



PERSONAL CARE SERVICES PROVIDER MANUAL

Chapter Thirty of the Medicaid Services Manual

Issued November 1, 2009

**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

The Department of Health and Hospitals (DHH) established Long Term-Personal Care Services (LT-PCS) as an optional service under the Medicaid State Plan. This program is designed for Medicaid recipients who require assistance with the activities of daily living and are either in a nursing home or at imminent risk of nursing facility placement.

The purpose of LT-PCS is to provide limited assistance to a recipient, whose needs would otherwise require placement in a nursing facility, so that he/she may remain safely in his/her home. The mission of Medicaid funded LT-PCS is to supplement the family and/or community supports that are available to maintain the recipient in the community. This service program is not intended to be a substitute for available family and/or community supports nor is it an employment program for family caregivers. LT-PCS must be prior authorized and provided in accordance with an approved Plan of Care and supporting documentation. In addition, LT-PCS must be coordinated with the other Medicaid services, community services and informal supports being provided to the recipient and will be considered in conjunction with those services.

LT-PCS requires a nursing facility level of care determination by the DHH for entry into the program. The information collected during the level of care screening process is used to determine whether nursing facility admission is imminent.

As part of the LT-PCS application process, a face-to-face assessment using the Minimum Data Set-Home Care (MDS-HC) is performed for LT-PCS applicants who have been determined to meet nursing facility level of care and are at imminent risk of nursing facility placement. This face-to-face MDS-HC assessment is utilized for the following purposes:

- To verify that the individual meets level of care.
- To determine if the individual meets LT-PCS program requirements,
- To identify the individual's long-term care needs and preferences,
- To identify the availability of family and community supports, and
- To develop the Plan of Care.

The services offered under the LT-PCS program are provided by a Medicaid enrolled agency that has a valid Personal Care Attendant license issued by the Bureau of Health Services Financing (BHSF), Health Standards Section (HSS).

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COVERED SERVICES

Long Term-Personal Care Services (LT-PCS) are defined as those services that provide assistance with the activities of daily living (ADL) and the instrumental activities of daily living (IADL). An applicant for LT-PCS must score at least at the limited assistance level (as defined by the MDS-HC) with one or more of the activities of daily living in order to qualify for LT-PCS. Once program requirements are met, assistance may be either the actual performance of the personal care task for the individual or supervision and prompting so the individual performs the task by himself/herself.

See Recipient Criteria in Section 30.3 for further information regarding this requirement.

All services must be provided in the recipient's home except when certain IADL are normally performed outside of the home, e.g. grocery shopping or accompanying the recipient to a medical appointment.

Service Definitions

Activities of daily living (ADL) are personal, functional activities required by an individual for continued well-being, health and safety. LT-PCS include the following activities:

- Bathing – verbal reminder to take a bath, preparation of the bath, assistance in and out of the bath/shower, and/or physical assistance with bathing and/or drying off;
- Grooming – verbal reminder to do the task, assistance with shaving, application of make-up and/or body lotion or cream, brushing or combing hair, brushing teeth and/or other grooming activities;
- Dressing – verbal reminder to do the task, and/or physical assistance with putting on clothing;
- Ambulation –assistance with walking;
- Eating – verbal reminder to eat, cutting up food, partial assistance with feeding, and/or assistance with adaptive feeding devices (not to include tube feeding);
- Transferring – assistance with moving from a bed to a chair or moving from a wheelchair to a commode;
- Toileting – verbal reminder to toilet, assistance with bladder and/or bowel requirements, including bedpan routines. This does not include insertion or removal of a catheter.

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Instrumental activities of daily living (IADL) are routine household tasks that are essential for sustaining the individual's health and safety, but may not require performance on a daily basis. These tasks are performed for the **recipient only**. Allowable tasks are limited to the following:

- Laundry;
- Meal preparation and storage;
- Grocery shopping, including purchase of personal hygiene items and medications. The recipient does not have to accompany the worker to the store;
- Light housekeeping tasks (vacuuming, mopping floors, cleaning bathroom and kitchen, making the bed). These tasks should only be performed in the area of the home used exclusively by the recipient, or those parts of common areas used solely by the recipient. The worker should make sure that pathways are free from obstructions;
- Medication oversight – assistance with self-administration of prescription and non-prescription medication. This assistance is limited to the following:
 - verbal reminder;
 - assistance with opening the bottle or bubble pack;
 - reading the directions from the label;
 - checking the dosage according to the label directions; and/or
 - assistance with ordering medication from the drug store.

NOTE: The worker is **not allowed** to give medication to the recipient. This includes taking medicine out of a bottle to set up pill organizers.

- Assistance with medical appointments when necessary.
 - assisting with scheduling medical appointments;
 - accompanying the recipient to medical appointments when necessary; and

NOTE: These medical appointments include, but are not limited to physician visits, physical therapy, occupational therapy, and speech therapy.

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- assisting the recipient with accessing medical transportation.

NOTE: Emergency and non-emergency medical transportation is a covered Medicaid service and is available to all recipients. Non-medical transportation is not a required component of LT-PCS. However, providers may choose to furnish transportation for recipients during the course of providing LT-PCS. If transportation is furnished, the provider must accept all liability for their employee transporting a recipient. It is the responsibility of the provider to ensure that the employee has a current, valid driver's license and automobile liability insurance.

Location of Service

LT-PCS must be provided in the recipient's home except when certain IADL are normally performed outside of the recipient's home, if the provision of these services allows the recipient to participate in normal life activities as they pertain to the IADL cited in the Plan of Care. Services that are provided in the recipient's home must be provided while the recipient is present. The recipient's home is defined as the recipient's place of residence. This includes the recipient's own house or apartment, a boarding house, or the house or apartment of a family member or unpaid primary caregiver.

NOTE: LT-PCS cannot be provided in a hospital, an institution for mental disease, a nursing facility, an adult day health care facility or an intermediate care facility for individuals with a developmental disability.

Services rendered outside of the recipient's home do not include trips outside of the borders of the state. Consideration will be given when the recipient lives in an area adjacent to the state's border and it is customary to seek medical and other services in the neighboring state.

LT-PCS shall not be provided in the personal care worker's home, unless it can be satisfactorily assured that:

- The selection of the place of service is consistent with the recipient's choice;
- The recipient's health and safety can be maintained when services are provided in the personal care worker's home; and
- The services do not substitute for otherwise available family and/or community supports.

The place of service must be documented in the Plan of Care and service log.

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Service Limitations

LT-PCS are limited to no more service hours than those which are approved in the Plan of Care in any week.

For tasks that a recipient can complete without physical assistance or difficulty, assistance shall be limited to prompting or reminding the recipient to complete the task.

Minor children are not considered part of the informal supports available to a recipient.

Excluded Services

Long Term-Personal Care Services **does not** include:

- Insertion and sterile irrigation of catheters, although changing and emptying the catheter bag is allowed;
- Irrigation of any body cavities which require sterile procedures;
- Application of dressing, involving prescription medication and aseptic techniques, including care of mild, moderate or severe skin problems;
- Skilled nursing services as defined in State Nurse Practices Act, including medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;
- Teaching a family member or friend how to care for a recipient who requires assistance with activities of daily living;
- Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;
- 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 exercise, weight measurement, enemas;

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- Administration of medication;
- Rehabilitative services such as those performed by an occupational therapist, speech therapist, audiologist, or respiratory therapist;
- 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;
- Food preparation or 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;
- Housekeeping in areas of the house not used by the recipient;
- Companionship; or
- Continuous supervision

NOTE: LT-PCS is not designed to provide continuous supervision to a recipient while informal caregivers work or are otherwise unavailable. LT-PCS is a task-oriented service tied to ADL and IADL. It is not a time-oriented sitting or supervision service).

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SECTION 30.3: LT-PCS - RECIPIENT CRITERIA**PAGE(S) 1**

RECIPIENT CRITERIA

LT-PCS are available to recipients who meet the following qualifications. The recipient:

- Is age 65 years or older, or 21 years of age or older with disabilities. Disabled is defined as meeting the disability criteria established by the Social Security Administration;
- Meets nursing facility level of care criteria as presumptively determined by the Level of Care Eligibility Tool (LOCET) and verified by the MDS-HC;
- Is at imminent risk of nursing facility placement, which means that a person faces a substantial possibility of deterioration in mental or physical condition or functioning if either home and community-based services or nursing facility services are not provided in less than 120 days. This criterion is considered met if the recipient:
 - Is in a nursing facility and could be discharged if community-based services were available;
 - Is likely to require nursing facility admission within the next 120 days as determined by the LOCET and MDS-HC; or
 - Has a primary caregiver who has a disability or is age 70 or older.
- Requires at least limited assistance (as defined by the MDS-HC) with one or more ADL. The MDS-HC defines Limited Assistance for most ADL as the receipt of physical help or a combination of physical help and weight-bearing assistance at specified frequencies during the period just prior to the MDS-HC assessment.
- Is able to participate in his/her care and self-direct the services of the worker independently or through a personal representative.

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SECTION 30.4: LT-PCS - RECIPIENT RIGHTS AND RESPONSIBILITIES

RECIPIENT RIGHTS AND RESPONSIBILITIES

Rights

Recipients of personal care services have the following rights:

- To be treated with dignity and respect;
- To receive services according to the approved Plan of Care;
- To have freedom of choice in the selection of a provider;
- To change providers after every 3 months without good cause or any time with good cause;
- To actively participate in the development of the Plan of Care;
- To actively participate in the decision-making process regarding service delivery; and
- To have an informal resolution process to address complaints and/or concerns regarding LT-PCS.

Responsibilities

Recipients and personal representatives have the following responsibilities to cooperate with the selected agency in the delivery of services by:

- Being available to receive scheduled services;
- Contacting the agency to cancel a scheduled visit;
- Being courteous and respectful to the worker; and
- Maintaining a safe and lawful environment.

Changing Providers

A recipient may change providers without good cause once after **every 3 months** of service. A recipient may request to change providers with good cause at any time during the service

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authorization period. Good cause is defined as the failure of the provider to furnish services in compliance with the Plan of Care. Good cause shall be determined by OAAS or its designee. All requests for change of provider shall be submitted in writing to the access contractor. Providers will receive written notification when approval has been given for recipients to change providers.

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SECTION 30.5: LT-PCS – SERVICE AUTHORIZATION PROCESS

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SERVICE AUTHORIZATION PROCESS

Recipients who have been presumptively determined to meet nursing facility level of care and imminent risk requirements by the LOCET will have an MDS-HC assessment performed by the Office of Aging and Adult Services (OAAS) or its designee. The assessment and any other documentation are reviewed to determine if the recipient meets nursing facility level of care and qualifies for other program requirements. A Plan of Care is developed based on the results of the MDS-HC.

Provider Selection

If approved for services, an approval notice is sent to the recipient with two copies of the Plan of Care, a list of enrolled Medicaid LT-PCS agencies that provide services in his/her area, and an Agreement to Provide Services form. The recipient is instructed to select and contact a provider to arrange for services. Providers will need to meet with the recipient to review the Plan of Care and discuss provision of the services.

If the provider agrees to provide the services, the appropriate access contractor should be contacted and the appropriate documentation must be sent to them within 14 calendar days. Refer to Appendix F for access contractor information.

If the chosen provider declines to serve an individual, the provider must furnish to the entity that developed the Plan of Care written documentation that supports an inability to meet the individual's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The individual will then be asked to choose another provider.

Prior Authorization

All services for LT- PCS must be prior authorized. It is the responsibility of the provider to verify current prior authorizations before services begin for a recipient. Services provided without a current prior authorization are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current prior authorization.

A prior authorization (PA) number is assigned for a year. Approved units of service are released on a weekly basis to the provider and must be used for the specified week. Units of service approved for one week cannot be combined with units of service for another week. For prior authorization purposes, a week is defined as beginning midnight Sunday and ending midnight Saturday.

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SECTION 30.5: LT-PCS – SERVICE AUTHORIZATION PROCESS

A PA number will be issued to providers for the service authorization period, unless the recipient changes providers. Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

All requests for changes in services and/or service hours must be made by the recipient or his/her personal representative. A status change assessment will be performed for all requests where a change in the recipient’s level of functioning is reported. The status change assessment may be done by telephone or in person, at the discretion of OAAS or its designee.

Reassessments will be conducted at the end of the certification period to determine ongoing qualification for services.

