LTC
Provider Training

Nursing Facilities & ADHCs

Medicaid Issues for 2004
(Fall Issue)

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

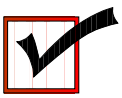
UNISYS

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).

***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.

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 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.

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.**

***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.

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.

***

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.

***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.

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.

***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.

TABLE OF CONTENTS

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 your Software Vendor, Billing Agent or Clearinghouse (VBC) to submit HIPAA approved 837 transactions to Louisiana Medicaid.

The following table contains the current DHH implementation schedule for transition to HIPAA compliant electronic submissions by the applicable Medicaid Programs. Affected providers will be required to bill Louisiana Medicaid using the compliant 837 format by the implementation date stated below. **Additionally, in the near future claims submitted using the proprietary specifications will be held for 21 days. Please watch for further information that will be forthcoming about this change.**

PROGRAM	IMPLEMENTATION DATE
Ambulance Transportation	January 1, 2005
DME	January 1, 2005
Dental	January 1, 2005
Hemodialysis	November 1, 2004
Hospice	November 1, 2004
Hospital Inpatient/Outpatient	November 1, 2004
KIDMED	TBD
Personal Care Services (PCS)	TBD
Professional: Ambulatory Surgical Centers EPSDT Health Services Independent Lab & X-ray Mental Health Clinics Mental Health Rehabilitation Centers Physician Services (including physicians, optometrists, podiatrists, audiologists, psychologists, chiropractors, APRNs) Rehabilitation Centers Vision	To Be Phased In Beginning April 1, 2005 (Further information concerning dates of phases and programs will be forthcoming.)
Rural Health Clinics/Federally Qualified Health Centers	TBD
Waiver (all)	TBD

NOTE 1: Long Term Care/LTC (Nursing Facilities, ICF-MR Facilities, Hospice Room and Board, Adult Day Health Care Facilities) MUST ultimately transition to either 837 electronic billing or UB-92 paper billing. The final implementation date for this transition is to be determined.

NOTE 2: Non-Emergency Medical Transportation and Case Management Providers are excluded from HIPAA and will continue to submit electronic claims with the Louisiana Medicaid Proprietary Transactions.

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 www.lamedicaid.com/hipaa to view the VBC list and select a VBC that is approved for your program. This list is updated monthly by the EDI group. **YOU MUST BE TRANSITIONED TO THE 837 HIPAA COMPLIANT FORMAT BY THE APPLICABLE DATES IN ORDER TO CONTINUE TO SUBMIT CLAIMS ELECTRONICALLY.**

The list includes contact information, the types of X12N HIPAA 837 transactions supported, and a status of "Enrolled", "Testing", "Parallel", or "Approved". The final "Approved" status means a provider can submit HIPAA EDI 837 transactions THROUGH the approved VBC to Louisiana Medicaid.

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.*

Providers can also monitor the list to see how their VBC is progressing toward production approval.

HIPAA DESK TESTING SERVICE ENROLLMENT

The first step towards HIPAA readiness is to have the VBC complete the HIPAA Testing Enrollment Form located at www.lamedicaid.com/hipaa. All VBCs MUST complete the required testing before any electronic claims may be submitted for providers. Therefore, the VBC must contact the LA Medicaid HIPAA EDI Group to enroll. (Providers who develop their own electronic means of submitting claims to LA Medicaid are considered the VBC).

VBCs can also get an enrollment form by e-mailing the HIPAA EDI group at *hipaaedi@unisys.com or by calling (225) 237-3318. The VBC must complete the form and return it by e-mail to Louisiana Medicaid. A HIPAA EDI representative will issue the VBC login information for our testing service.

Throughout the implementation of HIPAA requirements, Louisiana Medicaid has offered intense support. One of the support systems offered to the VBCs is HIPAADesk.com, which is a completely automated testing site for validation of X12 syntax. While the HIPAADesk.com is available for any VBC's use to validate X12 transactions, Louisiana Medicaid has furnished additional resources within this site. **The enhanced Louisiana-specific service will be offered through January 31, 2005 only.** After that, it will be the responsibility of the VBC to validate X12 syntax before testing with Louisiana Medicaid. Validation of X12 syntax does not validate 837 transactions for submission to Louisiana Medicaid. Additional testing is required.

With the exception of Long Term Care providers, individual providers using software that has been approved for a VBC do not need to test individually. Once a VBC is approved for production, this approval is also applied to those providers using the approved software.

In the Louisiana-specific section of HIPAADesk.com all Companion Guides for the 837I, 837P, 837D, and 278 transactions are available for download. **Our testing service through HIPAADesk.com is available 24 hours a day, 7 days a week and will maintain those hours through the end of January 2005.**

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.

The testing service is a secure web based application that requires an internet connection and a web browser. The testing service contains all necessary information for a VBC to test for compliance with Louisiana Medicaid. Companion Guides for the 837I, 837P, 837D, and 278 transactions and other necessary and useful documentation are available for download from within the HIPAADesk.com testing service.

Each 837 testing program includes several tasks that must be performed successfully to complete EDI Desk.com testing. Upon completion of EDI testing, the VBC will begin MMIS Parallel Testing. The testing service is comprehensive and evaluates SNIP 1-7 types of testing.

MMIS PARALLEL TESTING

Please refer to the section on Connectivity with the Payer/Communications in the Louisiana Medicaid General Companion Guide for instructions on how to gain access to our test Bulletin Board System (BBS). This guide is also available for download from within HIPAADesk.com.

Parallel testing will compare a current proprietary electronic claim file with a parallel HIPAA EDI file both utilizing the same source data. Generally, the current proprietary and HIPAA EDI file should adjudicate the same.

NOTE: For those submitters who did not previously send proprietary electronic Medicaid claims, such as TAD billers, the parallel testing process will be slightly different. Instead of sending a copy of an EDI file to the BBS, you will e-mail 25 Internal Control Numbers (ICNs) from paper-billed claims from your last remittance advice to your HIPAA EDI QA parallel testing support person. If there weren't 25 ICNs on your last remittance advice, e-mail all the ICNs on your most recent weeks remittance advice and that is acceptable. If a tester does not have an assigned support person, contact the HIPAA EDI Test Team at *hipaaedi@unisys.com or call (225) 237-3318.

These claims will be compared to the HIPAA file sent to the test BBS, which was generated from the same data.

LTC RATE ADJUSTMENTS

Effective July 1, 2004 the following changes were made to the per diem rates for LTC providers (including Nursing Facilities and Adult Day Health Care facilities):

- The rate no longer includes the nursing wage and staff enhancement add-on of $1.26 that was added on January 1, 2003. However, under compromise with DHH, the direct care floor remains at 94%.

- The rate no longer contains the $.67 reduction to the capital component that was imposed on January 1, 2003.

- The rate no longer contains the $.67 reduction to the case mix adjusted rate that was imposed on July 1, 2003.

- The rate now contains a $.85 reduction to the per diem rate effective for all of State Fiscal Year 2005.

EVACUATIONS

When local conditions require evacuations of residents in LTC facilities, the following payment procedures apply:

- If clients are absent from the facility for less than 24 hours, the facility should charge for a service day.

- If the facility sends staff with the clients to the evacuation site, the facility should charge for a service day.

- If the clients go to a family or friend's home at the facility's request, the facility should charge neither a service day nor a leave day. The clients should be discharged from the facility the day they leave and be re-admitted to the facility the day they return. Providers billing on the TAD should use an admit code of “6” for the re-admission and make a notation on the TAD of the circumstances for the discharge and re-admission. Providers billing on the UB-92 or 837I must submit two claims – one claim for services through the discharge date and another claim for services beginning with the re-admission date. Regardless of the billing method (TAD, UB-92, or 837I), no hard copy documents or attachments are required to substantiate the re-admission of these clients.

  In this circumstance, the facility should not collect patient liability.

- If the clients go home at the family's request or on their own initiative, the facility should charge a leave day.

- If a client evacuates to the hospital, the hospital should not charge Medicaid for a hospital day.

