Basic Services Training

Medicaid Issues for 2004

(Fall Issue)

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

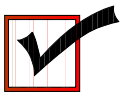
UNISYS

ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the Fall 2004 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability. Such information is presented only in the Basic Medicaid Information Training packet. This packet may be obtained by attending the Basic Medicaid Information workshop; by requesting a copy from Unisys Provider Relations; or by downloading it from the Louisiana MEDICAID website, www.lamedicaid.com.



FOR YOUR INFORMATION! SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

I. MR/DD WAIVER WAITING LIST

The MR/DD Waiver Program provides services in the home, instead of institutional care, to persons who are mentally retarded or have other developmental disabilities. Each person admitted to the Waiver Program occupies a "slot." Slots are filled on a first-come, first-served basis. Services provided under the MR/DD Waiver are different from those provided to Medicaid recipients who do not have a Waiver slot. Some of the services that are only available through the Waiver are: *Respite Services; Substitute Family Care Services; Supervised Independent Living and Habilitation/Supported Employment*. There is currently a Waiting List for waiver slots.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

II. BENEFITS FOR CHILDREN AND YOUTH ON THE MR/DD WAIVER WAITING LIST

CASE MANAGEMENT

If you are a Medicaid recipient under the age of 21 and have been on the MR/DD Waiver Waiting list at any time since October 20, 1997, you may be eligible to receive case management *NOW*.

YOU NO LONGER NEED TO WAIT FOR THIS SERVICE. A case manager works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services), then assists you in obtaining them.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

Notice P-17
Revised November 1, 2000
*****DISCLAIMER: This information is currently being updated and some content may be incorrect or incomplete. If you are unable to get assistance using the telephone numbers listed under the specific programs, you may contact Medicaid Program Operations at 225-342-5774.**

III. BENEFITS AVAILABLE TO ALL CHILDREN AND YOUTH UNDER THE AGE OF 21

THE FOLLOWING SERVICES ARE AVAILABLE NOW. YOU DO NOT NEED TO WAIT FOR A WAIVER SLOT TO OBTAIN THEM.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history, physical exam, immunizations, vision and hearing checks, and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed.

TO OBTAIN AN EPSDT SCREEN OR DENTAL SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

EPSDT screens may help to find problems which need other health treatment or additional services. **Children under 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.** Some of these additional services are very similar to services provided under the MR/DD Waiver Program. There is no waiting list for these Medicaid services.

PERSONAL CARE SERVICES

Personal care services are provided by attendants to persons who are unable to care for themselves. These services assist in bathing, dressing, feeding, and other non-medical activities of daily living. PCS services *do not* include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. Once ordered by a physician, the PCS service provider must request approval for the service from Medicaid.

FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A PCS SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

EXTENDED HOME HEALTH SERVICES

Children and youth may be eligible to receive *Skilled Nursing Services* and *Aide Visits* in the home. These can exceed the normal hours of service and types of service available for adults. These services are provided by a Home Health Agency and must be provided in the home. This service must also be ordered by a physician. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A HOME HEALTH SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY , AND AUDIOLOGY SERVICES

If a child or youth wants *Rehabilitation Services* such as *Physical, Occupational, or Speech Therapy, or Audiology Services* outside of or in addition to those being provided in the school, these services can be provided by Medicaid at hospitals on an outpatient basis, or, in the home from Rehabilitation Centers or under the *Home Health* program. These services must also be ordered by a physician. Once ordered by a physician, the service provider must request approval for the service from Medicaid.

FOR ASSISTANCE IN APPLYING FOR THESES SERVICES AND LOCATING A SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

SERVICES IN SCHOOLS OR EARLY INTERVENTION CENTERS

Children and youth can also obtain *Physical, Occupational, and Speech Therapy, Audiology Services, and Psychological Evaluations and Treatment* through early intervention centers (for
ages 0-2) or through their schools (For ages 3-21). Medicaid covers these services if the services are a part of the IFSP or IEP. These services may also be provided in the home.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR EARLY INTERVENTION CENTER OR SCHOOL OR CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions. *Medical Equipment and Supplies* must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

FOR ASSISTANCE IN APPLYING FOR MEDICAL EQUIPMENT AND SUPPLIES AND LOCATING MEDICAL EQUIPMENT PROVIDERS CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

MENTAL HEALTH REHABILITATION SERVICES

Children or youth with mental illness may receive *Mental Health Rehabilitation Services*. These services include: clinical and medical management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. *MENTAL HEALTH REHABILITATION SERVICES MUST BE APPROVED BY THE LOCAL OFFICE OF MENTAL HEALTH*.

FOR ASSISTANCE IN APPLYING FOR MENTAL HEALTH REHABILITATION SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

TRANSPORTATION

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment.

TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

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Other Medicaid Covered Services

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

NOTICE TO ALL PROVIDERS

Pursuant to Chisholm v. Cerise DHH is required to inform both recipients and providers of certain services covered by Medicaid. The following two pages contain notices that are sent by DHH to some Medicaid recipients notifying them of the availability of services for EPSDT recipients (recipients under age 21). These notices are being included in this training packet so that providers will be informed and can help outreach and educate the Medicaid population. Please keep this information readily available so that you may provide it to recipients when necessary.

DHH reminds providers of the following services available for all recipients under age 21:

- Children under age 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. **This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.**

- Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

- Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment. **TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).**

- **Recipients may also CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544) for referral assistance with all services, not just transportation.**

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Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

*Doctor's Visits
*Hospital (inpatient and outpatient) Services
*Lab and X-ray Tests
*Family Planning
*Home Health Care
*Dental Care
*Rehabilitation Services
*Prescription Drugs
*Medical Equipment, Appliances and Supplies (DME)
*Case Management
*Speech and Language Evaluations and Therapies
*Occupational Therapy
*Physical Therapy
*Psychological Evaluations and Therapy
*Psychological and Behavior Services
*Podiatry Services
*Optometrist Services
*Hospice Services
*Extended Skilled Nurse Services
*Residential Institutional Care or Home and Community Based (Waiver) Services
*Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
*Immunizations
*Eyeglasses
*Hearing Aids
*Psychiatric Hospital Care
*Personal Care Services
*Audiological Services
*Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
*Appointment Scheduling Assistance
*Substance Abuse Clinic Services
*Chiropractic Services
*Prenatal Care
*Certified Nurse Midwives
*Certified Nurse Practitioners
*Mental Health Rehabilitation
*Mental Health Clinic Services

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD waiver, you may be eligible for case management services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office.

You may access other services by calling KIDMED at (toll-free) 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

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Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

If you live in a CommunityCARE parish, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

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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 accept as payment in full the amounts established by the BHSF and refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.

- 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.

Under this expansion, providers should anticipate an audit during their association with the Medicaid program. When audited, providers should cooperate with the representatives of DHH, which includes Unisys, in accordance with their participation of 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

Louisiana Medicaid's Surveillance and Utilization Review (SURS) Unit has uncovered a disturbing billing practice in which entities not enrolled as Medicaid providers are using enrolled physicians' Medicaid numbers in order to submit billing for their services. SURS has found that some physicians have unknowingly become involved in this fraudulent billing practice, and wants to raise physician awareness of this practice so that physicians may not become liable for this billing.

The scam is put into motion when a non-Medicaid enrolled entity hires an enrolled physician provider, and then uses the physician's Medicaid number for billing. These fraudulent billings are detected by SURS audits, which find unusual aberrant billing patterns; for example, inappropriate testing may be detected. Physicians risk being drawn into a long, complicated fraud investigation, and the unenrolled entities risk criminal prosecution. Providers should be careful with their Medicaid numbers.

☞ 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 created a new 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.

PROVIDER ENROLLMENT

Change of Address/Enrollment Status

The mailing address for all Provider Enrollment related issues is:

Unisys Provider Enrollment
PO Box 80159
Baton Rouge, LA 70898-0159
(225) 923-8510

General Information

Policies and procedures include the following:

- Enrollment packets are revised continuously. Therefore, if the requested enrollment packet is not completed timely, or if a copy of the packet is kept on file and used later to enroll another individual, a new packet should be requested if 6 months or more have lapsed since the original enrollment packet was requested.
- All application forms **MUST** be completed in their entirety. Please review all instructions prior to completing forms. If an application is submitted with incomplete or inaccurate information, the entire application will be returned to the submitting provider with a cover letter identifying the needed information. The provider must correct the form(s) as needed and re-submit the entire enrollment application. Once corrections are made, the entire packet should be resubmitted to Provider Enrollment for processing. This process will be repeated until all information is correct.
- Applications, updates or any other changes to provider enrollment records must be submitted to the Unisys Provider Enrollment Unit **IN WRITING**. Unless specifically directed by the Provider Enrollment staff, **no** faxes will be accepted.
- Requests for linkages of individual providers to group numbers will continue to require a completed PE-50 form (if the linking professional is not currently enrolled) or a completed Group Linkage Form (if the linking professional is currently enrolled).
- All correspondence should contain a request that the provider's file be updated with current information and should include the 7-digit provider number, the old information currently on the Medicaid file and the new information. Please be advised that some information cannot be changed without additional information or completed enrollment packets.
- Providers should notify Unisys Provider Enrollment, **IN WRITING**, when a mailing or service address and/or phone number change occurs to allow Louisiana Medicaid correspondence (including rejected/approved claims) to be sent more quickly to providers.
- The Post Office returns excessive amounts of provider mail, including remittance advices, due to invalid addresses. In many cases, when attempts are made to contact these providers, the telephone numbers on file are also invalid or no longer in service. The mail is returned to Unisys because forwarding orders at the post office have expired. Any provider whose address and/or telephone number are not current and accurate should request an Address/Telephone Change Form to update the information. If the provider cannot be located, the provider number is closed.

- Please be aware that RAs and checks are mailed to the provider's "Pay To" address on our files, not the address written on a claim form; therefore, it is imperative that any change in address be reported to Unisys Provider Enrollment immediately
- It is important that the provider ensures the Pay-To Name on the provider file information is kept accurate. To change the Pay-To name on file, a copy of a preprinted IRS document showing the taxpayer identification number and legal name must be attached. All documents requesting pay-to names must match the IRS documentation exactly. Differences in the IRS documentation and the provider enrollment forms may result in delays in updating your provider file information. Any discrepancies will be returned to you for correction.
- All correspondence to the Unisys Provider Enrollment Unit **MUST** be mailed to the address above.

Identity Theft

Due to reports and concerns of provider identity theft, the Provider Enrollment Unit is **not** authorized to disclose any provider information to any third party. Third parties include billing companies and/or clearinghouses, management companies, and credentialing companies or other entities not directly associated with the provider. Requests for release of provider information to a third party must be submitted in writing with the provider's original signature (no stamps or initials).

Individual Provider Number Linkages to Group Numbers

An individual's provider number can be "linked" to a group provider number for purposes of billing services provided under the relationship with the individual and the group. Claims submitted under the group number, with an individual's number included as the attending provider, will be processed and the remittance will be sent directly to the group's Pay-To address. *It is not necessary for the individual's Pay-To address to be the same as the group's Pay-To address for these Remittance Advice notices to be sent to the group if billed correctly.* **It is vital that the provider adequately identifies whether the request is for an individual number to be "linked" to a group number or to update the individual file with the group information. If the individual file is to be updated, the individual provider must initiate the request.** Requests of group representatives to update information on an individual's provider file are returned to the requestor.

The PE-50 Form

When completing the Provider Enrollment Form (PE-50), providers should submit a one-page form (front and back). In other words, **providers should NOT submit the form on two separate pages**. In addition, providers should ensure that the PE-50 has an original signature. Stamped or copied signatures are **NOT** accepted.

Providers who have questions pertaining to filing the PE-50 need to contact Provider Enrollment at (225) 237-3370.

Correct Taxpayer ID Information

An entity's Taxpayer Identification Number (TIN) is the IRS number assigned to a business entity by the IRS. The name and number in the Medicaid records must match the information on the IRS files. **The Pay-To Name on the PE-50 MUST match the first line of the entity's name on the pre-printed IRS document exactly. Any variations in the name submitted will result in the rejection of the enrollment application for corrections.**

Internal Revenue Service considers the TIN, also known as Employer Identification Number (EIN), as incorrect if either the name or number shown on an account does not match a name or number combination in their files or in the files of the Social Security Administration (SSA).

Providers who have submitted a Form SS-4 to the Internal Revenue Service for a new employer identification number and have obtained a new number should send a copy of the Notice of New Employer Identification Number Assigned to the Unisys Provider Enrollment Unit, with a letter indicating Medicaid provider numbers affected by any changes.

NOTICE: If appropriate action is not taken to correct the mismatches, the law requires the agency to withhold 31% of the interest, dividends and certain other payments that we make to your account. This is called backup withholding. In addition to backup withholding, you may be subject to a $50.00 penalty by the IRS for failing to give us your correct name/TIN combination. An individual's TIN is his or her social security number (SSN). However, sometimes an account or transaction may not contain the actual owner's correct SSN. An account should be in the name and SSN of the actual owner.

Auto Closures

Under current policy, Louisiana Medicaid numbers are automatically closed for non-participation if there has been no billing or payment using the provider number for the previous 18 months. If a number is automatically closed, the provider will be required to re-enroll if they wish to participate in Louisiana Medicaid.

Electronic Funds Transfer (EFT) Requirements

The Department of Health and Hospitals mandates electronic funds transfer (EFT), for the direct deposit of weekly (monthly for long term care) payments for Medicaid services.

Enrollment in the EFT program is mandatory. Providers who have not enrolled, need additional forms, or have any questions regarding the EFT payment process or completion of the "Medicaid Direct Deposit Authorization Agreement" form should contact Unisys Provider Relations at (800) 473-2783 or (225) 924-5040.

NOTICE: The EFT enrollment process requires that **a voided check or a letter** from the bank identifying your account number and routing number be submitted with the agreement papers. **Please be aware that a deposit slip for the account WILL NOT be accepted.**

Once completion of the electronic funds transfer process has been completed, the summary page of the remittance advice will indicate that direct deposit has been established and the date of deposit of funds. Deposits are credited to the account at the end of the business day indicated on the RA.

Provider file updates and/or changes should include the direct deposit agreement if appropriate. **For example, if an individual physician is currently employed by a hospital or clinic, payments for his services are being deposited into the bank account for that facility. If the physician chooses to open his own private practice, he must complete a new direct deposit agreement in order to have payments made to his own bank account.** Also, when changing bank accounts, you **must** notify the Unisys Provider Enrollment Unit in a timely manner in order for payments to be made to the appropriate account. Failure to submit the necessary forms timely may result in delays in payment or funds being deposited to incorrect accounts.

The monthly bank statement should be reviewed in order to determine the date and amount of the payment made by the Department of Health and Hospitals. The deposit account number on your bank statement consists of the middle five digits of your Medicaid provider number with two leading zeros plus the remittance advice number. The amount for the deposit for a particular date is the same as the total payment shown on the financial page of the remittance advice of the corresponding date.

Providers should attempt to resolve any EFT problems with their accounting departments or their banking institution prior to contacting the Unisys Provider Enrollment Unit at (225) 237-3370.

Changes of Ownership (CHOWs)

All changes of ownership **MUST** be reported to Provider Enrollment as quickly as possible after the CHOW occurs. Failure to do so may result in closure of the provider number or delays in payment. **Direct Deposit information will not be changed when a CHOW has occurred without a full enrollment packet being completed**.

IDENTIFICATION OF ELIGIBLE RECIPIENTS

All recipients enrolled in Louisiana's Medicaid Program are issued **Plastic Identification Cards**. These permanent identification cards are issued as evidence of Medicaid eligibility. Use of these cards will require provider verification. The department of Health and Hospitals (DHH) now offers several options to assist providers with verification of current eligibility. The following eligibility verification options are available: (1) Medicaid Eligibility Verification System (MEVS), an automated eligibility verification system using a swipe card device or PC software. (2) Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system. (3) e-MEVS, a web application accessed through www.lamedicaid.com. (4) Pharmacy Point of Sale (POS).

These eligibility verification systems provide confirmation of the following:

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

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

- CMS Regulations limit providing recipient eligibility older than the most current 12 months.
- Card issue date is no longer required when using the card control number.
- REVS and Provider Relations will no longer allow access to eligibility information with only the Recipient Medicaid ID Number.
- 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)

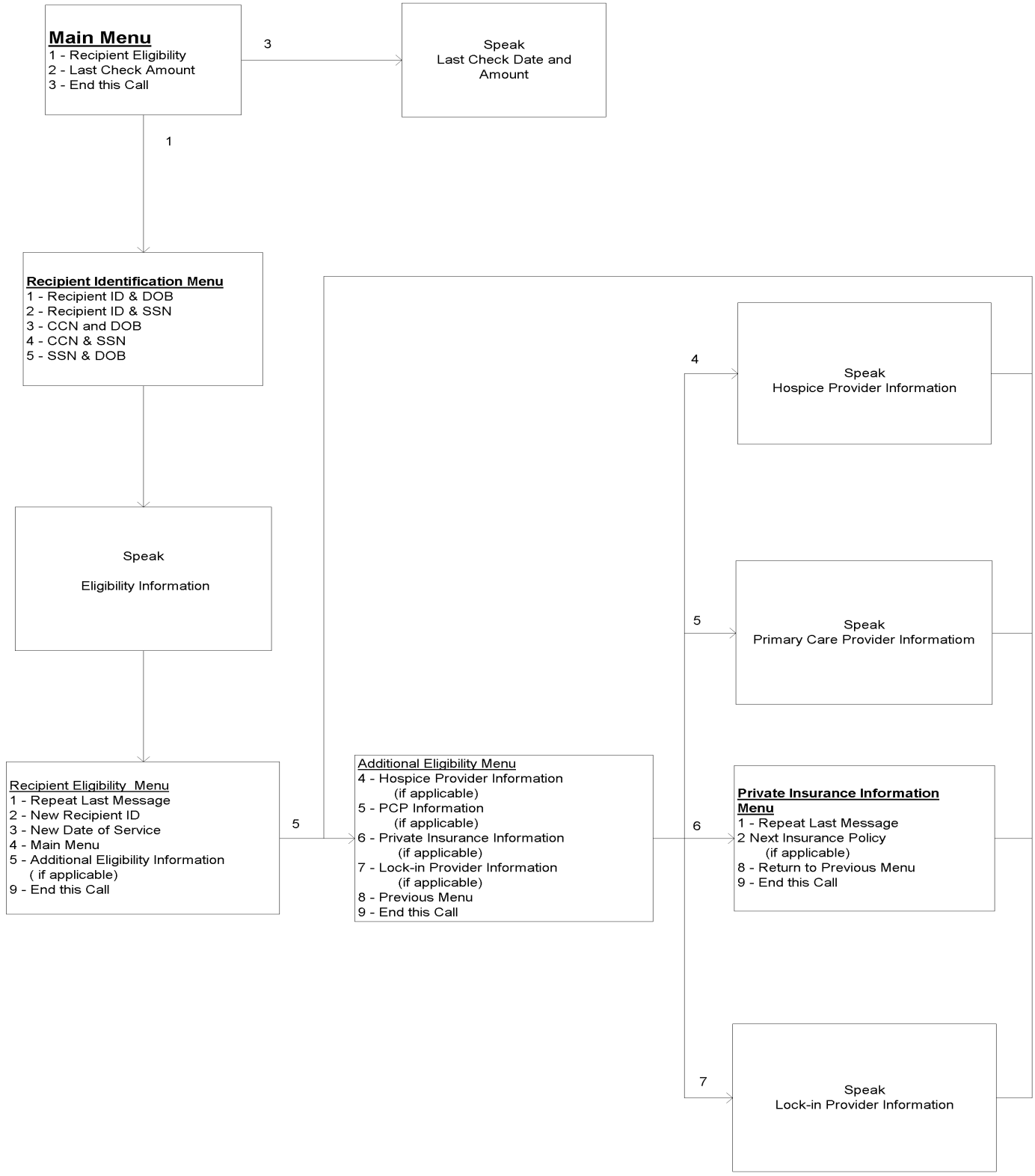
The Recipient Eligibility Verification System (REVS) is a toll-free telephonic eligibility hotline that is used to verify Medicaid eligibility and is provided at no additional cost to enrolled providers. REVS can be accessed through touch-tone telephone equipment using the Unisys toll-free telephone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

Accessing REVS

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
- 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



Medicaid Eligibility Verification System (MEVS)

The Medicaid Eligibility Verification System (MEVS) is an electronic system used to verify Medicaid eligibility. MEVS access is provided through contracts with approved "Switch Vendors" who are responsible for provision of the magnetic card reader, PC software, or computer terminal necessary to access this system. Providers are charged a fee for this service and this fee will depend on the type of service selected.

MEVS allows providers to retrieve **printed** verification by using one of the three following verification methods:

- point of sale technology, using "swipe card devices" similar to retail credit cards
- personal computer (PC) software tailored to fit the individual provider's specific needs; or
- computer terminal

The following vendors are approved by DHH:

Vendor	Contact	Phone	Website
WebMD	Envoy Target Marketing	(800) 366-5716	www.envoy-neic.com
Healthcare Data Exchange	Melinda Fulmer	(888) 737-8326	www.hdx.com
Passport Health Communications **Passport is available on the Internet only**	Beverly Roos	(504) 281-2551	www.passporthealth.com
Health Data Link (HDL)	Lucy Joseph/Sandy Sawyer	(985) 331-6500 (800) 338-1079	www.ehdl.com
SNS Healthcare Technology Group	Gary Stafford	(561) 859-2760	www.snsmevs.com

NOTE: Except for a short time needed each week for maintenance, MEVS is available 24 hours a day, 7 days a week to allow providers easy and immediate retrieval of current recipient eligibility information.

Accessing MEVS

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
- Medicaid ID number (valid during the last 12 months) and name
- 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
- Recipient name and recipient birth date
- Recipient name and social security number

e-MEVS

Providers can now verify eligibility and service limits for a Medicaid recipient using a web application accessed through www.lamedicaid.com. This application was implemented to provide eligibility verification capability in addition to MEVS swipe card transactions and REVS. 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.

Since its release, the application has undergone some cosmetic and informational changes to make it more user-friendly and allow presentation of more complete, understandable information.

Accessing e-MEVS

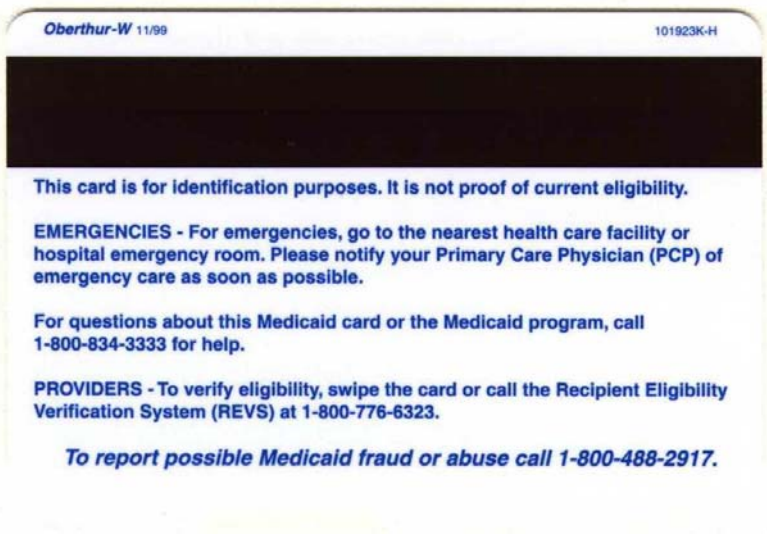
Providers may access recipient eligibility by using the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Medicaid ID number (valid during the last 12 months) and name
- 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
- 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, MEVS, and e-MEVS is not necessary except in an instance of recipient retroactive eligibility.


HEALTH NETWORK for LOUISIANA
LOUISIANA
Department of HEALTH and HOSPITALS
Medicaid
CCN: 7779999999999101
Lou Z O'Ana
Issue Date: 03-01-1998
BIN 610551


Oberthur-W 11/99
101923K-H
This card is for identification purposes. It is not proof of current eligibility.
EMERGENCIES - For emergencies, go to the nearest health care facility or hospital emergency room. Please notify your Primary Care Physician (PCP) of emergency care as soon as possible.
For questions about this Medicaid card or the Medicaid program, call 1-800-834-3333 for help.
PROVIDERS - To verify eligibility, swipe the card or call the Recipient Eligibility Verification System (REVS) at 1-800-776-6323.
To report possible Medicaid fraud or abuse call 1-800-488-2917.

MEVS, REVS, and e-MEVS Reminders

It is important to remind you of areas that may potentially cause problem responses through MEVS, REVS and e-MEVS:

- You must listen to the menu and press the appropriate keys to obtain CommunityCARE or Lock-In information through REVS.

- When using a recipient's 13-digit Medicaid number, remember that all systems carry only recipient numbers which are valid for the last 12 months. If you are entering an old number (valid prior to the last 12 months), you will receive a response that indicates the recipient is not on file.

- An error message will be returned through the automated systems if the date is not a valid 8-digit date.

- Claims must be filed with the 13-digit Medicaid identification number.

- CMS Regulations limit providing recipient eligibility older than the most current 12 months.

- Providers cannot obtain KIDMED linkage through traditional forms of eligibility verification, such as REVS, MEVS, or e-MEVS. In order to obtain KIDMED linkage, providers must call Unisys or ACS. When requesting KIDMED linkage, providers must be specific as to whether they are requesting KIDMED or CommunityCARE linkage. In addition, when rendering a screening, the recipient must either be linked to the screening provider, or the screening provider must have a contractual agreement with the provider to whom the recipient is linked.

Eligibility Verification Responses

The eligibility verification systems for MEVS, REVS, and e-MEVS provide response messages that supply all information required to service the recipient. The following table is representative of the types of information received from these verification systems:

Recipient Eligibility	Response
Recipient is a CommunityCARE recipient	Message indicates that the recipient is CommunityCARE and includes the name of the recipient's PCP and the telephone number of the PCP to allow the inquiring provider to contact the PCP for a referral prior to providing services.
Recipient is eligible through a category of service that limits coverage of certain services or by certain providers	Information provided as part of eligibility response. For example: If the recipient is covered through the Medically Needy Program, which does not cover certain services, and the provider calling is a provider of a non-covered service, the response will include a message indicating that the recipient is Medically Needy and the services provided by the calling provider would not be covered.
Recipient is QMB eligible • QMB Only • QMB Plus • Non QMB	In cases where the recipient is **QMB Only**, the REVS response will state: "This recipient is only eligible for Medicaid payment of deductible and co-insurance of services covered by Medicare. This recipient is not eligible for other types of Medicaid assistance." If the recipient is **QMB Plus** the REVS message will state "The recipient is eligible for both Medicare co-insurance and deductible and Medicaid services." Finally, if the recipient is a **Non-QMB** there will be no specific message, however REVS will indicate that the recipient has Medicare in the TPL segment of the response.
Recipient is presumptively eligible	Response will indicate: "This recipient may be eligible for outpatient ambulatory services only. Providers must call 1-800-834-3333 to verify current eligibility."
Recipient is a child	Message indicates that the recipient is EPSDT eligible, meaning the recipient is under 21 years of age and eligible for all services and service limits allowed for children.

All eligibility and service limitation information is related to the inquiring provider. However, it is the provider's responsibility to know and understand all policy limitations.

Medicaid Paper Eligibility Forms

Some types of Medicaid eligibles will still receive paper eligibility forms. These groups of eligibles are *presumptive eligibles, illegal aliens (covered for emergency medical services, type case 47), and deceased retroactive eligibles*. Included in this section are examples of sample forms for these categories. Providers may want to refer to these samples to assist in understanding the information appearing on the eligibility forms.

Presumptive Eligibility

Pregnant women may have "**Presumptive Eligibility** (PE)" established by a "qualified provider" such as a state hospital or public health unit for a period of **up to (45) days**. The Form 18-PE (p.17) is issued for this eligibility type. During this period the "presumptively eligible" pregnant women will be eligible for ambulatory (outpatient) prenatal care including non-emergency transportation. **Once fully certified, she will be given a plastic ID card and can receive any pregnancy-related services including hospital and delivery until 60 days after** delivery. Pregnancy-related services cover any medical conditions that can impact the pregnancy by affecting the mother's health.

During the 45-day period of presumptive eligibility, coverage may expire at any time if eligibility requirements are not met. MEVS, REVS, and e-MEVS eligibility verification responses will alert providers that the recipient may be eligible for outpatient ambulatory services only and that providers must inquire to verify eligibility. **Verification should be made at the parish office during the 45-day period or by calling the Regional Office at (800) 834-3333**.

Illegal Aliens

These individuals are certified only for limited periods of eligibility via Form 18-EMS (p 19). Their dates of eligibility only cover dates of service on which emergency services were rendered. Once such a person's eligibility ceases, he must re-apply at the parish office if coverage for new emergency services is to be granted.

Retroactive Long Term Care (LTC) Coverage For Deceased Persons

If Medicaid eligibility determination is not made for a recipient until after the recipient has died in a long term care facility, Form 18-LTC (p.21) is issued posthumously to allow the long term care provider to be paid.

BHSF Form 18-PE
Rev. 08/01
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Notice of Decision-**Presumptive Eligibility (PE)**

_____

_____, LA _____

_____, 20_____

Case ID # _____

SSN _____

Dear _____:

☐ You have been approved for **temporary** Medicaid coverage which is **limited** to pregnancy-related outpatient services, beginning _____. Coverage under this program **cannot** extend beyond _____ , **unless** you have applied for regular Medicaid coverage and our decision on that application has not been made. This **temporary** coverage may be shortened to less than this time if you are found to be ineligible **or** if you fail to comply with eligibility requirements.

You **must** complete an application for Medicaid and comply with all eligibility requirements if you are interested in having Medicaid coverage continue throughout your pregnancy and for sixty (60) days after your pregnancy ends **and** for Medicaid to cover your labor and delivery charges.

☐ Please complete the enclosed application for continued Medicaid coverage and return it to us by _____ (seven days from the date of this notice) to protect your application date.

☐ An appointment has been scheduled for you at _____on _____ at _____ o'clock to discuss your application for CHAMP-Pregnant Woman coverage. **If you cannot keep this appointment, please let me know immediately so that other plans can be made.**

☐ Your coverage under this program is terminated effective _____ because _____ _____. Policy reference for our decision is _____.

Please share the eligibility information found on this notice with any medical services provider who has (or will) provide covered out-patient care to you during this period. You will not receive any other proof of your eligibility for this coverage.

Sincerely,

You are not entitled to advance notice and appeal rights with denial or termination of coverage under this program.

cc. Qualified Provider _____

Agency Representative

_____

Phone Number

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Louisiana's **Medicaid Program** Proof of Coverage for Presumptive Eligibility (Type Case 16-12)		
Recipient Name	Medicaid (Person) ID Number	Date of Birth
Presumptive eligibility period begins _____. Services are limited to outpatient prenatal care **only**. Eligibility under this program ends: when this recipient is determined eligible for other coverage; on the date shown on the front of this letter, if an application for other coverage has not been made; at any time ineligibility is established; or at any time this recipient fails to comply with program requirements. **Inpatient hospital care (including labor and delivery) and long term care services ARE NOT covered by this Proof of Coverage statement.**		

BHSF Form 18-EMS
Rev. 08/01
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Notice of Decision-**Emergency Medical Services**

_____

_____, LA _____

_____, 20_____

Case ID # _____

SSN _____

Dear _____:

☐ _____ has been approved for Emergency Medical Services **Only**, beginning and ending _____. Your case has automatically been closed.

Please share the eligibility information found on this notice with any medical services provider who provided covered outpatient care to you during this period. You will not receive any other proof of your eligibility for this coverage.

☐ _____is (are) not eligible for Medicaid coverage because .

Policy reference for our decision is _____.

Sincerely,

_____
Agency Representative

_____
Phone Number

Louisiana's **Medicaid Program** Proof of Coverage for Aliens for Emergency Services **Only** (Type Case 47)		
Recipient Name	Medicaid (Person) ID Number	Date of Birth
The eligibility period for coverage of **Emergency Services Only** begins _____ and ends _ . **Coverage is limited to emergency care only provided during this period.**		

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

YOUR FAIR HEARING RIGHTS

If you disagree with this decision, you may discuss it with a supervisor in the **Medicaid Program** office. The supervisor can review this decision and give you any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you **must** do so by _____ (thirty days from the date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the **Medicaid Program** office at _____ **or** you may mail it directly to the DHH Appeals Bureau at P. O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the rights to: review your case record and/or any other information which the agency plans to use before the hearing; appear in person; represent yourself or have anyone else you choose to represent you; present your own evidence or witnesses; and question any person who testifies against you.

You may be able to get free legal help by calling the nearest legal assistance office at _____.

COMPLETE THIS SECTION ONLY IF YOU WANT TO REQUEST A FAIR HEARING

I want to appeal the decision on my case as shown on the front of this notice. I think it is unfair because:

Date: _____

Signature: _____
Applicant/Recipient/Representative
Phone No.(_____) _____
Address: _____
_____

BHSF Form 18-LTC
Rev. 05/02
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Adequate Notice of Nursing Facility Decision

_____
_____, LA _____
_____, 20 _____
Case ID# _____
Person ID# _____
SSN _____
Provider(s) _____
_____

Dear _____:

The following decision has been made on your application or existing certification for Medicaid health care **and** nursing facility vendor payment coverage:

☐ Your application for Medicaid health care coverage has been approved effective _____.