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SECTION 30.6: LT-PCS - PROVIDER REQUIREMENTS**PAGE(S) 7**

PROVIDER REQUIREMENTS

Standards of Participation

Providers must meet the following requirements in order to participate in the program:

- Possess a current license for Personal Care Attendant Services issued by Health Standards Section;
- Demonstrate experience in successfully providing direct care services to the target population or demonstrate the ability to successfully provide direct care services to the target population;
- Comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996;
- Maintain an office in each region in which it proposes to provide services.
- Maintain hours of operation that conforms to customary operating hours for similar businesses in the local community;
- Do not subcontract for direct care or supervisory staff;
- Have at least \$200,000 of general liability insurance with the Department of Health and Hospitals named on the certificate of insurance; and
- Comply with all applicable laws, rules and regulations as well as the policies and procedures contained in the Long Term-Personal Care Services provider manual chapter.

Providers shall not refuse to serve any recipient who chooses their agency unless there is documentation to support an inability to meet the recipient's health, safety and welfare needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services. OAAS or its designee must be notified immediately of the circumstances surrounding the refusal. This requirement can only be waived by OAAS or its designee.

Failure to meet the minimum standards shall result in a range of required corrective actions including, but not limited to the following:

- Removal from the Freedom of Choice listing,
- A citation of deficient practice,

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SECTION 30.6: LT-PCS - PROVIDER REQUIREMENTS**PAGE(S) 7**

- A request for corrective action plan, and/or
- Administrative sanctions.

Continued failure to meet the minimum standards shall result in the loss of referral of new LT-PCS recipients and/or continued enrollment as an LT-PCS provider.

Provider Responsibilities

In addition, providers must:

- Employ a sufficient number of direct care and supervisory staff to ensure adequate coverage in the event that a worker's illness or an emergency prevents him/her from reporting for work;
- Ensure that a criminal background check is conducted on all direct care and supervisory staff prior to a permanent offer of employment being made. This background check must be performed by the Louisiana Office of the State Police or by an agency authorized by the Office of State Police. If the results of any criminal background check reveal that the employee was convicted of any offenses as described in R.S. 40:1300.53, pursuant to the statutory revision authority of the Louisiana State Law Institute, the employer shall not hire or may terminate the employment of such person.

NOTE: A worker may be assigned to provide services to a recipient prior to the results of the criminal background check under the direct supervision of a permanent employee, or in the presence of a member of the immediate family of the recipient or a caregiver designated by the immediate family of the recipient as outlined in R.S. 40:1300.52(C) (2).

- Ensure that the direct care and supervisory staff are qualified to provide personal care services;
- Ensure that recipients are eligible for services by accessing MEVS/REVS at the beginning of each month in the service authorization period;
- Document and maintain recipient records in accordance with federal and state regulations governing confidentiality and licensing requirements.
- Implement and maintain an internal quality assurance plan to monitor recipient satisfaction with services on an ongoing basis; and

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- Have a written policy and procedures manual describing the provisions governing the agency's operations, including an informal and formal resolution process to address recipient complaints. The informal resolution process must be conducted at the supervisory or a higher level and the formal process must be conducted at the administrative level.

Staffing Requirements

Worker Qualifications

The LT-PCS worker should demonstrate empathy toward the elderly and persons with disabilities, an ability to provide care to the recipient, and the maturity and ability to deal effectively with the demands of the job.

- LT-PCS workers must be at least 18 years of age or older at the time the offer of employment is made. Verification of age must be provided at the time of employment and maintained in each worker's personnel record.
- All LT-PCS workers must meet one of the following minimum education and experience qualifications:
 - High school diploma or general equivalency diploma (GED) from an accredited school; or
 - A trade school diploma in the area of human services. Training in human services includes, but is not limited to Home Health Aide or Certified Nursing Assistant; or
 - Documented, verifiable experience providing direct care services to the elderly and/or persons with disabilities;

NOTE: High school or GED diplomas acquired from an internet source cannot be used to fulfill this educational requirement.

- The LT-PCS worker must have the ability to read and write in English as well as to carry out directions promptly and accurately.

A legally responsible relative is prohibited from being the paid direct service worker for a family member. A legally responsible relative is defined as the recipient's spouse, curator, tutor, or legal guardian. A relative who is not legally responsible could be the recipient's LT-PCS worker if he/she meets the qualifications to be a PCS worker and is hired by a licensed, Medicaid-enrolled LT-PCS agency.

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SECTION 30.6: LT-PCS - PROVIDER REQUIREMENTS

Persons designated as the personal representative of an individual may not be the paid LT-PCS worker for the individual they are representing.

Supervisor Qualifications

The supervisor must be at least 23 years old or older at the time the offer of employment is made. Verification of age must be maintained in each employee's personnel record.

LT-PCS supervisors must be full-time employees and meet one of the following minimum education and experience qualifications:

- A bachelor's degree in a human service-related field: social work, psychology, sociology, physical therapy, recreational therapy, occupational therapy or counseling from an accredited college or university and two years of paid experience in a human service-related field providing direct services to the elderly and/or persons with disabilities; or
- A licensed registered nurse (RN) or a licensed practical nurse (LPN) with one year paid experience providing direct services to the elderly and/or persons with disabilities; or
- A high school diploma or GED from an accredited school and five years of paid experience providing direct care services to the elderly and/or persons with disabilities.

NOTE: High school or GED diplomas acquired from an internet source cannot be used to fulfill this educational requirement.

Thirty hours of graduate level course credit in any of the above referenced human service-related fields may be substituted for one year of required paid experience.

Supervisory Responsibilities

Each provider must have and implement a written plan of supervision for all LT-PCS workers.

Supervisors shall be responsible for conducting an annual evaluation for each LT-PCS worker. The evaluation shall include reviewing individual cases, providing constructive feedback, and assisting staff to provide services in a more effective manner. Supervisors shall also conduct:

- Quarterly face-to-face meetings with LT-PCS worker (not to be held at the recipient's residence), and

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- Quarterly unannounced visits to the recipient's residence to observe service delivery.

Hours of Supervision

Each supervisor must maintain on-site office hours at least 50% of the time during normal business hours or be continuously available to LT-PCS workers by telephone or beeper when not on site.

Orientation and Training

A minimum of eight hours of orientation must be provided to new direct care and supervisory employees within one week of employment. Orientation must be conducted on-site at the provider's office. Orientation must be documented in the employee's personnel record. Documentation must include:

- The trainer or presenter's name and title,
- The trainer's agency affiliation (if applicable),
- The trainer's qualifications, and
- The dates and hours of specific training.

The orientation provided to staff shall include, but is not limited to:

- Agency policies and procedures;
- Staff duties and responsibilities;
- Ethics and confidentiality;
- Record keeping;
- A description of the population served by the agency; and
- A discussion of issues related to providing care for these individuals, including physical and emotional problems associated with aging and disability.

Direct care staff must also receive training in cardiopulmonary resuscitation (CPR) and basic first aid within one week of employment. A current, valid certification for CPR and first aid may

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be accepted as verification of training. Training must be provided by a certified CPR and first aid instructor.

A minimum of 16 hours of training must be furnished to new employees within 30 days of employment. The training curriculum must, at a minimum, include the following components:

- Communication;
- Observation, reporting and documentation of the recipient status and the care or service furnished;
- Basic infection control procedures;
- Basic elements of body functioning and changes in body function that must be reported to a worker's supervisor;
- Safe transfer techniques and ambulation;
- Appropriate and safe techniques in personal hygiene and grooming that include:
 - Bed bath,
 - Sponge, tub or shower bath,
 - Sink, tub or bed shampoo,
 - Nail and skin care,
 - Oral hygiene, and
 - Toileting and elimination.
- Recognizing emergencies and knowledge of emergency procedures including completing incident/accident reports;
- Maintenance of a clean, safe and healthy environment; and
- Treating the recipient with dignity and respect, including the need to respect his/her privacy and property.

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Annual Training

It is important for LT-PCS workers to receive continuing training to maintain and improve their skills. Each LT-PCS worker must satisfactorily complete at least 20 hours of personal care related training within the first year of hire and annually thereafter. Annual training may include training updates on subjects covered in orientation and initial training. Orientation and normal supervision are not considered annual training. This training must be documented as described in Section 30.6 – Orientation and Training.

SERVICE DELIVERY

Plan of Care

The Plan of Care identifies the recipient's physical dependency needs that are covered in the LT-PCS program. The OAAS or its designee will develop the Plan of Care to correlate with the needs identified in the in-home assessment. The Plan of Care will describe each routine or activity listed including:

- The specific ADL and IADL tasks in which the individual requires assistance and the LT-PCS worker is to perform, assist or cue the recipient, and
- The frequency of service for each routine and activity, including:
 - The number of days per week each routine or activity will be accomplished.
 - The estimated time the LT-PCS worker should spend on all authorized tasks each service day.
 - The preferred time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.

This plan will be sent to the chosen provider for implementation.

Service Delivery and Plan of Care Revisions

Weekly units of service should be delivered in accordance with the Plan of Care and should not be more than the units specified in the plan. Where service delivery differs from the Plan of Care, the provider should document the reason on the service log and describe the reason(s)/justification, *e.g.*, services were not provided because recipient refused services.

Under no circumstances may LT-PCS units be "banked," "borrowed" or "saved" from one week to the next. **Service must be given in the week for which it was intended**, based upon the Plan of Care. Recipients have the flexibility to use the weekly LT-PCS units according to their preferences and personal schedule within the prior authorized week.

NOTE: A prior authorized week begins at 12:00 a.m. on Sunday and ends at 12:00 a.m. the following Sunday.

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All variations from the Plan of Care must be documented in the recipient's record. Documentation examples include the following:

- Monday, April 25, 2010: Ms. Jones called and declined services for today since her sister was visiting from Houston.
- Wednesday, April 28, 2010: Ms. Jones declined assistance with bathing and dressing today. She chose to stay in her pajamas. She stated she was not feeling well and chose to stay in bed. Her clothing was laundered today at her request.
- Friday, April 30, 2010: Went grocery shopping today with Ms. Jones rather than Wednesday since she was not feeling well Wednesday.

During brief periods (less than 30 days duration) the provider may deviate from the Plan of Care. A description of the extenuating circumstances requiring a temporary deviation from the plan must be documented.

Whenever an apparently permanent change in the recipient's level of functioning and/or an availability of other supports is noted, the recipient or personal representative should request a status change assessment to determine if the Plan of Care needs to be revised. Status change assessments may result in the number of hours approved being decreased or increased.

Back-up Plan

Providers must have a written back up plan to provide services if the primary worker is unable to report to work. This plan must include a toll-free telephone number with twenty-four hour availability manned by an answering service that allows the recipient to contact the provider if the worker fails to show up for work. Providers must also have a pool of on-call or substitute workers available to ensure that services to the recipient will not be interrupted. On call or substitute workers must meet the same qualifications as the regular LT-PCS workers before he/she can provide services to the recipient.

This policy governing back up plans **must** be made available to recipients and/or their personal representative when the Agreement to Provide Services form is being completed.

Service Log

A separate service log must be kept for each recipient. Reimbursement is only payable for services documented in the service log. Providers are required to use the standardized weekly service log (OAAS-PF-09-002) for documentation of LT-PCS. A copy of this form and detailed instructions for its completion are located in Appendix D of this chapter.

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SECTION 30.7: LT-PCS - SERVICE DELIVERY**PAGE(S) 5**

The weekly service log is not a substitute for a timesheet. A separate timesheet is required for each LT-PCS worker. Providers may use their own timesheet to document each worker's hours. The time entered on the timesheet must correspond to the activities and time documented on the LT-PCS service log.

The worker must record the following information on the service log:

- The time the service began each day with his/her signed initial and the time service ended with his her signed initials. The LT-PCS task performed as indicated by the worker's signed initials on the day it was performed,
- The total number of hours worked that day,
- Documentation of any circumstances that require change in the LT-PCS Plan of Care,
- The justification for not performing any task identified in the LT-PCS Plan of Care,
- The location where the LT-PCS task is performed if not performed in the recipient's home, and
- Any observation the worker believes should be noted and reported to the supervisor.

The provider's office staff may complete all other portions of the service log, including, but not limited to:

- Provider agency name,
- Recipient name,
- Recipient date of birth,
- Weekly date range, beginning on Sunday and ending the following Saturday,
- Dates for the respective days of the week in which services are scheduled to be performed,
- Total hours of LT-PCS performed for that week.

All portions of the service log must be completed.

