



# ***HOSPICE PROVIDER SERVICES***

## ***Emergency Billing Policy and Procedures for Hurricane Evacuees***

**Issue Date: August 27, 2005  
Emergency Period Only**

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

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

## PURPOSE

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

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

Parish Name	Parish Number
Orleans	36
Jefferson (East and West)	26/65
St. Bernard	44
St. Tammany	52
St. Charles	45
St. John	48
LaFourche	29
Terrebonne	55
Tangipahoa	53
Plaquemines	38
Washington	59
St. James	47

## PROVIDER ENROLLMENT

All providers rendering services for Louisiana Medicaid recipients must enroll with Louisiana Medicaid in order to receive reimbursement from the Louisiana Medicaid Program. Providers must complete and submit a Louisiana provider enrollment application. A link to the Hurricane Emergency Provider Enrollment Packets may be found on the home page for Louisiana Medicaid's website at [www.lamedicaid.com](http://www.lamedicaid.com). Once approved, providers will receive a Louisiana Medicaid 7-digit provider number assigned on a temporary basis. This number is to be used when verifying recipient eligibility and when submitting claims. While going through the enrollment process, providers may contact Provider Relations at 1-800-473-2783 to obtain temporary access codes necessary to verify eligibility. Once each provider receives a provider number, that number should be registered on the Louisiana Medicaid website at [www.lamedicaid.com](http://www.lamedicaid.com) and used for any future eligibility inquiries.

## RECIPIENT ELIGIBILITY VERIFICATION

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

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

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

### **Recipient Eligibility Verification System (REVS)**

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

### **e-MEVS**

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

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

### **Pharmacy Point of Sale (POS)**

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

## **BILLING**

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

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

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## STANDARDS FOR PARTICIPATION

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

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

### Picking and Choosing Services

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

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

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

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

## **Statutorily Mandated Revisions to All Provider Agreements**

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

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

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

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

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

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

## Surveillance Utilization Review

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

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

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

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

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

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

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

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

### **Provider Warning**

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

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

### **Fraud and Abuse Hotline**

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

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

## IDENTIFICATION OF ELIGIBLE RECIPIENTS

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

These eligibility verification systems provide confirmation of the following:

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

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

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

### Recipient Eligibility Verification System (REVS)

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

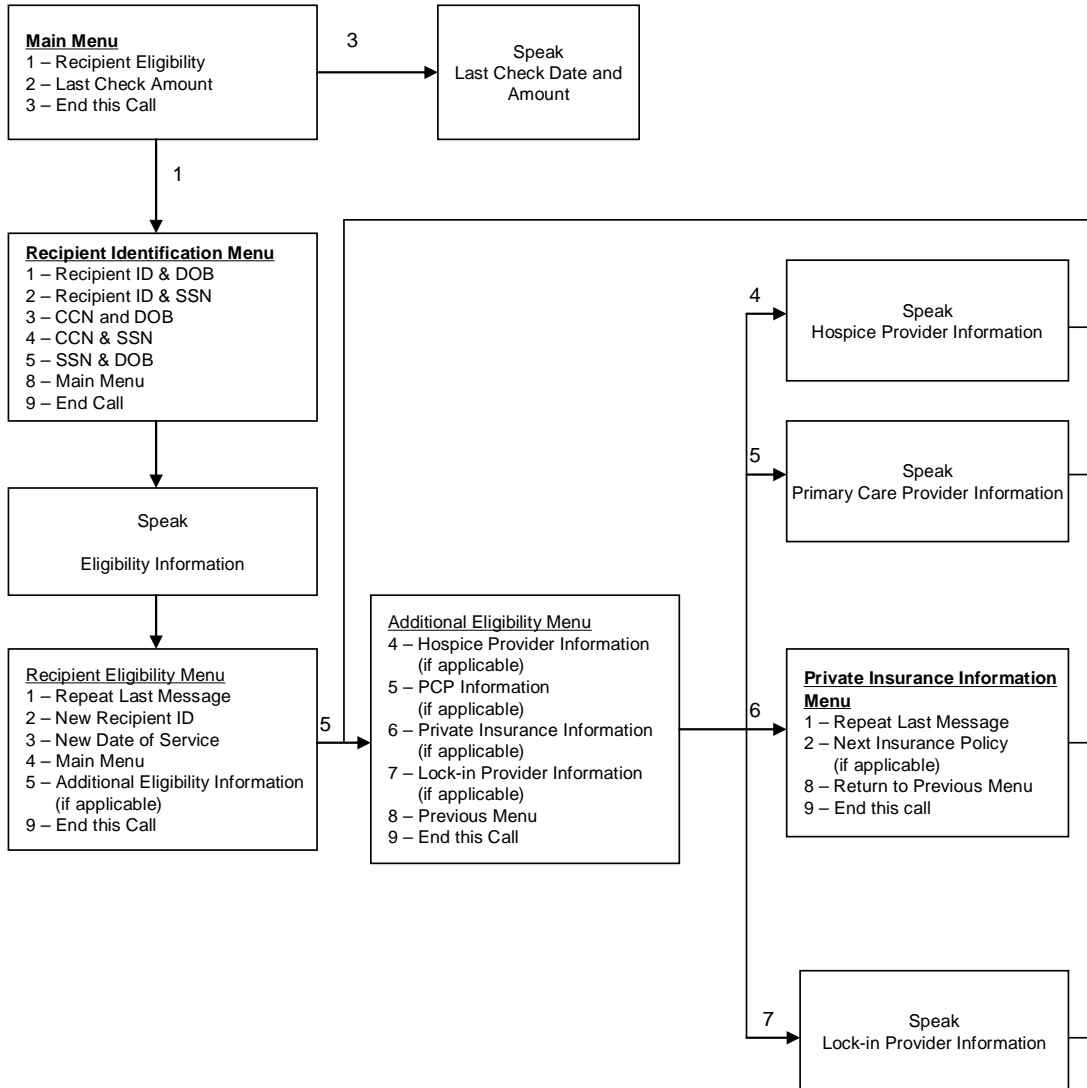
### Accessing REVS

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

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Medicaid ID number (valid during the last 12 months) and recipient birth date
- Medicaid ID number (valid during the last 12 months) and social security number
- Social Security number and recipient birth date

## REVS MENU – (800) 776-6323

The 7-digit Louisiana Medicaid provider number must be entered to begin the eligibility verification process.



## **e-MEVS**

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

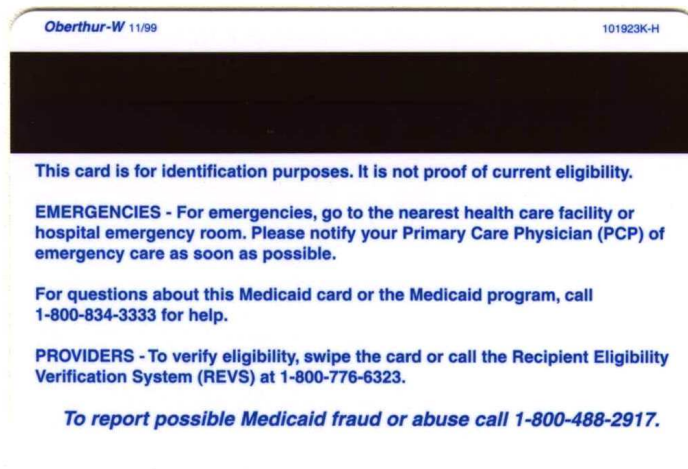
### **Accessing e-MEVS**

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

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

### **Pharmacy Point of Sale (POS)**

For pharmacy claims being submitted through the POS system, eligibility is automatically verified. Checking eligibility through REVS and e-MEVS is not necessary except in an instance of recipient retroactive eligibility.





Kathleen Babineaux Blanco  
GOVERNOR

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



Frederick P. Cerise, M.D., M.P.H.  
SECRETARY

Date: \_\_\_\_\_

To Whom It May Concern:

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

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

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

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

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

Name of Eligible Person	Medicaid ID Billing Number	Date of Birth

Sincerely,

Ben A Bearden  
Medicaid Director

By: \_\_\_\_\_  
Louisiana Medicaid Eligibility Representative

MEDICAL VENDOR ADMINISTRATION  
1201 CAPITOL ACCESS ROAD • P.O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030  
PHONE #: 225/342-3891 • FAX #: 225/342-9508  
"AN EQUAL OPPORTUNITY EMPLOYER"

## THIRD PARTY LIABILITY

Federal regulations and applicable state laws require that third-party resources be used before Medicaid is billed. **Third-party** refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, which can be applied toward the Medicaid recipient's medical and health expenses. Providers should check the recipient's TPL segment to verify that the third-party liability (TPL) codes are accurate according to the TPL listing and the name of the third-party insurance carrier. (TPL carrier code listings can be found on the Medicaid website at [www.lamedicaid.com](http://www.lamedicaid.com) under "Forms/Files" or by contacting Unisys Provider Relations at (800)473-2783 or (225)924-5040). If the TPL code is not correct, the provider should instruct the recipient to contact his/her parish worker to correct the file, especially if the insurance has been canceled. Claims submitted for payment will deny unless the insurance coverage is noted on the claim with the appropriate TPL code or unless a letter explaining the cancellation of the insurance from the carrier is attached to the claim.

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

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

### TPL Billing Procedures

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

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

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

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

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

## **Requests to Add or Remove Recipient TPL/Medicare Coverage**

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

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

## **Payment Methodology When TPL is Involved**

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

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

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

## **Prenatal and Preventive Pediatric Care Pay and Chase**

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

Service classes which do not require private health insurance claim filing by most providers are:

1. Primary prenatal diagnoses confined to those listed below. All recipients qualify. **Hospitals are not included and must continue to file claims with the health insurance carriers;**

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

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

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

3. EPSDT medical, vision, and hearing screening services (KIDMED screening services);
4. EPSDT dental services;
5. EPSDT services to children with special needs (formerly referred to as school health services) which result from screening and are rendered by school boards;
6. Services which are a result of an EPSDT referral, indicated by entering "Y" in block 24H of the CMS-1500 claim form or "1" as a condition code on the UB-92 (form locators 24 - 30).
7. Services for Medicaid eligibles whose health insurance is provided by an absent parent who is under the jurisdiction of the State Child Support Enforcement Agency. All providers and all services (regardless of diagnosis) qualify.

### **Voiding Accident-Related Claims for Profit**

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

## Outgoing Medical Records Stamp

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

<p><b>Medicaid Provider No. (7 digits) (Optional Control Number)</b></p> <p><b>Services have been provided under Louisiana's Medicaid Program and are payable under R.S. 46:446:1 to:</b></p> <p><b>DHH Bureau of Health Services Financing P. O. Box 91030 Baton Rouge, LA 70821-9030 ATTN: Third Party Liability Unit</b></p> <p>Any additional authorization needed may be obtained <b>from DHH/BHSF's TPL Unit at (225) 342-9250.</b></p>
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## Trauma Diagnosis Codes

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

## Third Party Liability Recovery Unit

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

## HMO TPL Codes

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

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

## HMO and Medicaid Coverage

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

- **The recipient must use the services of the HMO that they freely choose to join.** These claims must be submitted hard copy with a copy of the HMO EOB from the carrier that is on file with the state.
- If the HMO denies the service because the service is not a covered service offered under the plan, the claim will be handled as a straight Medicaid claim and processed based on Medicaid policy and pricing.
- If the HMO denies the claim because the recipient sought medical care outside of the HMO network and without the HMO's authorization, Medicaid will deny the claim with a message that HMO services must be utilized.
- If the recipient uses out of network providers for emergency services and the HMO does not approve the claim, Medicaid will deny the claim with a similar edit.

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

## Qualified Medicare Beneficiaries (QMBs)

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

- Have incomes less than 90 percent of the Federal poverty level,
- Have countable resources worth less than twice the level allowed for Supplemental Security Income (SSI) applicants,
- Have the general nonfinancial requirements or conditions of eligibility for Medical Assistance, i.e., application filing, residency, citizenship, and assignments of rights.

Individuals under this program are referred to as Qualified Medicare Beneficiaries (QMBs). The three groups of recipients under this category are: QMB Only, QMB Plus and Non QMB.

QMBs	Status
QMB Only	Identified through the REVS and e-MEVS systems and

(Formerly Pure QMB)	are eligible only for Medicaid payment of deductibles and coinsurance for all Medicare covered services. Hospice services are not available to QMB Only recipients.
QMB Plus (Formerly Dual QMB)	Individuals who are eligible for both Medicare and traditional types of Medicaid coverage (SSI, etc). QMB Plus is identified by the REVS and e-MEVS systems and are eligible for Medicaid payment of deductibles and coinsurance for all Medicare covered services as well as for Medicaid covered services.
Non QMBs	Identified in the TPL segment of REVS and e-MEVS. Non QMBs are eligible for only Medicaid covered services.