The BHSF, Health Standards Section, requires that LTC facilities have an evacuation plan approved for emergency situations, such as tornadoes, floods, etc. The plan must include decisions about sites, medications, and identification of clients.

LTC BILLING TRANSITION

The implementation of standardized billing requirements through the Healthcare Portability and Accountability Act of 1996 (HIPAA) caused Louisiana Medicaid to transition providers from Medicaid proprietary electronic billing transactions and state specific claim forms to standardized, HIPAA acceptable electronic specifications and standardized claim forms.

This standardization included transitioning the billing of room and board by Long Term Care providers from the long-standing Turnaround Document (TAD). For the first time ever, this transition allows LTC providers to bill Louisiana Medicaid electronically using the 837I HIPAA electronic transaction. We believe this is an important step for LTC providers who bill Louisiana Medicaid.

Providers who choose to continue to bill Medicaid hard copy must transition to the UB-92 claim form.

The initial transition from the TAD was delayed because vendors testing to transmit these electronic claims were not approved and ready to accept clients for LTC billing. These vendors are now approved and ready to accommodate providers billing LTC room and board.

We have learned that many providers have contracts with approved vendors and are ready to submit claims electronically; yet these providers continue to submit the TAD for claims payment. We encourage you to begin transmitting claims electronically through your approved vendor.

The final transition of all providers to HIPAA compliant billing practices will be phased in beginning October 31, 2004. Several provider types are scheduled for final implementation between October 31st and December 31st. In early 2005 Medicaid, will finalize this plan for all remaining providers, including LTC providers, and the final implementation dates will be published.

LTC providers who have not transitioned from the TAD to either the 837I electronic specification or the UB-92 hard copy billing form should make the transition as quickly as possible. This will allow time for learning the new billing methodology and making any minor adjustments to ensure a smooth billing process.

A year has passed since our HIPAA workshops, and we want to ensure that all providers have current information related to the use of standardized billing requirements. The following material reiterates the billing forms and instructions presented during the LTC HIPAA workshop.

CODE CONVERSION

The transition from the TAD to the new billing methodology mandates the use of the standard codes required for UB-92 or 837I electronic transactions. The following outlines the significant billing changes in the coding structure:

Action Code

For UB-92 claim form or 837I billing, action codes are no longer valid and should not be used.

Admit Code

For UB-92 claim form or 837I billing, action codes are no longer valid and should not be used.

Patient Status

For UB-92 claim form or 837I billing, single-digit LMMIS proprietary Patient Status codes are replaced by two-digit standard National Uniform Billing Committee (NUBC) codes. This field (No. 22) is a required field on the UB-92.

LMMIS Proprietary Values		NUBC Values	
Code	**Description**	**Code**	**Description**
1	Discharged to other than LTC	05	Discharged/transferred to another type of institution for inpatient care
3	Transferred to another LTC	03	Discharged/transferred to SNF
4	Discharged due to death	20	Expired
5	Discharged to home	01	Discharged to home
6	Still resident	30	Still patient
7	Discharged, recipient exceeded hospital leave days	02	Discharged/transferred to another hospital

Level of Care to Revenue Code

Because the UB-92 claim form and the 837I do not provide a field designation for Level of Care, that code is replaced with the standard Revenue Codes for submission. The following tables list the LTC Level of Care codes and their corresponding standard Revenue Codes.

FOR NURSING FACILITY PROVIDERS:

Level of Care		Revenue Code & Description	
88	Case Mix (Formerly LOC 20, 21, 22)	022	Skilled Nursing Facility Prospective Payment System (RUGS) (For Dates of Service 01/01/03 and after)
31	NF Rehabilitation	118	Room & Board-Private Subacute Rehabilitation

Level of Care		Revenue Code & Description	
20	SNF/Hospice in Nursing Facility	190	Subacute Care-General Classification (For dates of service prior to 01/01/03)
21	ICF I/Hospice in Nursing Facility	191	Subacute Care Level I (Skilled Care) (For dates of service prior to 01/01/03)
22	ICF II	192	Subacute Care Level II (Comprehensive Care) (For dates of service prior to 01/01/03)
32	NF Complex Care	193	Subacute Care Level III (Complex Care)
28	SNF Technology Dependent Care	194	Subacute Care Level IV
30	SNF Infectious Disease	199	Other Subacute Care

FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:

Level of Care		Revenue Code & Description	
27	Adult Day Health Care	932	Medical Rehabilitation Day Program-Subcategory 2 – Full Day

LEAVE OF ABSENCE CODES

FOR ALL PROVIDERS (Excluding ADHC Providers):

Leave of Absence		Revenue Code & Description	
A	Home Leave	183	Leave of Absence – Subcategory Therapeutic
B	Hospital Leave	185	Leave of Absence – Subcategory Nursing Home (for Hospitalization)

TYPE OF BILL

A Type of Bill code is required on the UB-92 claim form and 837I. The 3-digit code provides useful information regarding the facility where services were rendered, the classification of services, and the frequency of billing including definition of adjusted bills. This 3-digit code is a combination of three distinct values, as follows:

Nursing Facilities

1st Digit – Type of Facility	2	Skilled Nursing, Skilled Nursing/Intermediate Care
2nd Digit – Classification	7	Subacute Inpatient (SNF/Case Mix)
	5	Intermediate Care Level I (Use for DOS prior to 1/1/03)
	6	Intermediate Care Level II (Use for DOS prior to 1/1/03)
3rd Digit – Frequency	1	Admit Through Discharge Claim
	2	Interim – First Claim
	3	Interim – Continuing Claim
	4	Interim – Final Claim
	7	Adjustment/Replacement of Prior Claim
	8	Void/Cancel of a Prior Claim

Adult Day Heatlh Care (ADHC)

1st Digit – Type of Facility	8	Special Facility (LOC = Adult Day Health Care)
2nd Digit – Classification	9	Other (Adult Day Health Care – ADHC)
3rd Digit – Frequency	1	Admit Through Discharge Claim
	2	Interim – First Claim
	3	Interim – Continuing Claim
	4	Interim – Final Claim
	7	Adjustment/Replacement of Prior Claim
	8	Void/Cancel of a Prior Claim

RUG-III CASE MIX REIMBURSEMENT SYSTEM FOR NURSING FACILITIES

The RUG-III Case Mix Reimbursement System **has not changed**. HIPAA implementation does not impact this payment methodology which remains in place for payment of claims to nursing homes. Provider contacts for this process remain the same and are as follows:

Medicaid MDS RN Reviewers
Questions concerning Medicaid MDS Reviews

Ruby Pecot (225) 342-6158

Medicaid RUG-III Classification Calculations, Resident Listing Reports and MDS Medical Record Review
All questions concerning the areas of classification calculations, resident listing reports and MDS medical record review

Myers and Stauffer LC (800) 763-2278 or (317) 816-4124

Provider Rates
All questions concerning provider rates

Myers and Stauffer LC (800) 374-6858 or (913) 234-1166

Louisiana MDS Help Line
Questions concerning the definition, completion or interpretation of the MDS 2.0 Resident Assessment Instrument.

DHH Health Standards Section, Cathy Brunson, RN, RAI/MDS Coordinator
(800) 261-1318

Medicare Data Communication Network Problems (MDCN)
Questions concerning connection problems to MDCN (Ids, passwords)

MDCN Helpdesk (800) 905-2069

Raven Help Desk
Questions concerning the RAVEN software (800) 339-9313

Claims Billing Issues

Unisys Provider Relations (800) 473-2783 or (225) 924-5040
Unisys Long Term Care Unit (225) 237-3259

Medicaid Enrollment of Providers

Unisys Provider Enrollment (225)237-3370

Recipient Eligibility Verification (REVS) (800) 776-6323 or (225) 216-7387

DHH Regional Office (800) 834-3333

BILLING ROOM AND BOARD ON THE UB-92

Long Term Care (LTC) providers, including Nursing Facility (NF), Adult Day Health Care (ADHC), Intermediate Care Facility-Mentally Retarded (ICF-MR), and Hospice (Room and Board Only) have routinely submitted claims to DHH on the hardcopy Turnaround Document (TAD). Beginning with date of service October 1, 2003, DHH began accepting the HIPAA standard 837 Institutional (837I) electronic claim transaction and, as an alternative, the hardcopy UB-92 claim form (which the 837I is based on) for claim submission by these providers. The 837I is the preferred method of claim submission.

