



***EPSDT HEALTH 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.

\*\*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 and [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)**.

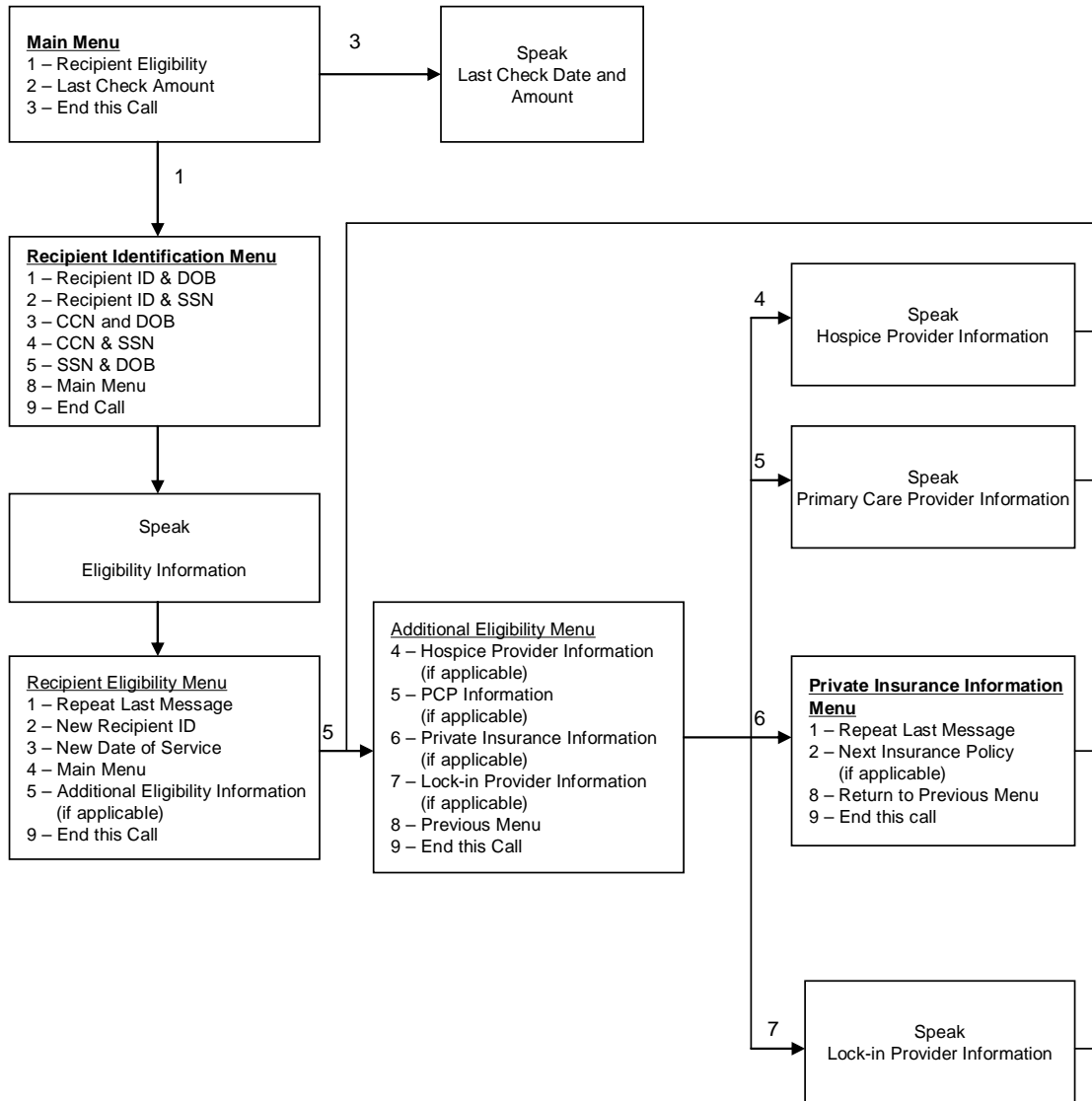
### Accessing REVS

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.