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

### Medicare Crossover Claims

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

- If your Medicare claims are not crossing electronically, please call Unisys Provider Relations at (800) 473-2783 or (225) 924-5040. Be very specific with your inquiry. You should indicate whether **all** of your claims are not crossing over or only claims for certain recipients. Were the claims crossing over previously and suddenly stopped crossing, or is this an ongoing problem? The more information you can give, the better. The Unisys representative will check certain pieces of information against the provider and/or recipient files to determine if an identifiable file error exists. If a file update is required, the Unisys representative will route this information to the Unisys Provider Enrollment or Third Party Liability Unit to correct the Medicaid file. If a problem cannot be identified, you may be referred to the Third Party Liability Unit for further assistance.
- If you are not certain that you have supplied your Medicare provider number(s) to Unisys Provider Enrollment, please write to this unit to have your number(s) loaded correctly on your Medicaid provider file. Many Medicare providers have a primary provider number and one or more secondary provider numbers linked to this primary number. **Claims will cross electronically ONLY if the Medicare provider number(s) is cross-referenced to the Medicaid provider number.** If any or all of your Medicare provider numbers have not been reported to Unisys Provider Enrollment, please do so **immediately**.

Medicare adjusted claims **DO NOT** crossover. Providers must submit Medicaid adjustments with the Medicare adjustment EOB attached for corrected payment.

**Providers are responsible for verifying on the Medicaid Remittance Advice that all Medicare payments have successfully crossed over. If Medicare makes a payment**

which is not adjudicated by Medicaid within 30 days of the Medicare EOB date, you should submit your crossover claim hard copy with the Medicare EOB attached. All timely filing requirements must be met even if a claim fails to cross over.

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

## Medicare Advantage

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

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

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

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

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

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

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

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

When it is necessary to submit these claims hardcopy, a Medicare Advantage institutional or professional cover sheet **MUST** be completed for each claim and attached to the top of the claim and EOB. Once finalized, these cover sheets will be available on the Louisiana Medicaid website for easy download. Claims received without this cover sheet will be rejected.

The calculated reimbursement methodology currently used for pricing Medicare claims will be used to price these claims. Thus, claims may price and pay a zero payment if the plan payment exceeds the Medicaid allowable for the service.

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

## CLAIMS PROCESSING REMINDERS

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

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

- Submit an original claim form whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.
- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.
- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. DO NOT use a highlighter to draw attention to specific information.
- Paper claims must be legible and in good condition for scanning into our document imaging system.
- Sign and date your claim form. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.
- Continuous feed forms must be torn apart before submission.
- Use high quality printer ribbons or cartridges - black ink only.
- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.
- Do not use italic, bold, or underline features.
- Do not submit two-sided documents.
- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

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

## Rejected Claims

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

The criteria for legible claims are:

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

## Attachments

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

## Changes to Claim Forms

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

## Data Entry

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

## TIMELY FILING GUIDELINES

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

- Straight Medicaid claims must be filed within 12 months of the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations.
- Claims which fail to cross over via tape and have to be filed hard copy **MUST** be adjudicated within six months from the date on the Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.
- Claims with third-party payment must be filed to Medicaid within 12 months of the date of service.

### Dates of Service Past Initial Filing Limit

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

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

**OR**

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

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

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

### Submitting Claims for Two-Year Override Consideration

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

- 1) The recipient was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted.
- 2) The recipient won a Medicare or SSI appeal in which he or she was granted retroactive Medicaid Benefits.
- 3) The failure of the claim to pay was the fault of the Louisiana Medicaid Program rather than the provider's each time the claim was adjudicated.

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

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

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

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

# THE REMITTANCE ADVICE

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

## The Purpose of the Remittance Advice

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

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

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

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

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

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

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

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

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

## **Remittance Advice Breakdown**

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

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

## **Remittance Summary**

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

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

are processed. As the adjustments/voids are processed, they will appear on the RA and the amount of money being recouped will be deducted from the "Suspense Balance Brought Forward" until all claims payments returned are processed.

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

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

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

<b>Suspense Balance Brought Forward</b>	A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed.
<b>Approved Original Claim</b>	Total of all approved (paid) claims appearing on this RA.
<b>Adjustment Claims</b>	Total of all claims being adjusted on this RA.
<b>Previously Paid Claim</b>	Total of all previously paid claims which correspond to an adjustment or void appearing on this RA.
<b>Void Claims</b>	Total of all claims being voided on this RA.
<b>Net Current Claims Transactions</b>	Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process).
<b>Net Current Financial Transactions</b>	Total number of all financial transactions appearing on the RA.
<b>Prior Negative Balance</b>	If a negative balance has been created through adjustments or voids processed, the negative balance is carried forward to the next RA. (This also includes state recoupments, SURS recoupments and cost settlements.)

<b>Withheld for Future Recoveries</b>	Difference between provider checks posted on the RA and the deduction from those checks when associated claims are processed on the same RA as the posting of the check. (This is added to Suspense Balance Brought Forward on the next RA.)
<b>Total Payments This RA</b>	Total of current check.
<b>Total Copayment Deducted This RA</b>	Total pharmacy co-payments deducted for this RA.
<b>Suspense Balance Carried Forward</b>	Total of Suspense Balance Brought Forward and withheld for future recoveries.
<b>Y-T-D Amount Paid</b>	Total amount paid for the calendar year.
<b>Denied Claims</b>	Total of all denied claims appearing on this RA.
<b>Claims in Process</b>	Total of all pending claims appearing on this RA.

## Claims in Process

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

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

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

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

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

## Denied Claim Turnarounds (DTAs)

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

### **TPL Denied Claims Notification List**

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

PROFESSIONAL REMITTANCE ADVISE  
 LOUISIANA MEDICAL ASSISTANCE PROGRAM  
 FISCAL AGENT - UNISYS  
 PO BOX 33194

RECIPIENT NUMBER INTERNAL RECORDING	RECIPIENT NAME	DATE OF SERVICE		UNITS	PROCEDURE/ACCOMMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BELIED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	MEDICAL CONTROL NUMBER
		FROM	THRU							
61 1733	HAL, CL	5	3-24	1	850	3200	3204	0	3204	52 36 161
61 1733	SON	5	041105	1	850	3200	3205	0	3205	52 36 161
61 1733	SON	5	041305	1	850	3200	3200	0	3200	52 36 161
61 1733	SON	5	041305	1	850	3200	3200	0	3200	52 36 161
61 1733	SON	5	041305	1	850	3200	3200	0	3200	52 36 161
61 1733	SON	5	070805	1	850	3200	3200	0	3200	52 15 14
61 1733	SON	5	082005	1	850	3200	3203	0	3203	52 15 15
61 1733	SON	5	104004	1	850	3500	3500	0	3500	52 15 17
61 1733	SON	5	072005	1	850	3200	3200	0	3200	52 15 21
61 1733	SON	5	072605	1	850	3200	3200	0	3200	52 15 19
61 1733	SON	5	072605	1	850	3200	3200	0	3200	52 15 19
61 1733	SON	5	071805	1	850	5000	5000	0	5000	52 13 18
61 1733	SON	5	072205	1	850	3000	3000	0	3000	52 15 61
61 1733	SON	5	032404	1	850	7000	2004	0	2004	51 16 161
61 1733	SON	5	071105	1	850	2100	8005	0	8005	52 15 15
61 1733	SON	5	071205	1	850	2300	14202	0	14202	51 16 84
61 1733	SON	5	080105	1	850	9000	3023	0	3023	52 15 91
61 1733	SON	5	062305	1	850	2200	4000	0	4000	52 15 34
61 1733	SON	5	062305	1	850	14000	2000	0	2000	52 15 34
61 1733	SON	5	062305	1	850	9000	500	0	500	52 15 34
61 1733	SON	5	063005	1	850	4100	1000	0	1000	51 16 27
61 1733	SON	5	071205	1	850	2300	1200	0	1200	52 15 72
61 1733	SON	5	071105	1	850	31000	5000	0	5000	52 15 62
61 1733	SON	5	071105	1	850	11000	4000	0	4000	52 15 63
61 1733	SON	5	071305	1	850	14000	2000	0	2000	52 15 63

PROFESSIONAL REMITTANCE ADVISE  
 LOUISIANA MEDICAL ASSISTANCE PROGRAM  
 FISCAL AGENT - TWISTS  
 PO BOX 3394  
 BATON ROUGE, LOUISIANA 70811

RECEIPT NUMBER MEDICAL RECORD NO.	RECEIPT NAME	DATE OF SERVICE FROM	UNITS	PROCEDURE/ACCOMMODATION CPT, ICD, MOD, SECTORS	AMOUNT BILLED	AMOUNT ALLOWED	REDUCTIONS	AMOUNT PAID	CONTROL NUMBER
41 1243 01 LII	ILL	A C	4	9593 26	28500	00	00	00	1211
41 1243 01 LII	ILL	A C	4	9593 26 50	6000	00	00	00	1211
41 1243 01 LII	ILL	A C	2	9594 26	18000	00	00	00	1211
2 1243 06 LII	IV	A, D	1	74020 26	3000	00	00	00	1892
1 1704 54 LII	IV	A, D	1	91010 ECG; INTERPRETATION AND X-RAY EXAM OF ANEPL	3000	00	00	00	1897
1 1781 20 LII	IBS	B, C	1	7610 26	2000	00	00	00	1414
1 1741 14 LII	IBS	L, O	1	13500 CONFLICTING CONTROL NO. 3; ECG; INTERP. 3; AND 3000	3000	00	00	00	1502
3 1501 01 LIX	IBS	D, M	1	71010 26 X-RAY CHEST. 0 1 ANTE	2100	00	00	00	1891
6 1201 93 LIX	IBS	D, M	1	81002 CONFLICTING CONTROL NO. 8 ROUTINE URII A 15	400	00	00	00	1881
4 1741 01 MAJ	IBS	F, L	1	76942 26 ECHO GUIDE 1 IV	7000	00	00	00	1344
4 1741 01 MAJ	IBS	F, L	1	131700 CONFLICTING CONTROL NO. 0 INSECT TUBE D 1701	19000	00	00	00	1344
2 1051 01 MAJ	IBS	F, L	1	76817 26 CONFLICTING CONTROL NO. 0 ULTRASOUND, EL . T	8000	00	00	00	1876
2 1051 01 MAJ	IBS	F, L	2	71010 26 X-RAY CHEST. CE 1 TE	4000	00	00	00	1892
2 1051 01 MAJ	IBS	F, L	1	71010 26 X-RAY CHEST; 14 3 500	2100	00	00	00	1922
2 1741 42 MCI	IBS	E, C	60	08840 AA CONFLICTING CONTROL NO. 4 3 501	77000	00	00	00	1135
3 1681 01 MCI	IBS	L, A	1	92333 CONFLICTING CONTROL NO. 15 3 100	15000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 16 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 17 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 18 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 19 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 20 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 21 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 22 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 23 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 24 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 25 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 26 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 27 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 28 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 29 .800	11000	00	00	00	1881
3 1681 01 MCI	IBS	L, A	1	92322 CONFLICTING CONTROL NO. 30 .800	11000	00	00	00	1881

NON-INSTITUTIONAL TITLE XVIII REMITTANCE ADVISE  
LOUISIANA MEDICAL ASSISTANCE PROGRAM  
FISCAL AGENT - UNISYS  
PC BOX 3396  
BATON ROUGE, LOUISIANA 70821

DATE: 08/09/2005 PAGE 122  
REMITTANCE NO.

