VISION (EYE WEAR) SERVICES BILLING

2024

LOUISIANA
DEPARTMENT OF HEALTH

ABOUT THIS DOCUMENT

This document was produced at the direction of the Louisiana Department of Health (LDH), the agency that establishes all policy regarding Louisiana Medicaid and Gainwell Technologies (Gainwell), the LDH contracted fiscal intermediary, who administers certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by LDH. 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.

The purpose of this document is to guide Vision (Eyewear) providers with billing of vision claims for Legacy Medicaid beneficiaries.

This packet does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third-party liability. Providers must review the applicable provider manuals on www.lamedicaid.com for such information.

Providers should use this packet in conjunction with the Physician Services Medicaid Provider manual, the Vision (Eyewear) Provider manual, and, relevant forms located on www.lamedicaid.com .

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VISION (EYEWEAR) OVERVIEW

Medicaid covered eyewear services are available to Medicaid eligible beneficiaries who are under the age of 21. No eyewear services are available for beneficiaries aged 21 years and older unless the beneficiary receives both Medicare and Medicaid. In these cases, Medicare covers the required eyewear. Medicaid may pick up a calculated portion of the payment as a Medicare crossover claim.

Eyewear is limited to three (3) pairs per calendar year without prior authorization. Billing for the fourth and subsequent pairs must have documentation attached justifying the need for more than three (3) pairs of eyewear per year.

Providers may NOT require a payment or deposit for eyewear pending payment from Medicaid. Payment from Medicaid must be accepted as payment in full.

NOTE: Beneficiaries are not allowed to pay any remaining difference for eyewear under any circumstance, including upgrades for cosmetic purposes. Vision (Eyewear) Policy is located on www.lamedicaid.com.

It is the responsibility of the provider to verify the beneficiary's Medicaid eligibility. The Recipient Verification System (REVS), the Medicaid Eligibility System (MEVS), or the Medicaid Electronic Eligibility System (e-MEVS) should be used to obtain recipient eligibility information. e-MEVS is available on the web at www.lamedicaid.com. The recipient must be eligible for each date of service. Providers should keep on file proof of eligibility from MEVS and/or e-MEVS.

Providers will need their 7-digit Medicaid Provider ID and 10-digit National Provider Identifier (NPI) to log into the provider portal via www.lamedicaid.com. The provider portal allows a provider to submit prior authorizations electronically, as well as submit claims electronically.

ELECTRONIC DATA INTERCHANGE TRANSITION

It is very important for providers billing electronically to take the necessary steps to ensure that their claims are submitted using the HIPAA-mandated 837 specifications. The following information will assist a software vendor, billing agent, or clearinghouse (VBC) in submitting HIPAA-approved 837 transactions to Louisiana Medicaid.

Companion Guides	
RESOURCE	**LINK**
CSI Companion Guide	CSI Companion Guide
CAQH Connectivity Guide	CAQH Connectivity Guide
5010 EDI General Companion Guide	5010 EDI General Companion Guide
820 Payment Order/Remittance Advice	820 Payment Order/Remittance Advice
835 Companion Guide	835 Companion Guide
837 Health Care Claim –Professional Companion Guide	837 Health Care Claim –Professional Companion Guide
Batch MEVS – Submitter Companion Guide	Batch MEVS – Submitter Companion Guide

Companion Guides can be located via the below steps:

From www.lamedicaid.com

Click on:

1. CLAIMS and BILLING
2. HIPAA
3. 5010v of the Electronic Transactions

Electronic Filing

Providers can contact Provider Enrollment at 225-216-6370 and select option 1 to request the paperwork to enroll their Medicaid provider number or add a 450-submitter number on their provider file to bill EDI. Providers may also obtain their 50-submitter number to send as provider-owned submitter numbers directly and not through the clearinghouse. Providers may obtain information on submitting EDI claims by selecting option 2. EDI information is also available here.

If you are not currently submitting the HIPAA-compliant 837 transaction, Louisiana Medicaid strongly recommends that you contact your VBC to determine if they can meet your needs as a Louisiana Medicaid provider. If your VBC has not started testing, you may go to the Current VBC Listing list and select a VBC that is approved for your program. The EDI group updates this list monthly.