☐ You have been approved as a Qualified Medicare Beneficiary. Beginning _____, the **Medicaid Program** will pay for your Medicare premiums and deductibles, provide medically necessary ambulance transportation, and may provide the co-insurance for other Medicare-covered services if the medical services provider accepts you as a Medicaid patient. You will get a plastic Medicaid card to help pay for your medical expenses. The automated process used to pay your Medicare premiums may take up to 90 days after you are certified. You will be reimbursed by Social Security for any premiums you have paid, back to the effective month of coverage.

☐ You have been approved as a Specified Low-Income Medicare Beneficiary. Beginning _____, the **Medicaid Program** will pay **only** your Medicare Part B premiums. You **will not** receive a plastic Medicaid card. The automated process used to pay your Medicare premiums may take up to 90 days after you are certified. You will be reimbursed by Social Security for any premiums you have paid, back to the effective month of coverage.

☐ Your application for Medicaid coverage and vendor payment for nursing facility care was not approved because _____ _____. Policy reference for our decision is _____.

☐ Nursing facility vendor payment to the provider(s) named above has been approved effective _____. Your responsibility toward the cost of your nursing facility care is $_____ for _____ days in _____ (the month of entry). Thereafter, your responsibility **each month** toward the cost of your care is $_____ for _____, $_____ for _____, and $_____ for (continuing).

☐ Nursing facility vendor payment to the provider(s) named above has not been approved because you transferred resources for less than fair market value. You will remain **ineligible** for vendor payment to **any** nursing facility provider from through _____. Policy reference for our decision is _____.

☐ Nursing facility vendor payment to the provider(s) named above is being:

☐ re-instated; ☐changed; ☐ terminated effective _____ because _____

_____.

Effective _____, you will pay a total of $_____ toward the cost for your nursing facility care. Thereafter, your responsibility **each** month toward the cost of your care is
$_____ for _____; $_____ for _____; and $_____ for _____.
Policy reference for our decision is _____.

☐ You are entitled to keep $_____ of your monthly income. This amount includes $_____ for your needs, $_____ for the Medicare premiums that are deducted from your Social Security check, and $ for your other monthly medical insurance premiums or other medical expenses. It also includes $_____ to give to your spouse and/or other dependent(s) in the community.

☐ An SSI payment of $_____ will be made directly to you by the Social Security Administration.

☐ A State Supplemental payment of $_____ will be made to you to cover your personal care needs beginning
.

☐ The State Supplemental payment for your personal care needs will be:

☐ increased to $_____; ☐ reduced to $_____; ☐ terminated effective _____

because _____.
Policy reference for your decision is _____.

☐ Medicaid health care coverage and nursing facility services will be closed _____because we were informed that the recipient is:

☐ no longer a Louisiana resident ☐ deceased. Policy reference for our decision is_____.

☐ Recipients under age 21 are eligible for EPSDT services, including KIDMED. KIDMED services include immunizations; vision, dental, and hearing checkups; nutrition/health education; unlimited doctor visits; medical equipment; and any other medically necessary services. You will be contacted by the KIDMED office OR you may call them toll-free at 1+800+259-4444 or 1+877+455-9955.

☐ If you are unable to make arrangements for non-emergency medical transportation, you may call 1+800+864-6034 toll free. You must call at least 2 days before the appointment to schedule transportation.

You need to let your local Medicaid office know about changes in where you live or get your mail. You also need to report any changes in your situation. This includes changes in the income and resources (cash, property, vehicles, etc.) that you, your spouse or other dependents receive, your marital status, the number of persons who depend on you for support, and health insurance coverage. If you do not report such changes, you may get Medicaid health care/vendor payment coverage or money to which you are not entitled. You will be expected to repay any benefits received or paid on your behalf for which you are not eligible.

The Medicaid Program must renew your eligibility for continued assistance at certain times during the year. We will let you know when this must be done. If an agency representative whom you do not know visits you, ask to see an identification card.

Sincerely,

_____
Agency Representative

_____
Phone Number

_____
Fax Number

CC ☐ _____ (Provider)
☐ _____ (Other)

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

YOUR FAIR HEARING RIGHTS

If you disagree with this decision, you may discuss it with a supervisor in the **Medicaid Program** office. The supervisor can review this decision and give you any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you **must** do so by _____ (thirty days from the date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the **Medicaid Program** office at _____ **or** you may mail it directly to the DHH Appeals Bureau at P.O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the rights to: review your case record and/or any other information the agency plans to use before the hearing; appear in person; represent yourself or have anyone else you choose to represent you; present your own evidence or witnesses; and question any person who testifies against you.

You may be able to get free legal help by calling the nearest legal assistance office at _____.

COMPLETE THIS SECTION <u>ONLY</u> IF YOU WANT TO REQUEST A FAIR HEARING

I want to appeal the decision on my case as shown on the front of this notice. I think it is unfair because:

Date: _____

Signature: _____
Applicant/Recipient/Representative

Phone No.: (_____)_____

Address: _____

_____ _____

Retroactive Eligibility

Recipients granted retroactive eligibility will receive both a plastic ID card and a paper eligibility form. The paper eligibility form will be used in a manner similar to that of the previous retroactive eligibility paper card. The paper retroactive eligibility form will indicate the period for which eligibility has been retroactively granted as well as the date the determination was made.

The issue/certification date and recipient Medicaid ID number are found in the upper right-hand block of the Eligibility Notice. Only the paragraphs applicable to the recipient's will be printed on the form.

For cases in which retroactive eligibility exceeds the one year timely filing limit, a copy of the Eligibility Notice should be attached to the claim and forwarded to

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

- ✓ A cover letter must be attached explaining that an override is being requested for proof of timely filing in a retroactive eligibility case.

- ✓ Additionally, claims which exceed the timely filing deadlines must be submitted for payment consideration within one year from the certification date on the Eligibility Notice. Any claim not filed within this time period cannot be considered for payment.

- ☞ For cases in which the recipient could not provide a copy of the retroactive Eligibility Notice, the claim and a cover letter requesting a timely filing override should be submitted to:

Attention: Claims Processing & Resolution Unit
DHH/MVA/MMIS
P. O. Box 91030
Baton Rouge, LA 70821-9030

NOTE: There are several different Eligibility Notice forms; however, on the following page is an example of one of the most commonly used Eligibility Notice forms, the 18-SSI.

BHSF Form 18-SSI
Rev. 05/02
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
SSI Notice of Decision

_____

_____, LA _____

_____, 20 _____

Case ID #_____

SSN _____

Dear _____:

The following decision has been made regarding your Medicaid coverage:

☐ You are currently receiving monthly Supplemental Security Income (SSI) benefits. As an SSI recipient, you are eligible for Medicaid coverage beginning _____. For each month that you remain eligible for SSI, your plastic Medicaid card will help pay for that month's medical expenses. If your SSI check stops, we will review your situation to see if you can still get Medicaid in another program.

☐ You were eligible for SSI cash benefits for a prior period, beginning _____ and ending _____. You will receive a plastic Medicaid card to help pay for medical expenses you had during those months.

☐ The Social Security Administration has told us that you were recently approved for SSI. At the time you applied with the Social Security Administration, you reported that you had medical bills for the 3 months before you applied for SSI. If you have medical bills for that time period and want Medicaid coverage, you may call the local Medicaid office at (_____)_____ for assistance by _____ (90 days from the date of this notice).

☐ You have been approved for retroactive Medicaid coverage for the months _____, _____, and _____*. You will receive a plastic Medicaid card to help pay for medical expenses you had during those months.

☐ Although you **are not** currently getting SSI benefits, you have been found eligible for retroactive Medicaid coverage for the months of _____, _____, and _____*. You will receive a plastic Medicaid card to help pay for Medicaid expenses you had during those months, **only**.

☐ As an SSI recipient eligible for Medicare, you have been approved as a Qualified Medicare Beneficiary. Beginning _____, the **Medicaid Program** will pay for your Medicare premiums and deductibles, and may provide co-insurance for Medicare-covered services if the medical services provider accepts you as a Medicaid patient. The automated process used to pay your Medicare premiums may take up to 90 days after you are certified. You will be reimbursed by Social Security for any premiums you have paid, back to the effective month of coverage.

☐ Your Medicaid coverage will continue until _____, because children under age 19 who remain in Louisiana are eligible for one year of continuous coverage. At that time, your eligibility for other Medicaid programs will be reviewed.

☐ *Take the plastic Medicaid card you will get and a copy of this letter to any druggist, hospital, doctor, or other medical services provider from whom you received medical care during this time. If you have not paid for these services, the medical provider can immediately bill the **Medicaid Program** for payment. If you have already paid for a service, please look on the back of this notice for important information about eligibility for retroactive reimbursement of the money you have spent.

☐ Recipients under age 21 are eligible for EPSDT services, including KIDMED. KIDMED services include immunizations; vision, dental, and hearing checkups; nutrition/health education; unlimited doctor visits; medical equipment; and any other medically necessary services. You will be contacted by the KIDMED office OR you may call them toll-free at 1+800+259-4444 or 1+877+455-9955. Children under age five, pregnant women, and nursing mothers may be eligible for WIC services, which provide juices, cereal, milk and other dairy products. Applications for this program are available at Public Health units or other local WIC sites.

If you are unable to make arrangements for non-emergency medical transportation, you may call 1-800-864-6034 toll free. You must call at least 2 days before the appointment to schedule transportation.

☐ You have not been approved for retroactive Medicaid coverage for the months of _____, _____, and

You need to let your local Medicaid office and Social Security know about changes in where you live or get your mail, income and resources (cash, property, vehicles, etc.), and health insurance coverage.

_____ because _____
_____. Policy reference for our decision is _____.

☐ Your application for Medicaid coverage was not approved because _____
_____
_____. Policy reference for our decision is _____.

Sincerely,

_____
Agency Representative

_____
Phone Number

_____
Fax Number

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

YOUR FAIR HEARING RIGHTS

If you disagree with this decision, you may discuss it with a supervisor in the **Medicaid Program** office. The supervisor can review this decision and give you any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you **must** do so by _____ (thirty days from the date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the **Medicaid Program** office at _____ **or** you may mail it directly to the DHH Appeals Bureau at P.O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the rights to: review your case record and/or any other information the agency plans to use before the hearing; appear in person; represent yourself or have anyone else you choose to represent you; present your own evidence or witnesses; and question any person who testifies against you.

You may be able to get free legal help by calling the nearest legal assistance office at _____.

COMPLETE THIS SECTION <u>ONLY</u> IF YOU WANT TO REQUEST A FAIR HEARING

I want to appeal the decision on my case as shown on the front of this notice. I think it is unfair because:

Date: _____ Signature: _____
Applicant/Recipient/Representative

Phone No.: (_____)_____
Address: _____
_____

ELIGIBILITY FOR RETROACTIVE REIMBURSEMENT

The decision of the Federal Court of Appeals in New Orleans requires that we consider reimbursing recipients for any medical bills paid between _____ (the beginning date of eligibility) and _____ (the date the Medicaid Card is expected to be received). Louisiana's **Medicaid Program** will make reimbursements only up to the maximum allowable Medicaid rate.

In order to qualify for reimbursement:

1. The bill(s) must be for medical care, services or supplies received during the dates shown above.

2. The bill(s) must be for medical care, services or supplies covered by the **Medicaid Program** at the time of service.

3. The bill(s) must be for medical care, services or supplies furnished by a provider who was enrolled in the **Medicaid Program** at the time of service.

4. The bill(s) must have been paid during the dates shown above **AND** have not been reimbursed in full by the provider, a third party (such as an insurance company or charitable organization), or already by the **Medicaid Program**.

Contact us by _____ (thirty days) from the date of this letter) at the address shown above or telephone us at _____ if reimbursement is requested. At the time you contact us, you will be given time to provide proof of your payment.

Recipient Refunds Due To Retroactive Eligibility Policy

If a recipient was Medicaid certified on or after February 15, 1995, the recipient is eligible for reimbursement of paid medical costs incurred from the first retroactive date of Medicaid eligibility up until the recipient received a medical card. This does not cover those recipients who had a medical card at the time service was delivered.

Providers who have provided Medicaid covered services to such recipients for periods of retroactive coverage may choose to accept the recipient as a Medicaid patient retroactively only after a Medicaid identification card is issued to the recipient.

Providers who agree to bill Medicaid must reimburse the patient immediately. The patient should be reimbursed the full amount they paid for the Medicaid covered services. Providers do not have the option to refund only the Medicaid allowed amount for the covered Medicaid services; the recipient must be refunded the amount they paid for the services. Providers may not withhold a refund until Medicaid pays on the claim, nor may they apply the amount of the refund to another outstanding balance without the recipient's permission.

Providers who agree to reimburse recipients should follow established claim filing procedures. Claims for dates of service less than one year old may be submitted to Unisys as usual (EDI, pharmacy POS, or paper). Claims for dates of service between one and two years old, and those over two years old should be filed in accordance with retroactive eligibility procedures on p. 25.

Providers who choose not to accept the recipient as a Medicaid patient retroactively, should not reimburse the recipient; the State will reimburse the recipient directly. A provider's ability to participate in the Medicaid program will not be affected if they choose not to accept a Medicaid patient retroactively.

If the provider chooses not to accept the Medicaid recipient retroactively, the recipient should contact his parish Medicaid office to obtain reimbursement information for Medicaid covered expenses incurred during the period of retroactive eligibility. The LaCHIP office will contact the provider via a Provider Contact Letter (Form RRP-P). This form is pictured on the following page and the provider is asked to complete and return the form. This completed document is used by the State to determine the appropriate refund for the recipient.

BHSF Form RRP-P
Rev. 11/00
II

Medicaid Program

Provider Contact Letter

Date

Recipient Name

Recipient Medicaid Number

Louisiana's **Medicaid Program** has received a claim for reimbursement from the recipient identified above for services you provided on the following date(s):_____.
Please consider refunding the payment(s) previously paid by this recipient and submitting a claim to Medicaid for payment of these services. We ask that you complete the Response section below and return this form to our office within 15 days (by _____) so that we can process the recipient's claim. A stamped, self-addressed envelope is enclosed for your convenience in replying. If we do not receive your response by this date, we will process the recipient's claim for reimbursement, you will not be entitled to receive Medicaid payment for these services, and any subsequent claim by you could constitute fraud. Your consideration of and prompt attention to this matter are appreciated.

Sincerely,

Agency Representative

Provider Response

As an enrolled Medicaid provider are you willing to reimburse the recipient the full amount of payment and bill Medicaid for these services? ❑ Yes ❑ No

If **yes**, please indicate the date and amount of your reimbursement:

Reimbursement Date

Reimbursement Amount

If **no**, please complete the following for each service provided on the date(s) shown above or attach a copy of your standard billing form (HCFA 1500, UB92 or pharmacy drug profile):

Date of Service	Date of Service	Date of Service	Date of Service	Date of Service	Date of Service
Type of Service	Type of Service	Type of Service	Type of Service	Type of Service	Type of Service
Billed Amount	Billed Amount	Billed Amount	Billed Amount	Billed Amount	Billed Amount
Procedure Code	Procedure Code	Procedure Code	Procedure Code	Procedure Code	Procedure Code
National Drug Code	National Drug Code	National Drug Code	National Drug Code	National Drug Code	National Drug Code
Diagnosis Code	Diagnosis Code	Diagnosis Code	Diagnosis Code	Diagnosis Code	Diagnosis Code
# Units	# Units	# Units	# Units	# Units	# Units

Provider Signature

Provider Name and Number

Phone Number

Date

Parish Office Phone Numbers

01 Acadia	(337) 788-7610
02 Allen	(337) 639-4173
03 Ascension	(888) 474-2070
	(225) 644-3700
04 Assumption	(800) 401-0132
	(985) 449-5021
05 Avoyelles	(318) 253-5946
	(318) 253-5947
06 Beauregard	(337) 463-9131
07 Bienville	(800) 256-3068
	(318) 263-9477
08 Bossier	(800) 256-3068
	(318) 862-9875
09 Caddo	(800) 256-3068
	(318) 862-9875
10 Calcasieu	(337) 491-2439
11 Caldwell	(800) 460-7726
	(318) 435-2101
12 Cameron	(337) 491-2439
13 Catahoula	(318) 339-4213
14 Claiborne	(800) 256-3068
	(318) 862-9875
15 Concordia	(318) 757-3202
16 DeSoto	(800) 873-8987
	(318) 357-2466
17 E. Baton Rouge	(225) 922-1542
18 E. Carroll	(888) 738-0792
	(318) 428-3252
19 E. Feliciana	(800) 259-9841
	(225) 683-4757
20 Evangeline	(337) 363-4262
21 Franklin	(800) 460-7726
	(318) 435-2101
22 Grant	(318) 627-5408
23 Iberia	(337) 373-0062
24 Iberville	(800) 631-0941
	(225) 692-7014
25 Jackson	(888) 436-6561
	(318) 251-5049
65 Jefferson-EB	(504) 599-0656
26 Jefferson-WB	(504) 361-6973
27 Jefferson Davis	(337) 824-2014
28 Lafayette	(337) 262-5111
29 Lafourche	(800) 401-0132
	(985) 449-5021
30 LaSalle	(318) 922-5320
31 Lincoln	(888) 436-6561
	(318) 251-5049
32 Livingston	(225) 665-1899
33 Madison	(800) 460-7701
	(318) 728-0344
34 Morehouse	(318) 556-7014
35 Natchitoches	(800) 873-8987
	(318) 357-2466
36 Orleans	(504) 599-0656
37 Ouachita	(800) 510-5378
	(318) 362-3300
38 Plaquemines	(800) 259-5805
	(504) 393-5805
39 Pointe Coupee	(225) 638-6584
40 Rapides	(318) 487-5670
41 Red River	(800) 873-8987
	(318) 357-2466
42 Richland	(800) 460-7701
	(318) 728-0344
43 Sabine	(800) 873-8987
	(318) 357-2466
44 St. Bernard	(504) 599-0656
45 St. Charles	(800) 788-4827
	(985) 651-4809
46 St. Helena	(225) 222-1899
47 St. James	(800) 788-4827
	(985) 651-4809
48 St. John	(800) 788-4827
	(985) 651-4809
49 St. Landry	(337) 942-0155
50 St. Martin	(337) 394-3228
51 St. Mary	(800) 351-4879
	(337) 828-2611
52 St. Tammany	(985) 871-1359
53 Tangipahoa	(985) 543-4216
54 Tensas	(318) 766-9040
55 Terrebonne	(800) 723-1598
	(985) 873-2030
56 Union	(800) 510-5378
	(318) 362-3300
57 Vermillion	(337) 893-2854
58 Vernon	(337) 238-7202
59 Washington	(985) 732-6844
60 Webster	(800) 256-3068
	(318) 862-9875
61 W. Baton Rouge	(800) 631-0941
	(225) 692-7014
62 W. Carroll	(888) 738-0792
	(318) 428-3252
63 W. Feliciana	(800) 259-9841
	(225) 683-4757
64 Winn	(318) 628-2746

Medically Needy Program

Medically Needy

Recipients who meet all of the requirements of a specific Medicaid program **except** the **income requirement**, are classified as **Medically Needy**. There are two groups of Medically Needy recipients:

- Regular Medically Needy
- Spend-Down Medically Needy

Regular Medically Needy recipients are not financially responsible for any medical services which are reimbursed by Medicaid.

Spend-Down Medically Needy recipients may, in certain instances, be financially liable for a portion of their medical expenses. Eligibility for Spend-Down Medically Needy begins on the exact date that these recipients' medical expenses incurred, allowing them to "spend-down" to the level of income (MNIES) to qualify for Medicaid.

Any provider who has provided services to a Medicaid recipient on the recipient's spend-down date will receive a **Spend-Down Medically Needy Notice (Form 110-MNP)** from BHSF. This form will notify the provider of the amount due by the recipient (spend-down portion) and of the amount to be billed to the Medicaid Program. The provider should attach Form 110-MNP to the claim and submit it to the Fiscal Intermediary for processing.

Note: If any provider who rendered services to a patient on the spend-down date does not see his charges on the 110-MNP form, then the provider needs to contact the parish office and provide the information so that the form can be updated. Problems obtaining a Form 110-MNP from a parish office should be referred to: DHH Eligibility Field Operations Section at 225-342-5716.

Note: The provider CANNOT bill the recipient for any amount over the amount specified on the 110-MNP form under 'Beneficiary Liability'.

Note: Medically Needy Recipients are identified on the MEVS, REVS, and e-MEVS systems. MEVS, REVS, and e-MEVS denote the appropriate eligibility information based on the provider type of the inquiring provider. RECIPIENTS ELIGIBLE THROUGH PROGRAMS OTHER THAN THE MEDICALLY NEEDY PROGRAM ARE NOT AFFECTED. Recipients with questions should be advised to direct inquiries to BHSF Eligibility Operations Section at (888) 342-6207. Providers with inquiries should call Unisys Provider Relations at (800) 473-2783 or (225) 924-5040.

The Department of Health and Hospitals does not pay for the following services through its Medically Needy Program: 1) dental services or dentures, 2) alcohol and substance abuse clinic, 3) mental health clinic, 4) home and community based waiver services (HCBS), 5) home health (nurse aide and physical therapy), 6) case management, 7) mental health rehabilitation, 8) psychiatric inpatient hospital for persons under age 22, 9) sexually transmitted disease (STD), and 10) tuberculosis clinic.

110-MNP Form

The following form is used in conjunction with the Medically Needy Program. It is constructed by the Parish Office after receiving statements from providers who performed services to the recipient on the “from” date of service. The providers listed on the form who provided services on the "from" date should collect the amount shown under “Beneficiary Liability Amount”. This amount will be withheld from your billed claims for that date. In addition, the providers who rendered services on the “from” date must attach the 110MNP to their hardcopy claims for that date of service

NOTE: Problems obtaining a Form 110-MNP from a parish office should be referred to: DHH Eligibility Field Operations Section at 225-342-5716.

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BHSF 110-MNP
Revised 12/99
Prior Issue Usable
IV

MEDICAID PROGRAM
Spend-Down Medically Needy Notice

Case Name _____ MEDS Case Identification Number _____ Parish _____

Recipients listed below are eligible for Medicaid coverage **from** _____ / _____ / _____ (spend-down date) **through** _____ / _____ / _____.

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

Patient Name and MEDS Person No. (13 digits)	Provider Name and Vendor No.	Service or Rx Received on Spend-Down Date	Total Unpaid Charges for Services Received	Recipient Liability Amount	Medicaid Liability? Yes	Medicaid Liability? No
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑

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

LOCK-IN PROGRAM

The BHSF has developed a program to educate recipients who may be unintentionally misusing program benefits and to ensure that program funds are used to provide optimum health services for recipients. Recipients who misuse pharmacy and/or physician benefits may be restricted to the use of one pharmacy or one pharmacy and one primary care physician and specialists if needed.

A Lock-In recipient is asked to choose one pharmacy provider or one physician provider and one pharmacy provider to be his Lock-In providers. Under most circumstances recipients with providers listed under the Lock-In segment of MEVS, REVS, and e-MEVS are restricted to receiving physician and/or pharmacy services from these providers. Patients choosing to change Lock-In providers or to add a specialist must do so at the local Parish Office. Providers wishing no longer to be a recipient's Lock-In provider should contact the Pharmacy Benefits Management Unit at DHH at (225) 342-9768 and fax a brief explanation to (225) 237-3334, or phone the Lock-In Unit at (225) 237-3245.

Providers not named on the Lock-In segment accessed through MEVS, REVS, or e-MEVS can provide services; however, no payment will be made to these providers. The BHSF recognizes that there will be unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In recipient when the provider is not named on MEVS, REVS, and e-MEVS. Payment will be made to any physician or pharmacist enrolled in Louisiana Medicaid who grants services to a Lock-In recipient in emergency situations or when life-sustaining medicines are required. If a physician who is not named on the recipient's Lock-In segment renders an emergency service to the recipient, the provider should submit a claim to UNISYS and include "EMERGENCY" in the diagnosis section of the claim form. The physician or the dispensing pharmacist should also write "EMERGENCY" on any prescription resulting from such an emergency.

Providers that suspect that recipients are misusing the Medicaid Program services may contact Mary Wolf with Pharmacy Benefits Management at 225-342-9768 to ask for a review of a recipient's profile for possible inclusion in the Physician/Pharmacy Lock-In Program.

For cases in which a Lock-In physician wishes to refer the recipient for consultation on a one time basis, the consulting physician may be reimbursed if he enters the name and provider number of the referring Lock-In physician in the Referring Physician block on the claim form. If the consulting physician subsequently becomes the treating physician, that physician should remind the recipient to report this information to the BHSF local parish office, because reimbursement cannot be made for continued services until the provider's name and number are entered on the recipient's Lock-In segment.

Pharmacists other than those named in the recipient's Lock-In segment may fill prescriptions for life-sustaining medication or upon receiving a prescription containing the term "EMERGENCY" written by the prescribing or dispensing physician. NCPDP Field 418-DI "Level of Service" should be used to indicate an emergency situation with a value of "3" – Emergency" submitted on the claim. True Emergency prescriptions will be exempt form Lock-In restrictions. If pharmacy providers need further assistance with submitting claims for emergency prescriptions they may contact Unisys Point Of Sale (POS) at (800)-648-0790.

The Lock-In system affects the recipients **only in the areas of physician and/or pharmacy services.** Providers other than physicians or pharmacists may provide the services, which they normally do for any eligible recipient.

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 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.

Prenatal and Preventive Pediatric Care Pay and Chase

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

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

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

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

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

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

3. EPSDT medical, vision, and hearing screening services (KIDMED screening services);

4. EPSDT dental services;

5. EPSDT services to children with special needs (formerly referred to as school health services) which result from screening and are rendered by school boards;

6. Services which are a result of an EPSDT referral, indicated by entering "Y" in block 24H of the CMS-1500 claim form or "1" as a condition code on the UB-92 (form locators 24 - 30).

7. Services for Medicaid eligibles whose health insurance is provided by an absent parent who is under the jurisdiction of the State Child Support Enforcement Agency. All providers and all services (regardless of diagnosis) qualify.

Voiding Accident-Related Claims for Profit

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

Outgoing Medical Records Stamp

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

Medicaid Provider No. (7 digits)
(Optional Control Number)

Services have been provided under Louisiana’s Medicaid Program and are payable under R.S. 46:446:1 to:

DHH Bureau of Health Services Financing
P. O. Box 91030
Baton Rouge, LA 70821-9030
ATTN: Third Party Liability Unit

Any additional authorization needed may be obtained from DHH/BHSF’s TPL Unit at (225) 342-9250.

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, MEVS, 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, MEVS, 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. 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 Plus Choice Claims

Unisys will begin processing Medicare Plus Choice claims with a tentative effective date of December 1, 2004 (pending approved claims testing by the Medicare Plus Choice carriers).

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

The Managed Care Plans currently participating in this program are: Ochsner (Ochsner 65), 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:

Ochsner 65	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 Plus Choice 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 Plus Choice claims.

Recoupments by TPL Collections Contractor - Public Consulting Group

Recoupments are routinely made by Public Consulting Group (PCG), a TPL Collections contractor. This private company is contracted by DHH to review payments and recoup any payment made as Medicaid primary when the recipient had Medicare or private insurance.

PCG identifies these claims and notifies the provider via letter with a claim report of Medicaid recipients whose claims paid as Medicaid primary when other resources were available. The providers are then allowed approximately 90 days to bill Medicare or the private insurance company. If Medicare is involved, this 90 days will allow the provider time to VOID the payments and resubmit claims for consideration of co-insurance and deductible. If private insurance is involved, the provider can ADJUST the original Medicaid payment and include all required private insurance information including the TPL payment. At the end of the 90 days, information is sent to Unisys to recoup the claim payment for claims not already adjusted or voided. When a "P" appears at the beginning of the medical records number found on the

Medicaid remittance advice, it is a PCG recoupment. For further information, the provider may call the PCG Provider Recoupment Team at (866) 567-6318 extension 10.

The following three pages are copies of the PCG letters. These examples reference Medicare. The letters for TPL recoupments are identical to the Medicare recoupment letters except for the reference to private insurance.

- The first notice is the original notice letter that gives a provider 60 days from the notice to review records, etc.

- The second notice letter gives the provider an additional 30 days to review records, etc. before recoupments are processed.

- The third notice letter is a listing of the manual recoupments made by PCG. (Claims that were unable to be automatically recouped due to adjudication dates beyond 24 months.)

State of Louisiana
Department of Health and Hospitals

Month Day, Year

Dear Medicaid Provider:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Public Consulting Group, Inc. (PCG) to supplement its Medicaid Third Party Liability recovery activities. As part of this initiative, PCG is providing the attached reports identifying Medicaid expenditures for claims on recipients who have since been identified as Medicare Part A or Part B eligible.

PCG activity included matching with Medicare files provided to the Department and a review of claims paid by Medicaid. The review identified Medicare coverage for Medicaid recipients for whom your facility received reimbursement from the Louisiana Medicaid Program. Since Medicare is the primary payer to the Medicaid Program, federal regulations require that Medicaid recover funds when a liable third party is identified.

Your facility has **60** days from the date of this notice to: (1) review your records; (2) bill Medicare, if you have not already done so; (3) forward documentation to PCG to refute the impending recoupment action for each of these claims if Medicare denies your claim; and (4) in all correspondences, use the claim ICN from this report to identify the claim in question.

If you receive a denial when you bill, forward a copy of the EOMB to the address shown below. Denials will only be accepted for non-covered services, no eligibility on the date of service, or for provider credentials not accepted by the insurance carrier***. Please be advised, in accordance with Medicaid Program requirements, you have to bill Medicare for all claims. Verification of Medicare eligibility on the Medicare online system or by phone will not be accepted for denials***. You are expected to comply with any requirements concerning accepting assignment, or supplying additional information. Where appropriate, request waivers of time limit or prior authorization.

An unsatisfactory response or no response to this notification will require that we recoup these payments from future remittance advices. It is important that you read this notice carefully, review the attached report thoroughly and take the steps outlined above to prevent a recoupment action. Since recoupment is the preferred means of collection for these expenditures, ***do not send a refund check or a void claim transaction to PCG, DHH or the fiscal agent, UNISYS. Please do not contact any unit of the Department of Health and Hospitals or UNISYS regarding this notice.***

Please direct your response to this notice, or any questions, to the address and phone number that follows:

Louisiana DHH-TPL
Attn: Provider Recoupment Team
P.O. Box 22053
Albany, NY 12201-2053
(866) 567-6318, ext. 10

We appreciate your cooperation in this effort to maximize Medicaid coordination with liable third parties.

Sincerely,

Nicole D. Lisk, Consultant
Public Consulting Group, Inc.

State of Louisiana
Department of Health and Hospitals

Month Day, Year

RE: **Recoupment Report – <u>Second Notice</u>**

Dear Medicaid Provider:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Public Consulting Group, Inc. (PCG) to supplement its Medicaid Third Party Liability recovery activities. PCG sent you a claim report dated mm/dd/yy of Medicaid recipients who received services from your facility and subsequently were found to have Medicare coverage on the date(s) of service. At that time, we requested that you bill Medicare and advised that Medicaid will recoup the funds paid for services provided by your facility and for which Medicare should have been billed.

Attached with this letter is a reprint of the original claims report. In accordance with DHH, PCG will allow providers an additional **30** days from the day of this notice to complete the process. At the end of this period PCG will forward DHH notification to recoup claims for which appropriate documentation has not been received. The recoupment will be made through the method of withholding these amounts from your future payments. If you are currently in the process of adjusting Medicaid's payment, or have not sent the insurance denial, please provide this documentation immediately. It is critical that you keep us informed of your billing process. **Please note that this is an exact copy of the report sent to you on mm/dd/yy and not a new report**. If you completed your process prior to receiving this reminder, you do not have to reprocess.

Please direct your response to this notice, or any questions, to the address and phone number that follows:

Louisiana DHH-TPL
Attn: Provider Recoupment Team
P.O. Box 22053
Albany, NY 12201-2053
(866) 567-6318, ext. 10

We sincerely appreciate your cooperation in this effort to maximize Medicaid coordination with liable third parties.

Respectfully,

Nicole D. Lisk, Consultant
Public Consulting Group, Inc.

CC: Bill Perkins, TPL Program Director
Louisiana Department of Health and Hospitals

State of Louisiana
Department of Health and Hospitals

Month Day, Year

Dear Medicaid Provider:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Public Consulting Group, Inc. (PCG) to supplement its Medicaid Third Party Liability recovery activities.

On **MM/DD/YYYY**, PCG provided your facility with a list of claims that were previously paid for by Medicaid. The recipients associated with these claims, were subsequently identified by PCG as having Medicare coverage in effect on these dates-of-service.

Your facility was advised to (1) review your records; (2) bill Medicare, if you have not already done so; (3) forward documentation to PCG to refute the impending recoupment action for each of these claims if Medicare denies your claim; and (4) in all correspondences, use the claim ICN from this report to identify the claim in question.

The automatic Medicaid recoupment of the claims forwarded to your facility on the above referenced date has already been processed by the State's automated claims processing system for all eligible claims. However, the State's automated claims processing system cannot automatically recoup claims with an adjudication date older than twenty four (24) months.