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SECTION 30.7: LT-PCS - SERVICE DELIVERY**PAGE(S) 5**

The provider's office staff may not change any of the documentation entered by the LT-PCS worker. Any errors made by the LT-PCS worker must be corrected by him/her using the appropriate error correction method.

Service logs must be completed daily as tasks are performed. Service logs may not be completed prior to the performance of a task. The service log must be signed and dated by the worker and by the recipient or personal representative after the work has been completed at the end of the week. The direct service worker's name should include his/her printed (legible) name, his/her signature, and the date he/she signed the form. Photocopies of previously completed weekly service logs will not be accepted.

Interruption of Services

A recipient may have his/her services interrupted for a period not to exceed **30 days** without his/her services being terminated by the provider agency.

Services may be interrupted for the following circumstances:

- A hospital admission, or
- A temporary stay outside the home (e.g., a vacation).

Reimbursement is not available during service interruption periods.

Discontinuation of Services

A provider must provide written notification to the recipient or the personal representative when discontinuing services for good cause. The notice must be sent at least 30 days before the date on which the services are to be discontinued and should address the reason for discontinuation.

A provider may discontinue services to a recipient without 30 days notice under the following circumstances:

- Upon the recipient's request,
- If the recipient's hospitalization is expected to last more than 30 days, the provider may terminate services because of the unavailability of the recipient to receive services. When the recipient is discharged and returns home, he/she may choose the provider or another provider to continue receipt of services,

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- Unsafe working conditions prevent the worker from performing his/her duties or threaten the worker's personal safety (e.g., unsanitary conditions, illegal activities in the home). The provider must make a documented reasonable effort to notify the recipient and/or the personal representative of the unsafe working conditions in the home and attempt to resolve the problem. At the same time, OAAS should be notified of the provider's concerns for staff's safety,
- The recipient no longer meets the Medicaid financial eligibility criteria,
- The recipient no longer meets the program requirements for LT-PCS,
- The recipient is incarcerated or placed under the supervision of the judicial system,
- The recipient is admitted to a long-term care facility, or
- The recipient moves out of service area (permanently or for a period over 30 days).

If services are discontinued, the provider must notify the appropriate access contractor **within 24 hours**. See Appendix F for contact information.

RECORD KEEPING

Providers must maintain case records for all LT-PCS recipients and personnel records on all supervisory and direct care staff. Providers should always maintain adequate documentation of the units of services provided. The provider should ensure that timesheets and service logs include matching times for the units of service provided by the employee. Records must be complete, accurately documented, readily accessible, and organized. Personnel and recipient records must be retained for a period of five years.

Any error made in a recipient's or employee's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid must never be used in a recipient's or employee's record.

Recipient Records

Records at the Provider's Office

Providers must provide reasonable protection for recipient records against loss, damage, destruction, and unauthorized use. A provider must have a separate written record for each recipient that includes:

- A copy of all Plans of Care,
- Standardized weekly LT-PCS service logs completed by the worker,
- Timesheets substantiating the units of services billed for the service dates on the claim,
- Accident/incident reports involving the recipient,
- A copy of all complaints received involving the recipient, and
- A copy of signed Agreement to Provide Services (and, if applicable, CPOC Task List/Provider Agreement).

Records at the Recipient's Home

Providers must maintain a binder at the recipient's home that includes the following:

- A copy of the recipient's Plan of Care, and

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SECTION 30.8: LT-PCS - RECORD KEEPING**PAGE(S) 3**

- Copies of the recipient's service logs for the most recent two week period.

NOTE: A copy of the "Log of Weekly Services/Supports & Daily Progress Notes" along with instructions for using and completing this form can be found in Appendix D.

In the event that DHH or its designee notices irregularities in documentation, the records may be seized, copied and returned to the recipient's home.

Personnel Records

A provider must have a written record on each employee that includes:

- The application for employment,
- Verification of age (when applicable),
- Verification of education and work experience (when applicable),
- Documentation of the employee's current physical home address,
- Documentation of orientation and annual trainings, including the following:
 - Date of training
 - Time spent in training session
 - Subjects covered
 - Name of the trainer

NOTE: Verification of training shall be furnished to the Office of Aging and Adult Services or its designee upon request.

- Criminal background check findings,
- Periodic, at least annual, performance evaluations,
- An employee's starting and termination dates along with salary paid,
- Time sheets for all times on duty, and
- Any complaints or disciplinary action concerning the employee.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.8: LT-PCS - RECORD KEEPING**PAGE(S) 3****Availability of Records**

Providers must make recipient and personnel records available to DHH, its designee and/or other state and federal agencies upon request. The provider shall be responsible for incurring the cost of copying records for DHH or its designee.

Confidentiality and Protection of Records

The provider shall comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as established by the Centers for Medicare and Medicaid Services. Providers and their employees must not directly or indirectly disclose or knowingly permit the disclosure of any information concerning the agency, the recipients or their families to any unauthorized person. The provider must safeguard the confidentiality of any information which may identify the recipient or his/her family. Confidential information shall only be released under the following conditions:

- By court order, or
- By the recipient's written, informed consent for release of information.

A system must be maintained that provides for the security of all records. Recipient and personnel records must be maintained at the provider's main office. If the provider establishes a satellite office, a copy of the records may be maintained at the satellite office.

NOTE: Under no circumstances should provider staff remove recipient records from the office.

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SECTION 30.9: LT-PCS - QUALITY ASSURANCE**PAGE(S) 1**

QUALITY ASSURANCE

All providers must have a written quality assurance (QA) plan as part of the agency's operational manual. The QA plan must include a process for obtaining input from the recipient, personal representative and/or family members regarding level of satisfaction with the service delivery. The quality assurance plan should include a description of the supervisory staff's role in monitoring the direct care worker. The provider must also include a description of the back-up plan to assure that there is sufficient coverage when a direct care worker is unable to provide services at any given time.

NOTE: Individuals who provide coverage in the LT-PCS worker's absence must meet all staffing requirements for the LT-PCS worker or supervisor as described in Section 30.6 of this manual chapter.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.10: LT-PCS - INCIDENTS/ACCIDENTS/COMPLAINTS

INCIDENTS, ACCIDENTS, AND COMPLAINTS

LT-PCS staff must report all incidents, accidents, or suspected cases of abuse, neglect, exploitation or extortion to the on-duty supervisor immediately and as mandated by law to the appropriate agency named below. Only reporting to a supervisor does not satisfy the legal requirement to report. The supervisor shall be responsible for ensuring that a report or referral is made to the appropriate agency.

Incident/Accident Reports

Providers are responsible for documenting and maintaining records of all incidents and accidents involving the recipient that occurred during the course of delivering services. The Incident/Accident report shall be maintained in the recipient's record. The report shall include:

- Date of the incident/accident;
- Circumstances surrounding the incident/accident;
- Description of medical attention required;
- Action taken to correct or prevent incident/accident from occurring again; and
- Name of person completing the report.

Imminent Danger and Serious Harm

Providers shall report all suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation or extortion to the appropriate authorities. In addition, any other circumstances that place the recipient's health and well-being at risk should be reported.

If the recipient needs emergency assistance, the worker shall call 911 or the local law enforcement agency before contacting the supervisor.

For recipients age 18 through 59, Adult Protective Services (APS) must be contacted at **1-800-898-4910** or **(225) 342-9057**. APS investigates and arranges for services to protect disabled adults at risk of abuse, neglect, exploitation or extortion.

For recipients age 60 or older, Elderly Protective Services (EPS) must be contacted at **1-800-259-4990**. EPS investigates situations of abuse, neglect and/or exploitation of individuals age 60 or older.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.10: LT-PCS - INCIDENTS/ACCIDENTS/COMPLAINTS

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Internal Complaint Policy

Recipients must be able to file a complaint regarding his/her LT-PCS worker without fear of reprisal. The provider shall have a written policy to handle recipient complaints. In order to ensure that the complaints are efficiently handled, the provider shall comply with the following procedures:

- Each provider shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint and resolution of the complaint.
- All written complaints should be forwarded to the complaint coordinator. If the complaint is verbal, the staff member receiving the complaint must document all pertinent information in writing and forward it to the complaint coordinator.
- The complaint coordinator shall send a letter to the complainant acknowledging receipt of the complaint **within five working days**.
- The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the recipient, the personal representative, the worker, and other interested parties. The provider is encouraged to use all available resources to resolve the complaint internally. The LT-PCS supervisor must be informed of the complaint and the resolution.
- The provider must inform the recipient, the complainant, and/or the personal representative in writing **within ten working days** of receipt of the complaint, the results of the internal investigation.
- If the recipient is dissatisfied with the results of the internal investigation, he/she may continue the complaint resolution process by contacting OAAS in writing **within thirty calendar days** of the date of the complaint resolution letter at:

Office of Aging and Adult Services
P.O. Box 2031
Baton Rouge, LA 70821-2031
Attn: Quality Assurance Section

OAAS will notify the complainant **within ten working days** that the complaint has been received and is being investigated.

REIMBURSEMENT

All claims for LT-PCS shall be filed by electronic claims submission 837P or on the CMS 1500 claim form. Providers must utilize the HIPAA compliant billing procedure code and modifier. Refer to Appendix E for information about procedure code, unit of service and current reimbursement rate.

- The claim submission date cannot precede the date the service was rendered.
- Claims cannot be span-dated for a specified time-period. Each line on the claim form must represent billing for a single date of service.

Services to Multiple Recipients in the Same Home by the Same Provider

Providers who provide services to more than one recipient in the same household must bill separately for each recipient based on his/her Plan of Care. The timeframes for shared IADL services for recipients in the same household will be divided equally between the recipients on the respective Plans of Care.

Services to Multiple Recipients in the Same Home by Different Providers

Different providers who provide services to multiple recipients in the same household must bill for their respective client based on the respective Plans of Care. The timeframes for shared IADL for the recipients will be divided equally on the respective Plans of Care unless one of the recipients requires a special diet as verified by a physician statement. Shared housekeeping activities will also be divided equally between recipients on the respective Plans of Care.

FRAUD AND ABUSE

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.

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.

Provider Fraud

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

- Billing for services that are not rendered to, or used for, Medicaid recipients;
- Claiming costs for non-covered or non-chargeable services disguised as covered items;
- Materially misrepresenting dates and descriptions of services rendered, the identity of the individual who rendered the services, or of the recipient of the services;
- Submitting duplicate billing to the Medicaid Program or to the recipient, which appears to be a deliberate attempt to obtain additional reimbursement; and
- 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 Medicaid.

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SECTION 30.12: LT-PCS - FRAUD AND ABUSE**PAGE(S) 2**

Recipient Fraud

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

- 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;
- 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
- The unauthorized use of a Medical Eligibility Card by persons not eligible to receive medical benefits under Medicaid.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.13: EPSDT-PCS – OVERVIEW**PAGE(S) 1**

EPSDT - PCS OVERVIEW

The Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) established a program that may provide Personal Care Services (PCS) to eligibles (recipients up to age 21 years) meeting the medically necessary criteria for these services. The services offered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) PCS program are provided by a Medicaid enrolled agency that has a valid Personal Care Attendant License issued by the DHH.

The EPSDT – PCS program, by definition, does not include any medical tasks such as medication administration, tracheotomy care, feeding tubes, or catheters. If such tasks are necessary, they must be requested under either the Home Health Program or, if the recipient is certified for home and community based waiver services, through the waiver program. BHSF will not accept the physician’s delegation for EPSDT – PCS providers to perform such medical tasks.

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SECTION 30.14: EPSDT – PCS COVERED SERVICES**PAGE(S) 5**

EPSDT – PCS COVERED SERVICES

Personal care services are defined as 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, and these services 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.

Service Definitions

EPSDT – Personal Care Services include the following tasks:

- Basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with clothing,
- Assistance with bladder and/or bowel requirements or problems, including helping the recipient to and from the bathroom or assisting the recipient with bedpan routines, but excluding catheterization.
- Assistance with eating and food, nutrition and diet activities, including preparation of meals for the recipient only.
- 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. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the recipient.

Examples of such activities are:

- Changing and washing the recipient's soiled bed linens.
- Rearranging furniture to enable the recipient to move about more easily in his/her own home.
- Cleaning the recipient's eating area after completion of the meal and/or cleaning items used in preparing the meal, for the recipient only.
- Accompanying, not transporting, the recipient to and from his/her physician and/or medical facility for necessary medical services.

