PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid)

HOME HEALTH AGENCY

(Enrollment packet is subject to change without notice)

PT 44
Revised 6/2021

GENERAL INFORMATION FOR PROVIDER ENROLLMENT

Provider Enrollment works on a three-week turnaround time frame. If enrollment requirements are not met, the entire application will be returned for correction and would need to be re-submitted once the corrections are made. Any re-submission of the enrollment packet is subject to additional three-week turnaround period.

The effective date for this enrollment will be the day the application is actually worked by Provider Enrollment.

No billing for 18 months will result in an automatic closure of this provider number, which will require a new enrollment application in order to be re-activated. No notification will be made to the provider regarding automatic closure.

Upon completion of the Medicaid enrollment process, all OAAS Waiver Service providers and some providers of other Medicaid services will automatically be added to a Freedom of Choice listing in a web-based program called Provider Locator Tool. This enables public users to search for Medicaid and/or Home and Community Based Service providers who accept Louisiana Medicaid.

If at any time during enrollment as a Waiver Medicaid provider, the provider has a change of physical address, then the provider must first obtain an updated license indicating the new address, and then submit notification of the change of address along with a copy of the updated license to Gainwell Provider Enrollment (see address on checklist, below).

NOTICE

Home Health Agencies Billing DME Directly to Louisiana Medicaid

The Louisiana Department of Health mandates that Medicaid will adhere to the accreditation requirement under the Medicare Modernization Act of 2003 for Home Health Agency providers seeking reimbursement for DME.

Home Health providers wanting to bill DME directly through their Louisiana Medicaid Provider number must submit a written request to Gainwell Provider Enrollment and attach verification of their accreditation - from one of the following (10) national organizations authorized by Medicare:

- The Joint Commission (JC); website: http://www.jointcommission.org/
- National Association of Boards of Pharmacy (NABP); website: www.nabp.net
- Board of Orthotist/Prosthetist Certification (BOC); website: www.bocusa.org
- The Compliance Team, Inc; website: www.exemplaryprovider.com
- American Board for Certification in Orthotics & Prosthetics, Inc (ABC); website: www.abcop.org
- The National Board of Accreditation for Orthotic Suppliers (NBAOS); website: www.nbaos.org
- Commission on Accreditation of Rehabilitation Facilities (CARF); website: www.carf.org
- Community Health Accreditation Program (CHAP); website: www.chapinc.org
- HealthCare Quality Association on Accreditation (HQAA); website: www.hqaa.org/
- Accreditation Commission for Health Care, Inc; website: www.achc.org

ATTENTION!!
Waiver service providers are required to comply with all requirements contained in:

1. The provider manuals located at:

https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

And
2. The information located on the LDH/OCDD website at

http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8

3. The information located on the DHH/OAAS website at http://new.dhh.louisiana.gov/index.cfm/subhome/12/n/7

Home Health Agency

CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Gainwell Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as a Home Health Agency provider:

Completed	Document Name
☐ *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
☐ *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business
☐ *	5. **(If submitting claims electronically)** Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form **and** Power of Attorney Form (if applicable).
☐	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited **(deposit slips are not accepted**).
☐	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (**W-9 forms are not accepted**).
☐	8. Copy of Home Health Agency license issued by Health Standards.
☐	9. To bill for DME services directly: Submit a written request **–and-** Attach the DME accreditation certificate.
☐	10. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 87 (All Other).
FOR NOW/ROW SERVICES:	
☐**	11. To request NOW Skilled Nursing Services and/or ROW Nursing Services, complete the NOW/ROW Provider Verification Form.
FOR ROW SERVICES:	
☐	12. To report "Sub-specialty" for this provider type to provide ROW Nursing Services, use Code 4W (Waiver Services) on Section A of the PE-50.
FOR COMMUNITY CHOICES WAIVER SERVICES:	
☐**	13. Completed and notarized *"Provider Attestation for OAAS Community Choices Waiver Skilled Maintenance Therapy and Nursing Services"* form.
☐	14. To report "Sub-Specialty" for this provider type to provide one or more of the 4 Community Choices Waiver Skilled Maintenance Therapies on Section A of the PE-50, please **use <u>one</u> of the following codes**: <u>6T</u> (Community Choices Waiver – Physical Therapy) <u>7H</u> (Community Choices Waiver – Occupational Therapy) <u>7G</u> (Community Choices Waiver – Speech/Language Therapy) <u>3E</u> (Community Choices Waiver – Physical Therapy & Occupational Therapy) <u>3F</u> (Community Choices Waiver – Physical Therapy & Speech/Language Therapy) <u>3H</u> (Community Choices Waiver – Occupational Therapy & Speech/Language Therapy) <u>3L</u> (Community Choices Waiver – Physical Therapy, Occupational Therapy & Speech/Language Therapy) <u>3R</u> (Community Choices Waiver – All Skilled Maintenance Therapies)
☐	15. To report "Sub-Specialty" for this provider type to provide Nursing Services under the Community Choices Waiver on Section A of the PE-50, please use Code 8N.
☐	16. To report "Sub-Specialty for this provider type to provide Personal Assistance Services under the Community Choices Waiver on Section A of the PE-50, please use Code 5W.
☐	17. To report "Sub-Specialty" for this provider type to provide Nursing Services **<u>AND</u>** Personal Assistance Services under the Community Choices Waiver on Section A of the PE-50, please use Code 9A.

*****These forms are available in the **Basic Enrollment Packet for Entities/Businesses**.

******Forms are included here.

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

Provider Verification for NOW/ROW Services
To Be Completed By the Home Health Agency

Provider Number:	**LA Medicaid Provider #** (leave blank if new applicant)								**National Provider Identifier (NPI)**												
Provider Name:																					
Physical Address:																					
Nursing Services Being Requested:	NOW Skilled Nursing Service ☐ ROW Nursing Service ☐ NOW Skilled Nursing Service and ROW Nursing Service ☐																				
Contact Person for questions regarding this form:																					
Contact Person Phone Number:	( ) -																				

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct, and
- that I can receive reimbursement for services provided only to those persons within the New Opportunities Waiver (NOW) and/or Residential Options Waiver (ROW), and
- that all Professional Services provided to any NOW and/or ROW participants must be prior authorized before services are rendered, and
- that as a Professional providing services to ROW participants, I have one year paid experience working with people with developmental disabilities as outlined in the ROW Provider Manual, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of_____, State of_____on the _ day of_____, 20___.

Print Individual Provider's Name

Notary Public Signature

Individual Provider's Signature

Notary Seal or Notary Identification Number (required)

Complete this form in its entirety and mail the original to:

Gainwell Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898-0159

Provider Attestation for Community Choices Waiver
Skilled Maintenance Therapy and Nursing Services

PURPOSE

This form confirms that the provider specified below wishes to provide one or more of the Skilled Maintenance Therapy services and/or nursing services under the Community Choices Waiver program, and attests that the provider will conform to prior approval and reimbursement regulations and policies and that licensed Occupational Therapist, Physical Therapist, and/or Speech Therapist, personnel (as applicable) used will have one full year of verifiable experience working with the elderly.

Provider Number:	**LA Medicaid Provider #** (leave blank if new applicant)	**National Provider Identifier (NPI)**
Provider Name:		
Physical Address:		
Professional Category (choose all that apply):	OT ☐ PT ☐ ST ☐ Nursing ☐	
Contact Person for questions regarding this form:		
Contact Person Phone Number:	( ) -	

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct; and
- that I can receive reimbursement for services provided only to those persons within the Community Choices Waiver; and
- that Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare; and
- that failure to exhaust these above referenced third party payer sources may subject this/my Medicaid enrolled agency to recoupment of funds previously paid by Medicaid; and
- that all Professional Services provided to Community Choices Waiver participants must be prior authorized before services are rendered; and
- that as a provider of services to Community Choices Waiver participants, any licensed therapist used will have one full year of verifiable experience working with the elderly, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

Print Authorized Representative's Name _____ Signature of Authorized Representative _____ Date of Signature _____

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____, State of _____ on the day of _____, 20____.

Notary Public Signature _____

Notary Seal or Notary Identification Number (required)

Complete this form in its entirety. Original signature required – blue ink only