The attached report outlines Medicaid paid claims, which PCG notified you of on the above referenced date, but have adjudication dates beyond the past 24 months. As a result, the States claims processing system was unable to recoup these claims automatically.

This letter will serve as notice to your facility that DHH will manually recoup the amount of funds identified on the last page of the attached report as **"Total Paid"**. The attached report provides the detailed listing of each claim in order to support the total amount to be manually recouped. This manual recoupment will occur **30 days** from the date of this notice and will appear on your remittance advice as a one line negative adjustment amount.

Since recoupment is the preferred means of collections for these expenditures, ***please do not send a refund check or initiate an adjustment with PCG, DHH or the fiscal agent, Unisys as this may result in a duplicated recovery.***

If you have any questions or concerns regarding the recoupment of these claims, please direct your response to the address and phone number below:

Louisiana DHH-TPL
Attn: Provider Recoupment Team
P.O. Box 22053
Albany, NY 12201-2053
(866) 567-6318, ext. 10

We appreciate your cooperation in this effort to maximize Medicaid coordination with liable third parties.

Sincerely,

Nicole D. Lisk, Consultant
Public Consulting Group, Inc.

Quarterly Medicare Recoveries By Unisys

Every quarter Unisys does a Medicare recovery where DHH has identified recipients who have Medicare coverage and Medicaid has paid claims which should have been submitted to Medicare for primary payment.

Approximately two weeks before these recoveries are made, the provider receives a letter with a listing of recipients for which the recoupments will be made. The recoupments are for Part A Medicare and appear as voids on the provider's Medicaid remittance advice. Examples of both the recoupment letter and a list of recipient recoupments follow.

********** MEDICARE RECOVERY ADJ/VOID NOTIFICATION **********

FEDERAL REGULATIONS REQUIRE THAT THE LA MEDICAL ASSISTANCE PROGRAM RECOVER MEDICAID PAYMENTS FOR SERVICES WHICH SHOULD HAVE BEEN COVERED BY MEDICARE PART A OR PART B WHICH MUST BE FILED TO THE PART A CARRIER. REVIEW THE ENCLOSED CLAIM LISTING WHICH SHOWS CLAIMS THAT WILL BE AUTOMATICALLY VOIDED (PART A SERVICES) OR ADJUSTED (DEDUCTION OF INPATIENT PART B ANCILLARY) BY UNISYS APPROXIMATELY 2 WEEKS AFTER RECEIPT OF THIS LETTER. CLAIMS WITH DATES OF SERVICE FROM JANUARY 1 THROUGH SEPTEMBER 30 CAN BE FILED TO MEDICARE UNTIL DECEMBER 31 OF THE FOLLOWING YEAR. CLAIMS WITH DATES OF SERVICE FROM OCTOBER 1 THROUGH DECEMBER 31 CAN BE FILED TO MEDICARE UNTIL DECEMBER 31 TWO YEARS FOLLOWING THE YEAR OF THE DATE OF SERVICE. IT IS RECOMMENDED THAT FILING TO MEDICARE BE DONE PROMPTLY UPON RECEIPT OF THIS NOTIFICATION. CLAIMS FILED TO PART A BLUE CROSS/BLUE SHIELD MISSISSIPPI, TO TEXAS BLUE CROSS (HEMODIALYSIS FACILITIES ONLY), OR TO MUTUAL OF OMAHA'S MEDICARE DIVISION AUTOMATICALLY CROSS TO LA MEDICAID FOR COINSURANCE AND DEDUCTIBLE PAYMENT RECONSIDERATION. CLAIMS FILED TO OTHER MEDICARE CARRIERS MUST BE REFILED HARDCOPY TO UNISYS WITH A COPY OF THE MEDICARE EOMB. ALL REFILES MUST BE PROCESSED EITHER BEFORE EXPIRATION OF ONE YEAR FROM DATE OF SERVICE OR SIX MONTHS FROM MEDICARE ADJUDICATION DATE. MAIL HARDCOPY CROSSOVERS TO UNISYS, PO BOX 91023, BATON ROUGE, LA 70821. THE INPATIENT PORTION OF YOUR CLAIM FOR A RECIPIENT WHO HAS PART B ONLY WILL REMAIN PAID AND YOU WILL BE ENTITLED ONLY TO COINSURANCE AND DEDUCTIBLE FOR THE ANCILLARIES ASSOCIATED WITH THE INPATIENT STAY. FOR A CLAIM THAT WAS VOIDED/ADJUSTED IN ERROR, MAIL TO ATTN: MEDICARE PROJECT COORDINATOR AT THE ADDRESS SHOWN BELOW (1) CLAIM FORM, (2) COPY OF CLAIM LISTING OR UNISYS REMITTANCE ADVICE SHOWING VOID, (3) OTHER PERTINENT INFORMATION - NOTATE IF CLAIM VOIDED IN ERROR. DO NOT SEND CLAIMS VOIDED IN ERROR TO UNISYS AS THEY WILL BE DENIED. QUESTIONABLE MEDICARE ENTITLEMENT WILL BE DETERMINED BY THE TPL/MEDICAID RECOVERY UNIT IN ORDER TO RESOLVE A CLAIM. IF PAYMENT FOR THE COINSURANCE AND/OR DEDUCTIBLE IS DENIED FOR ERROR CODE 911 (RECIPIENT HAS USED ALL ALLOWABLE HOSPITAL DAYS), SEND THESE CLAIMS TO ATTN: MEDICARE PROJECT COORDINATOR, ADDRESS SHOWN BELOW, AND INCLUDE (1) CLAIM FORM, (2) MEDICARE EOMB, (3) UNISYS REMITTANCE ADVICE SHOWING VOID AND 911 DENIAL.

ADDRESS - TPL/MEDICAID RECOVERY UNIT
PO BOX 91030
BATON ROUGE, LA 70821-9030

LAM2D012 CP-O-12C
RUN: 07/01/04

LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS
DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAL (BHSF)

PROVIDER ID:

CYCLE: 06/30/04

MEDICARE RECOVERY PROJECT - CLAIM DETAIL LISTING

PAGE: 1

RECIPIENT ID	HIC	NAME	MEDICARE TYPE COVG	CLAIM ICN	PROC	DATES OF SERVICE	MEDICAID PAYMENT	HOSPITAL ANCILLARIES
			PART B		HR821	01/12/2004-01/12/2004	$123.99	$0.00
	*** TOTAL:	RECORDS 1					$123.99	$0.00

TPL and Eligibility Reminders

Many services covered under the Louisiana Medicaid Program require some form of prior authorization, pre-certification, or extension request. Please remember that authorization of services does not override any other Medicaid Program policy and does not guarantee payment of the claim. This includes, but is not limited to, the following examples:

- If a recipient is Medicare eligible, an authorization does not override the fact that the claim must be submitted to Medicare for consideration prior to being submitted to Medicaid. Please be aware of this fact when submitting your claims for processing.

- If a recipient is eligible for other insurance, a prior authorization or pre-certification does not override the fact that the claim must be submitted to the other insurance for consideration prior to being submitted to Medicaid.

- Likewise, other insurance coverage does not negate the need for prior authorization or pre-certification if the provider intends to bill Medicaid secondary.

- If a recipient is not eligible for services on the specified date of service, an authorization does not override ineligibility, and the claim will not be paid.

- Recipients with Medicare benefits, and recipients who have other primary insurance with physician benefits, (including HMOs) are exempt from CommunityCARE. However, until these benefits are loaded on the Unisys Medicaid files and the CommunityCARE linkage is closed, a referral is required.

NOTICE: IF YOU ARE SUBMITTING A CLAIM IN WHICH THE THIRD PARTY LIABILITY CARRIER HAS DENIED, THE EOB ATTACHED MUST ALSO INCLUDE A <u>COMPLETE DESCRIPTION</u> OF THE DENIAL CODE.

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.
- KIDMED screening claims (KM-3 forms) must be filed within 60 days from 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 Medicare 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.

Dates of Service Over Two Years Old

Claims with dates of service over two years old are not to be submitted to Unisys or to the BHSF for overriding of the timely filing edit unless one or more of the guidelines listed below is met:

- The recipient was certified for retroactive Medicaid benefits;
- The recipient won a Medicare or SSI appeal in which he was granted retroactive Medicaid benefits; and/or

The failure of the claim to pay was the state's, rather than the provider's, fault each time the claim was adjudicated.

COMMUNITYCARE

Program Description

CommunityCARE is operated in Louisiana under a freedom of choice waiver granted by the Centers for Medicare and Medicaid Services (CMS). It is a system of comprehensive health care based on a primary care case management (PCCM) model. CommunityCARE links Medicaid eligibles with a primary care physician (PCP) that serves as their medical home.

Recipients

Participation in the CommunityCARE program is mandatory for most Medicaid recipients. Currently, seventy-five to eighty percent of all Medicaid recipients are linked to a primary care provider. Recipients not linked to a CommunityCARE PCP may continue to receive services without a referral/authorization just as they did before CommunityCARE. Those recipient types that are **EXEMPT** from participation in CommunityCARE, and will not be linked to a PCP, are listed below. (This list is subject to change.)

- Residents of long term care nursing facilities, psychiatric facilities, or intermediate care facilities for the mentally retarded (ICF/MR) such as state developmental centers and group homes
- Recipients who are 65 years or older
- Recipients with Medicare benefits, including dual eligibles
- Foster children or children receiving adoption assistance
- Office of Youth Development recipients (children in State custody)
- Recipients in the Medicaid 'Lock In' program
- Recipients who have other primary insurance with physician benefits, including HMO's
- Recipients who have an eligibility period of less than 3 months
- Recipients with retroactive eligibility (for the retroactive eligibility period only as CommunityCARE linkages may not be retroactive)
- BHSF case-by-case approved "Medically High Risk" exemptions
- Recipients enrolled in Hospice
- Native American Indians residing in parish of reservation (currently Jefferson Davis, St. Mary, LaSalle, and Avoyelles Parishes)

CommunityCARE recipients are identified under the CommunityCARE segment of REVS, MEVS, and the online verification system (e-MEVS) through the Unisys website – www.lamedicaid.com. This segment gives the name and telephone number of the linked PCP.

Primary Care Physician

As part of the case management responsibility, the PCP is obligated to ensure that referrals/authorizations for medically necessary healthcare services which they can not/do not provide are furnished promptly and without compromise to quality of care. The PCP cannot unreasonably withhold them **OR** require that the requesting provider complete them. **Any referral/authorization requests must be responded to, either approved or denied, within 10 business days.** The need for a PCP referral/authorization does not replace other Medicaid policies that are in existence. For example, if the service requires prior authorization, the

provider must still obtain prior authorization **in addition to** obtaining the referral/authorization from the PCP.

The Medicaid covered services, which do not require a referral/authorization from the CommunityCARE PCP, are "**exempt**." The current list of exempt services is as follows:

- Chiropractic service upon KIDMED referral (ages 0-21)
- Dental services for children, ages 0-21 (billed on the ADA claim form)
- Dental services for pregnant women, ages 21-59 (billed on the ADA claim form)
- Dentures for adults
- The three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services. (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but do require POST authorization). Refer to "Emergency Services" in the CommunityCARE Handbook.
- Inpatient Care that has been pre-certed (this also applies to public hospitals even though they aren't required to obtain pre-certification for inpatient stays) and related hospital, physician and ancillary services
- EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program

  Note: A REFERRAL/AUTHORIZATION from the PCP IS REQUIRED for "Children's Special Health Services" clinics (Handicapped Children's Services) operated by The Office of Public Health.
- Family planning services
- Prenatal/Obstetrical Services
- Services provided through the Home and Community Based Waiver programs.
- Targeted case management
- Mental Health Clinic services (State facilities)
- Mental Health Rehabilitation services
- Neonatology services while in the hospital
- Ophthalmologist and Optometrist services
- Pharmacy
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists Services
- Transportation services
- Hemodialysis
- Hospice services
- Specific lab and radiology codes

Non-PCP Providers and Exempt Services

Any provider, other than the recipient's PCP, must obtain a referral/authorization from the recipient's PCP in order to receive payment for services rendered. Any provider who provides a non-exempt, non-emergent (routine) service for a CommunityCARE enrollee, without obtaining the appropriate referral/authorization prior to the service being provided risks non-payment by Medicaid.

When a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the patient's PCP to obtain the

appropriate referral/authorization for any follow-up services the patient may need after discharge (i.e. Durable Medical Equipment (DME) or home health). Neither the home health nor DME provider can receive reimbursement from Medicaid without the appropriate PCP referral/authorization. **The DME and home health provider must have the referral/authorization in hand prior to rendering the services.**

General Assistance – all numbers are available Mon-Fri, 8am-5pm

Providers:

Unisys - (800) 473-2783 or (225) 924-5040 - CommunityCARE Program policy, procedures, and problems, complaints concerning CommunityCARE

ACS - (800) 609-3888 - PCP assignment for CommunityCARE recipients, inquiries related to monitoring, certification

ACS - (877) 455-9955 - referral assistance

Recipients:

ACS - (800) 259-4444

HOSPICE SERVICES

Overview

Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

A recipient must be terminally ill in order to receive Medicaid hospice care. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

Payment of Medical Services Related to the Terminal Illness

Once a recipient elects to receive hospice services, **the hospice agency is responsible for <u>either providing or paying for</u> all covered services related to the treatment of the recipient's terminal illness.**

For the duration of hospice care, an individual recipient waives all rights to Medicaid payments for:

- Hospice care provided by a hospice other than the hospice designated by the individual recipient or a person authorized by law to consent to medical treatment for the recipient.
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected OR a related condition OR that are equivalent to hospice care, except for services provided by: (1) the designated hospice; (2) another hospice under arrangements made by the designated hospice; or (3) the individual's attending physician if that physician IS NOT an employee of the designated hospice or receiving compensation from the hospice for those services.

Payment for Medical Services NOT Related to the Terminal Illness

Any claim for services submitted by a provider other than the elected hospice agency will be denied if the claim does not have attached justification that the service was medically necessary and **WAS NOT related to the terminal condition for which hospice care was elected.** If documentation is attached to the claim, the claim pends for medical review. Documentation may include:

- A statement/letter from the physician confirming that the service was not related to the recipient's terminal illness, or
- Documentation of the procedure and diagnosis that illustrates why the service was not related to the recipient's terminal illness.

If the information does not justify that the service was medically necessary and not related to the terminal condition for which hospice care was elected, the claim will be denied. If review of the claim and attachments justify that the claim is for a covered service not related to the terminal condition for which hospice care was elected, the claim will be released for payment. *Please note, if prior authorization or precertification is required for any covered Medicaid services not related to the treatment of the terminal condition, that prior authorization/precertification is required and must be obtained just as in any other case.*

NOTE: Claims for prescription drugs and home and community based waiver services will not be denied but will be subject to post-payment review.

LOUISIANA WEB APPLICATIONS

The Louisiana Medicaid Website, www.lamedicaid.com, has several web applications that can be used by providers. These applications require that providers establish an online account with LAMEDICAID.COM. This section provides "how to" information for these web applications including obtaining a valid provider online account; completing the login ID/password process, and accessing the applications. It also provides screen samples of the Main Menu and web applications. All web applications are available 24 hours a day 7 days a week at no cost to providers.

Provider Login and Password

To ensure appropriate security of recipient's patient health information (PHI) and provider's personal information, the secure area of the web site is available to providers only. It is the responsibility of each provider to become "Web Enrolled" by obtaining a login and password for this area of the site to be used with his/her provider number. Once the login and password are obtained by the provider who "owns" the provider number, that provider may permit multiple users to login using the provider number. This system allows multiple individuals to login using the same login and password OR a provider may have up to 500 individual logins and passwords established for a single provider number. The administrative account rights are established when a provider initially obtains a login and password, and should remain with the provider or designated office staff employed by the provider.

A login and password may be obtained by using the link, Provider Web Account Registration Instructions. Instructions for obtaining a login and password are available by selecting this link located in the navigation menu on the left side of the Louisiana Medicaid home page or through information found in this training packet. Providers who experience difficulty accessing the link or in obtaining the instructions file from the web site may contact the Unisys Technical Support Desk at 1-877-598-8753 Monday – Friday 8 a.m.- 5 p.m. (Central Time) or request support by emailing lasupport@unisys.com.

☞ Unisys has received inquiries from billing agents/vendors attempting to access this web application. DHH and CMS Security Policy restrictions will not permit Unisys to allow access of this secure application to anyone except the owner of the provider number being used for accessing the site. In cases where an outside billing agent/vendor is contracted to submit claims on behalf of a provider, any existing business partner agreement is between the provider and the billing agent/vendor. **Unisys** may not permit anyone except the provider to receive or ask for information related to a login and password to access secured information.

Requirements for Establishing An Online Account With LAMedicaid.Com

Providers must have the following:

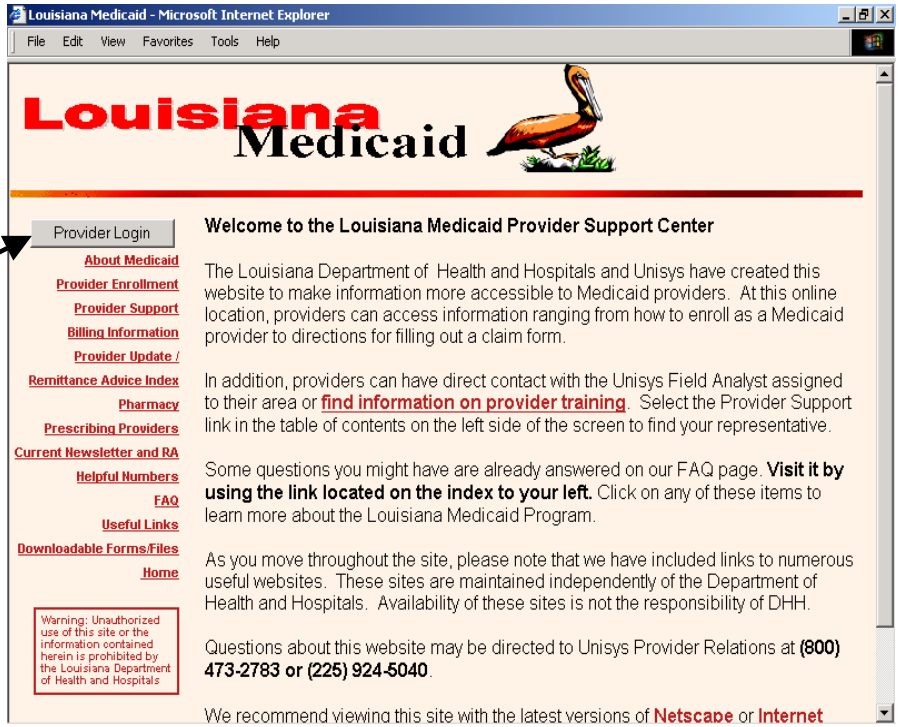
1. A valid 7-digit Provider ID number assigned by Louisiana Medicaid
2. An Internet account with an Internet Service Provider (not provided by DHH or Unisys).
3. A valid e-mail address (not provided by DHH or Unisys).
4. A Web Browser that supports SSL with 128-bit encryption, for example, Microsoft Internet Explorer v5 or v6 or Netscape Navigator v6 or v7.

Instructions for Establishing A Login And Password

Part One: Create your own Login ID, Challenge Word and Challenge Number

Step 1.

Open your Web browser and go to www.lamedicaid.com



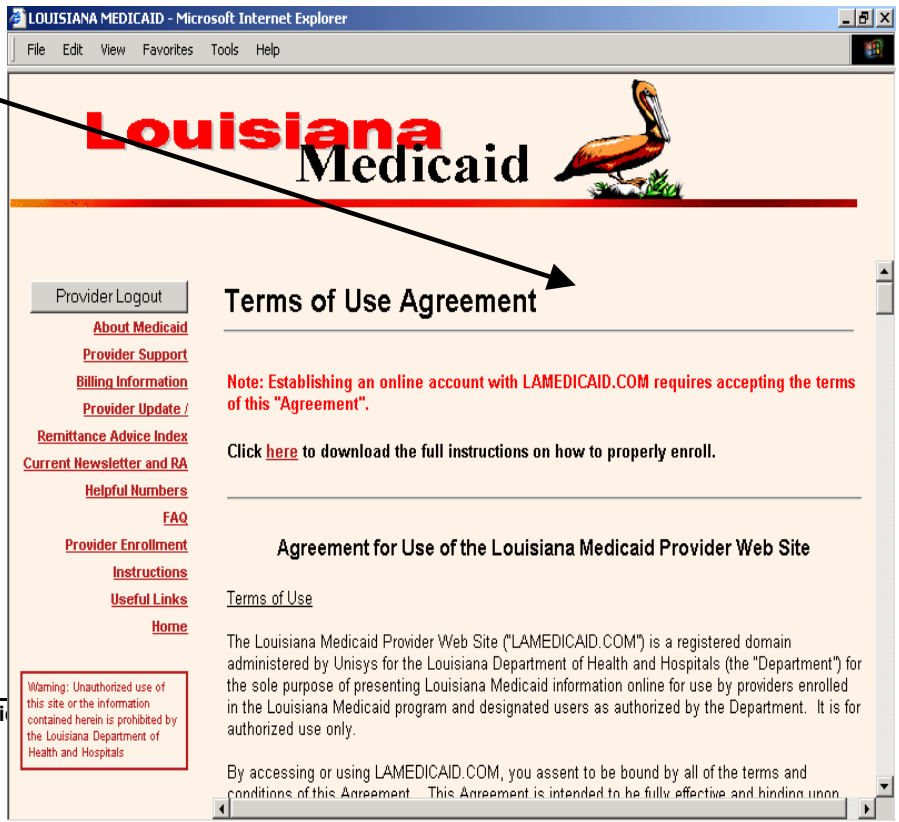
Step 2.

Click on the **Provider Login** button.

Step 3.

Enter your 7-Digit Medicaid Provider ID Number.

Click on the **Enter** button.



Step 4.

Read the “Terms of Use Agreement”.

Step 5.

At the bottom of the “Terms of Use Agreement” are two buttons: **Accept** and **Decline**.

Click on the button that indicates your action. If you accept, you will continue to Step 6. If you decline, the process is terminated and you will not be allowed to access restricted applications on LAMEDICAID.com.

Step 6.

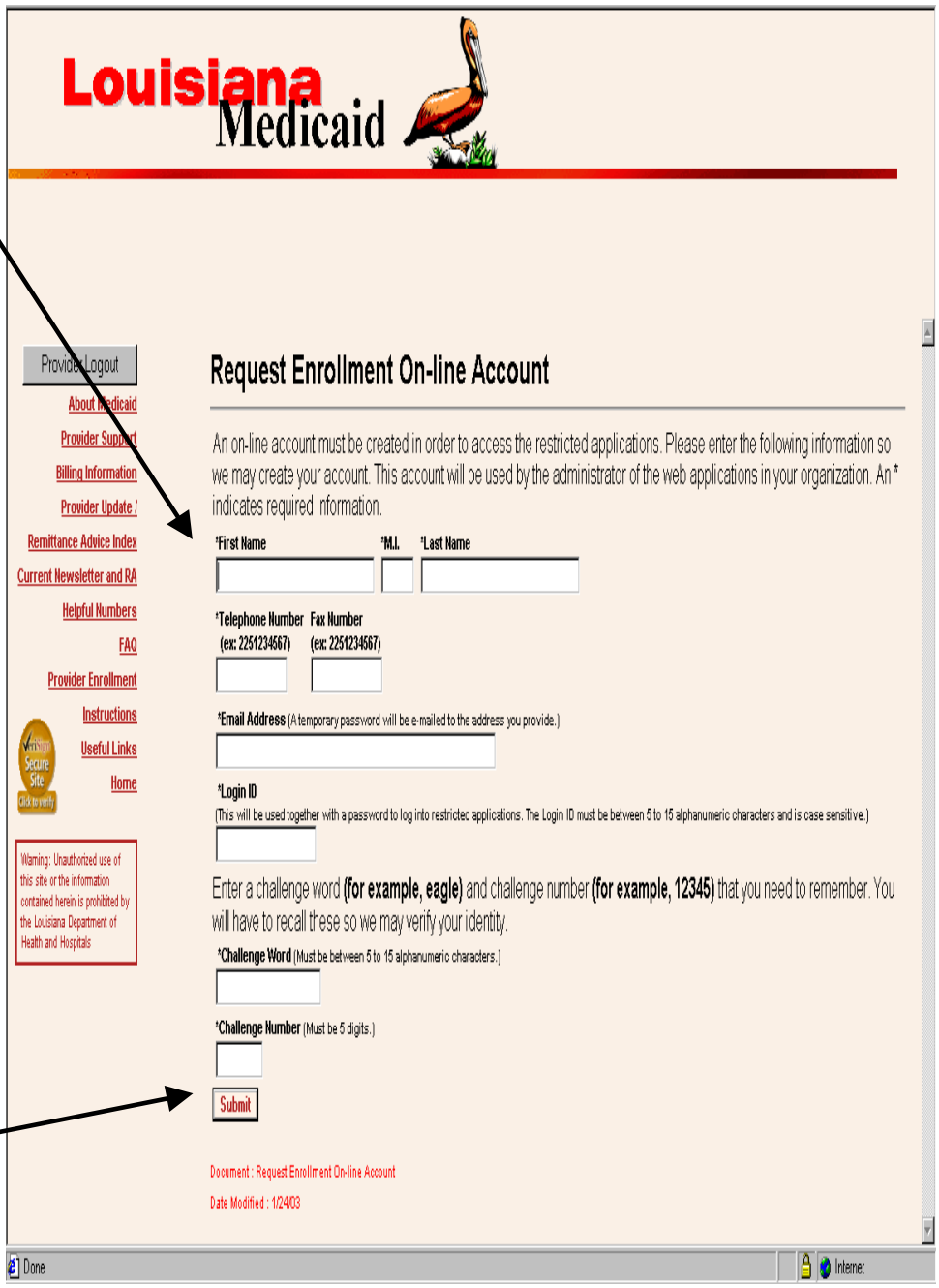
Enter the following information:

- your First Name,
- your Middle Initial,
- your Last Name,
- your telephone number,
- your fax number,
- your e-mail address,
- a login ID of your choice (see note below)
- a challenge word of your choice (see note below), and
- a challenge number of your choice (see note below).

NOTES:

- Your **login ID** must be between 5 and 15 letters and/or numbers, and it is case-sensitive.
- Your **challenge word** must be between 8 and 15 letters. It is not case-sensitive.
- Your **challenge number** must be 5 digits.

Click on the **Submit** button.



Step 7.

A message will appear stating the first part of the new account process has been complete.

Click on the **OK** button.

Step 8.

Close your Web browser.

Within an hour (approximately), an e-mail message from lasupport@unisys.com, which contains your temporary password, should be received.

Once the temporary password has been received, providers can proceed to Part 2 of the instructions for establishing a login and password.

THE TEMPORARY PASSWORD ALONG WITH THE LOGIN ID AND CHALLENGE WORD MUST BE USED WITHIN 5 DAYS OF RECEIPT OF THE E-MAIL IN ORDER TO ESTABLISH A PERMANENT PASSWORD.

If the temporary password is not used within the 5 day period, please call Unisys toll-free at **1-877-598-8753**.

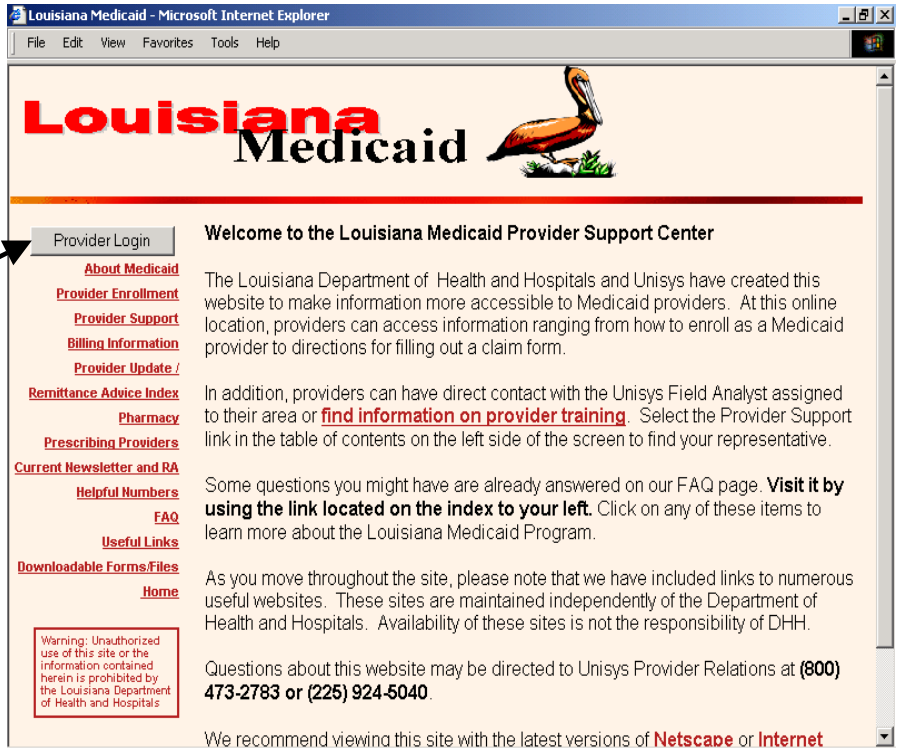
Part Two: Create a Permanent Password

Step 1.

Open your Web browser and go to www.lamedicaid.com

Step 2.

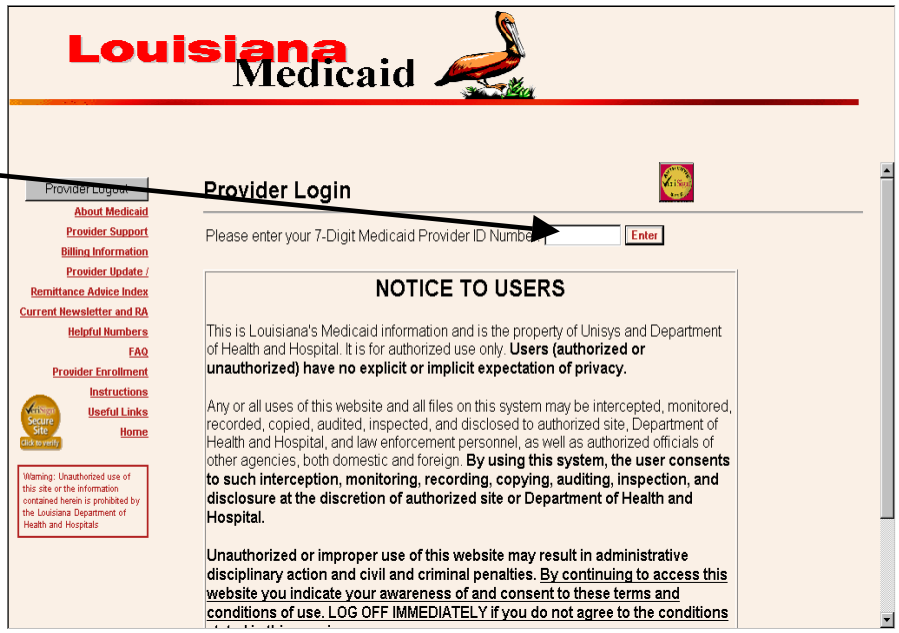
Click on the **Provider Login** button.



Step 3.

Enter your 7-Digit Medicaid Provider ID Number.

Click on the **Enter** button.

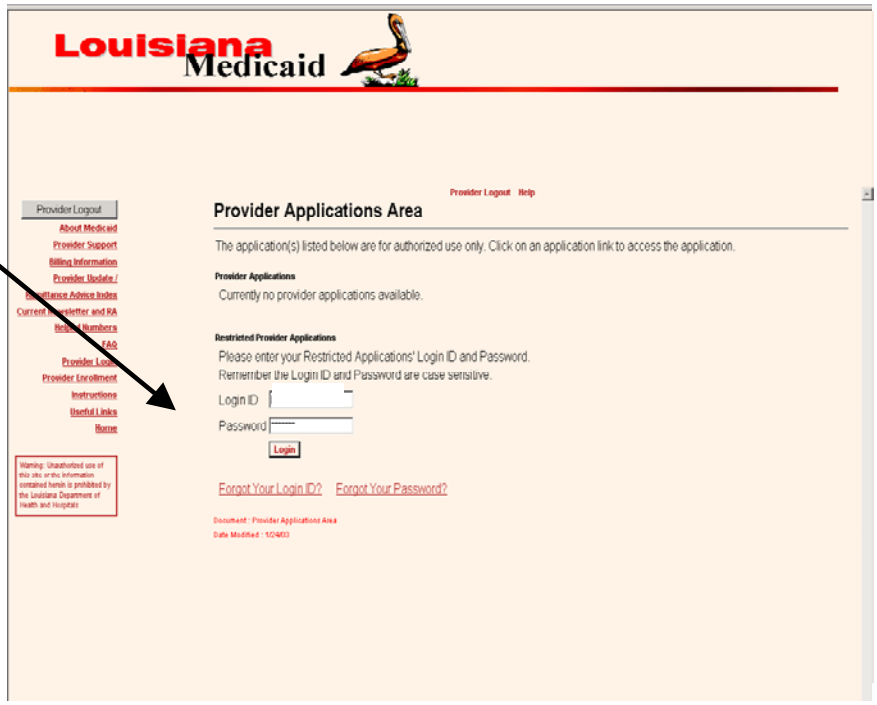


Step 4.