The Current VBC Listing can be located on www.lamedicaid.com by clicking on:

1. CLAIMS and BILING
2. HIPAA
3. Current VBC List

Louisiana Medicaid encourages all providers to use the VBC list to shop for a VBC that best suits their needs and budget. The features, functions, and costs vary significantly between VBCs. *Find the one that is right for you.*

HIPAA-Compliant 837 Transaction Testing Service

Testing of 837 transactions involves two levels: validation of 837 transaction syntax and parallel testing of claims submitted in proprietary and HIPAA-compliant formats. Once the VBC has contacted Louisiana Medicaid and the enrollment process is complete, login information will be furnished to the identified testers on the enrollment form.

Claim Submission

Claims Submission

All claims for payment for eyewear should be submitted with the procedure code(s) that are identified on the Vision (Eyewear) fee schedule located at www.lamedicaid.com

Reimbursement Fee

Prior authorization (PA) is required for most vision (eyewear) services. Reimbursement for the services is the rate on file for the date of services that have been established for each code listed on the Vision (Eyewear) fee schedule except for certain "non-specific" codes, which are manually priced**.**
These non-specific codes require prior authorization and the reimbursement fee will be determined at the time of prior authorization based on invoice cost. A copy of the invoice must be submitted with the prior authorization request to determine the amount of reimbursement. Use of these codes should be limited to the instance when there is no established code available to describe the service being rendered.

Modifier Requirements

The following modifiers should be used for prior authorization and claims for payment *ONLY* in conjunction with procedure code V2102 when the lens is over 12.00D sphere:

1) **RT** indicates right eye; and
2) **LT indicates** left eye.

These modifiers should not be used when billing procedure code V2102 when the lens is plus, minus 7.12 to plus or minus 12.00D sphere, or with any other procedure code.

PRIOR AUTHORIZATION

Prior authorization for eyewear will be considered only when the item is medically necessary. If the service requires prior authorization, the provider shall not fill the prescription or dispense the eyewear until an approval letter is obtained from Medicaid.

Information on completing the Prior Authorization Form (PA-01) is available at http://www.lamedicaid.com/provweb1/Forms/PA-01.pdf.

Completed requests with all required documentation shall be mailed or submitted electronically to the Prior Authorization Unit (PAU).

Gainwell Technologies– Prior Authorization
P.O. Box 14919
Baton Rouge, LA 70898-4919
(800) 488-6334

Required Documentation for Prior Authorization

Request for prior authorization shall include the following:

1. Completed Form PA-01 (located on www.lamedicaid.com);
2. Copy of the prescription;
3. Letter that documents medical necessity for all PA requests (**NOTE:** The letter of medical necessity must be obtained from the prescribing provider and must be specific to each beneficiary); and

4. Copy of the invoice and a detailed description of the items(s) for all codes "manually priced," as noted on the eyewear fee schedule (www.lamedicaid.com).

The Form PA-01 must include information regarding all eyewear items that will be delivered on the same date of service to the beneficiary, including those items that do not require PA. The items, that require PA, must be listed on the first line(s) of the Form PA-01, under the "Description of Services" section and must include the following:

1. Field 11 - Procedure Code
2. Field 11A - Modifier-when applicable
3. Field 11B – Description
4. Field 11C - Requested Units
5. Field 11D - Requested Amount

NOTE: Prior authorization requests that do not include all items as listed above will be returned to the provider for more information.

Providers must review Chapter 46: Vision (Eyewear) Services provider manual for additional information and examples for completion of the PA-01 Form.

CLAIM ERROR CODES RELATED TO PA

Providers must bill services exactly as they are authorized. The Medicaid computer system compares several items, which must be the same on both the claim form and the prior authorization record, for example: PA number, Medicaid recipient ID number, provider number, procedure code, and date of service.

The remittance advice (RA) reflects the PA number entered on each processed claim on the left-hand side of the document, just below the recipient's name.

Several claim error codes pertain to the process the computer uses in matching items on the claim to items on the prior authorization record. A discussion of these claim error codes follows. Please note that this is not a complete list of claim error codes. The remittance advice (RA) contains a brief description of each error code reported; however, if further explanation/information is required regarding a PA error code, the provider should contact Gainwell Provider Relations by calling (800) 473-2783 or (225) 924-5040.

BILLING INSTRUCTIONS AND CLAIMS FILING

Gainwell accepts standardized professional 837P electronic transactions if the VBC used by the provider has tested and been approved by Gainwell. Providers billing hard copy claims will continue to bill on the CMS-1500 (formerly known as HCFA-1500). All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

CMS-1500 Claim Form Instructions

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

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

Instructions and examples for completing the CMS-1500 are located in the Vision (Eyewear) Services Manual located **here**.

