

**EPSDT HEALTH SERVICES/
EPSDT PERSONAL CARE SERVICES
Provider Manual**

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

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PREFACE

Louisiana Medicaid Program (Title XIX), also known as the Louisiana Medical Assistance Program, is designed to help eligible Medicaid recipients in accessing medical care within the applicable federal and state rules and regulations. The Louisiana Medicaid Program is administered by the Bureau of Health Services Financing (BHSF), a subdivision of the Louisiana Department of Health and Hospitals (DHH). Reimbursement may be made for professional services when qualified, enrolled providers provide these services to eligible Medicaid recipients.

This manual is one of a series published for medical services providers enrolled in the Louisiana Medicaid Program. It is not a legal description of all aspects of the Louisiana Medicaid Program or Title XIX rules and regulations, but it does set forth the conditions and requirements professional services providers must meet to qualify for reimbursement. In addition, this manual provides the procedural information professional services providers need to file claims for services promptly and accurately.

This manual is applicable to providers who file claims with the fiscal intermediary for services to Medicaid recipients. This manual is divided into easily accessible sections, so providers may find information quickly. We suggest that this material be studied then maintained in a special file for future reference.

From time to time, policies governing professional services change. Providers will be notified via written memorandums and revised manual pages regarding revisions and updates to policies in this manual. All revisions received should be placed in the appropriate section of the manual. Should there be a conflict between manual material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

Providers may obtain copies of this manual by contacting the Provider Relations Unit of the fiscal intermediary, Unisys at (504) 924-5046 or 1 (800) 473-2783.



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I. INTRODUCTION

The Louisiana Medicaid Assistance Program, now called the Louisiana Medicaid Program, became effective on July 1, 1966, under provisions of Title XIX of the 1965 Amendments to the *Federal Social Security Act* and Article 18, Section 7, Subsection 1, of the *Louisiana Constitution*, as amended. The Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), is the designated state agency responsible for administering the program. The Louisiana Medicaid Program is designed to provide certain health care benefits for those *categorically needy* and *medically needy recipients* who are in need of medical services.

The BHSF is responsible for the overall management of the Louisiana Medicaid Program, including the following functions:

- Determining all necessary regulations and guidelines for the Louisiana Medicaid Program policy;
- Administering the program;
- Determining the services covered by the program and setting the reimbursement rates within federal guidelines;
- Determining eligibility of recipients, maintaining the recipient eligibility file, and issuing identification cards to certain categories of recipients;
- Enrolling providers who wish to participate in the program;
- Operating a Medicaid Management Information System (MMIS) and processing claims from providers through its fiscal intermediary;
- Operating an EPSDT tracking system through its contractor.

II. MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

A fiscal intermediary is required to operate an approved Medicaid Management Information System (MMIS) consistent with guidelines established by DHH.

A. Major Objectives

MMIS is a claim processing and information retrieval system designed to improve the management and control of Title XIX expenditures. The system is designed to reduce program costs through effective claims processing and utilization control. The major objectives of the system are as follows:

1. Improve services to recipients;
2. Reduce payment time to providers;
3. Provide faster responses to inquiries;
4. Improve claims processing efficiency;
5. Increase use of computer capabilities;
6. Provide greater utilization of the information databases;
7. Improve control and audit trails;
8. Improve ability to handle increased claims volume; and,
9. Improve ability to handle federal reporting requirements.

Automation serves as the foundation for the system. Data entry of claims is done through batch key-entry and online teleprocessing technology. The capability exists for online data entry and update of the informational files which support claims processing. Data security is provided through the employment of batch controls and audit trails. Backup and recovery procedures exist that support the security efforts. Manual operations provide a smooth interface with the automated aspects of the system.

B. Administrative Duties

The fiscal intermediary is also responsible for doing portions of the work associated with the administration of the program. Duties include providing the following:

1. Clerical staff to process claims;
2. Computer systems designed to DHH standards for federal funding for administrative control;
3. Computer equipment and program support;
4. Management information tools to improve control of the program;
5. Provider Relations personnel;
6. Pharmacy Benefits Management Program including a drug utilization review program (DUR);
7. A Surveillance and Utilization Review Subsystem (SURS) and SURS personnel;
8. Recommendations regarding medical policy; and,
9. Prior Authorization personnel.

III. WHAT IS MEDICAID?

Medicaid is a means of delivering medical care to eligible needy individuals. The term *Medicaid* is derived from the words *Medical* and *aid*, and it suggests the financial and the medical assistance that many patients require.

The state's Medicaid plan is formally included within the Louisiana Medicaid Program. The legal basis for the plan is contained in Title XIX of the *Social Security Act*; and thereafter, the term **Title XIX** is also used to refer to the program. Therefore, the Louisiana Medicaid Program may be called the Medical Assistance Program or Title XIX.

The Medicaid system provides state and federal funds for health professionals who perform and/or deliver medically necessary services and/or supplies for eligible Medicaid recipients. The administration of the Louisiana Medicaid Program is a cooperative effort of the federal and state government.

Health Care Financing Administration (HCFA) sets the guidelines for the states' participation in Medicaid and monitors the different state programs. The Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) determines policies for complying with state laws and federal guidelines. It is directly responsible for the administration and monitoring of the Louisiana Medicaid Program and for distributing information to providers.

IV. COMPONENTS OF MEDICAID

A. The Provider

The provider's role is to render health care services within a specialized field to eligible Medicaid recipients. To receive reimbursement for these services, the provider must agree to abide by the rules and regulations set forth by the program.

B. The Recipients

The purpose of Medicaid is to make health services available to the needy. Determining eligibility for Medicaid is the responsibility of the Louisiana Medicaid Program, BHSF. The BHSF reports the eligible recipients to the fiscal intermediary.

In Louisiana, Medicaid recipients are classified as *Categorically Needy* or *Medically Needy*.

C. The Card

The recipients, in either classification, will be issued a medical eligibility card monthly. The purpose of this card is:

1. To serve as a notice to recipients of their eligibility for Medicaid;
2. To identify eligible recipients to providers of medical care services.

A detailed explanation of the Medical Eligibility Card can be found in the *Eligibility* section of this manual.

V. STANDARDS FOR PARTICIPATION

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

- A. Provider agreement and enrollment with BHSF;
- B. Agreement to charge Medicaid no more for services furnished eligible recipients than is charged on the average for similar services to others;
- C. Agreement to accept as payment in full the amounts established by the BHSF and not to seek additional payment from the recipient for any unpaid portion of a bill; except in cases of Spend-Down Medically Needy recipients;
- D. Agreement to maintain medical records, all Remittance Advices, and any information regarding payments claimed by the provider for furnishing services; and,

NOTE: Records must be retained for three (3) years and be furnished as requested, to BHSF, its authorized representative, representatives of DHH's or the state Attorney General's Medicaid Fraud Control Unit.

- E. 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 1973*, and, where applicable, Title VII of the *1964 Civil Rights Act*.

VI. INDICATION OF AGREEMENT

Although this is a voluntary program, providers should note that their signature on a claim form will serve as their agreement to abide by all policies and regulations of the Louisiana Medicaid Program. This agreement also certifies that, to the best of the provider's knowledge, information contained on the claim form is true, accurate, and complete.

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ELIGIBILITY

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I. ELIGIBILITY

Medicaid eligibility is determined by the BHSF. This section contains an explanation of the different types of Medicaid eligibles and an example of the Medicaid eligibility card.

II. CLASSIFICATION OF ELIGIBLE RECIPIENTS

There are two classifications for eligible recipients in the Louisiana Medicaid Program:

A. Categorically Needy

Recipients classified as Categorically Needy have met all requirements, including the income requirement, for the Louisiana Medicaid Program. No payment can be accepted from these recipients for benefits billed to Medicaid.

B. Medically Needy (Types 20, 21, and 25)

Medically Needy recipients may be either:

1. **Regular Medically Needy** or
2. **Spend-down Medically Needy**—Eligibility begins on the exact date that medical expense incurred by these recipients allow them to “spend-down” to the income that will qualify them for Medicaid. These recipients are responsible for a co-payment for some expenses.

Any provider who has medical bills from the exact date of the recipient’s spend-down will receive a **Spend-down Medically Needy Notice (Form 110-MNP)** from the BHSF. A sample of this form is provided on the following page. This form will notify the provider of the co-payment amount due by the recipient for the bill and of the amount to be billed to Medicaid. *The provider must attach this form to the claim and submit the claim manually to the fiscal intermediary for processing.* The provider cannot bill the recipient for any amount over the amount specified on the Form 110-MNP under **Recipient Liability**.

NOTE: Service restrictions apply to Medically Needy benefits effective August 1, 1997. **Eligibility for service coverage should be verified.**

MEDICAID PROGRAM Spend-Down Medically Needy Notice

Case Name _____ Identification Number _____

Recipients listed on the medical eligibility card are eligible for Medicaid health care coverage from ____ / ____ / ____ (spend-down date) through ____ / ____ / ____

PROVIDER NOTICE: The services listed below occurred on the spend-down date (beginning date of Medicaid coverage) according to information available to us. Bill our Fiscal Intermediary (FI) for the services rendered on this date **only** if Medicaid Liability for the service is indicated by a in the Yes block of the last column below. Medicaid payment for services rendered on the spend-down date will be made **only** for the services listed below and **only** if a copy of this form is attached to your claim. Payment will be made in accordance with the limits established as usual, reasonable, and customary charges. Enter the Recipient Liability Amount shown below in the Recipient Liability column of the billing document.

Patient Name and Identification No. (13 digits)	Provider Name and Vendor No.	Service or Rx Received on Spend-Down Date	Total Unpaid Charges for Services Received	Recipient Liability Amount	Medicaid Liability? Yes No
.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
.....				<input type="checkbox"/> Yes <input type="checkbox"/> No

Agency Representative Signature/Title _____ Telephone No. _____ Date _____

III. IDENTIFICATION OF ELIGIBLE RECIPIENTS

A Louisiana Medical Eligibility Card is issued to each eligible recipient and/or family each month. These cards may be issued by the Department of Social Services, the recipient's parish BHSF office or Office of Family Support, or the fiscal intermediary (FI). Included in this section is a reproduction of a sample card the Categorically Needy recipient. Providers may want to refer this sample for help in understanding the information appearing on the recipient monthly Medical Eligibility Card.

An example of a Medical Eligibility Card issued by the fiscal intermediary is shown on the following page.

LOUISIANA MEDICAL ELIGIBILITY CARD ELIG. FOR - OCT. 94

* KIDMED/ EPSDT

1

TYPE CASE: 01	ELIGIBLE	BIRTH	TPL	CARRIER
ID. NUMBER	RECIPIENT	NAME	DATE	CODE
9903001667401	*1JOHN	DOE I	11/09/84	
9903001667403	*1JOHN	DOE II	03/28/88	
9903001667404	*1JOHN	DOE III	02/12/90	
9903001667420	1JOHN	DOE IV	03/31/67	

DOE IV R JOHN
 P O BOX 999
 SUGARTOWN LA 70622

COMMUNITY CARE PATIENT
 PROVIDER NAME TELEPHONE #
 1 GHANTA M RMD 3183354393

MESSAGES

IMPORTANT: PATIENT MUST SHOW THIS CARD WHEN RECEIVING MEDICAL SERVICES

TPL CODES: A = MEDICARE A; B = MEDICARE B; C = MEDICARE A&B
 D = PRIVINS-DRUGS; E = AMBUL; F = PRIVNS-NO DRUGS; G = INS/PAY-CHASE.

The person(s) shown above is eligible for the payment of certain medical services authorized by Louisiana's Medicaid Program. Benefits under other insurance coverage, including Medicare must be used first. Eligibility for medical services is effective only for the month shown on the upper portion of this card.

Use of this card to obtain medical services to which a person is not entitled will subject that person to arrest and trial under state and federal laws and regulations.

Figure -1: Sample Medical Eligibility Card Issued by the Fiscal Intermediary

IV. COMMUNITYCARE PROGRAM

A. What is CommunityCARE?

CommunityCARE is a managed care program administered by the Louisiana Medicaid Program. A primary care case management (PCCM) system of comprehensive health care has been adopted because of its advantages in rural communities.

1. The program provides Medicaid recipients under age 65 in designated parishes with a primary care physician (PCP) who serves as the recipient's family doctor.
2. The PCP provides basic primary care, referral, and after hours coverage of medical services for each recipient.
3. The PCP receives a small monthly care management fee for recipients assigned to him/her in addition to fee-for-service reimbursement for medical services rendered.

B. The Goals of CommunityCARE

The goals of CommunityCARE are to improve the accessibility, the continuity and quality of care and reduce inappropriate utilization of medical services and the overall cost of care for Medicaid recipients. Medicaid recipients in designated parishes have the opportunity to select a participating physician in their parish or an adjoining parish to be their family doctor. If they do not select a PCP, one is assigned.

C. Identification of CommunityCARE Eligibles

1. CommunityCARE recipients receive a monthly Medicaid eligibility card showing the name and telephone number of the selected/assigned CommunityCARE provider in the lower right-hand corner. The recipient will receive the initial Medicaid card approximately 60 days after the selection or assignment of a primary care physician.
2. One Medicaid card will be issued for each certified household. Each eligible recipient in a certification may select or be assigned to a different CommunityCARE provider. If members of a family unit select different

participating providers, each primary care physician will be listed on the card. For example: A pediatrician may be selected for an infant, a general practitioner may be selected for the parents.

3. Reissuance of lost or stolen Medicaid cards is the responsibility of the parish/regional offices. Replacement cards will be issued manually, listing the recipient's assigned primary care physician. Parish offices and enrolling centers will receive monthly printouts showing primary care physician assignments for eligible recipients.

V. THIRD-PARTY LIABILITY (TPL)

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, that can be applied toward the Medicaid recipient's medical and health expenses. The lack of a third-party code on the eligibility card **does not** negate the provider's responsibility for asking recipients if they have insurance coverage.

- A. Usually, except for those services provided to EPSDT eligibles, it the provider's responsibility to bill the third-party carrier before billing Medicaid.
 1. Where the insurance payment is received after Medicaid has been billed and has made payment, the provider must reimburse Medicaid, not the recipient.
 2. Reimbursement must be made **immediately** to comply with federal regulations.
 3. Providers may reimburse Medicaid by forwarding a check or by submitting an adjustment request. Checks must have identifying information such as date of service, Internal Claim Number (ICN), recipient name and number, and the reason for the reimbursement.
- B. EPSDT providers need not bill a third-party insurance carrier before billing the Louisiana Medicaid Program. The fiscal intermediary will pay the provider for services rendered and "chase" or pursue collection on the portion of the bill that is due by another income source.

SECTION 3
PROVIDER ENROLLMENT AND PROGRAM REQUIREMENTS

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I. PROVIDER ENROLLMENT

Providers who wish to participate in the Louisiana Medicaid Program should contact Unisys, Provider Relations, to request an enrollment packet. They must then complete the packet and submit it to the Provider Enrollment Unit, Bureau of Health Services Financing (BHSF). Enrollment will be approved if the provider meets all qualifications, censure requirements, and the standards for participation in the Louisiana Medicaid Program.

- A. Each enrolling provider must enter an agreement with the Louisiana Medicaid Program. The agreement requires that providers adhere to regulations, including the requirements contained in this provider manual. To participate in the EPSDT Program, providers must complete a Form PE-50 enrollment form and a Medicaid Supplement Agreement.
- B. Copies of enrollment packets may be obtained from the following address:

Unisys Provider Relations
Post Office Box 91024
Baton Rouge, LA 70821

☎ (504) 924-5040

☎ (800) 473-2783

- C. Completed forms should be submitted to the following address:

Bureau of Health Services Financing
Post Office Box 91030
Baton Rouge, LA 70821-9030

☎ (504) 342-9454

- D. If additional information is required, the applicant will be notified. Notification of provider enrollment in the Louisiana Medicaid Program is the assignment of a provider number to be used when submitting claims.

II. CHANGE OF ADDRESS/ENROLLMENT STATUS

- A. Providers who have address changes should notify the Provider Enrollment Unit of BHSF in writing.** Giving notification of address changes will allow correspondence, checks, and rejected claims to be delivered to the appropriate providers in a timely manner. The address and telephone numbers can be found on the preceding page.
- B. Providers who change their group affiliation should notify Provider Enrollment in writing to eliminate the possibility of payments being delivered to the wrong provider/group.**

III. EPSDT PROVIDER ENROLLMENT STATUS

A. Enrolling in EPSDT Health Services

Specific provider requirements that must be met to be a provider for EPSDT Health Services to children with disabilities includes:

1. Completing the Form PE-50 EPSDT Health Services Provider Enrollment Supplement Agreement. See Appendix A. This is a simple form that requires giving identifying information.
2. Submitting the Form PE-50 EPSDT with an original signature to the Provider Enrollment Unit, BHSF. Stamped or copied signatures are not acceptable. If provider enrollment assistance is needed, call Medicaid at (504) 342-9454.
3. Receiving notification of the agency's decision on the request for enrollment by mail within thirty (30) days of Medicaid's receipt of the Form PE-50. The enrollment notification letter will include the Medicaid provider number if approved.

NOTE: The EPSDT provider number will be different from the KIDMED screening provider number if a provider is enrolled in both programs.

B. Program Requirements

EPSDT Health Services program requirements for reimbursement are:

1. All services must be furnished in the interest of establishing or modifying a child's individualized education program (IEP) or an infant or toddler's individualized family services plan (IFSP) or the services furnished must already be included in the current IEP or IFSP. *Non-IEP or non-IFSP services may not be billed to Medicaid under the EPSDT Health Services program.*
2. If providing early intervention services to infants and toddlers, use one of the model IFSP forms found in Appendix C. Medicaid must approve any other IFSP forms before they may be used for reimbursement for these services.
3. *Only local education agencies (school boards) are eligible to enroll for children ages three (3) and above.*
4. *Both public and private early intervention centers may enroll directly with Medicaid as providers of these services for infants and toddlers under age three.*
5. These services must be coordinated with other age appropriate preventive health services, including KIDMED screenings and immunizations. An EPSDT provider may provide these services if they are also a Medicaid enrolled KIDMED screening provider and authorized by KIDMED.
 - a. If an EPSDT provider is **not** a KIDMED provider, contact Louisiana KIDMED at 1 (800) 259-8000 or (504) 928-9683 in Baton Rouge to determine the screening and immunization status of the child.
 - b. Louisiana KIDMED will follow up with the family to arrange for the screening and immunizations if due.
6. These EPSDT services must also be coordinated with the Supplemental Food Program for Women, Infants, and Children (WIC) and Head Start. Make age-appropriate referrals for these services.

7. Ensure that an infant or toddler under age three (3) years has been examined by a licensed physician as part of the Childnet referral process or multi-disciplinary evaluation (MDE). The examination should have been done within the past 90 days.
8. Employ or contract with professional staff qualified to provide the services that meet state and Medicaid practitioner standards regarding certification, licensure, and supervision. Documentation of staff qualifications must be provided to Medicaid as part of the enrollment and monitoring process. Applicable qualifications are listed in Section 5 of this manual.
9. A written referral or prescription must be obtained from a licensed physician to furnish occupational therapy, physical therapy, audiology or speech/language services. This must be done at least annually. The written referral or prescription is not required to conduct an initial evaluation.
10. Agree to bill electronically.
11. Medicaid collections from these services must be spent on the provision of health related services to children regardless of their Medicaid status.
 - a. Expenditures should be prioritized for expanding service delivery through additional employed or contracted staff before allocating funds for equipment and supplies, administrative support activities, capital improvements, or meeting the individual needs of children with disabilities.
 - b. Medicaid funds may not be used for strictly educational or non-medical purposes.

SECTION 4
EPSDT OVERVIEW

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I. WHAT IS EPSDT?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is the child-specific component of the Louisiana Medicaid Program. Louisiana began providing EPSDT services in 1972. EPSDT is designed to make health care available and accessible to low-income children. The more recent changes in the Medicaid statute enacted by Congress in 1989 have greatly expanded Medicaid and EPSDT's role in providing health services for Medicaid eligible children.

EPSDT, also known as KIDMED, provides a framework for routine health, mental health and developmental screening of children from birth to age 21 plus evaluation and treatment for illnesses, conditions or disabilities.

II. WHAT DOES THIS MANUAL COVER?

Primarily for school-based and early intervention services providers of EPSDT evaluation and treatment services for children with disabilities, this manual provides information on:

- What services are covered;
- Which children are eligible;
- How to qualify as an EPSDT provider;
- How to enroll as a provider;
- What the program requirements are;
- What records must be kept?
- What Medicaid pays for these services;
- How to submit billing claims to Medicaid;
- How providers will be monitored; and,
- How to get questions answered.

A separate KIDMED Provider Manual covers KIDMED's EPSDT medical, vision, and hearing screening services. This manual may be requested from the fiscal intermediary.

III. WHAT SERVICES ARE COVERED BY EPSDT?

- A. EPSDT Health Services for children with disabilities include health-related special education services provided by local school boards only for children ages three (3) to 21:
- Audiologic services
 - Occupational therapy evaluations and treatment services
 - Physical therapy evaluations and treatment services
 - Psychological evaluations and therapy (individual and group)
 - Speech and language evaluations and therapy (individual and group)
- B. Early intervention services are provided to infants and toddlers from birth to age three (3). Some of these services are not necessarily covered by *Title XIX*. These services include:
- Assistive technology
 - Audiologic services
 - Family service coordination
 - Health services
 - Medical services
 - Nursing services
 - Nutrition services
 - Occupational therapy
 - Physical therapy
 - Psychological services
 - Social work services
 - Special education services
 - Special instructions
 - Speech/language therapy
 - Transportation services
 - Vision services

IV. WHO IS ELIGIBLE FOR EPSDT HEALTH SERVICES?

All Medicaid eligible children under age 21 are eligible for EPSDT services. It is estimated that 40-60% of the children in public schools are Medicaid recipients and even a larger proportion potentially eligible.

- A. Families receiving Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) are automatically enrolled in Medicaid.
- B. Children from low-income families not receiving cash assistance may be eligible for Medicaid under the Medically Needy or Child Health and Maternity (CHAMP) program.

Under the CHAMP program, pregnant women and children under the age of six from families with incomes up to 133% of the Federal Poverty Level and children born after September 30, 1983 in families with incomes up to 100% of this level may be eligible for Medicaid if other eligibility factors are met.

- C. Families may apply for Medicaid at the local Office of Family Support or Medicaid eligibility offices, local health units or other designated Medicaid enrollment centers. As part of the Medicaid certification, the family must identify any other third party health care coverage they have and permit Medicaid to pursue payment from third party-coverage.

Once certified, the family receives a Medicaid card issued monthly listing the individuals in the family receiving Medicaid. An EPSDT eligible child is shown with a "★" on the Medicaid card. See Section 2 for a sample of the Medicaid card.

- D. *Medicaid eligibility is not permanent.* Infants are continuously eligible for Medicaid to the child's first birthday if the mother was Medicaid eligible at the time of delivery. Eligibility is redetermined every six months except on SSI eligibles that occurs every 12 months. Redetermination entails verification of eligibility criteria either in person or by mail.

V. WHAT IS THE LEGAL BASIS FOR THESE SERVICES?

The legal basis to coordinate Medicaid with state special education and early intervention programs dates from the enactment of the Individuals with Disabilities Education Act (IDEA) Public Law 101-476. This legislation was originally passed in 1975 as Public Law 94-142, the Education of the Handicapped Act.

VI. IDEA

A. Part B of IDEA

Part B of IDEA mandates that all children ages five (5) to 21 with disabilities receive a free, appropriate public education within the least restrictive environment.

1. The law mandates that public school systems must prepare an Individualized Education Program (IEP) for each child eligible under Part B specifying all special education and appropriate health-related services needed by the child.
2. Related services provided in the educational system must be directly related to the educational goals and objectives identified in the IEP.
3. Part B of Public Law 99-457, as amended in 1986, authorized a school grant program to provide the same services to children ages three to five.
4. The law specifically prohibited states using Part B funds to pay for services that should be paid for by other federal, state, and local agencies including Medicaid.

B. Part H of IDEA for Infants and Toddlers

The Part H program for infants and toddlers with developmental disabilities and their families was established as an amendment in 1986 of IDEA. Part H authorized the Secretary of Education to make formula grants available to states for planning, implementing, and coordinating early intervention services for children from birth to age three. In Louisiana, the Department of Education is the lead agency responsible for administering Part H.

1. Act 377 of Part III of Chapter 8 of Title 17 of Louisiana Revises Statutes established the Louisiana Handicapped Infants and Toddlers Program in 1989. This Act assures that eligible families will receive the following services:
 - a. Multi-disciplinary assessments;
 - b. Individualized family service plans; and,
 - c. Case management services.

2. The statutory provisions of Part H state that "Grant funds may be used for direct services that are not already funded by private or other public (Medicaid) sources and may not be used to reduce medical assistance or other services or to alter eligibility under Medicaid and the MCH Block Grant (public health) programs."
3. Legal authority to use multiple funding streams was reinforced by Congress in 1988. Section 1903 of the Social Security Act (42 U.S.C. 13966) the Medicare Catastrophic Coverage Act (MCCA) specifically reiterated that federal Medicaid matching funds are available for the cost of health services covered under a State's Medicaid plan furnished to a disabled infant, toddler, or child even though such services are included in an individualized program (IEP) or an individualized family service plan (IFSP).

Congress added that while the state education agencies are financially responsible for educational services for a Medicaid eligible disabled child, state Medicaid agencies remained responsible for the "related services" identified in the child's IEP if they are covered in the state's Medicaid plan, such as speech pathology and audiology, psychological services, physical and occupational therapy.

4. The Louisiana Medicaid Program expanded its EPSDT discretionary services in 1988 to cover health services provided in the schools to children with disabilities. Medicaid coverage of these services has provided a valuable revenue source allowing local school boards to expand health services to low-income children. The program was again expanded in 1990 to cover preschool age children besides infants and toddlers with disabilities.

VII. OBRA '89

The Omnibus Budget Reconciliation Act (OBRA) changes in Sections 1902 and 1905 of the Medicaid statute greatly expanded EPSDT's role as a financing mechanism of health services for Medicaid eligible children. OBRA '89 added a new required EPSDT services component of "other necessary health, diagnostic, treatment, and other measures....needed to ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state Medicaid plan." These EPSDT changes mean that health related services identified in an IEP or IFSP may be reimbursable for a Medicaid enrolled child.

Part B and Part H of IDEA and EPSDT programs have a set of goals in common: to improve health and provide related services for children as selected in the legislative history. While not a perfect match, the programs together create an excellent opportunity to improve coverage and the range of services for children with disabilities.