Enter your Login ID.

Enter the temporary password received by e-mail from Unisys.

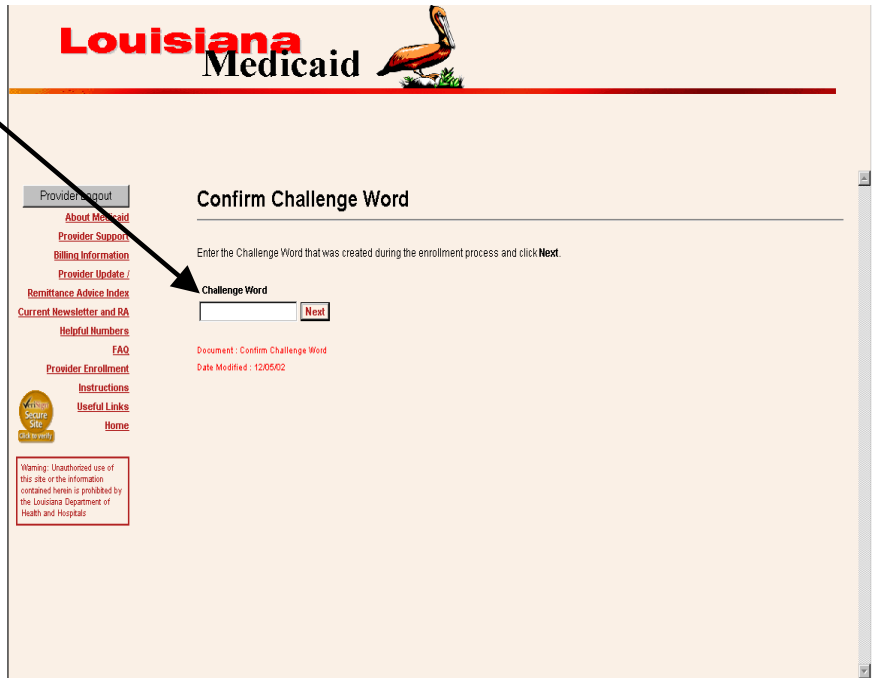
Click on the **Login** button.



Step 5.

Enter your Challenge Word.

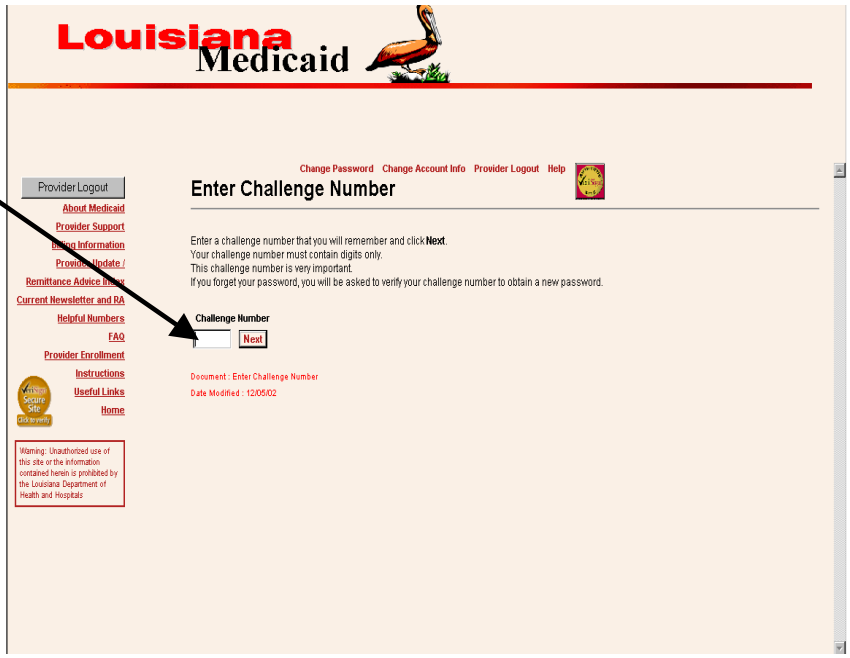
Click on the **Next** button.



Step 6.

Enter your Challenge Number.

Click on the **Next** button.



Step 7.

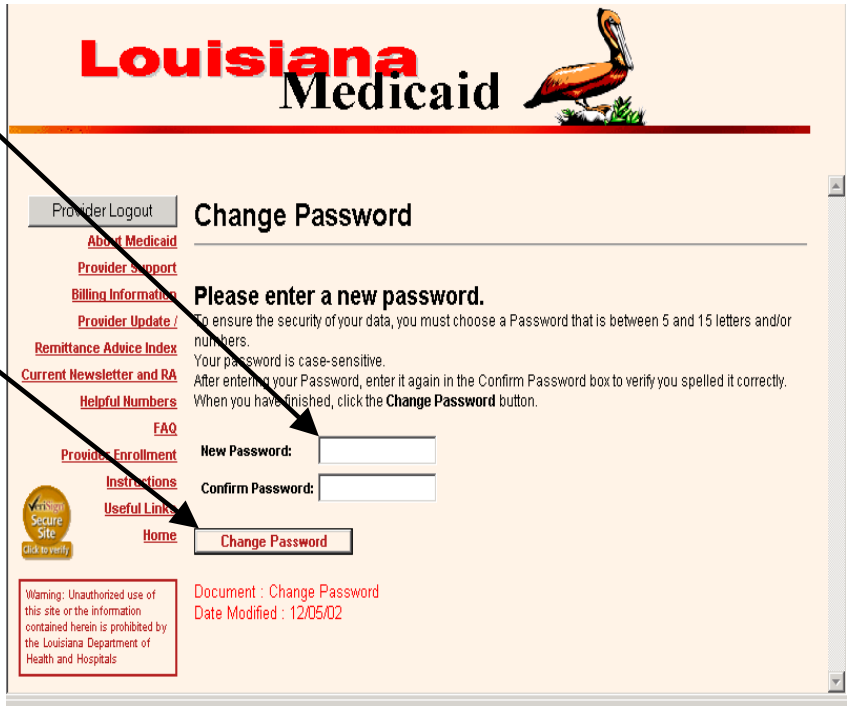
You will need to enter the same password twice.

Note: The new password must be between 5 and15 letters and/or numbers, and it is case-sensitive.

Click on the **Change Password** button.

Write down your new password.

You have completed the entire account activation process. From this point, you will use your LOGIN ID and PERMANENT PASSWORD to access LAMEDICAID.COM.



Part Three: Change your Permanent Password

NOTE: Your permanent password will expire after 180 days and you will be prompted to change it.

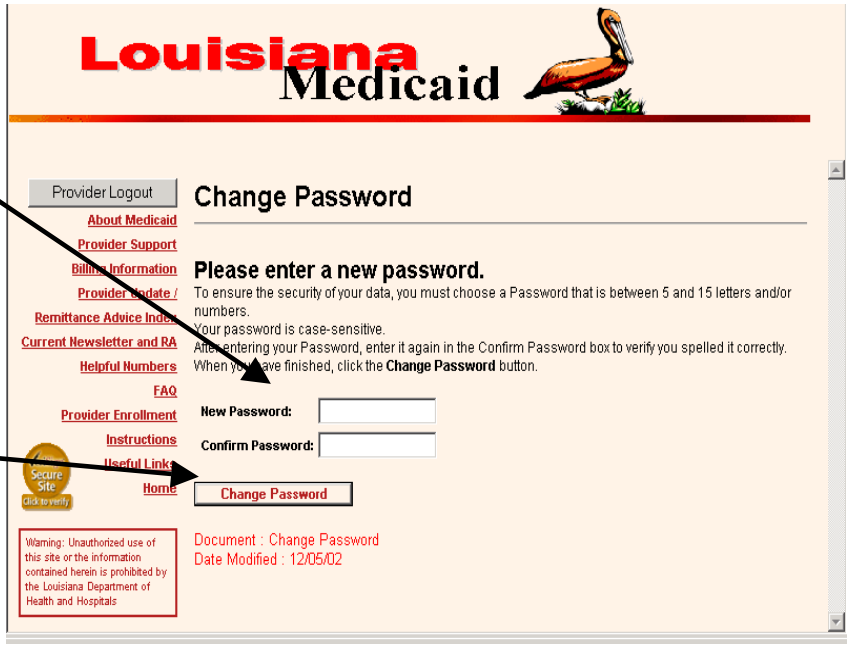
Step 1.

Enter your new password in both boxes:

- New Password
- Confirm Password

Note: The new password must be between 5 and15 letters and/or numbers, and it is case-sensitive.

Click on the **Change Password** button.



Instructions for Logging On to the Louisiana Medicaid Main Menu and Accessing the Web Applications

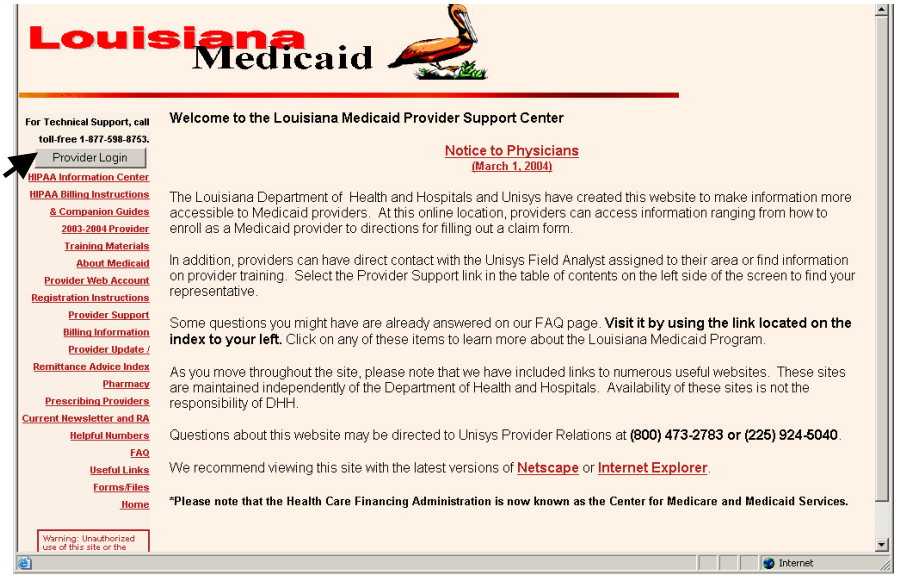
Accessing the Web Applications

Access to the web applications is controlled by login ID and password. The Louisiana Department of Health and Hospitals (DHH) determines who is an authorized user and defines user access capabilities. Directions for obtaining a valid online provider account are available here in this training packet or on the LA Medicaid website at www.lamedicaid.com.

The steps to access the secured web applications Main Menu are as follows:

1. Open your web browser entering the URL for the Louisiana Medicaid main menu: **http://www.lamedicaid.com**.

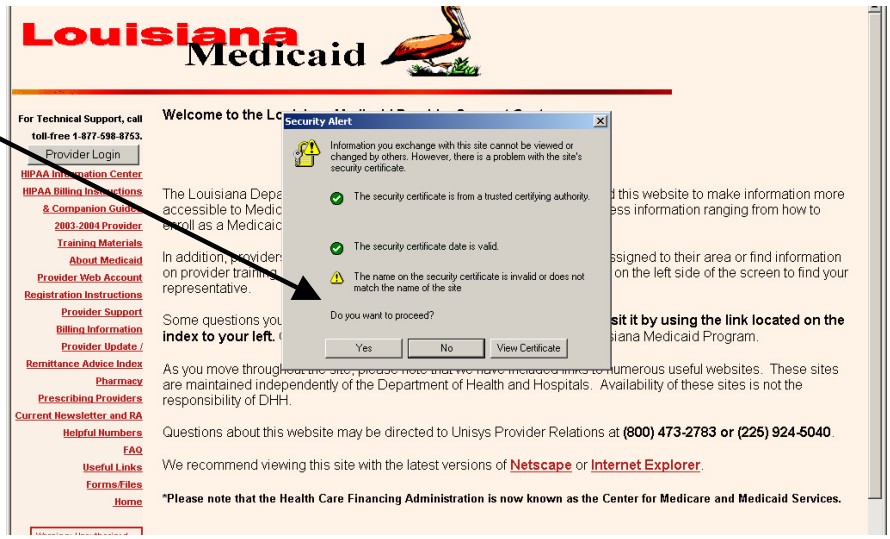
The following screen is displayed.



2. Select the **Provider Login** button on the left side.

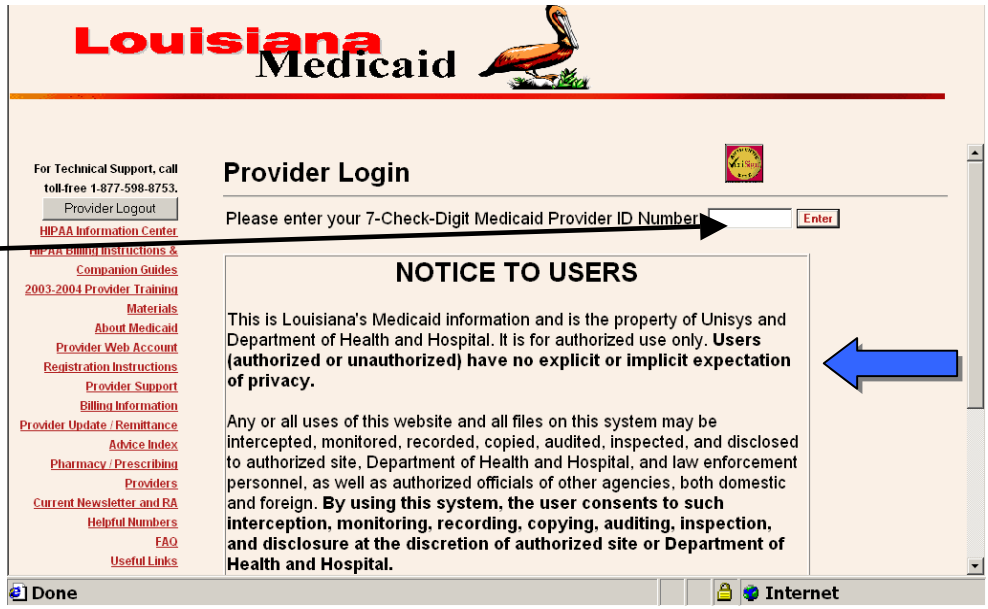
The following security message will appear.

3. Select the appropriate button.



The Provider Login screen is displayed.

4. Enter your 7-digit Medicaid Provider ID Number in the field provided and select the **Enter** button.



The Provider Applications Area login window is displayed.

5. Enter the Restricted Provider Applications' **Login ID** and **password** in the appropriate fields and select the **Login** button directly below the Password field.

The following screen is displayed.

6. Select the desired **Medicaid Web Application** link.

Accessing the Web-Based Applications

There are a number of web applications available on the Medicaid website, however, the following web applications are the most commonly used:

- e-MEVS (Medicaid Eligibility Verification System) for recipient eligibility inquiries;
- e-CSI (Claims Status Inquiry) for inquiring on claims status;
- e-CDI (Clinical Data Inquiry) for inquiring on pharmacy prescriptions as well as other recipient medical claims data

To Access Any of the Web-Based Applications, Follow the Steps Listed Below:

1. Using your Internet browser, go to the www.lamedicaid.com Web page.
2. Click on the **PROVIDER LOG IN** button in the upper left hand corner of the home page.
3. If you see a pop-up screen with a security message, you should click on the **YES/OK** button.
4. A Web page titled **PROVIDER LOGIN** will be displayed.
5. Enter your **7-CHECK-DIGIT MEDICAID PROVIDER ID NUMBER** in the data entry box, and click on the **ENTER** button to the immediate right of the box.
6. A Web page titled **PROVIDER APPLICATIONS AREA** will be displayed.
7. Enter your **LOGIN ID** and **PASSWORD**, and then click on the **LOG-IN** button.
8. You are now at the **Restricted Provider Applications MAIN MENU** Web page.
9. Select the desired web application link to access the application. For example, the links for e-MEVS, e-CSI, and e-CDI follow:

    - e-MEVS - Medicaid Eligibility Verification System
    - e-CSI Claim Status Inquiry
    - e-CDI - Electronic Clinical Data Inquiry

e-MEVS Web Application

Providers can now verify eligibility and service limits for a Medicaid recipient using this web application. This application was implemented to provide recipient eligibility verification capability in addition to MEVS swipe card transactions and REVS. 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 printable web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Since its release, the application has undergone some cosmetic and informational changes to make it more user-friendly and allow presentation of more complete, understandable information.

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
- 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
- Recipient name and recipient birth date
- Recipient name and social security number

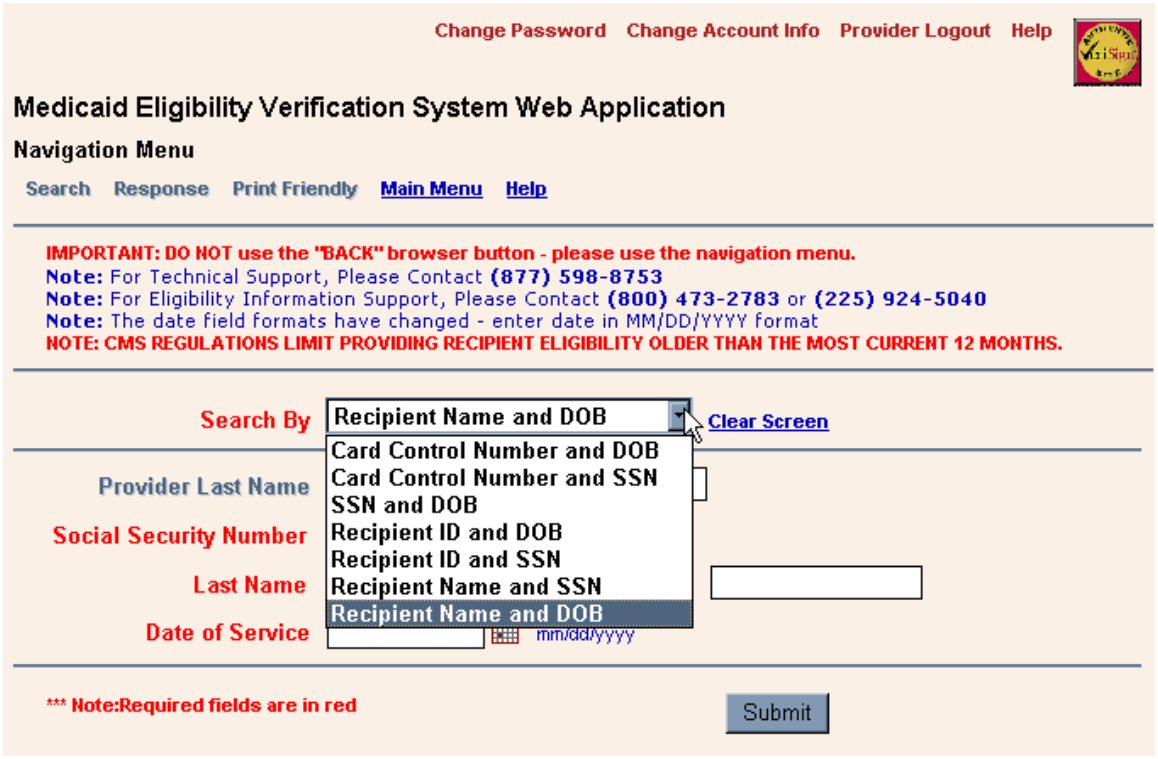
Using e-MEVS

Inquiries through e-MEVS may be requested using seven different methods provided in a pull down menu in the **Search By** field. Each choice is an alternate method of identifying a recipient. The response to each of the different inquiries for the same recipient will be the same. **All mandatory or required fields are noted in red.** Providers must select the **Submit** button to complete each inquiry.

Requests can be entered using the following criteria:

- Card Control Number and DOB
- Card Control Number and SSN
- SSN and DOB
- Recipient ID and DOB
- Recipient ID and SSN
- Recipient name and recipient birth date
- Recipient name and social security number

The following sections show sample screens using each of the seven inquiry methods. Each inquiry's mandatory or required fields are presented in tabular format.

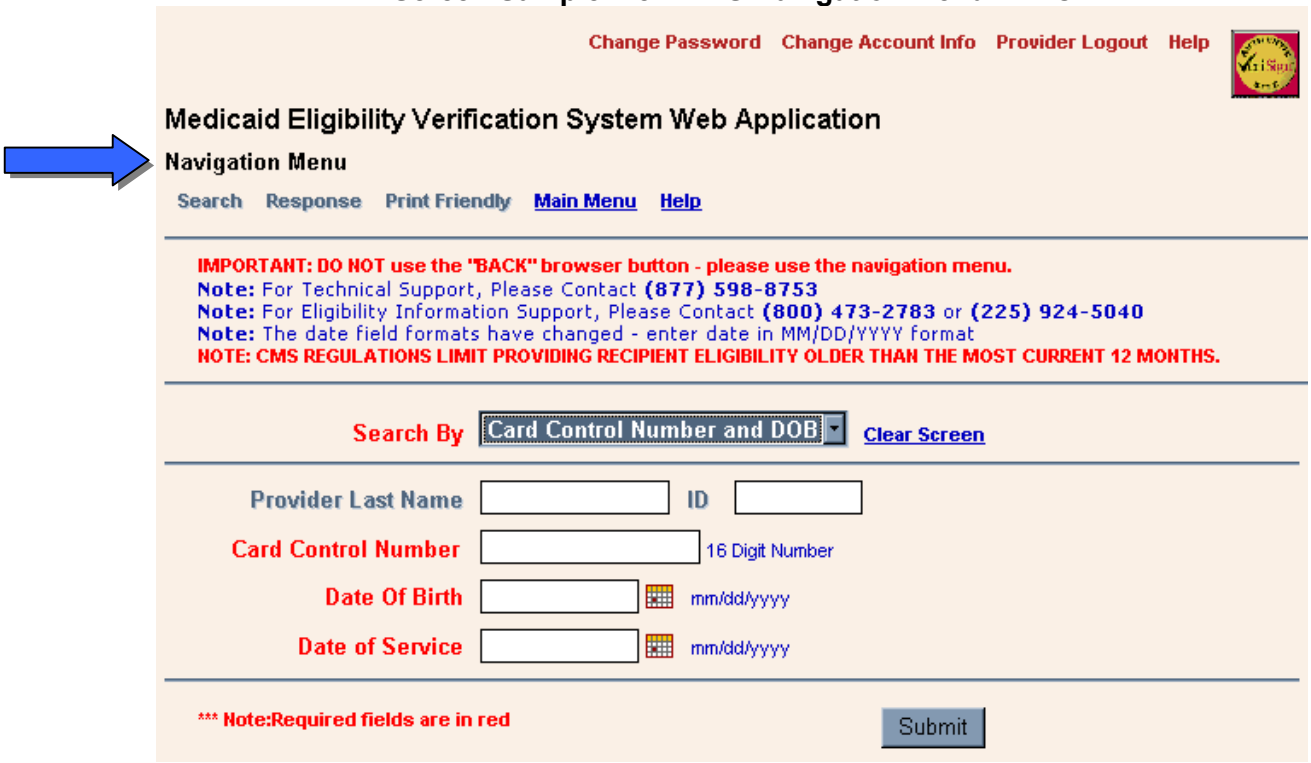


e-MEVS Navigation Menu

The five e-MEVS navigation links, Search, Response, Print Friendly, Main Menu, and Help assist providers with navigating within the e-MEVS Web Application. If the user's mouse hovers, i.e., remains stationary for a short period of time over one of these links, a special message will appear to further identify the purpose of the link.

MEDICAID ELIGIBILITY VERIFICATION SYSTEM (e-MEVS) Navigation Menu	
Link Name	**Link Description**
Search	Returns the provider to the previous inquiry's search criteria.
Response	Takes the provider directly to the e-MEVS response.
Print Friendly	Provides a printer-friendly version of the results screen.
Main Menu	Takes the provider directly back to the e-MEVS Main Menu.
Help	Accesses a "help request" screen designed to allow the provider a text box to enter unique help requests and submit them online.

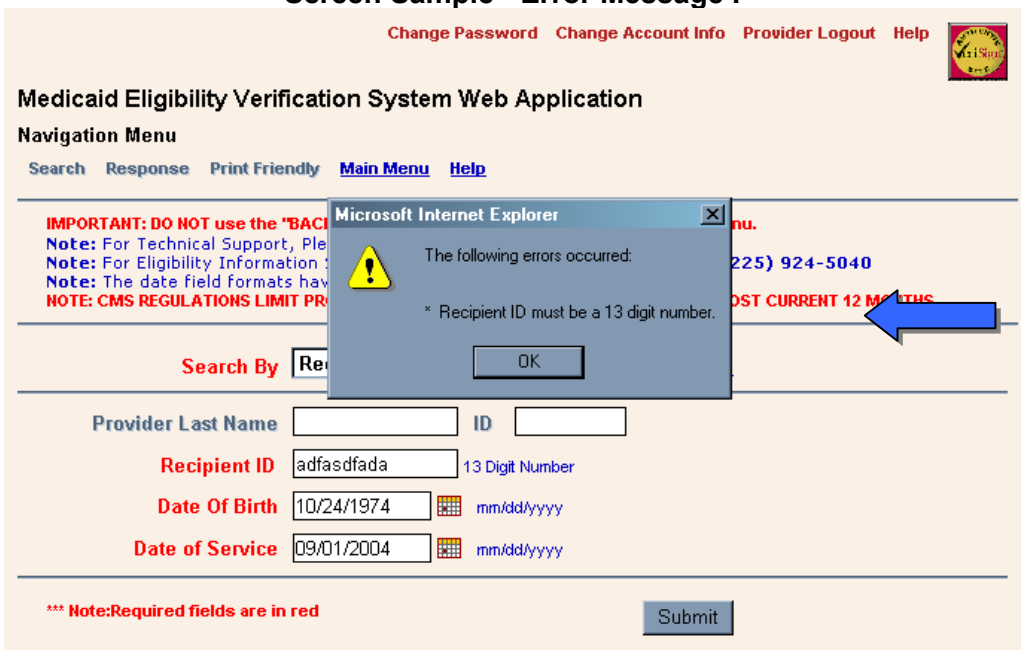
Screen Sample - e-MEVS Navigation Menu Links



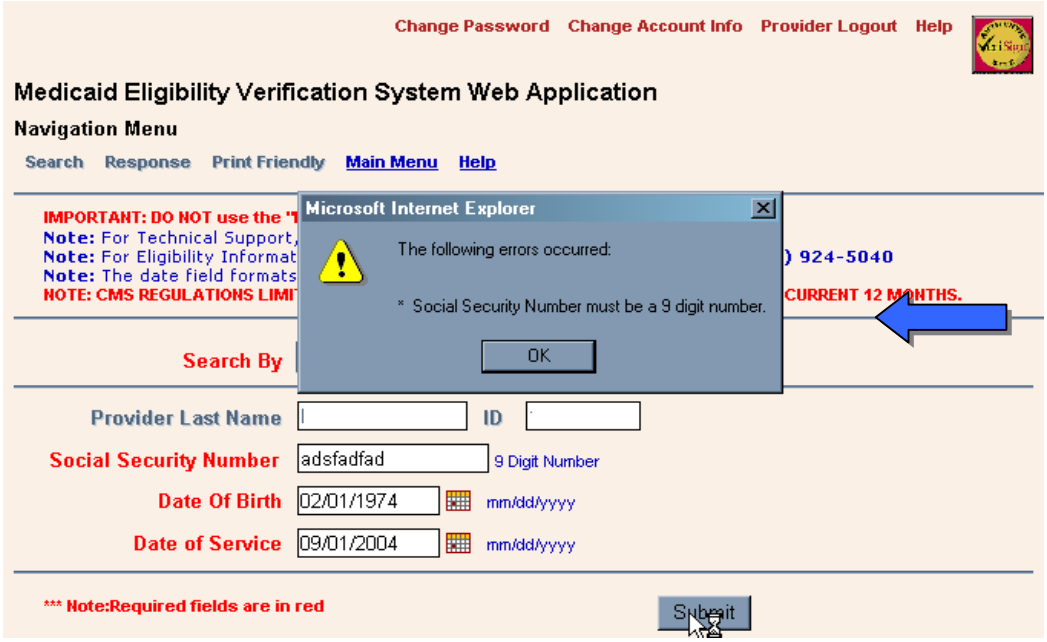
e-MEVS Error Messages

The e-MEVS web-based application provides logical, user-friendly error messages in response to either a required field containing erroneous or incomplete information or where a required field has been left blank. Error messages indicate exactly which required field must be corrected or completed as well as the exact number and/or type of character that must be entered into that field. The error message is specific to the field where the data was incompletely or erroneously entered. The message gives explicit instructions as to what data should be entered in the field.

Screen Sample - Error Message I

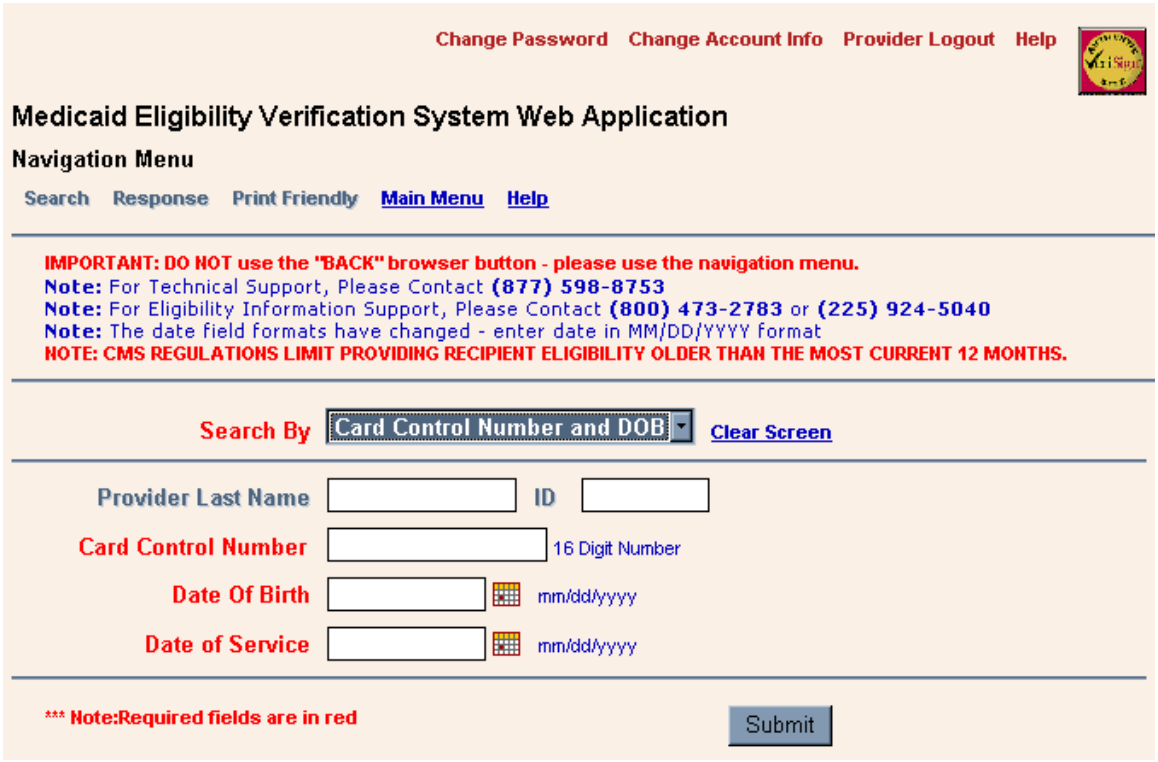


Screen Sample - Error Message II



e-MEVS Inquiry by Card Control Number and Date of Birth (DOB)

Screen Sample - Inquiry by Card Control Number and Date of Birth (DOB)



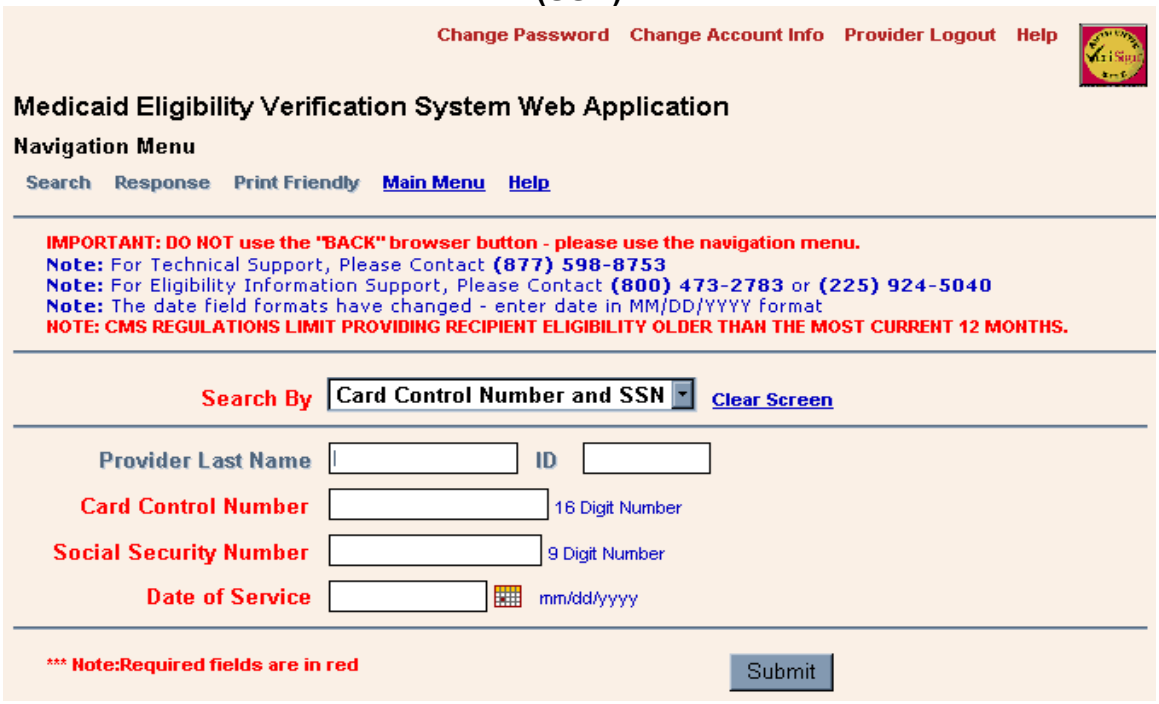
Data Fields - Inquiry by Card Control Number and Date of Birth (DOB)

Card Control Number and Date of Birth (DOB) Inquiry Fields	
Field Name	**Field Description**
Provider Last Name	The first (13) characters of the provider's last name will self-populate this field.
ID	The 7-digit provider ID of the provider whose login process has been authenticated will self-populate this field.
Card Control Number	Enter the 16-digit Card Control Number for the recipient.
Date of Birth	Enter the Recipient's Birth Date in the format, MM/DD/YYYY. (For example, enter 04/17/1962, for a birth date of April 17, 1962.)
Date of Service	Enter the Date of Service in the format, MM/DD/YYYY. (For example, enter 04/09/2003, for a service date of April 9, 2003.)