Since October 2003, approximately 35-40% of LTC providers have transitioned to either the 837I electronic transaction or the UB-92 for hard copy billing. Providers who have not made this transition should begin this transition as quickly as possible.

When filing on the 837I format, each reel of tape, diskette (5 ¼" or 3 ½") 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 media. The certification must be included in each tape or diskette submitted while providers submitting by telecommunications must submit this certification to the Unisys EDI department within 48 hours. The address is Unisys EDI Department, P.O. Box 91025, Baton Rouge, LA 70821.

Beginning January, 2005, regardless of date of service (DOS), the TAD will no longer be accepted and all providers will be required to submit either the 837I or the hardcopy UB-92 for LTC claims.

Providers currently submitting the TAD may continue to do so until noon on December 22, 2004. DHH will generate the last set of TADs in November for billing November dates of service. The November TADs may be submitted to Unisys and will be accepted for payment. **Beginning at noon on December 22, 2004, DHH will no longer accept TADs**. Any TADs received after that point will be returned to the submitting provider. All December dates of service must be billed on the 837I or the hardcopy UB-92 claim form. Once a provider begins billing on the 837I or the hardcopy UB-92, they will no longer be permitted to bill using the TAD **(i.e., TADs will no longer be generated for the provider).**

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

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

NOTE 2: When billing hard copy on the UB-92 form or the 837I electronic transaction, attachments are not required for LTC billing.

UB-92 Claim Form

This section includes several notes regarding the use of specific UB-92 claim form fields and associated attachment forms, the billing instructions for the UB-92 claim form, and a sample UB-92 claim form.

NOTE: 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.

Special Field and Form Considerations

The following UB-92 claim form fields and associated forms are described in more detail below to assist the providers in understanding the expected use of these fields and forms.

Type of Bill (Field No. 4): - Required

This 3-digit code is a combination of three distinct values representing the following:

- The first digit identifies the type of facility.
- The second digit classifies the type of care.
- The third digit indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Covered Days (Field No. 7): - Required

The total covered days must equal the total number of Service Units (Field No. 46) billed for level of care revenue codes.

Patient Status (Field No. 22): - Required

The single-digit LMMIS proprietary Patient Status codes are replaced by two-digit HIPAA standard Patient Status codes.

Revenue Code & Description (Field No. 42-43): - Required

This form does not provide a field designation for Level of Care. HIPAA standard Revenue Codes will be used in their place, and a Level of Care to Revenue Code crosswalk is included in this packet.

The TAD provided for three occurrences of Levels of Care and five Leaves of Absence from the home. While the UB-92 provides 23 Revenue Code detail lines, the LMMIS is restricted to processing a maximum of five Revenue Codes related to Level of Care and eight Revenue Codes related to Leave Days. Providers should not submit more than the maximum; those exceeding the maximum will not be processed.

A Level of Care Revenue Code should only be billed once during the month unless the Level of Care changes during the month.

Service Date (Field No. 45): - Required

A beginning and ending day of service (e.g., 01-31) must be entered for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided. The claim must reflect the total number of days billed at a particular Level of Care (LOC) corresponding to the Revenue Code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate Revenue Code for that LOC and the correct number of days indicated for that LOC for the month of service. **[Leave days do not apply to ADHC providers.]**

Note: Leave days begin 24 hours after the resident signs out of the facility. (Ex: If the resident leaves at 8:00 a.m. on January 1, 2004 to go to the hospital and does not return again until January 4, 2003 at 10:00 a.m., leave days are indicated as January 2–4 [e.g.02-04])
If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 02-03). **[Leave Days do not apply to ADHC providers.]**

Service Units (Field No. 46): - Required

Calculate the number of days of service and enter that number as the units of service for each type of Level of Care service on the line adjacent to the level of care revenue code, description, and service date. **When billing for home or hospital leave days, leave this field blank.**

UB-92 Claim Form Instructions

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 1	PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER	Required. Enter the provider's name, address, and phone number.
FIELD NO. 2	UNLABELED	Leave blank
FIELD NO. 3	PATIENT CONTROL NO.	Situational. A patient control number may be entered using letters and/or numbers and may be a maximum of 16 characters.
FIELD NO. 4	TYPE OF BILL	Required. Enter the 3-digit code indicating the specific type of facility, bill classification and frequency. This 3-digit code requires one digit each, in the following format: • The first digit identifies the type of facility. • The second classifies the type of care. • The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. Code Structure: **FOR NURSING FACILITY PROVIDERS:** *1st Digit - Type of Facility* 2 – Skilled Nursing (LOC = ICF I) (LOC = ICF II) (LOC = SNF) (LOC = SNF Technology Dependent Care) (LOC = SNF Infectious Disease) (LOC = NF Rehab) (LOC = NF Complex Care) Skilled Nursing/ Intermediate Care (LOC = Case Mix effective 1/1/2003) *2nd Digit – Classification* 7 – Subacute Inpatient (SNF/Case Mix) 5 – Intermediate Care Level I (Use for DOS prior to 1/1/03) 6 – Intermediate Care Level II (Use for DOS prior to 1/1/03) *3rd Digit – Frequency* *Definition* 1 Admit Through Discharge Claim Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient.

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		2 Interim - First Claim Use this code for the first of an expected series of claims for a course of treatment. 3 Interim - Continuing Claim Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 Interim - Final Claim Use this code for a claim which is the last claim. The "Through" date of this bill (Field 6) is the discharge date or date of death. 7 Adjustment/ Replacement of Prior Claim Use this code to correct a previously submitted and paid claim. 8 Void/Cancel of a Prior Claim Use this code to void a previously submitted and paid claim. **FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:** *1st Digit - Type of Facility* 8 - Special Facility (LOC = Adult Day Health Care) *2nd Digit - Classification* 9 – Other (Adult Day Health Care - ADHC) *3rd Digit – Frequency* *Definition* 1 Admit Through Discharge Claim Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 2 Interim - First Claim Use this code for the first of an expected series of claims for a course of treatment. 3 Interim - Continuing Claim Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted.

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		4 Interim - Final Claim Use this code for a claim which is the last claim. The "Through" date of this bill (Field 6) is the discharge date or date of death. 7 Adjustment/ Replacement of Prior Claim Use this code to correct a previously submitted and paid claim. 8 Void/Cancel of a Prior Claim Use this code to void a previously submitted and paid claim.
FIELD NO. 5	FED. TAX NO.	Leave blank
FIELD NO. 6	STATEMENT COVERS PERIOD FROM/THROUGH	Required. Enter the beginning and ending service dates of the period covered by this claim in numeric digits (MM-DD-YY).
FIELD NO. 7	COV D.	Required. Enter the number of total covered days for the Statement Period. (NOTE: ADHC claims cannot exceed 23 days for an entire month or the number of days of service if less than 23 days.) Covered days must equal the total number of units of service (Field 46) billed for **level of care** revenue codes. Note: For discharge due to death, the covered days and the statement through date in Field 6 should include the date of death. For all other discharges, the number of covered days will be one less than the Statement Covers Period From/Through (Field 6) which should include the discharge day. (Excluding ADHC providers)
FIELD NO. 8	N-C D.	Leave blank
FIELD NO. 9	C-I D.	Leave blank
FIELD NO. 10	L-R D.	Leave blank
FIELD NO. 11	UNLABELED	Leave blank
FIELD NO. 12	PATIENT NAME	Required. Enter the recipient's name (last name, first name, and middle initial) exactly as it appears on the recipient's Medicaid ID card.