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SERVICES AND FEES

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This section describes the minimum components, maximum fees paid by Medicaid and service limits covered under the EPSDT Health Services program for children with disabilities. There is a limit of one service per date of service per provider unless otherwise stated in the service description. It also gives applicable staff qualifications. The related services covered under EPSDT Health Services for children with disabilities include:

- Audiologic services;
- Speech and language evaluations and therapy (individual and group);
- Occupational therapy evaluations and treatment services;
- Physical therapy evaluations and treatment services;
- Psychological evaluations and therapy (individual and group)

Use of assessment tools and guides not listed in this section require prior approval by Medicaid.

Bulletin 1879, *Related Services in the Educational Setting: Guidelines for IEP Committees* identify three methods of service provision for related services in an educational setting:

- Direct Service;
- Tracking / Monitoring
- Consultative

I. THE DIRECT SERVICE MODEL

The direct service model consists of individual treatment provided to a student. Although this model is the most restrictive, it is analogous to the "medical model" of service delivery billable under Medicaid.

- A. Tracking/monitoring consist of directly observing the student, talking with his parents and school staff, conducting any needed assessments and occasional hands-on interaction between the therapist and the student.
- B. Only direct observation and hands-on intervention is Medicaid billable as therapy. Case colleague or system consultation cannot be billed as a therapy service.
- C. Intervention on an indirect nature that does not directly involve the student and therapist is not billable as a Medicaid health service.

II. AUDIOLOGIC SERVICES

Audiology Services are for the identification of children with auditory impairment, using at risk criteria and appropriate audiologic screening techniques. These services include:

- determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures;
- referral for medical and other services necessary for the rehabilitation of children with auditory impairment;
- provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services;

A. Professional Requirements

These services must be provided by or under the direction of an audiologist or a physician in Louisiana in accordance with the licensing standards of the State Examining Board for Audiologists or Physicians.

1. The audiologist or physician must be licensed in Louisiana to provide these services. Federal regulations also require that the audiologist have one of the following:
 - a. A certificate of clinical competence from the American Speech and Hearing Association (ASHA);
 - b. Completion of the equivalent educational requirements and work experience necessary for the certification; or
 - c. Completion of the academic program and is acquiring supervised work experience to qualify for the certificate.
2. A referral must be made by the child's physician, preferably the primary care physician, at least annually in accordance to federal Medicaid regulations.

B. Audiologic Evaluation

Audiologic evaluation is the determination of the range, nature, and degree of a child's hearing loss and communication functions for modifying communicative behavior.

1. The procedures for audiologic evaluation tests, including reports, are listed with their procedure codes, descriptions, and maximum fees reimbursed by Medicaid. These procedures should be billed separately unless otherwise stated in the description for the procedure:

Code	Description	Fee/Unit
92551	Screening test—Puretone, air only	\$ 3.60
92552	Puretone Audiometry (threshold); air only. Hand held devices may not be used.	\$22.50

2. The following codes, except codes 92567, 92568, and 92569, must be done in a sound treated enclosure that meets ANSS-S 3.1-1977 (R. 1986) criteria for permissible ambient noise during audiometric testing, by only an ASHA-certified audiologist or a physician otologist. Table audiometers must be calibrated every two (2) years; portable audiometers must be calibrated every year.

Code	Description	Fee/Unit
92553	Puretone Audiometry (threshold); air and bone. Do not bill in combination with 92552.	\$45.00
92555	Speech Audiometry; threshold only Do not bill in combination with 92556 or 92583.	\$9.00
92556	Speech Audiometry; threshold and discrimination. Do not bill in combination with 92555 or 92583.	\$22.50
92557	Basic Comprehensive Audiometry (puretone, air and bone, and speech, threshold and discrimination) Do not bill in combination with the above codes or 92583.	\$54.00

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Code	Description	Fee/Unit
92563	Tone Decay Test. Bill only once no matter how many frequencies.	\$10.00
92564	Short Increment Sensitivity Index (SISI)	\$20.00
92565	Stenger Test, Puretone	\$15.00
92567	Tympanometry (Impedance testing) Exempted from a sound proof booth requirement. Do not bill in combination with 92568.	\$22.50
92568	Acoustic Reflex Testing Do not bill in combination with 92567.	\$22.50
92569	Acoustic Reflex Decay Test. Exempted from a sound proof booth requirement.	\$36.00
92571	Filtered Speech Test. This is not a preliminary test code Exempted from a sound proof booth requirement.	\$25.00
92572	Staggered Spondaic Word Test	\$75.00
92575	Sensorineural Acuity Level Test	\$20.00
92576	Synthetic Sentence Identification Test	\$25.00
92577	Stenger Test, speech	\$13.50
92582	Conditioning Play Audiometry	\$45.00
92583	Select Picture Audiometry Do not bill in combination with 92556.	\$22.50
92584	Electrocochleography	\$200.00

Code	Description	Fee/Unit
Z9916	Brainstem Evoked Response Screening (Full service fee)	\$ 50.00
Z9916-26	Brainstem Evoked Response Screening (Professional Component Only)	\$ 18.00
92585	Brainstem Evoked Response Recording (A licensed physician must supervise the procedure if sedation is required.)	\$180.00
92590	Hearing Aid Exam and Selection; Monaural	\$65.00
92591	Hearing Aid Exam and Selection; Binaural	\$65.00
92592	Hearing Aid Check; Monaural	\$22.50
92593	Hearing Aid Check; Binaural	\$45.00
92594	Electroacoustic Evaluation for Hearing Aid; Monaural	\$22.50
92595	Electroacoustic Evaluation for Hearing Aid; Binaural	\$45.00

3. **Place of Service codes** on the claim form must use one of the following codes:

- 12 Service provided in the home
- 99 Service provided in an unlisted facility
(school or Early Intervention Center)

III. SPEECH PATHOLOGY SERVICES

Speech Pathology Services are services for the identification of children with communicative or oropharyngeal disorders and delays in development of communication skills including diagnosis and appraisal of specific disorders and delays in those skills. These services include:

- referral for medical or other professional services necessary for the rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills; and
- provision of services for the rehabilitation or prevention of communicative or oropharyngeal disorders and delays in development of communication skills.

A. Professional Requirements

These services must be provided by or under the direction of a speech pathologist or audiologist in accordance with the licensing standards of the State Examiners Board for Speech Pathologists or Audiologists.

1. The speech pathologist or audiologist must be licensed in Louisiana to provide these services. Federal regulations also require that the speech pathologist or audiologist have one of the following:
 - a. A certification of clinical competence from the American Speech and Hearing Association;
 - b. Completion of the equivalent educational requirements and work experience necessary for the certification; or
 - c. Completion of the academic program and is acquiring supervised work experience to qualify for the certificate.
2. A referral must be made by the child's physician, preferably the primary care physician, at least annually in accordance to federal Medicaid regulations.

B. Speech/Language Evaluation

1. Speech/language evaluation includes tests used to determine a child's ability to understand and use appropriate verbal communication, identify communication impairments, and assess:

- a. phonology and language;
 - b. voice and fluency;
 - c. oral structure; and
 - d. mechanism and functioning
2. These services must include the following:
- a. oral motor examination/consultation;
 - b. velopharyngeal examination/consultation;
 - c. child language consultation; and
 - d. observations of feeding dysphagia, when appropriate.
3. The speech/language evaluation procedure code is listed below with the maximum fee reimbursed by Medicaid. This code should be used for any combination of the services in the preceding list. The evaluation procedure may only be reimbursed once in a 180-day period by the same provider.

Code	Description	Fee/Unit
X0412	Speech/language evaluation with report	\$48.60

B. Speech/Language and Hearing Therapy

Speech/language therapy services include the provision of services for the prevention of or rehabilitation of communicative oral pharyngeal disorders, dysphagia disorders, and delays in development of communication.

1. Speech, language, and hearing therapy include the following services, as appropriate and medically necessary:
 - a. speech/language or hearing therapy (individual or group)
 - b. stuttering therapy
 - c. speech reading/oral rehabilitation
 - d. voice therapy
 - e. feeding/dysphagia training
 - f. esophageal speech training therapy
 - g. speech defect training therapy

2. The speech, language and hearing therapy services are listed below with their procedure codes and maximum fees reimbursed by Medicaid.

a. Individual Speech, Language and Hearing Therapy

Code	Description	Fee/Unit
Y2615	Speech, language and hearing therapy-60 minutes	\$27.00
X0423	Speech, language and hearing therapy-30 minutes	\$13.50
Y2611	Speech, language and hearing therapy-20 minutes	\$ 9.00
X0424	Speech, language and hearing therapy-additional 15 minutes; limit two per day	\$ 7.20

b. Group Speech, Language and Hearing Therapy

Code	Description	Fee/Unit
Y2512	Speech, language and hearing therapy-60 minutes	\$14.40
Y2509	Speech, language and hearing therapy-30 minutes	\$ 7.20
Y2510	Speech, language and hearing therapy-20 minutes	\$ 4.50
Y2511	Speech, language and hearing therapy-additional 15 minutes; limit two per day	\$ 3.60

3. **Place of Service codes** on the claim form must use one of the following codes at the end of each individual service:

- 12 Service provided in the home
- 99 Service provided in an unlisted facility (school or Early Intervention Center)

IV. OCCUPATIONAL THERAPY (OT) SERVICES

Occupational Therapy Services address the functional needs of a child related to the performance of self-help skills, adaptive behavior, play and sensory, motor and postural development. OT services include:

- identification, assessment, and intervention;
- adaptation of the environment;
- selection, design, and fabrication to Assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
- prevention or reducing the impact of initial or future impairment, delays in development, or loss of functional ability.

A. Professional Requirements

Occupational therapy must be provided to a child by or under the direction of a qualified occupational therapist licensed in Louisiana to provide these services in accordance with the licensing standards of the State Examiners Board for Occupational Therapists..

1. Federal regulations also require that the occupational therapist must be:
 - a. Registered (OTR) by the American Occupational Therapy Association, Inc. (AOTA); or
 - b. A graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the AOTA.
 - c. Services provided under the direction of an occupational therapist must be provided by an occupational therapy assistant (OTA) certified by the AOTA, who is licensed to assist in the practice of occupational therapy under the supervision of an occupational therapist licensed in Louisiana.
2. Occupational therapy treatment services require a written referral or prescription by a physician licensed in Louisiana on at least an annual basis. An initial evaluation may be done without such a referral or prescription.

B. Occupational Therapy (OT) Evaluation

1. Occupational therapy (OT) evaluation must include assessment of the functional abilities and deficits as related to the child's needs in the following areas:
 - a. Muscle tone, movement patterns; reflexes, and fine motor/perceptual motor development;
 - b. Daily living skills; including self-feeding, dressing, and toileting (Informal assessment tools may be used);
 - c. Sensory integration;
 - d. Prosthetic evaluation, when appropriate;
 - e. Orthotic (splint) evaluation, when appropriate;
 - f. Need for positioning/seating equipment and other adaptive equipment.

2. All evaluation methods must be appropriate to the child's age, education, cultural, and ethnic background, medical status, and functional ability. The evaluation method may include observation, interview, record review, and the use of evaluation techniques or tools.

3. The standard tests listed below must be used, when appropriate:
 - a. Pediatric Screening: A Tool for Occupational and Physical Therapists
 - b. Joint Range or Motion Test
 - c. Berry Developmental Test of Visual-Motor Integration (VMI)
 - d. The Meeting Street School Screening Test (MSSSI)
 - e. Preschool Development Profile (PDP)
 - f. Motor Free Visual Perception Test
 - g. Denver II Developmental Screening Test
 - h. Manual Muscle Tests
 - i. The Macquarrie Test for Mechanical Ability
 - j. Early Intervention Developmental Profile (EIDP)
 - k. Southern California Sensory Integration Test (SCSIT)
 - l. The Miller Assessment for Preschoolers (MAP)
 - m. The Developmental Test of Visual Perception (Frostig)
 - n. Test Visual Perception Skills (TVPS)
 - o. Bruininks-Oseretsky Test of Motor Proficiency
 - p. Informal Methods, including observation of behavior during testing and supplemental observations

4. Evaluation data must be analyzed and documented in summary form to suggest the child's current status. The specific evaluation tools and methods used must also be documented.
5. The applicable procedure code is listed below with the maximum fee reimbursed by Medicaid. This code should be used for any combination of the tests on the preceding list.

Code	Description	Fee/Unit
X0411	Occupational Therapy (OT) evaluation (includes report)	\$48.60

B. Occupational Therapy (OT)

1. The occupational therapy services are listed below with their procedure codes and maximum fees reimbursed by Medicaid:

Code	Description	Fee/Unit
97504	Orthotics training, each 15 minute unit; limit to four units per day	\$ 7.20
97530	Therapeutic activities with direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance); 15 minute units; limit to four units per day	\$ 7.20
97750	Physical performance test of measurement (musculoskeletal, functional capacity) with a written report; 15 minute units; limit to four units per day	\$ 7.20

2. **Place of Service** codes on the claim form must use one of the following codes:

- 12 Service provided in the home
- 99 Service provided in an unlisted facility (school or Early Intervention Center)

V. PHYSICAL THERAPY (PT) SERVICES

Physical Therapy Services are designed to improve the child's movement dysfunction. Includes:

- screening of infants and toddlers to identify movement dysfunction;
- obtaining, interpreting and integrating information appropriate to program planning;
- services to prevent or alleviate movement dysfunction and related functional problems.

A. Professional Requirements

1. Physical therapy services must be provided by or under the directions of a qualified physical therapist in accordance with the state licensing standards of the State Examiners Board for Physical Therapist. Federal regulations also require that the individual must be a graduate of a program of physical therapy approved by both the Council in Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent.
2. Physical therapy treatment requires a written referral or prescription by a physician licensed in Louisiana on at least an annual basis. An initial evaluation does not require such a referral or prescription.

B. Physical Therapy (PT) Evaluation

1. Physical therapy (PT) evaluation includes testing of gross motor skills and orthotic and/or prosthetic, neuromuscular, musculoskeletal, cardiovascular, respiratory, and sensorimotor functions. These services must include the following:
 - a. Muscle, manual, extremity, or trunk testing, with report;
 - b. Total physical therapy evaluation;
 - c. Range-of-motion measurements and report on each extremity excluding hand; and
 - d. Range-of-motion measurements and report.

2. Informal methods, including observation of behavior during the evaluation and supplemental testing, may be used. Standard assessment tools listed below must be used when appropriate:
- a. Pediatric Screening: A Tool for Occupational and Physical Therapists
 - b. Joint Range of Motion Test
 - c. Berry Development Test of Visual-Motor Integration (VMI)
 - d. The Macquarrie Test Mechanical Ability
 - e. Early Intervention Development Profile (EIDP)
 - f. Preschool Development Profile (PDP)
 - g. Motor Free Visual Perception Test
 - h. Denver Development Screening Test
 - i. Manual Muscle Tests
 - j. Southern California Sensory Integration Test (SCSIT)
 - k. The Miller Assessment for Preschoolers (MAP)
 - l. The Developmental Test of Visual Perception (Frostig)
 - m. Test of Visual Perceptual Skills (TVPS)
 - n. Bruininks-Oscretsky Test of Motor Proficiency
 - o. Bayley Developmental Scales
 - p. Callier-Azusa Scale
 - q. Bender Visual Motor Integration Test
 - r. Errhardt Developmental Test of Visual Perception
 - s. Frostig Developmental Test of Visual Perception
 - t. Gesell Developmental Schedules
 - u. McCarthy Scales of Children's Abilities
 - v. Milani-Compareth
 - w. North Carolina Curriculum
 - x. Perceptual Motor Screening
 - y. Purdue Perceptual Motor Survey
 - z. Reflex Testing Methods of Evaluation Central Nervous System Development
3. The procedure code with the maximum fee reimbursed by Medicaid is listed below. This code should be used for any combination of tests of the preceding list.

Code	Description	Fee/Unit
X0404	Physical Therapy (PT) Evaluation including report	\$48.60

C. Physical Therapy Treatment Services

1. The physical therapy/treatment services are listed below with their procedure codes, descriptions, and maximum fees reimbursed by Medicaid.

Code	Description	Fee/Unit
97032	Application of modality to one or more areas; electrical stimulation (manual); 15 minute units; limit to four units per day	\$ 7.20
97110	Therapeutic procedure, one or more areas. Therapeutic exercises to develop strength and endurance, range of motion and flexibility; 15 minute units; limit to four units per day	\$ 7.20
97112	Neuromuscular reduction of movement, balance, coordination, kinesthetic sense, posture and proprioception, 15 minute units; limit to four units per day	\$ 7.20
97116	Physical medicine; gait training; 30 minutes; limit to two units per day	\$14.40
97124	Massage, including effeurages, patrisage, and/or tapotement (stroking, compression, etc.); 15 minute units; limit to four units per day	\$ 7.20
Y7200	Combination of physical medicine treatment procedures; initial 30 minutes	\$14.40
Y7201	Physical Therapy; 45 minute session; limit to one unit per day	\$21.60

2. **Place of Service codes** on the claim form must use one of the following codes:

- 12 Service provided in the home
- 99 Service provided in an unlisted facility (school or Early Intervention Center)

VI. PSYCHOLOGICAL SERVICES

Psychological Services are for obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development. These services include:

- administering psychological and developmental tests and other assessment procedures;
- interpreting assessment results;
- planning and managing a program of psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

A. Psychological Evaluation

The psychological evaluation includes a battery of tests, interviews, and behavioral evaluations that appraise cognitive, emotional, social, and behavioral functioning and self-concept. A licensed physician, psychiatrist, psychologist or certified school psychologist must provide these services.

- B. The Procedure Code** for psychological evaluation is listed below and the maximum fee reimbursed by Medicaid.

Code	Description	Fee/Unit
X0413	Psychological Evaluation (including report)	\$76.50

C. The Standard Tests listed below must be used, when appropriate:

1. Adaptive Behavior Inventory for Children
2. AAMD Adaptive Behavior Scale
3. Alpern-Boll Developmental Profile
4. Battelle Developmental Inventory
5. Bayley Scales of Infant Development
6. Behavior Rating Inventory for Autistic and Other Atypical Children
7. Bender Visual Motor Gestalt Test
8. Brigance Kindergarten Screening

9. Burks Behavior Rating Scales
10. Catell Infant Intelligence Scale
11. Children's Apperception Test
12. Cognitive Observation Guide
13. Columbia Mental Maturity Scale
14. Motor-Free Visual Perception Test
15. Nonverbal Test of Cognitive Skills
16. Peabody Individual Achievement Test
17. Peabody Picture Vocabulary Test-Revised
18. Projective Drawings
19. Psycho-Diagnostic Tests
20. Rorschach Projective Technique
21. Ravens Progressive Matrices
22. Sentence Completion Test
23. Southern California Ordinal Scales of Development
24. Stanford-Binet Intelligence Scale
25. System of Multicultural Pluralistic Assessment
26. Developmental Test of Visual Motor Integration
27. Frostig Developmental Test of Visual Motor Integration
28. Functional Profile
29. Gilmore Oral Reading Test
30. Hiskey-Nebraska Test of Learning Aptitude
31. Inventory of Readiness Skills
32. Kaufman Assessment Battery for Children
33. Key Math Diagnostic Arithmetic Test
34. Largo and Howard Play Assessment
35. Leiter International Performance Scale
36. McCarthy Scales of Children's Abilities
37. Merrill Palmer Scale of Mental Abilities
38. Test of Nonverbal Intelligence
39. Test of Visual Perceptual Skills
40. Thematic Apperception Test (TAT)
41. Ugziris-Hunt Ordinal Scales of Infant Development
42. Wechsler Adult Intelligence Scale-Revised
43. Wechsler Intelligence Scale for Children-Revised (WIS-R)
44. Wechsler Preschool and Primary Scale of Intelligence
45. Westby Play Scale
46. Wide Range Achievement Test
47. Woodcock Reading Mastery Tests

D. Psychological Therapy

Psychological therapy includes diagnosis and psychological counseling for children and their families. These services must be provided by a Louisiana licensed physician, psychiatrist, psychologist, or certified school psychologist.

1. Psychological therapy services are listed below with their procedure codes, descriptions, and maximum fees reimbursable by Medicaid.

Code	Description	Fee/Unit
X0417	Individual Counseling/Therapy, 60 minutes	\$45.00
X0425	Individual Counseling/Therapy, 30 minutes	\$22.50
X0421	Group Counseling/Therapy, 60 minutes	\$22.50
X0422	Family Counseling/Therapy, 60 minutes	\$22.50

2. **Place of Service** codes on the claim form must use one of the following codes:

- | | |
|----|---|
| 12 | Service provided in the home |
| 99 | Service provided in an unlisted facility
(school or Early Intervention Center) |

VII. OTHER EPSDT COVERED SERVICES

Medicaid covers all medically necessary diagnosis and treatment services in addition to EPSDT Health Services for recipients under age 21. The Louisiana Medicaid Program may determine medical necessity of the services.

A. Durable Medical Equipment (DME)

Medicaid-covered services include purchase of medical supplies or rental/purchase of durable medical equipment and appliances for children with disabilities. These services are only covered if authorized in advance by the Prior Authorization Unit (PAU) at the fiscal intermediary. A licensed physician must recommend the item in writing. It must be medically necessary and not a convenience item. A Medicaid enrolled vendor must

make the request for payment of the item. The request is submitted to the PAU at the fiscal intermediary on a form PA 01 with appropriate medical documentation attached. *The request must be acted upon within 25 days for a non-emergent request or the item is automatically approved.*

The DME provider manual contains detailed information on items covered, requirements for approval, and request procedures. It is available from the fiscal intermediary.

B. Transportation

Medicaid provides necessary transportation and scheduling assistance for health related services excluding transportation to pharmacy services. Medicaid does not provide transportation to school settings where both instructional and health services are provided. Transportation services will not be paid by Medicaid if other transportation sources are available at no cost to the recipient. These sources include friends, family members, neighbors, private insurance, free community resources, Title XIX providers, and other personal means.

1. **Recipients must contact the local Office of Family Support or Medicaid regional office at least 48 hours before the medical appointment to request transportation arrangements.**
2. Recipients residing in the Alexandria region must call 1 (800) 446-3490 or (318) 445-9851 in Alexandria to request these services.
3. Recipients in the Lafayette and Lake Charles regions may access these services by calling 1 (800) 864-6034.
4. Questions or complaints regarding transportation services should be referred to the Transportation Program, Bureau of Health Services Financing, Post Office Box 91030, Baton Rouge, LA 70821-9030 or telephoned to (504) 342-9320.

SECTION 6
MONITORING AND DOCUMENTATION

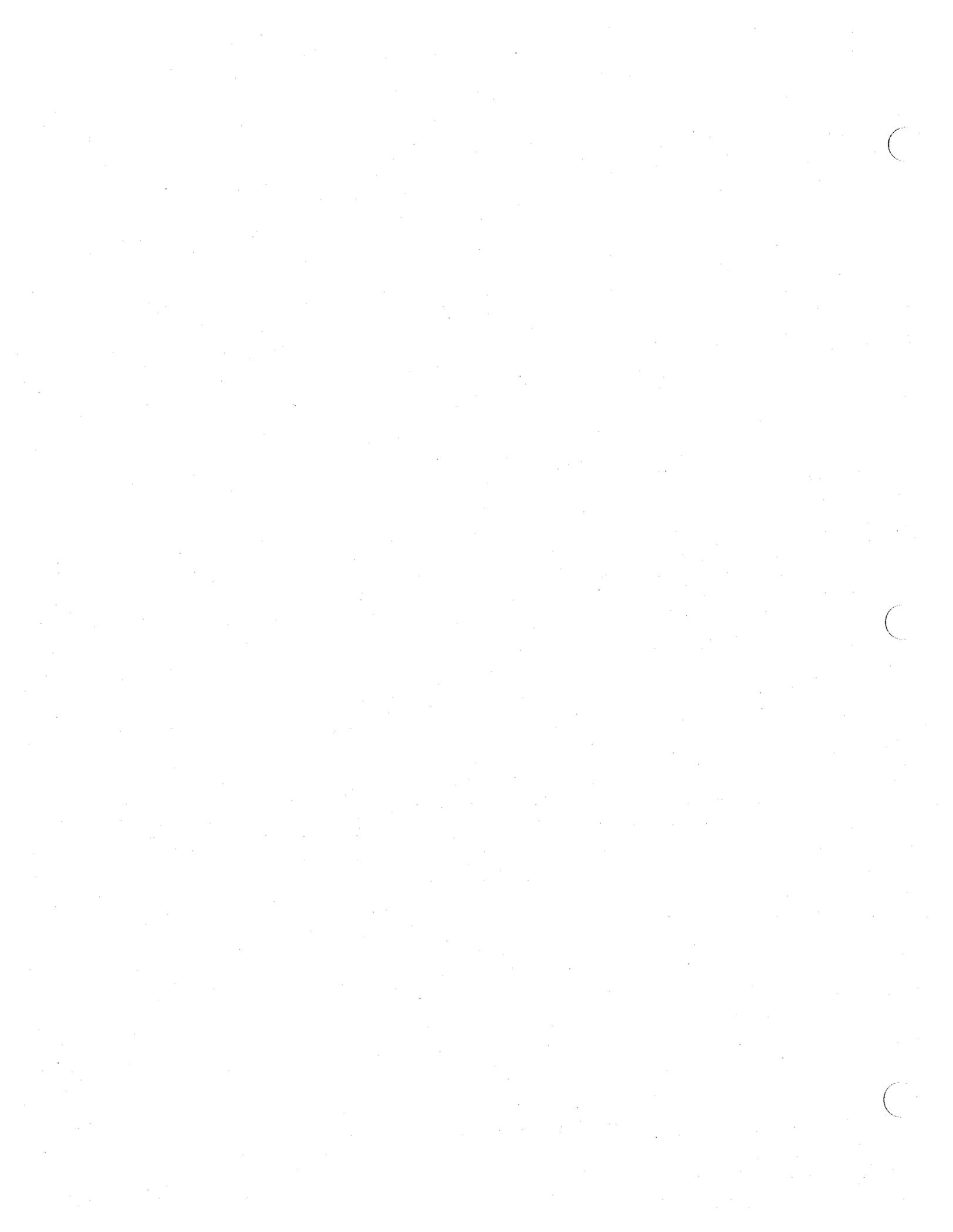
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MONITORING AND DOCUMENTATION 6-2



Providers must make available to BHSF all records of EPSDT services provided to children with special health needs. The following documentation must be maintained for at least three years from the date of payment on all children for whom claims have been submitted.