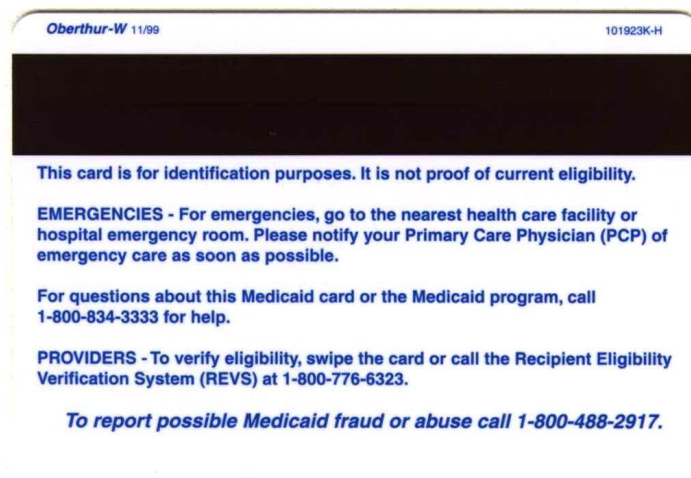
### **Accessing e-MEVS**

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

- 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	

- EPSDT medical, vision, and hearing screening services (KIDMED screening services);
- EPSDT dental services;
- EPSDT services to children with special needs (formerly referred to as school health services) which result from screening and are rendered by school boards;
- 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).
- 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 style="text-align: center;"><b>Medicaid Provider No. (7 digits)</b> (Optional Control Number)</p> <p style="text-align: center;">Services have been provided under Louisiana's Medicaid Program and are payable under R.S. 46:446:1 to:</p> <p style="text-align: center;">DHH Bureau of Health Services Financing P.O. Box 91030 Baton Rouge, LA 70821-9030 ATTN: Third Party Liability Unit</p> <p style="text-align: center;">Any additional authorization needed may be obtained from DHH/BHSF's TPL Unit at (225)342-9250.</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 (Formerly Pure QMB)	Identified through the REVS and e-MEVS systems and are eligible only for Medicaid payment of deductibles and coinsurance for all Medicare covered services.
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 on-line. This process allows the Unisys Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

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

- Submit an original claim form whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.
- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.
- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. DO NOT use a highlighter to draw attention to specific information.
- Paper claims must be legible and in good condition for scanning into our document imaging system.
- Sign and date the claim form. Unisys will accept stamped or computer-generated signatures, 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.