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 13	PATIENT ADDRESS	Leave blank
FIELD NO. 14	BIRTHDATE	Leave blank
FIELD NO. 15	SEX	Leave blank
FIELD NO. 16	MS	Leave blank
FIELD NO. 17	ADMISSION DATE	Required. Enter the recipient's admission date to the facility. Show the month, day, and year numerically as MM-DD-YY.
FIELD NO. 18	ADMISSION HR	Leave blank
FIELD NO. 19	ADMISSION TYPE	Leave blank
FIELD NO. 20	ADMISSION SRC	Leave blank
FIELD NO. 21	D HR	Leave blank
FIELD NO. 22	STAT	Required (maximum of 2 digits). This code indicates the patient's status as of the "Through" date of the billing period (Field 6). **Code Structure** 01 Discharged to home or self care (routine discharge) 02 Discharged/transferred to another short-term general hospital for inpatient care 03 Discharged/transferred to a skilled nursing facility (SNF) 03 Discharged/transferred to an intermediate care facility (ICF) 04 Discharged/transferred to another type of institution for inpatient care 05 Discharged/transferred to home under care of organized home health services organization 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of Home IV (Intravenous Therapy) provider 09 Admitted as inpatient to a hospital

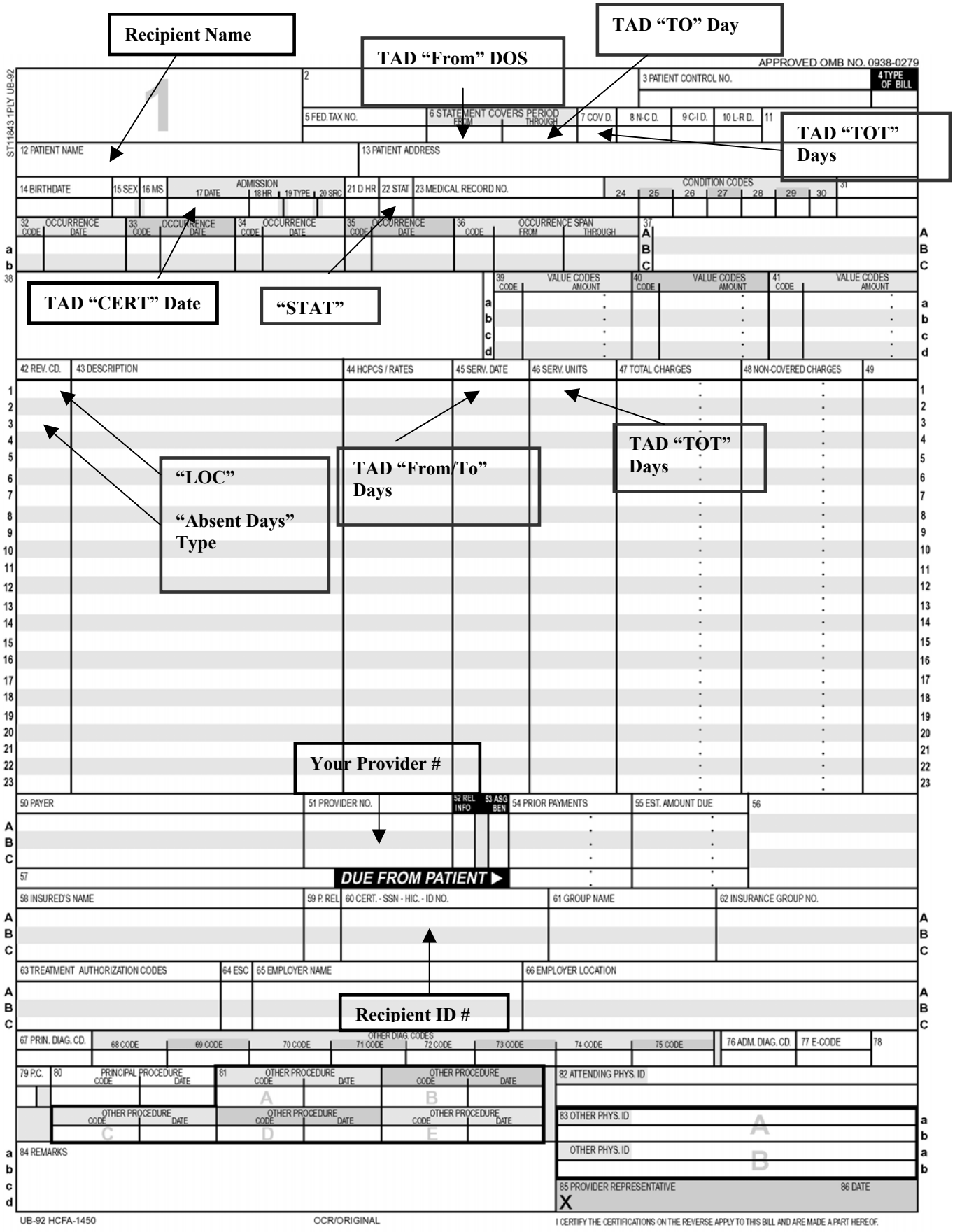
FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		20 Expired/Discharged Due to Death 30 Still a patient 61 Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 63 Discharged/transferred to a long term care hospital
FIELD NO. 23	MEDICAL RECORD NO.	Situational. Facility may enter a patient's medical record number (up to 16 characters).
FIELD NO. 24 – 30	CONDITION CODES	Leave blank
FIELD NO. 31	UNLABELED	Leave blank
FIELD NO. 32 – 35	OCCURRENCE CODES/DATES	Leave blank
FIELD NO. 36	OCCURRENCE SPAN CODE, FROM/THROUGH	Leave blank
FIELD NO. 37A, B, C	UNLABELED	Leave blank
FIELD NO. 38	UNLABELED	Leave blank
FIELD NO. 39-41	VALUE CODES CODE(S)/AMOUNT	Leave blank
FIELD NO. 42-43	REV CD/DESCRIPTION	Required. 3-digit numeric. Enter the applicable revenue code(s) and description(s) that identify the service provided. Bill a Level of Care (LOC) Revenue Code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill LA Medicaid: **FOR ALL PROVIDERS (Excluding ADHC Providers):** Revenue Code & Description *Leave of Absence* 183 Leave of Absence – Subcategory Therapeutic (for Home Leave) *A Home Leave* 185 Leave of Absence – Subcategory Nursing Home (for Hospitalization) *B Hospital Leave*

