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**CHAPTER 30: PERSONAL CARE SERVICES** 

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#### **CLAIMS FILING**

Hard copy billing of Personal Care Services (PCS) are billed on the CMS-1500 (02/12) claim form or electronically in the 837P transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

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

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

Paper claims should be submitted to:

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

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers, or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

**NOTE:** Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at <a href="https://www.lamedicaid.com">www.lamedicaid.com</a>, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and a sample of a completed CMS-1500 claim form.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

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# CMS 1500 (02/12) Billing Instructions for Personal Care Services

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.  NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	Required – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Leave Blank.	
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	

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Locator #	Description	Instructions	Alerts
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Optional.	
17a	Unlabelled	Optional.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

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Locator #	Description	Instructions	Alerts
	ICD Ind.	Required Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.	The most specific diagnosis codes must be used.
21	Diagnosis or Nature of Illness or Injury	9 ICD-9-CM 0 ICD-10-CM  Required Enter the most current ICD diagnosis code.  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.	Louisiana Medicaid currently accepts ICD-9- CM codes. The acceptance of ICD-10-CM codes will be announced at a later date.
22	Resubmission Code	Situational – If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field.  Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.  Appropriate reason codes follow:  Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other  Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	Effective with date of processing 5/19/14 providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).  To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization Number	Required – Enter the 9-digit prior authorization number for the authorized services.	
24	Supplemental Information	Situational	

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

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Locator #	Description	Instructions	Alerts
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Leave Blank.	
30	Rsvd for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional – The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabelled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Ph #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabelled	Required – Enter the billing provider's 7-digit Medicaid ID number.  ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number must appear on paper claims.

A sample form is on the following page

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# **PCS – Example Claim Form**

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	( )			( )	
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#### **Adjustments and Voids**

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. 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.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved control number (ICN) can be adjusted or voided; thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

#### Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

LOUISIANA MEDICAID PROGRAM	<b>ISSUED:</b>	04/30/14
	<b>REPLACED:</b>	11/01/10
<b>CHAPTER 30: PERSONAL CARE SERVI</b>	CES	

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The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

A sample form is on the following page

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**ISSUED:** 04/30/14 11/01/10 **REPLACED:** 

**CHAPTER 30: PERSONAL CARE SERVICES** 

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## **PCS – Example Adjustment Form**