RECIPIENT NUMBER (MEDICAL RECORDS NO.)	RECIPIENT NAME	DATES OF SERVICE		UNITS	PROCEDURE/ACCOMMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	MEDICAL CONTROL NUMBER
		FROM	THRU							
11 02 01 51	LAEMG PH	05 05 11	05 11 05	1	1 85661 51 ARTERY BYPASS GRAFT 850 996	323000	300	300	300	1 '07 1
34 38 01 59	TA )/	06 07 05	06 07 05	1	1 89212 24 CONFLICTING CONTROL M 15801	6500	6500	ADJUDICATION DATE:2005 705	300	1 '51 0
24 89 70 72	VE )/	06 10 05	06 10 05	1	1 89232 847 SISQMT MUST, XPADED,MOO	11500	300	300	300	1 '140 3
91 81 57 72	WA )/	07 08 05	07 08 05	1	1 89213 847 CONFLICTING CONTROL NO	9000	300	ADJUDICATION DATE:2005 809	300	1 '103 0
61 90 03 71	WE )/	06 20 05	06 20 05	1	1 21010 26 X-RAY CHEST; POSTEROANTE 847	2120	200	300	300	1 '171 2
34 68 01 58	WH PH	05 21 04	05 21 04	1	1 89252 267 CONFLICTING CONTROL NO	14700	300	ADJUDICATION DATE:2005 802	300	1 '103 0
11 51 62 72	WE )/	06 17 05	06 17 05	1	1 89204 807 OFFICE,HEM PT, COMPREHEN	23200	300	300	300	1 '103 0
24 56 20 72	JA )/	01 17 05	01 17 05	1	1 89214 799	13500	300	300	300	1 '100 0
52 15 01 58	MC )/	06 20 03	06 20 03	1	1 73510 RT 799	10500	300	300	300	1 '100 0
01 27 59 08	RE )/	02 18 05	02 18 05	1	1 89214 799	13500	300	300	300	1 '100 0
000	CLAI			1	44 CLAIMS	1700000	00	00	00	
34 38 01 59	CU )/	04 11 02 04	04 11 02 04	1	1 50360 280 HOMO TRANSPLANT/IMPLANT G	490200	300	300	300	1 '05 0
34 38 01 59	CU )/	04 11 02 04	04 11 02 04	1	1 50200 897 BIOPSY OF KIDNEY	41800	300	300	300	1 '05 1
31 37 30 70	IV PH	05 05 12 05	05 05 12 05	1	1 89213 293 CONFLICTING CONTROL NO.	9000	300	ADJUDICATION DATE:2005 802	300	1 '15 0
34 67 01 59	RE )/	05 05 04 05	05 05 04 05	1	1 89213 293	9000	300	300	300	1 '05 0
34 28 01 59	ST )/	05 05 25 05	05 05 25 05	1	1 89213 266	9000	300	300	300	1 '03 0
34 83 01 70	YG PH	05 01 18 05	05 01 18 05	1	1 89213 293	9000	300	300	300	1 '06 0
000	TOTALS				6 CLAIMS	588400	00	00	00	



PROFESSIONAL REMITTANCE ADVISE  
LOUISIANA MEDICAL ASSISTANCE PROGRAM  
FISCAL AGENT - UNISTS  
BATON ROUGE, LOUISIANA, 70821

RECIPIENT NUMBER INTERNAL RECORD NO.	RECIPIENT NAME	DATE OF SERVICE		UNITS	PROCEDURE ABBREVIATION DMO CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	REVISIONS	AMOUNT PAID	MEDICAL CONTROL NUMBER
		FROM	THRU							
1	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
6400	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1100	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
3604	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
5741	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1161	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1161	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
TOTALS										
1	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
4414	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
3241	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
5204	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
6841	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
3462	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
3462	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
3634	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
2608	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
5104	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2
1033	WJ	05/05/04	05/04/05	1	99212	11000	4250		4250	091 91 2



# 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

<b>ERROR CODE 201 – PROVIDER NOT ELIGIBLE ON DATES OF SERVICE</b>
<b>Cause:</b> 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.
<b>Resolution:</b> 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.
<b>Note: Providers must be enrolled as</b> Medicaid providers in order to be reimbursed by Medicaid.

<b>ERROR CODE 206 – BILLING PROVIDER NOT ON FILE</b>
<b>Cause:</b> The billing provider number entered on the claim form is not on the State provider files.
<b>Resolution:</b> 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.
<b>Note:</b> 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	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

# EPSDT HEALTH SERVICES

EPSDT Health Services for children with disabilities include health-related special education services and may only be provided by local school boards for children ages three (3) to 21, and by Early Intervention Centers or the Part C Program for children from birth to age three (3). All EPSDT Health Services must be included on the child's individualized education program (IEP) or individualized family services plan (IFSP).

## PROGRAM REQUIREMENTS

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

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

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

Again, this information must be supplied to the recipient and/or caregiver at the time the IEP or IFSP is developed.

## School Boards (Ages 3 to 21)

School boards may provide the following services for children ages three (3) to twenty-one (21):

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

**PLEASE NOTE:** A written referral or prescription is no longer required from a licensed physician to provide speech pathology services. However, speech pathology services must still be included in a student's IEP in order to be reimbursed by Medicaid.