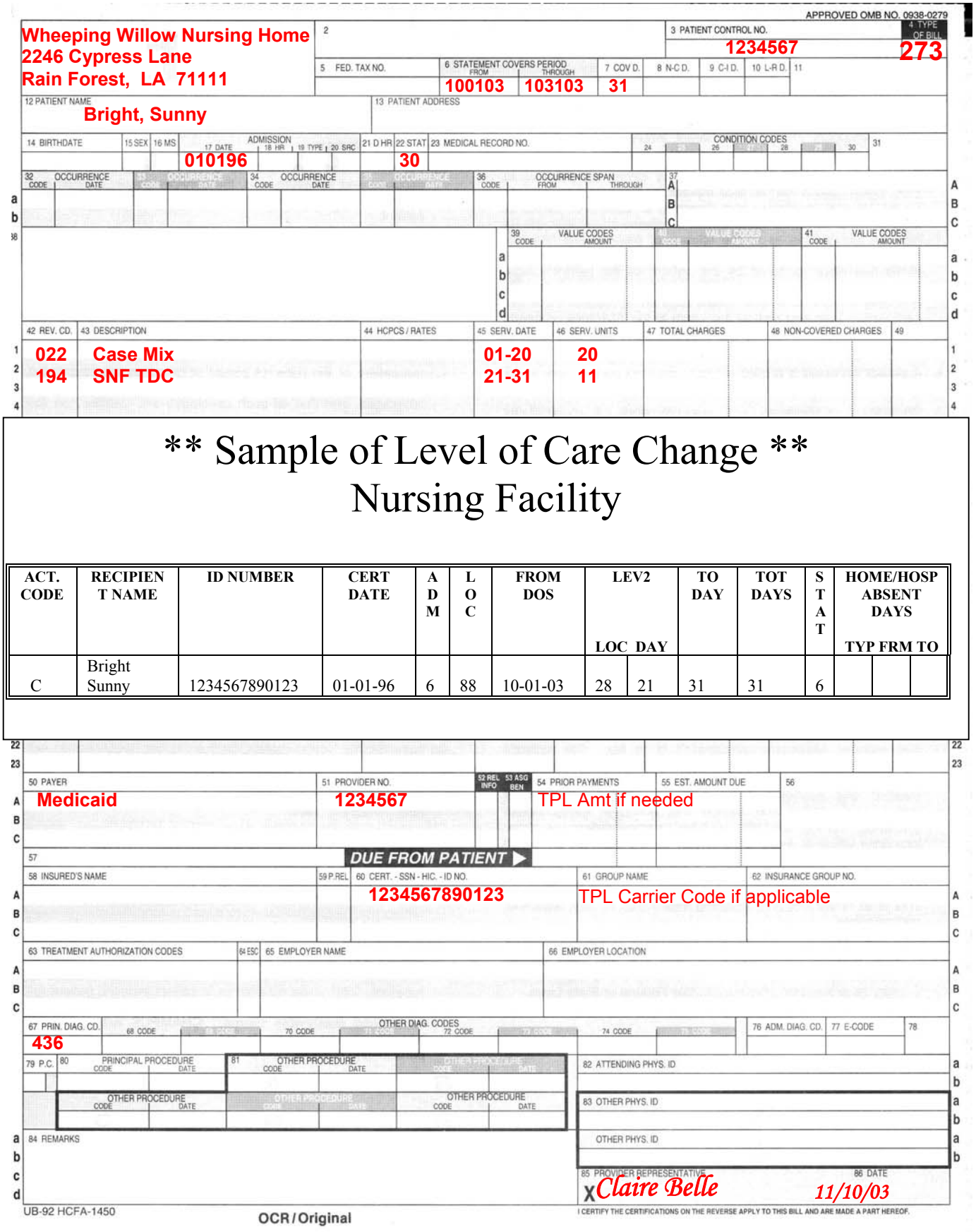
FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		FOR NURSING FACILITY PROVIDERS: Revenue Code & Description *Level of Care* 022 Skilled Nursing Facility Prospective Payment System (RUGS) (For dates of service 01/01/03 and after) *88 Case Mix (Formerly LOC 20, 21, 22)* 118 Room & Board-Private Subacute Rehabilitation *31 NF Rehabilitation* 190 Subacute Care-General Classification (For dates of service prior to 01/01/03) *20 SNF/Hospice in Nursing Facility* 191 Subacute Care Level I (Skilled Care) (For dates of service prior to 01/01/03) *21 ICF I/Hospice in Nursing Facility* 192 Subacute Care Level II (Comprehensive Care) (For dates of service prior to 01/01/03) *22 ICF II* 193 Subacute Care Level III (Complex Care) *32 NF Complex Care* 194 Subacute Care Level IV *28 SNF Technology Dependent Care* 199 Other Subacute Care *30 SNF Infectious Disease* **FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:** Revenue Code & Description *Level of Care* 932 Medical Rehabilitation Day Program-Subcategory 2 – Full Day 27 *Adult Day Health Care*
FIELD NO. 44	HCPCS/RATES	Leave blank
FIELD NO. 45	SERV. DATE	Required. A beginning and ending day of service (e.g., 01-31) MUST BE ENTERED for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided.

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		(Example 1: If SNF TDC care (Revenue Code 194) is provided for the entire month of March, the Service Date should be entered 01-31. Example 2: If the recipient is on Hospital Leave (Revenue Code 185) from March 6 – 12, the Service Date should be entered 07-12, just as previously entered on the TAD -- **If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11).**) (Note: The claim must reflect the total number of days billed at a particular Level of Care (LOC) corresponding to the Revenue Code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate Revenue Code for that LOC and the correct number of days indicated for that LOC for the month of service**.**)
FIELD NO. 46	SERV. UNITS	Required. Enter in DAYS the number of units of service for each type of Level of Care service on the line adjacent to the Level of Care revenue code, description, and service date. (Example 1 above, Service Date 01-31 should indicate 31 units or days for Revenue Code 194. Example 2 above (Revenue Code 185), Service date 07-12, service units should be left blank.) (Note: ADHC cannot exceed 23 days per month. Enter the number of days of service provided.) Do not enter the actual number of units when billing for home or hospital leave days, only indicate the from and to days in Field 45.
FIELD NO. 47	TOTAL CHARGES	Leave blank
FIELD NO. 48	NON-COVERED CHARGES	Leave blank
FIELD NO. 49	UNLABELED	Leave blank
FIELD NO. 50	PAYER	Required. Enter “Medicaid” on line “A”.
FIELD NO. 51	PROVIDER NO.	Required. Enter the facility’s seven (7) digit Medicaid provider identification number on line “A”.
FIELD NO. 52	REL INFO	Leave blank
FIELD NO. 53	ASG BEN	Leave blank
FIELD NO. 54	PRIOR PAYMENTS	Situational. If third party insurance is primary, enter the amount paid toward this claim by TPL or enter zero (0) if nothing was paid.
FIELD NO. 55	EST. AMOUNT DUE	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELDS NO. 56/57	UNLABELED	Leave blank
FIELD NO. 58	INSURED'S NAME	Leave blank
FIELD NO. 59	P REL	Leave blank
FIELD NO. 60	CERT. – SSN. – HIC. – ID NO.	Required. Enter the recipient's 13-digit Medicaid ID number.
FIELD NO. 61	GROUP NAME	Leave blank
FIELD NO. 62	INSURANCE GROUP NO.	Situational. If third party insurance is primary, enter the six-digit Louisiana-specific TPL carrier code assigned to the carrier in this field.
FIELD NO. 63	TREATMENT AUTHORIZATION CODES	Leave blank
FIELD NO 64	ESC	Leave blank
FIELD NO. 65	EMPLOYER NAME	Leave blank
FIELD NO. 66	EMPLOYER LOCATION	Leave blank
FIELD NO. 67	PRIN. DIAG. CD.	Required. Enter the ICD-9-CM diagnosis code for the principal diagnosis.
FIELD(S) NO. 68-75	OTHER DIAG CODES	Situational. Enter the ICD-9-CM diagnosis codes for any other applicable diagnoses.
FIELD NO. 76	ADM DIAG CD	Leave blank
FIELD NO. 77	E – CODE	Leave blank
FIELD NO. 78	UNLABELED	Leave blank
FIELD NO. 79	P.C.	Leave blank
FIELD NO. 80	PRINCIPAL PROCEDURE CODE/DATE	Leave blank
FIELD NO. 81	OTHER PROCEDURE CODE/DATE	Leave blank