RECIPIENT NUMBER (MEDICAL RECORD NO.)	RECIPIENT NAME	DATE OF SERVICE FROM	UNITS	PROCEDURE/ACCOMMODATION DESCRIPTION AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	MEDIA - 1 CONTROL NUMBER
11 02 01 51	LA, M G	05 05 11	1 051005	1 35661 51 ARTERY BYPASS GRAFT MED 996	323500	300	300	300	1 '07 1
34 38 01 TA	PH	06 06 06	060705	1 39212 24 CONFLICTING CONTROL M 15401 ADJUDICATION DATE: 2005 0705	6500	300	300	300	1 '51 0
24 89 70 VE	PH	06 06 06	061005	1 39232 SUBQNT INJST, XPANDED, MOO	11500	300	300	300	1 140 3
24 72 01 51	PH	06 06 06	070805	1 39213 CONFLICTING CONTROL NO	9000	300	300	300	1 103 0
21 81 57 WA	PH	06 06 06	062005	1 31010 26 X-RAY CHEST, POSTEROMANTE	2120	200	200	200	1 171 2
21 82 01 51	PH	06 06 06	052104	1 39252 CONFLICTING CONTROL NO	14700	300	300	300	1 103 0
21 51 62 WZ	PH	06 06 06	061705	1 39204 OFFICE, NEW PT, COMPREHEN	23500	300	300	300	1 103 0
24 56 20 JA	PH	06 06 06	011705	1 39214	13500	300	300	300	1 100 0
52 15 01 MC	PH	06 06 06	062003	1 33510 RT	10500	300	300	300	1 100 0
01 27 59 08	RE	05 05 11	021805	1 39214	13500	300	300	300	1 100 0
000	CLAI	05 05 11	021805	44 CLAIMS	1700000	00	00	00	
34 38 01 CU	PH	04 04 04	110204	1 50360 HOMOTRANSPLANT/IMPLANT G	490200	300	300	300	1 05 0
34 38 01 CU	PH	04 04 04	110204	1 50200 BIOPSY OF KIDNEY	41500	300	300	300	1 05 1
31 37 30 IV	PH	05 05 11	051205	1 39213 CONFLICTING CONTROL NO.	9000	300	300	300	1 15 0
34 87 01 RE	PH	05 05 11	050405	1 39213	9000	300	300	300	1 05 0
34 28 01 ST	PH	05 05 11	052505	1 39213	9000	300	300	300	1 03 0
34 83 01 YC	PH	05 05 11	011805	1 39213	9000	300	300	300	1 06 0
000	TOTALS			6 CLAIMS	588400	00	00	00	







## **REMITTANCE ADVICE CLAIM DENIAL RESOLUTION FOR LOUISIANA MEDICAID**

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

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

### **General Claim Form Completion Error Codes**

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

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

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

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

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

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

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

**Cause:** 1. No procedure code was entered on the claim form, OR

2. The procedure code entered on the claim form is invalid (e.g., usually because it has fewer than five characters).

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

### **Recipient Eligibility Error Codes**

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

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

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

**ERROR CODE 216 - RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE**

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

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

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

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

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

2. The first and last names have been entered in reverse order on the claim form.

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

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

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

**Resolution:** 1. Verify the recipient's eligibility using REVS or e-MEVS for all dates of service on the claim. If there is an e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

2. If there is no verification of eligibility for the date of service, resubmit the claim for covered dates of service only.

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

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

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

**ERROR CODE 364 – RECIPIENT INELIGIBLE/DECEASED**

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

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

## Timely Filing Error Codes

### ERROR CODE 272 – CLAIM EXCEEDS 1 YEAR FILING LIMIT

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

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

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

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

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

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

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

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

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

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

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

## Duplicate Claim Error Code

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

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

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

### Third Party Liability Error Codes

#### **ERROR CODE 273 - 3RD PARTY CARRIER CODE MISSING - REFER TO CARRIER CODE LIST**

**Cause:** No carrier code was indicated on the claim for a recipient with other insurance coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Medicare/Medicaid Error Codes**

#### **ERROR CODE 275 – RECIPIENT IS MEDICARE ELIGIBLE**

**Cause:** The state files indicate that the recipient is eligible for Medicare. Since Medicaid is always the payer of last resort, it will be necessary to bill Medicare first and then submit the claim to Medicaid along with the EOMB.

**Resolution:** Submit the claim to Medicare. Once the Medicare EOB is received, attach it to the claim and send to Medicaid for adjudication.

#### **ERROR CODE 330 - QMB NOT MEDICAID ELIGIBLE**

**Cause:** The claim was filed for a recipient who is a QMB ONLY, meaning that Medicaid will only pay the co-insurance or deductible after Medicare has made payment. If the service is not a Medicare covered service or if Medicare did not make a payment on the claim (for whatever reason), Medicaid will not pay either. This type of recipient is not truly a Medicaid recipient. The recipient only has Medicaid coverage if Medicare has paid the claim and only co-insurance/deductible is owed.

**Resolution:** In general, recipients may be billed for services considered non-covered by Medicaid.

#### **ERROR CODE 922 – MEDICARE EOMB INVALID/OR MISSING**

**Cause:** 1. The claim was received by Unisys with no Explanation of Medicare Benefits (EOMB) attached; OR

2. The claim was received by Unisys with an EOMB which was invalid (missing date of

service, recipient name, etc.).

**Resolution:** If no Medicare EOB was filed with the claim, resubmit the claim with the corresponding EOMB. If an invalid EOMB was attached to the claim, resubmit the claim with a corrected EOMB.

#### **ERROR CODE 942 – DENIED BY MEDICARE, NOT COVERED BY MEDICAID**

**Cause:** The billed service was denied by Medicare and so is not payable by Medicaid.

**Resolution:** Unless the recipient is a QMB plus, Medicaid is not required to make payment on services when Medicare denies payment. If the Medicare denial states the service was “not medically necessary,” the service is not payable by Medicaid, even for QMB PLUS recipients. If the service is for a QMB PLUS and the denial is for other than medical necessity, the claim and EOMB should be submitted to the Correspondence Unit with a cover letter explaining the problem.

#### **ERROR CODE 996 – DEDUCTIBLE & OR CO-INSURANCE REDUCED TO MAX ALLOWABLE**

**Cause:** The Medicaid payment was reduced because of a Medicare payment.

**Resolution:** This claim has been approved and is considered paid in full. The provider cannot bill the patient for any remaining balance. In determining the Medicaid payment, the computer system will calculate the amount Medicaid would pay if there were no Medicare. If Medicare has paid more than that amount, the claim is considered approved at \$0.00. Otherwise, Medicaid will pay the difference between the Medicaid allowable and what Medicare paid, up to the coinsurance and deductible amount.

### **Adjustment/Void Error Codes**

#### **ERROR CODE 798 – HISTORY RECORD ALREADY ADJUSTED**

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

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

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

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

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

**Resolution:** Review previous RAs to determine the correct ICN to be adjusted. If the ICN submitted on the adjustment/void form is incorrect, submit a corrected adjustment or void. If

the ICN on the claim is correct, send a copy of the adjustment/void form and all related documentation to Unisys Correspondence Unit with a cover letter explaining the problem.

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

## Miscellaneous Error Codes

### **ERROR CODE 299 - PROCEDURE/DRUG NOT COVERED BY MEDICAID**

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

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

### **ERROR CODE 232 - PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM**

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

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

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

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

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

## Provider Eligibility Error Codes

### **ERROR CODE 201 – PROVIDER NOT ELIGIBLE ON DATES OF SERVICE**

**Cause:** The billing provider number entered on the claim form is on the State provider files, but the provider's enrollment was not effective on the claim date(s) of service.

**Resolution:** Review the claim that was filed, ensuring that the correct Medicaid provider

number was entered on the claim form. Make any necessary corrections and resubmit the claim.

**Note: Providers must be enrolled as** Medicaid providers in order to be reimbursed by Medicaid.

**ERROR CODE 206 – BILLING PROVIDER NOT ON FILE**

**Cause:** The billing provider number entered on the claim form is not on the State provider files.

**Resolution:** Review the claim that was filed, ensuring that the correct Medicaid provider number was entered on the claim form. Make any necessary corrections and resubmit the claim.

**Note:** Medicaid provider numbers are seven digits in length and begin with “1.” All seven digits of the Medicaid provider number must be correct in order for the claim to be paid.

## PROVIDER ASSISTANCE

The Louisiana Department of Health and Hospitals and Unisys maintain a website to make information more accessible to Medicaid providers. At this online location, [www.lamedicaid.com](http://www.lamedicaid.com), providers can access information ranging from how to enroll as a Medicaid provider to directions for filling out a claim form.

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

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

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

### Unisys Provider Relations Telephone Inquiry Unit

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

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

### Unisys Provider Relations Correspondence Group

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

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

## IMPORTANT UNISYS ADDRESSES

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

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

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

Department	P.O. Box	Zip Code
EMC, Unisys business & Miscellaneous Correspondence	91025	70898
Prior Authorization	14919	70898
Provider Enrollment	80159	70898

# DIRECT HOSPICE CARE SERVICES

## REIMBURSEMENT

Medicaid reimbursement for hospice care is made at one of four predetermined per diem rates for each day in which a Medicaid recipient is under the care of the hospice (with the exception of payment for physician services). The rates are calculated based on the geographic location (Metropolitan Statistical Area – MSA) where the services are furnished.

## CLAIM SUBMISSION

### Recipients Residing in the Home

Hospice providers only bill for direct hospice services when a patient resides in the home, unless the recipient is dual eligible with Medicare Part A, then no bill should be submitted to Medicaid since Medicare Part A reimburses hospice services at 100 percent.

### Recipients Residing in a Long Term Care Facility

Hospice providers bill for both direct **hospice** services and **room and board** when a recipient resides in a Nursing Facility, **unless** the recipient is dual eligible with Medicare Part A, then Hospice providers will bill only for room and board. Because Medicare Part A reimburses hospice services at 100 percent, no bill for direct hospice services should be submitted to Medicaid.

## DOCUMENTATION REQUIREMENTS

The Louisiana Medicaid election statement for hospice care, BHSF Form Hospice (issued 07/02), must be filed by the recipient or by a person authorized by law to consent to medical treatment for the recipient. For dually eligible recipients, hospice care must be elected for both the Medicaid and Medicare programs simultaneously. **The provider must submit a copy of the BHSF Notice of Election Form (81A or 82A) to the Bureau's Hospice Manager for every recipient who elects Medicaid Hospice.** Providers are required to complete a Certification of Terminal Illness (CTI). For dually eligible recipients, it is acceptable for providers to use Medicare's CTI; otherwise, the Louisiana Medicaid CTI, BHSF Form Hospice-TI (issued 07/02), must be used.

**PENDING MEDICAID ELIGIBLES** - The Notice of Election and Certification of Terminal Illness forms may be faxed to the State Hospice Unit for patients electing hospice who have "Pending" Medicaid. Providers enrolling patients with "Pending" status are assuming responsibility for those patients. If the patient becomes eligible for Medicaid and the effective date of eligibility is on or prior to the election date and the NOE and CTI were timely sent to the State Hospice Unit, the recipient will be entitled to hospice

services with the protected election date. If the patient is not eligible for Medicaid, he is not eligible for hospice services.

- ☞ **To ensure optimal reimbursement providers should make every effort to submit the required documents in a timely fashion.**

# HOSPICE NOTICE OF ELECTION AND CERTIFICATION OF TERMINAL ILLNESS FORMS

## ELECTION FORM

The hospice must obtain the recipient's signed Election Form (BHSF Form Hospice) and at least the verbal verification of the terminal illness (BHSF Form Hospice – TI) within 2 days of the recipient signature date on the election form. Both forms must be submitted to the Bureau of Health Services Financing (BHSF) no later than 2 days from the recipient signature date on the election form.

## CERTIFICATION OF TERMINAL ILLNESS

The hospice must obtain Certification of Terminal Illness no later than 2 calendar days after hospice care is initiated. If written certification is not obtained within 2 calendar days, verbal verification from the physician must be received by an interdisciplinary team member and the verbal verification section on the form must be completed and submitted to BHSF within 2 calendar days following the initiation of hospice care. Once the Certification of Terminal Illness has been obtained, BHSF Form Hospice – TI must be received by the Bureau of Health Services Financing (BHSF) within 8 days of the verbal verification.

**Note: If the Notice of Election Form and the Certification of Terminal Illness are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date that BHSF receives the completed documentation.**

Once the recipient hospice election and the Certification of Terminal Illness forms have been received by BHSF, the hospice election information will be loaded on the recipient's Medicaid file. Claims will not process and pay until the hospice election segment is loaded on the Medicaid files. If a hospice claim is received prior to the Medicaid files being updated, the claim will pend for three (3) weekly RA cycles waiting for the files to be updated with the hospice election information. If the files are not updated within the three (3) weeks, the claim will then deny stating the recipient was not hospice eligible. After the hospice election information is loaded on the recipient's Medicaid file, BHSF will notify providers, both Hospice and Long Term Care if applicable, of the election date via letters.

**NOTE: Please make sure that the Election Form, Certification of Terminal Illness and any necessary attachments are properly completed prior to submitting to BHSF. This will help ensure that recipient Medicaid files are updated in a timely manner.**

- ▶ The hospice provider **MUST** obtain written certification of terminal illness **FOR EACH ELECTION PERIOD**. For the initial 90-day period and the subsequent 90-day period, the certification may be completed 2 weeks prior to the beginning of each election period. Once periods requiring PA begin, the certification may be completed at least 10 calendar days prior to the end of a preceding period.