## **EARLY Intervention Centers/Part C Program**

An infant or toddler (under the age of 3) who meets or may meet the medical or biological eligibility criteria of the Early Intervention/Part C program of the state providing services must be referred to that state's Early Intervention/Part C program. Encouraging the recipient to enroll in the Medicaid program of the state providing services is one option for continued service in the Early Intervention/Part C program. For information on Louisiana's Part C/Early Intervention program, **Early Steps**, contact: (866)327-5978.

## **PROGRAM REQUIREMENTS FOR REIMBURSEMENT**

EPSDT Health Services program requirements for reimbursement are:

- All services must be furnished in the interest of establishing or modifying a child's individualized education program (IEP) or an infant or toddler's individualized family services plan (IFSP) or the services furnished must already be included in the current IEP or IFSP. ***Non-IEP or non-IFSP services may not be billed to Medicaid under the EPSDT Health Services program.***
- Only local education agencies (school boards) are eligible to enroll for children ages three (3) and above.
- Both public and private early intervention centers may enroll directly with Medicaid as providers of these services for infants and toddlers under age three.
- These services must be coordinated with other age appropriate preventive health services.
- These EPSDT services must also be coordinated with the Supplemental Food Program for Women, Infants, and Children (WIC) and Head Start. Make age-appropriate referrals for these services.
- Employ or contract with professional staff qualified to provide the services that meet state and Medicaid practitioner standards regarding certification, licensure, and supervision.
- Medicaid payments from these services must be spent on the provision of health related services to children regardless of their Medicaid status.
- Expenditures should be prioritized for expanding service delivery through additional employed or contracted staff before allocating funds for equipment and supplies, administrative support activities, capital improvements, or meeting the individual needs of children with disabilities.
- Medicaid funds may not be used for strictly educational or non-medical purposes.

## EPSDT HEALTH SERVICES PROCEDURE CODES

The following chart lists the codes most commonly billed by EPSDT Health Services providers:

Procedure Code	Description	Fee
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility; approximately 20 – 30 minutes face to face with the patient	\$22.50
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45-50 minutes face to face with the patient	\$45.00
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, approximately 20-30 minutes face to face with patient	\$22.50
90812	Individual psychotherapy, interactive, using play equipment, physical device, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, approx 45-50 minutes face to face with the patient	\$45.00
90846	Family psychotherapy( w/o Patient)	\$22.50
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	\$22.50
90853	Group psychotherapy (other than of a multiple family group)	\$22.50
90857	Interactive group psychotherapy	\$22.50
92506	Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation status	\$45.00
92507	Treatment of speech, language, voice, communication and/or auditory processing disorder (includes aural rehabilitation); individual	\$7.50
92508	Treatment of speech, language, voice, communication and/or auditory processing disorder (includes aural rehabilitation); group, 2 or more individuals	\$7.50
92551	Screening test, pure tone, air only	\$3.60
92552	Pure tone audiometry (threshold), air only.	\$22.50
92553	Pure tone audiometry (threshold), air and bone.	\$45.00
92555	Speech audiometry threshold	\$9.00
92556	Speech audiometry threshold ; with speech recognition	\$22.50
92557	Comprehensive audiometry, threshold evaluation and speech recognition	\$54.00
92563	Tone decay test	\$10.00
92564	Short increment sensitivity index (SISI)	\$20.00
92565	Stenger test, pure tone	\$15.00
92567	Tympanometry (impedance testing)	\$22.50
92568	Acoustic reflex testing	\$22.50
92569	Acoustic reflex decay test	\$36.00
92571	Filtered speech test	\$25.00
92572	Staggered spondaic word test	\$75.00
92575	Sensorineural acuity level test	\$20.00
92576	Synthetic sentence identification test	\$25.00
92577	Stenger test, speech	\$13.50
92582	Conditioning play audiometry	\$45.00