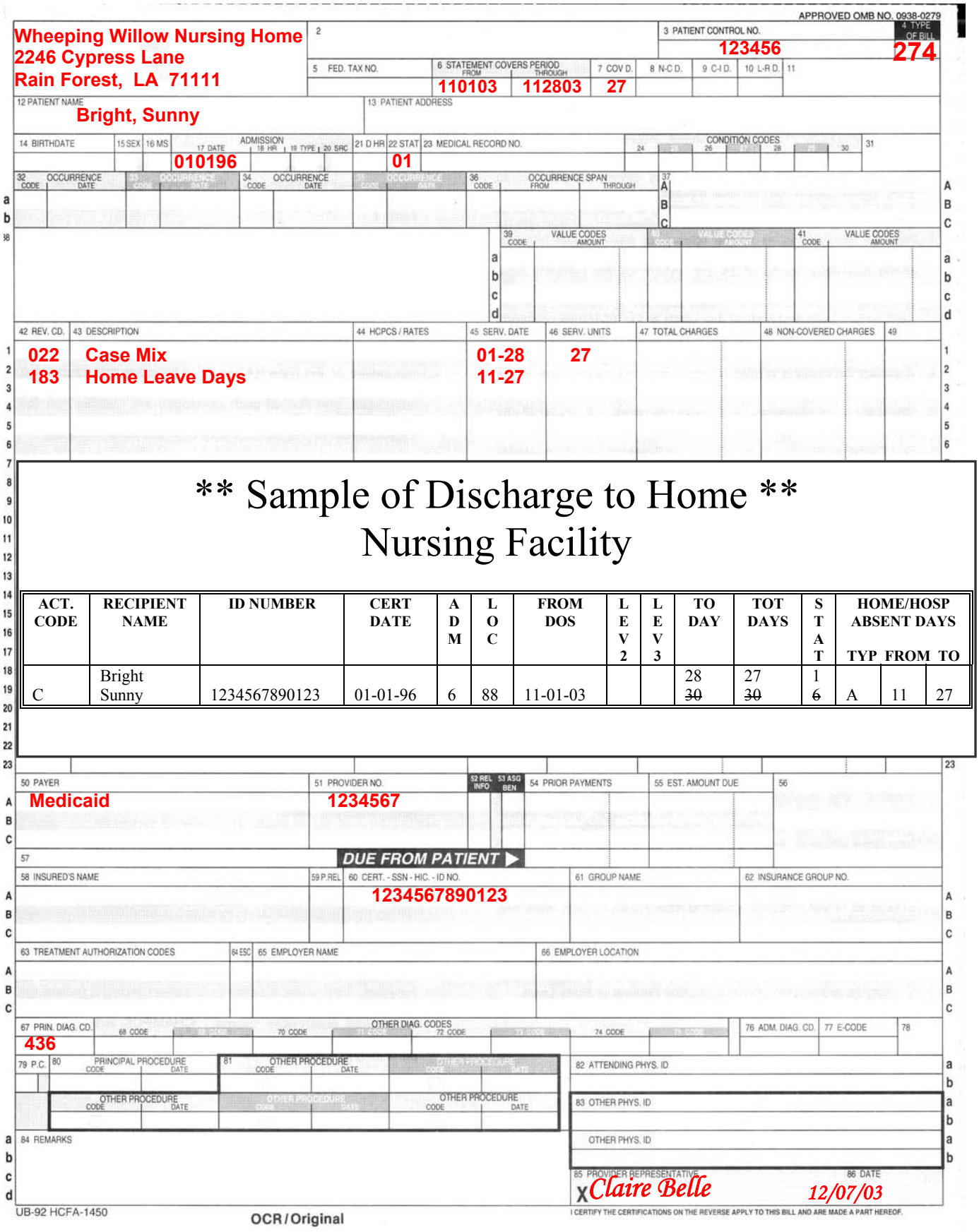
FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 82	ATTENDING PHYS. ID	Leave blank
FIELD NO. 83	OTHER PHYS. ID	Leave blank
FIELD NO. 84	REMARKS	Situational. Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment. For Adjustment/Void Claims: 1. Enter an "A" for an adjustment or a "V" for a void. 2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice. 3. Enter one of the appropriate reason codes: Adjustments: 01 - Third Party Liability Recovery 02 - Provider Correction 03 - Fiscal Agent Error 99 - Other - Please Explain Voids: 10 - Claim Paid for Wrong Recipient 11 - Claim Paid for Wrong Provider 00 - Other Examples: Adjustment: A 2184562646500 02 Void: V 2205164253000 00
FIELD NO. 85	PROVIDER REPRESENTATIVE	Required. Enter the signature of the appropriate person at the facility who is authorized to submit Medicaid claims. (Stamped signatures must be initialed.)
FIELD NO. 86	DATE	Required. Enter the date the claim was signed. The date should be in valid MMDDYY format and should be greater than the through date in Form Locator 6.


Recipient Name
TAD "From" DOS
TAD "TO" Day
TAD "TOT" Days
TAD "CERT" Date
"STAT"
"LOC"
"Absent Days" Type
TAD "From/To" Days
TAD "TOT" Days
Your Provider #
Recipient ID #
APPROVED OMB NO. 0938-0279
ST11843 1PLY UB-92
DUE FROM PATIENT
UB-92 HCFA-1450
OCR/ORIGINAL
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



** Sample of Level of Care Change **
Nursing Facility

ACT. CODE	RECIPIENT NAME	ID NUMBER	CERT DATE	ADM	LOC	FROM DOS	LEV2 LOC	LEV2 DAY	TO DAY	TOT DAYS	STAT	HOME/HOSP ABSENT DAYS TYP	FRM	TO
C	Bright Sunny	1234567890123	01-01-96	6	88	10-01-03	28	21	31	31	6			



APPROVED OMB NO. 0938-0279

Wheeping Willow Nursing Home
2246 Cypress Lane
Rain Forest, LA 71111

3 PATIENT CONTROL NO. 123456
4 TYPE OF BILL 274
6 STATEMENT COVERS PERIOD FROM 110103 THROUGH 112803
7 COV D. 27
12 PATIENT NAME Bright, Sunny
17 ADMISSION DATE 010196
22 STAT 01

42 REV. CD. | 43 DESCRIPTION | 45 SERV. DATE | 46 SERV. UNITS
022 | Case Mix | 01-28 | 27
183 | Home Leave Days | 11-27 |

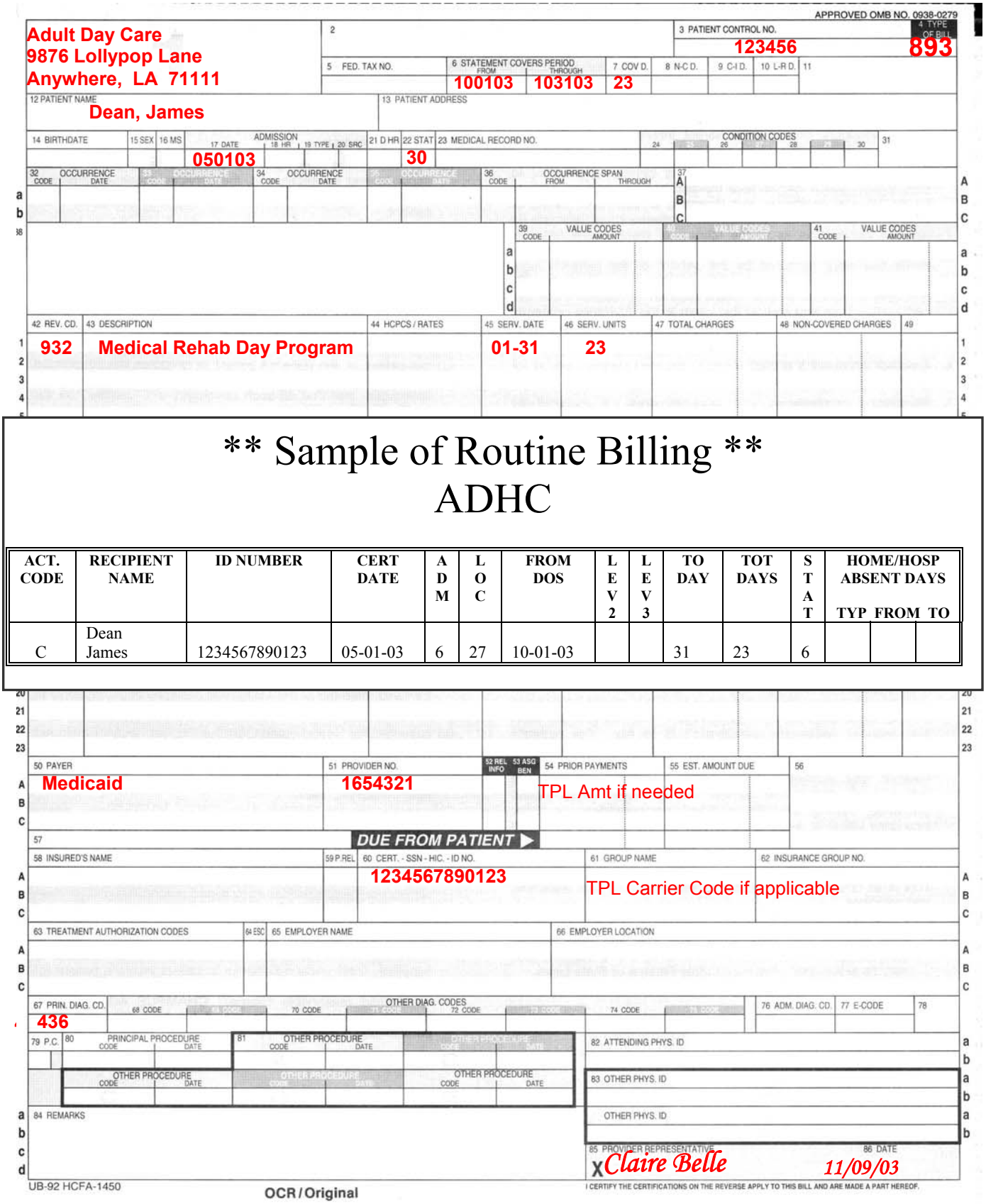
** Sample of Discharge to Home **
Nursing Facility