ADJUSTMENT/VOID CLAIMS

Claims paid on the CMS-1500 form are adjusted or voided using the Gainwell 213 adjustment/void form. These may be ordered from Gainwell at no cost. Denied claims must be corrected and resubmitted—not adjusted or voided.

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

Only a paid claim can be adjusted or voided. Adjustments and\ or voids can be denied, and the denial code is indicated on the Remittance Advice on which the adjustment appears as a denied claim.

Electronic submitters may electronically submit adjustment/void claims.

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

1. A claim is paid on the RA dated 7-15-04, ICN 4170567890123.
2. The claim is adjusted on the RA dated 8-19-04, ICN 4200590123456.
3. If the claim requires further adjustment or needs to be voided, only ICN 4200590123456 may be used.

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

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original claim and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column. An example of a completed adjustment form appears on page 28.

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

Filing Adjustments for a Medicare/Medicaid Claim

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

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

In order for the provider to receive an adjustment, it is necessary for the provider to file a hard copy claim (Gainwell Form 213) with Medicaid. A copy of both the most recent Medicare explanation of benefits and the original explanation of benefits must be attached to the adjustment form and should be mailed to the following address:

Gainwell
Attention: Crossover Adjustments
P.O. Box 91023
Baton Rouge, LA 70821

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

INSTRUCTIONS FOR FILING
GAINWELL 213 ADJUSTMENT/VOID CLAIMS

*1. ADJ/VOID—Check the appropriate block.

*2. Patient's Name

   a. Adjust—Print the name exactly as it appears on the original claim if not adjusting this information.

   b. Void—Print the name exactly as it appears on the original claim.

3. Patient's Date of Birth

   a. Adjust—Print the date exactly as it appears on the original claim if not adjusting this information.

   b. Void—Print the name exactly as it appears on the original claim

*4. Medicaid ID Number—Enter the 13-digit recipient ID number.

5. Patient's Address and Telephone Number

   a. Adjust—Print the address exactly as it appears on the original claim.

   b. Void—Print the address exactly as it appears on the original claim.

6. Patient's Sex

   a. Adjust—Print this information exactly as it appears on the original claim if not adjusting this information.

   b. Void—Print this information exactly as it appears on the original claim.

7. Insured's Name— Leave blank

8. Patient's Relationship to Insured—Leave blank

9. Insured's Group No.—Complete if appropriate or blank

10. Other Health Insurance Coverage—Leave blank

11. Was Condition Related to—Leave blank

12. Insured's Address—Leave blank

13. Date of—Leave blank

14. Date First Consulted You for This Condition—Leave blank

15. Has Patient Ever had Same or Similar Symptoms—Leave blank

16. Date Patient Able to Return to Work—Leave blank

17. Dates of Total Disability-Dates of Partial Disability—Leave blank

18. Name of Referring Physician or Other Source—Leave this space blank

19. For Services Related to Hospitalization, Give Hospitalization Dates—Leave blank

20. Name and Address of Facility Where Services Rendered (if other than home or office)—Leave blank

21. Was Laboratory Work Performed Outside of Office—Leave blank

*22. Diagnosis of Nature of Illness

    a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information.

    b. Void—Print the information exactly as it appears on the original claim

23. Attending Number—Enter the attending number submitted on the original claim, if any, or leave this space blank

24. Prior Authorization #—Enter the PA number if applicable or leave blank

*25. A through F

    a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information.

    b. Void—Print the information exactly as it appears on the original claim.

*26. Control Number—Print the correct Control Number as shown on the Remittance Advice.

*27. Date of Remittance Advice that Listed Claim was Paid—Enter MM DD YY from RA form.

*28. Reasons for Adjustment—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.

*29. Reasons for Void—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.

*30. Signature of Physician or Supplier—All Adjustment/Void forms must be signed

*31. Physician's or Supplier's Name, Address, Zip Code, and Telephone Number—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. *The form will be returned if this information is not entered.*

32. Patient's Account Number—Enter the patient's provider-assigned account number.

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

LOUISIANA MEDICAID WEBSITE APPLICATIONS

General and specific Medicaid information is available on the Louisiana Medicaid Provider Website, which is **www.lamedicaid.com.**

This website has several applications that should be used by Louisiana Medicaid providers. These applications require that providers establish an online account for the site.