## **Hospice Recipient Election/Cancellation/Discharge Notice BHSF Form Hospice**

### **PURPOSE**

The BHSF Form Hospice is used to notify Department of Health & Hospitals, Bureau of Health Services Financing's Hospice Manager of a Medicaid hospice recipient's voluntary election or cancellation of the Hospice Program as provided by Louisiana Medicaid. It is also used to update changes in the Medicaid hospice recipient's condition and status.

### **PREPARATION**

**The first section of the form is to be completed by the patient or legal representative. The signature of the patient or legal representative is required.**

#### Admission/Election Date (Required):

Enter the admission/election date, which is the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days, and is the same as the certification date if the certification is not completed on time.

**Note: If the Notice of Election Form and the Certification of Terminal Illness are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date that BHSF receives the proper documentation.**

EXAMPLE:       The hospice election date (admission) is January 1, 2004. The physician's certification is dated January 3, 2004. The hospice date for coverage and billing is January 1, 2004. The first hospice benefit period ends 90 days from January 1, 2004.

Show the month, day, and year numerically as MM-DD-YYYY.

The admission date will change when the patient re-elects hospice anytime after a revocation or discharge.

Detailed instructions for items required for the Notice of Election:

#### Type of Bill (Required):

Enter the three-digit numeric type of bill code: 81A, B, C, D, or 82A, B, C, D, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure:

<u>1st Digit</u>	- <u>Type of Facility</u>	
8	- Special facility (hospice)	
<u>2nd Digit</u>	- <u>Classification</u>	
1	- Hospice (Non-hospital based)	
2	- Hospice (Hospital based)	
<u>3rd Digit</u>	- <u>Frequency</u>	<u>Definition</u>
A	- Hospice Admission Notice	Use when the hospice is submitting Form as an Admission Notice.
B	- Hospice Termination/Revocation Notice	Use when the hospice is submitting Form as a notice of termination/revocation for a previously posted hospice election.
C	- Hospice Change of Provider Notice	Use when Form is used as a Notice of Change to the hospice provider.
D	- Hospice Election Void/Cancel	Use when Form is used as a Notice of Void/Cancel of hospice election.
E	- Hospice Change of Ownership	Use when Form is used as a Notice of Change in Ownership for the hospice.

Statement Covers Period:

This field should be used when filing an 81B/82B document only. The "From" date is the start date of the period from which the patient is revoking. The "Through" date is the date of revocation.

Patient's Name (Required):

Enter the patient's last name, first name, and middle initial.

Patient's Medicaid ID Number (Required):

Enter the recipient's 13-digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid "swipe" card, e-MEVS, or through REVS. Make certain that the last two digits are the correct individual suffix for your recipient. The number must match the recipient's name.

If the recipient has applied for Louisiana Medicaid and no decision has been made on his application, the word "Pending" can be written in this field. If the patient becomes eligible for Medicaid, re-send the NOE with a line drawn through the word "Pending", and write in the 13-digit Medicaid ID number. If the original NOE and CTI were timely sent to the State Hospice Unit and the patient's effective date of eligibility is on or prior to the election date, the recipient will be entitled to hospice services. If the patient is not eligible for Medicaid, he is not eligible for hospice services. Providers enrolling patients with "Pending" ID numbers are assuming responsibility for those patients.

Patient's Address (Required):

Enter the patient's complete mailing address, including Zip code.

Patient's Date of Birth (Required):

Enter the month, day, and year of birth (MM-DD-YYYY) of patient. Example: 06121903 If the full correct date is not known, zero fill the field.

Patient's Medicare Number (Required, if applicable):

This field should only be used if the patient has Medicare. Enter the patient's Medicare health insurance number.

Principal Diagnosis Code (Required):

**Use the most specific, and accurate numeric ICD-9-CM diagnosis code for the terminal illness that is current.** The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. CMS only accepts ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260, or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. **Use full ICD-9-CM diagnoses codes including all five digits where applicable.**

Other Diagnosis Codes (Required, if applicable):

Enter the full ICD-9 codes, including all five digits where applicable, for any other terminal diagnosis or related condition.

Hospice Name and Address:

Enter the following: Provider Name, Street Name and Number or P. O. Box Number, City, State, and ZIP code, Telephone Number Required, FAX number is optional.

Provider Number (Required):

Enter the seven (7) digit Medicaid provider identification number.

Attending Physician I.D and Name (Required):

Enter the seven (7) digit Medicaid provider identification number and name of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.

Other Physician I.D. (Required):

Enter the word "employee" or "non-employee" here to describe the relationship the patient's attending physician has with the hospice. "Employee" also refers to a volunteer under your jurisdiction.

Name of Nursing Facility or ICF-MR (Required, if applicable):

Enter the name of the facility in which the individual resides or intends to reside. Medicaid field office staff handles long-term care cases.

Mail or fax the original form to the address below. Fax is preferred due to the time frames involved.

**Hospice Manager  
Louisiana Medicaid/Bureau of Health Services Financing  
Program Operations, Bin # 24  
P.O. Box 91030  
Baton Rouge, LA 70821-9030  
FAX: (225) 342-1411**

**Medicaid Program  
Hospice Recipient Election/Cancellation/Discharge Notice**

**TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE**

I elect to receive Hospice from the provider named below effective \_\_\_\_\_  
Admission Date

**PATIENT'S DECLARATION**

I understand and acknowledge:

- Medicaid Hospice consists of the following election periods:  
An initial 90-day period;  
a subsequent 90-day period; and  
subsequent periods of 60 days each.
- if I reach a point of stability, and am no longer considered terminally ill, that the Hospice will be unable to certify me, and I will return to the traditional Medicaid services, if applicable.
- by electing Medicaid Hospice, I waive all rights to Medicaid covered services related to the treatment of my terminal illness(es).
- if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit simultaneously with Medicaid Hospice.
- By this election, I have been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to my terminal illness(es).

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date signed

**TO BE COMPLETED BY THE HOSPICE PROVIDER**

\_\_\_\_\_  
Type of Bill

\_\_\_\_\_  
FROM                      THROUGH  
Statement Covers Period

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Medicaid ID Number

\_\_\_\_\_  
Patient's Address

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient's Medicare Number

\_\_\_\_\_  
Principal Diagnosis Code

\_\_\_\_\_  
Other Diagnosis Codes

\_\_\_\_\_  
Hospice Name and Address

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

\_\_\_\_\_  
Attending Physician I.D. & Name

\_\_\_\_\_  
Other Physician I.D.

\_\_\_\_\_  
Name of Nursing Facility or ICF-MR

\_\_\_\_\_  
Provider Representative Signature

\_\_\_\_\_  
Date signed

## **CERTIFICATION OF TERMINAL ILLNESS**

The hospice must obtain written certification of terminal illness for each of the election periods, even if a single election continues in effect for two or more periods. Written certifications may be completed two weeks before the beginning of each election period, except that for periods requiring prior approval, written certifications may be completed 20 to 30 calendar days prior to the end of a preceding election period.

For the first 90-day period of coverage, the hospice must obtain certification of the terminal illness no later than 2 calendar days after hospice care is initiated (by the end of the third calendar day). If written certification is not obtained within 2 calendar days following the initiation of hospice care, a verbal certification must be received within 2 calendar days following the initiation of hospice care, with a written certification obtained no later than 8 days after care is initiated. If these requirements are not met, reimbursement is not available for the days prior to the certification. Reimbursement will be effective on the date that BHSF receives the completed TI Form.

For the subsequent periods, a written certification must be on file in the recipient's record prior to the submission of a claim.

Hospice staff must make an appropriate entry in the patient's clinical record as soon as they receive an oral certification and file written certification in the clinical record.

### **THE CERTIFICATION FORM (BHSF FORM HOSPICE-TI)**

The hospice must use the BHSF Form Hospice-TI (Certification of Terminal Illness Form) for documentation of written and verbal certification of terminal illness for Medicaid only recipients. A sample of this form is provided on the following page. For dually eligible recipients, the form that is used for Medicare Certification of Terminal Illness, which also meets the requirements as detailed in this section, may be used.

The certification must specify that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. The certification shall be based on the physician's clinical judgment regarding the normal course of the individual's illness and must include the signature(s) of the physician(s). A stamped physician's signature is not acceptable on the certification.

If verbal certification is made, the referral from the physician must be received by a member of the hospice interdisciplinary group (IDG). The entry of the verbal certification in the patient's clinical record must include, at a minimum, the patient's name, physician's name, terminal diagnosis(es), prognosis, and the name and signature of the IDG member taking the referral.

Submission of the physician's Certification of Terminal Illness is required for the initial election period and for those periods requiring prior authorization. However, copies of certification forms for all election periods shall be made available to the Bureau upon request.

## **SOURCES OF CERTIFICATION**

For the initial 90-day period, the hospice must obtain a completed certification form or documented receipt of a verbal certification statement, if applicable, from:

- The hospice's medical director or a physician member of the hospice's interdisciplinary group; and
- The recipient's attending physician if he/she has an attending physician. The attending physician must be a doctor of medicine or osteopathy and must be identified by the recipient, at the time of election for hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

For subsequent periods, the certification form may be completed by either the medical director of the hospice or the physician member of the hospice interdisciplinary group.

## Medicaid Program Hospice Certification of Terminal Illness

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Medicaid ID Number

\_\_\_\_\_  
Patient's Date of Birth

**First Benefit Period (90 days):**

Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

\_\_\_\_\_  
Signature of Attending Physician

\_\_\_\_\_  
Signature of Hospice Medical Director or physician member of interdisciplinary group

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Date signed

**Second Benefit Period (90 days):**

Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

\_\_\_\_\_  
Signature of Hospice Medical Director or physician member of interdisciplinary group

\_\_\_\_\_  
Date signed

**Third Benefit Period (60 days):**

Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

\_\_\_\_\_  
Signature of Hospice Medical Director or physician member of interdisciplinary group

\_\_\_\_\_  
Date signed

**Fourth Benefit Period (60 days):**

Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

\_\_\_\_\_  
Signature of Hospice Medical Director or physician member of interdisciplinary group

\_\_\_\_\_  
Date signed

**Note: If additional periods are to be certified use an additional form**

**VERBAL VERIFICATION (within two days of election date)**

I certify that on the date signed below a verbal verification was obtained from the physician named below, confirming that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Terminal diagnosis(es)

\_\_\_\_\_  
Name of IDG member taking referral

\_\_\_\_\_  
Signature of IDG member taking referral

\_\_\_\_\_  
Date signed

## **PRIOR AUTHORIZATION**

At this time, the PA-88 authorization form is not being used. Until you receive notice of the effective date of this form, providers requesting prior authorization (PA) of services should send the following: (1) a letter of request on hospice letterhead; (2) Certification of Terminal Illness form signed by the Hospice Medical Director or physician member of the interdisciplinary group for the period PA is being requested; (3) updated Plan of Care; (4) updated Physician's Orders; (5) Progress Notes for all services rendered; (6) Social Evaluation; and (7) any other documentation supporting the continuation of hospice services. The packet should be mailed to:

**Hospice Program Manager  
Bureau of Health Services Financing  
Program Operations, Bin #24  
P.O. Box 91030  
Baton Rouge, LA 70821-9030**

Prior authorization is required after the initial 180 days of hospice coverage. Prior authorization requests should be submitted 20-30 days before the end of the 180 days. If the PA is approved, it covers sixty (60) days. If another 60-day election period is required, the PA request should be submitted at least ten (10) days prior to the end of the current election period. This will ensure that requests are received and approved/denied before the preceding period ends.

**Note:** Prior authorization is not required for the initial 90-day election period or the subsequent 90-day election period. It is required for all subsequent 60-day election periods for recipients with only Medicaid and/or private insurance. PAs are not required for Medicare primary recipients.

## **HOSPICE BILLING AND EDIT CLARIFICATIONS**

The expansion of the Louisiana Medicaid Hospice Program on July 1, 2002 resulted in a number of changes in policy, procedures, and systems programming.

As we have monitored these changes in Program activity and received feedback from the provider community, claims billing and processing issues were identified and addressed in the following areas:

### **REVENUE CODE CLARIFICATIONS**

**Routine Home Care Revenue Code 651** should be used for the following situations:

1. The day of discharge when a recipient is discharged ALIVE from general inpatient care or respite care.
2. The recipient is in a non-contracted facility.
3. The recipient is in a facility for a reason unrelated to the terminal condition.
4. Fewer than 8 hours of continuous care are provided to the recipient.