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SECTION 30.14: EPSDT – PCS COVERED SERVICES**PAGE(S) 5**

- 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.
- EPSDT – PCS are not allowable for the purpose of providing respite care for the primary care giver. Respite services are only available through the home and community based waiver programs.
- 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.

Location of Service

EPSDT personal care services must be provided in the recipient's home or in another location outside the recipient's home, if it is medically necessary to be outside of the recipient's home. 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.

Institutions such as a hospital, institution for mental diseases, nursing facility, intermediate care facility for the developmentally disabled or residential treatment center are not considered a recipient's home.

Service Limitations

EPSDT – personal care services are not subject to service limits. The units of service approved shall be based on the physical requirements of the recipient and medical necessity for the covered services in the EPSDT – PCS program.

Hours may not be “saved” to be used later or in excess of the number of hours specified according to the approval letter.

Excluded Services

The following services are not appropriate for personal care and are not reimbursable as EPSDT – PCS:

- Insertion and sterile irrigation of catheters (although changing of a catheter bag is allowed),
- Irrigation of any body cavities which require sterile procedures,

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SECTION 30.14: EPSDT – PCS COVERED SERVICES**PAGE(S) 5**

- Application of dressing, involving prescription medication and aseptic techniques, including care of mild, moderate or severe skin problems,
- Administration of injections of fluid into veins, muscles or skin,
- Administration of medicine (as opposed to assisting with self-administered medication for EPSDT eligibles over eighteen years of age),
- 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 or an area shared with other household members,
- 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,
- 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,
- Skilled nursing services as defined in the state Nurse Practices Act, including medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks,
- 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,
- Specialized nursing procedures such as:
 - Insertion of nasogastric feeding tube
 - In-dwelling catheter
 - Tracheotomy care
 - Colostomy care
 - Ileostomy care
 - Venipuncture
 - Injections

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SECTION 30.14: EPSDT – PCS COVERED SERVICES**PAGE(S) 5**

- Rehabilitative services such as those administered by a physical therapist,
- Teaching a family member or friend techniques for providing specific care,
- Palliative skin care with medicated creams and ointments and/or required routine changes of surgical dressings and/or dressing changes due to chronic conditions,
- Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process,
- 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
- Home IV therapy,
- Custodial care or provision of only instrumental activities of daily living tasks or provision of only one activity of daily living task,
- Occupational therapy,
- Speech pathology services,
- Audiology services,
- Respiratory therapy,
- Personal comfort items,
- Durable medical equipment,
- Oxygen,

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SECTION 30.14: EPSDT – PCS COVERED SERVICES

- Orthotic appliances or prosthetic devices,
- Drugs provided through the Louisiana Medicaid pharmacy program,
- Laboratory services, and
- Social work visits,

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SECTION 30.15: EPSDT – PCS RECIPIENT CRITERIA **PAGE(S) 2**

EPSDT – PCS RECIPIENT CRITERIA

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

- **Medicaid Eligibility**

The person must be a categorically eligible Medicaid recipient birth through 20 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.

- **Medical Necessity**

An EPSDT eligible must meet medical necessity criteria as established by the Bureau of Health Services Financing (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.

To establish medical necessity, the parent or guardian must be physically unable to provide personal care services to the child.

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.

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.

- **Available Supports**

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. EPSDT – PCS are not to function as a substitute for child care arrangements.

A parent or other adult caregiver must be in the home with an EPSDT eligible 14 years of age or younger. Recipients over 14 years of age must be mentally and intellectually competent to direct their own care if they are to be left with the PCS worker without the presence of a parent or other adult caregiver.

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SECTION 30.15: EPSDT – PCS RECIPIENT CRITERIA **PAGE(S) 2**

- **Physician Referral**

EPSDT – PCS 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.

The Plan of Care shall be acceptable for submission to BHSF only after the physician signs and dates the form.

The physician’s signature must be an original signature and not a rubber stamp.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.16: EPSDT – PCS RIGHTS AND RESPONSIBILITIES

EPSDT – PCS RIGHTS AND RESPONSIBILITIES

The recipient shall be allowed the freedom of choice to select an EPSDT – PCS provider. This freedom also extends to the recipient’s right to change providers at any time should he or she finds it necessary to cease the relationship with the current provider.

Recipients may contact the Bureau of Health Services Financing directly for assistance in locating an EPSDT – PCS provider to submit a prior authorization request for medically necessary personal care services. (See Appendix H for contact information.)

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SECTION 30.17: EPSDT – PCS PRIOR AUTHORIZATION PAGE(S) 5

EPSDT – PCS PRIOR AUTHORIZATION

EPSDT – personal care services must be prior authorized by the BHSF or its designee. Services shall not be authorized for more than a six month period. A face-to-face medical assessment must be completed by the physician. The recipient's choice of a personal care services provider may assist the physician in developing a plan of care which shall be submitted for review/approval by BHSF or its designee. Recipients may contact the BHSF directly for assistance in locating a provider to submit a prior authorization request for medically necessary personal care services. (See Appendix H for contact information.)

Initial and Subsequent Prior Authorization Requests

All initial and subsequent prior authorization requests for EPSDT – PCS must be accompanied by the following documents:

- Copy of the recipient's Medicaid Eligibility Card,
- Physician's referral for PCS,
 - EPSDT – PCS **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. The prescription does not have to specify the number of hours being requested, but must specify PCS and not PCA.
 - The physician's signature must be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted.
 - Signatures by nurse practitioners and registered nurses on the referrals are not acceptable.
- Plan of Care prepared by the PCA agency with physician approval,
 - The provider may not initiate services or changes in services under the Plan of Care prior to approval by BHSF.
- EPSDT – PCS Form 90,
 - Completed by the attending physician,
 - Completed within the last 90 days,
 - Documents the recipient requires/would require institutional level of care equal to an Intermediate Care Facility 1, and

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SECTION 30.17: EPSDT – PCS PRIOR AUTHORIZATION PAGE(S) 5

- Documents a face-to-face medical assessment was completed.
- EPSDT – PCS Daily Schedule Form,
- EPSDT Personal Care Services - Social Assessment Form,
 - Specifies the personal care activities which the parent or other caregiver is providing and requires assistance with, and
 - States the reason the parent cannot provide the assistance.
- Request for Prior Authorization Form (PA-14), and
- Other documentation that would support medical necessity (i.e., other independent evaluations).

NOTE: Information about forms used with a prior authorization request can be found in Appendix I.

Requests for prior approval of EPSDT – Personal Care Services should be submitted by mail, by fax or electronically (e-PA) to the Prior Authorization Unit. (See Appendix H for contact information.)

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 to the recipient, the provider and the support coordination agency, if available, advising of the decision.

Chronic Needs Case

Recipients who have been designated by DHH as a “Chronic Needs Case” are exempt from the standard prior authorization process. A new request for prior authorization must still be submitted every 180 days; however, the provider shall only be required to submit a PA-14 form accompanied by a statement from the recipient’s primary physician verifying that the recipient’s condition has not improved and the services currently approved must be continued. The provider must indicate “Chronic Needs Case” on the top of the PA-14 form. This determination only applies to the services approved where requested services remain at the approved level.

Requests for an increase in these services will be subject to a full review requiring all documentation used for a traditional PA request.

NOTE: Only DHH or its designee will be allowed to grant the designation of a “chronic needs case” to a recipient.

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SECTION 30.17: EPSDT – PCS PRIOR AUTHORIZATION PAGE(S) 5

Plan of Care

The Plan of Care must be written on the current version of the EPSDT PCS POC – 1 Form which can be downloaded from the Louisiana Medicaid website. (See Appendix I) The form must be completed in its entirety and must specify the personal care task(s) to be provided (i.e., activities of daily living for which assistance is needed) and the frequency and duration required to complete each of these tasks.

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.

The recipient's attending physician shall review and/or modify the Plan of Care and sign and date it prior to the Plan of Care being submitted to BHSF.

The Plan of Care shall include the following information:

- Recipient name, Medicaid ID number, date of birth and address, phone number,
- Date EPSDT personal care services are requested to start,
- Provider name, Medicaid provider number and address of personal care 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/caregiver, if parent/caregiver is disabled),
- Other in-home services the recipient is receiving,
- Specific personal care tasks (bathing, dressing, eating, etc.) with which PCS provider is to assist the recipient,
- Goals for each activity,
- Number of days services are required each week,
- Time requested to complete each activity,
- Total time requested to complete each activity each week,

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.17: EPSDT – PCS PRIOR AUTHORIZATION PAGE(S) 5

- Child care arrangements specified for children 14 years of age or younger, (parent/relative/paid caregiver), and
- Signature of parent/primary caregiver, provider representative and the recipient's primary physician.

Changes in Plan of Care

Amendments or changes in the Plan of Care should be submitted as they occur and shall be treated as a new Plan of Care which begins a new six-month service period. Revisions of the Plan of Care may be necessary because of changes that occur in the recipient's medical condition which warrant an additional type of service, an increase or decrease in frequency of service or an increase or decrease in duration of service.

Documentation for a revised Plan of Care is the same as for a new Plan of Care. Both a new "start date" and "reassessment date" must be established at the time of reassessment. The provider may not initiate services or changes in services under the Plan of Care prior to approval by BHSF.

Subsequent Plans of Care

A new Plan of Care must be submitted at least every 180 days (rolling six months). The subsequent Plan of Care must:

- Be approved by the recipient's attending physician,
- Reassess the recipient's need for EPSDT – PCS,
- Include any updates to information which has changed since the previous assessment was conducted, and
- Explain when and why the change(s) occurred.

The physician shall only sign and date a fully completed Plan of Care that is acceptable for submission to BHSF.

The physician's signature must be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.17: EPSDT – PCS PRIOR AUTHORIZATION PAGE(S) 5

Reconsideration Requests

If the prior authorization request is not approved as requested, the provider may submit a request for a reconsideration of the previous decision. When submitting a reconsideration request, providers should include the following:

- A copy of the prior authorization notice with the word “Recon” written across the top and include the reason the reconsideration is being requested written across the bottom,
- All original documentation submitted from the original request, and
- Any additional information or documentation which supports medical necessity.

The reconsideration request packet should be sent to the Prior Authorization Unit via fax, mail, or e-PA. After the reconsideration request has been reviewed, a new notification letter with the same prior authorization number will be generated and mailed to the provider, recipient, and support coordinator, if the recipient has a case manager.

Changing PCS Providers

Recipients have the right to change providers at any time; however, approved authorizations are not transferred between agencies. If a recipient elects to change providers within an authorization period, the current agency must notify the Prior Authorization Unit of the recipient’s discharge, and the new agency must obtain their own authorization through the usual authorization process.

NOTE: Recipients may contact the Bureau of Health Services Financing directly for assistance in locating another provider.

Prior Authorization Liaison

The Prior Authorization Liaison (PAL) was established to facilitate the authorization process for EPSDT recipients who are part of the Request for Services Registry. The PAL assists by contacting the provider, recipient, and support coordinator (if the recipient has one) when a request cannot be approved by the Prior Authorization Unit because of a lack of documentation or a technical error.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.18: EPSDT – PCS PROVIDER REQUIREMENTS PAGE(S) 2

EPSDT – PCS PROVIDER REQUIREMENTS**Standards of Participation**

Personal care services must be provided by a licensed personal care services agency which is duly enrolled as a Medicaid provider. Agencies providing EPSDT – PCS shall conform to all applicable Medicaid regulations as well as all applicable laws and regulations by federal, state and local governmental entities regarding wages, working conditions, benefits, Social Security deductions, Occupational Safety and Health Administration requirements, liability insurance, Worker’s Compensation, occupational licenses, etc. Agencies shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

EPSDT – PCS may be provided only to EPSDT eligibles and only by a staff member of a licensed Personal Care Attendant (PCA) agency enrolled as a Medicaid personal care services provider.

A copy of the current PCA license must accompany the Medicaid application for enrollment as a PCS provider.

Additional copies of current licenses shall be submitted to Provider Enrollment thereafter as they are issued for inclusion in the enrollment record. The provider’s enrollment record must include a current PCA license at all times.

Enrollment is limited to providers in Louisiana and out-of-state providers only in trade areas of states bordering Louisiana (Arkansas, Mississippi, and Texas).

Provider agencies shall comply with the policies and procedures contained in the Personal Care Services provider manual for the EPSDT – PCS program.

Staffing

The PCS agency is responsible for ensuring that all individuals providing personal care services meet all training requirements applicable under state law and regulations. Individuals who provide coverage in the PCS worker’s absence must meet all staffing requirements for the PCS worker or supervisor.