92583	Select picture audiometry	\$22.50
92584	Electrocochleography	\$200.00
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	\$180.00
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the CNS; limited	\$50.00
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	\$25.00
92588	Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	\$50.00
92590	Hearing aid exam and selection, monaural	\$65.00
92591	Hearing aid exam and selection, binaural	\$65.00
92592	Hearing aid check, monaural	\$22.50
92593	Hearing aid check, binaural	\$45.00
92594	Electroacoustic evaluation for hearing aid, monaural	\$22.50
92595	Electroacoustic evaluation for hearing aid, binaural	\$45.00
96100	Psychological Testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour	\$76.50
97001	Physical Therapy evaluation	\$54.00
97003	Occupational Therapy Evaluation	\$51.00
97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes	\$10.00
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	\$10.00
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities	\$10.00
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	\$20.00
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effeurage, petrissage, and/or tapotement (stroking, compression, percussion, etc.)	\$10.00
97504	Orthotic(s) fitting and training upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes	\$8.00
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance); each 15 minutes	\$8.00
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	\$8.00

- Reimbursement Fees as of August 27, 2005 and subject to change.

## CLAIMS FILING

EPSDT services are billed hardcopy on the CMS-1500 (formerly known as HCFA-1500) claim form.

Items to be completed are either required or situational. Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. Situational information may be required (but only in certain circumstances as detailed in the instructions below). Claims should be submitted to:

Unisys  
P.O. Box 91020  
Baton Rouge, LA 70821

- |      |             |   |
|------|-------------|---|
| 1.   | REQUIRED    | Enter an "X" in the box marked Medicaid (Medicaid #).   |
| *1A. | REQUIRED    | Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using REVS or e-MEVS.   |
|      |             | <b>NOTE: The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable.</b>   |
|      |             | <b>NOTE: If the 13-digit Medicaid ID number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.</b>  |
| *2.  | REQUIRED    | Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through e-MEVS or REVS.  |
| 3.   | SITUATIONAL | Enter the recipient's date of birth as reflected in the current Medicaid information available through e-MEVS or REVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "x" in the appropriate box to show the sex of the recipient. |
| 4.   | SITUATIONAL | Complete correctly if appropriate or leave blank.   |
| 5.   | SITUATIONAL | Print the recipient's permanent address.  |
| 6.   | SITUATIONAL | Complete if appropriate or leave blank.   |
| 7.   | SITUATIONAL | Complete if appropriate or leave blank.   |
| 8.   | SITUATIONAL | Leave blank.  |
| 9.   | SITUATIONAL | Complete if appropriate or leave blank.   |

9A.	SITUATIONAL	If recipient has no other coverage, leave blank. If there is other coverage, put the state assigned 6-digit TPL carrier code in this block-make sure the EOB is attached to the claim.
9B.	SITUATIONAL	Complete if appropriate or leave blank.
9C.	SITUATIONAL	Complete if appropriate or leave blank.
9D.	SITUATIONAL	Complete if appropriate or leave blank.
10.	SITUATIONAL	Leave blank.
11.	SITUATIONAL	Complete if appropriate or leave blank.
11A.	SITUATIONAL	Complete if appropriate or leave blank.
11B.	SITUATIONAL	Complete if appropriate or leave blank.
11C.	SITUATIONAL	Complete if appropriate or leave blank.
12.	SITUATIONAL	Complete if appropriate or leave blank.
13.	SITUATIONAL	Obtain signature if appropriate or leave blank.
14.	SITUATIONAL	Leave blank.
15.	SITUATIONAL	Leave blank.
16.	SITUATIONAL	Leave blank.
17.	SITUATIONAL	Leave blank.
17A.	SITUATIONAL	Leave blank.
18.	SITUATIONAL	Leave blank.
19.	SITUATIONAL	Leave blank.
20.	SITUATIONAL	Leave blank.
*21.	REQUIRED	Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.
22.	SITUATIONAL	Leave blank.
23.	SITUATIONAL	Complete if required or leave blank.