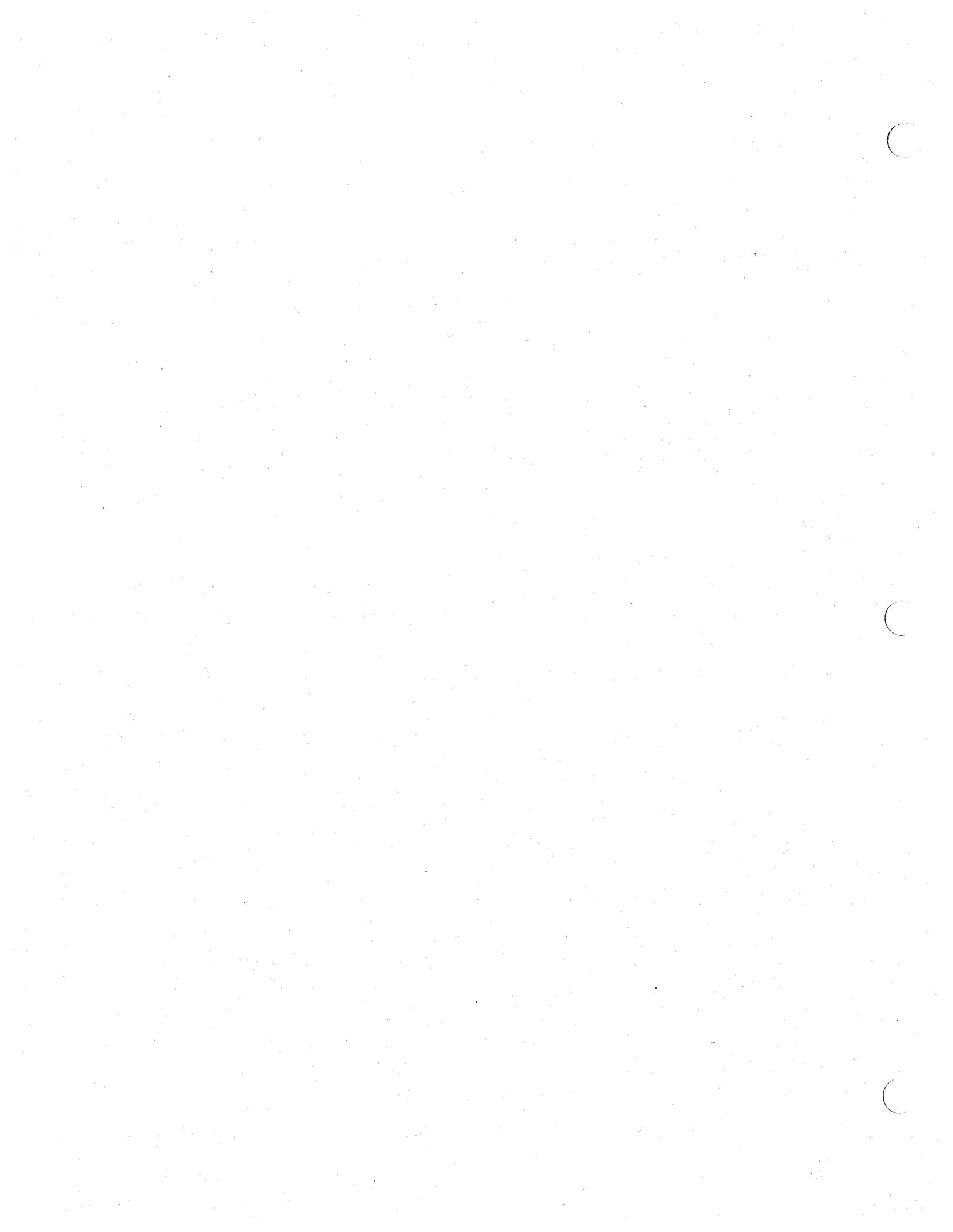
- I. Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying an IEP or IFSP, including the specific tests performed and copies of evaluation and diagnostic assessment reports signed by the individual and supervisor, if appropriate, that administers the test or does the assessment.
- II. Copies of the IEP or IFSP documenting the need for the specific therapy or treatment services, the time and frequency required.
- III. Documentation of the provision of treatment services by individual physicians, therapist, and other qualified professionals including dates and times of services, billing forms, log books, reports on services provided, and the child's record(s) signed by the individual providing the services and signature of supervisor, if appropriate.
- IV. Written referral or prescription from a licensed physician for any occupational therapy, physical therapy, audiology or speech/language services for the current school year (must be dated within the last 365 days).
- V. Report of a complete examination by a licensed physician for a child under age three initially referred to early intervention services. (See Health Services Form in Appendix B). Documentation of appropriate certification, licensure, education and/or training and supervision of professional staff providing services.
- VI. Documentation of dates and results of the most recent medical, vision, and/or hearing screening(s) or dates of KIDMED contacted to determine screening status.



SECTION 7
CLAIMS FILING

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I. CLAIMS SUBMISSION AND PROCESSING

This section goes step-by-step through the process of billing for EPSDT Health Services. The HCFA 1500 universal claim form (revised 12/90) is to be used. Supplies of these forms can be obtained from

Superintendent of Documents
Post Office Box 371954
Pittsburgh, PA 15250-7954
(202) 512-1800

or national claims forms vendors. A sample, along with detailed instructions for completing the HCFA 1500 are also included in this section.

Providers agree to bill Medicaid by electronic media claims (EMC) submission for EPSDT services provided to children with disabilities.

EMC is the submission of claims via the computer. Claims must be sent for processing on diskette (3 1/2", 5 1/4", or 8"), on tape (reel-to-reel), or by telecommunications (modem). EMC runs on any IBM-compatible PC. In addition, a list of billing and management companies who can provide electronic billing services is available from the fiscal intermediary Unisys.

NOTE: Claims with attachments cannot be billed via EMC.

For more information or to request EMC specifications, please contact the EMC Coordinator at Unisys at (504) 237-3303.

 Refer to the *KIDMED Provider Manual* for applicable policy and instructions for billing for vision and hearing screening services. These screening services must be billed under the screening provider number.

II. FILING CLAIMS

A. Recipient Eligibility Verification System

The Provider Relations Inquiry Staff of the fiscal intermediary respond to provider inquiries. Providers who have the following types of questions may use the Recipients Eligibility Verification System (REVS) telephone service:

- Is a particular recipient eligible for services on a specific date of service?
- What are the service limits for a particular recipient?
- What other payment source does a particular recipient have?
- What is my current check amount?

REVS is operational 24 hours a day/ 7 days a week, except for a short period on Sunday when the system is updated. To access the system, dial (800) 776-6323 on a touch-tone telephone. Once the system is accessed, the provider will be given voice response prompt messages. Begin entering the following required information as soon as the system prompts:

1. Provider number
2. Appropriate recipient identification number
3. Date of service

There may be other times when a provider needs to speak to an Inquiry Representative. These questions may concern printed policy, claims processing problems or a need to determine the status of a particular claim. The provider should gather all necessary information and call Unisys's Provider Relations at 1 (800) 473-2783 or (504) 924-5040 for these kinds of clearances.

B. Timely Filing Guidelines

1. In order to be reimbursed for services rendered, all providers must comply with the following filing limits set by the Louisiana Medicaid Program:
 - a. Medicaid only claims must be filed within 12 months from the date of service.
 - b. Claims for recipients covered by Medicare and Medicaid (dual eligibility) must be billed to **Medicare** within 12 months of the date of service.
 1. Most dual eligible claims will cross over from Medicare to Medicaid via tape and do not have to be filed with the Medicaid fiscal intermediary.

2. For those claims that fail to cross over via tape, a hardcopy may be filed up to six (6) months after the date on the Medicare Explanation of Benefits (EOMB) *provided* that they were filed with Medicare within a year of the date of service.
- c. Claims with third-party (TPL) payment must be filed within 12 months of the date of service. After receipt of payment from the TPL, the Medicaid claim must be filed *hardcopy with an Explanation of Benefits (EOB)* attached.

NOTE: *EPSDT Services may be billed without waiting for other third-party payments.*

- d. KIDMED claims must be filed within two months of the date of service.
- e. Medicaid claims received after the one (1) year maximum timely filing date **cannot** be processed unless the provider is able to furnish documentation of timely filing. This documentation must be legible and reference the individual recipient and date of service. It may include:
 - 1) A remittance advice (RA) indicating that the claim was processed within the original appropriate time frame; or
 - 2) Correspondence from either the state or parish Bureau of Health Services Financing office concerning the claim and/or the eligibility of the recipient.
- f. Claims with retroactive coverage should be sent to the Provider Relations Unit of the fiscal intermediary with documentation such as a copy of the recipient's medical card to establish timely filing as soon as possible. These claims should be mailed to:

Unisys
Provider Relations
Post Office Box 91024
Baton Rouge, LA 70821

- g. Claims over two years old must be submitted with a written request to the Program Manager for consideration of an override. These claims should be mailed to:

Department of Health and Hospitals
Bureau of Health Services Financing
Post Office Box 91030
Baton Rouge, LA 70821-9030

In order for this request to be considered, the provider must document timely filing and attempts to resolve the billing problem. This includes Remittance Advices (RAs) that reflect attempts to correct submission of claim, correspondence to and/or from the fiscal intermediary, the local Medicaid Eligibility Office or BHSF. The documents must clearly identify the claim in question by recipient number and date of service.

NOTE: *Only claims involving retroactive eligibility, administrative error or under court order can be considered for an override of the two years timely filing limitations.*

2. Tips on Timely Filing for Providers
- a. Providers must know how to bill correctly and how to resolve billing problems.
 - b. Because of timely filing limitations, providers must make the necessary claim corrections within the timely filing limits. Refiling a claim several times without correcting previously cited errors IS NOT considered a valid attempt to resolve a billing problem.
 - c. All required items on the claim must be completed correctly.
 - d. Providers are notified of claims that are denied for payment by the RA. A three (3) digit error code designating the error is printed for each claim. These codes are listed with a brief explanation being given for each one on the RA a separate page following the status listing of all claims.

- e. **Providers must make their own corrections.** It is against regulations for the fiscal intermediary to make claim corrections for a provider.
- f. The fiscal intermediary offers consultation for providers having problems billing correctly and/or resolving billing problems. Contact Provider Relations at (800) 473-2783 or (504) 924-5040.

C. Claim Documentation

The Louisiana Medicaid Program is often required to make payment decisions based on information in medical records. These records need to be properly documented to prevent payment errors. Proper documentation should include:

1. Diagnosis and chief complaint
2. Relevant history
3. Examination findings
4. Response to therapy
5. Progress notes and patient disposition
6. Procedures performed and test results
7. X-ray, lab, diagnostic tests ordered with results

**LOUISIANA MEDICAID PROGRAM
EPSDT HEALTH SERVICES**

**SECTION 7
CLAIMS FILING**

III. HCFA 1500

APPROVED OMB 0938 0008

HEALTH INSURANCE CLAIM FORM

1 MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
 (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 3 PATIENT'S BIRTH DATE MM DD YY SEX M F

4 INSURED'S NAME (Last Name, First Name, Middle Initial)

5 PATIENT'S ADDRESS (No. Street) CITY STATE 6 PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7 INSURED'S ADDRESS (No., Street) CITY STATE

8 PATIENT STATUS Single Married Other

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO Employment Full-Time Student Part Time Student

11 INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F b. AUTO ACCIDENT? YES NO PLACE (State) _____

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? YES NO

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE

4. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____

14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN _____

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19 RESERVED FOR LOCAL USE 20 OUTSIDE LAB? YES NO \$ CHARGES _____

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

22 MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

23 PRIOR AUTHORIZATION NUMBER _____

A	B		C	D	E	F	G	H	I	J	K
	DATE(S) OF SERVICE From MM DD YY To MM DD YY	Place of Service									
1											
2											
3											
4											
5											
6											

25 FEDERAL TAX ID NUMBER SSN ERN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28 TOTAL CHARGE \$ _____ 29 AMOUNT PAID \$ _____ 30 BALANCE DUE \$ _____

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made a part thereof) SIGNED _____ DATE _____

32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) _____

33 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE & PHONE # _____

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA 1500 (12-90)
FORM QWCP 1500 FORM RRB 1500

HCFA 1500 BILLING INSTRUCTIONS

If items marked with an asterisk "*" are not completed, the claim will be denied.

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 on the recipient's current monthly Medicaid card.

Make certain that the last two digits are the correct individual suffix for your recipient. If the 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 it appears on the recipient's current Medicaid card.
3. **Patient's Birth Date and Sex**—Enter the recipient's date of birth as reflected on the current Medicaid card 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 of leave this space blank.
8. **Patient Status**—Leave this space blank.
9. **Other Insured's Name**—Complete if appropriate of leave this space blank.
- 9A. **Other Insured's Policy or Group Number**—Complete if appropriate or 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 Group 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 of 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**—Leave this space blank.
- 17A. **ID Number of Referring Physician**—Enter the physician's PCP number.
- 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 numeric code and literal description. Use of ICD-9-CM coding is mandatory. Accepted abbreviations are appropriate.
- 22. **Medical Resubmission Code**—Leave this space blank.

23. **Prior Authorization**—Leave this space blank.
- *24A. **Date of Service**—Enter the date the service for each procedure billed using six (6) digits (MM DD YY). If “from” and “to” dates are shown here for a series of identical procedures on the same day or on consecutive days, enter the number of services in item 24G. The date of dissemination may be used for evaluation services.
- *24B. **Place of Service**—Enter the appropriate code.
- 24C. **Type of Service**—Leave this space blank.
- *24D. **Procedure Code**—Enter the procedures using the applicable CPT-4 or HCPCS codes found in Section 5 of this manual.
- *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 usual and customary charges for this procedure.
- *24G. **Days or Units**—Enter the number of the same procedure being billed for the same date of service.
- *24H. **EPSDT**—Enter a “Y”.
- 24I. **EMG**—Leave this space blank.
- 24J. **COB**—Leave this space blank.
- 24K. **Reserved for Local Use**—Enter the attending provider number if applicable.
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 sixteen (16) characters.

27. **Accepts Assignment**—Leave this space blank. Medicaid does not make payments to the recipient. Claim filing shows acceptance of Medicaid assignment.
- *28. **Total Charge**—Total of all charges listed on the claim.
29. **Amount Paid**—Leave this space blank for EPSDT.
30. **Balance Due**—Leave this space blank for EPSDT.
- *31. **Signature of Physician/Supplier**—The claim form **MUST** be signed. The therapist is not required to sign the claim form. However, the therapist's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the physician, therapist or authorized representative. *If this item is left blank, or if the stamped or computer-generated signature is not initialed, the claim will be returned.*
- Date**—Enter the date of the signature.
32. **Name and Address Where Services Were Rendered**—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 provider number must be entered in the space next to "PIN #." *If no Medicaid provider number is entered, the claim will be returned to the provider for correction and resubmission.*

IV. PAID CLAIM ADJUSTING/VOIDING INSTRUCTIONS

The **Health Insurance Claim Adjustment/Void Form 213** is used to adjust or void a claim. *Only a paid claim can be adjusted or voided.* When adjusting a paid claim, never change the Provider Identification Number or the Recipient/Patient Identification Number. The Adjustment/Void form allows the adjustment or voiding of only one line on one Adjustment/Void form. To adjust or void more than one claim line on a multiple line claim form, a separate Adjustment/Void form is required for each claim line.

A. General Guidelines:

1. Complete the information on the adjustment form exactly as it appears on the original claim, changing only that item or items that were in error and giving the reasons for the changes in the space provided.
2. To void a paid claim, enter all of the information from the original claim **exactly** as it appears on the original claim. After a voided claim has appeared on the Remittance Advice (RA), an original claim can be resubmitted giving all of the correct information that should appear on that claim.

Note: *It is important to enter the correct Internal Control Number and Remittance Advice date from the paid claims in blocks 26 and 27 on the adjustment/void form. If this information is not entered exactly, the claim will deny with error message 799 (no history for this adjustment/void).*

3. When an Adjustment/Void form has been processed it will appear on the RA under **Adjusted or Voided Claims**. The adjustment or void will appear first. The original claim line will appear in the section directly beneath under the heading **Previously Paid Claims**.
4. An Adjustment/Void will generate credit and debit entries that will appear in the Remittance Summary on the last page of the RA as "Adjusted Claims", "Previously Paid Claims" or "Voided Claims".

**LOUISIANA MEDICAID PROGRAM
EPSDT HEALTH SERVICES**

**SECTION 7
CLAIMS FILING**

B. HEALTH INSURANCE ADJUSTING/VOIDING FORM 213

MAIL TO
UNISYS
P O BOX 91022
BATON ROUGE, LA 70821
(800) 473-2763
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

<input type="checkbox"/> ADJ <input type="checkbox"/> VOID																																																																																							
PATIENT AND INSURED (SUBSCRIBER) INFORMATION																																																																																							
1 PATIENT'S NAME (LAST NAME FIRST NAME MIDDLE INITIAL)		2 PATIENT'S DATE OF BIRTH	4 MEDICAID ID NUMBER																																																																																				
3 PATIENT'S ADDRESS (STREET CITY STATE, ZIP CODE)		5 PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6 INSURED'S NAME																																																																																				
TELEPHONE NO		7 PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8 INSURED'S GROUP NO (OR GROUP NAME)																																																																																				
10 OTHER HEALTH INSURANCE COVERAGE ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER		11 WAS CONDITION RELATED TO A PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> IS AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	12 INSURED'S ADDRESS (STREET CITY STATE ZIP CODE)																																																																																				
PHYSICIAN OR SUPPLIER INFORMATION																																																																																							
13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		14 DATE FIRST CONSULTED YOU FOR THIS CONDITION	15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																				
14 DATE PATIENT ABLE TO RETURN TO WORK		16 DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	17 DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____																																																																																				
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		19 REFERRING ID NUMBER	20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____																																																																																				
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/>	22 CHARGES																																																																																				
23 DIAGNOSIS OR NATURE OF ILLNESS RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 OR DX CODE		24 ATTENDING NUMBER	25 PRIOR AUTHORIZATION NO																																																																																				
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26 CONTROL NUMBER		27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID																																																																																					
THIS IS FOR CHANGING OR VOIDING A PAID ITEM (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED)																																																																																							
28 REASONS FOR ADJUSTMENT <input type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY <input type="checkbox"/> 02 PROVIDER CORRECTIONS <input type="checkbox"/> 03 FISCAL AGENT ERROR <input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN																																																																																							
29 REASONS FOR VOID <input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT <input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN																																																																																							
30 SIGNATURE OF PHYSICIAN OR SUPPLIER I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.		31 PHYSICIAN'S OR SUPPLIER'S NAME ADDRESS ZIP CODE AND TELEPHONE																																																																																					
32 YOUR PATIENT'S ACCOUNT NUMBER																																																																																							

FISCAL AGENT COPY

UNISYS - 213
5/97

C. Health Insurance Claim Adjustment/Void Form 213 Instructions

- *1. **ADJ/VOID**—Check the appropriate block.
- *2. **Patient's Name**
 - a. **Adjust**—Print the name exactly as it appears on the original invoice if not adjusting this information.
 - b. **Void**—Print the name exactly as it appears on the original invoice.
- 3. **Patient's Date of Birth**
 - a. **Adjust**—Print the date exactly as it appears on the original invoice if not adjusting this information.
 - b. **Void**—Print the name exactly as it appears on the original invoice.
- 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 invoice.
 - b. **Void**—Print the address exactly as it appears on the original invoice.
- 6. **Patient's Sex**
 - a. **Adjust**—Print this information exactly as it appears on the original invoice if not adjusting this information.
 - b. **Void**—Print this information exactly as it appears on the original invoice.
- *7. **Insured's Name**— Leave this space blank.
- 8. **Patient's Relationship to Insured**—Leave this space blank.
- 9. **Insured's Group No.**—Leave this space blank.
- 10. **Other Health Insurance Coverage**—Leave this space 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.
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 invoice if not adjusting the information.
 - b. **Void**—Print the information exactly as it appears on the original invoice.
23. **Attending Number**—Leave this space blank.
- *24. **Prior Authorization #**—Enter the PA number if applicable.
- *25. **A through F**
 - a. **To Adjust**—Print the information exactly as it appears on the original invoice if not adjusting the information.
 - b. **To Void**—Print the information exactly as it appears on the original invoice.

- *26. **Control Number**—Print the correct Control Number as shown on the RA.
- *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 account number.

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

D. Submission of Claim and Adjustment/Void Forms

HCFA 1500 claims and Adjustment/Void transactions for these claims on Form 213 must be submitted to the fiscal intermediary. A supply of form 213 should also be requested from the fiscal intermediary.

V. CLAIMS PAYMENT SYSTEM

This section is to familiarize the provider with the claims payment system and the design and contents of the Remittance Advice (RA) document which gives the status of submitted claims. The RA plays an important communication role between the provider, Medicaid, and the fiscal intermediary. The RA provides a recording of transactions and helps in resolving and correcting possible errors and reconciling paid claims.

A. Review of Submitted Claims

When the fiscal intermediary receives a claim, addressed properly for the claim type, it will be reviewed first for missing data.

1. If the signature, Recipient Medical Assistance Number, Service Dates, or Provider Name or Number is missing, the claim will be rejected.
2. If the claim has missing or incomplete information, the original invoice will be returned with a Return Letter. The Return Letter will say why the invoice has been returned.
3. Complete the missing or incomplete items on the original invoice and resubmit it. This is the only instance where the original is returned to the provider. A returned claim **will not** appear on the RA because it will not enter the processing system.
4. Claim Classification

All claims that have been processed will fall into one of the following three classifications:

1. Approved (paid) claims
2. Pended claims (Claims in Process)
3. Denied claims

5. When Are RA's Issued?

A RA will be sent after each weekly payment cycle in which a new claim is submitted. After that, each time activity occurs on a claim, a RA will be issued.

B. Approved Paid Claims

A claim that is correctly completed for a covered service provided to an eligible recipient by an enrolled provider will be approved for payment and paid. It will appear on the RA on the first page, or pages, which list all claims to be paid. If the payment is different from the billed charges, an explanation will appear on the RA.

C. Pended Claims (Claims in Process)

Pended claims (claims in process) are those claims held for in-house review by the fiscal intermediary. If after review, it is determined that a correction by the provider is required, the claim will be denied. If the correction of a claim can be made during the review, the claim will be paid.

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

1. Errors were made in entering data from the claim into the processing system
2. Errors were made in submitting the claim. These errors can only be corrected by the provider who submitted the claim.
3. Critical information is missing or incomplete.

D. Denied Claims

A claim will be denied if:

1. the recipient is not eligible on the date of service;
2. the provider is not enrolled on the date of service;
3. prior authorization is required but not reflected;

4. the service is not covered by the program;
5. it is a duplicate of a prior paid claim;
6. the date is invalid or logically inconsistent;
7. the program limitations are exceeded.

VI. HOW TO CHECK THE STATUS OF A INTERNAL CONTROL NUMBER

A. The Remittance Advice (RA)

The Remittance Advice (RA) informs the provider of the current status of submitted claims.

1. On the line immediately below each claim, a code will be printed representing denial reasons, suspense reasons and payment reduction reasons. The only type of claims status that will not have a code is one paid as billed. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims.
2. When a medical record number is used, whether it consists of alpha and/or numeric characters, it will appear on the line immediately following the recipient's number.
3. A unique 13 digit ID number, called an Internal Control Number, is given to each claim. The Internal Control Number reflected on the RA can be used to track the status of a claim from receipt to final adjudication.
 - a. The first four digits of the Control Number are the actual year and day the claim was received.
 - b. The next seven digits tell whether the claim was received on paper or tape and then reflects the batch and sequence numbers of the claim's entry into the processing system.
 - c. All claims lines on a given claim form will have the same first 11 digits.

- d. The last two numbers will help determine which line of a claim form is referenced.

Example:	13650234567 <u>00</u>	refers to first claim line
	13650234567 <u>01</u>	refers to second claim line
	13650234567 <u>02</u>	refers to third claim line

B. Reminders to Providers

There are a number of ways in which the provider can assist the Provider Relations staff at the fiscal intermediary in responding to inquiries.

1. The Provider Relations telephone unit is for **PROVIDERS ONLY**, not recipients. If recipients have problems with eligibility, refer them to their eligibility worker at the parish office.
2. Please *review and reconcile* the RA in question BEFORE calling Provider Relations for the status of the claim. Frequently, providers questions are answered if the RA is reviewed thoroughly.
3. Questions regarding issues other than claims should be directed as follows:
 - a. Unisys Electronic Claims: (504) 237-3303
 - b. Unisys Recipient Eligibility Verification System (REVS): (800) 766-6323
4. Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:
 - a. The correct Medicaid provider number
 - b. The recipient's Medicaid ID number
 - c. The date of service
 - d. Any other information, such as procedure code and billed charge, that will help identify the specific claim in question
 - e. The RA showing disposition of the specific claim in question
5. The provider should get the name of the representative they are speaking to in case a call back is necessary.

6. Providers calling with difficult problems requiring extensive research may be asked to submit those request in writing, along with pertinent documentation, to Unisys's Provider Relations Unit.

VII. THIRD-PARTY LIABILITY

Federal regulations and state policy determine reimbursement to EPSDT providers.

- A. Medicaid, by law, is intended to be *the payor of last resort*. Other available third party resources including private insurance must be used before Medicaid pays for the care of a Medicaid recipient.
- B. Medicaid uses "*cost avoidance*" to process most Medicaid claims involving third party liability.
 1. If probable third party liability is established at the time the claim is filed, Medicaid rejects the claim and returns it for determination of third party liability.
 2. When third party liability is determined, the agency pays the claim to the extent that payment is allowed under Medicaid's fee schedule exceeds the amount of the third party's payment.
- C. Congress enacted new provisions in Medicaid law in 1986 revising the methods of paying claims. The purpose of these changes was to alleviate the administrative burden associated with TPL efforts to encourage participation in the Medicaid program by providers of pediatric care, including EPSDT. The regulations set forth certain exceptions to the cost avoidance method of claims payment in TPL situations. *These exceptions include EPSDT screening and diagnostic services.* The exceptions do not include treatment or therapy. Treatment and therapy services must be billed to the recipient's available third-party resource before Medicaid can be billed. When these services are billed to Medicaid, an Explanation of Benefits from the third-party resource must be attached.