Providers must conduct criminal background checks on the direct care and supervisory staff. A worker may be assigned to provide services to a recipient prior to the results of the criminal background check under the direct supervision of a permanent employee or in the presence of a member of the immediate family of the recipient or a caregiver designated by the immediate family of the recipient as outlined in R.S. 40:1300.52(C)(2). If the results of any criminal background check reveal that the employee was convicted of any offenses as described in R.S.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.18: EPSDT – PCS PROVIDER REQUIREMENTS PAGE(S) 2

40:1300.53, pursuant to the statutory revision authority of the Louisiana State law institute, the employer shall not hire or may terminate the employment of such person.

Staff assigned to provide personal care services shall not be a member of the recipient’s immediate family. (Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the recipient.) Personal care services may be provided by a person of a degree of relationship to the recipient other than immediate family, if the relative is not living in 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.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.19: EPSDT – PCS SERVICE DELIVERY

EPSDT – PCS SERVICE DELIVERY

EPSDT – PCS providers may provide Children’s Choice waiver services to the recipient on the same date as PCS; however, both Children’s Choice waiver services and PCS may not be performed at the same time. If the recipient is receiving home health, respite, and/or any other related service, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider. PCS recipients may not receive hospice services while receiving PCS.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.20: EPSDT – PCS RECORD KEEPING**PAGE(S) 2**

EPSDT – PCS RECORD KEEPING

Providers must maintain case records for all EPSDT – PCS recipients and personnel records on all supervisory and direct care staff. Records must be complete, accurately documented, readily accessible, and organized. All records must be retained for a period of five years. Billing records must be maintained for a period of five years from the date of payment.

Any error made in a recipient's or employee's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid must never be used in a recipient's or employee's record.

There must be a clear audit trail between:

- The prescribing physician,
- The personal care services provider agency,
- The person providing the personal care services to the recipient, and
- The services provided and reimbursed by Medicaid.

Recipient Records

Providers must provide reasonable protection for recipient records against loss, damage, destruction, and unauthorized use. A provider must have a separate written record for each recipient that includes:

- Copies of all Plans of Care, Social Assessments, EPSDT PCS Form 90, EPSDT – PCS Daily Schedule Forms and Physician's Order/Prescription for EPSDT Personal Care Services,
- 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,
- Documentation of approval of services by BHSF or its designee, and
- Documentation of the provision of services by the Personal Care Services worker including signed daily notes by the worker, and supervisor if appropriate, that include:

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.20: EPSDT – PCS RECORD KEEPING**PAGE(S) 2**

- Date of service,
- Services provided (checklist is adequate),
- Total number of hours worked,
- Time period worked,
- Condition of recipient,
- Service provision difficulties,
- Justification for not providing scheduled services, and
- Any other pertinent information.

Availability of Records

Providers must make recipient and personnel records available to DHH, its designee and/or other state and federal agencies upon request. The provider shall be responsible for incurring the cost of copying records for DHH or its designee.

CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.21: EPSDT – PCS REIMBURSEMENT**PAGE(S) 1**

EPSDT – PCS REIMBURSEMENT

All claims for EPSDT – PCS shall be filed by electronic claims submission 837P or on the CMS 1500 claim form. Providers must utilize the HIPAA compliant billing procedure code and modifier. Refer to Appendix E for information about procedure code, unit of service and the current reimbursement rate. EPSDT – PCS shall be paid the lesser of billed charges or the maximum unit rate set by BHSF.

The claim submission date cannot precede the date the service was rendered.

If the claim for EPSDT – PCS is submitted without the prior authorization number, the claim will automatically deny with the error code “191” (Procedure Requires Prior Authorization).

If the dates of services on the claim are not within the dates in the prior authorization, the claim will be denied with error code “193” (Date on Claim Not Covered by PA).

If an incorrect number of units are billed, the claim will be denied with error code “194” (Claim Exceeds Prior Authorized Limits).

Hours may not be “saved” to be used later or in excess of the number of hours specified in the approval letter.

Hardcopy claims must be mailed to the Fiscal Intermediary. (See Appendix H for contact information.)

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX A – LT-PCS CORRESPONDENCE

**DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program**

Provider Name
Street Address
City, LA Zip Code

Date
Recipient Name
Recipient Number

PROVIDER NOTICE

Dear _____:

This letter is to notify your agency of the following regarding Medicaid Long Term-Personal Care Services (LT-PCS):

- We have been notified by the above named recipient that your agency was selected and has agreed to provide LT-PCS. Before services can be authorized, you must submit a signed Agreement to Provide Services. This information must be received within **14 days** of the date of this notice to the following address/fax:

Affiliated Computer Services
5700 Florida Blvd.
13th Floor
Baton Rouge, LA 70806
Fax: (225) 231-8151
Attn: Long Term-Personal Care Services

- We notified you on ___(date of notice of selection letter)___ that your agency was selected to provide LT-PCS to the above named recipient. As of this date, we have not received the required information as indicated below:

_____ A signed copy of your Agreement to Provide Services.

Since we have been unsuccessful in reaching you by telephone, we are requesting that you contact our office by ___(5 days from date of this letter)___ to discuss this matter. **Failure to contact this office may result in the recipient selecting another provider.**

- We have been notified that the above named recipient wishes to change LT-PCS providers. Effective _____ your authorization to provide these services to this recipient will end.

NOTE: PRIOR AUTHORIZATION WILL BE EFFECTIVE THE DATE THE AGREEMENT TO PROVIDER SERVICE IS APPROVED. PAYMENT WILL NOT BE MADE FOR SERVICES PROVIDED PRIOR TO THE AUTHORIZATION DATE.

Agency Representative

Phone Number

LT-PCS 3 Provider Notice
Issued 02/13/04
Reissued 03/02/2009

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX A – LT-PCS CORRESPONDENCE

**DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program**

Recipient Name Street Address City, LA Zip Code

_____ **Date**

_____ **Recipient Name**

_____ **Recipient Number**

_____ **Recipient Phone Number**

_____ **Personal Representative Name**

PROVIDER NOTICE – STATUS CHANGE REVIEW

Dear _____:

The above named recipient has been approved for additional service units. This change is effective _____ through _____. Before these services can be authorized, you must submit a signed Agreement to Provide Services. Please submit this information within **3 days** to Affiliated Computer Services (ACS) at fax number **(225) 231-8151**.

This change will not be implemented until ACS receives an Agreement to Provide Services signed by both the provider agency and the recipient/personal representative.

Failure to timely submit this information to ACS may result in the recipient selecting another provider.

Agency Representative

Phone Number

LT-PCS 3 A Provider Notice-Status Change Review
Issued 09/02/04
Reissued 03/02/2009

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX A – LT-PCS CORRESPONDENCE

**DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program**

Recipient Name
Street Address
City, LA Zip Code

Date
Recipient Name
Recipient Number

PROVIDER NOTICE – REASSESSMENT

Dear _____:

- The above named recipient has been approved for personal care services for the new certification period _____ through _____. Before these services can be authorized, you must submit a signed Agreement to Provide Services. Please submit this information within **5 days** of the date of this notice to the following address or fax number:

Affiliated Computer Services
5700 Florida Blvd.
13th Floor
Baton Rouge, LA 70806
Fax: (225) 231-8151
Attn: Long Term -Personal Care Services

- We notified you on _____ that the above named recipient was recertified effective _____ through _____. As of this date, we have not received the required information as indicated below:

_____ A signed Agreement to Provide Services

Since we have been unsuccessful in reaching you by telephone, we are requesting that you contact our office by _____ to discuss this matter. **Failure to contact this office may result in the recipient selecting another provider.**

Agency Representative

Telephone Number

LT-PCS 13 C Provider Notice-Reassessment
Issued 05/11/05
Reissued 06/20/2007

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX B – LT-PCS AGREEMENT TO PROVIDE SERVICES

**DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program**

Agreement to Provide Services

Recipient Name: _____ **Date:** _____

Recipient Medicaid #: _____ **Provider #:** _____
(Your Agency's Provider Number)

Recipient SSN: _____ **Provider Name:** _____
(Your Company's Name)

A representative from our agency met with _____
(Recipient's Name)

on _____ We have reviewed his/her Plan of Care that has been approved by
(Date of Meeting with Recipient)

the Department of Health and Hospitals.

We agree to provide services to this recipient according to the:

- Initial Plan of Care dated _____.
- Reassessment Plan of Care dated _____.
- Status Change Plan of Care dated _____.

We understand that Affiliated Computer Systems (ACS) will not be able to issue an authorization to our agency until they receive this form signed by both the recipient or their personal representative and our agency representative.

Recipient Signature

Date of Signature

Personal Representative Signature

Date of Signature

Provider Agency Representative Signature

Date of Signature

CHAPTER 30: PERSONAL CARE SERVICES
APPENDIX C – LT-PCS PLAN OF CARE FORM

Louisiana Department of Health and Hospitals Bureau of Health Services Financing Personal Care Services - Plan of Care																																																					
Identifying Information																																																					
Name:																																																					
ID No.:	Phone No.:																																																				
Address 1:																																																					
Address 2:																																																					
City:	State: Zip:																																																				
Responsible Representative:																																																					
Representative's Phone No.:																																																					
Household Composition																																																					
House - Hold Member 1	a. Name: _____ b. Age: _____ c. Relationship 1. Parent 4. Grandchild 2. Spouse 5. Sibling 3. Child 6. Other d. Attends Work or School 0. None 1. Work 2. School e. Work / School Start Time (use 24 hour clock) : _____ f. Work / School End Time (use 24 hour clock) : _____																																																				
House - Hold Member 2	a. Name: _____ b. Age: _____ c. Relationship 1. Parent 4. Grandchild 2. Spouse 5. Sibling 3. Child 6. Other d. Attends Work or School 0. None 1. Work 2. School e. Work / School Start Time (use 24 hour clock) : _____ f. Work / School End Time (use 24 hour clock) : _____																																																				
House - Hold Member 3	a. Name: _____ b. Age: _____ c. Relationship 1. Parent 4. Grandchild 2. Spouse 5. Sibling 3. Child 6. Other d. Attends Work or School 0. None 1. Work 2. School e. Work / School Start Time (use 24 hour clock) : _____ f. Work / School End Time (use 24 hour clock) : _____																																																				
House - Hold Member 4	a. Name: _____ b. Age: _____ c. Relationship 1. Parent 4. Grandchild 2. Spouse 5. Sibling 3. Child 6. Other d. Attends Work or School 0. None 1. Work 2. School e. Work / School Start Time (use 24 hour clock) : _____ f. Work / School End Time (use 24 hour clock) : _____																																																				
Health Status - Notes																																																					
Physical																																																					
Medical																																																					
Psych - iatric / Behav - ioral																																																					
Services Identified - Activities of Daily Living																																																					
For each activity, identify the results of the MDS-HC and whether or not assistance is needed. If support is needed, identify who currently provides the support with a brief description of the support being provided. If the need is not being met, describe the support being recommended and the frequency that support is needed. Refer to Daily Level of Service Guide for Time Allotment.																																																					
CODES: MDS-HC Level 0. Independent 1. Limited 2. Extensive 3. Total	Needs Assistance 0. No v Yes																																																				
Frequency 0. None 1. 1 per day 2. 2 per day 3. 3 per day	4. Once per week 5. Twice per week 6. Once per month																																																				
<table border="1"> <thead> <tr> <th rowspan="2">Activity</th> <th rowspan="2">HC Level Need Asst.</th> <th rowspan="2">Current Natural Support (Describe current support)</th> <th rowspan="2">Type of Support Needed</th> <th colspan="2">Schedule/ Frequency of Support</th> <th rowspan="2">Time for Each Activity</th> </tr> <tr> <th>Day</th> <th>Freq</th> </tr> </thead> <tbody> <tr> <td rowspan="7">Eating</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Sun</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Mon</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Tue</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Wed</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Thu</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Fri</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Sat</td> </tr> </tbody> </table>	Activity	HC Level Need Asst.	Current Natural Support (Describe current support)	Type of Support Needed	Schedule/ Frequency of Support		Time for Each Activity	Day	Freq	Eating						Sun						Mon						Tue						Wed						Thu						Fri						Sat	
Activity					HC Level Need Asst.	Current Natural Support (Describe current support)		Type of Support Needed	Schedule/ Frequency of Support		Time for Each Activity																																										
	Day	Freq																																																			
Eating						Sun																																															
						Mon																																															
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						Wed																																															
						Thu																																															
						Fri																																															
						Sat																																															