ACT. CODE	RECIPIENT NAME	ID NUMBER	CERT DATE	ADM	LOC	FROM DOS	LEV2	LEV3	TO DAY	TOT DAYS	STAT	HOME/HOSP ABSENT DAYS TYP	FROM	TO
C	Bright Sunny	1234567890123	01-01-96	6	88	11-01-03			28 ~~30~~	27 ~~30~~	1 ~~6~~	A	11	27

50 PAYER Medicaid
51 PROVIDER NO. 1234567
DUE FROM PATIENT
60 CERT. - SSN - HIC. - ID NO. 1234567890123
67 PRIN. DIAG. CD. 436
85 PROVIDER REPRESENTATIVE X Claire Belle
86 DATE 12/07/03

UB-92 HCFA-1450 OCR / Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



** Sample of Routine Billing **
ADHC

ACT. CODE	RECIPIENT NAME	ID NUMBER	CERT DATE	ADM	LOC	FROM DOS	LEV 2	LEV 3	TO DAY	TOT DAYS	STAT	HOME/HOSP ABSENT DAYS TYP	FROM	TO
C	Dean James	1234567890123	05-01-03	6	27	10-01-03			31	23	6			

ADJUSTMENTS AND VOIDS

Claim Adjustment Form 212 (Adjustments/Voids):

Once TAD billing for room & board is no longer accepted, this form will only be used when filing adjustments/voids for claims originally billed and paid on a TAD.

Claim Adjustments/Voids Using the UB-92 Form:

Once a provider transitions to the UB-92 or 837I for billing, LTC adjustments and voids must be submitted using the UB-92 or 837I. Adjustments/Voids are identified through the third digit in the bill type (Field No. 4). The value "7" in the third digit indicates a claim adjustment, and "8" in the third digit indicates a voided claim. When submitting an adjustment or void, the following additional information is required in Field No. 84 (Remarks) of the UB-92:

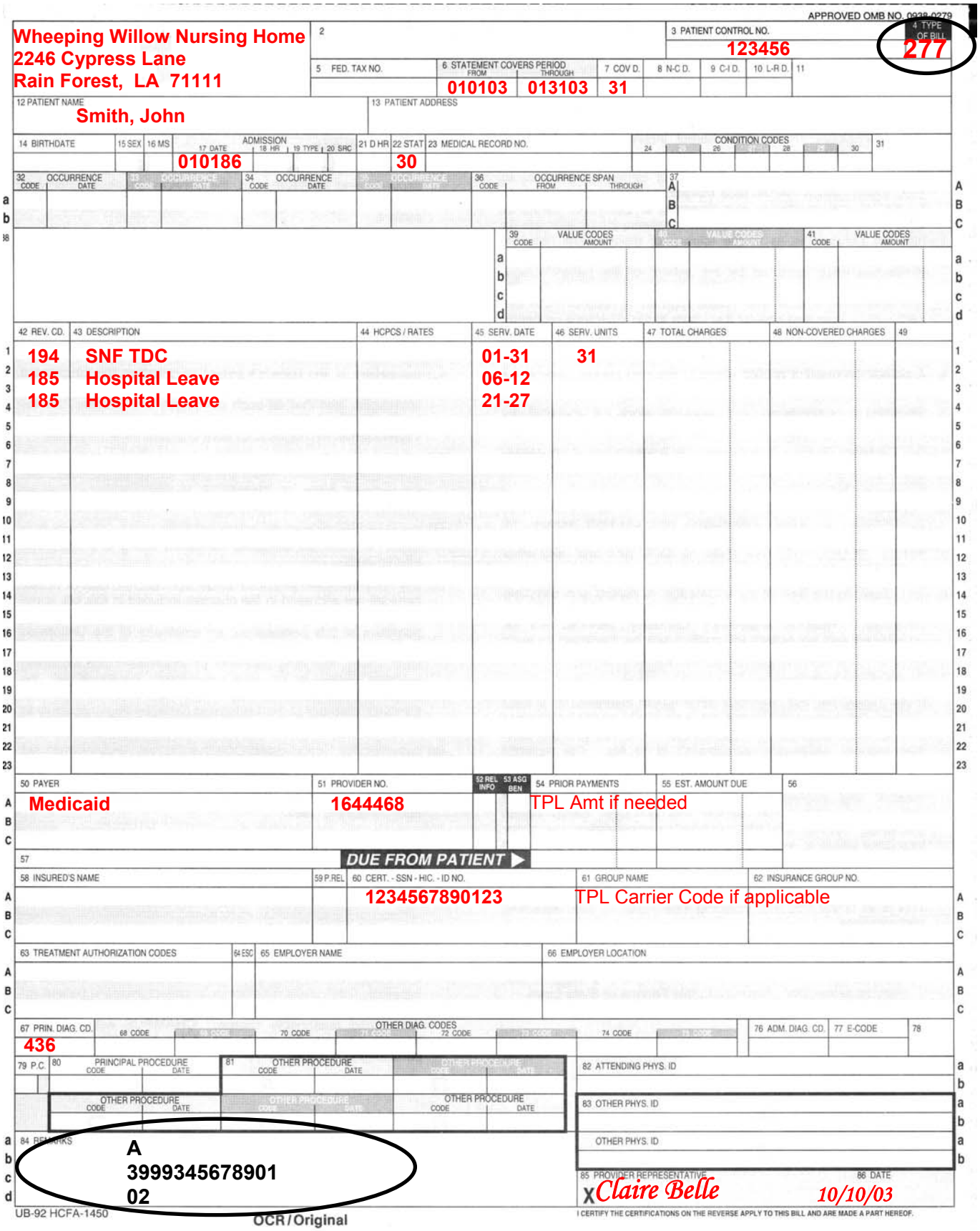
UB-92 Field No. 84 (Remarks) Instructions for Adjustments/Voids	
1. Enter an "A" for an adjustment or a "V" for a void.	
2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.	
3. Enter one of the appropriate reason codes:	
Adjustments:	Voids:
01 - Third Party Liability Recovery 02 - Provider Correction 03 - Fiscal Agent Error 99 - Other - Please Explain	10 - Claim Paid for Wrong Recipient 11 - Claim Paid for Wrong Provider 00 - Other
Examples:	
Adjustment: A 2184562646500 02	Void: V 2205164253000 00

Claim Adjustment Form 148 (Patient Liability):

LTC adjustments billed when the recipient's patient liability is changed retroactively are processed as 148/PLI adjustments. The Adjustment Reason Code included on this form is necessary to process these claims and calculate reimbursement correctly. This claim form will continue to be used with no changes in the submission process. DHH policy does not currently require Patient Liability for ADHC recipients.

NOTE: (1) The Patient Status Code (block 12) should be the HIPAA standard 2-digit status code.

(2) The Level of Care (Block 5) should continue to indicate the locally assigned LOC code as opposed to the revenue code entered on the UB-92 form.