When all fields have been entered, select the **Submit** button. If any required fields have not been completed or are entered with invalid data, an error message will be displayed at the bottom of the search screen. Make the appropriate corrections and select the **Submit** button again.

e-MEVS Inquiry by Card Control Number and Social Security Number (SSN)

Screen Sample - Inquiry by Card Control Number and Social Security Number (SSN)



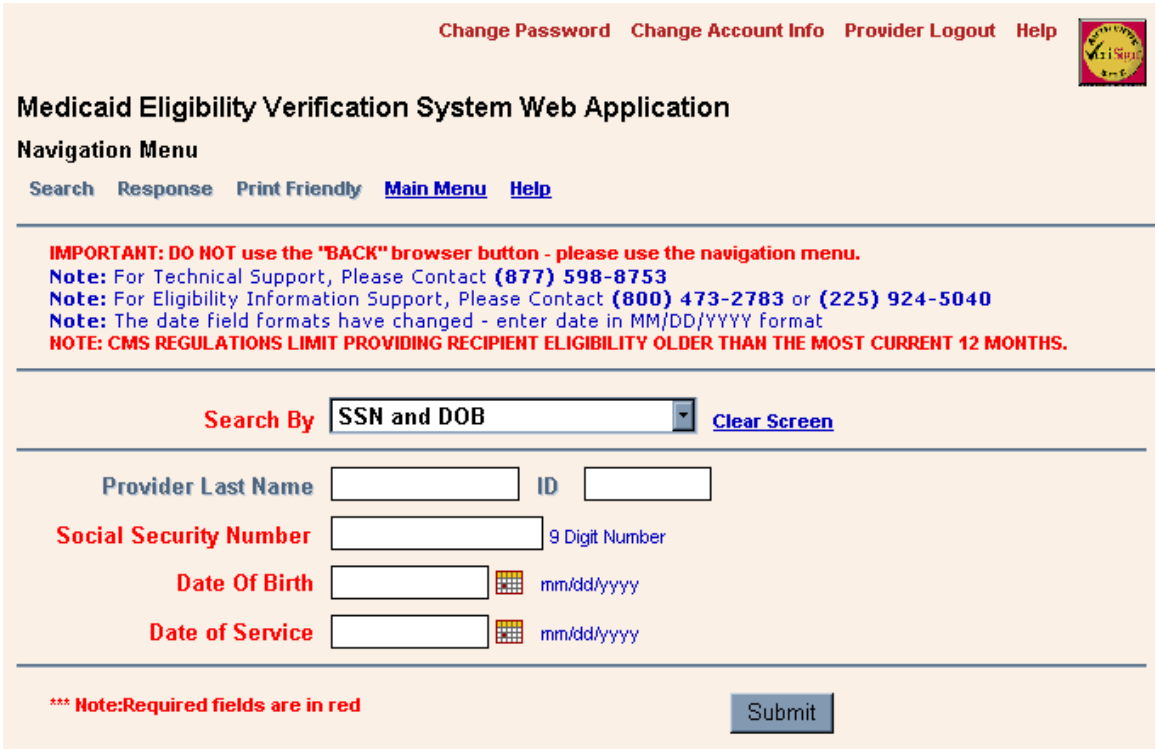
Data Fields - Inquiry by Card Control Number and Social Security Number (SSN)

Card Control Number (CCN) and Social Security Number (SSN) Inquiry Fields	
Field Name	**Field Description**
Provider Last Name	The first (13) characters of the provider's last name will be displayed in this self-populating field.
ID	The 7-digit provider ID of the provider whose login process has been authenticated will self-populate this field.
Card Control Number	Enter the 16-digit Card Control Number for the recipient.
Social Security Number	Enter the 9-digit social security number in the format, NNNNNNNNN. **Do not enter dashes (-); enter only numbers.**
Date of Service	Enter the Date of Service in the format, MM/DD/YYYY. (For example, enter 04/09/2003, for a service date of April 9, 2003.)

When all fields have been entered, select the **Submit** button. If any required fields have not been completed or are entered with invalid data, an error message will be displayed at the bottom of the search screen. Make the appropriate corrections and select the **Submit** button again.

e-MEVS Inquiry by Social Security Number (SSN) and Date of Birth (DOB)

Screen Sample - Inquiry by Social Security Number (SSN) and Date of Birth (DOB)



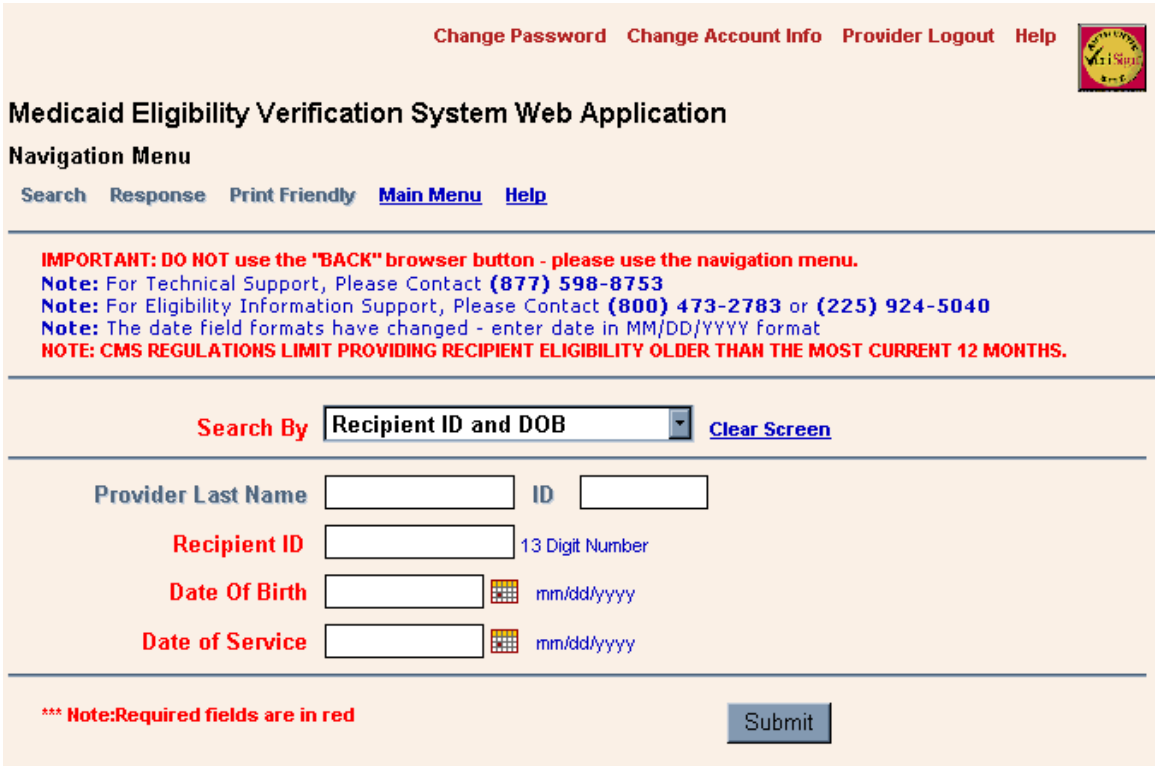
Data Fields - Inquiry by Social Security Number (SSN) and Date of Birth (DOB)

Social Security Number (SSN) and Date of Birth (DOB) Inquiry Fields	
Field Name	**Field Description**
Provider Last Name	The first (13) characters of the provider's last name will be displayed in this self-populating field.
ID	The 7-digit provider ID of the provider whose login process has been authenticated will self-populate this field.
Social Security Number	Enter the 9-digit social security number in the format, NNNNNNNNN. **Do not enter dashes (-); enter only numbers.**
Date of Birth	Enter the Recipient's Birth Date in the format, MM/DD/YYYY. (For example, enter 04/17/1962 for a birthdate of April 17, 1962.)
Date of Service	Enter the Date of Service in the format, MM/DD/YYYY. (For example, enter 04/09/2003, for a service date of April 9, 2003.)

When all fields have been entered, select the **Submit** button. If any required fields have not been completed or are entered with invalid data, an error message will be displayed at the bottom of the search screen. Make the appropriate corrections and select the **Submit** button again.

e-MEVS Inquiry by Recipient ID and Date of Birth (DOB)

Screen Sample - Inquiry by Recipient ID and Date of Birth (DOB)



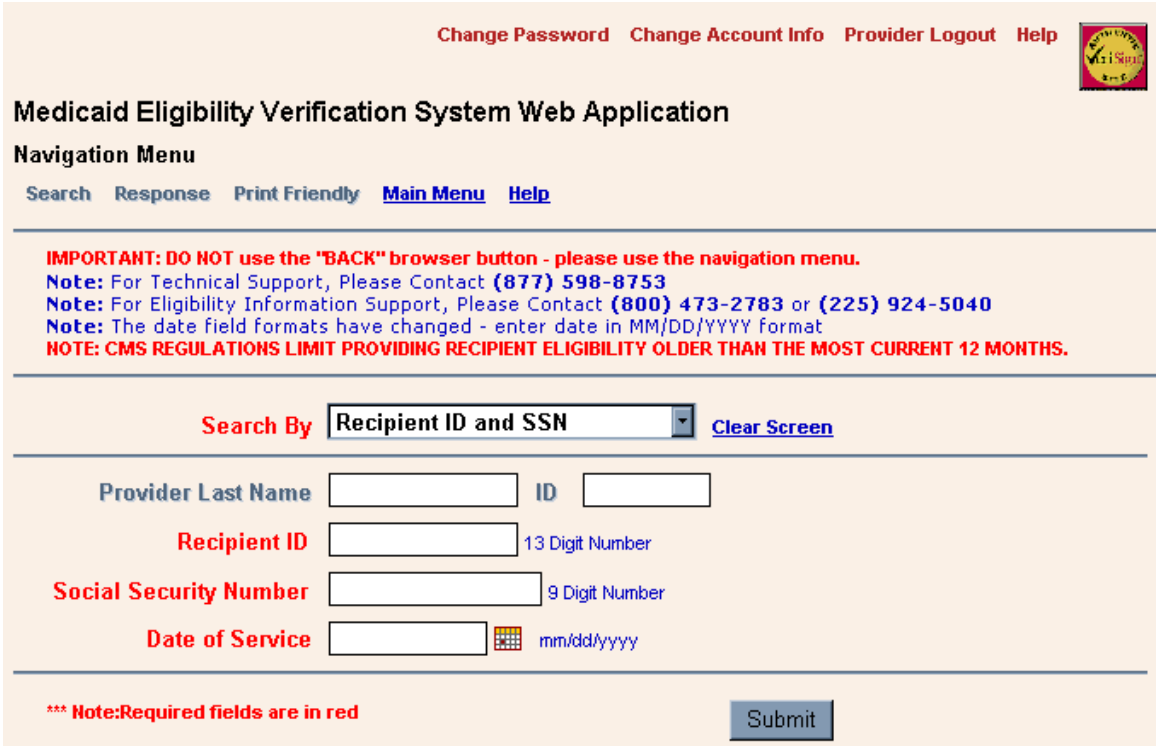
Data Fields - Inquiry by Recipient ID and Date of Birth (DOB)

Recip ID and Date of Birth (DOB) Inquiry Fields	
Field Name	**Field Description**
Provider Last Name	The first (13) characters of the provider's last name will be displayed in this self-populating field.
ID	The 7-digit provider ID of the provider whose login process has been authenticated will self-populate this field.
Recipient ID	Enter the 13-digit recipient ID.
Date of Birth	Enter the Recipient's Birth Date in the format, MM/DD/YYYY. (For example, enter 04/17/1962, for a birth date of April 17, 1962.)
Date of Service	Enter the Date of Service in the format, MM/DD/YYYY. (For example, enter 04/09/2003, for a service date of April 9, 2003.)

When all fields have been entered, select the **Submit** button. If any required fields have not been completed or are entered with invalid data, an error message will be displayed at the bottom of the search screen. Make the appropriate corrections and select the **Submit** button again.

e-MEVS Inquiry by Recipient ID and Social Security Number (SSN)

Screen Sample - Inquiry by Recipient ID and Social Security Number (SSN)



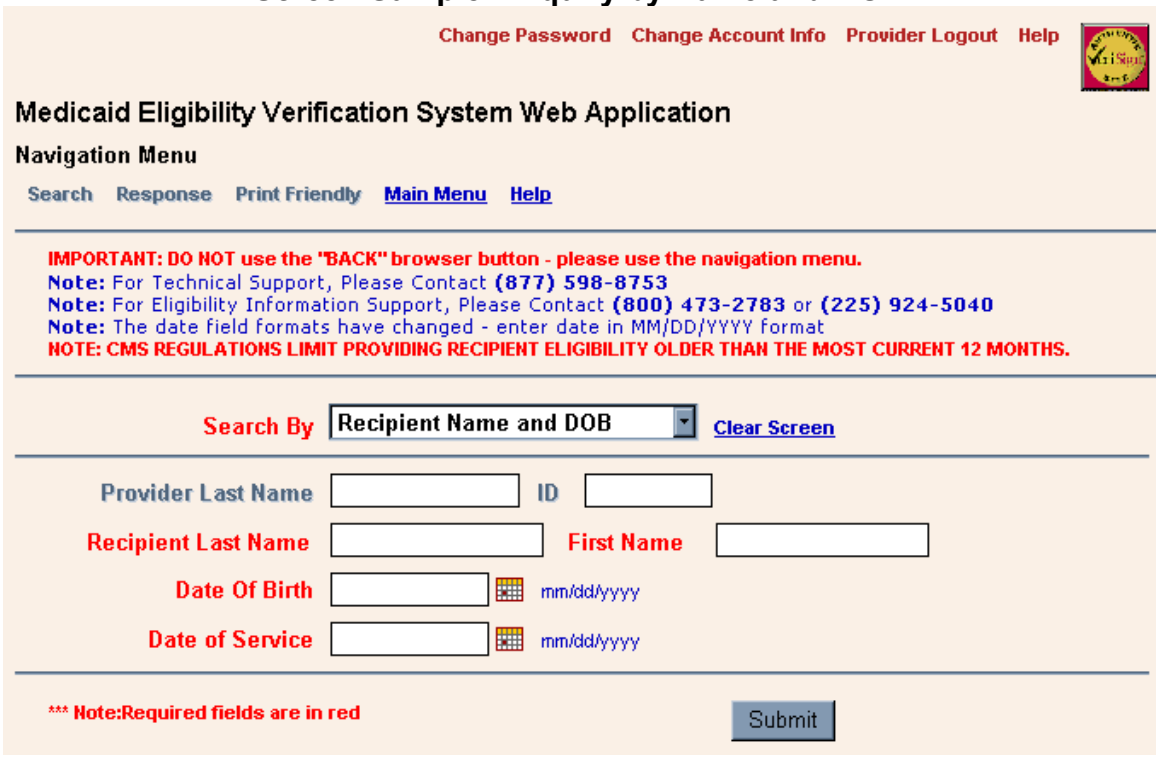
Data Fields - Inquiry by Recipient ID and Social Security Number (SSN)

Recipient ID and Social Security Number (SSN) Inquiry Fields	
Field Name	**Field Description**
Provider Last Name	The first (13) characters of the provider's last name will be displayed in this self-populating field.
ID	The 7-digit provider ID of the provider whose login process has been authenticated will self-populate this field.
Recipient ID	Enter the 13-digit recipient ID.
Social Security Number	Enter the 9-digit social security number in the format, NNNNNNNNN. **Do not enter dashes (-); enter only numbers.**
Date of Service	Enter the Date of Service in the format, MM/DD/YYYY. (For example, enter 04/09/2003, for a service date of April 9, 2003.)

When all fields have been entered, select the **Submit** button. If any required fields have not been completed or are entered with invalid data, an error message will be displayed at the bottom of the search screen. Make the appropriate corrections and select the **Submit** button again.

e-MEVS Inquiry by Recipient Name and DOB

Screen Sample - Inquiry by Name and DOB



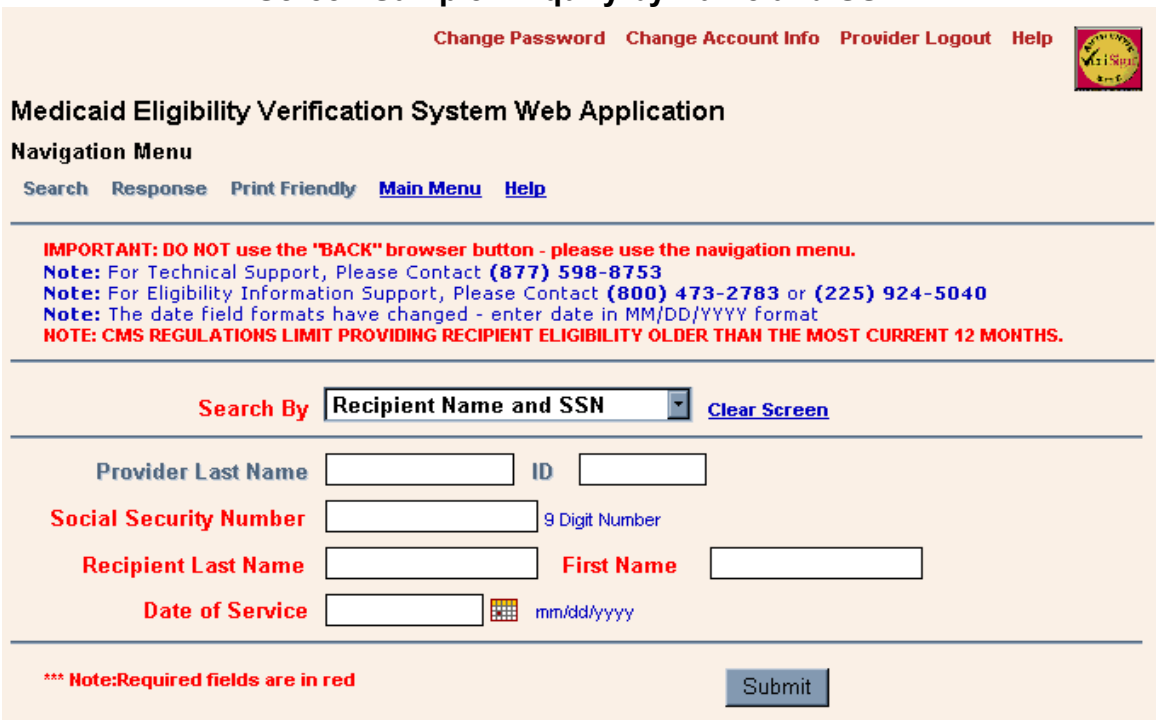
Data Fields - Inquiry by Name and DOB

Name and Date of Birth (DOB) Inquiry Fields	
Field Name	**Field Description**
Provider Last Name	The first (13) characters of the provider's last name will be displayed in this self-populating field.
ID	The 7-digit provider ID of the provider whose login process has been authenticated will self-populate this field.
Recipient Last Name	Enter the Recipient's Last Name up to 35 letters as seen on the Medicaid eligibility card.
First Name	Enter the Recipient's First Name up to 25 letters as seen on the Medicaid eligibility card.
Date of Birth	Enter the Recipient's Birth Date in the format, MM/DD/YYYY. (For example, enter 04/17/1962, for a birth date of April 17, 1962.)
Date of Service	Enter the Date of Service in the format, MM/DD/YYYY. (For example, enter 04/09/2003, for a service date of April 9, 2003.)

When all fields have been entered, select the **Submit** button. If any required fields have not been completed or are entered with invalid data, an error message will be displayed at the bottom of the search screen. Make the appropriate corrections and select the **Submit** button again.

e-MEVS Inquiry by Recipient Name and SSN

Screen Sample - Inquiry by Name and SSN



Data Fields - Inquiry by Name and SSN

Name and Social Security Number (SSN) Inquiry Fields	
Field Name	**Field Description**
Provider Last Name	The first (13) characters of the provider's last name will be displayed in this self-populating field.
ID	The 7-digit provider ID of the provider whose login process has been authenticated will self-populate this field.
Social Security Number	Enter the 9-digit social security number in the format, NNNNNNNNN. Do not enter dashes (-); enter only numbers.
Recipient Last Name	Enter the Recipient's Last Name up to 35 letters as seen on the Medicaid eligibility card.
First Name	Enter the Recipient's First Name up to 25 letters as seen on the Medicaid eligibility card.
Date of Service	Enter the Date of Service in the format, MM/DD/YYYY. (For example, enter 04/09/2003, for a service date of April 9, 2003.)

When all fields have been entered, select the **Submit** button. If any required fields have not been completed or are entered with invalid data, an error message will be displayed at the bottom of the search screen. Make the appropriate corrections and select the **Submit** button again.

Viewing Valid and Invalid e-MEVS Responses

When all required fields of the inquiry page have been entered and the **Submit** button is selected, the message is sent to the e-MEVS system. When the response is received, it is parsed and displayed on the web browser. Some responses will be lengthy, requiring the use of the scroll bar to see the entire response.

Responses may be **valid**, (where the input data is correct and matches are found for provider and recipient in the database) or **invalid**, (where the input data has errors or a provider and/or recipient match is not found in the database).

The following two pages show examples of valid responses. One response includes a recipient with TPL and the other includes a recipient in the CommunityCARE Program.

Medicaid Eligibility Verification System Web Application

Navigation Menu

Search | Response | Print Friendly | Main Menu | Help

IMPORTANT: DO NOT use the "BACK" browser button - please use the navigation menu.
Note: For Technical Support, Please Contact **(877) 598-8753**
Note: For Eligibility Information Support, Please Contact **(800) 473-2783** or **(225) 924-5040**
Note: The date field formats have changed - enter date in MM/DD/YYYY format
NOTE: CMS REGULATIONS LIMIT PROVIDING RECIPIENT ELIGIBILITY OLDER THAN THE MOST CURRENT 12 MONTHS.

Search Criteria

Search Type	Recipient ID and DOB
Recipient ID	[redacted]
Date of Birth	
Date of Service	

Provider Information

Name	[redacted]
Provider ID	
Telephone	

Subscriber Information

Name	[redacted]
Member ID Number	
Date of Birth	
Sex	

Health Benefit Plan Coverage

Benefit	Coverage Level	Insurance Type	Plan Coverage Description
Active Coverage	Individual	Medicaid	Eligible for Medicaid on Date of Service.
Benefit Description	Individual	Medicaid	[redacted]
Benefit Description	Individual	Medicaid	
Benefit Description	Individual	Medicaid	Recipient is EPSDT Eligible.
Benefit Description	Individual	Medicaid	Preferred Language: English.

Contact Following Entity for Eligibility or Benefit Information

Plan Network Identification Number	[redacted] (Carrier Code)
Insurance Type	Individual Policy
Service Type	Medical Care
Provider Name	BLUE CROSS OF TEXAS
Address	[redacted]

Other or Additional Payor

Insurance Policy Number	[redacted]
Insured or Subscriber	

Request Reference Number	[redacted]
Response Reference Number	

Transaction run on 09/23/2004 at 01:37:45 CT by LAMedicaid - Louisiana Medicaid

Medicaid Eligibility Verification System Web Application

Navigation Menu

Search | Response | Print Friendly | Main Menu | Help

IMPORTANT: DO NOT use the "BACK" browser button - please use the navigation menu.
Note: For Technical Support, Please Contact **(877) 598-8753**
Note: For Eligibility Information Support, Please Contact **(800) 473-2783** or **(225) 924-5040**
Note: The date field formats have changed - enter date in MM/DD/YYYY format
NOTE: CMS REGULATIONS LIMIT PROVIDING RECIPIENT ELIGIBILITY OLDER THAN THE MOST CURRENT 12 MONTHS.

Search Criteria

Search Type	Card Control Number and DOB
Card Control Number	[redacted]
Date of Birth	
Date of Service	

Provider Information

Name	[redacted]
Provider ID	
Telephone	

Subscriber Information

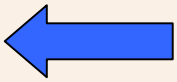
Name	[redacted]
Member ID Number	
Card Control Number	
Date of Birth	
Sex	

Health Benefit Plan Coverage

Benefit	Coverage Level	Insurance Type	Plan Coverage Description
Active Coverage	Individual	Medicaid	Eligible for Medicaid on Date of Service.
Benefit Description	Individual	Medicaid	Recipient is EPSDT Eligible.
Benefit Description	Individual	Medicaid	Preferred Language: English.

Primary Care Provider

Provider Name	[redacted]
Telephone	
Coverage Level	
Service Type	
Insurance Type	Medicaid
Plan Coverage Description	LOUISIANA COMMUNITYCARE PROGRAM

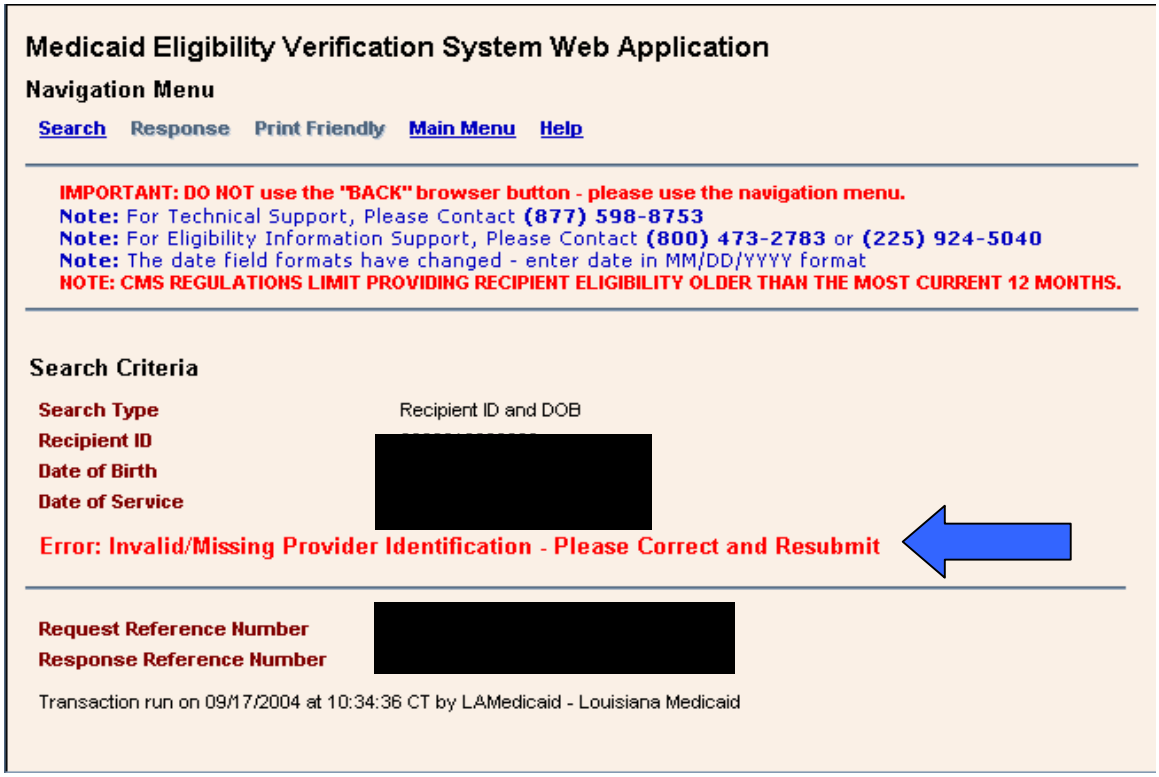


Request Reference Number	[redacted]
Response Reference Number	

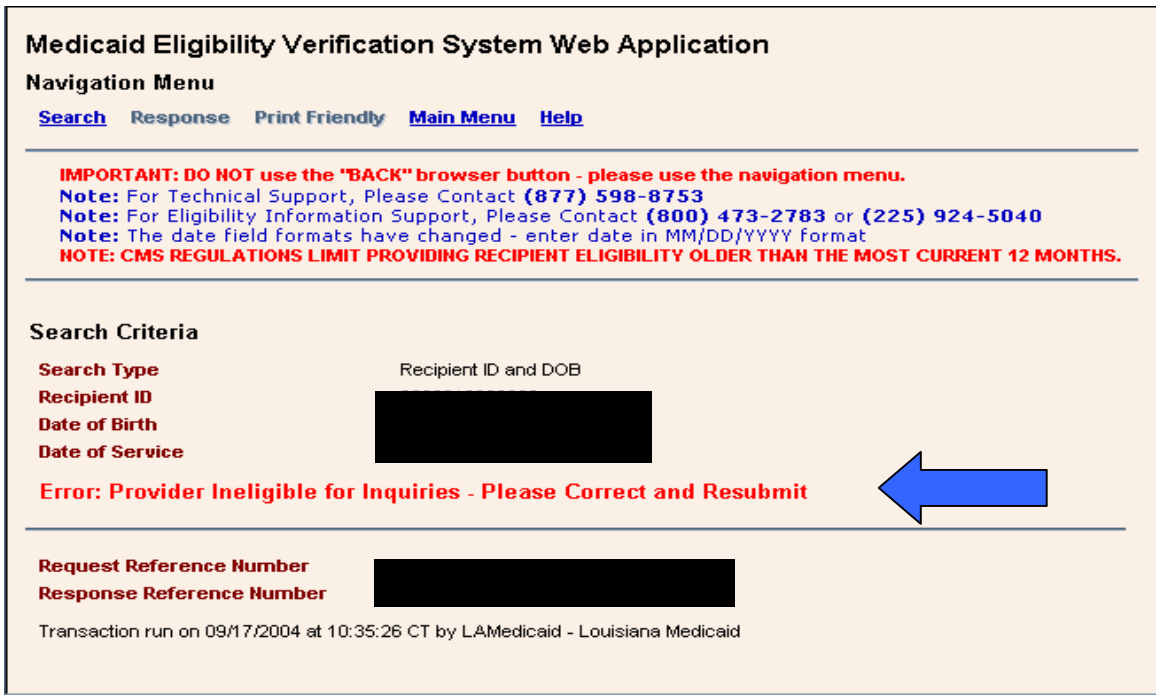
Transaction run on 09/23/2004 at 11:13:54 CT by LAMedicaid - Louisiana Medicaid

The following two examples show invalid responses including error messages.

Screen Sample – Invalid e-MEVS Response



Invalid Response



e-CSI WEB APPLICATION

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. This application is required to use HIPAA compliant denial and reference codes and descriptions to report information. If the information displayed on e-CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the e-CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to remittance advices for this purpose. An LA Medicaid/HIPAA Error Code Crosswalk is available on the LAMEDICAID.com website by accessing the link, “Forms/Files”.

Please allow ample time for claims to enter the processing system before attempting to inquire through e-CSI. Providers should wait approximately one week for electronic submissions and approximately three to four weeks from receipt (not including mailing time) for hard copy claims.