**Continuous Home Care Revenue Code 652** should be used for the following situations:

1. During brief periods of crisis when a recipient requires continuous care which is primarily nursing care. Homemaker and aide services may also be provided to supplement the nursing care.
2. A minimum of 8 hours of care must be provided during a 24-hour day which begins and ends at midnight.
3. The Continuous Home Care rate is divided by 24 hours in order to arrive at an hourly rate.
4. The provider should bill for the total number of hours and they should be listed in the units field next to revenue code 652.

**Inpatient Respite Care Revenue Code 655** should be used for the following situations:

1. When a recipient is receiving care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home.
2. The day of admission to the inpatient facility.
3. The day of discharge when a recipient EXPIRES while receiving respite inpatient care.
4. A maximum of 5 consecutive days at a time including the date of admission, but not counting the date of discharge alive.

**General Inpatient Care Revenue Code 656** should be used for the following situations:

1. The day of admission to the inpatient facility when the admission is related to the recipient's terminal diagnosis.

2. The day of discharge when a recipient EXPIRES while receiving general inpatient care.
3. When the recipient is in an inpatient facility that has a contract with the hospice agency.

**Physician Services Revenue Code 657 should be used in the following situations:**

1. When physician professional services are being provided to hospice patients; and the hospice is responsible for reimbursing the physician.
2. The physician can be an employee of the hospice, a volunteer, or a consultant.

**Medicare Part B Only Recipients**

Claims for recipients that have Medicare Part B ONLY on the recipient's Medicaid files (DO NOT have Medicare Part A on the recipient file) are now exempt from requiring a Medicare EOB for claims processing. However, the Medicaid Recipient Resource File must reflect this information for these claims to be excluded from this edit. If the file indicates the recipient has Medicare Part A (even if incorrect), claims must be submitted hardcopy with the Medicare EOB attached.

**PROGRAM EDITS**

The following edits are now in place:

**Edit 494 (Invalid MSA Code).** This edit is received when the MSA code entered in the Value Code Fields 39-41 is not a valid MSA code. Please remember that the MSA code must appear to the left of the delimiter in the amount field, and double zeros (00) must appear to the right of the delimiter in the amount field.

**Edit 495 (Not Hospice Eligible).** The recipient file does not indicate the recipient has elected Hospice. These claims will pend systematically for three (3) weekly cycles before denying with this edit.

**Edit 511 (Provider/Recipient Mismatch).** If the claim submitted is for a Hospice provider, but that Hospice provider is not the provider linked to the recipient on the date of service billed, the billing Hospice provider will receive this edit denying the claim, because the provider ID number on the claim must match the provider ID number on the recipient's linkage file.

**Edit 493 (Non-Hospice Provider).** The hospice agency is responsible for either providing or paying for all covered services related to the treatment of the recipient's terminal illness. If claims are received from providers other than the hospice provider of record, those claims must have documentation attached to justify that the services were medically necessary and were not related to the terminal condition for which hospice care was elected. These claims will pend to the Unisys Medical Review Department to determine if the services being billed are not related to the hospice condition. If the services are not related to the hospice condition, the claims will be released for payment. If the services are related to the hospice condition, the claims will be denied with this edit.

The servicing provider should obtain payment for these services from the hospice agency.

**Edit 042 (Invalid UB-92 Bill Type Code).** If hospice claims are received with a Bill Type that is not “81” or “82”, the claims will deny for this edit.

**Edit 085 (Invalid Units/Visits).** If hospice claims are received with a correct Bill Type, but the dates of service and the units do not match, the claims will deny for this edit.

**Edit 303 (Inpatient Respite Days Greater Than Five).** Payment for respite care will be reimbursed for a maximum of five consecutive days at a time (including the date of admission but not including the date of discharge.) **NOTE:** Medicaid will pay for the date of death.

**Edit 358 (No Valid Rate was found for LTC Level of Care).** This edit is received when the Hospice recipient does not have a Nursing Home (LTC) provider number on the Hospice Link File. This edit will be resolved by DHH/BHSF.

**Edit 356 (Total LTC Days Conflict with Sum of LTC LOC Days).** This edit is received when the hospice bills for room & board and there is an error in one or more of the following fields on the UB-92 claim: Field No. 4, 6, 7, 22, 46, and/or 47.

**Edit 271 (Services Related to Terminal/Submit Charges to Hospice).** This edit is received when a non-hospice provider bills for services provided on dates the recipient was receiving hospice services.

## BILLING HOSPICE SERVICES ON THE UB-92

UB-92 instructions for completion of the **REQUIRED** Form Locators for Hospice services, as well as a sample claim form, follow.

**Field 1. (Untitled) - Provider Name, Address, and Telephone Number**

Required. The minimum entry is the provider's name, City, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. This information is used to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

**Field 4. Type of Bill**

Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure

<u>1st Digit</u>	<u>- Type of Facility</u>	
8	- Special facility (hospice)	
<u>2nd Digit</u>	<u>- Classification</u>	
1	- Hospice (Non-hospital based)	
2	- Hospice (Hospital based)	
<u>3rd Digit</u>	<u>- Frequency</u>	<u>Definition</u>
1	- Admit Through Discharge Claim	Use this code for a bill encompassing an entire course of hospice treatment for which you expect payment, i.e., no further bills will be submitted for this patient.
2	- Interim – First Claim	Use this code for the first of an expected series of payment bills for a hospice course of treatment.
3	- Interim – Continuing Claim	Use this code when a payment bill for a hospice course of treatment has been submitted and further bills are expected to be submitted.
4	- Interim – Final Claim	Use this code for a payment bill

which is the last of a series for a hospice course of treatment. The "Through" date of this bill (Field 6) is the discharge date or date of death.

- |   |                                |  |
|---|--------------------------------|--|
| 7 | - Replacement of Prior Claim   | Use this code to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.   |
| 8 | - Void/Cancel of a Prior Claim | This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. Submit a code "7" (Replacement of Prior Claim) to show the corrected information. |

**Field 6. Statement Covers Period (From-Through)**

Required. Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YYYY). Do not show days before the patient's entitlement began. The "From" date is used to determine timely filing. Be sure that the "From" date does not overlap with the "Through" date on your prior bill. A claim cannot span more than one month of service at a time.

**Field 12. Patient's Name**

Required. Enter the patient's last name, first name, and middle initial at the time services were rendered.

**Field 13. Patient's Address**

Required. Enter the patient's full mailing address, including street number and name, post office box number, city, state (2-digit alpha), and valid zip code (minimum of 5 digits).

**Field 14. Patient's Birth Date**

Required. Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, zero fill the field.

**Field 15. Patient's Sex**

Required. Enter an "M" for male or an "F" for female.

**Field 17. Admission Date**

Required. Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. On the first claim, the date of admission should match the From date in the Statement Covers Period (Field 6). The date of admission may not precede the physician's certification by more than 2 calendar days.

**Note: If the Notice of Election Form and the Certification of Terminal Illness are not received within 10 calendar days, the date of admission (election) will be the date that BHSF receives the proper documentation.**

EXAMPLE: The hospice election date (admission) is January 1, 2004. The physician's certification is dated January 10, 2004. The hospice admission date for coverage and billing is January 8, 2004. The first hospice benefit period will end 90 days from January 8, 2004.

Show the month, day, and year numerically as MM-DD-YYYY.

**Field 22. Patient Status**

Required (maximum of 2 digits). This code indicates the patient's status as of the "Through" date of the billing period (Field 6).

Code Structure

- 01 Discharged to home or self care (routine discharge).
- 30 Still patient or expected to return for outpatient services.
- 40 Expired at home.
- 41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice.
- 42 Expired - place unknown.

Verify that patient's status matches type of bill (Field 4).

Example: 811 or 821 bill types should have a patient status of 01, 40, 41, or 42.

**Fields 32, 33, 34, and 35. Occurrence Codes and Dates**

Required. Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YYYY). If there are more occurrences than there are spaces on the form, use Field 36 (occurrence span) or Field 84 (remarks) to record additional occurrences and dates.

Use the following codes where appropriate:

<u>Code</u>		<u>Definition</u>
27*	Date of Hospice Certification	Code indicates the date of written certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
42	Termination date	Enter code to indicate the date on which recipient terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.)

\* This occurrence code must be present in order to show when certification occurred for each new benefit period. If the occurrence code 27 with a date is not present for each certification or re-certification of an individual, the claim will reject.

Claims that are submitted between certifications or prior to the due date of the next certification do not require occurrence code 27. Any claim that starts a new hospice period or that contains services that overlap the next hospice period must show the occurrence code 27 and the re-certification date.

**Field 36. Occurrence Span Code and Dates**

Not Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY. Use the following code where appropriate:

<u>Code</u>	<u>Title</u>	<u>Definition</u>
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients.

Note: If more than 1 episode of Inpatient Respite Care occurred during the billing period, record those episodes beyond the first episode in Field 84. Remarks

**Fields 39-41. Value Code.**

Required. Hospices are required to submit claims for payment for hospice care based on the geographic location where the service(s) was provided. The Value Code and Metropolitan Statistical Area (MSA) code/rural state code for each service are required for correct claim payment. (The current MSA code listing is found at the end of this packet in Appendix A.)

Value codes must be entered horizontally across the line to match the corresponding revenue codes listed vertically in Field 42. In other words, enter fields 39a, 40a, 41a before fields 39b, 40b, 41b, and so forth. (The first line of “a” codes is used before entering information in “b” codes.) Enter value code 61 in the “code” section of the field; the MSA code/rural state code in the dollar portion of the “amount” section of the field; and double zeros (00) in the “cents” portion of the “amount” section of the field.

Multiple Occurrences of the Same Service: Enter the value codes/MSAs multiple times if there are multiple occurrences of the same service during the same month. (See further explanation under Fields 42 and 45.)

**Field 42. Revenue Code**

Required. 3-digit numeric. Assign a revenue code for each service provided in order to be paid properly. Revenue codes should be listed vertically in ascending order. If more than one (1) occurrence of any hospice service occurs during the billing period list each occurrence of that revenue code on a separate line in ascending order. (See field 45 for instructions for associated dates of service.)

Example:	651 Routine Home Care	07/01/04
	651 Routine Home Care	07/08/04
	652 Continuous Home Care	07/06/04
	656 General Inpatient Care	07/31/04

Use these revenue codes to bill Medicaid:

<b>Code</b>	<b>Description</b>	<b>Standard Abbreviation</b>
651	Routine Home Care	RTN Home
652	Continuous Home Care	CTNS Home (A minimum of 8 hours, <b>not necessarily consecutive</b> , in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is reported as 1 hour.)
655	Inpatient Respite Care	IP Respite
656	General Inpatient Care	GNP IP
657	Physician Services	PHY Ser ( <b>must be accompanied by a physician procedure code</b> )

**NOTE:** Revenue code 001 (Total Charges) MUST always be the final revenue code.

**Field 43.--Revenue Description**

Not Required. Enter a narrative description or standard abbreviation for each revenue code shown in Field 42 on the adjacent line in Field 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown under Field 42.

**Field 44. HCPCS Rates**

Required if applicable. When using Revenue Code 657 (Physician Services), enter the appropriate CPT-4 code for the physician's professional services. Procedure codes should be obtained from the physician providing the service and are required in order for the intermediary to make reasonable charge determinations when paying you for physician services.

**Field 45. Service Date**

Required. A service date MUST BE ENTERED for each revenue code indicated. The service date should be the first date that a service began.

Multiple Occurrences of the Same Service: If the same service occurs multiple times during a month of service (i.e., there is a break in the service dates for that service – not consecutive dates), that service must be entered multiple times on separate lines. In these cases, the initial date for that SEGMENT of that service should be used as the Service Date (see example under Field 42). In other words, if routine care is provided beginning the first day of the month of service for 5 days; the patient then has continuous care beginning the sixth day of the month for 2 days; followed by routine care again for the eighth day through the 30<sup>th</sup> of the month, the revenue code for routine care should be indicated twice – one entry with a service date of the first day of the month and one entry with a service date of the eight day of the month.

**Field 46. Units of Service**

Required. Enter the number of units of service for each type of service on the line adjacent to the revenue code, description, and service date.

Units of Revenue Code 651 (Routine Care) are measured in DAYS.

Units of Revenue Code 655 (Inpatient Respite Care) are measured in DAYS.

Units of Revenue Code 656 (General Inpatient Care) are measured in DAYS.

Units of Revenue Code 657 (Physician Service) are measured in PROCEDURES.