APPROVED OMB NO. 0938-0279
Wheeping Willow Nursing Home
2246 Cypress Lane
Rain Forest, LA 71111
3 PATIENT CONTROL NO.
123456
4 TYPE OF BILL
277
6 STATEMENT COVERS PERIOD
FROM 010103
THROUGH 013103
7 COV D. 31
12 PATIENT NAME
Smith, John
14 BIRTHDATE
17 DATE ADMISSION 010186
22 STAT 30
42 REV. CD. 43 DESCRIPTION 44 HCPCS / RATES 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES
194 SNF TDC 01-31 31
185 Hospital Leave 06-12
185 Hospital Leave 21-27
50 PAYER
Medicaid
51 PROVIDER NO.
1644468
54 PRIOR PAYMENTS
TPL Amt if needed
DUE FROM PATIENT
58 INSURED'S NAME
60 CERT. - SSN - HIC. - ID NO.
1234567890123
61 GROUP NAME
TPL Carrier Code if applicable
67 PRIN. DIAG. CD.
436
84 REMARKS
A
3999345678901
02
85 PROVIDER REPRESENTATIVE
XClaire Belle
86 DATE
10/10/03
UB-92 HCFA-1450
OCR/Original

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

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

LONG TERM CARE
PATIENT LIABILITY ADJUSTMENT FORM

FOR OFFICE USE ONLY

TO: **Medical Assistance**

FROM: **LTC Facility**

1 PROVIDER NO.	2 RECIPIENT I.D. NUMBER	3 RECIPIENT LAST NAME	4 FIRST NAME
1234567	4004004001213	Holden	Hugh

5 LEVEL OF CARE	6 INITIATED BY
88	[X] FACILITY [ ] PARISH OFS

7 FROM DATE OF SERVICE	8 TO DATE OF SERVICE	9 TOTAL DAYS	10 CONTROL NUMBER	11 CORRECT PATIENT LIABILITY	12 STATUS	SDC OFFICE USE ONLY
10/01/03	10/31/03	31	3000008100000	$175.00	30	

ADJUSTMENT

AUTHORIZED SIGNATURES

13. FACILITY *Jane Friday* DATE *11/15/03*

14. PARISH OFS _____ DATE _____

FISCAL AGENT COPY

UNISYS 148/PLI

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

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

LONG TERM CARE
PATIENT LIABILITY ADJUSTMENT FORM

FOR OFFICE USE ONLY

TO: _____

FROM: _____

1 PROVIDER NO.	2 RECIPIENT I.D. NUMBER	3 RECIPIENT LAST NAME	4 FIRST NAME

5 LEVEL OF CARE	6 INITIATED BY ▱ FACILITY ▱ PARISH OFS

7 FROM DATE OF SERVICE	8 TO DATE OF SERVICE	9 TOTAL DAYS	10 CONTROL NUMBER	11 CORRECT PATIENT LIABILITY	12 STATUS	SDC OFFICE USE ONLY

ADJUSTMENT

AUTHORIZED SIGNATURES

13. FACILITY _____ DATE _____

14. PARISH OFS _____ DATE _____

FISCAL AGENT COPY

UNISYS 148/PLI

DENIAL CODES/EDITS

Current Denial Codes Associated With Room & Board Billing

Providers will **continue** to see the following denial codes when applicable:

Edit 356 **To Day/Tot/Status Conflict**

Edit 373 **Invalid Leave Date**

Edit 395 **Hospital Leave Days Exceed 7**

Edit 853 **Duplicate Claim**

Denial Codes Specifically Associated With Billing Room & Board On The UB-92 Form

The following **new** denial codes will be seen by providers when applicable:

Edit 042 **Invalid Bill Type**

Edit 045 **Patient Status Invalid or Missing**

Edit 093 **Revenue Code Missing or Invalid**

ELECTRONIC DATA INTERCHANGE (EDI)

CLAIMS SUBMISSION

Electronic data interchange submission is the preferred 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 media. 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.

Required Certification forms may be obtained from lamedicaid.com under the HIPAA Information Center link. The required forms are also 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).

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.

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

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.**

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

    - Case Management services
    - Non-Ambulance Transportation

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 MEDIA 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 MEDIA 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.

General Information

- 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.

LOUISIANA MEDICAID
WEBSITE APPLICATIONS

The newest way to obtain general and specific Medicaid information is on our Louisiana Medicaid Provider Website:

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 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. Should you need assistance with obtaining a login and password or have questions about the technical use of the application, please contact the Unisys Technical Support Desk at 877-598-8753.

☞ **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.**

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 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 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 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 finger tips at any practice location.

The nine (9) clinical services information components are:

1. Clinical Drug Inquiry
2. Physician/EPSDT Encounters
5. Ancillary Services
6. Lab & X-Ray Services

3. Outpatient Procedures
4. Specialist 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 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.

ADDITIONAL 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

http://www.dhh.state.la.us/RAR - DHH Rate and Audit Review

Nursing Homes (NH) can use this website to obtain relevant information for topics such as:

- Nursing Home Update Section
- Frequently Asked Questions
- NH Cost Report Areas of Concern
- Links to information related to NH reimbursements
- Information related to cost report audit process and MDS review
- Contact Information

PROVIDER ASSISTANCE

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

UNISYS 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:

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

* Please 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 Louisiana Medicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

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

RECIPIENT HELPLINE (800) 834-3333

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

UNISYS 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:

Unisys 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 Third Party Liability (TPL) should be directed to:

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

"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 is available in this training packet under "Unisys Claims Filing Addresses".

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

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

Upon request, Provider Relations Field Analysts are available to visit and 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, since Field Analysts routinely work in the field, they <u>are not</u> 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 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)	

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) 237-3334
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 questions concerning 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.
Referral Assistance - ACS	(877) 455-9955	Providers or recipients may use this phone number for referral assistance.
KIDMED Provider Hotline – ACS	(800) 259-8000	Providers may obtain information on KIDMED linkage, referrals, monitoring, certification, and names of PCA/PCS agencies to provide EPSDT 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 a change in 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)
BHSF Rate and Audit Review Section-DHH	(225) 342-5039 (225) 342-3926 (225) 342-6116	Providers may request assistance for claim payment resolution requiring system overrides.
LINKS	(504) 483-1900	Providers may obtain immunization information on recipients.

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

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 <u>70821</u>:	
Pharmacy (original claims and adjustment/voids).....	91019
HCFA-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
EDI, Unisys Business, and Miscellaneous Correspondence.....	91025
The zip code for the following P.O. Boxes is <u>70898</u>:	
Provider Enrollment……	80159
Prior Authorization.....	14919
KIDMED.....	14849

CLAIMS PROCESSING GENERAL 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 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 you 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 must be made 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.

Appendix A

Summary of LTC Changes

Attention: LTC Providers

LTC Changes for HIPAA	Description	TAD BILLING	UB-92/837I BILLING
Claim Form	Room and Board billed for LTC	• Can not bill electronically • Pre-printed TAD provided for billing of on-going patients • Appropriate attachments required when applicable with the TAD	• Bill hardcopy on the UB92 claim form • Bill electronically using the 837I transaction • Claims must be submitted for each individual recipient for each month • No attachments required
	212 Adjustment Form Used for claim adjustments excluding adjustments of Patient Liability	212 Adjustment	Bill with the UB-92 or 837I. Must include: • Bill Type – 3rd digit: 7=Adjustment 8=Void • In block #84: 1. A = Adjustment V = Void 2. ICN # of paid claim 3. Appropriate reason code
	Adjustments 148 PLI Patient liability changes only	148 PLI	No Changes

LTC Changes for HIPAA	Description	TAD BILLING	UB-92/837I BILLING
Codes Changes	Codes necessary to bill for Room and Board	TAD Billing: • LOC • 1-digit status codes • Leave Day codes (alpha) • Certification Date • Use “From/To” Days & “TOT” Days	UB-92/837I Billing: • Use appropriate Revenue Code for LOC • Use 2-digit Status Codes instead of 1-digit codes • Use appropriate Revenue Code for Leave Days • Admission Date replaces Certification Date • Use Statement Dates/Service Date/Service Units • Action Codes no longer required • Admit Code no longer required • Use appropriate Bill Type for service rendered

NOTE: LTC providers are allowed to bill using TADs, UB-92s, or 837I electronic transactions through December, 2004. Effective January, 2005, providers MUST bill using either UB-92s or 837I transactions, regardless of date of service.

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 Medicaid 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
MEDICAID 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: LTC					

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.**