**
  - **L.**

**Certification**
- The service listed has been rendered by a qualified screening provider, that the charge is within the Department's payment rate, and the payment has not been received. I agree to adhere to the published regulations concerning screening and KIDMED administrative procedures. I have performed a complete screening as stated in the KIDMED provider manual.

**I certify that any medical screening listed above include the following minimum set of activities:**
- A comprehensive health and developmental history
- A comprehensive physical exam or assessment
- Appropriate immunizations according to age and health history (unless medically contraindicated or parent refused at the time)
- Appropriate laboratory tests including appropriate lead blood level assessment
- Health education (including anticipatory guidance)

I have read and understand the above notice plus the notice on the back of this form and do hereby certify that I am in compliance therewith.
INTERPERIODIC SCREENINGS

Interperiodic screenings may be performed if medically necessary. Any parent, medical provider or qualified health, developmental, or educational professional that comes into contact with the child outside the formal health care system may request the interperiodic screening.

An interperiodic screening can only be billed if the recipient has been given an age-appropriate medical screening. If their medical screening has not been performed, the provider should bill an age-appropriate medical screening. It is not acceptable to bill for an interperiodic screening if the age-appropriate medical screening had not been performed.

An interperiodic screening by a KIDMED provider must include all of the components required in the periodic screening. This includes a complete unclothed exam or assessment, health and history update, measurements, health education, and other age-appropriate procedures.

An Interperiodic screening may be performed and billed for a required Headstart physical or school sports physical but must include all of the components required in the periodic screening. Providers should document in the recipient’s records who requested the interperiodic screening, why it was requested, and the outcome of the screening. The concern, symptoms or condition that led to the request must be documented, as well as any diagnosis and/or referral resulting from the screening. Documentation must indicate that all components of screening were completed.

There is no limit on the number or frequency of medically necessary interperiodic screenings, or on their proximity to other screenings. Therefore, documenting who requested the interperiodic screening, why it was requested, and the outcome of the screening is essential.

These codes are billed hard copy on the CMS-1500 form and are listed below. These codes are to be listed in addition to T1015-EP. Completed examples are on the following pages.

Registered Nurse interperiodic screening codes:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>TD plus TS</td>
<td>Interperiodic Re-evaluation and Management (infant under 1 year)</td>
</tr>
<tr>
<td>99392</td>
<td>TD plus TS</td>
<td>Interperiodic Re-evaluation and Management (ages 1-4)</td>
</tr>
<tr>
<td>99393</td>
<td>TD plus TS</td>
<td>Interperiodic Re-evaluation and Management (ages 5-11)</td>
</tr>
<tr>
<td>99394</td>
<td>TD plus TS</td>
<td>Interperiodic Re-evaluation and Management (ages 12-17)</td>
</tr>
<tr>
<td>99395</td>
<td>TD plus TS</td>
<td>Interperiodic Re-evaluation and Management (ages 18-21)</td>
</tr>
</tbody>
</table>

TD = Nurse  
TS = Interperiodic screening

Physician interperiodic screening codes:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>TS</td>
<td>Interperiodic Re-evaluation and Management (infant under 1 year)</td>
</tr>
<tr>
<td>99392</td>
<td>TS</td>
<td>Interperiodic Re-evaluation and Management (ages 1-4)</td>
</tr>
<tr>
<td>99393</td>
<td>TS</td>
<td>Interperiodic Re-evaluation and Management (ages 5-11)</td>
</tr>
<tr>
<td>99394</td>
<td>TS</td>
<td>Interperiodic Re-evaluation and Management (ages 12-17)</td>
</tr>
<tr>
<td>99395</td>
<td>TS</td>
<td>Interperiodic Re-evaluation and Management (ages 18-21)</td>
</tr>
</tbody>
</table>

TS = Interperiodic screening
**EXAMPLE OF:**

Interperiodic Screening Performed by a Nurse on a 7 Year Old Child.

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### CMS 1500 Interperiodic Claim Example

**EXAMPLE OF:** Interperiodic Screening Performed by a Nurse on a 7 Year Old Child.

#### Patient Information

- **Name:** Smith, Johnny
- **DOB:** 01/18/98
- **Gender:** Male
- **Address:** Smith, Johnny
- **City:** Sunny, LA
- **Phone:** 1111111

#### Claim Information

- **Primary Diagnosis:** 314 0
- **Diagnosis Code:** T1015
- **Procedure:** EP
- **Date:** 11/03/05
- **Time:** 05
- **Duration:** 72

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### NOTE

For detailed instructions, refer to the original document. This example is a simplified representation for educational purposes.
EXAMPLE OF:
Interperiodic Screening Performed by a Physician on a 7 Year Old Child.
## RHC/FQHC AND KIDMED ERROR CODES