*24A.	REQUIRED	Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.
*24B.	REQUIRED	Enter the appropriate code from the approved Medicaid Place of Service code list.
24C.	SITUATIONAL	Leave blank.
*24D.	REQUIRED	Enter the procedure code(s) for services rendered.
*24E.	REQUIRED	Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a "1", "2", etc. More than one diagnosis may be related to a procedure. Do not enter the ICD-9-CM diagnosis code.
*24F.	REQUIRED	Enter usual and customary charges for the service rendered.
*24G.	REQUIRED	Enter the number of units billed for the procedure code entered on the same line in 24D.
24H.	SITUATIONAL	Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.
24I.	SITUATIONAL	Leave blank.
24J.	SITUATIONAL	Leave blank.
24K.	SITUATIONAL	Leave blank.
25.	SITUATIONAL	Leave blank.
26.	SITUATIONAL	Enter the provider specific information assigned to identify the patient. This number will appear on the Remittance Advice(RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.
27.	SITUATIONAL	Leave blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.
*28.	REQUIRED	Total of all charges listed on the claim.
29.	SITUATIONAL	If block 9A is completed, indicate the amount paid; otherwise, leave blank.
30.	SITUATIONAL	If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from billed charges.

- \*31.     **REQUIRED**                    The claim form **MUST** be signed. The practitioner is not required to sign the claim form. However, the practitioner's authorized representative must sign the form. Signature stamps or computer generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned unprocessed.
- Date                            Enter the date of the signature.
32.     **SITUATIONAL**                Complete as appropriate or leave blank.
- \*33.     **REQUIRED**                    Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid billing provider number must be entered in the space next to Group (Grp)#."

Note: If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567891234</b>							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) _____					3. PATIENT'S BIRTH DATE <b>1 18 97</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) _____					
5. PATIENT'S ADDRESS (No., Street) _____					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) _____					
CITY		STATE			CITY		STATE					
ZIP CODE		TELEPHONE (Include Area Code)			ZIP CODE		TELEPHONE (INCLUDE AREA CODE)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) _____					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER _____					
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>(TPL Info her if applicable)</b>					a. INSURED'S DATE OF BIRTH MM   DD   YY M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME _____					
b. OTHER INSURED'S DATE OF BIRTH MM   DD   YY M <input type="checkbox"/> F <input type="checkbox"/>					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME _____					
c. EMPLOYER'S NAME OR SCHOOL NAME _____					10d. RESERVED FOR LOCAL USE _____		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.					
d. INSURANCE PLAN NAME OR PROGRAM NAME _____					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. <b>Example of occupational therapy</b> SIGNED _____ DATE _____							
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM   DD   YY							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE _____					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM   DD   YY _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY					
19. RESERVED FOR LOCAL USE _____					17a. I.D. NUMBER OF REFERRING PHYSICIAN _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <b>713.40</b>					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____					
2. _____					23. PRIOR AUTHORIZATION NUMBER _____		24. TABLE OF SERVICES					
DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS   MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
11   28   05   11   28   05		03					56.00	1				
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 56.00 (TPL Amt)	29. AMOUNT PAID \$		30. BALANCE DUE \$ 56.00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>Ima Biller</b> 12/15/05					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) <b>ABC School Board</b> <b>45 Oak St. Sunny, La 70000</b>		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>ABC School Board</b> <b>45 Oak St. Sunny, La 70000</b>					
SIGNED _____ DATE _____					PIN# _____ GRP# _____							

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

PLEASE PRINT OR TYPE

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

## UNISYS 213 ADJUSTMENT/VOID FORM

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

### Form Completion

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

Only an **approved claim** can be adjusted or voided.

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

1. A claim is approved on the R.A. dated 04/01/2005, ICN 5091567890123.
2. The claim is adjusted on the R.A. dated 04/15/2005, ICN 5105890123456.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (5105890123456) and R.A. date (04/15/2005) must be used.

3Provider numbers and recipient Medicaid ID numbers cannot be adjusted. They must be voided, then resubmitted.

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

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

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

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

**Unisys  
P.O. Box 91020  
Baton Rouge, LA 70821**

An example of a correctly completed 213 form is shown on the following pages. Only the blocks that are completed are required for claims processing.