Units of Revenue Code 652 (Continuous Care) are measured in HOURS.

(Remember that a minimum of 8 hours—not necessarily consecutive—in a 24-hour period is required. Less than 8 hours is considered routine care.)

Please be sure that the units and dates billed for each occurrence match.

**Field 47. Total Charges**

Required. Enter the total charges for the billing period by revenue code (Field 42) on the adjacent line in Field 47. The last revenue code entered in Field 42 ("0001") represents the grand total of all charges billed. The total is in Field 47 on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

**Fields 50. Payer Identification**

Required. If Medicaid is the primary payer, enter "Medicaid" on line A.

**Field 51. Provider Number**

Required. Enter the seven (7) digit Medicaid provider identification number. It must be entered on the same line as "Medicaid" in Field 50.

**Field 54. Prior Payments**

Situational. If third party insurance is primary, enter the amount paid on this claim by TPL or 0 if nothing was paid.

**Field 60. Patients Medicaid ID Number**

Required. Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid "swipe" card, through e-MEVS or REVS. Make certain that the last two digits are the correct individual suffix for your recipient. If the number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.

**Field 62. Insurance Group No.**

Situational. If third party insurance is primary, enter the six-digit Louisiana-specific TPL carrier code assigned to the carrier in this field.

**Field 67. Principal Diagnosis Code**

Required. Use the most specific and accurate full ICD-9-CM diagnosis code for the terminal illness that is current. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. CMS only accepts ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260, or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Use full ICD-9-CM diagnoses codes including all five digits where applicable.

**Field 68-75. Other Diagnostic Codes**

(Required if applicable). Enter the full ICD-9-CM diagnosis codes, including all five digits where applicable, for any other terminal diagnoses or related conditions.

**Field 82. Attending Physician I.D.**

Required. Enter the seven (7) digit Medicaid provider identification number and name (last, first name and middle initial) of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.

**Field 83. Other Physician.**

Required. Enter the word "employee" or "non-employee" in reference to whether the attending physician entered in Field 82 is an employee of the hospice. If the attending physician volunteers for the hospice, he or she is considered an employee.

**Field 84. Remarks**

Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.

**Field 85-86. Provider Representative Signature and Date**

Required. A hospice representative verifies that the required physician's certification, and a signed hospice election statement are in the records before signing Form UB-92. A stamped signature is acceptable in field 85. Also enter the date the provider representative signed the form.

The UB-92 claim form is a proprietary form owned by the National Uniform Billing Committee (NUBC), and therefore cannot be provided by Unisys. Providers may purchase preprinted forms from most national form suppliers and office supply stores.

Your Hospice 200 Get Paid Drive Noreiects. LA 70000														2		3 PATIENT CONTROL NO.					4 TYPE OF BILL 813														
5 FED. TAX NO.														6 STATEMENT COVERS PERIOD FROM		7 COV D.		8 N-C.D.		9 C-I.D.		10 L-R.D.		11											
12 PATIENT NAME Sun, Maybell														13 PATIENT ADDRESS Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000																					
14 BIRTHDATE 01201919		15 SEX F		16 MS		17 DATE		ADMISSION 18 HR		19 TYPE		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO.		24		25		26		27		28		29		30		31	
32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		37		A		B		C		A		B		C		A		B		C			
a 27																																			
38														39 CODE		40 VALUE CODES AMOUNT		41 CODE		42 VALUE CODES AMOUNT		43 CODE		44 VALUE CODES AMOUNT		45		46		47		48		49	
a		b		c		d		a		b		c		d		a		b		c		d		a		b		c		d					
42 REV. CD.		43 DESCRIPTION										44 HCPCS / RATES		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49													
1		651 Routine Home Care														5		450:00		.		.													
2		651 Routine Home Care														23		900:00		.		.													
3		652 Continuous Home Care														16		300:00		.		.													
4		656 General Inpatient Care														1		200:00		.		.													
5		657 Physician Services														1		130:00		.		.													
6																		.		.															
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21																		.		.															
22																		.		.															
23																		.		.															
50 PAYER Medicaid														51 PROVIDER NO. 1234567		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56											
A														B		C		D		E		F		G											
57														DUE FROM PATIENT ▶																					
58 INSURED'S NAME														59 P. REL		60 CERT. - SSN - HIC. - ID NO. 1234567890123		61 GROUP NAME		62 INSURANCE GROUP NO.															
A														B		C		D		E		F		G											
63 TREATMENT AUTHORIZATION CODES														64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION																	
A														B		C		D		E		F		G											
67 PRIN. DIAG. CD. 9494		68 CODE		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD.		77 E-CODE		78													
79 P.C.		80		81		82		83		84		85		86		87		88		89		90													
PRINCIPAL PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE													
A				B				C				D				E				F															
84 REMARKS														82 ATTENDING PHYS. ID Dr. David Doe #7654321		83 OTHER PHYS. ID Employee A		84 OTHER PHYS. ID B		85 PROVIDER REPRESENTATIVE X Ima Biller		86 DATE 10312004													
a														b		c		d		e		f													

## ADJUSTMENTS AND VOIDS

Adjustments and voids must be submitted using the UB-92. Adjustment and/or voids are completed only for paid claims. Adjustments/Voids are identified through the third digit the bill type (Field No. 4). The value "7" in the third digit indicates a claim adjustment, and "8" in the third digit indicates a voided claim. When submitting an adjustment or void, the following additional information is required in Field No. 84 (Remarks) of the UB-92:

<b>UB-92 Field No. 84 (Remarks) Instructions for Adjustments/Voids</b>	
1. Enter an " A" for an adjustment or a " V "for a void.	
2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.	
3. Enter one of the appropriate reason codes:	
<u>Adjustments:</u> 01 - Third Party Liability Recovery 02 - Provider Correction 03 - Fiscal Agent Error 99 - Other—Please Explain	<u>Voids:</u> 10 - Claim Paid for Wrong Recipient 11 - Claim Paid for Wrong Provider 00 - Other
Examples:	
<u>Adjustment:</u> A 400012646500 02	<u>Void:</u> V 4000164253000 00

ST11843 1PLY UB-92

Your Hospice 200 Get Paid Drive Norejects, LA 70000		2	3 PATIENT CONTROL NO. <b>123456</b>		4 TYPE OF BILL <b>817</b>
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 10012004	6 STATEMENT COVERS PERIOD THROUGH 10312004	7 COV. D.	8 N-C.D.	9 C-I.D.
			10 L-R.D.	11	

12 PATIENT NAME Sun, Maybell	13 PATIENT ADDRESS Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000
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14 BIRTHDATE 01201919	15 SEX F	16 MS	17 DATE ADMISSION 10012004	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
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32 OCCURRENCE DATE 27	33 CODE 10012004	34 OCCURRENCE DATE	35 OCCURRENCE DATE	36 OCCURRENCE DATE	37 OCCURRENCE SPAN FROM THROUGH	A	B	C
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38	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	61	7680.00		.		.
b		.		.		.
c		.		.		.
d		.		.		.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	651 Routine Home Care		10012004	5	450.00	.	1
2					.	.	2
3					.	.	3
4					.	.	4
5					.	.	5
6					.	.	6
7					.	.	7
8					.	.	8
9					.	.	9
10					.	.	10
11	001 Total Charges				450.00	.	11
12					.	.	12
13					.	.	13
14					.	.	14
15					.	.	15
16					.	.	16
17					.	.	17
18					.	.	18
19					.	.	19
20					.	.	20
21					.	.	21
22					.	.	22
23					.	.	23

**\*\* Sample of Adjustment \*\***  
**(Correcting MSA Code)**

50 PAYER Medicaid	51 PROVIDER NO. 1234567	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
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**DUE FROM PATIENT**

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC - ID NO. 1234567890123	61 GROUP NAME	62 INSURANCE GROUP NO.
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63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
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67 PRIN. DIAG. CD. 9494	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	82 ATTENDING PHYS. ID Dr. David Doe	#1234566			
	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	83 OTHER PHYS. ID Employee				
							OTHER PHYS. ID				

84 REMARKS A 5012345678901 02	85 PROVIDER REPRESENTATIVE X Ima Biller	86 DATE 10312004
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# LONG TERM CARE ROOM AND BOARD

## REIMBURSEMENT

For hospice recipients residing in a Long Term Care (LTC) facility, including Nursing Facilities or ICF-MRs, Medicaid payment to the LTC facility for room and board is to be discontinued, and effective as of the date of the resident's hospice election, payment is made to the hospice to take into account the room and board furnished by the facility for a Medicaid recipient. The hospice must then reimburse the LTC facility for room and board. The Medicaid rate of reimbursement is 100 percent of the per diem rate that would have been paid to the LTC facility for that recipient, except that any Patient Liability Income (PLI) determined by the Bureau will be deducted from the payment amount. (It is the responsibility of the nursing facility or ICF-MR to collect the recipient's PLI.)

### Note:

- Hospice providers can obtain appropriate LTC facility per diem rates by contacting the Rates and Audit section at DHH.
- Patient Liability Income (PLI) can be obtained by contacting the recipient who has the PLI amount stated on their 18-LTC (Notice of Decision), or the parish office who issues eligibility for the recipient.

## Calculating Reimbursement

### Full Month

$$[(\text{Per diem rate} \times 365) \div 12] - \text{Patient liability} = \text{Payment}$$

### Partial Month

$$(\text{Per diem rate} \times \text{Number of days}) - A = \text{Payment},$$

Where  $A = [(\text{patient liability} \times 12) \div 365] \times \text{number of approved days}$

**(Round off numbers to the nearest penny.)**

## LEAVE DAYS

A leave day is an absence from the facility for a 24 hour period or more. A leave of absence is broken only when the recipient returns to the facility for at least a 24 hour period. All qualified leave days must be recorded on the Medicaid bill **except for Special Event Leave Days for recipients in an ICF-MR**. Patients are limited as to how many leave days Medicaid will pay for per year.

- Reported **home** leave days are paid at **100%** of the per diem for the LTC facility.
- Reported **hospital** leave days are paid at **75%** of the per diem for the LTC facility.

An individual's direct transfer from one institution to another does not change the number of home leave days allowed per calendar year if cared for in a nursing home or in an intermediate care facility for the handicapped.

Leave day limits do not exclude the recipient being **permitted** to take additional leave days. However, Medicaid **will not** pay for extra leave days. Arrangements for payment must be made with the recipient's responsible party. Such arrangements may include a charge by the facility to the family for the full Medicaid rate or for a reduced daily rate, or the facility may absorb the cost of non-covered days into its operating costs. **Except in the case where home leave days in an ICF-MR exceed 30 consecutive days; then, the recipient must be discharged on the 31<sup>st</sup> consecutive day of absence.**

## Leave Day Limits

### Home Leave Days

#### Nursing Facility

Recipients are limited to 15 days per **calendar year**.

#### ICF-MR Facility

Recipients are limited to 45 days per **State fiscal year**, not to exceed 30 consecutive days. The recipient must be discharged on the 31<sup>st</sup> consecutive day of absence.

### Hospital Leave Days

#### Nursing Facility

Recipients are limited to 7 days **per occurrence**.

#### ICF-MR Facility

Recipients are limited to 7 days **per occurrence**.

### Special Event Leave Days

#### ICF-MR Facilities ONLY

Leave days are also permitted under the following circumstances:

- Special Olympics
- Roadrunner sponsored events
- Louisiana planned conference
- Trial discharges

These special event leave days are limited to 30 consecutive days per occurrence. If the recipient is absent from the facility for more than 30 consecutive days, the facility should discharge the recipient.

These special event leave days are not deducted from the 45 home leave days allowed per fiscal year. These leave days must be included in the recipient's plan of care, but are not to be reported when billing.

## **NON-COVERED DAYS**

The date of discharge (except discharge due to death) is not covered by Medicaid.

## **BILLING**

Hospice providers bill for room and board using the UB-92 Form, regardless of the date of service. All supplemental billing must also be submitted on the UB-92 hard copy claim form.

**A separate claim for room and board is billed for each recipient for each calendar month of service.**

## **CLAIMS SUBMISSION SCHEDULE (ROOM AND BOARD ONLY)**

Claims for room and board are processed according to a predetermined schedule set by DHH and is updated every calendar year. This schedule includes deadlines for initial monthly claim submissions as well as for monthly supplemental claim submissions. Claims received after the published deadline will be held and processed. The LTC room and board monthly processing schedule for the year 2005 can be found in Appendix B.