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Message</th>
<th>Reason for Denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>092</td>
<td>Invalid procedure modifier</td>
<td>When procedure T1015 is billed without the EP modifier on the KM3 claim form</td>
</tr>
</tbody>
</table>
| 136        | No eligible service paid, encounter denied | Several different types of errors can cause this denial:  
- When encounter code T1015, mod. EP, is billed without an approved corresponding detail line item(s)  
- When line item detail is billed without the corresponding encounter code T1015 with modifier EP  
- When immunizations, vision and/or hearing screenings are billed without a physician or nurse screening |
| 210        | Provider/Procedure Conflict       | Billing a code after May 1, 2003 that has been put in a non payable, non billable status will trigger this denial                                 |
| 517        | KIDMED Format Required            | The claim was not submitted in the KIDMED format.                                                                                                |
| 518        | KIDMED information missing        | The immunization and suspected condition information was not indicated on the claim form                                                      |
| 715        | Duplicate edit                    | In situations where a medical screening is billed with T1015 EP on the KM3 and immunizations are listed on the CMS 1500 with T1015 EP for the same day of service one of the encounters will pay at the providers established rate and the others will deny |

*Note: This is not an all-inclusive list.

**REMINDER:** An encounter code, modifier(if necessary) and supporting detail must be entered on each claim form to get the correct error code.
In response to hurricane Katrina, DHH has issued the following announcements with regards to the Louisiana Medicaid Dental Program:

**MESSAGE # 1 – DENTAL PRIOR AUTHORIZATION TEMPORARILY DISCONTINUED**

The LSUHSC, School of Dentistry, which provides Medicaid dental prior authorization, is located in New Orleans, LA and was affected by Hurricane Katrina. **As a result, Medicaid is discontinuing the dental prior authorization requirement for the EPSDT Dental, Adult Denture and Expanded Dental Services for Pregnant Women Programs for dates of service from August 29, 2005 through September 30, 2005. Dental providers are reminded that they must continue to follow applicable dental program policy for all dental programs and must check the established patient's treatment record to ensure that policy requirements are being met. Effective October 1, 2005, dental prior authorization requests should be sent to the following address**: 

LSU School of Dentistry, Dental Medicaid Unit  
1100 Florida Ave., Box F5-510  
New Orleans, LA 70119*

*Note: The above address has been changed. Please refer to Message # 5 entitled “New Temporary Address for Medicaid Dental Prior Authorization Requests” for the updated address.*

Although the New Orleans location may not be back in operation at that time, the mail will be rerouted to their temporary location. Please refer to the following website for information updates: [www.lamedicaid.com](http://www.lamedicaid.com). If you have any questions, you may contact Terri Norwood, Dental Program Specialist, by calling (225) 342-9403

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**MESSAGE # 2 – DENTAL BILLING REQUIREMENTS AND ADDITIONAL PRIOR AUTHORIZATION INFORMATION**

Special billing requirements and prior authorization procedures that are necessary as a result of the temporary discontinuance of dental prior authorization are as follows:

**Billing Requirement 1**

If a prior authorization number was issued for a dental procedure, the prior authorization number must be entered on the claim for payment regardless of the date of service.

**Billing Requirement 2**

A prior authorization number must not be entered on a claim for payment when billing for a dental procedure in which:
• The prior authorization was temporarily discontinued; and
• The date of service is between August 29, 2005 and September 30, 2005; and
• A prior authorization number was not previously issued for that procedure.

If a prior authorization number is entered on a claim for payment in this instance, the claim will deny.

If the two billing requirements referenced above apply to the same patient, two separate claims for payment should be submitted as follows: One claim for the services in which a prior authorization number was issued (enter PA number on the claim); and a separate claim for services in which the prior authorization was temporarily discontinued and a PA number was not previously issued (no PA number on the claim). In these instances, if dental services that never require prior authorization are also rendered, they can be listed on either claim form.

Additional Prior Authorization Information

Dental prior authorization requests that are received by LSU School of Dentistry, Dental Medicaid Unit prior to October 1, 2005 that have not already been issued a prior authorization number will not be processed.

If a post authorization is required for a date of service prior to August 29, 2005, a post authorization request that includes the date of service must be submitted on or after October 1, 2005 to the following address*:

LSU School of Dentistry, Dental Medicaid Unit
1100 Florida Avenue, Box F5-510
New Orleans, LA 70119*

* Note: The above address has been changed. Please refer to Message # 5 entitled “New Temporary Address for Medicaid Dental Prior Authorization Requests” for the updated address.

Although the New Orleans location may not be back in operation at that time, the mail will be re-routed to their temporary location.

Effective October 1, 2005, requests for prior authorization of dental services which are to be rendered on or after October 1, 2005 should be submitted to the above-referenced address.