## 213 ADJUSTMENT/VOID FORM INSTRUCTIONS

- \*1. ADJ/VOID—Check the appropriate block.
- \*2. Patient's Name
  - a. Adjust—Print the name exactly as it appears on the original claim if not adjusting this information.
  - b. Void—Print the name exactly as it appears on the original claim.
3. Patient's Date of Birth
  - a. Adjust—Print the date exactly as it appears on the original claim if not adjusting this information.
  - b. Void—Print the name exactly as it appears on the original claim.
- \*4. Medicaid ID Number—Enter the 13 digit recipient ID number.
5. Patient's Address and Telephone Number
  - a. Adjust—Print the address exactly as it appears on the original claim.
  - b. Void—Print the address exactly as it appears on the original claim.
6. Patient's Sex
  - a. Adjust—Print this information exactly as it appears on the original claim if not adjusting this information.
  - b. Void—Print this information exactly as it appears on the original claim.
7. Insured's Name— Leave blank.
8. Patient's Relationship to Insured—Leave blank.
9. Insured's Group No.—Complete if appropriate or blank.
10. Other Health Insurance Coverage—Complete with 6-digit TPL carrier code if appropriate or leave blank.
11. Was Condition Related to—Leave blank.
12. Insured's Address—Leave blank.
13. Date of—Leave blank.
14. Date First Consulted You for This Condition—Leave blank.
15. Has Patient Ever had Same or Similar Symptoms—Leave blank.
16. Date Patient Able to Return to Work—Leave blank.
17. Dates of Total Disability-Dates of Partial Disability—Leave blank.

18. Name of Referring Physician or Other Source—Leave this space blank.
- 18A. Referring ID Number – Enter the CommunityCARE authorization number if applicable or leave blank.
19. For Services Related to Hospitalization Give Hospitalization Dates—Leave blank.
20. Name and Address of Facility Where Services Rendered (if other than home or office)—Leave blank.
21. Was Laboratory Work Performed Outside of Office—Leave blank.
- \*22. Diagnosis of Nature of Illness
  - a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information.
  - b. Void—Print the information exactly as it appears on the original claim.
23. Attending Number—Enter the attending number submitted on original claim, if any, or leave this space blank.
24. Prior Authorization #—Enter the PA number if applicable or leave blank.
- \*25. A through F
  - a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information.
  - b. Void—Print the information exactly as it appears on the original claim.
- \*26. Control Number—Print the correct Control Number as shown on the Remittance Advice.
- \*27. Date of Remittance Advice that Listed Claim was Paid—Enter MM DD YY from RA form.
- \*28. Reasons for Adjustment—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.
- \*29. Reasons for Void—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.
- \*30. Signature of Physician or Supplier—All Adjustment/Void forms must be signed.
- \*31. Physician's or Supplier's Name, Address, Zip Code and Telephone Number—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. *The form will be returned if this information is not entered.*
32. Patient's Account Number—Enter the patient's provider-assigned account number.

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

MAIL TO:  
 UNISYS  
 P.O. BOX 91022  
 BATON ROUGE, LA 70821  
 (800) 473-2783  
 924-5040 (IN BATON ROUGE)

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

FOR OFFICE USE ONLY

<b>1</b> ADJ. <input type="checkbox"/> VOID <input type="checkbox"/>																																														
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<b>3</b> PATIENT'S DATE OF BIRTH																																														
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<b>5</b> PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)																																														
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<b>7</b> INSURED'S NAME																																														
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<b>32</b> YOUR PATIENT'S ACCOUNT NUMBER																																														

**FISCAL AGENT COPY**

UNISYS - 213  
5/97

MAIL TO:  
 UNISYS  
 P.O. BOX 91022  
 BATON ROUGE, LA 70821  
 (800) 473-2783  
 924-5040 (IN BATON ROUGE)