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX C – LT-PCS PLAN OF CARE FORM

Assistance Scheduling Medical Appointments			Hrs	Mins
Total Weekly Hours Recommended for IADLs				
Total Monthly Hours Recommended for IADLs				
Recommended Hours of Service				
1. Compute Weekly Hours	PLUS	Total weekly ADLs	Hrs	Mins
	EQUALS	Total weekly IADLs		
	MULTIPLIED BY	Total PCS hours / week recommended		
	EQUALS	4 units of service / hour		
2. Compute Monthly Hours	MULTIPLIED BY	Total ADL / IADL weekly units recommended	Hrs	Mins
	EQUALS	4 units of service / hour		
	MULTIPLIED BY	Total monthly IADLs		
	EQUALS	4 units of service / hour		
Completed By				
Assessor Info	a. Completed by			
	b. Date	Month	Day	Year
Reviewed By				
QA Review	a. Reviewed by			
	b. Date	Month	Day	Year
This section is to be completed by DLTSS				
1. Level of Service	a. The recipient's medical condition meets nursing facility level of care			
	0. No	1. Yes		
2. Services Approved	a. DLTSS representative's signature			
	b. Date	Month	Day	Year
3. Services Denied	a. DLTSS representative's signature			
	b. Date	Month	Day	Year
	c. DLTSS representative's signature			
	d. Date	Month	Day	Year
	e. Denial code			
4. Unable to Approve Packet	a. DLTSS representative's signature			
	b. Date	Month	Day	Year
	c. DLTSS representative's signature			
	d. Date	Month	Day	Year

5. Indicator Code - Used to assign the POC with a code to indicate a special follow up action

To be completed for waiver recipient's only

CPOC Dates

a. Begin Date: Month Day Year

b. End Date: Month Day Year

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX D – LT-PCS SERVICE LOG

LOG of WEEKLY SERVICES / SUPPORTS for LONG-TERM PERSONAL CARE SERVICES (LT-PCS) – SINGLE EMPLOYEE

PROVIDER AGENCY NAME:		RECIPIENT DOB:						
RECIPIENT NAME:		DIRECT SERVICE WORKER'S NAME:						
Week Of:	Through:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Day Of Week:	Sunday							
Date →								
1 st Arrival Time W/ Initials →								
1 st Departure Time W/ Initials →								
2 nd Arrival Time W/ Initials →								
2 nd Departure Time W/ Initials →								
↓ Tasks ↓	↓ Indicate Task Completed Each Day W/Initials ↓							
Eating								
Bathing								
Dressing								
Grooming								
Transferring								
Ambulation								
Toileting								
Light Housekeeping								
Food Preparation & Storage								
Shopping								
Laundry								
Medication Reminders								
Assist To Sched Med Appts								
Assist To Arrange Med Trans								
Accompany To Med Appts								
Daily Total # Of Hours →								

WEEKLY TOTAL # HOURS of LT-PCS → _____ HOURS

RECIPIENT/DESIGNATED PERSONAL REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: _____

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: _____

DSW SUPERVISOR'S REVIEW SIGNATURE & DATE (Use of this line is optional): _____

NOTE: DAILY SERVICES/SUPPORTS DESCRIPTIONS AND COMMENTS ARE TO BE RECORDED ON PAGE 2 OF THIS FORM. ADDITIONAL PAGES MAY BE USED.

Effective July 4, 2010

Page _____ of _____

OAAS-PF-10-010

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX D – LT-PCS SERVICE LOG

Instructions for Completion of Log of Weekly Services/Supports for Long Term Personal Care Services (LT-PCS) – Single Employee

Effective 7/04/10, the provision of all Long Term Personal Care Services (LT-PCS) must be documented on the Log of Weekly Services/Supports for Long Term Personal Care Services (LT-PCS), hereinafter referred to as the "Service Log." The Service Log must be used to document services provided to:

- A person who receives LT-PCS

NOTE: Services provided by only one worker to one recipient may be documented on a single Service Log.

The Service Log is not a substitute for a Time Sheet. A separate Time Sheet is required for each worker. The design of the Time Sheet is the responsibility of the provider agency.

When an error is made, only the individual who made the entry is allowed to correct the error. Corrections must be made by drawing a single line through the incorrect entry, writing "error" above the entry, initialing the correction, and placing the correct information on the form.

The use of carbon is permissible. It is also permissible for this form to be two-sided.

The following instructions should be used to complete the Service Log:

PAGE 1 OF THE SERVICE LOG

Form with fields: PROVIDER AGENCY NAME: (1), DIRECT SERVICE WORKER'S NAME: (2), RECIPIENT NAME: (3), RECIPIENT DOB: (4)

Items 1-7 are to be completed by the provider agency. It is permissible for this information to be typed onto the form.

- 1 Enter the provider agency's name.
2 Enter the name of the direct service worker.
3 Enter the recipient's name.
4 Enter the recipient's date of birth.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX D – LT-PCS SERVICE LOG

WEEK OF: (5) _____ THROUGH: (6) _____		SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
DAY OF WEEK:								
DATE→	(7)							
1 ST ARRIVAL TIME W/ SIGNED INITIALS→								
1 ST DEPARTURE TIME W/ SIGNED INITIALS→								
2 ND ARRIVAL TIME W/ SIGNED INITIALS→								
2 ND DEPARTURE TIME W/ SIGNED INITIALS→								

(5) Enter the beginning date of the prior authorization week (example: 7/04/10).

(6) Enter the ending date of the prior authorization week (example: 7/10/10).

NOTE: The prior authorization week begins on Sunday at 12:00 a.m. and ends on the following Sunday at 12:00 a.m. Unused portions of the prior authorized weekly allocation may not be saved or borrowed from one week for use in another week.

(7) Enter the date of each day in which services are scheduled to be performed. Start the date on the day of the week that services are to begin in accordance with the recipient’s plan of care. For example, if services are to begin on Monday, 7/05, place 7/05 in Monday’s block and continue through the week.

Item 8 MUST be completed by the Direct Service Worker (DSW) and must be handwritten.

WEEK OF: _____ THROUGH: _____		SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
DAY OF WEEK:								
DATE→								
1 ST ARRIVAL TIME W/ SIGNED INITIALS→		(8)						
1 ST DEPARTURE TIME W/ SIGNED INITIALS→								
2 ND ARRIVAL TIME W/ SIGNED INITIALS→		(8)						
2 ND DEPARTURE TIME W/ SIGNED INITIALS→								

(8) The DSW must write-in the time the services began each day with his/her signed initials **and** the time services ended each day with his/her signed initials. This form allows the DSW to document up to two periods of time for each day services were performed.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX D – LT-PCS SERVICE LOG

Items 9 MUST be completed by hand by the Direct Service Worker (DSW).

↓ Tasks ↓	↓ Indicate Task Completed Each Day W/Initials ↓						
Eating							
Bathing							
Dressing							
Grooming							
Transferring							
Ambulation	9						
Toileting							
Light Housekeeping							
Food Preparation & Storage							
Shopping							
Laundry							
Medication Reminders							
Assist To Sched Med Appts							
Assist To Arrange Med Trans							
Accompany To Med Appts							
Daily Total # Of Hours →							
Weekly Total # of Hours →							

9 The DSW must enter his/her signed initials next to each task. A signed initial in the appropriate block will indicate that the task was completed on that day. Only those tasks that were performed that day should be indicated with signed initials. If the task was not performed for that particular day, the box should be left blank. All entries must be completed on the Service Log by the DSW on the day he/she performs the task(s).

Items 10 and 11 are to be completed by either the DSW or the Provider Agency.

Daily Total # Of Hours →	10						
--------------------------	----	--	--	--	--	--	--

WEEKLY TOTAL # HOURS of LT-PCS → 11 HOURS

10 The total LT-PCS hours that were worked each day must be written-in on this row.

11 At the end of the week, total the number of LT-PCS hours worked for this recipient for the week and write-in this space.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX D – LT-PCS SERVICE LOG

Items 12 and 13 are to be completed only after the form has been fully completed for the given week.

RECIPIENT/DESIGNATED PERSONAL REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: _____ (12)

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: _____ (13)

(12) The signature of the recipient or the recipient's designated personal representative or the recipient's legal representative and the date of that signature must appear on this line. This signature should be obtained at the end of the prior authorized week.

(13) The printed (legible) name of the DSW must appear on this line, followed by the signature of the worker and the date the DSW signed the form. **The DSW should not complete this section until the work for that prior authorized week has been completed.**

Item 14 is for optional use at the discretion of the provider agency.

DSW SUPERVISOR'S REVIEW SIGNATURE & DATE (Use of this line is optional): _____ (14)

NOTE: DAILY SERVICES/SUPPORTS DESCRIPTIONS, COMMENTS, AND PROGRESS NOTES are to be recorded on page 2 of this form. Additional pages may be used.

(14) Use of this line is optional at the discretion of the provider agency. It can be used to document supervisory review of the completed service log.

SECOND PAGE OF THE SERVICE LOG

NOTE: The second page of this form is to be duplicated as needed.

Items 1-6 are to be completed the same way as described in the Instructions for items 1-6 for Page 1 of this form.

PROVIDER AGENCY NAME: _____ (1)	DIRECT SERVICE WORKER'S NAME: _____ (2)
RECIPIENT NAME: _____ (3)	RECIPIENT DOB: _____ (4)
WEEK OF: _____ (5) THROUGH: _____ (6)	

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX D – LT-PCS SERVICE LOG

Items 15 and 16 **MUST** be completed by the DSW for each day worked, as applicable, and must be handwritten.

DAILY SERVICES/SUPPORTS DESCRIPTIONS AND COMMENTS:

Day of Week & Date ↓	DESCRIPTIONS AND COMMENTS ↓
15	
	16

- 15 Anytime the DSW makes a description or comment entry, the day of the week should be noted with the particular date.
- 16 Use this area to document why assistance with a particular activity was not provided, or why assistance with an activity differed from the Plan of Care.

Example:

Tuesday, September 8	<i>Ms. Jones refused assistance with dressing today since she chose to remain in her</i>
	<i>pajamas all day.</i>

NOTE: In this case there would be no signed initials indicating the performance of assistance with the task of "dressing" in Tuesday's column on Page 1 of the Service Log.

Items 17, 18 & 19 are to be completed the same way as described in Instructions for items 12, 13 & 14 on Page 1 of this form.

RECIPIENT/DESIGNATED PERSONAL REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: _____ 17

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: _____ 18

DSW SUPERVISOR'S REVIEW SIGNATURE & DATE (Use of this line is optional): _____ 19

NOTE: If the second page is duplicated, the recipient/designated personal representative/legal representative and employee signatures must be obtained on each page.

NOTE: Number each page of the service log. This is located on the bottom right of each page as Page ___ of ___

Example: There are three pages. Write Page 1 of 3 on the bottom of the first page, Page 2 of 3 on the bottom of the second page, and Page 3 of 3 on the bottom of the third page.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX E – BILLING INFORMATION**PAGE(S) 1**

PERSONAL CARE SERVICE – BILLING INFORMATION

All personal care services must be prior authorized and billed using the appropriate provider number the agency was issued for personal care services.

Procedure Code	Modifier	Description	Unit Size	Reimbursement Rate
T1019	EP	EPSDT – Personal Care Services	15 min	\$2.53
T1019	UB	Long Term – Personal Care Services	15 min	\$2.89

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX F: LT-PCS – ACCESS CONTRACTOR INFORMATION

ACCESS CONTRACTOR INFORMATION

Access Contractor	Required Documentation to Request Prior Authorization	Service Area
Affiliated Computer Services 5700 Florida Blvd. 13 th Floor Baton Rouge, LA 70806 Fax: (225) 231-8151 Attn: Long Term-Personal Care Services 1-877-456-1146	Signed Agreement to Provide Services form	STATEWIDE (EXCEPT the following parishes: Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge and West Feliciana)
Capital Area Agency on Aging P.O. Box 66038 Baton Rouge, LA 70896-6038 Fax: (225) 287-7418 1-800-280-0908	Signed Agreement to Provide Services form And Signed Weekly Long Term Personal Care Services Task List	<u>REGION 2 Parishes</u> Ascension East Baton Rouge East Feliciana Iberville Pointe Coupee West Baton Rouge West Feliciana

ACRONYMS/DEFINITIONS

Abuse - The infliction of physical and mental injury on a recipient by other parties, including, but not limited to, such means as sexual abuse, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered.