**NOTE 1: Providers billing hardcopy claims should continue to submit the initial monthly UB-92 forms in one package and may be hand delivered or mailed to the following address:**

**Kay Brue  
Unisys LTC Unit  
8591 United Plaza Blvd. Ste: 300  
Baton Rouge, LA 70809**

# UP-92 CLAIM FORM INSTRUCTIONS FOR ROOM AND BOARD

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 1	PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER	<b>Required</b> Enter the provider's name, address, and phone number.
FIELD NO. 2	UNLABELED	Leave blank
FIELD NO. 3	PATIENT CONTROL NO.	<u>Situational.</u> A patient control number may be entered using letters and/or numbers and may be a maximum of 16 characters.
FIELD NO. 4	TYPE OF BILL	<p><b>Required</b> Enter the 3-digit code indicating the specific type of facility, bill classification and frequency. This 3-digit code requires one digit each, in the following format:</p> <ul style="list-style-type: none"> <li>• The first digit identifies the type of facility.</li> <li>• The second classifies the type of care.</li> <li>• The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.</li> </ul> <p><u>Code Structure:</u></p> <p><b>FOR HOSPICE PROVIDERS:</b> (Used for Nursing Facility Room and Board ONLY. <u>Do not use for billing hospice services.</u>)</p> <p><u>1st Digit - Type of Facility</u>            2 – Skilled Nursing (LOC = SNF/Hospice in Nursing Facility)            (LOC = ICF I/Hospice in Nursing Facility)</p> <p><u>2nd Digit - Classification</u>            7 – Subacute Inpatient Use for all service dates            (SNF/CASE MIX)</p> <p><u>3rd Digit – Frequency Definition</u></p>

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		<p>1 Admit Through Discharge Claim (Entire Claim) Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient.</p> <p>2 Interim - First Claim Use this code for the first of an expected series of claims for a course of treatment.</p> <p>3 Interim - Continuing Claim Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted.</p> <p>4 Interim - Final Claim Use this code for a claim that is the last claim. The "Through" date of this bill (Field 6) is the discharge date or date of death.</p> <p>7 Adjustment/ Replacement of Prior Claim Use this code to correct a previously submitted and paid claim.</p> <p>8 Void/Cancel of a Prior Claim Use this code to void a previously submitted and paid claim.</p>
FIELD NO. 5	FED. TAX NO.	Leave blank
FIELD NO. 6	STATEMENT COVERS PERIOD FROM/THROUGH	<b>Required</b> Enter the beginning and ending service dates of the period covered by this claim in numeric digits (MM-DD-YYYY).
FIELD NO. 7	COV D.	<b>Required</b> Enter the number of total covered days for the Statement Period. Covered days must equal the total number of units of service (Field 46) billed for level of care revenue codes.

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		Note: For discharge due to death, the covered days and the statement through date in Field 6 should include the date of death. For all other discharges, the number of covered days will be one less than the Statement Covers Period From/Through (Field 6) which should include the discharge day.
FIELD NO. 8	N-C D.	Leave blank
FIELD NO. 9	C-I D.	Leave blank
FIELD NO. 10	L-R D.	Leave blank
FIELD NO. 11	UNLABELED	Leave blank
FIELD NO. 12	PATIENT NAME	<b>Required</b> Enter the recipient's name (last name, first name, and middle initial) exactly as it appears on the recipient's Medicaid ID card.
FIELD NO. 13	PATIENT ADDRESS	Leave blank
FIELD NO. 14	BIRTHDATE	Leave blank
FIELD NO. 15	SEX	Leave blank
FIELD NO. 16	MS	Leave blank
FIELD NO. 17	ADMISSION DATE	<b>Required</b> Enter the recipient's admission date to the facility. Show the month, day, and year numerically as MM-DD-YYYY.
FIELD NO. 18	ADMISSION HR	Leave blank
FIELD NO. 19	ADMISSION TYPE	Leave blank
FIELD NO. 20	ADMISSION SRC	Leave blank
FIELD NO. 21	D HR	Leave blank
FIELD NO. 22	STAT	<b>Required (maximum of 2 digits)</b> This code indicates the patient's status as of the "Through" date of the billing period (Field 6).  <b>Code Structure:</b> 01 Discharged to home or self care (routine discharge)

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		<p>02 Discharged/transferred to another short-term general hospital for inpatient care</p> <p>03 Discharged/transferred to a skilled nursing facility (SNF)</p> <p>04 Discharged/transferred to an intermediate care facility (ICF)</p> <p>05 Discharged/transferred to another type of institution for inpatient care</p> <p>06 Discharged/transferred to home under care of organized home health services organization</p> <p>07 Left against medical advice or discontinued care</p> <p>08 Discharged/transferred to home under care of Home IV (Intravenous Therapy) provider</p> <p>09 Admitted as inpatient to a hospital</p> <p>20 Expired/Discharged Due to Death</p> <p>30 Still a patient</p> <p>61 Discharged/transferred within this institution to hospital-based Medicare approved swing-bed</p> <p>62 Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital</p> <p>63 Discharged/transferred to a long term care hospital</p>
FIELD NO. 23	MEDICAL RECORD NO.	<b>Situational</b> Facility may enter a patient's medical record number (up to 16 characters).
FIELD NO. 24 – 30	CONDITION CODES	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 31	UNLABELED	Leave blank
FIELD NO. 32 – 35	OCCURRENCE CODES/DATES	Leave blank
FIELD NO. 36	OCCURRENCE SPAN CODE, FROM/THROUGH	Leave blank
FIELD NO. 37A, B, C	UNLABELED	Leave blank
FIELD NO. 38	UNLABELED	Leave blank
FIELD NO. 39-41	VALUE CODES CODE (S)/AMOUNT	Leave blank
FIELD NO. 42-43	REV CD/DESCRIPTION	<p><b><u>Required. 3-digit numeric</u></b> Enter the applicable revenue code(s) and description(s) that identify the service provided. Bill a Level of Care (LOC) Revenue Code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill LA Medicaid:</p> <p><u>Revenue Code &amp; Description</u></p> <p><b>183</b> Leave of Absence – Subcategory Therapeutic <b>Home Leave</b></p> <p><b>185</b> Leave of Absence – Subcategory Nursing Home (for Hospitalization) <b>Hospital Leave</b></p> <p><b>FOR HOSPICE PROVIDERS:</b> <u>Revenue Code &amp; Description</u></p> <p>022 Skilled Nursing Facility Prospective Payment System (RUGS) (For Dates of Service 01/01/03 and after) (LOC 88 -Case Mix (Formerly LOC 20, 21, 22))</p>
FIELD NO. 44	HPCPS/RATES	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 45	SERV. DATE	<b>Required</b> A beginning and ending day of service (e.g., 01-31) <b>MUST BE ENTERED</b> for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided. (Example 1: If SNF PPS care (Revenue Code 022) is provided for the entire month of March, the Service Date should be entered 01-31. Example 2: If the recipient is on Hospital Leave (Revenue Code 185) from March 06 – 12, the Service Date should be entered 07-12, just as previously entered on the TAD.) <b>If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11).</b> (Note: The claim must reflect the total number of days billed at a particular Level of Care (LOC) corresponding to the Revenue Code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate Revenue Code for that LOC and the correct number of days indicated for that LOC for the month of service. <b>A Revenue Code indicating a specific LOC cannot be listed more than once.</b> )
FIELD NO. 46	SERV. UNITS	<b>Required</b> Enter in DAYS the number of units of service for each type of Level of Care service on the line adjacent to the Level of Care revenue code, description, and service date. (Example 1 above, Service Date 01-31 should indicate 31 units or days for Revenue Code 194. Example 2 above (Revenue Code 185), Service date 07-12, service units should be left blank.). <b>Do not enter the actual number of units when billing for home or hospital leave days, only indicate the from and to days in Field 45.</b>
FIELD NO. 47	TOTAL CHARGES	Leave blank
FIELD NO. 48	NON-COVERED CHARGES	Leave blank
FIELD NO. 49	UNLABELED	Leave blank
FIELD NO. 50	PAYER	<b>Required</b> Enter "Medicaid" on line "A".
FIELD NO. 51	PROVIDER NO.	<b>Required</b> Enter the facility's seven (7) digit Medicaid provider identification number on line "A".
FIELD NO. 52	REL INFO	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 53	ASG BEN	Leave blank
FIELD NO. 54	PRIOR PAYMENTS	<b>Situational</b> If third party insurance is primary, enter the amount paid on this claim by TPL or 0 if nothing was paid.
FIELD NO. 55	EST. AMOUNT DUE	Leave blank
FIELDS NO. 56/57	UNLABELED	Leave blank
FIELD NO. 58	INSURED'S NAME	Leave blank
FIELD NO. 59	P REL	Leave blank
FIELD NO. 60	CERT. – SSN. – HIC. – ID NO.	<b>Required</b> Enter the recipient's 13-digit Medicaid ID number.
FIELD NO. 61	GROUP NAME	Leave blank
FIELD NO. 62	INSURANCE GROUP NO.	<b>Situational</b> If third party insurance is primary, enter the six-digit Louisiana-specific TPL carrier code assigned to the carrier in this field.
FIELD NO. 63	TREATMENT AUTHORIZATION CODES	Leave blank
FIELD NO 64	ESC	Leave blank
FIELD NO. 65	EMPLOYER NAME	Leave blank
FIELD NO. 66	EMPLOYER LOCATION	Leave blank
FIELD NO. 67	PRIN. DIAG. CD.	<b>Required</b> Enter the ICD-9-CM diagnosis code for the principal diagnosis.
FIELD (S) NO. 68-75	OTHER DIAG CODES	<b>Situational</b> Enter the ICD-9-CM diagnosis codes for any other applicable diagnoses.
FIELD NO. 76	ADM DIAG CD	Leave blank
FIELD NO. 77	E – CODE	Leave blank
FIELD NO. 78	UNLABELED	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 79	P.C.	Leave blank
FIELD NO. 80	PRINCIPAL PROCEDURE CODE/DATE	Leave blank
FIELD NO. 81	OTHER PROCEDURE CODE/DATE	Leave blank
FIELD NO. 82	ATTENDING PHYS. ID	Leave blank
FIELD NO. 83	OTHER PHYS. ID	Leave blank
FIELD NO. 84	REMARKS	<p><b><u>Situational</u></b> Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.</p> <p><b><u>For Adjustment/Void Claims:</u></b></p> <ol style="list-style-type: none"> <li>1. Enter an " A" for an adjustment or a " V "for a void.</li> <li>2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.</li> <li>3. Enter one of the appropriate reason codes:</li> </ol> <p style="text-align: center;"><b><u>Adjustments:</u></b></p> <p style="text-align: center;">01 - Third Party Liability Recovery 02 - Provider Correction 03 - Fiscal Agent Error 99 - Other - Please Explain</p> <p style="text-align: center;"><b><u>Voids:</u></b></p> <p style="text-align: center;">10 - Claim Paid for Wrong Recipient 11 - Claim Paid for Wrong Provider 00 - Other</p> <p><b><u>Examples:</u></b></p> <p style="padding-left: 40px;">Adjustment:   A                           4184562646500                           02</p> <p style="padding-left: 40px;">Void:                V                           4205164253000                           00</p>
FIELD NO. 85	PROVIDER REPRESENTATIVE	<b><u>Required</u></b> Enter the signature of the appropriate person at the facility who is authorized to submit Medicaid claims. (Stamped signatures must be initialed.)

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 86	DATE	<b>Required</b> Enter the date the claim was signed. The date should be in valid MMDDYY format and should be greater than the through date in Form Locator 6.