For these exceptions, Medicaid is mandated to pay the claim in the full amount allowed under Medicaid's fee schedule and then seek reimbursement from any third party to the limit of legal liability. This method of claims payment is called "*pay and chase.*"

VII. REFUNDS

- A.** *In situations where the third-party resource payment is received after Medicaid has been billed and made payment, the provider must reimburse Medicaid. Reimbursement must be made **immediately** to comply with regulation. Providers may reimburse Medicaid by forwarding a check or by submitting an adjustment request. When making refunds by check, identify the claim or claims to which the refund is applied. The information necessary to identify these claims will help to reduce additional correspondence. This information can be found on the RA:*

1. Provider Number
2. Date of Payment
3. Control Number
4. Recipient Name and Identification Number
5. Date of Service
6. Amount Paid
7. Reason for Refund

NOTE: Refunds should be made only in the case of claims more than two years old. Use adjustments for claims less than two years old.

- B.** Refunds should be made payable to the Department of Health and Hospitals and mailed to:

Payment Management Section
Bureau of Fiscal Services
Post Office Box 91117
Baton Rouge, LA 70821-9117

IX. REMITTANCE ADVICE AND HISTORY REQUESTS

Provider participation in the Louisiana Medicaid Program is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. One of those

standards is the agreement to maintain any information regarding payments claimed by the provider for furnishing services for a period of three (3) years.

- A. It is the responsibility of the provider to retain all RAs for three (3) years. However, if a provider requests copies of RA or claim histories, the fiscal intermediary will supply this information for a fee.
 - 1. No fee will be charged in cases where a check and RA were never received by the provider.
 - 2. Requests for RAs never received must be made within three (3) weeks of the RA date or there will be a charge for this information.
- B. If providers are requesting RAs for multiple weeks or a large volume of RAs, the fiscal intermediary will determine whether RA copies or a claim history will be provided.
- C. Requests for RAs or claims histories may be made in writing to:

Unisys
Provider Relations
Post Office Box 91024
Baton Rouge, LA 70821

or by telephoning (800) 473-2783 or (504) 924-5040. The provider name and number, address, date(s) of the RA being requested, and name of the individual requesting and authorizing the request **must** be included in the request

- D. Upon receipt of a request, the provider will be notified of the number of pages to be copied and the cost of the request. The RA/history will be forwarded to the provider once payment is received.
 - 1. The fee for RA's is \$0.25 per page.
 - 2. Claims history fees are:

1— 99 pages	\$ 20.00
100—199 pages	\$ 38.00
200—499 pages	\$ 75.00
500+ pages	\$100.00 (or negotiated based on volume)

SECTION 8
PERSONAL CARE SERVICES

SECTION CONTENTS

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I. DESCRIPTION OF SERVICES

The Department of Health and Hospitals, Bureau of Health Services Financing has implemented a program that may provide Personal Care Services (PCS) to EPSDT eligibles (recipients up to age 21 years) meeting the medical necessary criteria for these services. Any enrolled Medicaid provider of MR/DD Waiver Personal Care Attendant (PCA) services is eligible to participate in this program.

EPSDT Personal Care Services by definition, may not include any medical tasks such as medication administration, tracheostomy care, feeding tubes, catheters. If such tasks are necessary, they must be requested under either the MR/DD Waiver PCA Program or the Home Health Program. BHSF will not accept the physician's delegation for EPSDT PCS providers to perform such medical tasks.

EPSDT PCS may not be provided to an EPSDT eligible receiving MR/DD Waiver Personal Care Attendant services until the waiver limit is exhausted.

The following information about the program will assist in providing EPSDT PCS in accordance with Medicaid policy and procedures:

A. Amount, Duration and Scope of EPSDT Personal Care Services (PCS)

1. EPSDT Personal Care Services (PCS) are defined as:
 - a. tasks that are medically necessary as they pertain to an EPSDT eligible's physical requirements when physical limitations due to illness or injury necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements.
 - b. those services which prevent institutionalization and enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.
2. EPSDT Personal Care Services (PCS) include:
 - a. Basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with clothing;

- b. Assistance with bladder and/or bowel requirements or problems, including helping the client to and from the bathroom or assisting the client with bedpan routines, but excluding catheterization;
- c. Assistance with eating and food, nutrition and diet activities, including preparation of meals for the recipient only;
- d. Performance of incidental household services, only for the recipient, not the entire household, which are essential to the recipient's health and comfort in his/her home. Examples are:
 - 1) Changing and washing the recipient's bed linens
 - 2) Rearranging furniture to enable the client to move about more easily in his/her own room
 - 3) Clean up of meal preparation for the recipient only
- e. Accompanying, not transporting, the recipient to and from his/her physician and/or medical facility for necessary medical services;
- f. EPSDT PCS are not to be provided to meet child care needs nor as a substitute for the parent in the absence of the parent.
 - 1) If an EPSDT eligible is fourteen years of age or younger, child care arrangements must be specified when requesting approval for EPSDT PCS.
 - 2) A parent or other care giver must be in the home with an EPSDT eligible fourteen years of age or younger.
- g. EPSDT PCS are not allowable for the purpose of providing respite care for the primary care giver. Respite services are only available under the MR/DD Waiver for Home and Community-based Services.
- h. EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or must be provided by the Department of Education.

- i. The following services are **not appropriate** for personal care and are **not reimbursable** as EPSDT Personal Care Services:
- 1) Insertion and sterile irrigation of catheters although changing of a catheter bag is allowed;
 - 2) Irrigation of any body cavities which require sterile procedures;
 - 3) Application of dressing, involving prescription medication and aseptic techniques, including care of mild, moderate or severe skin problems;
 - 4) Administration of medicine (as opposed to assisting with self-administered medication for EPSDT eligibles over eighteen years of age);
 - 5) Cleaning of floor and furniture in an area not occupied by only the recipient. Example: Cleaning entire living area if the recipient occupies only one room of an area shared with other household members;
 - 6) Laundry, other than that incidental to the care of the recipient. Example: Laundering of clothing and bedding for the entire household as opposed to simple laundering of the recipient's clothing or bedding;
 - 7) Shopping for groceries or household items other than items required specifically for the health and maintenance of the recipient, and not for items used by the rest of the household;
 - 8) Skilled nursing services as defined in State Nurse Practices Act, including medical observation, recording or vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;

- 9) Teaching a family member or friend how to care for a patient who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the patient is possible;
- 10) Specialized nursing procedures such as insertion of nasogastric feeding tube, indwelling catheter, tracheostomy care, colostomy care, ileostomy care venipuncture and/or injections;
- 11) Rehabilitative services such as those administered by a physical therapist;
- 12) Occupational therapy, speech pathology services, audiology services and respiratory therapy;
- 13) Teaching a family member or friend techniques for providing specific care;
- 14) Palliative skin care with medicated creams and ointments and/or requires routine changes of surgical dressings and/or dressing changes due to chronic conditions;
- 15) Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;
- 16) Specialized aide procedures such as:
 - rehabilitation of the patient (exercise or performance of simple procedures as an extension of physical therapy services);
 - measuring/recording patient vital signs (temperature, pulse, respiration and/or blood pressure, etc.), or intake/output of fluids;
 - specimen collection;

- special procedures such as non-sterile dressings, special skin care (non-medicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight measurement, enemas;
- 17) Home IV therapy;
 - 18) Custodial care or provision of only instrumental activities of daily living tasks or provision of only one (1) activity of daily living task;
 - 19) Personal comfort items, durable medical equipment, oxygen, orthotic appliances or prosthetic devices;
 - 20) Drugs provided through the Louisiana Medicaid pharmacy program;
 - 21) Laboratory services; or,
 - 22) Social Worker visits.

B. Conditions for Provisions of EPSDT Personal Care Services (PCS)

Conditions for provisions of EPSDT Personal Care Services (PCS) are as follows:

1. Medicaid Eligibility

The person must be a categorically eligible Medicaid recipient birth through twenty years of age (EPSDT eligible) and have been prescribed EPSDT PCS as medically necessary by a physician. The physician shall specify the health/medical condition which necessitates EPSDT Personal Care Services;

2. Medical Necessity

An EPSDT eligible must meet medical necessity criteria as established by BHSF which shall be based on criteria equivalent to at least an **Intermediate Care Facility 1 (ICF-1) level of care**; and be impaired in at least two activities of daily living tasks, as determined by BHSF.

- a. To establish medical necessity, the EPSDT eligible must be of an age at which the tasks to be performed by the PCS provider would ordinarily be performed by the individual, if he/she was not disabled due to illness or injury.
- b. If the parent(s) is in the home and is not providing care to the EPSDT eligible, medical documentation for the parent or guardian must be submitted with the request so that BHSF may determine that the parent(s) is physically unable to provide personal care services to the child.
- c. When determining whether a recipient qualifies for EPSDT PCS, consideration must be given not only to the type of services needed, but also the availability of family members and/or friends who can aid in providing such care. *Plans of care shall specify such information in the social history.* EPSDT PCS are not to function as a substitute for child care arrangements.

3. Referral

EPSDT Personal Care Services **must be prescribed** by the recipient's attending physician initially and every 180 days after that (or rolling six months), and when changes in the Plan of Care occur.

- a. The physician shall only sign a fully completed plan of care which shall be acceptable for submission to BHSF only after the physician signs and dates the form.
- b. **The physician's signature must be an original signature and not a rubber stamp.**

4. Plan of Care

- a. The recipient's choice of a Personal Care Services provider may assist the physician in developing a plan of care which shall be submitted by the physician for review/approval by BHSF or its designee.
- b. The plan of care must specify the personal care service(s) to be provided (i.e., activities of daily living for which assistance is

needed) and *the minimum and maximum frequency and the minimum and maximum duration* of each of these services. Dates of care not included in the plan of care or services provided before approval of the plan of care by BHSF are not reimbursable.

- c. The recipient's attending physician shall review and/or modify the plan of care and sign off on it prior to the plan of care being submitted to BHSF. A copy of the physician's prescription or referral for EPSDT PCS must accompany the request for authorization and also be retained in the personal care services provider's files.
- d. A new plan of care must be submitted at least every 180 days (rolling six months).
 - 1) Must be approved by the recipient's attending physician.
 - 2) The plan of care must reassess the patient's need for EPSDT PCS services. It must include:
 - any updates to information which has changed since the previous assessment was conducted; and
 - an explanation of when and why the change(s) occurred.
 - 3) Changes in the patient's medical condition may necessitate revisions of the plan of care because:
 - an additional type of service may be needed;
 - an increase or decrease in frequency of service may be needed; or,
 - an increase or decrease in duration of service may be needed.
 - 4) Documentation for a revised plan of care is the same as for a new plan of care.

- 5) A new "start date" and a new "reassessment date" must be established at the time of reassessment.
 - 6) Request for EPSDT PCS must be requested in increments of up to six months duration.
- e. Request for EPSDT PCS must be accompanied by the following documents:
- 1) Copy of the recipient's Medical Eligibility Card;
 - 2) Physician's referral for PCS and physician approval of plan of care prepared by PCA agency;
 - 3) Form 90-L completed by the attending physician within the last 90 days to document recipient requires/would require institutional level of care equal to an Intermediate Care Facility 1 along with a completed face-to-face medical assessment;
 - 4) Social Assessment Form;
 - 5) EPSDT PCS Daily Schedule Form;
 - 6) Plan of care approved by recipient's referring physician and a social history which provides the following information:
 - Recipient name, Medicaid ID number, date of birth and address;
 - Date EPSDT PCS services requested to start;
 - Provider name, Medicaid provider number and address of PCA agency;
 - Name and phone number of someone from the provider agency that may be contacted, if necessary, for additional information;
 - Medical reasons supporting the need for PCS (must

be accompanied by appropriate medical documentation for recipient and parent/care giver, if disabled);

- Goals for each activity;
- Specific activities (bathing, dressing, eating, etc.) with which PCS provider is to assist the recipient; number of days services are required each week; number of hours required for each activity for each day; times that services will be needed (i.e., 8-10 a.m. and 4-5 p.m.);
- Other in-home services utilized or requested for recipient (i.e., MR/DD Personal Care Attendant or Respite services, Home Health services—specify whether nurse, aide or Physical Therapy services, OCDD sponsored care, home teacher, etc.);
- For children 14 years of age and younger, child care arrangements must be specified (parent/relative/paid care giver) and if applicable, specify the personal care activities for which the parent or other care giver require the assistance of the PCS provider due to an inability to perform these services alone. The reason the parent cannot provide the services necessary should be specified and appropriate medical documentation attached to the request.

f. **The provider may not initiate services or changes in services under the plan of care prior to approval by BHSF.**

6. **Prior Authorization**

EPSDT Personal Care Services shall be prior authorized by the BHSF or its designee.

Requests for prior approval of EPSDT Personal Care Services should be submitted to the following address:

Bureau of Health Services Financing
Program Operations Section
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030
Attention: EPSDT Program Coordinator

The request shall be reviewed by BHSF's physician consultant and a decision rendered as to the approval of the service. A letter will be sent advising of the agency's decision.

7. Where will PCS be provided?

EPSDT PCS must be provided in the recipient's home or in another location outside the recipient's home, if it is medically necessary for the recipient to be there.

- a. The recipient's home is defined as the recipient's own dwelling, an apartment, a custodial relative's home, a boarding home, a foster home, a substitute family home or a supervised living facility.
- b. Institutions such as a hospital, institution for mental diseases, nursing facility, intermediate care facility for the mentally retarded or a residential treatment center are not considered a recipient's home.

8. Who provides PCS?

PCS must be provided by a licensed PCA agency which is duly enrolled as a Medicaid provider. Staff assigned to provide personal care services shall not be a member of the recipient's immediate family.

- a. Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law or any individual acting as parent or guardian of the recipient.
- b. PCS may be provided by a person of a degree of relationship to the recipient's home, or, if he/she is living in the recipient's home solely because his/her presence in the home is necessitated by the amount of care required by the recipient.

9. Limits of PCS

EPSDT PCS are limited to a maximum of four (4) hours per day per recipient as prescribed by the recipient's attending physician and prior authorized by BHSF or its designee. Extensions of this limit may be requested if additional units of service are documented to be medically necessary and are approved as medically necessary by BHSF or its designee.

II. STANDARDS FOR PAYMENT

- A.** EPSDT PCS may be provided only to EPSDT eligibles and only by a staff member of a licensed PCA agency enrolled as a Medicaid personal care services provider.
1. A copy of the current PCA license must accompany the Medicaid application for enrollment as a PCA provider.
 2. Additional copies of current licenses shall be submitted to Provider Enrollment as they are issued for inclusion in the enrollment record. The provider's enrollment record must include a current PCA license at all times.
 3. Enrollment is limited to providers in Louisiana and out-of-state providers only in trade areas of states bordering Louisiana (Arkansas, Mississippi, and Texas).
- B.** The unit of service billed by EPSDT PCS providers shall be one-half hour, exclusive of travel time to arrive at the recipient's home. The entire 30 minutes of the unit of time shall have been spent providing services in order to bill a unit. Payment can be made by Medicaid only for the hours of half-hours during which the provider is actually performing EPSDT PCS.
- C.** All EPSDT PCS must be prescribed by a physician at least every 180 days (rolling six months).
- D.** EPSDT PCS shall be prior authorized by BHSF by a Form 90-L, a Social Assessment Form, and a plan of care enumerating the tasks to be performed and the medical conditions requiring such personal care services submitted by the provider and approved by the physician, for no more than a six (6) month period.

1. Services must be reauthorized at least every six months and a new plan of care, a new 90-L, and a new Social Assessment Form must be submitted with each subsequent request for approval.
 2. Amendments or changes in the plan of care should be submitted as they occur.
- E.** The PCA agency is responsible for ensuring that all individuals providing personal care services meet all training requirements applicable under state law and regulations.
1. The personal care staff member must successfully complete the applicable examination for certification for PCA.
 2. Documentation of the personal care staff member's completion of all applicable requirements shall be maintained by the PCA provider.
- F.** The recipient shall be allowed the freedom of choice to select an EPSDT PCS provider.
- G.** Documentation for EPSDT PCS provided shall include at a minimum, the following:
1. Documentation of approval of services by BHSF or its designee
 2. Daily notes by PCS provider noting:
 - a. date of service,
 - b. services provided (checklist is adequate),
 - c. total number of hours worked,
 - d. time period worked,
 - e. condition of recipient,
 - f. service provision difficulties,
 - g. justification for not providing scheduled services,
 - h. any other pertinent information
 3. There must be a clear audit trail between the prescribing physician, the PCA provider agency, the individual providing the personal care services to the recipient, and the services provided and reimbursed by Medicaid.

- H. Agencies providing EPSDT PCS shall conform to all applicable Medicaid regulations plus all applicable laws and regulations by federal, state and local governmental entities regarding wages, working conditions, benefits, Social Security deductions, OSHA requirements, liability insurance, worker's compensation, occupational licenses, etc.
- I. EPSDT PCS provided to meet child care needs or as a substitute for the parent in the absence of the parent shall not be reimbursed. The plan of care submitted must document:
 - 1. For children fourteen (14) years of age and younger, that there will be a care giver in the home (parent/relative or paid child care); and
 - 2. The care that the care giver is providing or is unable to provide.
- J. EPSDT PCS provided for respite to the primary care giver shall not be reimbursed.
- K. EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or must be provided by the Department of Education.

III. REIMBURSEMENT METHODOLOGY FOR EPSDT PCS

A. Maximum Unit Rate

EPSDT PCS shall be paid the lesser of billed charges or the maximum unit rate set by BHSF. The maximum unit rate is \$3.74 per half hour unit.

- 1. This maximum rate was set based on the federal minimum hourly wage as of October 1, 1996, plus 22% for fringe benefits (insurance, worker's compensation, unemployment, etc.); plus 24% for agency administration and operating costs based on BHSF administrative and operating costs; plus a profit factor of 4% of the above calculated rate.
- 2. This rate will be adjusted whenever the federal minimum wage is adjusted.

B. Billing for EPSDT PCS

1. Form Used to Bill

For approved EPSDT PCS, the provider should bill using HCFA 1500. See Section 7, Claims Filing for a copy of this form and instructions on completing it.

2. Procedure Code

For approved EPSDT PCS, the provider should bill using the procedure code **"Z0200 - EPSDT Personal Care Service"**.

3. Other Requirements for Billing for EPSDT PCS

- a. The approval letter from BHSF *must* be attached to *each* hardcopy claim sheet when submitted to the fiscal intermediary for payment.

NOTE: If multiple claim sheets are submitted at the same time, a copy of the approval letter must be attached to *each* sheet.

- 1) The approval letter will be used to verify that the billed services have been approved.
- 2) If a claim for EPSDT PCS is submitted without the approval letter from BHSF attached, it will automatically be denied with error code "191" (Procedure Requires Prior Authorization).
- 3) If the dates of services on the claim are not within the dates in the approval letter, the claim will be denied with error code "193" (Date On Claim Not Covered by PA).
- 4) If an incorrect number of units are billed, the claim will be denied with error code "194" (Claim Exceeds Prior Authorized Limits).
- 5) *Hours may not be "saved" to be used later or in excess of the number of hours specified in the approval letter.*

- b. Remember: Each unit represents an half-hour of PCS.

- c. ***Billing for PCS must be hardcopy*** or claim will be automatically denied. This hardcopy claim must be mailed to:

Unisys
Post Office Box 91020
Baton Rouge, LA 70821

See Section 7, Claims Filing.

IV. MONITORING AND DOCUMENTATION FOR PCS

Providers must make available to BHSF all records of EPSDT PCS provided to children with special health needs. The documentation must be maintained for at least **three years** from the date of payment on all children for whom claims have been submitted.

- A. Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying the Plan of Care including the tests performed and results, copies of evaluation and diagnostic assessment reports signed by the individual performing the test and/or interpreting the results.
- B. Copies of the Plan of Care, Social Assessment Form 90-L, EPSDT PCS Daily Schedule Form and Physician's Order for EPSDT Personal Care Services.
- C. Documentation of approval of services by BHSF or its designee.
- D. Documentation of the provision of treatment services by the Personal Care Services worker including dates and times of services, log books, reports on services provided and signed by the individual providing the services and the supervisor, if appropriate.
- E. All billing records must be maintained for three (3) years.

**EPSDT Personal Care Services—Social Assessment
Must Be Submitted In Addition to Form 90-L**

RECIPIENT NAME: _____ MEDICAID # _____

1. HOUSEHOLD COMPOSITION:

Name	Age	Relationship	School/Work?

2. PRIMARY CAREGIVER ASSESSMENT:

Name: _____ Age _____ Relationship _____ Phone _____

Does Primary Caregiver have physical or mental limitations which would affect his/her ability to care for the recipient?
 Yes No If yes, explain and attach medical documentation of limitations:

Will the primary caregiver supervise the PCS worker? Yes No

3. CHILDCARE ARRANGEMENTS:

Age of the recipient: _____ If fourteen years or younger, explain childcare arrangements when the parent is gone from the home. (ie., when parent is at work, before/after school when parent works, or when parent is away on errands).

4. RECIPIENT ASSESSMENT:

Does recipient attend school or work? Yes No If yes, specify hours attended and name of school or work: _____

Is recipient Verbal Nonverbal?

Does recipient utilize adaptive equipment? Yes No

If yes, specify what type equipment: _____

Can recipient direct his/her own care? Yes No

If no, is primary caregiver or other caregiver in home? Yes No

Is recipient on medication: () Yes () No
If yes, who gives medication? _____

5. DIETARY FACTORS:

Who prepares meals? _____

Type of meals and number per day: _____

Assistive devices for eating (feeding tube, other): () Yes () No

If yes, specify: _____

6. HOME ENVIRONMENT:

Access (describe stairs, doors, walks, etc): _____

Living Space: _____

Location (rural, urban, on bus line, etc.): _____

7. Family Interpersonal Relationships: Which family members assume major responsibilities for caring for recipient and what tasks do they perform?

8. SOCIAL SUPPORT SYSTEM: Are there other friends or relatives that assist in caring for the recipient or in giving relief to the primary caregiver?

9. OTHER SERVICES: What other services is the recipient receiving at this time (home health, respite, etc.)?

10. PCS SERVICES: What is the name of the agency that will provide PCS services?

Signature(s) of person(s) completing assessment:

Date: _____

Date: _____

EPSDT PCS DAILY SCHEDULE

Client Name _____ Medicaid # _____

Specify hours of all services received by recipient. This includes EPSDT PCS as well as other services such as home health aide or nurse, respite or PCA from waiver or contract, physical therapy, etc. Be certain to show times the recipient is in school.

TIME	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
NOON							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							
12:00 PM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
Comments							

SECTION 9
SANCTIONS

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To maintain the integrity of the Louisiana Medicaid Program, providers must understand and follow Louisiana Medicaid Program's policy concerning fraud and abuse. This section of the manual defines the different types of fraud and abuse, and it sets forth specific sanctions for providers who commit fraud and abuse Medicaid.

I. GENERAL

Federal regulations require that the Louisiana Medicaid Program establish criteria that are consistent with principles recognized as affording due process of law for identifying situations where there may be fraud or abuse, for arranging prompt referral to authorities, and for developing methods of investigation or review that ascertain the facts without infringing on the legal rights of the individuals involved.

II. FRAUD

Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. The definition of fraud that governs between citizens and government agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.01.

- Legal action may be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-3).
- Prosecution for fraud and the imposition of a penalty, if the individual is found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts.
- All such legal action is subject to due process of law and to the protection of the rights of the individual under the law.

A. Provider Fraud

Cases involving one or more of the following situations shall constitute sufficient grounds for a provider fraud referral:

1. Billing for services, supplies, or equipment that are not rendered to, or used for, Medicaid patients;

2. Billing for supplies or equipment that are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;
3. Claiming costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items;
4. Materially misrepresenting dates and descriptions of services rendered, the identity of the individual who rendered the services, or of the recipient of the services;
5. Duplicate billing of the Medicaid Program or of the recipient, which appears to be a deliberate attempt to obtain additional reimbursement; and
6. Arrangements by providers with employees, independent contractors, suppliers, and others, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from the Medicaid.

B. Recipient Fraud

Cases involving one or more of the following situations constitute sufficient grounds for a recipient fraud referral:

1. The misrepresentation of facts in order to become or to remain eligible to receive benefits under the Louisiana Medicaid Program or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;
2. The transferring (by a recipient) of a Medicaid Eligibility Card to a person not eligible to receive services under the Louisiana Medicaid Program or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits; and
3. The unauthorized use of a Medical Eligibility Card by persons not eligible to receive medical benefits under Medicaid.

III. ABUSE

Abuse of the Louisiana Medicaid Program by either providers or recipients includes practices that are not criminal acts and may even be technically legal, but still represent the inappropriate use of public funds.

A. Provider Abuse

Cases involving one or more of the situations listed below constitute sufficient grounds for a provider abuse referral:

1. The provision of services that are not medically necessary;
2. Flagrant and persistent overuse of medical or paramedical services with little or no regard for the patient's medical condition or needs or for the doctor's orders;
3. The unintentional misrepresentation of dates and descriptions of services rendered, of the identity of the recipient of the services, or of the individual who rendered the services in order to gain a larger reimbursement than is entitled; and
4. The solicitation or subsidization of anyone by paying or presenting any person money or anything of value for the purpose of securing patients (Providers, however, may use lawful advertising **that abides by BHSF rules and regulations.**)

B. Recipient Abuse

Cases involving one or more of the following situations constitute sufficient grounds for a recipient abuse referral:

1. Unnecessary or excessive use of the prescription medication benefits of the Louisiana Medicaid Program;
2. Unnecessary or excessive use of the physician benefits of the program; and
3. Unnecessary or excessive use of other medical services and/or medical supplies that are benefits of the program.

IV. FRAUD AND ABUSE DETECTION

Provided in this subsection is the fraud and abuse detection process. The first step of the process is a referral of suspect claims to a review board.

A. Referrals

Situations involving potential fraud and/or abuse that are to be followed up for review by the Louisiana Medicaid Program may include any or all of the following:

1. Cases referred by the U.S. Department of Health and Human Services [the Louisiana Medicaid Program in turn refers suspected cases of fraud in the Medicare Program to the Health Care Financing Administration (HCFA) and works closely with that agency in such matters.];
2. Situations brought to light by special review, internal controls, or provider audits or inspections; and/or
3. Referrals from other agencies or sources of information.

B. Recipient Verification Notices (REOMBs)

The federal regulations (Public Law 92-693, Sec 253 3) for MMIS require that the Louisiana Medicaid Program provides prompt written notice of medical services that are covered to the recipients of these services. **A predetermined percentage of the recipients who have had medical services paid on their behalf during the previous month will receive the required notice, that is, the Recipient's Explanation of Medical Benefits (REOMB).** From time to time, the Louisiana Medicaid Program may send notices to 100% of the recipients receiving services from any provider for any given period.