■		
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)	02/12	
PICA		PICA
	AMPVA GROUP   FECA OTHER   HEALTH PLAN   BLK LUNG   (ID#) (ID#) (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	1234567891234 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
EVERE, PAUL	01 05 55 M X F	
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
TV 10	Self Spouse Child Other	CITY STATE
TY	TATE 8. RESERVED FOR NUCC USE	SIATE
P CODE TELEPHONE (Include Area Code	)	ZIP CODE TELEPHONE (Indude Area Code)
( )		( )
OTHER INSURED'S NAME (Last Name, First Name, Middle Initia	) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a FMDI OVMENTO (Correct on Province)	a, INSURED'S DATE OF BIRTH SEX
THER INSURED S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)  YES NO	a. INSURED'S DATE OF BIRTH SEX  MM DD YY  M F
RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES NO	
RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
NSURANCE PLAN NAME OR PROGRAM NAME	YES NO	A LO TUESS ANOTHER USA TUESDAM
NSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMP	LETING & SIGNING THIS FORM.	YES NO If yes, complete items 9, 9a and 9d.  13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I author to process this claim. I also request payment of government benefit below.	rize the release of any medical or other information necessary seither to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	SAMPLE FORM	Λ №OR
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP	) 15.OTHER DATE MM DD VV	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  MM DD YY  TO MM DD YY
QUAL.  NAME OF REFERRING PROVIDER OR OTHER SOURCE	XAMPLE ONL	XOM TO
	71b. NPI	TIS. FIOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO TO
. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES  YES NO
	-L to service line below (24E) ICD Ind. 9	YES NO  22. RESUBMISSION
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A	-L. to service line below (24E)   ICD Ind. 9	YES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A	i ios maijo	YES NO  22. RESUBMISSION ORIGINAL REF. NO. A 02 4094198765401  23. PRIOR AUTHORIZATION NUMBER
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY         Relate A	C. L D. L G. L L L	YES NO  22. RESUBMISSION ORIGINAL REF. NO. A 02 4094198765401  23. PRIOR AUTHORIZATION NUMBER 987654321
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY   Relate #	C D	YES NO  22. RESUBMISSION ORIGINAL REF. NO. A 02 4094198765401  23. PRIOR AUTHORIZATION NUMBER
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY   Relate A   462	C.   D.   G.   H.   K.   L.   PROCEDURES, SERVICES, OR SUPPLIES   (Explain Unusual Circumstances) DIAGNOSIS	YES NO  22. RESUBMISSION ORIGINAL REF. NO. A 02 4094198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. G. H. L. PENDERNIG
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY   Relate A   462   B.	C.   D.   G.   H.   K.   L.   PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Orcumstances) PT/HCPCS   MODIFIER   DIAGNOSIS POINTER	YES NO  22. RESUBMISSION ORIGINAL REF. NO. A 02 4094198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. G. H. L. RENDERING ORIGINAL REF. NO. A 02 4094198765401  \$ CHARGES UNITS PROVIDER ID. #
1462   B.	C.   D.   G.   H.   K.   L.   PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Orcumstances) PT/HCPCS   MODIFIER   DIAGNOSIS POINTER	YES NO  22. RESUMISSION ORIGINAL REF. NO. A 02 4094198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. G. H. I. RENDERING ORIGINAL REF. NO. A 02 4094198765401  S. CHARGES OR H. I. RENDERING OLUMITS Framily OLUMI. PROVIDER ID. #
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DIAGNOSIS OR NATURE OF ILLNESS OR INJURY   Relate A   462   B.	C.   D.   G.   H.   K.   L.   PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Orcumstances) PT/HCPCS   MODIFIER   DIAGNOSIS POINTER	YES NO  22. RESUBMISSION ORIGINAL REF. NO. A 02 4094198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. G. Hot I. Rendering Provider ID. Rendering Qual.  \$ CHARGES UNITS Print QUAL.  84 00 28 NPI
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY   Relate A   462   B.	C.   D.   G.   H.   K.   L.   PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Orcumstances) PT/HCPCS   MODIFIER   DIAGNOSIS POINTER	YES NO  22 RESUBMISSION ORIGINAL REF. NO. A 02 4094198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. DAYS BASIN ID. RENDERING PROVIDER ID. #  \$ CHARGES UNTS FREE QUAL PROVIDER ID. #  84 00 28 NPI  NPI
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A  462  B.	C.   D.   G.   H.   K.   L.   PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Orcumstances) PT/HCPCS   MODIFIER   DIAGNOSIS POINTER	YES NO  22. RESUMISSION ORIGINAL REF. NO. 4 094 198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. G. B. H. I. D. J. RENDERING OLD. PROVIDER ID. #  \$ CHARGES OR Femily OLD. PROVIDER ID. #  84 00 28 NPI  NPI  NPI  NPI
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY   Relate A   462   B.	C.	YES NO  22 RESUBMISSION ORIGINAL REF. NO. 4094198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. DAYS STATE OUAL PROVIDER ID. #  \$ CHARGES UNITS FROM QUAL PROVIDER ID. #  NPI  NPI  NPI  NPI  NPI
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A,   462	C. L D. L  G. L H. L  K. L E. E. C.	YES NO  22 RESUBMISSION ORIGINAL REF. NO. 4094198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. DAYS EMONT ID. RENDERING PROVIDER ID. #  \$ CHARGES UNTS Free QUAL PROVIDER ID. #  NPI  NPI  NPI  28. TOTAL CHARGE 28. AMOUNT PAID 30. BALANCE DUE \$ 84 00 \$ \$ \$ \$ \$
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY   Relate A   462	C. L D. L  G. L H. L  K. L E. E. C.	YES NO  22. RESUMMISSION ORIGINAL REF. NO. 4094198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. G. B. H. I. D. RENDERING PROVIDER ID. #  \$ CHARGES ON PROVIDER ID. #  84 00 28 NPI  NPI  NPI  NPI  NPI  NPI  10. NPI  NPI  NPI  NPI  28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ \$ 44 00 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A 462 B	C. L D. L  G. L H. L  K. L E. E. C.	YES NO  22. RESUBMISSION ORIGINAL REF. NO. 4094198765401  23. PRIOR AUTHORIZATION NUMBER  987654321  F. G. B. H. I. RENDERING OULTS PROVIDE ID. III.  \$ CHARGES OF PROVIDE ID. RENDERING PROVIDE ID. III.  84 00 28 NPI  NPI  NPI  NPI  28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE S 84 00 S S S S S S S S S S S S S S S S S S