Your Hospice 200 Get Paid Drive Norejects, LA 70000												2		3 PATIENT CONTROL NO.					4 TYPE OF BILL 274																
5 FED. TAX NO.												6 STATEMENT COVERS PERIOD FROM 10012004		7 COV D. 10		8 N-C.D.		9 C-I.D.		10 L-R.D.		11													
12 PATIENT NAME Skywalker, Luke												13 PATIENT ADDRESS Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000																							
14 BIRTHDATE		15 SEX		16 MS		17 DATE		18 HR		19 TYPE		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO.		24		25		26		27		28		29		30		31	
32 OCCURRENCE CODE		33 OCCURRENCE DATE		34 OCCURRENCE CODE		35 OCCURRENCE DATE		36 OCCURRENCE CODE		37 OCCURRENCE DATE		38 OCCURRENCE CODE		39 OCCURRENCE DATE		40 OCCURRENCE CODE		41 OCCURRENCE DATE		42 OCCURRENCE CODE		43 OCCURRENCE DATE		44 OCCURRENCE CODE		45 OCCURRENCE DATE		46 OCCURRENCE CODE		47 OCCURRENCE DATE		48 OCCURRENCE CODE		49 OCCURRENCE DATE	
50 PAYER Medicaid												51 PROVIDER NO. 1234567		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56													
57												<b>DUE FROM PATIENT</b>																							
58 INSURED'S NAME												59 P. REL		60 CERT. - SSN - HIC. - ID NO. 1234567890123		61 GROUP NAME		62 INSURANCE GROUP NO.																	
63 TREATMENT AUTHORIZATION CODES				64 ESC		65 EMPLOYER NAME				66 EMPLOYER LOCATION																									
67 PRIN. DIAG. CD. 150		68 CODE		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD.		77 E-CODE		78													
79 P.C. 80		81 OTHER PROCEDURE CODE		82 OTHER PROCEDURE CODE		83 OTHER PROCEDURE CODE		84 OTHER PROCEDURE CODE		85 OTHER PROCEDURE CODE		86 OTHER PROCEDURE CODE		87 OTHER PROCEDURE CODE		88 OTHER PROCEDURE CODE		89 OTHER PROCEDURE CODE		90 OTHER PROCEDURE CODE		91 OTHER PROCEDURE CODE													
84 REMARKS												85 PROVIDER REPRESENTATIVE X <i>Ima Biller</i>		86 DATE																					

**\*\* Sample of Patient Death \*\***

## ADJUSTMENTS AND VOIDS

### CLAIM ADJUSTMENTS/VOIDS USING THE UB-92 FORM

LTC adjustments and voids must be submitted using the UB-92 claim form. Adjustment and/or voids are completed only for paid claims. Adjustments/Voids are identified through the third digit the bill type (Field No. 4). The value "7" in the third digit indicates a claim adjustment, and "8" in the third digit indicates a voided claim. When submitting an adjustment or void, the following additional information is required in Field No. 84 (Remarks) of the UB-92:

<b>UB-92 Field No. 84 (Remarks) Instructions for Adjustments/Voids</b>	
1. Enter an " A" for an adjustment or a " V "for a void.	
2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.	
3. Enter one of the appropriate reason codes:	
<u>Adjustments:</u> 01 - Third Party Liability Recovery 02 - Provider Correction 03 - Fiscal Agent Error 99 - Other—Please Explain	<u>VOIDS:</u> 10 - Claim Paid for Wrong Recipient 11 - Claim Paid for Wrong Provider 00 - Other
Examples:	
<u>Adjustment:</u> A 400012646500 02	<u>Void:</u> V 4000164253000 00

### CLAIM ADJUSTMENT FORM 148 (PATIENT LIABILITY)

LTC adjustments billed when the recipient's patient liability is changed retroactively are processed as 148/PLI adjustments. The Adjustment Reason Code included on this form is necessary to process these claims and calculate reimbursement correctly. This claim form will continue to be used with no changes in the submission process.

- NOTE:** (1) The Patient Status Code (block 12) should be the HIPAA standard 2-digit status codes found in this Provider Manual under the billing instructions for Room and Board (Field 22).
- (2) The Level of Care (Block 5) should continue to indicate the locally assigned LOC Code 88 as opposed to the revenue code entered on the UB-92 form.

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS  
BUREAU OF HEALTH SERVICES FINANCING

MAIL TO:  
UNISYS  
P.O. BOX 91021  
BATON ROUGE, LA 70821  
(800) 737-8647  
924-5040 (IN BATON ROUGE)

LONG TERM CARE  
PATIENT LIABILITY ADJUSTMENT FORM

FOR OFFICE USE ONLY

TO: Medical Assistance

FROM: ABC Provider

1 PROVIDER NO. <b>1234567</b>			2 RECIPIENT I.D. NUMBER <b>4004004001213</b>		3 RECIPIENT LAST NAME <b>Holden</b>		4 FIRST NAME <b>Hugh</b>	
5 LEVEL OF CARE <b>88</b>			6 INITIATED BY <input checked="" type="checkbox"/> FACILITY <input type="checkbox"/> PARISH OFS					
7 FROM DATE OF SERVICE	8 TO DATE OF SERVICE	9 TOTAL DAYS	10 CONTROL NUMBER	11 CORRECT PATIENT LIABILITY	12 STATUS	SDC OFFICE USE ONLY		
<b>10012004</b>	<b>10312004</b>	<b>31</b>	<b>3000008100000</b>	<b>\$175.00</b>	<b>30</b>			

ADJUSTMENT

AUTHORIZED SIGNATURES

13. FACILITY Jane Friday      DATE 11152004

14. PARISH OFS \_\_\_\_\_      DATE \_\_\_\_\_

FISCAL AGENT COPY

UNISYS 148/PLJ

<b>Your Hospice</b> 2246 Cypress Lane Rain Forest, LA 71111 Sun, Maybell		2		3 PATIENT CONTROL NO. 123456		APPROVED OMB NO. 0900-0029 277	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM TO		7 COV B.		8 N.C.D.	
01012004		01312004		031			
13 PATIENT ADDRESS 625 Coulee Bend, Franklin, LA 70000							
14 BIRTHDATE 0127194		15 SEX M		16 ADMISSION DATE 30		21 D.H.I.	
32 OCCURRENCE DATE		34 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 CONDITION CODES	
42 REV. CD.		43 DESCRIPTION		44 HQCS/RATES		45 SERV. DATE	
022		Case/Mix				01-31	
185		Hospital Leave				031	
						06-12	
50 PAYER		51 PROVIDER NO.		52 PRC ID AND INFO		54 PRIOR PAYMENTS	
Medicaid		1644468				TPL Amt if needed	
57 DUE FROM PATIENT ▶							
58 INSURED'S NAME		59 PRC		60 CERT. - SSN - HLD. - ID NO.		61 GROUP NAME	
Sun, Maybell		01		1234567890123		TPL Carrier Code if applicable	
63 TREATMENT AUTHORIZATION CODES		64 ICD		66 EMPLOYER NAME		68 EMPLOYER LOCATION	
67 PRCAL DIAG. CD.		69 CODE		70 CODE		OTHER DIAG. CODES	
150							
79 P.C.		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID	
84 REMARKS		85 OTHER PROCEDURE CODE DATE		86 OTHER PROCEDURE CODE DATE		87 OTHER PHYS. ID	
A							
4000345678901							
02							
88 PROVIDER'S REPRESENTATIVE		89 DATE		90 DATE		91 DATE	
X <i>Clare Belle</i>		10102004					

**Sample Adjustment  
(Adjusting to reflect Hospital  
Leave Days)**

**A**  
**4000345678901**  
**02**

# **APPENDIX A**

## **LTC Monthly Processing Schedule**

## APPENDIX A – LTC MONTHLY PROCESSING SCHEDULE



October 5, 2004

**TO: LONG TERM CARE PROVIDERS**

Listed below is the LTC MONTHLY PROCESSING SCHEDULE FOR THE YEAR 2005. THIS SCHEDULE REPRESENTS THE ONE TO BE FOLLOWED SINCE THE IMPLEMENTATION OF DIRECT DEPOSIT OF PROVIDER PAYMENT BEGINNING WITH THE CHECK WRITE DATED 02/10/98. DIRECT DEPOSIT OF PAYMENTS MEANS FASTER ACCESS TO FUNDS.

**NOTE:** It is VERY IMPORTANT that your UB92 claim form is submitted to Unisys no later than the scheduled deadline for billing (EMC/ UB92 CLAIMS RECEIVED AT UNISYS) in order to receive payment on the “check release (issue) date” shown on the schedule below. If your billing is received at Unisys after the deadline & if the regular monthly LTC check write is missed, the billing will be processed for payment with the next regular check write. IF POSSIBLE SEND YOUR UB-92 CLAIMS VIA FEDERAL EXPRESS OR OVERNIGHT MAIL Once a provider is on direct deposit and paid in the regular check write, the funds will be available on the working day after the normal Tuesday check write date.

UB92 CLAIMS RECEIVED AT UNISYS	CHECK RELEASE (ISSUE) DATE	DAY	DIRECT DEPOSIT FUNDS AVAILABLE DATE	DAY
01/07/2005 12Noon	01/11/2005	Tuesday	01/12/2005	Wednesday
02/10/2005 12Noon	02/14/2005	Monday	02/15/2005	Tuesday
03/10/2005 12Noon	03/14/2005	Monday	03/15/2005	Tuesday
04/08/2005 12Noon	04/12/2005	Tuesday	04/13/2005	Wednesday
05/06/2005 12Noon	05/10/2005	Tuesday	05/11/2005	Wednesday
06/09/2005 12Noon	06/13/2005	Monday	06/14/2005	Tuesday
07/08/2005 12Noon	07/12/2005	Tuesday	07/13/2005	Wednesday
08/05/2005 12Noon	08/09/2005	Tuesday	08/10/2005	Wednesday
09/08/2005 12Noon	09/12/2005	Monday	09/13/2005	Tuesday
10/07/2005 12Noon	10/11/2005	Tuesday	10/12/2005	Wednesday
11/10/2005 12Noon	11/14/2005	Monday	11/15/2005	Tuesday
12/08/2005 12Noon	12/13/2005	Tuesday	12/14/2005	Wednesday

**YEAR 2005**  
**LTC SUPPLEMENTAL / LATE TAD/ UB-92 BILLING SCHEDULE**

<b>UB92'S RECEIVED AT UNISYS</b>	<b>DAY</b>	<b>CHECK RELEASE (ISSUE) DATE</b>	<b>DAY</b>	<b>DIRECT DEPOSIT FUNDS AVAILABLE</b>	<b>DAY</b>
<b><u>JANUARY</u></b>					
01/13/2005- 12NOON	THURSDAY	01/18/2005	TUESDAY	01/19/2005	WEDNESDAY
01/20/2005- 12NOON	THURSDAY	01/25/2005	TUESDAY	01/26/2005	WEDNESDAY
<b><u>FEBRUARY</u></b>					
02/17/2005- 12NOON	THURSDAY	02/22/2005	TUESDAY	02/23/2005	WEDNESDAY
<b><u>MARCH</u></b>					
03/17/2005- 12NOON	THURSDAY	03/22/2005	TUESDAY	03/23/2005	WEDNESDAY
<b><u>APRIL</u></b>					
04/14/2005- 12NOON	THURSDAY	04/19/2005	TUESDAY	04/20/2005	WEDNESDAY
04/21/2005- 12NOON	THURSDAY	04/26/200 5	TUESDAY	04/27/2005	WEDNESDAY
<b><u>MAY</u></b>					
05/12/2005- 12NOON	THURSDAY	05/17/2005	TUESDAY	05/18/2005	WEDNESDAY
05/19/2005- 12NOON	THURSDAY	05/24/2005	TUESDAY	05/25/2005	WEDNESDAY
<b><u>JUNE</u></b>					
06/16/2005- 12NOON	THURSDAY	06/21/2005	TUESDAY	06/22/2005	WEDNESDAY
06/23/2005- 12NOON	THURSDAY	06/28/2005	TUESDAY	06/29/2005	WEDNESDAY
<b><u>JULY</u></b>					
07/14/2005- 12NOON	THURSDAY	07/19/2005	TUESDAY	07/20/2005	WEDNESDAY
07/21/2005- 12NOON	THURSDAY	07/26/2005	TUESDAY	07/27/2005	WEDNESDAY
<b><u>AUGUST</u></b>					
08/11/2005- NOON	THURSDAY	08/16/2005	TUESDAY	08/17/2005	WEDNESDAY
08/18/2005- NOON	THURSDAY	08/23/2005	TUESDAY	08/25/2005	WEDNESDAY
<b><u>SEPTEMBER</u></b>					
09/15/2005- NOON	THURSDAY	09/20/2005	TUESDAY	09/21/2005	WEDNESDAY
09/22/2005- NOON	THURSDAY	09/27/2005	TUESDAY	09/28/2005	WEDNESDAY
<b><u>OCTOBER</u></b>					
10/13/2005- NOON	THURSDAY	10/18/2005	TUESDAY	10/19/2005	WEDNESDAY
10/20/2005- NOON	THURSDAY	10/25/2005	TUESDAY	10/26/2005	WEDNESDAY
<b><u>NOVEMBER</u></b>					
11/17/2005- NOON	THURSDAY	11/22/2005	TUESDAY	11/28/2005	WEDNESDAY
<b><u>DECEMBER</u></b>					
12/15/2005- NOON	THURSDAY	12/20/2005	TUESDAY	12/21/2005	WEDNESDAY
12/22/2005- NOON	THURSDAY	12/27/2005	TUESDAY	12/28/2005	WEDNESDAY