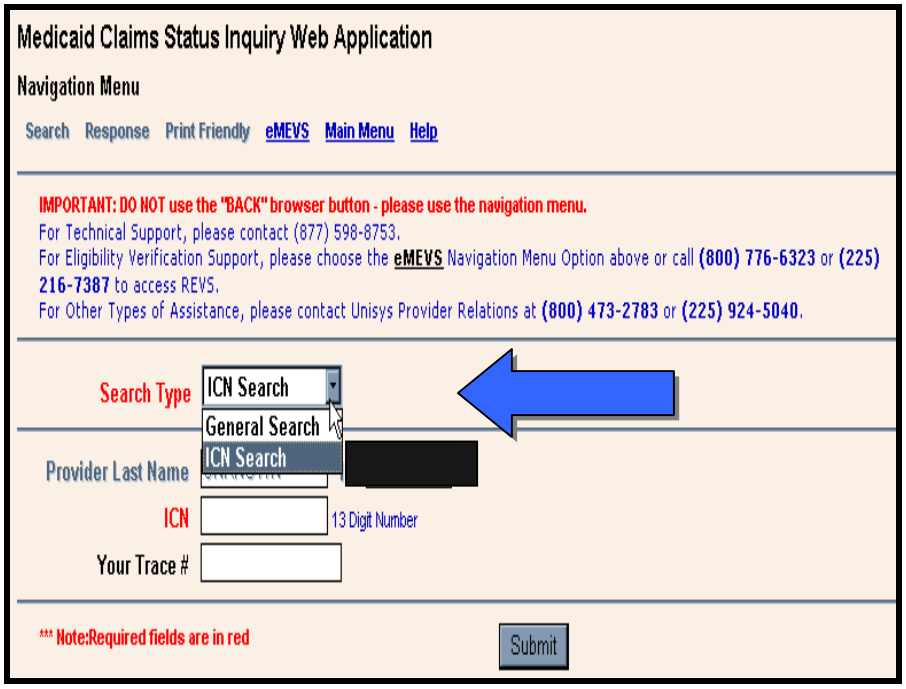
All active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

NOTE: When entering search criteria, it is important to remember that **each claim line is considered A CLAIM for processing purposes**. A provider inquiring on a multiple line claim should either check the status of **EACH** claim line OR inquire on the claim **without entering an amount in the “Amount Field”.**

Using e-CSI

The following provides information on navigating through the application, general search inquiry, ICN search inquiry, and the response transaction. The two different search methods are provided in a pull down menu in the Search Type field.

e-CSI Search Type Methods



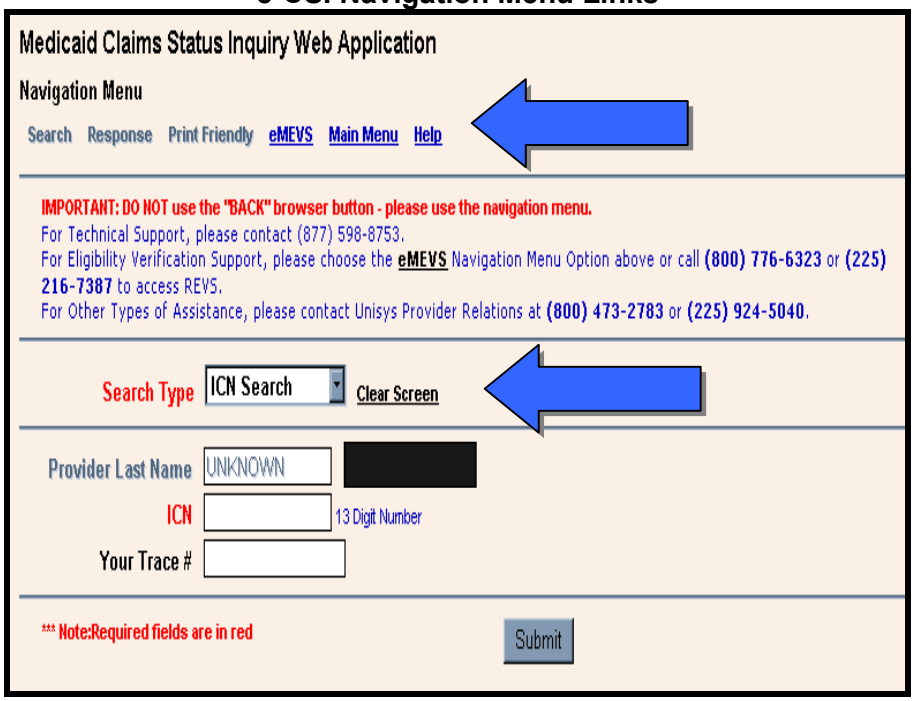
A provider is able to utilize the billing provider number or the servicing provider number; whichever the provider used to log into the application. If a billing provider number is used, e-CSI returns all claims for that billing provider regardless of the servicing provider. The servicing provider is only able to inquire on claims where they are the servicing provider.

Navigating Through the Application

Screen Buttons

The selection processing functions that appear on the e-CSI web user screen pages assist the user in navigating through the application. There are five navigational links that appear across the top of the web screen. These links are disabled if the function is not available from a particular screen. In addition, the Clear Screen link appears in the middle of the screen. If the user's mouse hovers, i.e., remains stationary for a period of time over one of these links, a message appears to identify the purpose of the link.

e-CSI Navigation Menu Links



- Select the ***Search*** link to perform a Claims Status Inquiry search by ICN or General Method
- Select the ***Response*** link to view the claims status response screen
- Select the ***Print Friendly*** link to view a print friendly version of the response screen
- Select the ***e-MEVS*** link to access the electronic Medicaid Eligibility Verification System
- Select the ***Main Menu*** link to discontinue current processing at any page and return to the Provider Applications Area Main Menu.
- Select the ***Help*** link to obtain field specific help information.
- Select the ***Clear Screen*** link to clear a page and reset the page data fields to their default values.

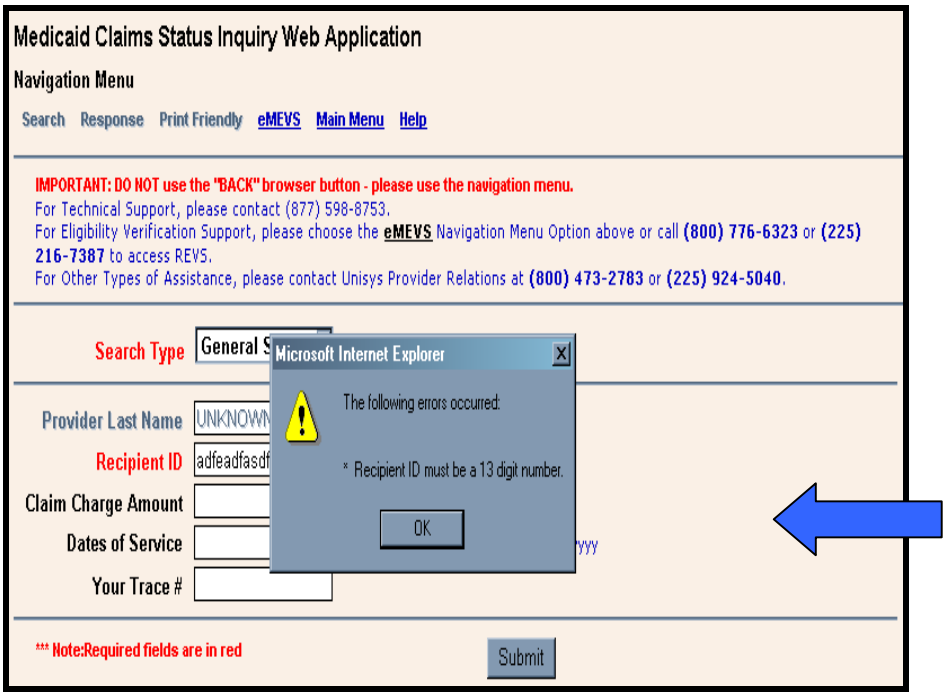
There is a selection-processing (submit) button that appears in the lower right hand corner of the web screen.

- Select the ***Submit*** button to process the data entered on a screen.

Error Messages

Logical, user-friendly error messages are provided during processing to inform the provider that an error has occurred and corrective action is needed. When an error is detected, the provider is informed via a message box that an error has occurred. The error message identifies the corrective action needed to fix the error. If a required field is blank when the provider selects the ***Submit*** button, an error message dialog box is displayed indicating that the required field(s) is blank. Most text fields require a certain number of characters to be entered. If fewer than the required number of characters is entered, a message will inform the provider that a minimum number of characters must be entered. This sequence continues until the provider has entered the appropriate information in all required fields. If data entered in a specific field is in an incorrect format; i.e., alphabetic instead of numeric data in a numeric field, then a message is returned identifying the error. All data must be entered in the correct format before processing continues. The following is an example of an error message.

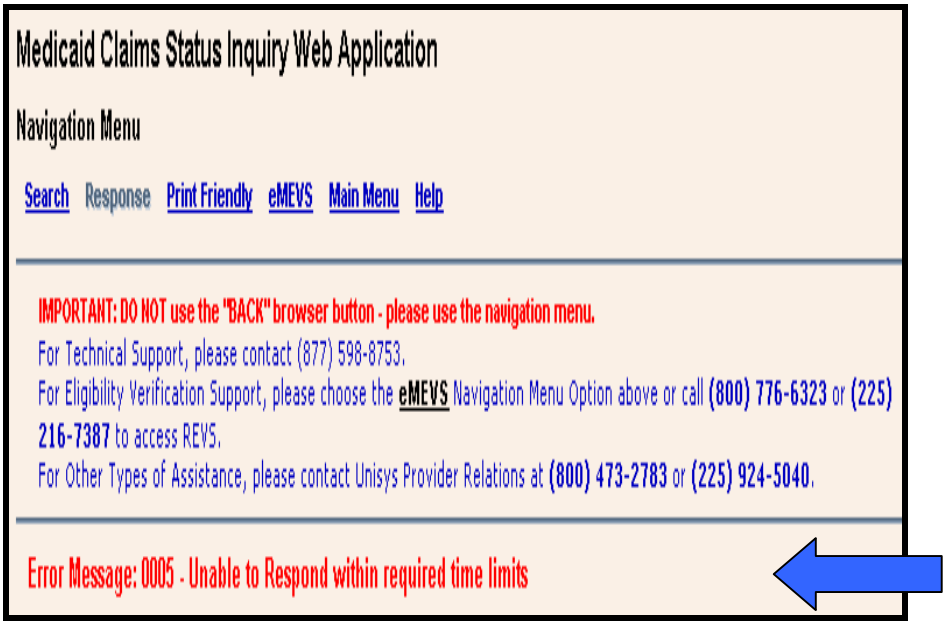
e-CSI Error Message



Informational Messages

During e-CSI web screens processing, the provider is kept aware of the processing status through the use of informational messages. If an informational message is received the provider does not have to initiate a corrective action. The message is for informational purposes solely and the processing continues. The following is an example of an informational message.

e-CSI Informational Message



General Search Screen

The General Search can return multiple claims that meet the parameters supplied by the provider when the inquiry does not uniquely identify a claim within the system. The provider may enter unique identifying elements to obtain an exact match. The system automatically populates the Provider Last Name and Provider ID fields based on the authentication process that occurs when a provider logs into the application. The provider is required to enter the Recipient ID number only; however, there are other search elements available for inquiry purposes. Required fields are denoted in red on the web screen. When a General Search inquiry is initiated, the application always checks the database against the following match criteria:

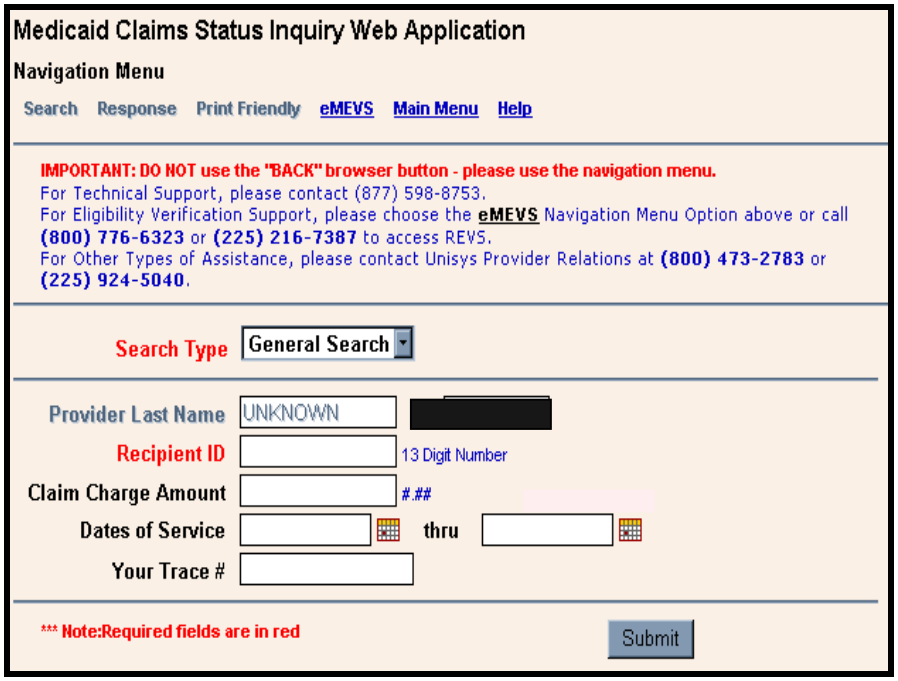
- Provider (Billing or Servicing)
- Recipient ID

All claims are returned where there is a match on provider and recipient ID. If the provider has entered incorrect information in a field, the correct data echoes back.

Screen Samples

The following is an example of a General Search Home Screen.

e-CSI General Search



General Search Screen Data Fields

Required fields are denoted in red on the web screen. All required data fields must contain valid entries before processing continues. The following table designates which fields are required.

Field Name	Required	Data Validation
Search Type	Yes	Use the dropdown box to select General Search or ICN Search.
Provider Last Name/Org Name	Yes	Maximum length – 13 characters (alphanumeric). This field is automatically populated based on the provider log in authentication information.
Provider ID	Yes	7 digits (numeric). This field is automatically populated based on the provider log in authentication information.
Recipient ID	Yes	13 digits (numeric).
Claim Charge Amount	No	Numeric with 2 decimal places.
Dates of Service	No	Type in dates of service or click on popup calendar and select calendar options.
Your Trace #	No	The provider's unique code to link a transaction to a recipient.

Selected fields are validated to ensure that data is entered in an acceptable format and range criterion. Many data fields require information to be entered in a specific format. If the data entered is not in the proper format, a message and an example of the required format are displayed. Processing continues after all data on the page is entered in the correct format. The following paragraphs define those data fields and their associated data formats.

Data Field Formats

Character fields:
- accept alphabetic, numeric, and special character data
- are NOT case sensitive for alphabetic characters

Numeric fields:
- accept only numeric values
- monetary amounts must be a number with 2 decimal places
- no dollar signs and positive/negative signs are accepted

ICN Search Screen

The ICN Search can uniquely identify a claim within the system by matching the ICN, and e-CSI automatically populates the Provider Last Name, and Provider ID fields based on the authentication process that occurs when a provider logs into the application. The provider is required to enter the ICN only, however there are other search elements available for inquiry purposes. Required fields are denoted in red on the web screen. When an ICN search inquiry is initiated, the e-CSI application checks the database against the following match criteria:

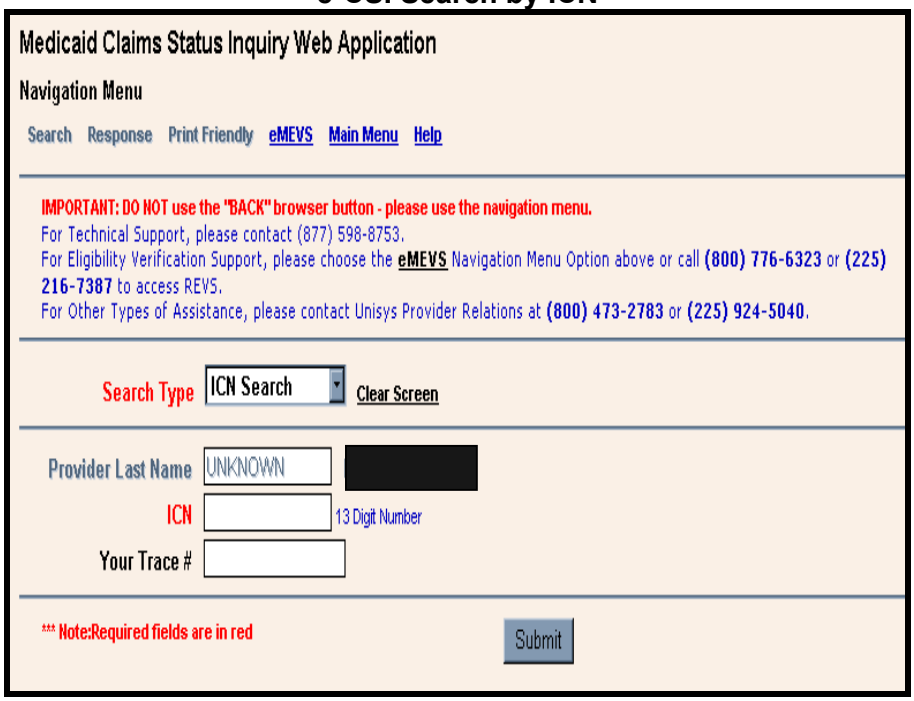
- Provider (Billing or Servicing)
- ICN

All claims are returned where there is a match on provider and ICN. If the provider has entered incorrect information in a field, e-CSI will echo back the correct data.

Screen Samples

The following is an example of an ICN Search Home Screen.

e-CSI Search by ICN



ICN Search Screen Data Fields

Required fields are denoted in red on the web screen. All required data fields must contain valid entries before processing continues. The following table designates which fields are required.

Field Name	Required	Data Validation
Search Type	Yes	Use the dropdown box to select General Search or ICN Search.
Provider Last Name/Org Name	Yes	Maximum length – 13 characters (alphanumeric). This field is automatically populated based on the provider log in authentication information.
Provider ID	Yes	7 digits (numeric). This field is automatically populated based on the provider log in authentication information.
ICN	Yes	13 digits (numeric)
Your Trace #	No	The provider's unique code to link a transaction to a recipient.

Response Screen

When all required fields of the inquiry page have been entered and the **Submit** button is selected, the message is sent to the e-CSI system. The application returns a response providing information about a claim once a match has been established using the search criteria.

When an ICN Search uniquely identifies a claim, the response is an exact match. For inquiries by ICN, it is possible to return status information about the claim history starting with the original ICN within the inquiry. For example if the original claim were adjusted twice, there would be (chronologically) three ICNs associated with the claim; the original and two adjustments. Should the inquiry contain the (chronologically) first (original) ICN, the response contains information about the original claim, then information about the first adjustment, and finally information about the last adjustment.

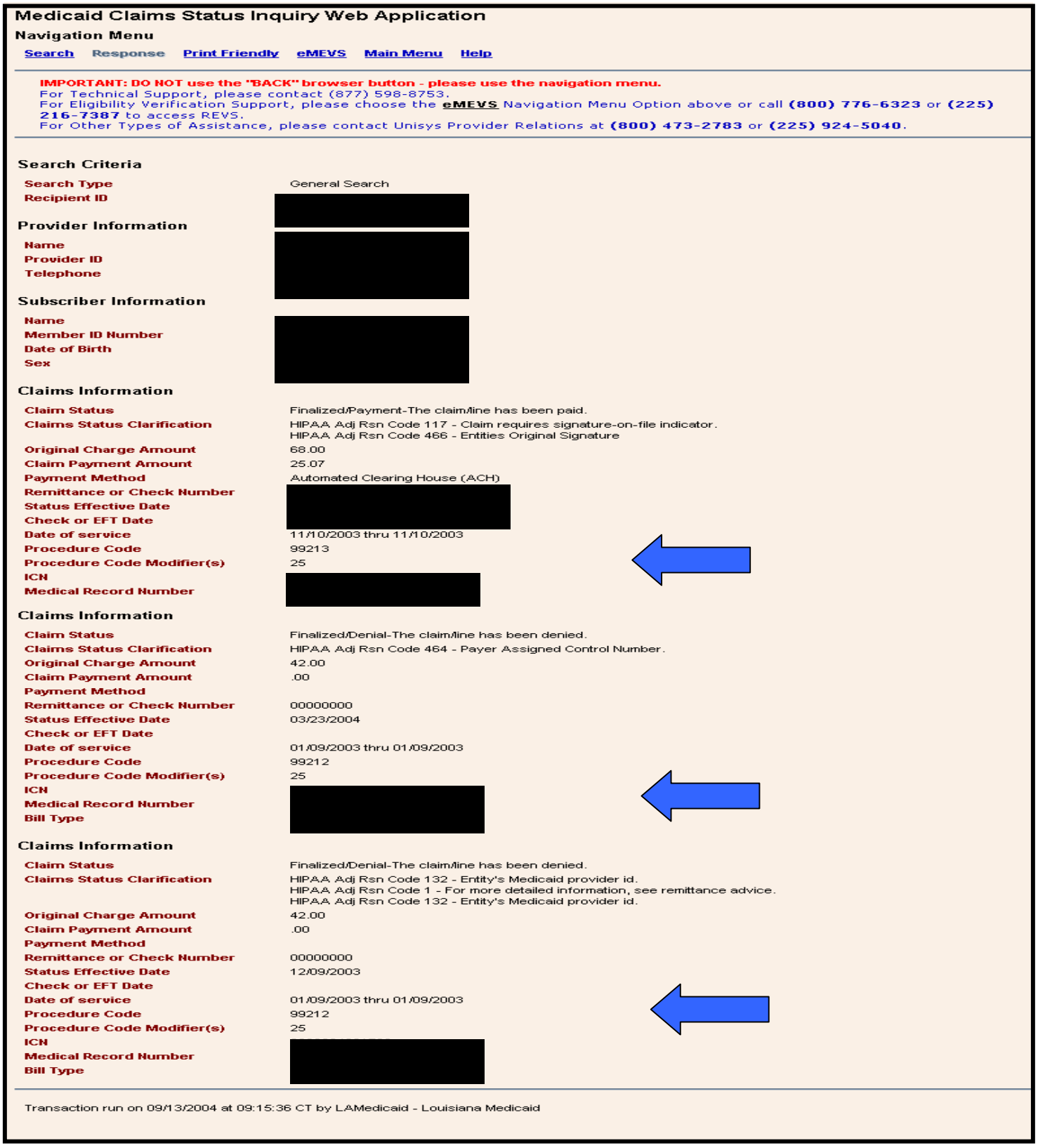
If an inquiry has been initiated utilizing the (chronologically) second ICN, then the response contains information about the first adjustment and then the second.

If the provider does not supply unique identifying elements and initiates a General Search, the response includes multiple claims that meet the parameters supplied by the provider.

Screen Samples

The following is an example of a General Response Screen. This response includes multiple claims because only the Recipient ID was entered for the inquiry.

e-CSI General Response Screen



Medicaid Claims Status Inquiry Web Application

Navigation Menu

Search Response Print Friendly eMEVS Main Menu Help

IMPORTANT: DO NOT use the "BACK" browser button - please use the navigation menu.
For Technical Support, please contact (877) 598-8753.
For Eligibility Verification Support, please choose the eMEVS Navigation Menu Option above or call (800) 776-6323 or (225) 216-7387 to access REVS.
For Other Types of Assistance, please contact Unisys Provider Relations at (800) 473-2783 or (225) 924-5040.

Search Criteria

Search Type: General Search
Recipient ID: [redacted]

Provider Information

Name: [redacted]
Provider ID:
Telephone:

Subscriber Information

Name: [redacted]
Member ID Number:
Date of Birth:
Sex:

Claims Information

Claim Status: Finalized/Payment-The claim/line has been paid.
Claims Status Clarification: HIPAA Adj Rsn Code 117 - Claim requires signature-on-file indicator.
HIPAA Adj Rsn Code 466 - Entities Original Signature
Original Charge Amount: 68.00
Claim Payment Amount: 25.07
Payment Method: Automated Clearing House (ACH)
Remittance or Check Number: [redacted]
Status Effective Date:
Check or EFT Date:
Date of service: 11/10/2003 thru 11/10/2003
Procedure Code: 99213
Procedure Code Modifier(s): 25
ICN:
Medical Record Number: [redacted]

Claims Information

Claim Status: Finalized/Denial-The claim/line has been denied.
Claims Status Clarification: HIPAA Adj Rsn Code 464 - Payer Assigned Control Number.
Original Charge Amount: 42.00
Claim Payment Amount: .00
Payment Method:
Remittance or Check Number: 00000000
Status Effective Date: 03/23/2004
Check or EFT Date:
Date of service: 01/09/2003 thru 01/09/2003
Procedure Code: 99212
Procedure Code Modifier(s): 25
ICN:
Medical Record Number: [redacted]
Bill Type:

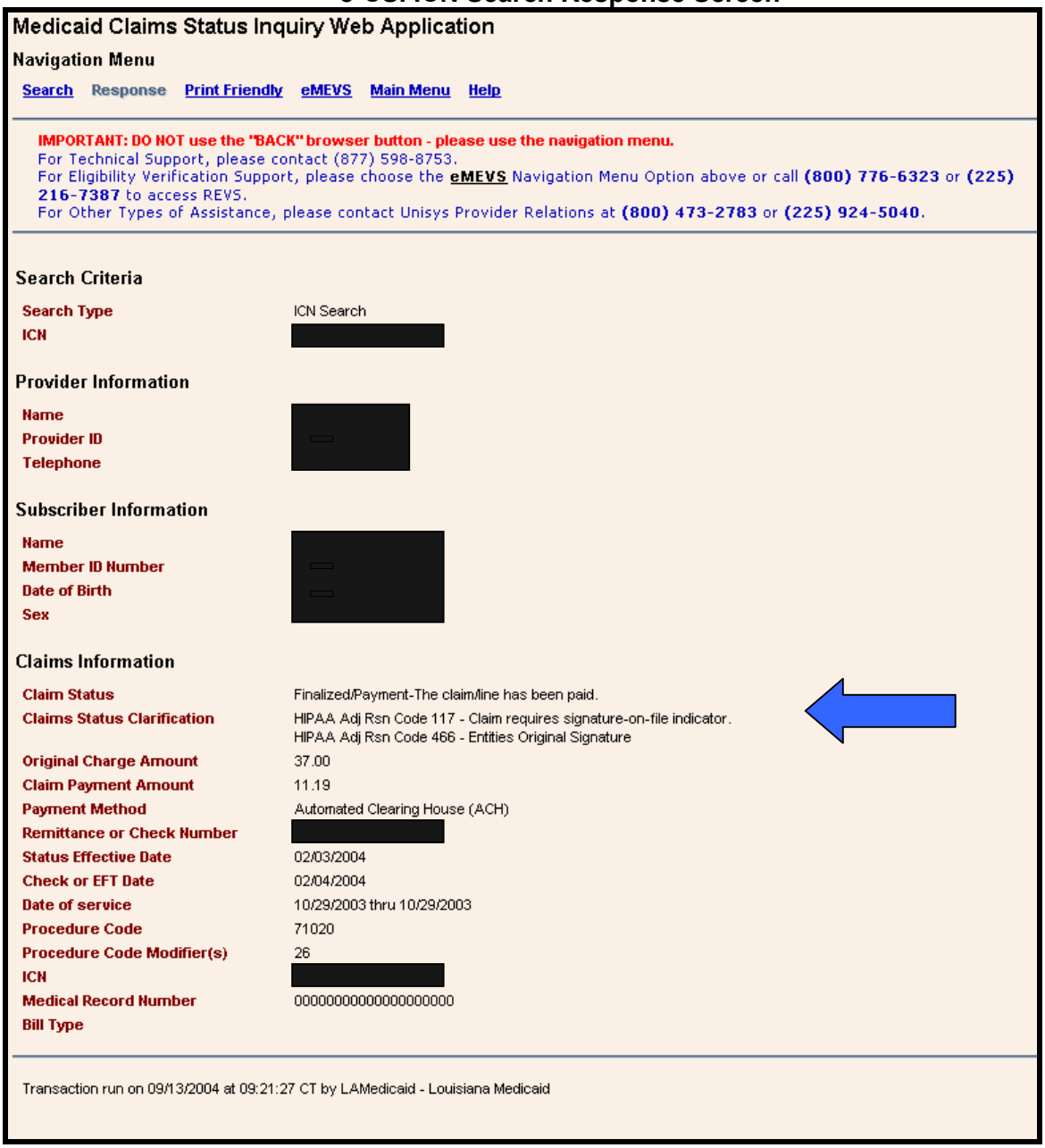
Claims Information

Claim Status: Finalized/Denial-The claim/line has been denied.
Claims Status Clarification: HIPAA Adj Rsn Code 132 - Entity's Medicaid provider id.
HIPAA Adj Rsn Code 1 - For more detailed information, see remittance advice.
HIPAA Adj Rsn Code 132 - Entity's Medicaid provider id.
Original Charge Amount: 42.00
Claim Payment Amount: .00
Payment Method:
Remittance or Check Number: 00000000
Status Effective Date: 12/09/2003
Check or EFT Date:
Date of service: 01/09/2003 thru 01/09/2003
Procedure Code: 99212
Procedure Code Modifier(s): 25
ICN:
Medical Record Number: [redacted]
Bill Type:

Transaction run on 09/13/2004 at 09:15:36 CT by LAMedicaid - Louisiana Medicaid

The following is an example of an ICN Search Response Screen. This response is an exact match because the ICN Search uniquely identifies a claim.

e-CSI ICN Search Response Screen



Medicaid Claims Status Inquiry Web Application

Navigation Menu

Search Response Print Friendly eMEVS Main Menu Help

IMPORTANT: DO NOT use the "BACK" browser button - please use the navigation menu.
For Technical Support, please contact (877) 598-8753.
For Eligibility Verification Support, please choose the eMEVS Navigation Menu Option above or call (800) 776-6323 or (225) 216-7387 to access REVS.
For Other Types of Assistance, please contact Unisys Provider Relations at (800) 473-2783 or (225) 924-5040.

Search Criteria

Search Type	ICN Search
ICN	[redacted]

Provider Information

Name	[redacted]
Provider ID	
Telephone	

Subscriber Information

Name	[redacted]
Member ID Number	
Date of Birth	
Sex	

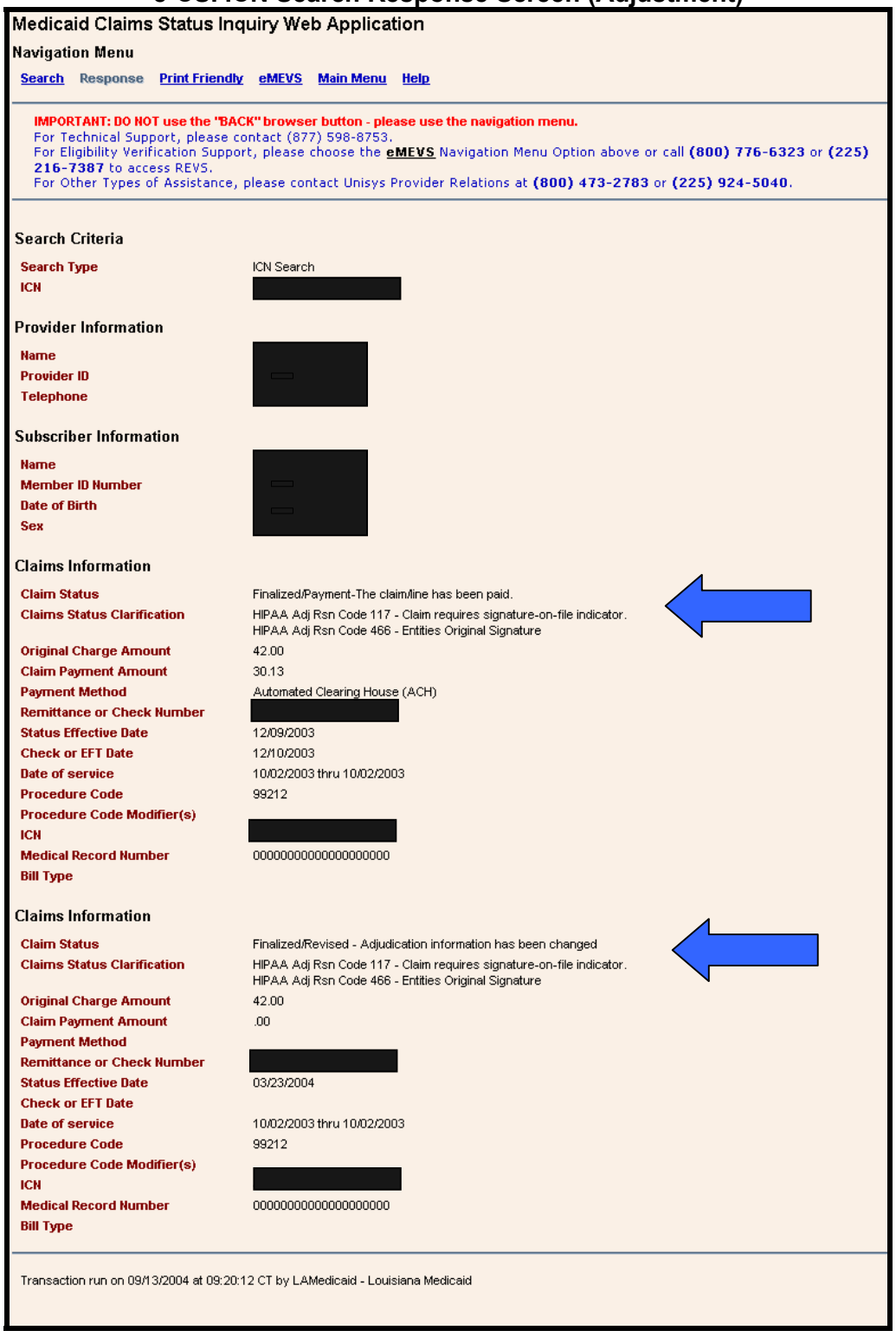
Claims Information

Claim Status	Finalized/Payment-The claim/line has been paid.
Claims Status Clarification	HIPAA Adj Rsn Code 117 - Claim requires signature-on-file indicator. HIPAA Adj Rsn Code 466 - Entities Original Signature
Original Charge Amount	37.00
Claim Payment Amount	11.19
Payment Method	Automated Clearing House (ACH)
Remittance or Check Number	[redacted]
Status Effective Date	02/03/2004
Check or EFT Date	02/04/2004
Date of service	10/29/2003 thru 10/29/2003
Procedure Code	71020
Procedure Code Modifier(s)	26
ICN	[redacted]
Medical Record Number	00000000000000000000
Bill Type	

Transaction run on 09/13/2004 at 09:21:27 CT by LAMedicaid - Louisiana Medicaid

The following is an example of an ICN Search Response Screen where the original claim and an adjustment are displayed.

e-CSI ICN Search Response Screen (Adjustment)



Medicaid Claims Status Inquiry Web Application

Navigation Menu

Search | Response | Print Friendly | eMEVS | Main Menu | Help

IMPORTANT: DO NOT use the "BACK" browser button - please use the navigation menu.
For Technical Support, please contact (877) 598-8753.
For Eligibility Verification Support, please choose the eMEVS Navigation Menu Option above or call (800) 776-6323 or (225) 216-7387 to access REVS.
For Other Types of Assistance, please contact Unisys Provider Relations at (800) 473-2783 or (225) 924-5040.