1. The REOMB contains the following information:
 - a. The recipient's Medicaid identification number,
 - b. The recipient's name,
 - c. The date of the REOMB (monthly, on the 15th),

- d. The date of the service for the services provided,
 - e. A narrative description of the services provided,
 - f. The place of service for the services provided,
 - g. The provider of the services, and
 - h. The amount paid for the services by the Louisiana Medicaid Program.
2. On the reverse side of the REOMB, preprinted instructions request the recipients to use the space provided to call attention to any mistakes they feel were made on their bill.
- a. If a service is listed on the REOMB that was not received by a recipient, or if the recipient were made to pay for a service covered by the Louisiana Medicaid Program, that recipient is expected to write a brief explanation of the error. The recipient should include his phone number, and he should return the REOMB, postage paid, to the fiscal intermediary.
 - b. The fiscal intermediary will then research the **claim copy and provider remittance documents** to make sure that the recipient, provider, and services on the returned REOMB are accurately presented.
 - c. If the information on the returned REOMB is not accurate, then the REOMB and all documentation will be reviewed by the fiscal intermediary's **Surveillance Utilization Review System (SURS) Unit**.
 - d. All situations that require further inquiry are reviewed by SURS.
 - e. Situations that require criminal investigation are referred to the State Attorney's General's Medicaid Fraud Control Unit.

C. Computer Profiling

The fiscal intermediary can identify potential fraud and abuse situations by means of **profile reports**. A profile report is produced by a computer from information gathered in the state's claims payment operation.

1. Providers are classified into peer groups according to geographic location,

medical specialties, and other categories.

2. Profile reports include the following information:
 - a. A statistical profile of each peer group classification to be used as a base line for evaluation;
 - b. A statistical profile of each individual participant compatible with the peer group profile;
 - c. An evaluation of each individual participant profile against its appropriate group profile; and
 - d. A listing of individual participants who deviate significantly from their group norm (These individuals are reported as exceptional and are flagged for analysis.).
3. Each profile reported as exceptional is reviewed and analyzed by a trained staff and by medical consultants. The analysis can include a review of:
 - a. the provider's paid claims,
 - b. a review of the provider's reply to the Louisiana Medicaid Program's written request for information,
 - c. a review of hospital charges and patient records, and
 - d. a review of other relevant documents.
 - e. **The overall review is not necessarily limited to areas identified as exceptional on the profile report.**

V. ADMINISTRATIVE SANCTIONS

To ensure the quality, quantity, and need for services, Medicaid payments may be reviewed by the Louisiana Medicaid Program. **Administrative sanctions** may be imposed against any Medicaid provider who does not meet the guidelines listed in the following subsection.

A. Definition of Administrative Sanctions

Administrative sanctions refer to any administrative actions taken by the single state agency against a medical service provider of Title XIX services. Any such administrative action is designed to remedy inefficient and/or illegal practices that are not in compliance with Medicaid of Louisiana policies and procedures, statutes, and regulations.

B. Levels of Administrative Sanctions

Listed below are the different levels of administrative sanctions that Louisiana Medicaid Program may impose against a Medicaid provider:

1. Issuing a warning to a provider through written notice or consultation;
2. Requiring that the provider receive education in policies and billing procedures;
3. Requiring that the provider receive prior authorization for services;
4. Placing the provider's claims on manual review status before payment is made;

NOTE: Any provider of Medicaid services may be placed on prepayment review as an administrative sanction of misuse of the Louisiana Medicaid Program. Prepayment review may be limited to those types of procedures for which misuse has been detected, or it may include a complete review of all of the provider's claims.

5. Suspending the provider or withholding payments from the provider;

NOTE: The Louisiana Medicaid Program may suspend or withhold payment to any provider who fails to meet the requirements for participation in the Louisiana Medicaid Program.

6. Recovering money from the provider by deducting from future payments or by requiring direct payment for money improperly or erroneously paid;
7. Referring a provider to the appropriate state licensing authority for investigation;

8. Referring a provider for review by the appropriate professional organizations;
9. Referring a provider to the Attorney General's Medicaid Fraud Control Unit for fraud investigation;
10. Suspending a provider from participating in Louisiana Medicaid Program; and
11. Refusing to allow a provider to participate in the Louisiana Medicaid Program.

C. Grounds for Sanctioning Providers

The Louisiana Medicaid Program may impose sanctions against any provider of medical goods or services if it discovers that any of the following conditions apply:

1. A provider is not complying with the Louisiana Medicaid Program's policy, rules, and regulations or with the terms and conditions prescribed by the Louisiana Medicaid Program in its provider agreement and signed claim that set the terms and conditions applicable to each provider group's participation in the program.
2. A provider has submitted a false or fraudulent application for provider status.
3. Such a provider is not properly licensed or qualified, or such a provider's professional license, certificate, or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated.
4. Such a provider has engaged in a course or conduct; has performed an act for which official sanction has been applied by the licensing authority, professional peer group, or peer review board or organization; or has continued the poor conduct after having received notification by a licensing or reviewing, indication that his conduct should cease.
5. Such a provider has failed to correct deficiencies in his delivery of services or his billing practices after having received written notice of these deficiencies from the Louisiana Medicaid Program.

6. Such a provider has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142, or such a provider has been convicted of Medicaid fraud (Louisiana R.S. 14:70.1).
7. Such a provider has been convicted of a criminal offense relating to performance of a provider agreement with the state, to fraudulent billing practices, or to negligent practice, resulting in death or injury to the provider's patient.
8. Such a provider has presented false or fraudulent claims for services or merchandise for the purpose of obtaining greater compensation than that to which the provider is legally entitled.
9. Such a provider has engaged in a practice of charging and accepting payment (in whole or in part) from recipients for services for which a charge was already made to the Louisiana Medicaid Program and for which payment was already made.
10. Such a provider has rebated or accepted a fee or a portion of a fee for a patient referral.
11. Such a provider has failed to repay or arrange to repay an identified overpayment or otherwise erroneous payment.
12. Such a provider has failed, after having received a written request from the Louisiana Medicaid Program, to keep or to make available for inspection, audit, or copying, records regarding payments claimed for providing services.
13. Such a provider has failed to furnish any information requested by the Louisiana Medicaid Program regarding payments for providing goods and services.
14. Such a provider has made, or caused to be made, a false statement or a misrepresentation of a material fact concerning the administration of the Louisiana Medicaid Program.
15. Such a provider has furnished goods or services to a recipient that are in excess of the recipient's needs, harmful to the recipient, or of grossly

inadequate or inferior quality (This determination would be based upon competent medical judgement and evaluation.).

16. The provider, a person with management responsibility for a provider, an officer or person owning (either directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate provider, an owner of a sole proprietorship that is a provider, or a partner in a partnership that is a provider is found to fall into one or more of the following categories:
17. Was previously barred from participation in the Louisiana Medicaid Program;
18. Was a person with management responsibility for a previously terminated provider during the time of conduct that was the basis for that provider's termination from participation in the Louisiana Medicaid Program;
19. Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a previously terminated corporate provider during the time of conduct that was the basis for that provider's termination from participation in the Louisiana Medicaid Program;
20. Was an owner of a sole proprietorship or a partner of a partnership that was previously terminated during the time of conduct that was the basis for that provider's termination from participation in the program;
21. Was engaged in practices prohibited by federal or state law or regulation;
22. Was a person with management responsibility for a provider at the time that such a provider engaged in practices prohibited by state or federal law or regulation;
23. Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a provider at the time such a provider engaged in practices prohibited by federal or state law or regulation;

24. Was an owner or a sole proprietorship or partner or a partnership that was a provider at the time such a provider engaged in practices prohibited by federal or state law or regulation;
25. Was convicted of Medicaid fraud under federal or state law or regulation;
26. Was a person with management responsibility for a provider at the time that such a provider was convicted of Medicaid fraud under federal or state law or regulation;
27. Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a provider at the time such a provider was convicted of Medicaid fraud under federal or state law or regulation; or
28. Was an owner or a sole proprietorship or partner or a partnership that was a provider at the time such a provider was convicted of Medicaid fraud under federal or state law or regulation;

VI. APPEALS

The Louisiana Department of Health and Hospitals (DHH) provides a hearing to any provider who feels that he has been unfairly sanctioned. Specifically, the Bureau of Appeals in the Department of Health and Hospitals is responsible for conducting hearings for providers who have complaints. Requests for hearings should explain the reason for the request and should be made in writing. The request should be sent directly to the Bureau of Appeals.

Detailed information regarding the appeals procedure may be obtained from the Bureau of Appeals at the following address:

DHH Bureau of Appeals
Post Office Box 4183
Baton Rouge, LA. 70821-4182



SECTION 10
GLOSSARY

SECTION CONTENTS

GLOSSARY 10-2



DEFINITIONS OF TERMS

This section provides definitions of terms *used in this manual*. It also explains commonly used acronyms.

Abuse—Inappropriate use of public funds by either providers or recipients. For further explanation, see page 9-4.

AFDC—Aid to Families with Dependent Children; the largest federal-state program providing cash payments to eligible needy families with dependent children.

AOTA—American Occupational Therapy Association, Inc.

ASHA—American Speech and Hearing Association.

Assessment—the collection and synthesis of information and activities to determine the state of a child's health plus any delays or problems in the child's cognitive, social, emotional, and physical development.

Assistive Technology Device—any item, piece of equipment, or product system used to increase, maintain, or improve the functional capabilities of a child with a disability. This does not include convenience items but covers medically necessary assistance achieved through the use of assistive technology.

At Risk—refers to children who are more likely to have substantial development delays if early intervention services are not provided.

Audiology Services—services for the identification of children with auditory impairment using at risk criteria and appropriate screening techniques. For further explanation, see page 5-4.

BHSF—Bureau of Health Services Financing. Also referred to as Medicaid.

Case Management—services provided to eligible consumers to help them gain access to the full range of needed services including medical, social, educational, and other support services. This definition adapted from P.L. 100-203(g)(2) and Section 4302A of the *State Medicaid Manual*.

CHAMP—Child Health and Maternity Program.

Childnet—the early intervention program for infants and toddlers with disabilities in Louisiana.

Cost Avoidance—term referring to avoiding the payment of Medicaid claims when other insurance resources are available to the Medicaid recipient.

COTA—Certified Occupational Therapy Assistant.

DD—acronym for developmental disability.

Developmental Delay—a severe, chronic disability of a person attributed to a mental and/or physical disability that has an onset before age 22 and is likely to continue indefinitely and results in substantial functional limitation in three or more of the major life activities.

Diagnosis—the determination of the nature and cause of the condition requiring attention.

Diagnostic services—any medical procedures recommended by a physician or other licensed practitioner to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

Early Intervention Services—services provided to children, birth through age two, who are experiencing developmental delays or have diagnosed conditions that may lead to developmental delays designed to meet the developmental needs of each child and provided under public supervision by qualified personnel in conformity with an individualized family services plan.

EPSDT—Early and Periodic Diagnosis and Treatment Program; a federally mandated cluster of preventive health, diagnosis, and treatment services for children age 0-21.

Evaluation (Part H)—the process of collecting and interpreting data obtained through observation, interview, record review, or testing.

EMC—Electronic Media Claim.

Family Service Coordination—An active process for implementing the IFSP that promotes and supports a family's capacities and competencies to identify, obtain, coordinate, monitor, and evaluate resources and services to meet needs.

Federal Poverty Level—a measure used by the federal government to denote a survival level of family income. It varies by family size. The figures are revised annually. The poverty income guidelines are used for administrative purposes as a set standard to determine eligibility for public assistance.

Fiscal Intermediary—the private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes the Title XIX (Medicaid) claims for services provided under the Medical Assistance Program and issues appropriate payment(s).

Fraud—an aspect of law. The definition that governs between citizens and agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.01. For further explanation, see Section 9.

HCFA—Health Care Financing Administration or the U. S. Department of Health and Human Services, the federal agency administering Medicaid in partnership with the states.

HCFA 1500—the universal claim form used to bill for Medicaid/EPSDT health services for children with disabilities.

ICN—Internal Claim Number.

IDEA—Individuals with Disabilities Education Act originally known as the Education of the Handicapped Act.

IEP—Individual Education Program that meets all the requirements of IDEA and Bulletin 1706 and includes all special educational and related services necessary to accomplish comparability of educational opportunity between exceptional children and children who are not exceptional.

IFSP—Individualized Family Service Plan. It is a written plan for providing early intervention services to a child eligibility under Part H and the child's family.

Infants and Toddlers with Disabilities—individuals from birth through age two who are early intervention services because they are experiencing developmental delays or have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay as defined by Childnet.

KIDMED—the EPSDT screening program in Louisiana.

LEA—a local Education Agency; the organization in charged of public schools in a particular geographic area. The LEA has a school board and a superintendent.

Major Life Activities—daily living activities that include self care, receptive expressive language, mobility, self-direction, capacity for individual living and economic self-sufficiency.

Medicaid—medical assistance provided under the State Plan approved under Title XIX of the Social Security Act.

Medicaid Agency—the single state agency responsible for the administration of the Medical Assistance Program (Title XIX). In Louisiana, the Bureau of Health Services Financing of the Louisiana Department of Health and Hospitals that is the single state Medicaid agency. Sometimes referred to as the Louisiana Medicaid Program.

Medicaid Management Information System (MMIS)—the computerized claims processing and information retrieval system which includes all ICF/MR providers eligible for participation in the Medical Assistance Program. This system is an organized method for payment for claims for all Title XIX Services.

OBRA '89—Omnibus Budget Reconciliation Act of 1989 that expanded Medicaid eligibility and EPSDT services.

Occupational Therapy (OT) Services—services that address the functional needs of a child related to the performance of self-help skills, adaptive behavior, play and sensory, motor, and postural development. For further explanation, see page 5-11.

OTA—Occupational Therapy Assistant.

OTR—Registered Occupational Therapist.

Pay and Chase—method of payment where Medicaid pays the recipient's medical bills and then pursues reimbursement from liable health insurance company(s) and other liable third parties.

PCA—Personal Care Attendant services. For further explanation, see Section 8.

PCCM—Primary Care Case Management system.

PCP—Primary Care Physician. Serves as the recipient's family doctor, providing basic primary care, referral and after hours coverage.

PCS—Personal Care Services. For further explanation, see Section 8.

Physical Therapy (PT) Services—services designed to improve the child's movement dysfunction. For further explanation, see page 5-14.

Plan of Care (POC)—specify's the personal care service(s) to be provided and the minimum and maximum frequency and the minimum and maximum duration of each of these services. For further explanation, see pages 8-7 and 8-8.

Preventive Services—services provided by a physician or other licensed practitioner to prevent disease, disability, and other health conditions or their progression, to prolong life. *These services include screening and immunizations.*

Prior Authorization (PA)—a request for approval for payment of service must be made by the provider before rendering the service. For further explanation, see page 8-10.

Provider—health professionals who perform and/or deliver medically necessary services and/or supplies for eligible Medicaid recipients. For further explanation, see page 1-5.

Psychological Services—obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development and planning and managing a program of psychological counseling for children and family based on the results of the information. For further explanation, see page 5-18.

RA—Remittance Advice.

Recipient—a Medicaid eligible individual.

RFP—Request for proposal(s).

Remittance Advice—control document which informs the provider of the current status of submitted claims.

Related Services—services provided in the education system only when it can be documented that the student needs or requires the services to benefit from the education program. These services include interpreter services, orientation and mobility training, audiological services, health services, speech therapy, counseling, and occupational or physical therapy.

REOMB—Recipient's Explanation of Medical Benefits. For further explanation, see page 9-5.

Screening Services—the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

Speech/Language Pathology—identifies children with communicative or oropharyngeal disorders and delays in development of communication skills including diagnosis and appraisal of specific disorders and delays in those skills. For further information, see page 5-7.

State Plan—a document submitted by a state setting forth how it will use federal funds and conform to federal regulations. The plan must be approved by federal officials.

SURS—Surveillance Utilization Review System.

Title XIX—see Medicaid.

TPL—Third-Party Liability.

Treatment—the provision of services medically necessary to control or correct diagnosed conditions.

Unisys—the fiscal intermediary for the Louisiana Medicaid Program.

APPENDICES

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EPSDT Personal Care Services for Children with Disabilities Provider Enrollment Supplement Agreement

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

Name of Provider: _____

Medicaid Provider Number: _____

Address (Mailing & Street): _____

Telephone Number including Area Code: _____

Address and Telephone Number of Other Sites (if applicable): _____

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

SERVICE	RESTRICTIONS
---------	--------------

- Audiologic Evaluations
- Speech and Language Evaluations
- Speech, Language or Hearing Therapy
- Occupational Therapy Evaluation
- Occupational Therapy
- Physical Therapy Evaluation
- Physical Therapy
- Psychological Evaluation
- Psychological Therapy

POST OFFICE BOX POINTERS

Mailing claims to the correct **Post Office Box** will enable Unisys to decrease the turnaround time on claims. When mailing a claim to Unisys, pick the appropriate post office box from below:

Pharmacy	Post Office Box 91019
Professional, Independent Labs, Substance Abuse, Mental Health, Hemodialysis Professional Services, Chiropractor, FQHC, Case Management, Rural Health Clinics, Durable Medical Equipment, Mental Health Rehab Health Services, EPSDT Health Services, EPSDT PCS (Providers billing on HCFA-1500)	Post Office Box 91020
Inpatient, Outpatient, and Long Term Care, Hospice, Free-Standing Psychiatric Hospitals Hemodialysis	Post Office Box 91021
Dental, Rehabilitation, Home Health Transportation (Emergency and Non-emergency)	Post Office Box 91022
Crossover and Adjustment Correspondence	Post Office Box 91023
Provider Relations Correspondence	Post Office Box 91024
EMC, Unisys Business and Miscellaneous Correspondence	Post Office Box 91025
Prior Authorization	Post Office Box 14919
Zip code for all post office boxes	70821

If there are any questions about these post office boxes, contact Provider Relations at 1 (800) 473-2783 or (504) 924-5040 for assistance.

APPENDIX C

IFSP MODEL

Model A

INDIVIDUAL FAMILY SERVICE PLAN

Child's Name _____

OUTCOME AND SERVICE PLAN

Outcome #:

Strategies/Activities:

Criteria:

Date Achieved _____

Service: _____

Part H: Yes No

Person(s) Responsible: _____

Phone Number: _____

Provider Agency: _____

How Often: _____

How Long: _____

Location: _____

Individual Group

Initiation Date: _____

Projected Duration: _____

Financial Responsibility: _____

APPENDIX C

IFSP MODEL

Model B

**INDIVIDUAL FAMILY SERVICE PLAN
FOR**

Child's Name _____

Date _____

I. General Information	II. Family Members & Support Persons	Relationship to Child
Date of Birth: _____ ID#: _____ Diagnosis: _____ Parent(s): _____ Address: _____ Phone #: _____ Misc.: _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
III. Physical Development	IV. Evaluation Information	V. Child's Strengths
Vision _____ Hearing _____ Health Status _____ _____ _____	Evaluation Date: _____ CA _____ Test Used: _____ Completed by: _____ Motor: _____ Cognitive Development: _____ Social/Emotional: _____ Communication: _____ Self-help: _____	_____ _____ _____ _____ _____
VI. Family Strengths		VII. Family Needs
_____ _____ _____ _____ _____		_____ _____ _____ _____ _____

**THE CHILD/FAMILY GOAL SHEET
INDIVIDUAL FAMILY SERVICE PLAN**

Page:

Child's Name:		DOB:	Family Name:	Case Manager:	
Child/Family Needs (Present Status)	Desired Outcomes for Child/Family	Family Strengths/Resources	Course of Action (Person Responsible)	Family's Evaluation	Rating
	Date			Date	
	Date				
	Date				
	Date				

- Family Evaluation (From the *Family Support*, by Dunst, Trivette, and Deal)
- 1....Situation unchanged, no longer a need
 - 2....Situation unchanged, still a need, goal, or project
 - 3....Implementation begun; still a need, goal or project
 - 4.... Outcome partially attained or accomplished...
 - 5.... Outcome accomplished or attained but not to the family's satisfaction
 - 6.... Outcome mostly accomplished or attained to the family's satisfaction
 - 7.... Outcome completely accomplished or attained to the family's satisfaction

**THE INTERAGENCY DOCUMENTATION FORM
INDIVIDUAL FAMILY SERVICE PLAN**

PAGE:

Child's Name:		DOB:	Family Name:	Case Manager(s):
Date	Agency/Resource		Action	Comments/Recommendations to Family and/or Other Agencies

APPENDIX C

IFSP MODEL

Model C

UNIVERSITY OF NEW ORLEANS
Department of Special Education and Habilitative Services

INDIVIDUALIZED FAMILY SERVICE PLAN

Child's Name _____ Family Name _____

Date of Birth _____ Date of IFSP Meeting _____

Review Evaluation Interim Initial

FAMILY MEMBERS	RELATIONSHIP TO CHILD

FAMILY SERVICE PLANNING TEAM

TITLE	NAME	AGENCY	DATE
Parent/Guardian			
Parent/Guardian			
Service Coordinator			

TEAM IFSP REVIEW/EVALUATION DATES

30 Days 3 Months 6 Months 1 Year Other _____

Date of next review/evaluation _____ Time _____ Location _____

Child's Name: _____ Family Name: _____ Date: _____

CHILD'S STRENGTHS

(Based on multi-sources; parent report, observation, direct testing)

FAMILY'S STRENGTHS

(Based on written self-reports, interview, observation)

CHILD'S FUNCTIONING LEVEL

TEST: _____
DATE: _____ CA _____

TEST: _____
DATE: _____ CA _____

Domain	Level	Domain	Level
Physical	_____	Physical	_____
Cognitive	_____	Cognitive	_____
Communicative	_____	Communicative	_____
Social	_____	Social	_____
Self-Help	_____	Self-Help	_____

CHILD'S PHYSICAL DEVELOPMENT

TEST: _____
DATE: _____ CA _____

TEST: _____
DATE: _____ CA _____

Domain	Level	Domain	Level
Vision	_____	Vision	_____
Hearing	_____	Hearing	_____
Health Status	_____	Health Status	_____
	_____		_____

Child's Name: _____ Family Name: _____ Date: _____

STATEMENT ON LEAST RESTRICTIVE ENVIRONMENT

Least restrictive environment is a term meaning individuals with exceptionalities must be served with children who are nonhandicapped to the maximum extent appropriate.

Was the family informed of the options available for the child that provide early intervention services in the LRE?..... Yes No

List activities that provide for the integration of the child into the community:

PLACEMENT DECISION(S)

- | | |
|---|---|
| <input type="checkbox"/> Home-based intervention program | <input type="checkbox"/> Private day care |
| <input type="checkbox"/> Integrated center-based intervention | <input type="checkbox"/> Family day care |
| <input type="checkbox"/> Center-based intervention program serving only children with handicaps | <input type="checkbox"/> Center-based speech only |
| <input type="checkbox"/> Hospital based | <input type="checkbox"/> Monitoring |
| | <input type="checkbox"/> Other _____ |

RESOURCES/SERVICES

Service _____ Frequency _____ Intensity _____ Location _____ Method _____ Payor _____ Start Date _____ End Date _____	Service _____ Frequency _____ Intensity _____ Location _____ Method _____ Payor _____ Start Date _____ End Date _____	Service _____ Frequency _____ Intensity _____ Location _____ Method _____ Payor _____ Start Date _____ End Date _____	Service _____ Frequency _____ Intensity _____ Location _____ Method _____ Payor _____ Start Date _____ End Date _____
Service _____ Frequency _____ Intensity _____ Location _____ Method _____ Payor _____ Start Date _____ End Date _____	Service _____ Frequency _____ Intensity _____ Location _____ Method _____ Payor _____ Start Date _____ End Date _____	Service _____ Frequency _____ Intensity _____ Location _____ Method _____ Payor _____ Start Date _____ End Date _____	Service _____ Frequency _____ Intensity _____ Location _____ Method _____ Payor _____ Start Date _____ End Date _____

Child's Name: _____

Family Name: _____

Date: _____

TRANSITION PLAN

Date	Plan of Operation	Who's responsible	Time line	Date Achieved
	_____ will be 3 yrs. old on _____ (date)			

Child's Name: _____ Family Name: _____ Date: _____

INTERDISCIPLINARY COMMUNICATION

Date	Seen By	Comments	Need To See Again

APPENDIX C

IFSP MODEL

Model D

**HUMAN DEVELOPMENT
INDIVIDUALIZED FAMILY SERVICE PLAN**

Child's Name: _____

Family Name: _____

Priority Number: _____

Date Identified: _____

Desired Outcomes: _____

Begin Date

End Date

Status

Evaluation Criteria: _____

Family Strengths/Resources

Infant Strengths/Resources

Family Needs (general)

Infant Needs (general)

Information reported above was derived from (check all that apply):

Family Interview Informal questionnaires Observations Evaluations

Family Objectives (specific)

Begin Date

End Date

Status

Infant Objectives (specific)

Begin Date

End Date

Status

Status Key

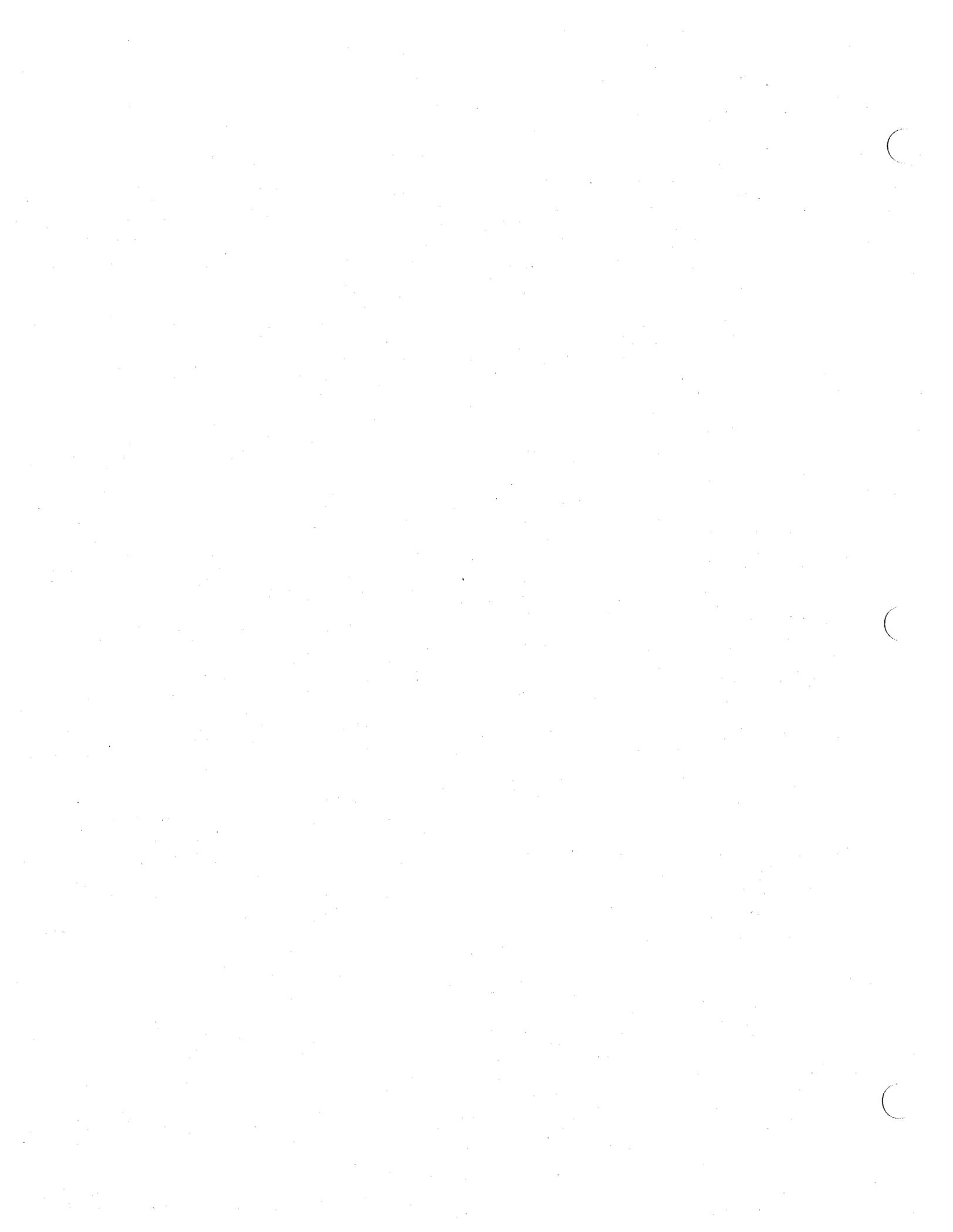
1= Achieved 2=Achieved by parental report 3=Ongoing 4=Changed 5=Deleted 6=No longer concern

MANUAL UPDATES

It is very important to read all the following documentation, as it contains information in addition to that found in the EPSDT Health Services/EPSDT Personal Care Services Manual issued October 1, 1997.