Dental providers should not submit a “post” authorization request for dental procedures in which the prior authorization was temporarily discontinued when the procedures were rendered for dates of service August 29, 2005 through September 30, 2005. Providers should submit the claim for payment for these dates of service directly to Unisys.

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MESSAGE # 3 - BILLING REQUIREMENTS FOR DENTURES & DENTURE RELATED SERVICES - EPSDT DENTAL AND ADULT DENTURE PROGRAMS

The following provides information related to complete or partial denture construction, complete or partial denture relines and other denture related services that were begun between the dates of August 29, 2005 through September 30, 2005.

General Information
As always, the date of service on a claim for Medicaid payment must be the date that the final service is completed or delivered to the patient.

Dental providers are reminded that they must continue to follow applicable dental program policy for all dental programs and must check the established patient’s treatment record to ensure that Medicaid policy requirements are being met.

Providers must fully document all services rendered. Records must include a chronological (dated) narrative account of each patient visit indicating what treatment was performed/provided or what conditions were present on those visits. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the patient’s treatment record.

**Billing Requirements for Complete and Partial Dentures and Denture Relines (EPSDT Dental & Adult Denture Programs)**

As previously announced, the dental prior authorization requirement has been discontinued for dates of service August 29, 2005 through September 30, 2005. The following will provide additional information specific to complete and partial dentures and complete and partial denture relines provided to patients in the EPSDT Dental and Adult Denture Programs.

If the new denture construction or denture reline process began between the dates of August 29, 2005 through September 30, 2005, every effort should be made to deliver the completed denture to the patient prior to October 1, 2005.

In the event that new denture construction or denture reline process began between the dates of August 29, 2005 and September 30, 2005 and the new or relined denture could not be completed and delivered to the patient until after September 30, 2005, Medicaid will extend the prior authorization discontinuance under these circumstances for these services through December 31, 2005 to allow adequate time for delivery.

Special billing instructions as identified below are required when filing a claim for payment for a new denture or denture reline between the dates of service October 1, 2005 through December 31, 2005 when the new denture construction or reline process began between the dates of August 29, 2005 and September 30, 2005:

- Claims for payment must be sent to the LSU School of Dentistry, Dental Medicaid Unit, 1100 Florida Avenue, Box F5-510, New Orleans, LA 70119*; along with the following:
  1) A cover letter explaining that this is a claim for payment for a denture that was begun during the dates of service when dental prior authorization was discontinued; and
  2) One original and one copy of the ADA claim form. NOTE: ADA claim form, Block 1, must be marked “Statement of Actual Services” and the claim completed so that it is acceptable by Unisys for payment; and
  3) The entire patient treatment record which includes the prosthetic prescription and laboratory bill(s); and
  4) All pertinent radiographs taken. If radiographs are unavailable because they were previously submitted to the Medicaid Dental Prior Authorization Unit and have not been returned, please document this information in the remarks section of the ADA claim form.

**Note:** The above address has been changed. Please refer to Message # 5 entitled “New Temporary Address for Medicaid Dental Prior Authorization Requests” for the updated address.
Upon completion of Medicaid review and approval, these claims will be submitted to Unisys for payment. Post authorization is not required and authorization requests must not be submitted in this instance.

If the denture construction or denture reline process began between the dates of services August 29, 2005 through September 30, 2005 and the denture is not able to be delivered prior to December 31, 2005, a post authorization for the service will be required. The date of service must be entered on all post authorization requests.

**Adult Denture Program - Other Denture Related Services**

Medicaid covered dental examinations and radiographs that were rendered according to Adult Denture Program policy for dates of service August 29, 2005 through September 30, 2005 are to be billed directly to Unisys without prior authorization. Prior or post authorization is required for these procedures for any other dates of service. If a prior authorization number was already obtained for the procedure, the prior authorization number must be entered on the claim regardless of the date of service.

**Prior/Post Authorization and Billing Questions in Unique Situations**

The new telephone number for the LSU School of Dentistry, Dental Prior Authorization Unit will be provided as soon as possible. You must contact the LSU Dental Prior Authorization Unit for further instructions on how to handle unique situations such as the following:

The date of service for an examination and radiograph was prior to August 29, 2005 and a prior authorization number has not already been obtained, and the new denture was completed and delivered for a date of service when the prior authorization requirement was discontinued. In this instance, the examination and radiograph will require a post authorization but the denture will not.

Providers must contact the Dental Prior Authorization Unit for instructions on completion of the post authorization claim form.

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**MESSAGE # 4 - MEDICAID DENTAL PRIOR AUTHORIZATION UNIT TEMPORARY TELEPHONE NUMBER**

The Medicaid Dental Prior Authorization Unit has been temporarily relocated due to Hurricane Katrina. The new temporary telephone number for the Medicaid Dental Prior Authorization Unit is **225-216-6470**.