Search Criteria

Search Type	ICN Search
ICN	[redacted]

Provider Information

Name	[redacted]
Provider ID	
Telephone	

Subscriber Information

Name	[redacted]
Member ID Number	
Date of Birth	
Sex	

Claims Information

Claim Status	Finalized/Payment-The claim/line has been paid.
Claims Status Clarification	HIPAA Adj Rsn Code 117 - Claim requires signature-on-file indicator. HIPAA Adj Rsn Code 466 - Entities Original Signature
Original Charge Amount	42.00
Claim Payment Amount	30.13
Payment Method	Automated Clearing House (ACH)
Remittance or Check Number	[redacted]
Status Effective Date	12/09/2003
Check or EFT Date	12/10/2003
Date of service	10/02/2003 thru 10/02/2003
Procedure Code	99212
Procedure Code Modifier(s)	
ICN	[redacted]
Medical Record Number	00000000000000000000
Bill Type	

Claims Information

Claim Status	Finalized/Revised - Adjudication information has been changed
Claims Status Clarification	HIPAA Adj Rsn Code 117 - Claim requires signature-on-file indicator. HIPAA Adj Rsn Code 466 - Entities Original Signature
Original Charge Amount	42.00
Claim Payment Amount	.00
Payment Method	
Remittance or Check Number	[redacted]
Status Effective Date	03/23/2004
Check or EFT Date	
Date of service	10/02/2003 thru 10/02/2003
Procedure Code	99212
Procedure Code Modifier(s)	
ICN	[redacted]
Medical Record Number	00000000000000000000
Bill Type	

Transaction run on 09/13/2004 at 09:20:12 CT by LAMedicaid - Louisiana Medicaid

Response Screen Data Fields

The Electronic Claim Status Inquiry application returns a response providing the following information about a claim.

Field Name	Data Validation
Search Criteria	
Search Type	Denotes whether search mechanism was General or ICN
ICN	If ICN search methodology was entered denotes the ICN number
Provider Information	
Name	Provides the name of the servicing provider.
Provider ID	Denotes the ID number for the servicing provider.
Telephone	Provides the area code and telephone number for the servicing provider.
Subscriber Information	
Name	Provides the name of the subscriber.
Member ID Number	Denotes the ID number for the subscriber.
Date of Birth	Provides the date of birth for the subscriber.
Sex	Provides the sex of the subscriber.
Claim Information	
Claim Status	Denotes whether a claim has been paid, denied, or pended. Provides any corrective action that is needed.
Claims Status Clarification	Explains in further detail the status of the claim, including the HIPAA adjustment reason code.
Original Charge Amount	Provides the original charge amount submitted by the provider.
Claim Payment Amount	Provides the amount paid by the payor
Payment Method	Denotes how the payment was made. The alternatives are Automated Clearing House (ACH), check, or non-payment data.
Remittance or Check Number	The Remittance or Check number.
Status Effective Date	Provides the date of the information being returned.

Field Name	Data Validation
Check or EFT Date	The date the check or EFT was sent.
Date of Service	Provides the date of service of the claim.
Procedure Code	Identifies the procedure code.
Procedure Code Modifier	Provides the procedure code modifier if applicable.
ICN	13-digit numeric Internal Control Number.
Medical Record Number	An internal number assigned by the provider if entered on the claim..
Bill Type	Code designation that is returned if the claim was associated with a UB92 claim.
Timestamp	The date and time that the e-CSI response was generated.

e-CDI Web Application

The e-CDI will provide a Medicaid recipient's essential clinical history information at the authorized practitioner's finger tips at any practice location.

The e-CDI's nine (9) clinical services information components are:

1. Clinical Drug Inquiry
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

The e-CDI will be updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which will be updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a six month period. A print-friendly version of the displayed information on each of the web-pages will be accessible and suitable for the recipient's clinical chart.

The major benefits of the use of e-CDI by the practitioner will include:

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by **all** providers that have provided services to each individual recipient.
2. Provides the practitioner rapid access to current clinical data to help him/her evaluate the need for "modifications" of an individual Medicaid recipient's health care treatment.
3. Promotes the deliberate evaluation by a practitioner to help prevent duplicate drug therapy and decreases the ordering of duplicate laboratory tests, x-ray procedures, and other services.
4. Supplies a list of **all** practitioner types providing health care services to each Medicaid recipient.
5. Assists the practitioner in improving therapeutic outcomes and decreasing health care costs.

Accessing e-CDI

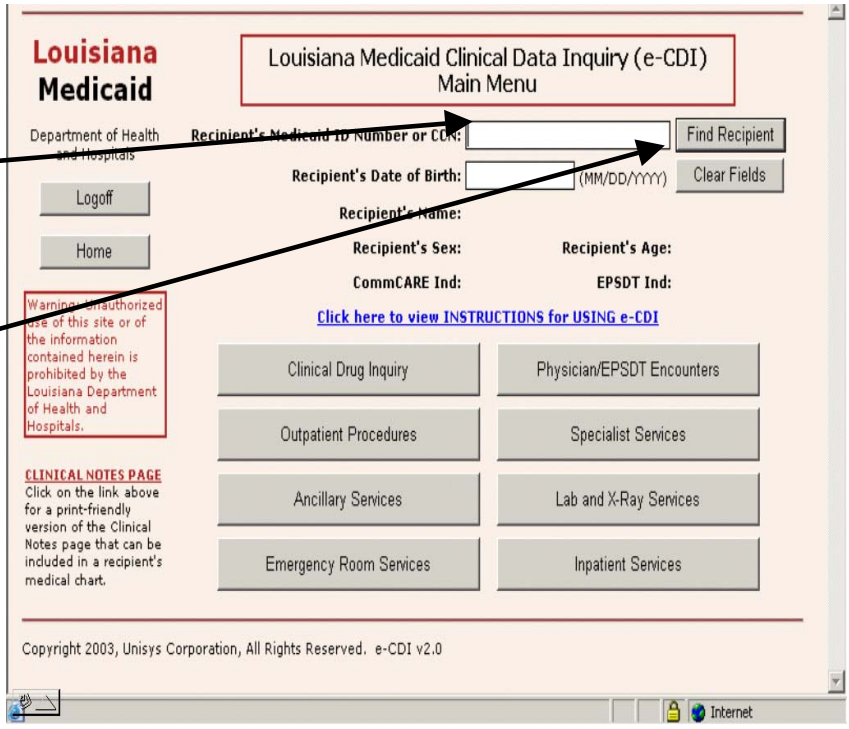
To ACCESS the e-CDI Web-based application follow the steps listed below:

1. Using your Internet browser, go to the www.LAMedicaid.com Web page.
2. Click on the **PROVIDER LOG IN** button in the upper left hand corner of the home page.
3. If you see a pop-up screen with a security message, you should click on the **YES/OK** button.
4. A Web page titles **PROVIDER LOGIN** will be displayed.
5. Enter your **7-CHECK-DIGIT-MEDICAID PROVIDER ID NUMBER** in the data entry box, and click on the **ENTER** button to the immediate right of the box.
6. A Web page titled **PROVIDER APPLICATIONS AREA** will be displayed.
7. Enter your **LOGIN ID** and **PASSWORD**, and then click on the **LOG-IN** button.
8. You are now at the **Restricted Provider Applications MAIN MENU** Web page.
9. Select the Electronic Clinical Data Inquiry link. You have now accessed the e-CDI web application.

Instructions on using e-CDI:

1. Enter the recipient's 13-digit Medicaid ID number or 16-digit CCN (Card Control Number) & Date of Birth.

2. Click on the **Find Recipient** button.



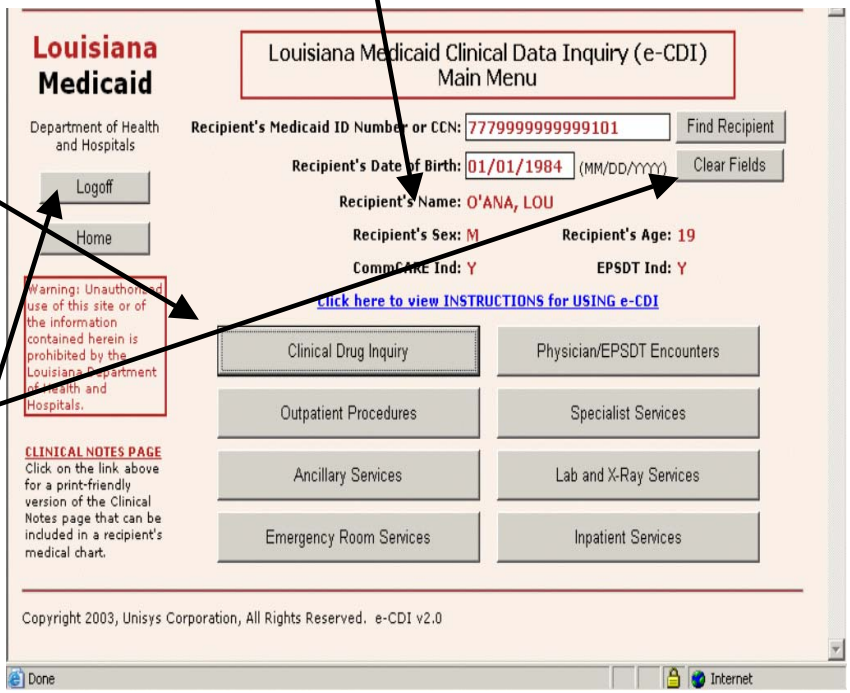
Recipient Fields will populate with specific information

3. Click one of the menu buttons to view the specific clinical inquiry pages for the selected recipient.

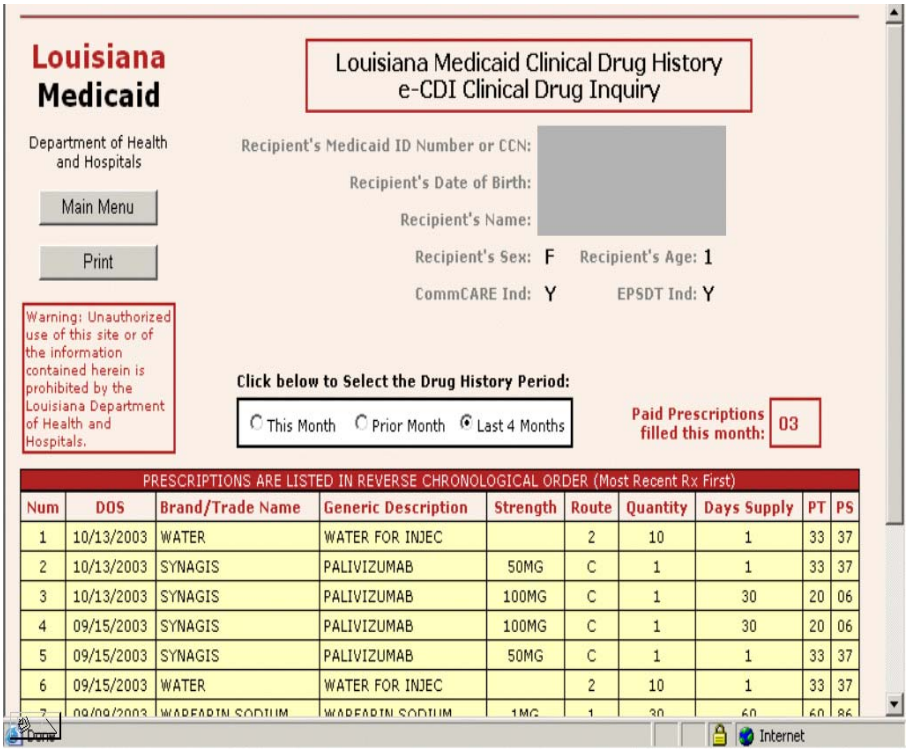
   (Once an option has been selected and the desired information was displayed, you will need to return to the **Main Menu** page to view additional clinical inquiry pages for the selected recipient.)

4. To find another recipient, you should first click on the **Clear Fields** button and then repeat the process described in steps 2, 3, & 4 above.

5. After completing all recipient clinical information inquiries, click on **Logoff**.

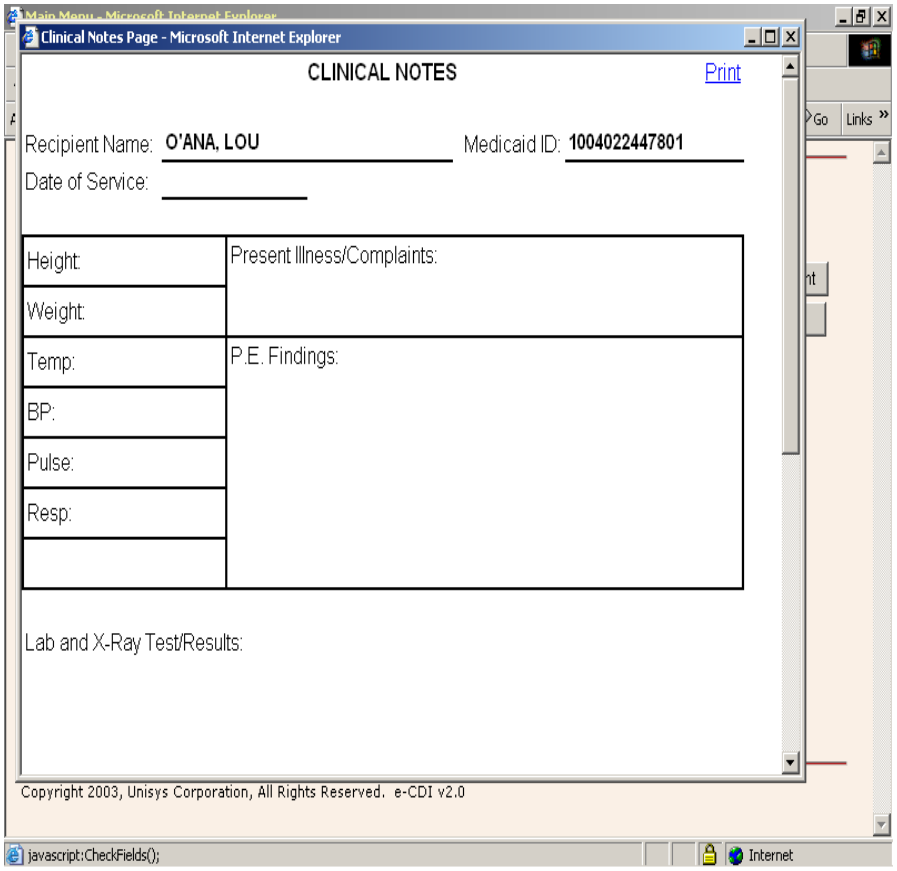


This example shows a specific recipient's clinical drug history for the last 4 months obtained by selecting the **Clinical Drug Inquiry** button.



Instructions on using the Clinical Notes Page link:

In the e-CDI **Main Menu**, click on the **CLINICAL NOTES PAGE** link to obtain a print-friendly version of the clinical notes page that can be used in a recipient's medical chart.



UNISYS CLAIMS FILING ADDRESSES

To expedite payment, providers should send "clean" claims directly to the appropriate Post Office Box as listed below. All Post Office Boxes are for Unisys Corporation, Baton Rouge, LA.

Type of Claim or Department	Post Office Box
The zip code for the following P.O. Boxes is 70821:	
Pharmacy (original claims and adjustment/voids)	91019
CMS-1500, including services such as Professional, Independent Lab, Substance Abuse and Mental Health Clinic, Hemodialysis, Professional Services, Chiropractic, Durable Medical Equipment, Mental Health Rehabilitation, EPSDT Health Services, Case Management, FQHC, and Rural Health Clinic (original claims and adjustment/voids)	91020
Inpatient and Outpatient Hospitals, Long Term Care, Hospice, Hemodialysis Facility, Freestanding Psychiatric Hospitals (original claims and adjustment/voids)	91021
Dental, Transportation (Ambulance and Non-ambulance), Rehabilitation, Home Health (original claims and adjustment/voids)	91022
All Medicare Crossovers and All Medicare Adjustments and Voids	91023
Provider Relations	91024
EMC/EDI, Unisys Business, and Miscellaneous Correspondence	91025
The zip code for the following P.O. Boxes is 70898:	
Provider Enrollment	80159
Prior Authorization	14919
KIDMED	14849

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.

If claims cannot be submitted electronically, prepare paper claim forms according to the following instructions to ensure appropriate and timely processing:

- Submit an original claim for 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.

- Don't forget to sign and date your claim form. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.

- Continuous feed forms must be torn apart before submission.

- Use high quality printer ribbons or cartridges - black ink only.

- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.

- Do not use italic, bold, or underline features.

- Do not submit two-sided documents.

- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

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

Rejected Claims

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

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

Attachments

All claim attachments should be standard 81/2 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. Any claims requiring changes, 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.

ELECTRONIC DATA INTERCHANGE (EDI)

GENERAL INFORMATION

- Please review the entire **General EDI Companion Guide** before completing any forms or calling the EDI Department.

- The following claim types may be submitted as approved HIPAA compliant 837 transactions:

  - Pharmacy
  - Hospital Outpatient/Inpatient
  - Physician/Professional
  - Home Health
  - Emergency Transportation
  - Adult Dental
  - Dental Screening
  - Rehabilitation
  - Crossover A/B

- The following claims types may be submitted under proprietary specifications (not as HIPAA-compliant 837 transactions):

  - Case Management services
  - Non-Ambulance Transportation

- Any number of claims can be included in production file submissions. There is no minimum number.

- EDI Testing is required for all submitters (including KIDMED) before they are approved to submit claims for production unless the testing requirement has been completed by the Vendor. LTC providers must test prior to submission to production.

- Case Management Services and Non-Ambulance Transportation submitters who file via modem MUST wait 24 hours, excluding weekends, between file submissions to allow time for processing.

Enrollment Requirements For EDI Submission

- **Submitters wishing to submit EDI 837 transactions without using a Third Party Biller** - complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA SUBMISSION OF CLAIMS** (EDI Contract).

- **Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse** – complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA SUBMISSION OF CLAIMS** (EDI Contract) **and** a Limited Power of Attorney.

- **Third Party Billers or Clearinghouses** (billers for multiple providers) are required to submit a completed HCFA 1513 – Disclosure of Ownership form and return it with a completed EDI Contract **and** a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Enrollment Requirements for 835 Electronic Remittance Advices

- All EDI billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EDI billers to download their remittance advices weekly.

- 835 Transactions may not contain all information printed on the hardcopy RA, ex. blood deductible, patient account number, etc.

- To request 835 Transactions – Electronic Remittance Advice, contact Unisys EDI Department at (225) 237-3200 ext. 2.

CLAIMS SUBMISSION

Electronic data interchange submission is an alternate method of submitting Medicaid claims to Unisys. With electronic data, a provider or a third party contractor (billing agent) submits Medicaid claims to Unisys on a computer encoded magnetic tape, diskette or via telecommunications.

Each claim undergoes the editing common to all claims, e.g., verification of dates and balancing. Each type of claim has unique edits consistent with the requirements outlined in the provider manuals. All claims received via electronic data must satisfy the criteria listed in the manual for that type of claim.

Advantages of submitting claims electronically include increased cash flow, improved claim control, decrease in time for receipt of payment, automation of receivables information, improved claim reporting by observation of errors and reduction of errors through pre-editing claims information.

Certification Forms

Each reel of tape, diskette or telecommunicated file submitted for processing must be accompanied by a submission certification form signed by the authorized Medicaid provider or billing agent for each provider whose claims are billed using electronic data. The certification must be included in each tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.

Third Party Billers are required to submit a Certification Form including a list of provider(s) name(s) and Medicaid Provider numbers. Additionally, all Third Party Billers **MUST** obtain a “Professional, Pharmacy, Hospital or KIDMED Services Certification" form on which the provider has attested to the truth, accuracy and completeness of the claim information. These forms **MUST** be maintained for a period of five years. This information must be furnished to the agency, the DHH Secretary, or the Medicaid Fraud Control Unit upon request.

Copies of required Certification forms are included on pages 109-113 of this packet and may also be obtained from lamedicaid.com under the HIPAA Information Center link. The required forms are available in both the General EDI Companion Guide and the EDI Enrollment Packet.

For telecommunication files, the required Certification Form must be mailed to the Unisys EDI Unit within 48 hours. The form must be completed in its entirety including the following fields:

- Provider Name
- Provider Number

- Submitter Number
- Claim Count
- Total Charges of submission
- Submission Date
- Original Signature
- For **THIRD PARTY BILLERS / CLEARINGHOUSES -** a list of Provider Names and Numbers contained in the submission must be attached.

Failure to correctly complete the Certification Form will result in the form being returned for correction.

To contact the EDI Department at Unisys, call (225) 237-3200 and select option 2. Providers may write to Unisys EDI Department, P.O. Box 91025, Baton Rouge, LA 70821.

Electronic Data Interchange (EDI) may be submitted by magnetic tape, 5 1/4" diskette, 3 1/2" diskette, or telecommunication (modem).

PROFESSIONAL SERVICES CERTIFICATION
(Physician, Home Health, Ambulance,
Non-Ambulance, Dental EPSDT, Dental Adult, Rehabilitation and
Durable Medical Equipment)

I certify that the services rendered were necessary, medically indicated and were rendered by me or under my personal supervision. I have reviewed the claim information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or otherwise required by law or regulation. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistant Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

PROVIDER NAME _____ PROVIDER NUMBER _____ SUBMITTER NUMBER _____

CLAIM COUNT _____ AMOUNT $ _____ CLAIM TYPE _____

TAPE REEL OR DISKETTE NUMBER _____ RUN DATE _____

TELECOMMUNICATIONS SUBMISSION DATE _____ TIME _____

DATE _____ PROVIDER SIGNATURE (ORIGINAL) _____

(This certification MUST be included in EACH tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.)

HOSPITAL SERVICES CERTIFICATION

I certify that the services rendered were necessary and medically indicated. I have reviewed the claim information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan. I hereby agree to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or as otherwise required by law. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistance Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws. NOTICE: This is to certify that the foregoing information is true, accurate and complete.

PROVIDER NAME _____ PROVIDER NUMBER _____ SUBMITTER NUMBER _____

CLAIM COUNT _____ AMOUNT $ _____

TAPE REEL OR DISKETTE NUMBER _____

INPATIENT REEL NUMBER _____ OUTPATIENT REEL NUMBER _____

TELECOMMUNICATIONS SUBMISSION DATE _____ TIME _____

DATE _____ PROVIDER SIGNATURE (ORIGINAL) _____

(This certification MUST be included in EACH tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.)

PHARMACY CERTIFICATION

I certify that the services provided have been rendered by a legally qualified person, that the charge is within the department's Prescription Package Regulations, and the payment has not been received. I agree to adhere to the regulations policies, criteria and procedures concerning pharmaceutical payments. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request for five years from date of service.

I understand that payment and satisfaction of these claims will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws.

PROVIDER NAME _____ PROVIDER NUMBER _____ SUBMITTER NUMBER _____

CLAIM COUNT _____ DOLLAR AMOUNT $ _____

TAPE REEL OR DISKETTE NUMBER _____

TELECOMMUNICATIONS SUBMISSION DATE _____ TIME _____

DATE _____ SIGNATURE OF VENDOR OR AUTHORIZED REPRESENTATIVE _____

(This certification MUST be included in EACH tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.)

LOUISIANA KIDMED

MEDICAL, HEARING AND VISION SCREENING SERVICES (EPSDT) CERTIFICATION

I certify that the services rendered were necessary, medically indicated and were rendered by me or under my personal supervision. I have reviewed the claim information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or otherwise required by law or regulation. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistant Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

PROVIDER NAME _____ PROVIDER NUMBER _____ SUBMITTER NUMBER _____

RECORD COUNT _____ CLAIM COUNT _____ AMOUNT $ _____

CLAIM TYPE **KIDMED**

TAPE REEL OR DISKETTE NUMBER _____ RUN DATE _____

TELECOMMUNICATIONS SUBMISSION DATE _____ TIME _____

DATE _____ PROVIDER SIGNATURE (ORIGINAL) _____

(This certification MUST be included in EACH tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.)

THIRD-PARTY BILLER CERTIFICATION

I certify that the claim information submitted is an exact duplicate of information transmitted to me by the identified provider(s) and that no revisions or alterations have been made by me. (Please attach a list of provider(s) name(s) and identification numbers.)

I also certify that the identified provider(s) have furnished me with a "Professional, Pharmacy, Hospital or KIDMED Services Certification" form on which the provider has attested to the truth, accuracy and completeness of the claim information and I agree to maintain these forms for a period of five years.

THIRD PARTY NAME _____ ADDRESS _____ SUBMITTER NUMBER _____

CLAIM COUNT _____ DOLLAR AMOUNT $ _____

TAPE REEL OR DISKETTE NUMBER _____ RUN DATE _____ CLAIM TYPE _____

TELECOMMUNICATIONS SUBMISSION DATE _____ TIME _____

DATE _____ AUTHORIZED SIGNATURE / TITLE _____

(This certification MUST be included in EACH tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.)

Submission Deadlines

Regular Business Weeks

Magnetic Tape and Diskettes	4:30 P.M. each Wednesday
KIDMED Submissions (All Media)	4:30 P.M. each Wednesday
Telecommunications (Modem)	10:00 A.M. each Thursday

Thanksgiving Week

Magnetic Tape and Diskettes	4:30 P.M. Tuesday, 11/23/04
KIDMED Submissions	4:30 P.M. Tuesday, 11/23/04
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/24/04

Electronic Adjustments/Voids

Adjustments and voids can be submitted electronically. If your present software installation does not offer this option, please contact your software vendor to discuss adding this capability to your software.

Important Reminders for EDI Submission

- Denied claims may be resubmitted electronically unless the denial code states otherwise. This includes claims that have produced a denied claim turnaround document (DTA). Claims with attachments must be submitted hardcopy.
- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.
- The total amount of the submitted file must equal the amount indicated on the Unisys response file.
- **All claims submitted must meet timely filing guidelines.**

REFUND CHECKS

When errors in billing occur (e.g., duplicate payments), instead of simply refunding payments, **providers should initiate claim adjustments or voids**. However, should providers find it necessary to refund a payment, they should make checks payable to the Department of Health and Hospitals, Bureau of Health Services Financing, and mail the refunds to the following address:

Payment Management Section
Bureau of Fiscal Services
P. O. Box 91117
Baton Rouge, LA 70821-9117

To reconcile an account with the Treasury Department, providers must attach a copy of the Remittance Advice to their return or refund. In addition, they must explain the reason for the return or refund.

To determine the amount of a refund, providers should consider the following rules:

- Whenever a duplicate payment is made, the full amount of the second payment must be refunded.

- If another insurance company pays after Medicaid has made its payment and the TPL payment is greater than the Medicaid payment, the full amount of the Medicaid payment should be refunded.

CHECKS SHOULD NOT BE MADE PAYABLE TO UNISYS

Note: Adjustment/void claims should be done initially. A refund check should be a last option, as this process takes a much longer time period to be completed and does not provide a clear audit trail as the adjustment/void process does.

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.

When providers or contractors are attempting to reconcile old accounts, if RAs are not available through the provider, it is necessary for the provider to order a claims history, which is available through Unisys Provider Relations (see p. 136).

Electronic Remittance Advices (e-RAs)

The EDI Department now 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 RA's 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.

Suspense Balance Brought Forward	A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed.
Approved Original Claim	Total of all approved (paid) claims appearing on this RA.
Adjustment Claims	Total of all claims being adjusted on this RA.
Previously Paid Claim	Total of all previously paid claims which correspond to an adjustment or void appearing on this RA.
Void Claims	Total of all claims being voided on this RA.
Net Current Claims Transactions	Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process).
Net Current Financial Transactions	Total number of all financial transactions appearing on the RA.
Prior Negative Balance	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.)

Withheld for Future Recoveries	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.)
Total Payments This RA	Total of current check.
Total Copayment Deducted This RA	Total pharmacy co-payments deducted for this RA.
Suspense Balance Carried Forward	Total of Suspense Balance Brought Forward and withheld for future recoveries.
Y-T-D Amount Paid	Total amount paid for the calendar year.
Denied Claims	Total of all denied claims appearing on this RA.
Claims in Process	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 Claims 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.