Access Contractor – The contractor of a geographical area who is responsible for managing the authorization of services for recipients in the Long Term-Personal Care Services program.

Activities of Daily Living (ADL) - Those activities that are required by an individual for continued well-being, health and safety.

Agreement to Provide Services - An agreement between the provider of Long Term-Personal Care Services and the recipient. The agreement specifies responsibilities with respect to the provision of services.

Appeal – A due process system ensuring a recipient an opportunity to contest certain decisions.

Approval Date – The date the Plan of Care is approved.

Assessment – The process of gathering and integrating formal and informal information relevant to the development of an individualized Plan of Care.

Bureau of Health Services Financing (hereafter referred to as the Bureau) - The office within the Department of Health and Hospitals that is responsible for the administration of the Medicaid Program.

Certification Period – The 12-month period that a Long Term-Personal Care Service recipient is qualified to receive services.

Chronic Needs Case – A designation granted to some EPSDT – Personal Care Service recipients by the Prior Authorization Unit when the recipient’s medical condition is such that services are expected to be continuous and remain at the level currently approved.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a recipient.

Department of Health and Hospitals (DHH) – The single state Medicaid agency for the state of Louisiana.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX G - ACRONYMS/DEFINITIONS**PAGE(S) 3**

Early and Periodic Screening Diagnosis and Treatment (EPSDT) – Medicaid’s comprehensive and preventive child health program for individuals who are under the age of 21.

Fiscal Intermediary – The private fiscal agent contracted to operate the Medicaid Management Information System, which includes claims processing, issuing payments for services rendered and providing assistance to providers.

Good Cause – The failure of the Long Term-Personal Care Service provider to furnish services in compliance with the Plan of Care. Good cause is determined by the Bureau or its designee.

Instrumental Activities of Daily Living (IADL) – Those routine household tasks that are considered essential for sustaining the individual’s health and safety, but may not require performance on a daily basis.

Intake – The Long Term-Personal Care Service screening process consisting of activities necessary to determine the need and qualifications for personal care services.

Long Term-Personal Care Services (LT-PCS) – An optional service offered under the Louisiana Medicaid State Plan to provide assistance with the activities of daily living and instrumental activities of daily living to qualified Medicaid recipients.

Medicaid – A federal-state financed entitlement program operated under Title XIX of the Social Security Act which provides payment for medically necessary services rendered to eligible individuals.

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program.

Office of Aging and Adult Services (OAAS) – The office within the Department of Health and Hospitals responsible for the determination of level of care and review of Plans of Care for the Long Term-Personal Care Services Program.

Prior Authorization Liaison (PAL) – Facilitates the prior authorization approval process for EPSDT-PCS recipients who are part of the Request for Services Registry.

Personal Representative – An individual designated by a Medicaid recipient to act on his/her behalf when applying for and/or receiving Medicaid services.

Plan of Care – The written document that outlines how service will be delivered to a recipient. It should identify each service area and specify how and the recipient’s preference as to when the services will be executed by the personal care worker.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX G - ACRONYMS/DEFINITIONS

Provider – A licensed agency or individual furnishing personal care service under a provider agreement with DHH.

Reassessment – The process utilized to review a recipient’s ongoing need and qualification for services on an annual basis. It provides the opportunity to gather information for reevaluating and revising the Plan of Care.

Recipient – An individual who has been determined to be eligible and receives Medicaid services.

Service Area – designated region where services are provided.

Service Period Authorization – The period that a provider is authorized to provide services.

Task List/Provider Agreement - An agreement between the Long Term-Personal Care Service provider and the recipient. The document specifies the recipient’s preferences and the provider’s responsibilities with respect to the provision of services.

Waiver – An optional Medicaid program established under Section 1915 of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional level of care

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX H: EPSDT-PCS – CONTACT INFORMATION PAGE(S) 1

**EPSDT-PCS
 CONTACT INFORMATION**

Common Questions	Who to Contact	Contact Information
Who can recipients call to request assistance in locating an EPSDT-PCS provider?	Bureau of Health Services Financing	1-888-758-2220
Where do providers send their prior authorization requests?	Molina – Prior Authorization Unit	Mail: Molina Medicaid Solutions P. O. Box 14919 Baton Rouge, La 70898-4919 Attn: Prior Authorization (PCS) Fax: (225) 216-6342 Electronic: www.lamedicaid.com
Where do providers send their claims?	Molina Medicaid Solutions	Molina Medicaid Solutions P. O. Box 91020 Baton Rouge, LA
Who do providers contact regarding billing problems?	Molina Medicaid Solutions	1-800-473-2783 or (225) 924-5040

EPSDT – PCS FORMS

The following forms are used in the EPSDT Personal Care Services program and can be downloaded from www.lamedicaid.com at the “Forms/Files/User Manuals” link:

- Request for Prior Authorization (PA – 14)
- Request for Medicaid EPSDT – Personal Care Services (EPSDT PCS Form 90)
- EPSDT Personal Care Services – Plan of Care (EPSDT PCS POC – 1)
- EPSDT Personal Care Services – Social Assessment Form (EPSDT PCS Social Assessment – 2)
- EPSDT PCS Daily Schedule (EPSDT PCS Daily Schedule – 3)

CLAIMS FILING

Personal Care Services (PCS) are billed on the CMS-1500 (08/05) claim form or electronically in the 837P transaction. Items to be completed are either **required** or **situational**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required (but only in certain circumstances as detailed in the instructions that follow).

Claims should be submitted to:

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

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

CMS 1500 (08/05) Billing Instructions for Personal Care Services

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Required – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	Patient Status	Optional.	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other coverage, the state assigned 6-digit TPL carrier code is required in this block (the carrier code list can be found at www.lamedicaid.com under the Forms/Files link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

Locator #	Description	Instructions	Alerts
9c	Employer's Name or School Name	Situational – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	Situational – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness Give First Date	Optional.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational	
17a	Unlabelled	Optional.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Reserved for future use. Do not use.	Usage to be determined.
20	Outside Lab?	Optional.	
21	Diagnosis or Nature of Illness or Injury	Required -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	The most specific diagnosis codes must be used.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

Locator #	Description	Instructions	Alerts
22	Medicaid Resubmission Code	Optional.	
23	Prior Authorization Number	Required – Enter the prior authorization number for the authorized services.	
24	Supplemental Information	Situational	
24A	Date(s) of Service	Required -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	Optional	
24D	Procedures, Services, or Supplies	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s). Enter appropriate modifier with procedure code: UB = LT-PCS EP = EPSDT-PCS	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	Required -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank	
25	Federal Tax I.D. Number	Optional.	
26	Patient’s Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

Locator #	Description	Instructions	Alerts
29	Amount Paid	<p>Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor.</p> <p>Enter '0' if the third party did not pay.</p> <p>If TPL does not apply to the claim, leave blank.</p>	
30	Balance Due	<p>Situational – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.</p>	
31	Signature of Physician or Supplier Including Degrees or Credentials	<p>Required -- The claim form MUST be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed.</p>	
	Date	<p>Required -- Enter the date of the signature.</p>	
32	Service Facility Location Information	<p>Situational – Complete as appropriate or leave blank.</p>	
32a	NPI	<p>Optional.</p>	
32b	Unlabelled	<p>Situational</p>	
33	Billing Provider Info & Ph #	<p>Required -- Enter the provider name, address including zip code and telephone number.</p>	
33a	NPI	<p>Optional – Enter the billing provider's NPI number.</p>	
33b	Unlabelled	<p>Required – Enter the billing provider's 7-digit Medicaid ID number.</p>	

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

LT-PCS – Example Claim Form

1500																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
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<table border="1"> <tr> <td colspan="10">1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <input type="checkbox"/></td> <td colspan="2">1a. INSURED'S I.D. NUMBER (For Program in Item 1) 6632147896325</td> </tr> <tr> <td colspan="6">2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Revere, Paul</td> <td colspan="3">3. PATIENT'S BIRTH DATE 01 05 155</td> <td colspan="3">4. INSURED'S NAME (Last Name, First Name, Middle Initial)</td> </tr> <tr> <td colspan="6">5. PATIENT'S ADDRESS (No., Street)</td> <td colspan="3">6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></td> <td colspan="3">7. INSURED'S ADDRESS (No., Street)</td> </tr> <tr> <td colspan="4">CITY</td> <td colspan="2">STATE</td> <td colspan="4">8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></td> <td colspan="2">CITY</td> <td colspan="2">STATE</td> </tr> <tr> <td colspan="4">ZIP CODE</td> <td colspan="4">TELEPHONE (Include Area Code)</td> <td colspan="4">ZIP CODE</td> <td colspan="4">TELEPHONE (Include Area Code)</td> </tr> <tr> <td colspan="6">9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td> <td colspan="3">10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td colspan="6">11. INSURED'S POLICY GROUP OR FECA NUMBER</td> </tr> <tr> <td colspan="6">a. OTHER INSURED'S POLICY OR GROUP NUMBER</td> <td colspan="3">a. INSURED'S DATE OF BIRTH MM DD YY</td> <td colspan="3">SEX M <input type="checkbox"/> F <input type="checkbox"/></td> <td colspan="6">b. EMPLOYER'S NAME OR SCHOOL NAME</td> </tr> <tr> <td colspan="6">b. OTHER INSURED'S DATE OF BIRTH MM DD YY</td> <td colspan="3">b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td colspan="3">PLACE (State)</td> <td colspan="6">c. INSURANCE PLAN NAME OR PROGRAM NAME</td> </tr> <tr> <td colspan="6">c. EMPLOYER'S NAME OR SCHOOL NAME</td> <td colspan="3">c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td colspan="3">10d. RESERVED FOR LOCAL USE</td> <td colspan="6">d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i></td> </tr> <tr> <td colspan="6">d. INSURANCE PLAN NAME OR PROGRAM NAME</td> <td colspan="6">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 _____</td> <td colspan="6">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 _____</td> </tr> <tr> <td colspan="6">14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY</td> <td colspan="3">15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY</td> <td colspan="6">16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</td> </tr> <tr> <td colspan="6">17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td> <td colspan="3">17a. _____</td> <td colspan="6">18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</td> </tr> <tr> <td colspan="6">17b. NPI</td> <td colspan="3">19. RESERVED FOR LOCAL USE</td> <td colspan="6">20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</td> </tr> <tr> <td colspan="6">21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 462</td> <td colspan="3">22. MEDICAID RESUBMISSION CODE</td> <td colspan="6">23. PRIOR AUTHORIZATION NUMBER</td> </tr> <tr> <td colspan="6">24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY</td> <td colspan="3">B. PLACE OF SERVICE</td> <td colspan="3">C. EMG</td> <td colspan="3">D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HOPCS I MODIFIER</td> <td colspan="3">E. DIAGNOSIS POINTER</td> <td colspan="3">F. \$ CHARGES</td> <td colspan="3">G. DAYS OF UNITS</td> <td colspan="3">H. EP301 Family Plan</td> <td colspan="3">I. ID QUAL</td> <td colspan="3">J. RENDERING PROVIDER ID #</td> </tr> <tr> <td colspan="6">1</td> <td colspan="3">01 10 10 01 10 10 12</td> <td colspan="3">T1019 UB</td> <td colspan="3">1</td> <td colspan="3">42.00</td> <td colspan="3">12</td> <td colspan="3">NPI</td> <td colspan="3"></td> </tr> <tr> <td colspan="6">2</td> <td colspan="3">01 11 10 01 11 10 12</td> <td colspan="3">T1019 UB</td> <td colspan="3">1</td> <td colspan="3">168.00</td> <td colspan="3">48</td> <td colspan="3">NPI</td> <td colspan="3"></td> </tr> <tr> <td colspan="6">3</td> <td colspan="3"></td> </tr> <tr> <td colspan="6">4</td> <td colspan="3"></td> </tr> <tr> <td colspan="6">5</td> <td colspan="3"></td> </tr> <tr> <td colspan="6">6</td> <td colspan="3"></td> </tr> <tr> <td colspan="6">25. FEDERAL TAX I.D. NUMBER</td> <td colspan="3">SSN EIN</td> <td colspan="3">26. PATIENT'S ACCOUNT NO.</td> <td colspan="3">27. ACCEPT ASSIGNMENT? (For gov. cases, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td colspan="3">28. TOTAL CHARGE \$ 210.00</td> <td colspan="3">29. AMOUNT PAID \$</td> <td colspan="3">30. BALANCE DUE \$ 210.00</td> </tr> <tr> <td colspan="6">31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) Ima Biller SIGNED _____ DATE 2/1/10</td> <td colspan="6">32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____</td> <td colspan="6">33. BILLING PROVIDER INFO & PH # A Very Reliable PCS Agency 123 Main St. Any Town, LA 700000 a. 1326547895 b. 1234567</td> </tr> </table>												1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 6632147896325		2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Revere, Paul						3. PATIENT'S BIRTH DATE 01 05 155			4. INSURED'S NAME (Last Name, First Name, Middle Initial)			5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)			CITY				STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY		STATE		ZIP CODE				TELEPHONE (Include Area Code)				ZIP CODE				TELEPHONE (Include Area Code)				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER						a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. INSURED'S DATE OF BIRTH MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME						b. OTHER INSURED'S DATE OF BIRTH MM DD YY						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			PLACE (State)			c. INSURANCE PLAN NAME OR PROGRAM NAME						c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>						d. INSURANCE PLAN NAME OR PROGRAM NAME						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 _____						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 PROVIDER OR OTHER SOURCE						17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						17b. NPI						19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 462						22. MEDICAID RESUBMISSION CODE			23. PRIOR AUTHORIZATION NUMBER						24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY						B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HOPCS I MODIFIER			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OF UNITS			H. EP301 Family Plan			I. ID QUAL			J. RENDERING PROVIDER ID #			1						01 10 10 01 10 10 12			T1019 UB			1			42.00			12			NPI						2						01 11 10 01 11 10 12			T1019 UB			1			168.00			48			NPI						3																											4																											5																											6																											25. FEDERAL TAX I.D. NUMBER						SSN EIN			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For gov. cases, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 210.00			29. AMOUNT PAID \$			30. BALANCE DUE \$ 210.00			31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) Ima Biller SIGNED _____ DATE 2/1/10						32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____						33. BILLING PROVIDER INFO & PH # A Very Reliable PCS Agency 123 Main St. Any Town, LA 700000 a. 1326547895 b. 1234567					
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 6632147896325																																																																																																																																																																																																																																																																																																																																																																																																																																																																			
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CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