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**MESSAGE # 5 - NEW TEMPORARY ADDRESS FOR MEDICAID DENTAL PRIOR AUTHORIZATION REQUESTS**

Effective October 1, 2005 and until further notice, all Medicaid dental prior authorization requests must be mailed to the following address: **LSUHSC School of Dentistry, Medicaid Dental Unit, P.O. Box 80159, Baton Rouge, LA 70898-0159.**
MESSAGE # 6 - RETURN OF MEDICAID DENTAL PRIOR AUTHORIZATION

Effective October 3, 2005, the Medicaid Dental Prior Authorization (PA) Unit will be operational at their new temporary location. The new temporary telephone number for the Medicaid Dental Prior Authorization Unit is 225-216-6470.

In addition, the following new temporary address has been established and should be used effective October 1, 2005 and until further notice when submitting dental prior authorization requests:

LSUHSC School of Dentistry
Medicaid Dental Unit
P.O. Box 80159
Baton Rouge, LA 70898-0159

The following will provide information regarding the handling of dental prior authorization requests. Due to Hurricane Katrina and the discontinuance of dental prior authorization for dates of service August 29, 2005 through September 30, 2005, all prior authorization requests that were postmarked prior to October 1, 2005 will be returned to the provider unprocessed with the following exception: The Medicaid Dental Prior Authorization Unit will process the prior authorization request if the date of service was prior to August 29, 2005, and the date of service is entered on the claim form submitted for prior authorization. Dental providers will be responsible for resubmitting the prior authorization request in the following instances:

- When the prior authorization request is for a date of service prior to August 29, 2005 and the date of service was not entered on the claim previously submitted for prior authorization. The provider must resubmit the request with the date of service entered on the claim form.

- When the date of service is after September 30, 2005. (Refer to the following website for further information regarding dentures and denture relines that were begun between the dates of August 29, 2005 and September 30, 2005 and not delivered by September 30, 2005: www.lamedicaid.com under the links entitled Hurricane Katrina Medicaid Provider and Recipient Information / Dental Providers)

If radiographs are unavailable because they were previously submitted to and have not been returned by the Medicaid Dental Prior Authorization Unit, providers must enter this information in the remarks section of the claim form submitted for prior authorization.
Reminders:

- Dental services rendered for dates of service August 29, 2005 through September 30, 2005 do not require prior authorization.
- A post authorization request must not be submitted to the dental prior authorization unit for services rendered between August 29, 2005 and September 30, 2005.
- The claim for payment for dates of service August 29, 2005 through September 30, 2005 for procedures that usually requires prior authorization should be submitted directly to Unisys without a prior authorization number and without attachments.

Please access this website (www.lamedicaid.com) frequently as updates will be provided through this medium.

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EMERGENCY PROVIDER ENROLLMENT

A link to the Hurricane Katrina Emergency Provider Enrollment Packets may be found on the home page for Louisiana Medicaid’s website at www.lamedicaid.com under the link entitled EMERGENCY PROVIDER ENROLLMENT PACKETS.

Recipient Eligibility Verification

Providers may call Provider Relations at 1-800-473-2783 for information on how to verify recipient eligibility.

Dental Billing/Policy and Procedures

Enrolled Louisiana Medicaid providers must follow the adopted guidelines issued due to Hurricane Katrina as well as those already established by Louisiana Medicaid. For complete billing procedures and policies providers must use the following materials:

- 2003 Dental Services Manual - Chapters 7(E) &16
- Dental Training Packet (2004 Fall Issue)
- Basic Services Training Packet (2004 Fall Issue)
- RHC/FQHC Training Packet (2004 Fall Issue)
- Dental Fee Schedules for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program, Adult Denture Program and Expanded Dental Services for Pregnant Women (EDSPW) Programs

These materials are located online at www.lamedicaid.com. Providers should visit this website frequently as updated information will be posted as necessary.

Dental services policy information provided in the 2004 Dental Training Packet replaces previously published policy. In addition, the 2004 Dental Training Packet contains the current policy and other information related to the Expanded Dental Services for Pregnant Women Program.

The 2004 Dental Training Packet, the 2004 Basic Services Training Packet, and the 2004 RHC/FQHC Training Packet may be found under the link entitled “Training” on the above-referenced website.

The current Medicaid Dental Program Fee Schedules are located under the link entitled “Fee Schedules” on the above-referenced website.
Note: Medicaid is accepting only hard copy billing claim forms from all providers enrolled as “emergency” providers. Electronic claims submission will not be accepted from providers enrolled on this emergency basis. The 2002 American Dental Association Claim Form and the 2002, 2004 American Dental Association Claim Form are the only hardcopy dental claim forms accepted for Medicaid prior authorization and reimbursement of services provided under the EPSDT Dental, Adult Denture and EDSPW Programs.