Provider Login and Password

To ensure the appropriate security of the recipient's patient health information (PHI) and the provider's personal information, the secure area of the website 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 log in 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. Should you need assistance with obtaining a login and password or have questions about the technical use of the application, please contact the Gainwell Technical Support Desk at 877-598-8753.

LDH and CMS Security Policy restrictions will not permit Gainwell 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. Gainwell may not permit anyone except the provider to receive or ask for information related to a login and password to access secured information.

Web Applications

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

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

These applications are available to providers 24 hours a day, 7 days a week at no cost.

e-MEVS:

Providers can now verify eligibility, primary insurance information, and service limits for a Medicaid recipient using this web application accessed through www.lamedicaid.com. This application provides 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 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.

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. 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 status to have access to remittance advices for this purpose. An LA Medicaid/HIPAA Error Code Crosswalk is available on this website by accessing the link, Forms/Files.

Once enrolled in the website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

e-CDI:

The e-CDI application provides a Medicaid recipient's essential clinical history information at the authorized practitioner's fingertips at any practice location.

The 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

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is 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. These updates are based on Medicaid claims history. A print-friendly version of the 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 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.

PROVIDER ASSISTANCE

Many of the most commonly requested items from providers including, but not limited to, Field Analyst listing, RA messages, Provider Updates, preferred drug listings, general information, program packets, etc. are available online

Gainwell Provider Relations Telephone Inquiry Unit

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure/ information/clarification, ordering printed material, requesting a Field Analyst visit, etc., and may be reached by calling:

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

* Listen to the menu options and press the appropriate key for assistance.

NOTE: Providers should access eligibility information via the Medicaid Eligibility Verification System (MEVS), or the automated Recipient Eligibility Verification System (REVS) at (800) 776-6323 or (225) 216-7387. Providers may also check eligibility by accessing the web-based application (e-MEVS) now available on the LA Medicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

NOTE: Gainwell cannot assist recipients. If recipients have problems, please direct them to the Parish Office or the number on their card:

Customer Service: 1-888-342-6207

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

Gainwell Provider Relations Correspondence Group

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims.

All requests to the Correspondence Unit should be submitted to the following address:

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

NOTE: All correspondence sent to Provider Relations, including recipient file updates, must include a separate 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, documentation verifying eligibility, etc.). **A COPY OF THE CLAIM FORM ALONG WITH APPLICABLE CORRECTIONS AND/OR ATTACHMENTS MUST ACCOMPANY ALL RESUBMISSIONS.**

Provider Relations staff does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

Requests to update TPL third-party liability should be directed to:

TPL.Inquiries@la.gov

"Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box. A complete list of claims filing addresses is available on page 42 of this training packet.

NOTE: CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.

Gainwell Provider Relations Field Analysts

Upon request, Provider Relations Field Analysts are available to train new providers and their office staff on-site. Providers are encouraged to request analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However, Field Analysts ARE NOT available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Gainwell Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

ELECTRONIC DATA INTERCHANGE (EDI)

CLAIMS SUBMISSION

Electronic data interchange submission is the preferred method of submitting Medicaid claims to Gainwell. With electronic data, a provider or a third-party contractor (billing agent) submits Medicaid claims to Gainwell 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, decreased 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.

The same information required when completing the CMS-1500 is required when billing claims electronically. Items to be completed are listed as required, situation, or optional.

Required information must be entered for the claim to be processed. Claims submitted with missing or invalid information in these fields may be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider. Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Examples and instructions on completing the CMS-1500 are located in Chapter 46: Vision (Eyewear) Services Provider manual on www.lamedicaid.com.

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 in 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 Gainwell response file.

- **All claims submitted must meet timely filing guidelines.**

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

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 Gainwell 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. deductible, patient account number, etc.

- To request 835 Transactions – Electronic Remittance Advice, contact Gainwell EDI Department at 225-216-6303 extension 1.

General Information

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

CLAIMS PROCESSING REMINDERS

Gainwell Louisiana Medicaid images and stores all Louisiana Medicaid paper claims online. This process allows the Gainwell 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 form whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.

- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.

- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. **DO NOT use a highlighter to draw attention to specific information.**

- Paper claims must be legible and in good condition for scanning into our document imaging system.

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

- Continuous feed forms must be torn apart before submission.

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

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

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

- Do not submit two-sided documents.

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

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

Rejected Claims

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

Attachments

All claim attachments should be standard 8 1/2 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 Gainwell staff from changing any information on a provider's claim form. Any claims requiring changes must be made before submission. Please do not ask Gainwell 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.