Please note that the following pages were issued after the printing of the manual.

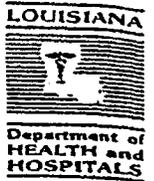
The information in the 1998 EPSDT Health Services/EPSDT PCS Training packet, Medicaid Issues for 1998, was published in September, 1998.





M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

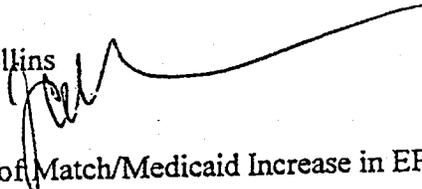


Bobby P. Jindal
SECRETARY

February 23, 1998

MEMORANDUM

TO: Medicaid EPSDT Health Services Providers - School Boards

FROM: Thomas D. Collins
Director 

RE: Certifications of Match/Medicaid Increase in EPSDT Health Services Rates

All certifications of the State Match required for the increase in Health Services Rates have been completed and received from the School Boards. We will be implementing the rate increase with dates of services of January 1, 1998.

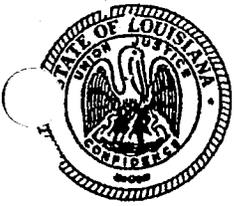
We want to point out that remittance advices for School Boards will show the full payment calculation, the percentage of cutback and the amount of the check. The amount of the check will be for the Federal share of 70.03% which is the full payment minus the cutback of the state match of 29.97%. The cutback reimbursement will go into effect with dates of payment of March 1, 1998.

The cooperation you have shown in this endeavor is very much appreciated. If there are questions, please contact Janis Souvestre at 504-342-9496.

TDC/BEG/JMS

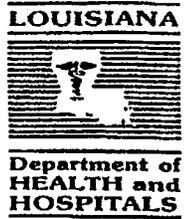
c: Ben Bearden
Bruce Gomez
Janis Souvestre
Dr. Cecil Picard
Nancy Hicks
Janice Fruge





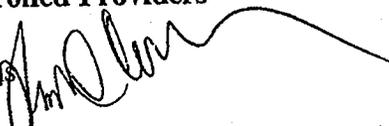
M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



David W. Hood
SECRETARY

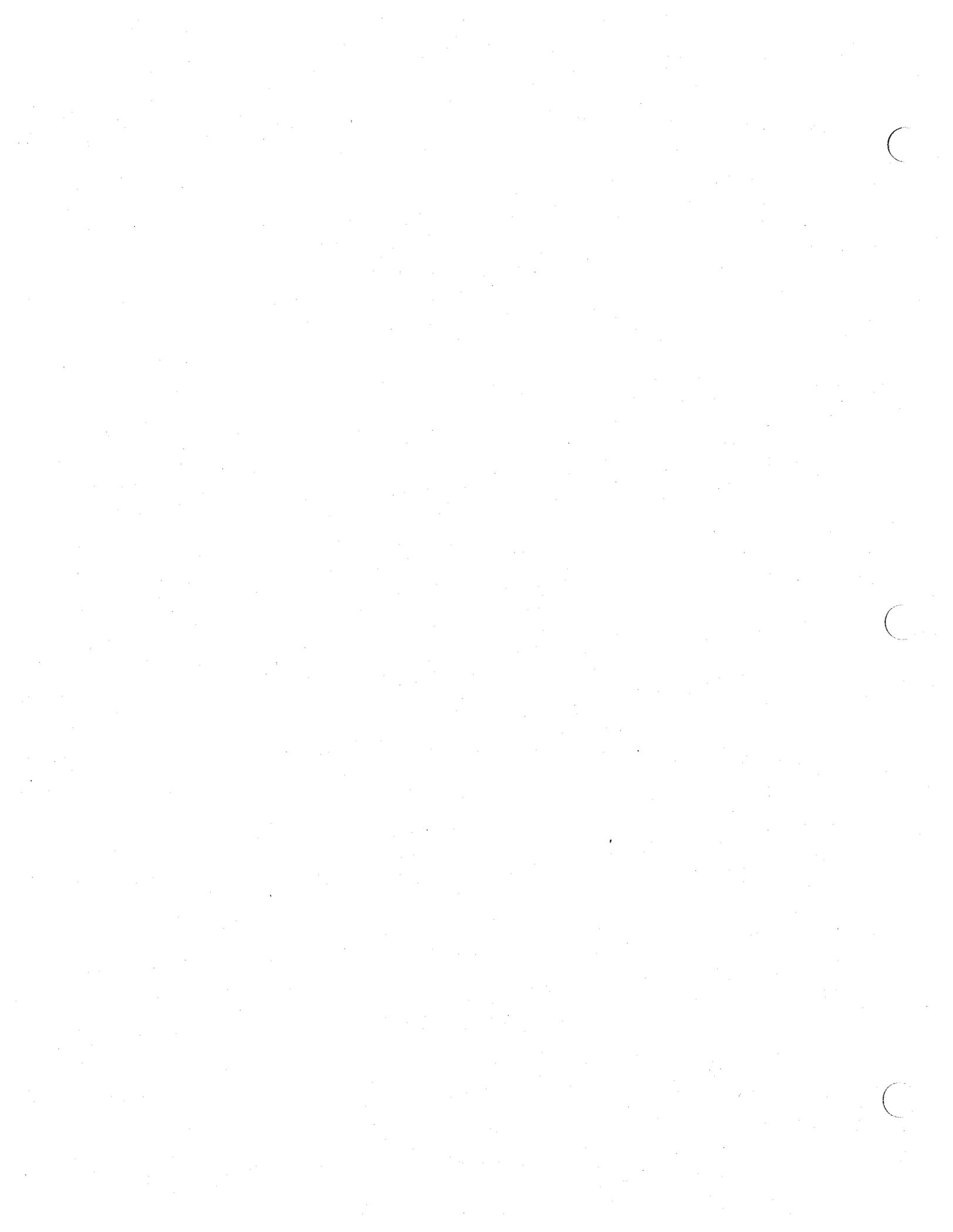
May 20, 1998

To: All Medicaid Enrolled Providers
From: Thomas D. Collins 
Re: 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:

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

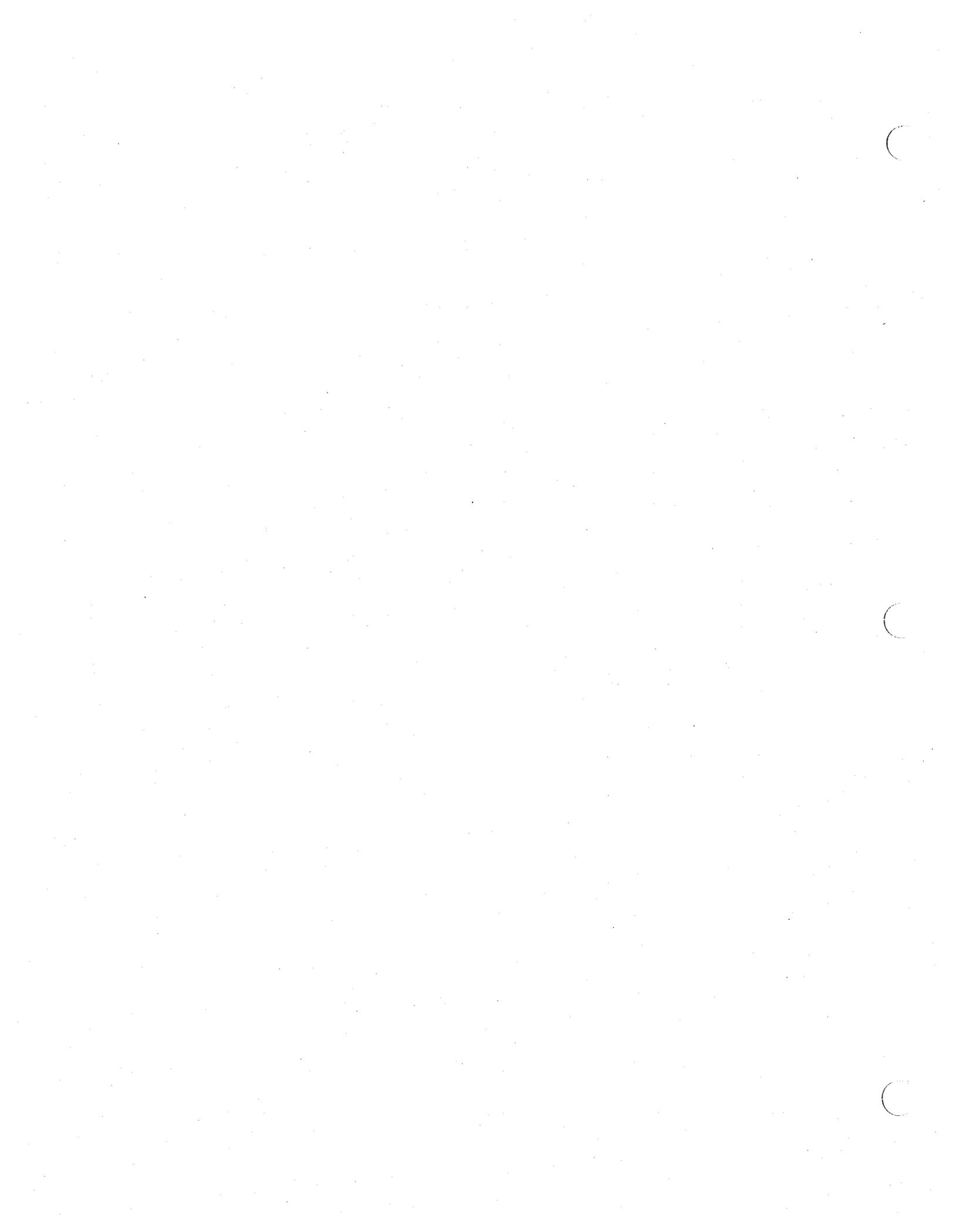


MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive.

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.

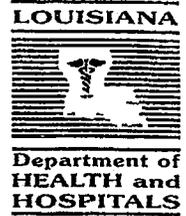
Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify provider enrollment in writing within ten (10) working days of the date of this letter that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.





M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



David W. Hood
SECRETARY

August 6, 1998

To: All Physicians, Audiologist and EPSDT Service Providers

From: Thomas D. Collins
Director

Re: Cochlear Device Implantation Policy

The Bureau of Health Services Financing is pleased to announce that effective for the dates of service on or after August 1, 1998, reimbursement is available for the cochlear implant device for Medicaid recipients with profound-to-total bilateral hearing loss.

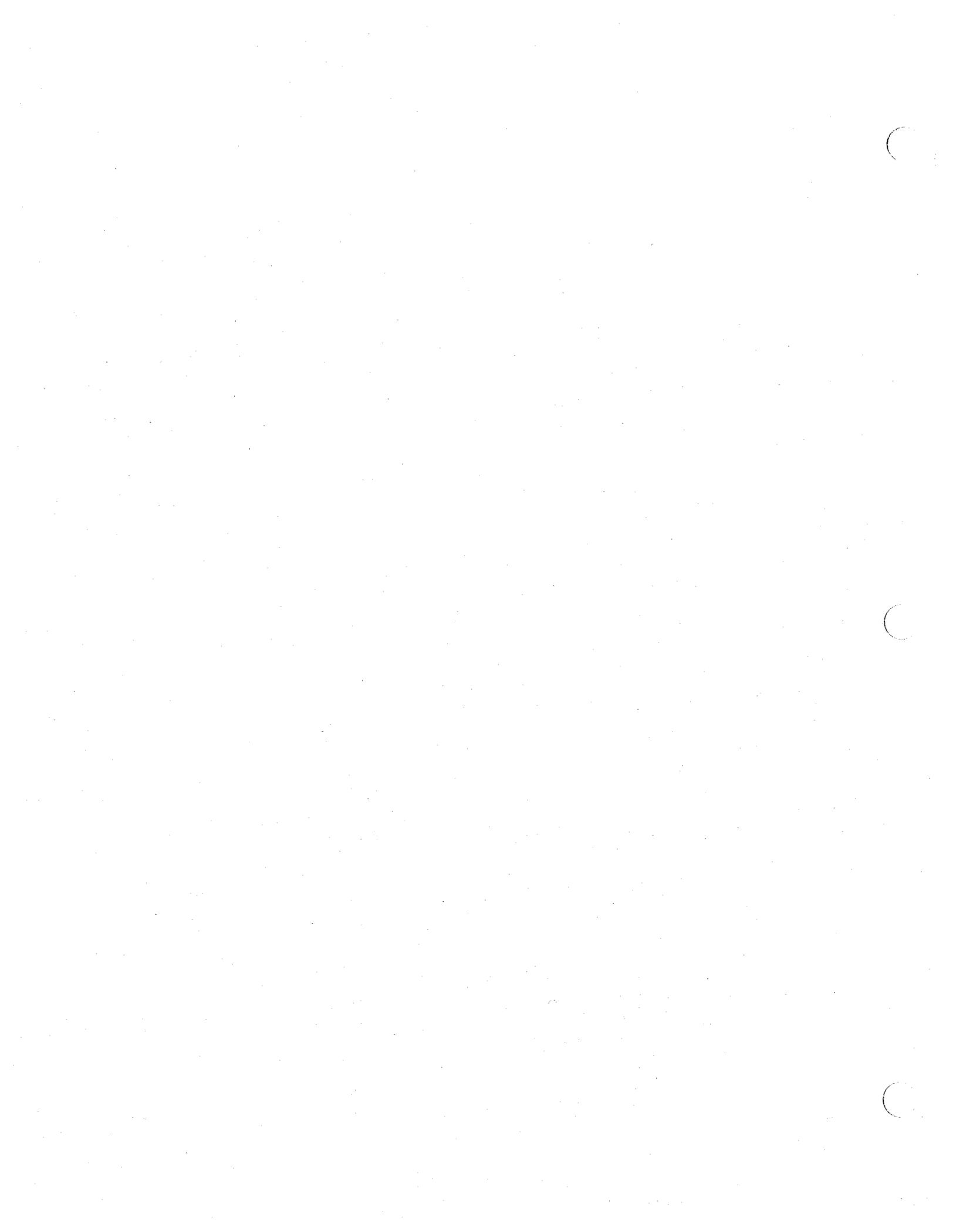
Only recipients two years of age through twenty years of age who meet the medical and social criteria listed below shall qualify for implantation.

Only one device per lifetime per eligible recipient shall be reimbursed unless the device fails or is damaged beyond repair, in which case reimbursement for another device and reimplantation will be considered.

RECIPIENT MEDICAL AND SOCIAL CRITERIA

The following criteria apply to all candidates for Cochlear Device Implantation. The recipient must:

1. have a profound bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;
2. be a profoundly deaf child age two years or older or be a post linguistically deafened adult through the age of twenty years;
3. receive no significant benefit from hearing aids as validated by the cochlear implant team;
4. have high motivation to be part of the hearing community as validated by the cochlear implant team;
5. have appropriate expectations;



6. have had radiologic studies that demonstrate no intracranial anomalies or malformations which would contraindicate implantation of the receiver-stimulator or the electrode array;
7. have no medical contraindications for undergoing implant surgery or post-implant rehabilitation; and
8. show that the candidate and his family are well-motivated, possess appropriate post-implant expectations and are prepared and willing to participate in and cooperate with pre and post implant assessment and rehabilitation programs as recommended by the implant team and in conjunction with Federal Drug Administration (FDA) guidelines.

Specific criteria:

A. Children Two Years Through Nine Years

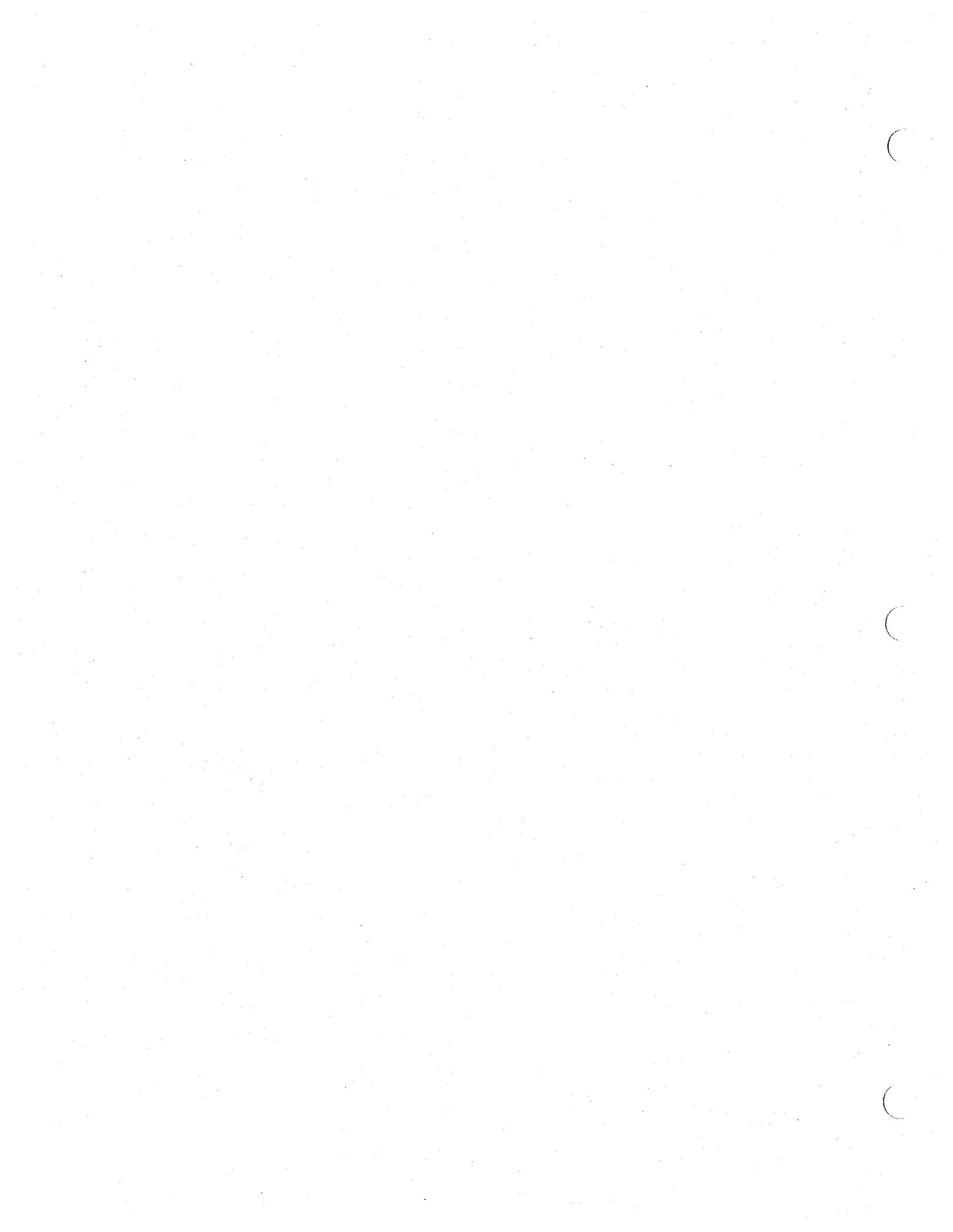
In addition to documentation that candidates meet general criteria the requestor shall provide documentation:

1. that profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;
2. that appropriate tests were administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age appropriate speech perception materials; and
3. that no responses were obtained to Auditory Brainstem Response, Otoacoustic Emission testing or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation.

B. Children 10 Years Through 17 Years

In additional to documentation that candidates meet general criteria, the requestor shall provide documentation:

1. that profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;
2. that appropriate tests were administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age and language appropriate speech perception materials;



3. that no responses were obtained to Auditory Brainstem Evoked Response, Otacoustic Emission Test or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;
4. the candidate has received consistent exposure to effective auditory or phonological stimulation in conjunction with oral method of education and auditory training;
5. that candidate utilizes spoken language as his primary mode of communication through one of the following: an oral/aural (re)habilitation program, or total communications educational program with significant oral/aural; and
6. that the individual has at least six months' experience with a hearing aid or vibrotactile device except in the case of meningitis (in which case the 6 month period will be reduced to 3 months).

C. Adults—8 Years through 20 Years

In addition to documentation that candidates meet general criteria, the requestor shall provide documentation:

1. that the candidates for implant is post linguistically deafened with severe to profound bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;
2. that no significant benefit from a hearing aid was obtained in the best aided condition for speech/sentence recognition material;
3. that no responses were obtained to Auditory Brainstem -Response, Otacoustic Emission testing or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;
4. that the candidate has received consistent exposure to effective auditory or phonological stimulation or auditory communication;
5. that the candidate utilizes spoken language as his primary mode of communication through one of the following:
 - an oral/aural (re)habilitation program, or
 - total communications educational program with significant oral/aural training; and



6. that the candidate has had at least six months experience with hearing aids or vibrotactile device except in the case of meningitis (in which case the 6 month period will be reduced to 3 months).

D. Multi-Handicapped Children

Criteria appropriate for the child's age group are applied.

NON-COVERED EXPENSES

The following expenses related to the maintenance of the cochlear device are the responsibility of either the recipient or his family or care giver(s):

1. All costs for service contracts and/or extended warranties;
2. All costs for insurance to protect against loss and theft.

PRIOR AUTHORIZATION

All aspects of this procedure (preoperative speech and language evaluation, implantation, device, repairs, supplies, therapy) must be prior authorized. The request to perform surgery must come from the multidisciplinary team which assessed the recipient's disability and determined him/her to be a possible candidate for implantation.

The multidisciplinary team shall consist of:

- a surgeon/otologist;
- an audiologist;
- a speech/language pathologist;
- a psychiatrist; and,
- an educator of the deaf with experience in oral/auditory instruction.

A Form PA-01 must be completed for the device and submitted to the Prior Authorization Unit as part of the multidisciplinary team's packet. A PA-01 form requesting approval to perform the surgery must be submitted to Prior Authorization by the surgeon as part of the multidisciplinary team's packet. The team's written decision regarding the recipient's candidacy for the implant and the results of all pre-operative testing (audiogram, tympanogram, speech and language evaluation, social evaluation, etc.) shall be included in the packet sent to Unisys. Post-operative speech and language evaluation services must be prior authorized, as well. The audiologist shall submit a PA-01 form requesting approval to Prior Authorization as part of the multidisciplinary team's packet.

The single packet requesting a Cochlear implant shall be submitted for review to Unisys labeled **Unisys Prior Authorization Unit—Request for Cochlear Implant to:**



Unisys
Prior Authorization Unit
Post Office Box 14919
Baton Rouge, LA 70898-4919

Requests for reimbursement for speech processor and/or microphone repairs, headset cords, headset replacements and batteries must be prior authorized and may be made on Form PA01 to the Prior Authorization Unit at the address given previously.

HOSPITAL BILLING FOR PROCEDURE

The hospital shall be reimbursed for the cochlear device and the hospital stay for the surgery. The hospital shall bill for the device on a HCFA 1500 claim form using HCPCS code L8614 (Cochlear Device System). The letters DME must be written in red on the top of the form, and the PA number must be written in Item 23. The device will be reimbursed at a fee of \$11,496.

Note: Reimbursement for the device will not be authorized until the surgical procedure has been approved.

PHYSICIAN BILLING PROCEDURE

The surgeon shall bill for the implantation on a HCFA 1500 claim form using CPT-4 procedure code 69930 (Cochlear device implantation, with or without mastoidectomy). The assistant surgeon shall bill using the same CPT procedure code with a modifier 80. **This procedure shall not be billed as either a team surgery or co-surgery (modifiers 62 and 66 respectively).**

The surgeon's fee for CPT code 69930 will be \$1319.24, and the assistant surgeon's fee will be \$263.85. The anesthesiologist's fee will be eight base units of anesthesia plus the actual number of time units (1 = 15 minutes) multiplied by the co-efficient of \$13.50. The surgeon's claim form must have the PA number written in Item 23. The assistant surgeon and anesthesiologist's claims may be submitted without a prior authorization number. These claim forms will pend to the Medical Review Unit for review and will be paid only if the surgeon's request for implantation has been approved.

AUDIOLOGIST BILLING PROCEDURES

The audiologist shall bill CPT procedure code 92506 (Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status) on a HCFA 1500 claim form to receive reimbursement for the pre-operative speech and language evaluation.