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

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<b>25</b> CONTROL NUMBER <b>5365567891234</b>		THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)		<b>27</b> DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID <b>12/31/05</b>	
<b>28</b> REASONS FOR ADJUSTMENT					
<input type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY <input type="checkbox"/> 02 PROVIDER CORRECTIONS <input type="checkbox"/> 03 FISCAL AGENT ERROR <input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN					
<b>29</b> REASONS FOR VOID					
<input checked="" type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT <input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN					
<b>ADJUSTMENT</b> Claim billed under incorrect recip number					

<b>30</b> SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.) <i>Ima Biller</i> <b>01/10/2006</b>		<b>31</b> PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE <b>ABC School Board</b> <b>123 Oak St</b> <b>Allen, La 70000</b> <b>1111111</b>	
<b>32</b> YOUR PATIENT'S ACCOUNT NUMBER			

FISCAL AGENT COPY

UNISYS - 213  
5/97

# APPENDIX A

## EPSDT HEALTH SERVICES PROCEDURE CODES

The following chart lists the codes most commonly billed by EPSDT Health Services providers:

Procedure Code	Description	Fee
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility; approximately 20 – 30 minutes face to face with the patient	\$22.50
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45-50 minutes face to face with the patient	\$45.00
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, approximately 20-30 minutes face to face with patient	\$22.50
90812	Individual psychotherapy, interactive, using play equipment, physical device, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, approx 45-50 minutes face to face with the patient	\$45.00
90846	Family psychotherapy( w/o Patient)	\$22.50
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	\$22.50
90853	Group psychotherapy (other than of a multiple family group)	\$22.50
90857	Interactive group psychotherapy	\$22.50
92506	Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation status	\$45.00
92507	Treatment of speech, language, voice, communication and/or auditory processing disorder (includes aural rehabilitation); individual	\$7.50
92508	Treatment of speech, language, voice, communication and/or auditory processing disorder (includes aural rehabilitation); group, 2 or more individuals	\$7.50
92551	Screening test, pure tone, air only	\$3.60
92552	Pure tone audiometry (threshold), air only.	\$22.50
92553	Pure tone audiometry (threshold), air and bone.	\$45.00
92555	Speech audiometry threshold	\$9.00
92556	Speech audiometry threshold ; with speech recognition	\$22.50
92557	Comprehensive audiometry, threshold evaluation and speech recognition	\$54.00
92563	Tone decay test	\$10.00
92564	Short increment sensitivity index (SISI)	\$20.00
92565	Stenger test, pure tone	\$15.00
92567	Tympanometry (impedance testing)	\$22.50
92568	Acoustic reflex testing	\$22.50
92569	Acoustic reflex decay test	\$36.00
92571	Filtered speech test	\$25.00
92572	Staggered spondaic word test	\$75.00
92575	Sensorineural acuity level test	\$20.00

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92576	Synthetic sentence identification test	\$25.00
92577	Stenger test, speech	\$13.50
92582	Conditioning play audiometry	\$45.00
92583	Select picture audiometry	\$22.50
92584	Electrocochleography	\$200.00
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	\$180.00
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the CNS; limited	\$50.00
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	\$25.00
92588	Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	\$50.00
92590	Hearing aid exam and selection, monaural	\$65.00
92591	Hearing aid exam and selection, binaural	\$65.00
92592	Hearing aid check, monaural	\$22.50
92593	Hearing aid check, binaural	\$45.00
92594	Electroacoustic evaluation for hearing aid, monaural	\$22.50
92595	Electroacoustic evaluation for hearing aid, binaural	\$45.00
96100	Psychological Testing with Interpretation and Report	\$76.50
97001	Physical Therapy evaluation	\$54.00
97003	Occupational Therapy Evaluation	\$51.00
97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes	\$10.00
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	\$10.00
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities	\$10.00
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	\$20.00
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effeurage, petrissage, and/or tapotement (stroking, compression, percussion, etc.)	\$10.00
97504	Orthotic(s) fitting and training upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes	\$8.00
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance); each 15 minutes	\$8.00
97750	Physical performance test or measurement with a written report, each 15 minutes	\$8.00