EPSDT-PCS – Example Claim Form

1500													
HEALTH INSURANCE CLAIM FORM													
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05													
PICA													
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID)						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 6632147896459							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Revere, Pauline				3. PATIENT'S BIRTH DATE (MM DD YY) 01 05 05		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> 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 _____													
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 PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 27650 3. _____													
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 837985629													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPTHOPOS I MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Form # I. ID QUAL J. RENDERING PROVIDER ID #													
1 01 10 10 01 10 10 12 T1019 EP 1 45.00 10 NPI													
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3 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____													
4 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____													
5 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____													
6 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____													
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (If or gov. agency 100 1000) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 215.00		29. AMOUNT PAID \$		30. BALANCE DUE \$ 215.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) Ima Biller 2/1/10 SIGNED _____ DATE _____				32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____				33. BILLING PROVIDER INFO & PH # A Very Reliable PCS Agency 123 Main St. Any Town, LA 70000 a. 1326547895 b. 1234567					
NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)													

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING**PAGE(S) 14**

Adjustments and Voids**Completing the 213 Adjustment/Void Form**

The 213 adjustment/void form is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Molina Medicaid Solutions by calling Provider Relations at (800) 473-2783 or at www.lamedicaid.com using the Forms/Files/User Guides link. Instructions and an example of a completed 213 adjustment form are shown on the following pages.

If a claim has been paid using the 837P claim transaction, an adjustment or void may be submitted electronically or by using the Molina 213 adjustment/void form.

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

Only a **paid** claim can be adjusted or voided. Denied claims must be corrected and resubmitted—not adjusted or voided.

Only the paid claim's most recently approved control number can be adjusted or voided. For example:

1. A claim is approved on the remittance advice dated 07/17/2010, ICN 0266156789000.
2. The claim is adjusted on the remittance advice dated 12/11/2010, ICN 0035126742100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (0035126742100) and RA date (12/11/2010) must be used.

Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

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

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

Filing Adjustments for a Medicare/Medicaid Claim

When a provider has filed a claim with Medicare, Medicare reimburses the claim, and the claim becomes a “crossover” to Medicaid for consideration of payment of the Medicare deductible and/or co-insurance/co-payment.

If, at a later date, it is determined that Medicare has overpaid or underpaid, the provider should re-bill Medicare for a corrected payment. These claims may “crossover” from Medicare to Medicaid, but cannot be automatically processed by Medicaid (as the electronic crossover claim appears to be a duplicate claim, and therefore must be denied by Medicaid).

In order for the provider to receive an adjustment, it is necessary for the provider to file a hard copy adjustment claim (Molina Form 213) with Medicaid. These should be sent with a copy of the most recent Medicare explanation of benefits and the original explanation of benefits attached to:

**Molina Medicaid Solutions
Attention: Crossover Adjustments
P.O. Box 91023
Baton Rouge, LA 70821**

In addition, the provider should write “2X7” at the top of the adjustment/void form to indicate the adjustment is for a Medicare/Medicaid claim.

Instructions for Completing the 213 Adjustment/Void Form

1. **REQUIRED** ADJ/VOID – Check the appropriate block
2. **REQUIRED** Patient’s Name
 - a. Adjust – Print the name exactly as it appears on the original claim if not adjusting this information.
 - b. Void – Print the name exactly as it appears on the original claim.
3. Patient’s Date of Birth
 - a. Adjust – Print the date exactly as it appears on the original claim if not adjusting this information.
 - b. Void – Print the name exactly as it appears on the original claim.
4. **REQUIRED** Medicaid ID Number – Enter the 13 digit recipient ID number
5. Patient’s Address and Telephone Number
 - a. Adjust – Print the address exactly as it appears on the original claim.
 - b. Void – Print the address exactly as it appears on the original claim.
6. Patient’s Sex
 - a. Adjust – Print this information exactly as it appears on the original claim if not adjusting this information.
 - b. Void – Print this information exactly as it appears on the original claim.
7. Insured’s Name – Leave blank
8. Patient’s Relationship to Insured – Leave blank
9. Insured’s Group No. – Complete if appropriate or leave blank
10. Other Health Insurance Coverage – Complete with 6-digit TPL carrier code if appropriate or leave blank

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

- 11. Was Condition Related to – Leave blank
- 12. Insured’s Address – Leave blank
- 13. Date of – Leave blank
- 14. Date First Consulted You for This Condition – Leave blank
- 15. Has Patient Ever had Same or Similar Symptoms – Leave blank
- 16. Date Patient Able to Return to Work—Leave blank
- 17. Dates of Total Disability-Dates of Partial Disability – Leave blank
- 18. Name of Referring Physician or Other Source – Leave blank
- 18a. Referring ID Number –Leave blank.
- 19. For Services Related to Hospitalization Give Hospitalization Dates – Leave blank
- 20. Name and Address of Facility Where Services Rendered (if other than home or office) – Leave blank
- 21. Was Laboratory Work Performed Outside of Office – Leave blank
- 22. **REQUIRED** Diagnosis of Nature of Illness
 - a. Adjust – Print the information exactly as it appears on the original claim if not adjusting the information.
 - b. Void – Print the information exactly as it appears on the original claim.
- 23. Attending Number – Leave this space blank
- 24. Prior Authorization # - Enter the PA number.
- 25. **REQUIRED** A through F
 - a. Adjust – Print the information exactly as it appears on the original claim if not adjusting the information.
 - b. Void – Print the information exactly as it appears on the original claim.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

- 26. **REQUIRED** Control Number – Print the correct Control Number as shown on the remittance advice
- 27. **REQUIRED** Date of remittance advice that Listed Claim was Paid – Enter MM DD YY from RA form
- 28. **REQUIRED** Reasons for Adjustment – Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.
- 29. **REQUIRED** Reasons for Void – Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.
- 30. **REQUIRED** Signature of Physician or Supplier – All Adjustment/Void forms must be signed.
- 31. **REQUIRED** Physician’s or Supplier’s Name, Address, Zip Code and Telephone Number – Enter the requested information appropriately plus the seven digit Medicaid provider number and provider NPI number.
- 32. Patient’s Account Number – Enter the patient’s provider-assigned account number.

REQUIRED items must be completed or form will be returned.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

LT-PCS – Example Adjustment Form

MAIL TO:
MOLINA
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
524-5040 (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

1. <input checked="" type="checkbox"/> ADJ. <input type="checkbox"/> VOID																																										
PATIENT AND INSURED (SUBSCRIBER) INFORMATION																																										
2. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) Adalam, Mary																																										
3. PATIENT'S DATE OF BIRTH 06/11/1955																																										
4. MEDICAID ID NUMBER 1234567891234																																										
5. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO.																																										
6. PATIENT'S SEX MALE <input type="checkbox"/> <input checked="" type="checkbox"/> FEMALE																																										
7. INSURED'S NAME																																										
8. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>																																										
9. 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"/> B. 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"/>																																										
16. DATE PATIENT ABLE TO RETURN TO WORK																																										
17. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____																																										
18. DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____																																										
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 10A. REFERRING TO NUMBER																																										
20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)																																										
21. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____																																										
22. WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> 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																																										
1 462 2 3																																										
25. PRIOR AUTHORIZATION NO. 987654321																																										
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">A. DATE(S) OF SERVICE</th> <th>B. PLACE OF SERVICE</th> <th>C. PROCEDURE</th> <th>D. DIAGNOSIS CODE</th> <th>E. CHARGES</th> <th>F. DAYS OR UNITS</th> <th>G. EPSON FAMILY PLAN</th> <th>H. TPLS</th> </tr> <tr> <th>From</th> <th>To</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>04</td> <td>16</td> <td>10</td> <td>04</td> <td>16</td> <td>10</td> <td>12</td> <td>T1019</td> <td>UB</td> <td>1</td> <td>65.00</td> <td>3</td> <td></td> <td></td> </tr> </tbody> </table>		A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. PROCEDURE	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. EPSON FAMILY PLAN	H. TPLS	From	To								MM	DD	YY	MM	DD	YY				04	16	10	04	16	10	12	T1019	UB	1	65.00	3		
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26. CONTROL NUMBER 0076156789501																																										
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)																																										
27. DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID 05/01/10																																										
REASONS FOR ADJUSTMENT																																										
<input checked="" type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY BILLED WRONG CPT CODE																																										
<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																																										
REASONS FOR VOID																																										
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SIGNATURE OF PHYSICIAN OR SUPPLIER I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.																																										
28. YOUR PATIENT'S ACCOUNT NUMBER																																										
29. PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE Angel Giggles 123 Smiley St. Sunny, LA 70000 Provider# 1234567 1234567891																																										

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CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

EPSDT-PCS – Example Adjustment Form

MAIL TO:
MOLINA
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
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

1 ADJ. <input checked="" type="checkbox"/> VOID <input type="checkbox"/>	
PATIENT AND INSURED (SUBSCRIBER) INFORMATION	
2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) Adalam, Mattie	3 PATIENT'S DATE OF BIRTH 06/11/2005
4 MEDICAID ID NUMBER 1234567891225	5 INSURED'S NAME
6 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	7 INSURED'S GROUP NO. (OR GROUP NAME)
8 PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	9 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
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"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>
PHYSICIAN OR SUPPLIER INFORMATION	
12 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	13 DATE FIRST CONSULTED YOU FOR THIS CONDITION
14 DATE PATIENT ABLE TO RETURN TO WORK	15 DATES OF TOTAL DISABILITY
16 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17 REFERRING ID NUMBER
18 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)	19 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
20 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE. 1 462 2 3	21 ATTENDING NUMBER
22 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04 16 10 04 16 10	23 PRIOR AUTHORIZATION NO. 123456789
B. PLACE OF SERVICE 12	C. PROCEDURE T1019
D. DIAGNOSIS CODE EP	E. CHARGES 65.00
F. DAYS OR UNITS 3	EPSDT FAMILY PLAN TPL \$
24 CONTROL NUMBER 0076156789501	25 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID 05/01/10
26 REASONS FOR ADJUSTMENT BILLED WRONG CPT CODE	
27 REASONS FOR VOID	
28 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.) Ima Biller	29 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE 06/01/2010 Angel Giggles 123 Smiley Street Sunny, LA 70000 Provider# 1234567
30 YOUR PATIENT'S ACCOUNT NUMBER	1234567891

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5/97