TO: B APP CAT NS L OUTPATIENT FACIL RE ANCE ADVICE DATE: 08/ /200 AGE: 1

LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

P O BOX 81
NEW ORL LA 7

REMITTANCE NO: 54543

M M D D Y Y 17 MEDIA: 3

APPROVED ORIGINAL CLAIMS

RECIPIENT NUMBER / MEDICAL RECORD NO	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION / DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
170 10873[illegible] 1	AI ORD R	010400	010400	1	634 EPOIETIN UNDER 10000	4000	4000	00	4000	02 057(300
(10: 25	)/ 036[illegible] 00020020									
170 10873[illegible] 1	A OR R	010600	010600	1	634 EPOIETIN UNDER 10000	4000	4000	00	4000	02 057(30(
(10: 25	)/ 036 00020020									
170 10873[illegible]	A OR R	010800	010800	1	634 EPOIETIN UNDER 10000	4000	4000	00	4000	02 1057(300
(10: 25	)/ 036 00020020									
170 10873[illegible]	A OR R	011200	011200	1	634 EPOIETIN UNDER 10000	4000	4000	00	4000	0[illegible] 1057(30(
(10: 25	)/ 036 00020020									
170 10873[illegible] 1	A OR R	011500	011500	1	634 EPOIETIN UNDER 10000	4000	4000	00	4000	0[illegible] 4057(30(
(10: 25	)/ 036 00020020									
170 10873 1	A OR R	010400	010400	1	636 DRUGS REQUIRING DETAI J1760	3496	3496	00	3496	0[illegible] 4057(30(
(10: 25	)/ 103[illegible] 00020020									
170 10873[illegible] 1	A OR R	010600	010600	1	636 DRUGS REQUIRING DETAI J1760	3496	3496	00	3496	02 1057(30(
(10 25	)/ 103[illegible] 00020020									
170 10873[illegible] 1	A OR R	010400	010400	1	821 650 HEMODIALYSIS/COMPOSIT 90935	12275	12129	00	12129	02 1057(30(
(10 25	)/ 103[illegible] 00020020									

TO: BI ·· I(. / ²L :A J — 91‹ I

P B((76(

NF OI E/ S LA 70162

OUTPATIENT FACIL . REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/' /200 'AGE: 13

REMITTANCE NO: 5781334

M M D D Y Y

1˙ 1‹ I MEDIA: 3

RECIPIENT NUMBER / MEDICAL RECORD NO	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
DENIED CLAIMS										
(10^^02	)/ 0360 99	11003C			272					
17(,89609501	ILEY RJ	072799	072799	1	821 90935	121 29	00	00	00	0214057)14
(1' 502	)/ 0360 99	11003C			272					
17 08 09501	LEY RJ	080399	080399	1	635 EPOIETIN OVER 10000 U	70 00	00	00	00	0214057)15(
(1 60	)/ 0360 99	11003D			770					
17 08 09501	LEY RJ	082099	082099	1	635 EPOIETIN OVER 10000 U	70 00	00	00	00	021405;)15(
(1 60	)/ 0360 99	11003D			770					
17 08 09501	LEY RJ	082899	082899	1	635 EPOIETIN OVER 10000 U	70 00	00	00	00	021405')15(
(1 60	)/ 036(99	11003D			770					

DENIED C	IMS	TOTALS			59 CLAIMS		00		00	
CLAIMS IN	OCES									
17 087^^8601	KNIG T L	072500	072500	1	821 90935	122 75	00	00	00	021‹ ;7001 9
(1 1434	)/( )34 00	02005D			216					
17 087‹ 3601	I (NIG T L	031600	031600	1	634	40 00	00	00	00	021‹ ;7002 0
(1 1434	)/( )34 00	04002H			216					
17 087‹ 3601	I (NIG T L	031800	031800	1	634	40 00	00	00	00	021‹ ;7002 1
(' ;434	)/( )34 00	04002H			216					
1: 1087‹ 3601	I (NIG T L	032100	032100	1	634	40 00	00	00	00	021‹ ;7002 2
(' 3434	)/(:)34:)00	04002H			216					

TO: E P I L A PUBLIC TIO I

F O B 760
P / O E S LA 70162

INSTITUTIONAL TITLE /III REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/ /200 AGE: 17
REMITTANCE NO: 57 334
M M D D Y Y 1 MEDIA: 3

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
DENIED CLAIMS										
17 101795 01 (1 1351	P JK,) /	030100	033100	1	CLINIC FACILITY 721 DED 00 BLDED 00 C N 41 56 846 978 CONFLICTING CONTROL NO: 435961 1800	203780	00	00	00	020 196015)
17 08868 01 (1 299 | L LL) /	D	050200	053000	1	CLINIC FACILITY 721 DED 00 BLDED 00 C N 117 0 846 978 CONFLICTING CONTROL NO: 721650 100	587049	00	00	00	02 5960145)
17 08868 01 (1 299 | L) /	D	030200	033000	1	CLINIC FACILITY 721 DED 00 BLDED 00 C N 113 9 846 978 CONFLICTING CONTROL NO: 161652 400	565743	00	00	00	02 5960146)
17 020052 01 (1 218 | S AD EY) /	I	050100	053100	1	CLINIC FACILITY 721 DED 00 BLDED 00 C N 54 5 846 978 CONFLICTING CONTROL NO: 721650 700	270325	00	00	00	02 5960138
24 002473 01 (1 337	ON /	L	050100	053100	1	CLINIC FACILITY 721 DED 00 BLDED 00 C N 91 4 846 978 CONFLICTING CONTROL NO: 721650 1200	456271	00	00	00	02 5960149
170 087547 1 (10 399 | WI E) /	JH	120198	121798	1	OUTPATIENT HOSPITAL 136 DED 00 BLDED 00 C N 45 1 799	225607	00	00	00	02 7396601
DENIED CLAIMS TOTALS					6 CLAIMS	2308775	00	00	00	

LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

P O BOX 81
NEW ORL LA 7

REMITTANCE NO: 54543

M M D D Y Y

17: MEDIA: 3

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
ADJUSTMENT CLAIMS										
36 16 1	E J	081999	081999	6	270 MED/SURG SUPPLY/DEVIC	215150	215150	86060	129090	5 914 6100
(8 46	(2064 781							REF. CONTROL NO.		5 21 6502
3E 16 1	E J	081999	081999	1	250 PHARMACY,GENERAL CLAS	82375	82375	32950	49425	5 914 6200
(E 46	(2064 781							REF. CONTROL NO.		5 121 6500
3(516 1	B J	081999	081999	1	360 OPERATING ROOM SERVIC 36831	161200	161200	64480	96720	5 914 6500
(546	(2064 781							REF. CONTROL NO.		5 121 6505
4 020 1	G IER T	081999	081999	3	250 PHARMACY,GENERAL CLAS	45400	45400	18160	27240	5 914 6000
(814	(2064 493							REF. CONTROL NO.		5 121 6600
4 020 1	G IER T	081999	081999	1	270 MED/SURG SUPPLY/DEVIC	262575	262575	105030	157545	5 914 6300
(814	2064 493							REF. CONTROL NO.		5 121 6602
(0020 1	G ER T	081999	081999	1	360 OPERATING ROOM SERVIC	328300	328300	131320	196980	5 914 6400
2814	2064 493							REF. CONTROL NO.		5 121 6603
0874 1	KI S	022598	022598	7	270 MED/SURG SUPPLY/DEVIC	26525	26525	10610	15915	3835 6900
0794	1109 716							REF. CONTROL NO.		5814 6602
0573 1	SM T	081399	081399	2	270 MED/SURG SUPPLY/DEVIC	10000	10000	4000	6000	5814 6000
38074	1114 968							REF. CONTROL NO.		3614 6300
						1131525		452610		
ADJUSTMENT CLAIMS		TOTALS			8 CLAIMS		1131525		678915	
PREVIOUSLY PAID CLAI										
3604 89601	E J	081999	081999	42	250 PHARMACY,GENERAL CLAS 0	64875	38925	00	38925	4214 6500
(820	(2064 781				FORMER REMITTANCE DATED : 09081999			REF. CONTROL NO.		5914 6200
3604 89601	E J	081999	081999	11	270 MED/SURG SUPPLY/DEVIC 0	97775	58665	00	58665	4214 6502
(82C	(2064 781				FORMER REMITTANCE DATED : 09081999			REF. CONTROL NO.		5914 6100
3604 89601	E J	081999	081999	1	360 OPERATING ROOM SERVIC 36831	157400	94440	00	94440	4214 6505
(82C	(2064 781				FORMER REMITTANCE DATED : 09081999			REF. CONTROL NO.		5914 6500

TO: D ME A LIC H
P BC O
NE OR A LA 70162

REMITTANCE SUMMARY
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/ /2000 PAGE: 20
REMITTANCE NO: 5781334
MMDDYY 13 .41 MEDIA: 3

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
					CURRENT NUMBER / TRANSACTIONS AMOUNT					
	APPROVED ORIGINAL CLAIMS				257 20,192.52 LAST REMITTANCE NO: 5773274 DATED: 08082000					
	ADJUSTMENT CLAIMS				3 1,716.61					
	PREVIOUSLY PAID CLAIMS				3 1,605.92-					
	VOIDED CLAIMS				.00					
	NET CURRENT CLAIM TRANSACTIONS				372 20,303.21					
	NET CURRENT FINANCIAL TRANSACTIONS				.00					
	PRIOR NEGATIVE BALANCE				.00					
	RECOUPMENTS BYPASSED BY D.H.H.				.00					
TOTAL PAYMENT THIS REMITTANCE					$20,303.21 EFT NO: 05 33 DIRECT DEPOSIT DATE: 08/16/2000					
TOTAL COPAYMENT DEDUCTED THIS REMITTANCE					$.00					
YEAR-TO-DATE AMOUNT PAID					$264,581.00					
	DENIED CLAIMS				65 26,704.67					
	CLAIMS IN PROCESS				44 8,578.00					

LAM1W110 1. 1 1 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS REPORT NO: CP-0-25
RUN: 08/ /00 22:52:41 DEPARTMENT OF HEALTH AND HUMAN RESOURCES - OFFICE OF FAMILY SECURITY PAGE: 1
CYCLE: 08/ /00 T P L DENIED CLAIMS NOTIFICATION LIST

PROVIDER ID 1 14

RECIPIENT ID	NAME	CLAIM ICN	ERROR	CARRIER CODE	POLICY NUMBER	CARRIER NAME
170 87468601	MCKNI L	0 4-0-!)-026 0	290	0485	612 '55	UNIVERSAL LIFE INSURANCE
				0485	611 156	UNIVERSAL LIFE INSURANCE
170 874(601	MCKNI L	0 4-0-!)-026 1	290	048!)	612 '55	UNIVERSAL LIFE INSURANCE
				048!)	61' 956	UNIVERSAL LIFE INSURANCE
170' 174 601	MCKNI L	0 4-0-!)-026 2	290	048!)	61! 755	UNIVERSAL LIFE INSURANCE
				048' 0	61' 956	UNIVERSAL LIFE INSURANCE
1701 174 601	MCKNI L	0 4-0-!)-026 3	290	048 0	61. 755	UNIVERSAL LIFE INSURANCE
				048 0	61 956	UNIVERSAL LIFE INSURANCE

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, providers can access information ranging from how to enroll as a Medicaid provider to directions for filling out a claim form.

Below are some of the most common topics found on the website:

New Medicaid Information
HIPAA Information Center
HIPAA Billing Instructions & Companion Guides
Provider Training Materials
Provider Web Account Registration Instructions
Provider Support
Billing Information
Provider Update / Remittance Advice Index
Pharmacy
Prescribing Providers
Current Newsletter and RA
Helpful Numbers
Forms/Files

☞ The website also contains a section for Frequently Asked Questions that provide answers to commonly asked questions received by Provider Relations.

Along with the website, The Unisys Provider Relations Department is available to assist providers. This department consist of three units, (1) Telephone Inquiry Unit, (2) Correspondence Unit, and (3) Field Analyst. The following information addresses each unit and their responsibilities.

Unisys Provider Relations Telephone Inquiry Unit

(800) 473-2783 or (225) 924-5040
FAX: (225) 237-3334*

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification, ordering printed materials, obtain TPL information, request a Field Analyst visit, etc.

The following menu options are available through the Unisys Provider Relations telephone inquiry phone numbers:

Press #2 To order printed materials only**
Examples: Orders for manuals, workshop packets, enrollment packs, Unisys claim forms, fee schedules, TPL carrier code lists, and provider newsletter reprints.

(To choose this option, press "2" on the telephone keypad. This option will allow providers to leave a message to request printed materials **only**. Please be sure to leave (1) the provider name, (2) provider number, (3) contact person, (4) complete mailing address and (5) phone number.)

☞ Only messages left in reference to printed materials will be processed when choosing this option. Please review the other options outlined in this section for assistance with other provider issues.

NOTE: Providers should access eligibility information via the Medicaid Eligibility Verification Sysyten (MEVS) or the automated Recipient Eligibility Verification System (REVS) at (800) 776-6323 or (225) 216-7387 in the Baton Rouge area. However, questions regarding an eligibility response may be directed to Provider Relations via the second option.

Press #3 To verify recipient or provider eligibility, Medicare or other insurance information, Primary Care Physician information, or service limits.

- Recipient eligibility
- Third Party (Insurance) Resources
- CommunityCARE
- Lock-In

Press #4 To obtain information regarding KIDMED or CommunityCARE claims or policy questions, or to resolve problem claims, obtain policy clarification, obtain procedure code reimbursement verification, request a field analyst visit, or obtain other information.

*Provider Relations will accept faxed information regarding provider inquiries on an **approved** case by case basis. However, faxed claims **are not acceptable** for processing.

** Provider Relations staff mail each new provider a current copy of the provider manual and training packet for his program type upon enrollment as a Medicaid provider. An enrolled provider may also request a copy of the provider manual and training packet for the Medicaid program in which he is enrolled. A fee is charged for provider manuals and training packets ordered for non-providers (attorneys, billing agents, etc.) or by providers wanting a manual for a program for which they are not enrolled. All orders for provider manuals and training packets should be made by contacting the Provider Relations Telephone Inquiry Unit. Those requiring payment will be forwarded to the provider once payment is received.

Unisys Provider Relations Correspondence Group

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims. Staff in this unit also handle requests to update recipient files with correct eligibility. Provider Relations staff do not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence department, so these may take additional time for final resolution.

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

NOTE: Many providers submit claims that do not require special handling to the Provider Relations Department hoping to expedite processing of these claims. However, this actually delays claim processing, as the claims must pass through additional hands before reaching the appropriate processing area. In addition, it diverts productivity that would otherwise be devoted to researching and responding to provider requests for assistance with legitimate claim problems. Providers are asked to send claims that do not require special handling directly to the appropriate post office box for that claim type.

Unisys Provider Relations Field Analysts

Provider Relations Field Analysts are available to visit and train new providers and their office staff on site, upon request. Providers are encouraged to request Analyst assistance to help resolve complicated billing issues and to help train their staff on Medicaid billing procedures. **However**, calls regarding eligibility, claim issues, requests for Unisys claim forms, manuals, or other policy documentation should **not** be directed to the Field Analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.

FIELD ANALYST	PARISHES SERVED		
Martha Craft **(225) 237-3306**	Jefferson Orleans	St. Charles Plaquemines St. Bernard	
Open	Bienville Bossier Caddo Claiborne East Carroll Lincoln Madison Morehouse Vicksburg, MS	Ouachita Richland Union Webster West Carroll Marshall, TX	
Mona Doucet **(225) 237-3249**	Acadia Evangeline Iberia Lafayette	St. Landry St. Martin St. Mary Vermillion	
Open	Allen Beauregard Calcasieu Cameron	Jeff Davis Lafourche Terrebonne Vernon	Jasper, TX Beaumont, TX
Sharon Harless **(225) 237-3267**	Avoyelles Iberville West Baton Rouge	East Feliciana West Feliciana Woodville/Centerville (MS) Pointe Coupee	
Erin McAlister **(225) 237-3201**	Ascension Assumption Livingston St. Helena St. James	St. John the Baptist St. Tammany Tangipahoa Washington McComb (MS)	
Courtney Patterson **(225) 237-3269**	East Baton Rouge		
Kathy Robertson **(225) 237-3260**	Caldwell Catahoula Concordia DeSoto Franklin Grant Jackson LaSalle	Natchitoches Rapides Red River Caldwell Sabine Tensas Winn Natchez (MS)	

Provider Relations Reminders

The Unisys Provider Relations inquiry staff strives to respond to provider inquiries quickly and efficiently. There are a number of ways in which the provider community can assist the staff in responding to inquiries in an even more timely and efficient manner:

- Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:

  - The correct Medicaid provider number
  - The recipient's Medicaid ID number
  - The date of service
  - Any other information, such as procedure code and billed charge, that will help identify the claim in question
  - The Remittance Advice showing disposition of the specific claim in question

- Obtain the name of the phone representative you are speaking to in case further communication is necessary.

- Because of the large volume of incoming provider calls, Telephone Inquiry staff are not allowed to be put on hold after answering a call.

- PLEASE review and reconcile the remittance advice before calling Provider Relations concerning claims issues. Some providers call Provider Relations frequently, asking questions that could be answered if the RA was reviewed thoroughly. However, providers are encouraged to call Provider Relations with questions concerning printed policy, procedures, and billing problems.

- Provider Relations **WILL NOT** reconcile provider accounts or work old accounts for providers. Calls to check claim status tie up phone lines and reduce the number of legitimate questions and inquiries that can be answered. It is each provider's responsibility to establish and maintain a system of tracking claim billing, payment, and denial. This includes thoroughly reviewing the weekly remittance advice, correcting claim errors as indicated by denial error codes, and resubmitting claims which do not appear on the remittance advice within 30 - 40 days for hard copy claims and three weeks for EDI claims.

- Providers can check claim status through the e-CSI (Claim Status Inquiry) web application found in the secure area of the Louisiana Medicaid website at www.lamedicaid.com. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on e-CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the e-CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to remittance advices for this purpose. A LA Medicaid/HIPAA Error Code Crosswalk is available on the website by accessing the link, Forms/Files.

- If a provider has a large number of claims to reconcile, it may be to the provider's advantage to order a provider history. Please see the Ordering Information section for instructions on ordering a provider history.

- Provider Relations cannot assist recipients. Please do not issue the Provider Relations telephone numbers to Medicaid recipients, as recipient inquiries directly reduce the number of incoming provider calls that can be answered. In addition, providers should not give their provider numbers to recipients in order that they may contact Provider Relations. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential. If recipients have problems, please direct them to the Parish Office or the number on their card.

- Providers who wish to submit problem claims for a written response **must submit a cover letter** explaining the problem or question.

- Calls regarding eligibility, claim issues, requests for Unisys claim forms, manuals, or other policy documentation should not be directed to the Field Analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit.

  Recipient Helpline (800) 834-3333

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

Department	Toll Free Phone	Phone	Fax
REVS - Automated Eligibility Verification	(800) 776-6323	(225) 216-7387	
Provider Relations	(800) 473-2783	(225) 924-5040	(225) 237-3334
POS (Pharmacy) - **Unisys**	(800) 648-0790	(225) 237-3381	(225) 237-3334
Electronic Data Interchange (EDI) - **Unisys**		(225) 237-3200 option 2	(225) 237-3331
Prior Authorization (DME, Rehab) - **Unisys**	(800) 488-6334	(225) 928-5263	(225) 237-3342 or (225) 929-6803
Home Health P.A. - **Unisys** EPSDT PCS P.A. - **Unisys**	(800) 807-1320		(225) 237-3342 or (225) 929-6803
Dental P.A. - **LSU School of Dentistry**		(504) 619-8589	(504) 619-8560
Hospital Precertification - **Unisys**	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - **Unisys**		(225) 237-3370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline-**Unisys**	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – **DHH**	(800) 834-3333 (225) 925-7948	Providers may request verification of eligibility for presumptively eligible recipients; recipients should contact to request a new card or to discuss eligibility issues.
Eligibility Operations – **BHSF**	(888) 342-6207	Recipients may address eligibility questions and concerns
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - Vaccines for Children Program	(504) 483-1900	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Referral Assistance - **ACS**	(877) 455-9955	Providers and recipients may obtain referral assistance.
KIDMED Provider Hotline – **ACS**	(800) 259-8000	Providers may obtain information on KIDMED linkage, referrals, monitoring, certification, and names of agencies that provide PCS services.
KIDMED Recipient Hotline – **ACS**	(800) 259-4444	Recipients request enrollment in KIDMED program and obtain information on KIDMED linkage.
CommunityCARE Provider Hotline – **ACS**	(800) 609-3888	Providers inquire about PCP assignment for CommunityCARE recipients and about CommunityCARE monitoring/certification.
CommunityCARE Recipient Hotline – **ACS**	(800) 359-2122	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, and express complaints concerning the CommunityCARE program.
Bureau of Community Support and Services – **BCSS**	(800) 660-0488 (225) 219-0200	Providers and recipients may request assistance regarding waiver services provided to waiver recipients (does not include claim or billing problems or questions)
EarlySteps Program - **OPH**	(866) 327-5978	Providers and recipients may information on the earlySteps Program and services offered.
LINKS	(504) 483-1900	Providers may obtain immunization information on recipients.

Other Sources Of Assistance

Additional Numbers For Provider Assistance		
Department	**Phone Number**	**Purpose**
ACS/Birch and Davis Health Management Corp.	(800) 259-8000 providers (800) 259-4444 - recipients	Both recipients and providers may obtain the names of participating Medicaid providers in referring patients for any medical services
KIDMED Provider Hotline – ACS/Birch & Davis	(800) 259-8000	Providers may obtain information on KIDMED linkage, referrals, monitoring, or certification, and the names of PCA/PCS agencies that provide EPSDT PCS services
KIDMED Recipient Hotline – ACS/Birch & Davis	(800) 455-9955	Recipients may request enrollment in KIDMED program and to obtain information regarding KIDMED linkage
ACS/Birch&Davis Referral Assistance	(877) 455-9955	Provider or Recipient may use this # for referral assistance.
CommunityCARE Provider Hotline – ACS/Birch & Davis	(800) 609-3888	Providers may inquire about PCP assignment for CommunityCARE recipients and about CommunityCARE monitoring and certification
CommunityCARE Recipient Hotline – ACS/Birch & Davis	(800) 359-2122	Recipients may choose a change in PCP, inquire about CommunityCARE program policy or procedures, and express complaints concerning the CommunityCARE program.
Unisys Provider Enrollment	(225) 923-8510	Providers may submit any changes to enrollment information and may submit a copy of their CLIA certificate if it is not already on file
Regional Office – DHH	(800) 834-3333	Providers may request verification of eligibility for presumptively eligible recipients; recipients should contact to request a new card or to discuss eligibility issues
Eligibility Operations –BHSF	(888) 342-6207	Recipients may address questions regarding the medically needy spend-down program or other eligibility issues
LaCHIP Program	(877) 252-2447	Providers and recipients may obtain information regarding the LaCHIP program, which expands Medicaid eligibility for children from birth to 19
Office of Public Health - Vaccines for Children Program	(504) 483-1900	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program
Program Integrity Unit -DHH	(225) 219-4153	Providers may request termination as a recipient's lock-in provider
Division of Home and Community-Based Waivers	(800) 660-0488	Providers and recipients may report complaints regarding waiver services provided to waiver recipients (does not include claim or billing problems or questions)

DHH Program Manager Requests

Questions regarding the rationale for Medicaid policy, procedure coverage and reimbursement, medical justification, written clarification of policy that is not documented, etc. should be directed in writing to the manager of your specific program:

Program Manager - (i.e. DME, Hospital, etc.)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

DHH Available Websites

www.lamedicaid.com/HIPAA: Louisiana Medicaid HIPAA Information Center

www.la-communitycare.com: DHH website – CommunityCARE (program information, provider listings, Frequently Asked Questions (FAQ)

www.la-kidmed.com: DHH website - KIDMED – (program information, provider listings, FAQ)

www.dhh.la.gov/BCSS DHH website - Bureau of Community Supports and Services

www.oph.dhh.state.la.us DHH website - earlySteps Program

www.oph.dhh.state.la.us DHH website - LINKS

www.dhh.state.la.us/RAR DHH Rate and Audit Review (nursing home updates and cost report information, contacts, FAQ)

ORDERING INFORMATION

Remittance Advice And History Requests

Provider participation in Medicaid of Louisiana is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. One of those standards is the agreement to maintain any information regarding payments to the provider for furnishing services for a period of five years.

Remittance Advice Copies

It is the responsibility of the provider to retain all remittance advices (RAs) for 5 years. However, in cases where a remittance advice was never received by the provider an RA copy may be provided at no charge, as long as the provider requests the RA copy within three weeks after the RA date. If the request for an RA is not received within three weeks after the RA date, a fee will be charged. Unisys does not accept requests for single pages of an RA.

The fee for Remittance Advice copies is $0.25 per page.

History Requests

History requests are necessary where providers or billing agents are attempting to reconcile a high volume or several months' worth of claims and when RA's have been destroyed, lost, etc. If providers are requesting remittance advices for multiple weeks or large volume remittance advices, Unisys will determine whether remittance advice copies or a claims history will be provided.

Requests for remittance advices or claims histories may be made by phone to Unisys Provider Relations at (800) 473-2783 or (225) 924-5040, or in writing to:

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

All requests must contain the provider name and number, address, and name of the individual authorizing the request. Remittance advice requests must indicate the date(s) of the remittance advice(s) being requested. Claim history requests must indicate the date of service period needed ("from" and "through" dates of service). Upon receipt of a request, the provider will be notified of the number of pages to be copied and the cost of the request. The RA/history will be forwarded to the provider once payment is received.

Medicaid Claim Forms

Unisys supplies the following forms:

PROVIDER TYPE	FORM NAME/NUMBER	ADJUSTMENT
Rehab Services	Unisys 102	Unisys 202
Ambulance (Claim form requires 105 Attachment)	Unisys 105	Unisys 205
Non-Ambulance Transportation	Unisys 106	Unisys 206
Dental EPSDT		Unisys 209
Dental Adult		Unisys 210
Pharmacy		Unisys 211
LTC TADs	Unisys 112	Unisys 212
Patient Liability Adjustments		Unisys 148 PLI
Professional Adjustments (Originally billed on CMS-1500)		Unisys 213
KIDMED Screening Form	KM-3	KM-3

Claim forms can be ordered by writing:

Unisys
ATTN: Forms Distribution
8591 United Plaza Boulevard, Suite 300
Baton Rouge, LA 70809

CMS-1500 Ordering Information:

The **CMS-1500** claim form is used to bill professional services (including physician, audiologist, CRNA, chiropractor, optometrist, podiatrist, nurse practitioner, and nurse midwife, certified nurse specialists, waiver, case management, mental health rehabilitation, mental health clinics, substance abuse clinics, EPSDT health services, EPSDT PCS, and DME.

> **NOTE: DME claims must indicate "DME" in large letters at the top of the CMS-1500 form. Waiver services claims must indicate "WAIVER" in large letters at the top of the form.**

CMS-1500 forms may be purchased by sending a letter of order request and a check to the following address:

Superintendent of Documents
P. O. Box 371954
Pittsburgh, PA 15250-7954
Phone (866) 512-1800 or (202) 512-1800
http://bookstore.gpo.gov

UB-92 Ordering Information:

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

Pharmacy Claim Form Ordering Information:

NCPDP Universal Claim Forms may be purchased form:
Moore North America, Inc
Tom Eddington
Phone: (602) 220-4913
e-mail: tom.eddington@email.moore.com

or

NCPDP Website
www.ncpdp.org/standards_purchase.asp

ADA Dental Claim Form Ordering Information:

ADA Catalog Sales
211 East Chicago Ave.
Chicago, IL 60611
Phone: (800) 947-4746
www.adacatalog.org

CPT-4 and ICD-9-CM Code Book Order Information:

The CPT-4 Procedure Code Book may be ordered from the following web address or phone number:

www.amapress.com
(800) 621-8335

ICD-9-CM Code Books are to be used to obtain diagnosis codes. Volume 1 is a numeric listing of diagnosis codes, Volume 2 is an alphabetical listing, and Volume 3 is a listing of ICD-9-CM procedure codes that are used by hospitals only. All three volumes are available in a single book. These books may be obtained from the following web address or phone number.

www.ingenixonline.com
(800) 464-3649, Option 1

> **NOTE**: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid. Claims with these codes will be denied with error code 252 (“diagnosis as coded not on file”). Claims denied with error code 252 may be resubmitted using three- to five-digit numeric or alpha/numeric codes (other than "E" or "M").

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. For additional denials specific to each Medicaid Program, please refer to that program's training packet.

☞ If the claim information on the remittance advice does not match the data on the claim (recipient ID number, date of service, procedure code, recipient name, charges, etc.), then a data entry error may have occurred. If the claim was submitted hard copy, then providers may call Unisys Provider Relations department to report the problem and request that the claim be reprocessed. If the claim was submitted electronically, providers will need to make the necessary corrections internally and resubmit the claim(s).

NOTE: Recipients may not be held responsible for claims denied due to provider errors such as failure to obtain a PCP referral, prior authorization or pre-cert number, failure to timely file, incorrect TPL carrier code, etc.

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, MEVS, and 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, MEVS, and e-MEVS and enter this number where required on the claim form. If there is a MEVS or 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, MEVS, and e-MEVS for all dates of service on the claim. If there is a MEVS or 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, MEVS, and 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, MEVS, and e-MEVS for all dates of service on the claim. If there is a MEVS or 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, MEVS, and e-MEVS and enter this number where required on the claim form. If there is a MEVS or 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.

Presumptive Eligibility Error Codes

ERROR CODE 225 – CLAIM NOT COVERED FOR PRESUMPTIVELY ELIGIBLE RECIPIENT
Cause: Services billed are not covered for presumptively eligible recipients.
Resolution: In this case there is no method for obtaining payment, as the recipient was ineligible for the services . If there is a MEVS or e-MEVS printout that verified normal eligibility (not presumptive) and was printed on the date of service in question, send a copy of the claim and a copy of the printout to Unisys Provider Relations Correspondence Unit with a cover letter stating the problem.

Lock-In Program Error Codes

ERROR CODE 218 – RECIPIENT IS MD, PHARMACY RESTRICTED--MD INVALID
Cause: The billing provider is not the provider to whom the recipient has been locked in.
Resolution: 1. If the billing provider saw the recipient at the request of the lock-in provider, the claim form must show the lock-in provider's name in block 17 of the CMS-1500.
2. If the billing provider saw the recipient for emergency services, the claim form must show "EMERGENCY" written in the diagnosis section of the claim form (block 21 of the CMS-1500).
3. If the billing provider did not have a referral from the lock-in physician, and the service was not an emergency, the claim is not payable.
Note: Lock-in restrictions should only affect physician and pharmacy claims.

Spend-Down Medically Needy Error Codes

ERROR CODE 429 – NOT PAYABLE FOR MEDICALLY NEEDY PROGRAM
Cause: Services billed are not covered for recipients classified as "Medically Needy".
Resolution: Ensure that the correct procedure code has been entered on the claim form. If not, correct the claim and resubmit. If the claim is correct, the recipient may be billed for the services, as they are considered non-covered by Medicaid.

ERROR CODE 919 – MEDICAID ALLOWED AMOUNT REDUCED BY RECIPIENT SPEND-DOWN
Cause: The recipient liability spend-down amount indicated on the 110-MNP form submitted with the claim 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 recipient liability indicated on the 110-MNP form. If so, the claim has processed correctly, and the recipient liability amount should be collected from the recipient.
Note: Code 919 is not a true "error" code, as the claim has not been denied. The message is to notify the provider why the payment is not the usual reimbursement amount.

ERROR CODE 943 – SPEND DOWN FORM 110MNP INVALID/MISSING
Cause: 1. No 110-MNP form was attached to the claim form for a spend down recipient, OR
2. A 110-MNP form was attached to the claim, but the 110-MNP form was invalid because critical information was missing from the form (such as provider name or recipient name), OR
3. The claim required a 110-MNP form to be attached but was filed electronically.
Resolution: 1. Obtain a 110-MNP form from the parish OFS and resubmit the claim hardcopy with the 110-MNP form.
2. If the 110-MNP form filed with the claim was invalid, contact the parish OFS to obtain a corrected 110-MNP form. Refile the claim hardcopy with the corrected 110-MNP form.
Note: If a service was provided on the first day of the recipient's spend-down period, it is necessary to attach the 110-MNP form to the claim form. If there is an amount on the 110-MNP in the 'Beneficiary Liability Amount' which corresponds with your provider name and number, it is your responsibility to collect that amount from the patient. When the claim is processed, Unisys will automatically deduct this amount from total charges due.

CommunityCARE Error Codes

ERROR CODE 106 – BILLING PROVIDER NOT PCP OR SERVICE NOT AUTHORIZED BY PCP
Cause: 1. No Primary Care Physician (PCP) authorization number was entered in the required block of the claim form.
2. The PCP authorization number entered in the appropriate field is not the correct authorization number. The number must be a seven-digit number beginning with "1." It may not be the Primary Care Physician's UPIN or Medicare provider number.
Resolution : 1. Ensure that the PCP authorization number is entered in the correct block of the claim form.
2. If the PCP authorization number entered on the claim is exactly the same as that of the hardcopy referral form, use REVS, MEVS, and e-MEVS to verify the recipient's Primary Care Physician. If the PCP according to REVS, MEVS, and e-MEVS is different from the PCP in the recipient's records, contact the PCP given by REVS, MEVS, and e-MEVS to obtain a correct referral.

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 in 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, MEVS, and 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, MEVS, and 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 MEOB.
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 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 dual QMB, 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 RA's 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 RA's 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 on 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. Another service which cannot be billed to the recipient is the administration of an injection of a vaccine for which the physician has to pay. Because the fee for administration of the vaccine is included in the fee for the office visit, the recipient cannot be billed when the administration code is denied

Provider Eligibility Error Codes

ERROR CODE 202 - PROVIDER CANNOT SUBMIT THIS CLAIM TYPE
Cause: 1. The claim form used to bill the claim is not appropriate for the type of provider performing the service (e.g., a physician billing office visits under his own provider number on a UB-92 claim form); OR
2. The claim is for durable medical equipment and did not have "DME" written at the top of the CMS-1500 claim form; OR
3. The claim is for services other than hospice or pharmacy and the recipient is under hospice care.
Resolution: 1. Resubmit the claim on the appropriate claim form.
2. If the claim is for durable medical equipment, resubmit the CMS-1500 claim form with "DME" written at the top of the form.
3. **Only hospice and pharmacy services are payable for recipients under hospice care.** Other providers (physicians, hospitals, DME providers, etc.) who render services to a hospice recipient should look to the hospice provider for reimbursement if the treatment is related to the diagnosis for which the recipient is in hospice.

ERROR CODE 201 – PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
Cause: The billing provider number entered on the claim form is on the State provider files, but the provider's enrollment was not effective on the claim date(s) of service.
Resolution: Review the claim that was filed, ensuring that the correct Medicaid provider number was entered on the claim form. Make any necessary corrections and resubmit the claim.
Note: Providers must be enrolled as Medicaid providers in order to be reimbursed by Medicaid.

ERROR CODE 206 – BILLING PROVIDER NOT ON FILE
Cause: The billing provider number entered on the claim form is not on the State provider files.
Resolution: Review the claim that was filed, ensuring that the correct Medicaid provider number was entered on the claim form. Make any necessary corrections and resubmit the claim.
Note: Medicaid provider numbers are seven digits in length and begin with "1." All seven digits of the Medicaid provider number must be correct in order for the claim to be paid.

HOW DID WE DO?

In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a Unisys representative or leave it on your table. **Your opinion is important to us**.

Seminar Date:_____ Location of Seminar (City):_____

Provider Subspecialty (if applicable):_____

FACILITY	**Poor**				**Excellent**
The seminar location was satisfactory	1	2	3	4	5
Facility provided a comfortable learning environment	1	2	3	4	5
SEMINAR CONTENT	**Poor**				**Excellent**
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS REPRESENTATIVES	**Poor**				**Excellent**
The speakers were thorough and knowledgeable	1	2	3	4	5
Topics were well organized and presented	1	2	3	4	5
Reps provided effective response to questions	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION: Basic Training					

What topic was most beneficial to you?_____

Please provide constructive comments and suggestions:_____

To order written materials provided by Unisys, please call Unisys Provider Relations Telephone Inquiry Unit at **(800) 473-2783 or (225) 924-5040.**