This service will be reimbursed for prospective cochlear implant candidates even if the candidate does not subsequently receive an implant.

Procedure code 92506 is reimbursed at a fee of \$300. It is limited to only once per candidate per



lifetime and is restricted to the specialty of Audiology. The PA number must be printed on the claim form in Item 23 in order for payment to be obtained.

Post-Operative Rehabilitative Services

Only the audiologist will be reimbursed for the aural rehabilitation of the cochlear implant recipient after implantation of the device. Procedure code 92510, payable at \$94.90, shall be billed on the HCFA 1500 for this service. This code does not require prior authorization.

Post-Operative Speech, Language and Hearing Therapy Services

Subsequent speech, language and hearing therapy services for cochlear implant recipients must be prior authorized like all other rehabilitation services. The request for prior authorization should be submitted to the Prior Authorization Unit on Forms PA-01 and PA-02 at the address previously given.

Billing for Speech Processor Repairs, Batteries, Headset Cords, etc.

The locally-assigned codes to use to request approval and reimbursement for these items and their fees are as follows:

- L8700 Speech Processor Repair - \$255
- L8701 Headset Replacement - \$360
- L8702 Microphone Repair - \$240
- L8703 Speech Processor Battery - \$6
- L8704 Headset Cord - \$12

Statistics show that, on the average, processors need repairing every 2.5 years and that headset cords need to be replaced from 2-4 times per year. Batteries require replacement every 10-12 months.

Requests for reimbursement for the items above should be made conservatively. The Prior Authorization Unit reserves the right to refuse reimbursement for these maintenance costs when/if it feels requests are being made too frequently due to patient negligence.

The procedure for obtaining reimbursement for the items above is the same as that for obtaining reimbursement for the device, i.e., the provider shall submit the applicable HCPCS code on a HCFA 1500 claim form with the letters DME written in red on the top of the form. The PA number must be written in Item 23.

REPLACEMENT OF THE EXTERNAL SPEECH PROCESSOR

The Louisiana Medicaid Program will consider replacing the external speech processor only if one of the following occurs:



1. The recipient loses his processor
2. The processor is stolen OR
3. The processor is irreparably damaged

An upgrade to the speech processor because of cosmetic or technological advances in the hardware shall not qualify as a reason for replacement.

Prior authorization for replacement of the external speech processor (HCPCS code L8619) must be obtained when/if replacement becomes necessary.

The multidisciplinary team shall initiate a new request for approval and shall submit the following information with its request for replacement:

1. A copy of Prior Authorization's initial approval letter for the implant
2. Documentation explaining the reason a new processor is needed

Billing for Replacement of the External Speech Processor

Hospitals or professional services billers shall bill for this component by submitting HCPCS code L8619 on a HCFA 1500 claim form with the letters DME written in red on the top. The PA number must be written in Item 23.

Replacement of the external speech processor shall be reimbursed at a fee of \$4,936.

BILLING FOR RE-PERFORMANCE OF THE IMPLANTATION SURGERY

Re-performance of the implantation surgery (CPT code 69930) because of infection, extrusion or other reasons must be prior authorized.

Documentation explaining the reason the initial implant surgery has to be repeated and the request for re-performance should be submitted simultaneously to the Prior Authorization Unit for review.

The PA number approving the re-performance must be on the claim form for reimbursement to be received.

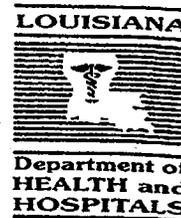
If you have any questions, please contact Kandis McDaniel at (504) 342-9490. Your cooperation is greatly appreciated.





M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



David W. Hood
SECRETARY

August 18, 1998

MEMORANDUM

TO: All Enrolled Medicaid Providers

FROM: Thomas D. Collins, Director of Bureau of Health Services Financing 

RE: Office for Civil Rights Policy Memorandum

The Department of Health and Human Services, Office for Civil Rights, recently issued a policy memorandum regarding nondiscrimination based on national origin as it relates to individuals who are limited-English proficient. Enclosed is the Health Care Financing Administration (HCFA) Civil Rights Compliance Statement which expresses our Agency's commitment to ensuring that there is no discrimination in the delivery of health care services through HCFA programs.

We have committed ourselves to full compliance with the requirements contained in this policy statement. As our partner with the administration of the Medicaid program you likewise are obligated to comply with those statutory civil rights laws. As stipulated in the policy statement, these laws include: Act of 1990 as amended and Title IX of the Education Amendments of 1972. The Office of Civil Rights of the Department of Health and Human Services has previously advised HCFA that detailed implementation regulations for the Rehabilitation Act of 1973, as amended, are located at 45 Code of Federal Regulations, Part 85.

It has been asked that we share this policy statement with you and that you do likewise with health care providers and all others involved in the administration of HCFA programs.

Questions regarding this memorandum should be directed to Don Fontenot at 342-1316.

HEALTH CARE FINANCING ADMINISTRATION (HCFA) CIVIL RIGHTS COMPLIANCE POLICY STATEMENT

The Health Care Financing Administration's vision in the current Strategic Plan guarantees that all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all HCFA program operations and activities. I want to emphasize my personal commitment to and responsibility for ensuring compliance with civil rights laws by recipients of HCFA funds. These laws include: Title VI of the Civil Rights Act, as amended; Section 504 of the Rehabilitation Act, as amended; the Age Discrimination Act of 1975, as amended; the Americans with Disabilities Act of 1990, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all HCFA operating components. Promoting attention to and ensuring HCFA program compliance with civil rights laws are among my highest priorities for HCFA, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of HCFA programs.

HCFA, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability. HCFA will, with your help continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

To achieve its civil rights goals, HCFA will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities including: collecting data on access to, and the participation of, minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing HCFA publications, program regulations, and instructions to assure support for civil rights; and working closely with the Department of Health and Human Services (DHHS), Office of Civil Rights, to initiate orientation and training programs on civil rights. HCFA will also allocate financial resources to the extent feasible to: ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

DHHS will seek voluntary compliance to resolve issues of discrimination whenever possible. If necessary, HCFA will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

HCFA's mission is to assure health care security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries; i.e., our customers. We will enhance our communication with constituents, partners, and stakeholders. We will seek input from health care providers, states, contractors, and DHHS Office for Civil Rights, professional organizations, community advocates, and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability.

Nancy-Ann Min DeParle





M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Department of
HEALTH and
HOSPITALS

David W. Hood
SECRETARY

MEMORANDUM

TO: EPSDT PERSONAL CARE SERVICES PROVIDERS

FROM: Thomas D. Collins
Director

DATE: September 30, 1998

RE: NEW PRIOR AUTHORIZATION AND BILLING PROCEDURES FOR EPSDT
PERSONAL CARE SERVICES (PCS)

Effective for dates of service November 1, 1998 and thereafter, The Medicaid Program will implement new procedures for prior authorization of billing for EPSDT Personal Care Services provided to recipients under the age of twenty-one. These procedures will replace the existing procedures used by EPSDT PCS Providers.

Prior authorization requests should be submitted on the newly created PA-14 Form. A copy of the PA-14 Form and instructions are attached. For your convenience, a blank PA-14 is also attached so that you may make copies of this form for use when requesting authorization for PCS services.

PRIOR AUTHORIZATION

To obtain prior authorization for a procedure, providers must complete a PA14-FORM and attach the following information:

- Form 90-L
- Prescription, Physician's Orders or Physician's Referral
- Plan of Care
- Social Assessment
- Any supporting documentation to warrant medical necessity.
- Daily Time Schedule Form

NOTE: IF THE RECIPIENT IS RECEIVING HOME HEALTH, RESPITE AND/OR ANY OTHER RELATED SERVICES, THE PCS PROVIDER CANNOT BE IN THE HOME AT THE SAME TIME.

The completed PA-14 Form, along with all necessary documentation to substantiate the medical necessity of the requested services, must be submitted to the Unisys Prior Authorization Unit (PAU), the following address:



UNISYS
P.O. Box 14919
Baton Rouge, La, 70898-4919
Attention: Prior Authorization (PCS Services)

Once the PA-14 form is received at Unisys, it will be screened for pertinent information prior to entry into the PA system. If the PA-14 form is incomplete or the required documentation is missing / incomplete, the form will be returned to the provider with a cover letter indicating what is needed.

After the PA-14 form is screened, a unique nine-digit prior authorization is assigned and the information is entered into the prior authorization system. Upon entry, the system will perform a series of front-end edits. It will check for a valid seven-digit Medicaid provider identification number, a valid thirteen-digit recipient identification number, recipient eligibility, a valid ICD-9 diagnosis code, age restrictions, etc. If any of the above do not clear the editing process, the system will deny the request automatically and generate a letter of denial to be sent to the provider and the recipient.

If the PA-14 form clears the above editing process, it will be reviewed by the Unisys review nurse and/or physician consultant(s) to determine medical necessity. Once the decision is made, the status of the review is entered into the prior authorization system and an approval or denial letter is generated that night to be sent to the provider and the recipient within the next two days. Once the notification of approval is received the provider may begin to render the services. **Approvals may be authorized for a period not to exceed six-months.**

If you are providing services previously approved under the old process for which you received an approval notification letter that include dates of service November 1, 1998 and thereafter, you must submit a completed PA-14 form with the original approval letter attached in order to receive a PA number. Please send these requests to the Prior Authorization Unit at the above address. The PA Unit will issue a prior authorization approval letter with a nine-digit PA number to the provider of services and the recipient. **All new requests must be processed in accordance with the new procedures.**

RECONSIDERATION REQUEST

If the request is denied, a notification letter with the PA number is generated giving the reason(s) for denial and is sent to the provider and the recipient. The recipient's letter will have a notice regarding their rights to appeal. A provider may then submit a reconsideration request to the Unisys prior authorization unit and the physician consultant(s) will re-review the request. To request a reconsideration (RECON), providers should follow the instructions outlined below:

- Make a copy of the denial letter, and write the word RECON across the top of the denial letter, and write the reason for the request for reconsideration at the bottom of the letter.
- Attach all of the original documentation, as well as any additional information /documentation which supports medical necessity, to the letter.

Mail the letter and all documentation to the Prior Authorization Unit at Unisys.



Unisys Physician Consultant(s) will re-review the request for medical necessity. If the request is approved or denied, another notification letter (with the same prior authorization number) will be generated and mailed to the provider and the recipient.

NEW BILLING INSTRUCTIONS

Hardcopy claims should be submitted on the HCFA 1500 claim form, as always. It will no longer be necessary to attach the approval letter to any claims prior authorized under the new process. This change will allow claims to be billed electronically. If you are billing via EMC, please remember to contact your software vendor to make the necessary updates for electronic billing.

The nine digit prior authorization (PA) number must be entered on the HCFA 1500 Claim Form in Block Number 23 (prior authorization number).

NOTE: ON THE HCFA 1500 CLAIM FORM IN BLOCK 24 -G (DAYS OR UNITS) ENTER THE NUMBER OF UNITS (NOT HOURS) BILLED.

Please keep this information for future reference. Providers may request PA-14 Forms from the Prior Authorization Unit at Unisys or you may make copies of the attached PA-14 Form.

Questions concerning prior authorization of services should be directed to the Unisys Prior Authorization Unit at (800) 807-1320.

Questions concerning claims/billing issues or policy should be directed to Unisys Provider Relations at (800) 473-5040.



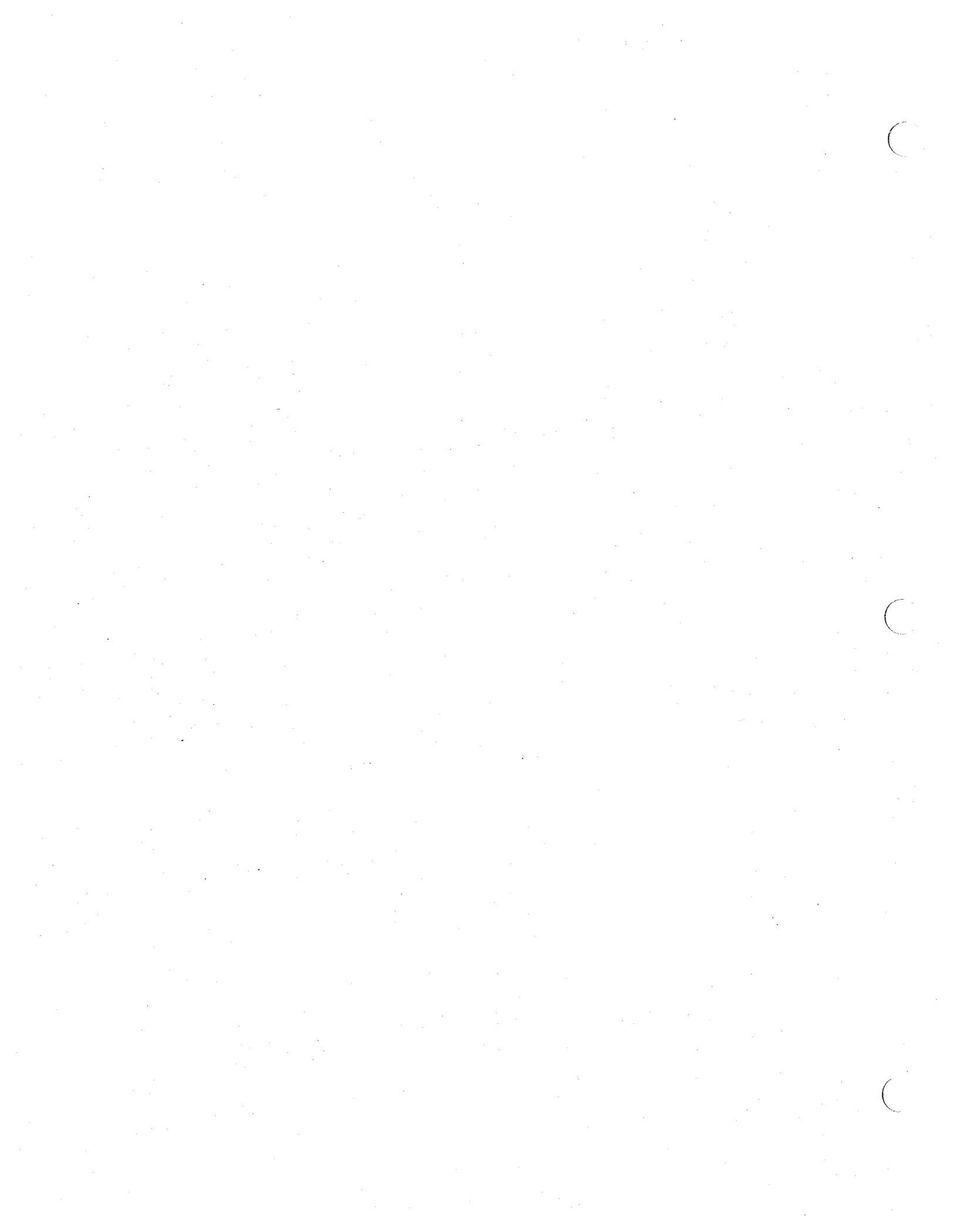
MAIL TO:
 UNISYS/LA. MEDICAID
 P.O. BOX 14919
 MONTE ROUGE, LA 70890-4919

DEPARTMENT OF HEALTH AND HOSPITALS
 Bureau of Health Services Financing
 Medical Assistance Program
 REQUEST FOR PRIOR AUTHORIZATION



NOTE: SHADED AREA IS FOR INTERNAL USE ONLY

PRIOR AUTHORIZATION TYPE <input type="checkbox"/> 14 - EPSDT PERSONAL CARE SERVICES		RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER					
RECIPIENT LAST NAME		FIRST	MI	DATE OF BIRTH			
MEDICAID PROVIDER NUMBER (SEVEN-DIGITS)		DATES OF SERVICE FROM THRU		STATUS CODES: 2 = APPROVED 3 = DENIED			
DIAGNOSIS INFORMATION: PRIMARY CODE AND DESCRIPTION <input type="text"/>		PHYSICIAN/NURSE REVIEWER'S COMMENT SECTION		PHYSICIAN/NURSE SIGNATURE:			
SECONDARY CODE AND DESCRIPTION <input type="text"/>							
Prescribing Physician's Name		Prescription Date					
DESCRIPTION OF SERVICES							
Procedure Code	Description	Requested Units	Authorized Units	Review Date	Status	P-A Message/Denial Codes	
Z0200	EPSDT Personal Care Services, 30 min.						
Provider Name: _____			Provider/Authorized Signature: _____				
Address: _____							
City: _____ State: _____ Zip Code: _____			Date of Request: _____				
Telephone Number: (____) _____							



INSTRUCTIONS FOR COMPLETING PRIOR AUTHORIZATION FORM (PA-14)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS.

FIELD NO. 1 - Enter recipient's 13-digit Medicaid ID number or the 16-digit CCN number.

FIELD NO. 2 - Enter the recipient's last name and first name as it appears on their Medicaid identification card.

FIELD NO. 3 - Enter the recipient's date of birth in month, day, year format (MMDDYY).

FIELD NO. 4 - Enter the provider's 7-digit Medicaid number, if associated with a group, enter the Attending provider number only.

FIELD NO. 5 - Enter in the From date of service block, the first day the service is requested to start. Enter in the Thru date of service block, the last day of service for that individual Treatment plan.

FIELD NO. 6 - Enter the numeric ICD9-Diagnosis code (Primary & Secondary) and a narrative description of each.

FIELD NO. 7 - Enter the name of the recipient's attending physician prescribing the services.

ELD NO. 8 - Enter the day the prescription, doctor's orders was written.

FIELD NO. 9 - Enter the number of times the requested services will be performed during the Treatment plan. Calculate the total units requested (1 unit = ½ hour) by multiplying the Number of units per day times the number of days per week times the number of weeks Covered in the treatment plan. This will give the total units requested. Below are two examples on the proper way to calculate the total units requested:

Example 1) Requesting four-hours per day for a six month period:

**4 hrs. Per day = 8 units per day, 7 days a week, 26 weeks =
8 x 7 x 26 = 1456 total units requested**

Example 2) Requesting two-hours per day on weekends and four-hours per day on Week days:

**2 hrs. Per day (weekends)= 4 units per day, 2days a week, 26 weeks =
4 x 2 x 26 = 208 total units requested for weekends**

**4 hrs. Per day (weekdays) = 8 units per day, 5 days a week, 26 weeks =
8 x 5 x 26 = 1040 total units requested for weekdays**

The total units requested would be the combination of the total weekend Units (208) and weekday units (1040), which would equal to 1248 total Units requested. This is the number (1248) to enter in Field Number 9.

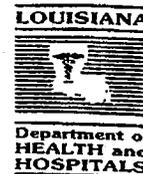
LD NO. 10 - Enter the name, mailing address and telephone number of the provider of service.

FIELD NO. 11 & 12 - Provider/ Authorized Signature are required. Your request will not be accepted if Not signed and dated. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.





STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



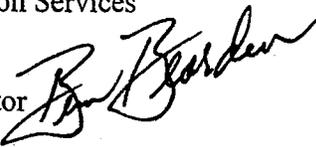
M. J. "Mike" Foster, Jr.
GOVERNOR

May 18, 2001

David W. Hood
SECRETARY

MEMORANDUM

TO: EPSDT Health Services Enrolled School Boards and
Early Intervention Services

FROM: Ben Bearden 
Medicaid Director

RE: Medicaid Recipients and IEP/IFSP Development

The Department of Health and Hospitals has been in negotiations for some time to settle a lawsuit filed against us. Many of the issues being addressed involve informing Medicaid recipients on all options available to them through our program. We have complied with this stipulation by conducting trainings statewide covering both eligibility and covered services. However, to remain compliant with the settlement, the Department of Health and Hospitals is now requiring that all EPSDT Health Services Providers enrolled in Medicaid give the following statement in writing to Medicaid-eligible recipients at the time their IEP or IFSP is developed.

If your child is Medicaid eligible, and is eligible to receive audiologic services, occupational therapy evaluations and treatment services, physical therapy evaluations and therapy (individual and group), psychological evaluations and therapy (individual and group), and speech and language evaluations and therapy (individual and group), you may choose to obtain them either through your school, an early intervention center, or other Medicaid enrolled provider of those services.

Children who do not qualify for these services for educational purposes may still be eligible for them through Medicaid. Services outside of or in addition to those provided at school or in an early intervention center must be ordered by a physician. Once the services are ordered by a physician, the service provider must request approval from Medicaid. To locate a provider other than the school or early intervention center, please contact your case manager, physician, or call the KIDMED Referral Assistance Hotline toll free at 1-877-455-9955.

Again, this information must be supplied to the recipient and/or caregiver at the time the IEP or IFSP is developed. This same information should be supplied to all students and their families that have received an IEP or IFSP anytime during the current school year prior to this memo. If you have any questions about this requirement, please call Randy Davidson EPSDT Program Coordinator, at 225 342-3935.

BB/RD





STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



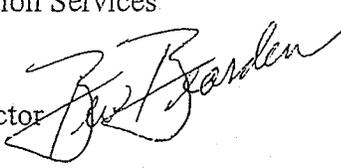
M. J. "Mike" Foster, Jr.
GOVERNOR

February 27, 2003

David W. Hood
SECRETARY

MEMORANDUM

TO: EPSDT Health Services Enrolled School Boards and
Early Intervention Services

FROM: Ben Bearden 
Medicaid Director

RE: Medicaid Recipients and IEP/IFSP Development

In a memo dated May 16, 2001, the Department of Health and Hospitals notified you of a new requirement that involves informing Medicaid recipients of all options available to them through our program. Attached is a copy of the aforementioned memo and we would like to take this opportunity to restate this policy. As you know, Medicaid frequently audits providers for compliance with established policy. Future audits of enrolled School Boards and Early Intervention Center providers will include review for compliance with this policy.

If you have any questions regarding this matter, please call Randy Davidson at 225 342-4818. We appreciate your enrollment in the Medicaid program and look forward to your continued provision of services to our recipients.

BB/RD

attachment

cc: Don Gregory
Program Integrity





**STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS**



M. J. "Mike" Foster, Jr.
GOVERNOR

David W. Hood
SECRETARY

September 22, 2003

MEMORANDUM

TO: EPSDT/PCS Providers

From: Ben A. Bearden
Director

RE: New Billing Code

The Department of Health and Hospitals, Bureau of Health Services Financing will be implementing a new procedure code to be used in billing Early and Periodic, Diagnosis, Screening and Treatment (EPSDT) Personal Care Services (PCS). This change is required as part of the Health Insurance Portability Accountability Act (HIPAA) that calls for the development and use of standardized transactions to be used in the electronic exchange of data. In addition, the rule requires the use of standardized national code sets to identify medical conditions, treatments and procedures.

Effective October 1, 2003, all services authorized under procedure code Z0200 should be billed using the following criteria:

Procedure Code	Modifier	Unit of Service	Cost per Unit
T1019	EP	15 minutes	\$2.03

For all current authorizations that span periods before and after the 10/1/03 effective date, the services that are rendered on or before 9/30/03 should be billed under procedure code Z0200 with 30-minute service unit increments. The Prior Authorization Unit will convert all unused units of services in the authorization period to the new 15-minute service unit increments beginning with services rendered on 10/1/03.

All requests for prior authorization with an authorization period beginning on 10/1/03 or after should be requested with the new procedure code and the new 15-minute service unit increments.

Should you have any questions regarding this change, please contact Provider Relations at 1-800-473-2783.

BAB/KG/lw





October 13, 2008

MEMORANDUM

To: All EPSDT-Personal Care Services Providers
From: Unisys Provider Relations
Subject: Revised EPSDT-Personal Care Services (EPSDT-PCS) Forms

Enclosed please find the Louisiana Medicaid recently issued:

- Request for Medicaid EPSDT – Personal Care Services (EPSDT-PCS Form 90; Revised 10/01/08);
- EPSDT Personal Care Services – Plan of Care (EPSDT PCS POC; Revised 06/20/08); and
- EPSDT-PCS Plan of Care Instructions (Revised 06/20/08).

Begin using these new forms effective **November 1, 2008**.

The EPSDT-PCS Form 90 replaces the Form 90-L for EPSDT-PCS requests. Thus, **any request submitted with a physician's signature date of November 1, 2008 forward MUST be submitted on the EPSDT-PCS Form 90.**

In the future, the only time a Form 90-L will be accepted for EPSDT-PCS is in circumstances where the recipient is a Children's Choice waiver recipient, and the Form 90-L was completed by the recipient's doctor within 90 days of the current EPSDT-PCS request.

When requesting authorization for services, providers should only use the EPSDT-PCS POC with a re-issue date of June 20, 2008. This form can be completed as an on-line form or downloaded for manual completion from the Louisiana Medicaid web site.

These new forms are located on the web site, www.lamedicaid.com, link [Forms/Files/User Guides](#), link [Web Forms](#), link [EPSDT-PCS Plan of Care](#) and [EPSDT PCS Form 90](#).

This transmittal reflects the most current program policy and supersedes any versions of these forms previously distributed.



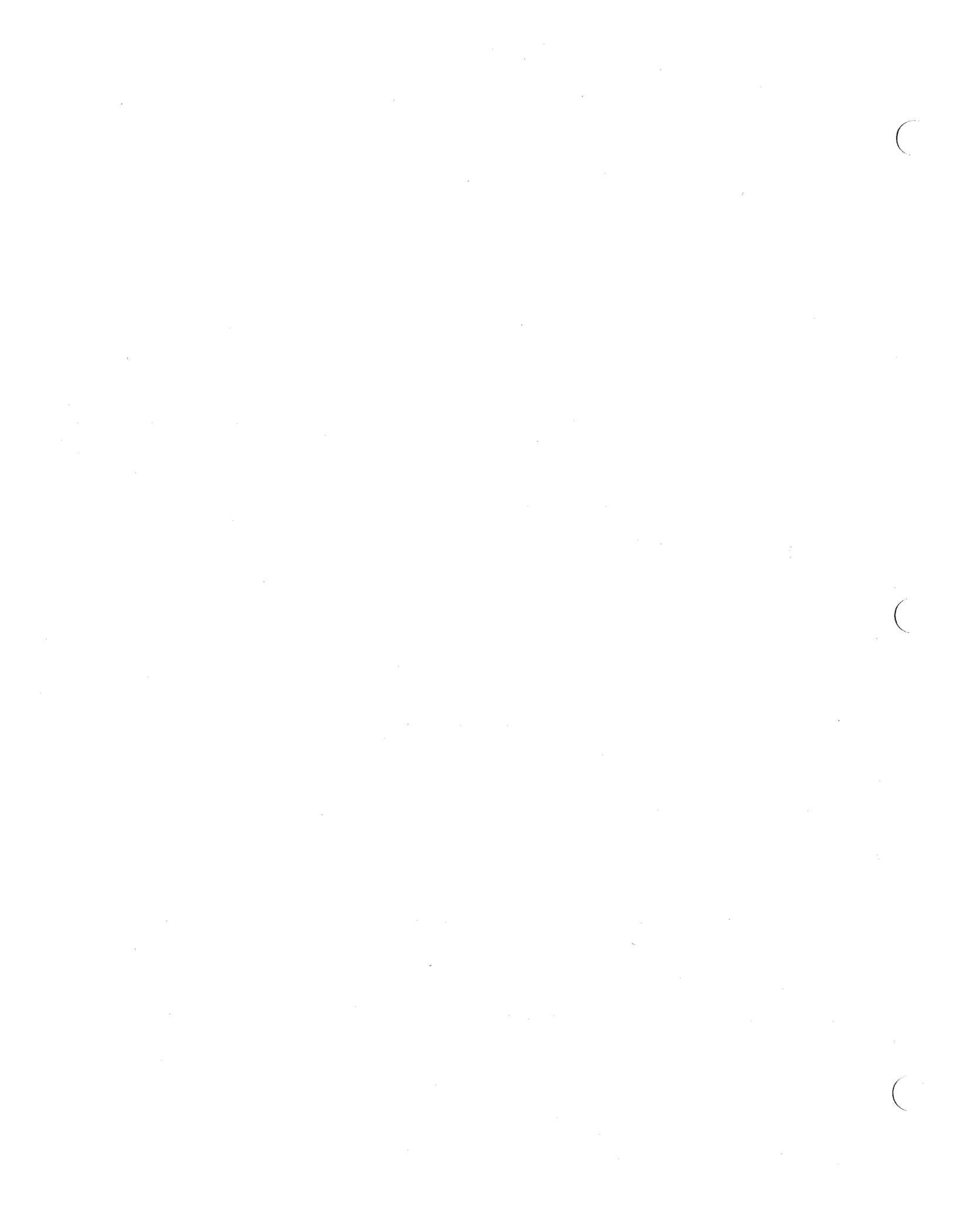
REQUEST FOR MEDICAID EPSDT - PERSONAL CARE SERVICES
(Personal Care Services are to be provided in the home and not in an institution)

I. IDENTIFYING INFORMATION

1. Applicant Name:	MID#
Address:	Ph # ()
	<input type="checkbox"/> Male <input type="checkbox"/> Female DOB:
2. Responsible Party/Curator:	Relationship:
Address:	Home Phone # ()
	Work or Cell Phone # ()
By signing this form I give my consent for my medical information to be released to the Department of Health and Hospitals to be used in determining eligibility for Personal Care Services.	
Signature: _____	Date: _____

II. MEDICAL INFORMATION

NOTE: The following information is to be completed by the applicant's attending physician.			
1. Patient Name:			
2. Primary Diagnosis:			Diagnosis Code:
Secondary Diagnosis:			Diagnosis Code:
3. Physical Examination:		4. Special Care/Procedures: check appropriate box and give type, frequency, size, stage and site when appropriate	
General _____	Head and CNS _____	<input type="checkbox"/> Trach Care: <input type="checkbox"/> Daily <input type="checkbox"/> PRN	
Mouth and EENT _____	Chest _____	<input type="checkbox"/> Respiratory: <input type="checkbox"/> Ventilator <input type="checkbox"/> Daily <input type="checkbox"/> Other _____	
Heart and Circulation _____	Abdomen _____	<input type="checkbox"/> Suctioning/Oral Care: <input type="checkbox"/> Daily <input type="checkbox"/> PRN	
Genitalia _____	Extremities _____	<input type="checkbox"/> Glucose Monitoring: <input type="checkbox"/> Insulin Injections <input type="checkbox"/> Daily <input type="checkbox"/> Other	
Skin _____	Height _____	<input type="checkbox"/> Restraints (positioning)	
Wt. _____	Pulse _____	<input type="checkbox"/> Dialysis	
Resp _____	Temp _____	<input type="checkbox"/> Urinary Catheter	
B/P _____	Bowel/Bladder Control _____	<input type="checkbox"/> Seizure Precautions	
Impaired Vision _____	Impaired Hearing _____	<input type="checkbox"/> Ostomy	
<input type="checkbox"/> Glasses	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> IV	
Lab Results:		<input type="checkbox"/> Decubitus/Stage _____	
HCT _____	HCB _____	<input type="checkbox"/> Diet/Tube Feeding	
U/A _____	Radiology _____	<input type="checkbox"/> Rehab (OT,PT,ST)	
		<input type="checkbox"/> Other _____	
5.			
Medications	Dosage	Frequency	Route



II. MEDICAL INFORMATION (Continued)

6. Recent Hospitalizations: (include psychiatric):					
7. Mental Status/Behavior: Check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always					
Oriented	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Depressed	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Wanders	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Comatose	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Verbal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Confused	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Forgetful	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Combative	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No

III. LEVEL OF CARE DETERMINATION

NOTE: The following information is to be completed by the applicant's attending physician.

Activities of Daily Living:

Based on the recipient's impairment, check the appropriate box as it applies to the recipient's ability to perform these age appropriate tasks using the following definitions:

Not Independent at this Age – not age appropriate to perform this task independently

Independent – recipient able to perform task **without assistance**

Limited Assistance – recipient aids in task, but receives help from other persons **some of the time**

Extensive Assistance – recipient aids in task, but receives help from other persons **all of the time**

Maximal Assistance – recipient is **totally dependent** on other persons

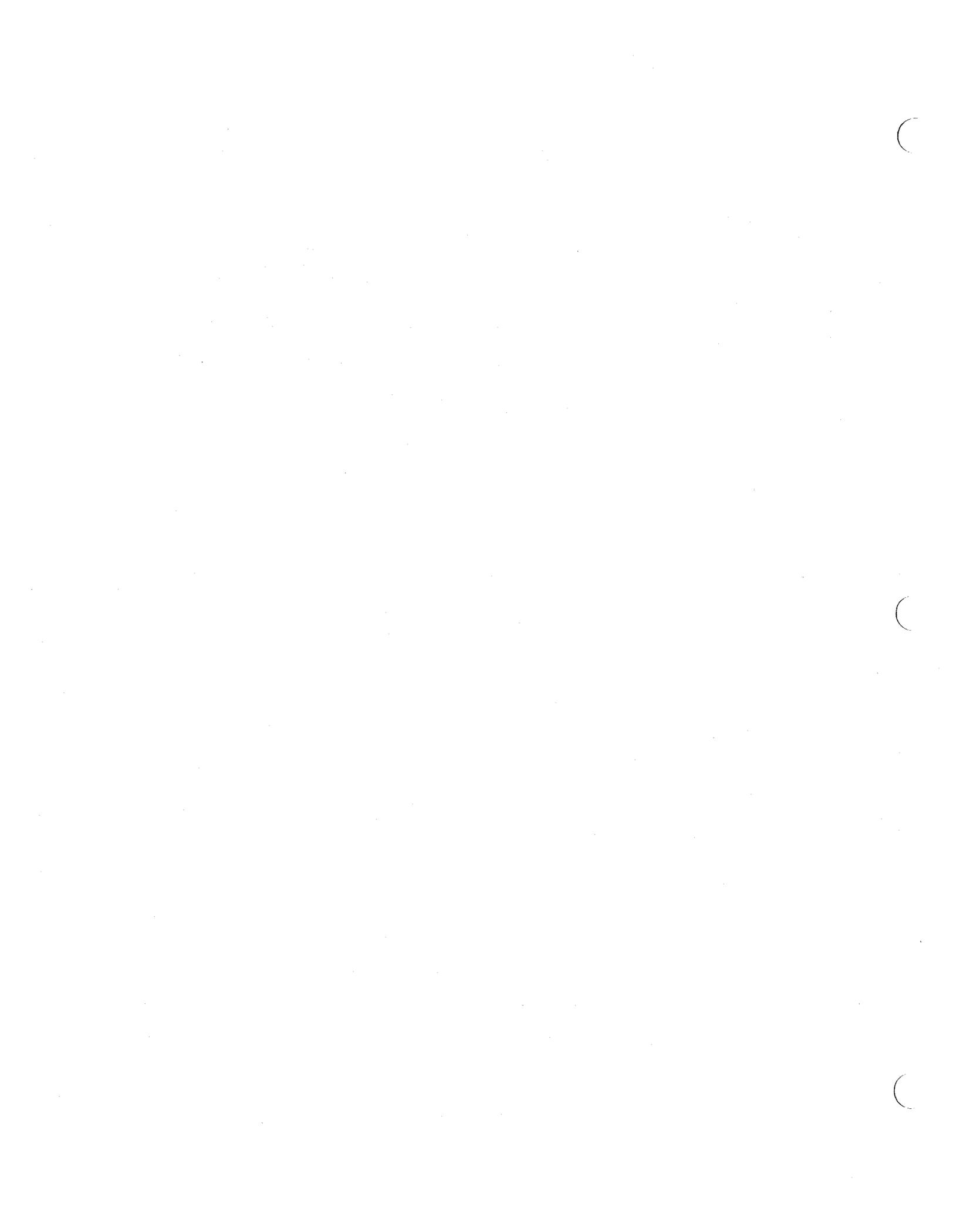
Activity	Not Independent at this Age	Independent	Limited Assistance	Extensive Assistance	Maximal Assistance	Comments
Bathing						
Dressing						
Grooming						
Toileting						
Eating						

Level of care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. **Please select one of the following:**

This individual's condition includes a need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization. May include professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

- Yes, this individual requires this level of care.
 No, this individual does not require this level of care.

Physician's Name (type or print)	Phone ()
Address:	
By signing this form I attest that I am this person's primary physician, and the information provided is accurate and correct to the best of my knowledge.	
Physician's Signature _____	Date _____



**Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
EPSDT Personal Care Services – Plan of Care**

New Renewal Reconsideration

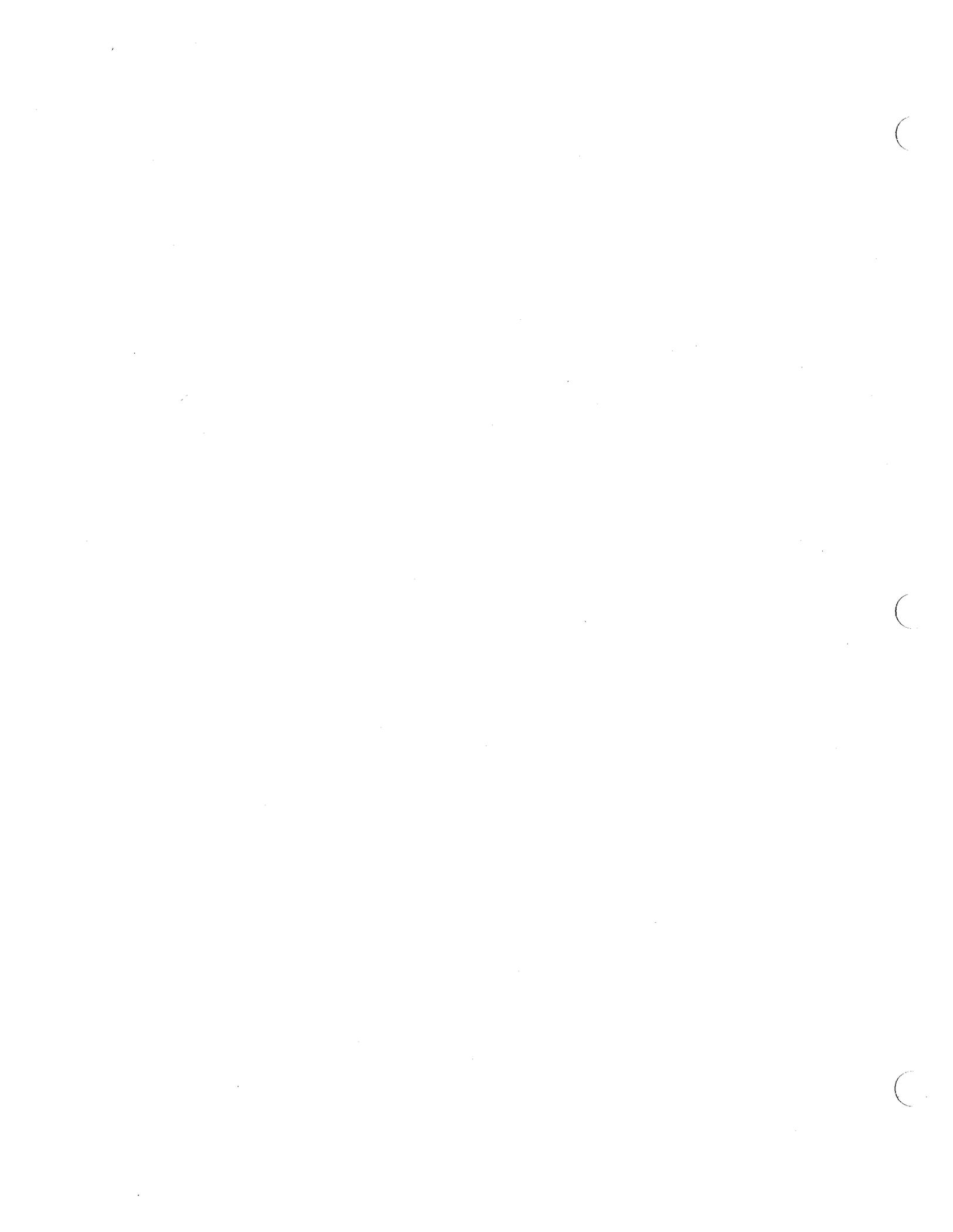
Date Services Requested to Start: _____

Identifying Information		Provider Information	
Name	Provider Agency Name		
ID#	DOB	Provider Number	Phone #
Address	Address		
Home Phone #	Cell Phone #	Contact Person e-mail	

Medical Reasons Supporting the Need for PCS
(Must be accompanied by appropriate medical documentation for recipient and parent/caregiver, if the parent/caregiver is disabled)

Other In-Home Services Requested or Currently Receiving

<input type="checkbox"/> New Opportunities Waiver	<input type="checkbox"/> Home Health Nursing Services	<input type="checkbox"/> Home Bound Teacher
<input type="checkbox"/> Children's Choice Waiver	<input type="checkbox"/> Home Health Aide Services	<input type="checkbox"/> Mental Health Rehab
<input type="checkbox"/> OCDD Family Support/Respite	<input type="checkbox"/> Home Health Therapy	<input type="checkbox"/> Other:



Recipient Name:

Recipient ID #:

Personal Care Tasks

Specify the personal care activities the parent/caregiver requires the assistance of the PCS provider due to an inability to perform these services alone.

PCS Activity	Goal	# of Days Requested per Week	Time Requested to Complete Activity	Total Time Requested for Week (# days x minutes)
Bathing			minutes	____ Hours ____ Minutes
Dressing			minutes	____ Hours ____ Minutes
Grooming			minutes	____ Hours ____ Minutes
Toileting			minutes	____ Hours ____ Minutes
Eating			minutes	____ Hours ____ Minutes
Meal Prep			minutes	____ Hours ____ Minutes
Incidental Household Services			minutes	____ Hours ____ Minutes

Total Weekly Hours Requested for Activities of Daily Living: _____

Accompanying to Medical Appointments	Frequency of Medical Appointments:			Time per trip
	Weekly	Monthly	Quarterly	
	Other: _____			



Recipient Name:

Recipient ID #:

Child Care Arrangements

For children 14 years of age or younger, or for those 15 years of age or older and unable to self direct their own care, specify child care arrangements. **Note: For the children who meet this criteria, when the PCS worker is in the home, another adult must be present.**

Signatures

Parent/guardian

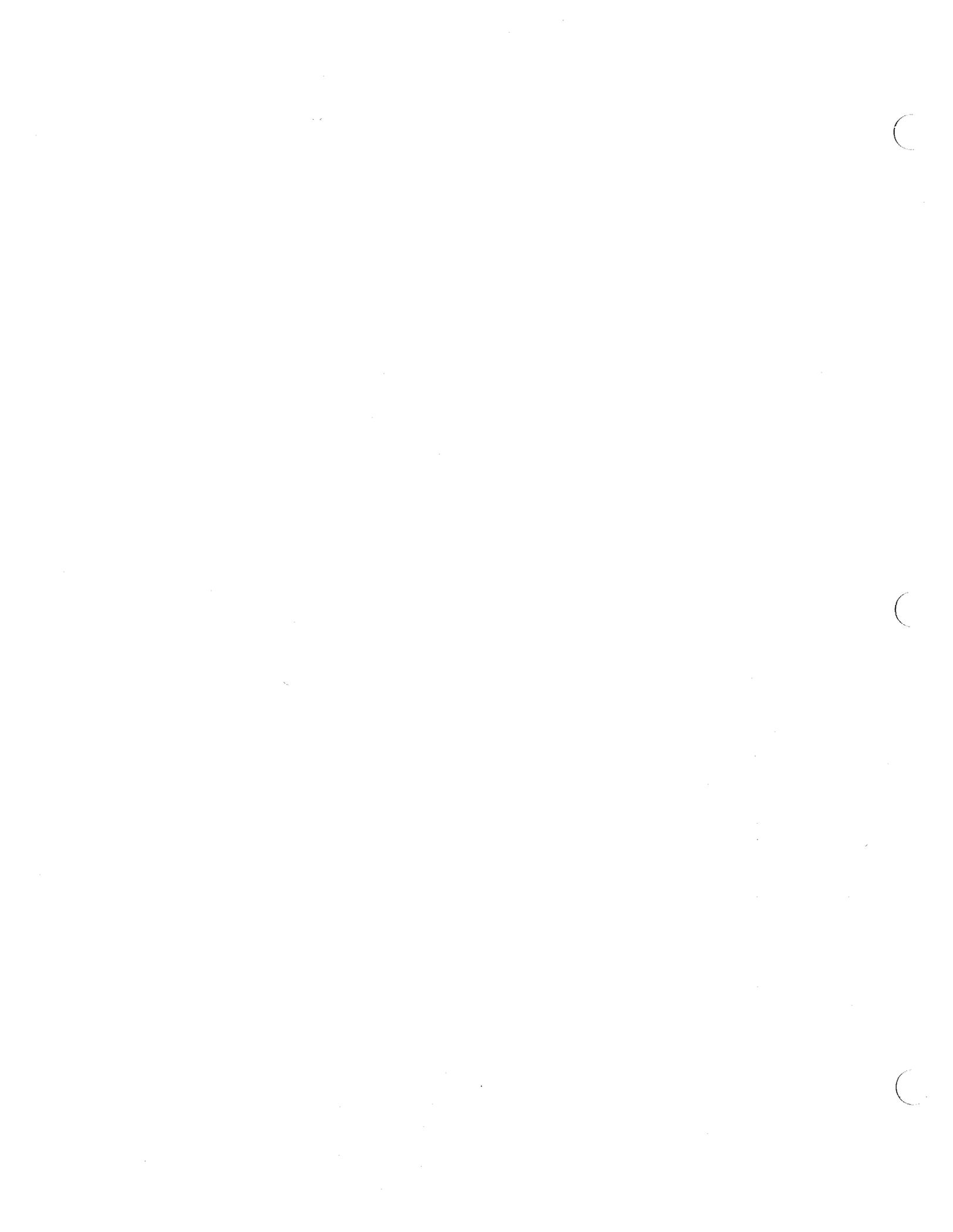
Provider Representative

Physician

Date

Date

Date



Instructions for Completing EPSDT PCS Plan of Care

Type of Plan of Care

Check the appropriate box to identify the Plan of Care:

- *New* – Used for agency’s initial Plan of Care for recipient
- *Renewal* – Used for Plan of Care completed for each new authorization period
- *Reconsideration* – Used when the Plan of Care changes during the authorization period

Date Services Requested to Start

Complete with the date the provider agency is requesting to start providing services.

Identifying Information

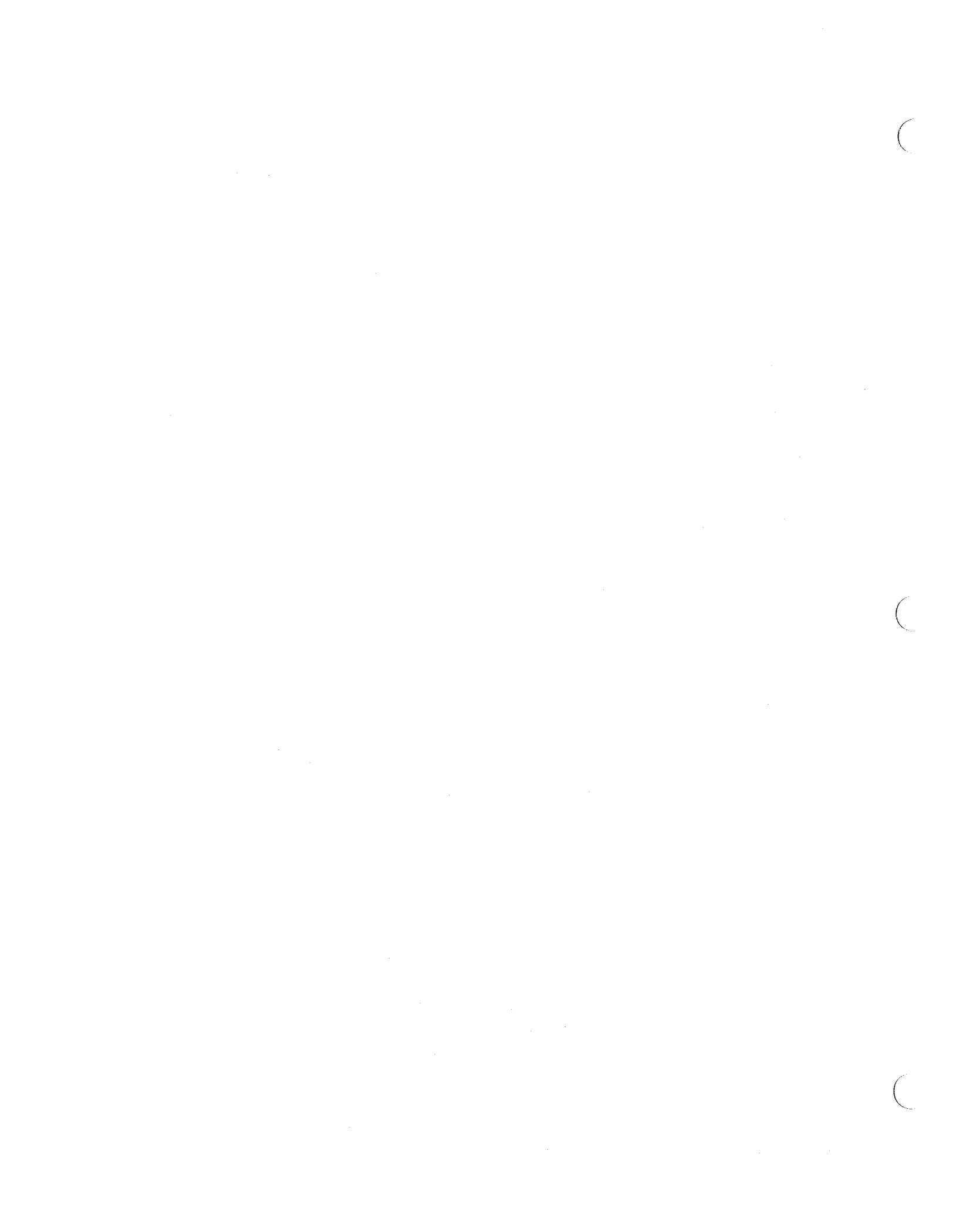
- *Name* – Recipient’s name
- *ID#* - Medicaid recipient number
- *DOB* – Recipient’s date of birth
- *Address* – Recipient’s address (street and city)
- *Home Phone#* - Recipient’s home phone number
- *Cell Phone #* - Recipient’s cell phone number

Provider Information

- *Provider Agency Name* – Name of the provider agency requesting authorization
- *Provider Number* – Provider agency’s assigned Medicaid provider number
- *Provider Phone Number* – Phone number of provider agency
- *Address* – Provider agency’s mailing address (street, city and ZIP Code)
- *Contact person, e-mail and Phone #* - Name of provider agency’s representative and e-mail address

Medical Reasons Supporting the Need for PCS

Summarize the recipient’s medical condition. If the recipient’s parent(s) or primary care giver(s) are disabled, summarize the parent(s) or primary care giver(s) medical condition **and provide medical documentation from his/her physician that includes this individual’s functional limitations and how it affects the care of the recipient.**



Other In-Home Services Requested or Currently Receiving

Identify all in-home services the recipient is currently receiving or has requested.

Personal Care Tasks

For the personal care tasks of “Bathing”, “Dressing”, “Grooming”, “Toileting”, “Eating”, “Meal Prep” and “Incidental Household Services” that the recipient requires assistance with because of his/her disability, complete the following:

- **Goal** – include the goal for the personal care task
- **# of Days Requested per Week** - indicate the number of days during the week assistance is being requested with the personal care task
- **Time Requested to Complete Activity** – indicate the time required in minutes to complete the activity, (i.e., 15 minutes, 30 minutes, etc.)
- **Total Time Requested for Week** – indicate the total time requested for the week by multiplying the number of days the service is requested by the time requested to complete the activity to obtain the total time needed each week to complete the task, (i.e., 1 hour 15 minutes, 3 hours 30 minutes, etc.)
- **Total Weekly Hours Requested for Activities of Daily Living** – add the **Total Time Requested for Week** for each PCS Activity to obtain the total time requested for the week to complete the covered personal care tasks

For the personal care task of “Accompanying to Medical Appointments”, complete the following when it is medically necessary that someone accompany the recipient and his/her caregiver to medical appointments:

- **Goal** – include the goal for the personal care task
- **Frequency of Medical Appointments** – indicate the frequency the recipient typically has medical appointments within the prior authorization period, (i.e., weekly appointment, monthly appointment, etc.)
- **Time per Trip** – indicate the time it typically takes the recipient to complete the medical appointment, (i.e., 1 hour, 2 hours, etc.)

Child Care Arrangements

Child care arrangements must be indicated for children 14 years of age or younger, or 15 years of age or older if they are unable to self direct their own care. If service is requested for a recipient meeting this criteria, and the parent(s) or primary care giver(s) are working or not in the home, indicate child care arrangements. *Note: child care provider must be 18 years of age or older.*

Signatures

A signature and date from the parent/guardian, the provider and the physician are required.

