HOSPICE PROVIDER TRAINING

Medicaid Issues for 2004
(Fall Issue)

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

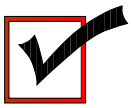
UNISYS

ABOUT THIS DOCUMENT

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

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

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



FOR YOUR INFORMATION! SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

I. MR/DD WAIVER WAITING LIST

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

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

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

CASE MANAGEMENT

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

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

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

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

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

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

EPSDT/KIDMED EXAMS AND CHECKUPS

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

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

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

PERSONAL CARE SERVICES

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

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

EXTENDED HOME HEALTH SERVICES

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

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

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

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

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

SERVICES IN SCHOOLS OR EARLY INTERVENTION CENTERS

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

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

MEDICAL EQUIPMENT AND SUPPLIES

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

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

MENTAL HEALTH REHABILITATION SERVICES

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

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

TRANSPORTATION

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

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

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OTHER MEDICAID COVERED SERVICES

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

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

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

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

NOTICE TO ALL PROVIDERS

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

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

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

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

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

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

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Services Available to Medicaid Eligible Children Under 21

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

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

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

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

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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.

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

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

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

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

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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 ROOM AND BOARD 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 Hospice HIPAA workshop.

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 For Room and Board

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 HOSPICE PROVIDERS**: (Used for Nursing Facility Room and Board ONLY. Do not use for billing hospice services.) *1st Digit - Type of Facility* 2 – Skilled Nursing (LOC = SNF/Hospice in Nursing Facility) (LOC = ICF I/Hospice in Nursing Facility) *2nd Digit - Classification* 7 – Subacute Inpatient (SNF/Case Mix) Use for all service dates, even those prior to 01/01/2003 *3rd Digit – Frequency Definition* 1 Admit Through Discharge Claim (Entire 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 that 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-YYYY).
FIELD NO. 7	COV D.	**Required** Enter the number of total covered days for the Statement Period. 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.
FIELD NO. 8	N-C D.	Leave blank
FIELD NO. 9	C-I D.	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
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.
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-YYYY.
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) 04 Discharged/transferred to an intermediate care facility (ICF) 05 Discharged/transferred to another type of institution for

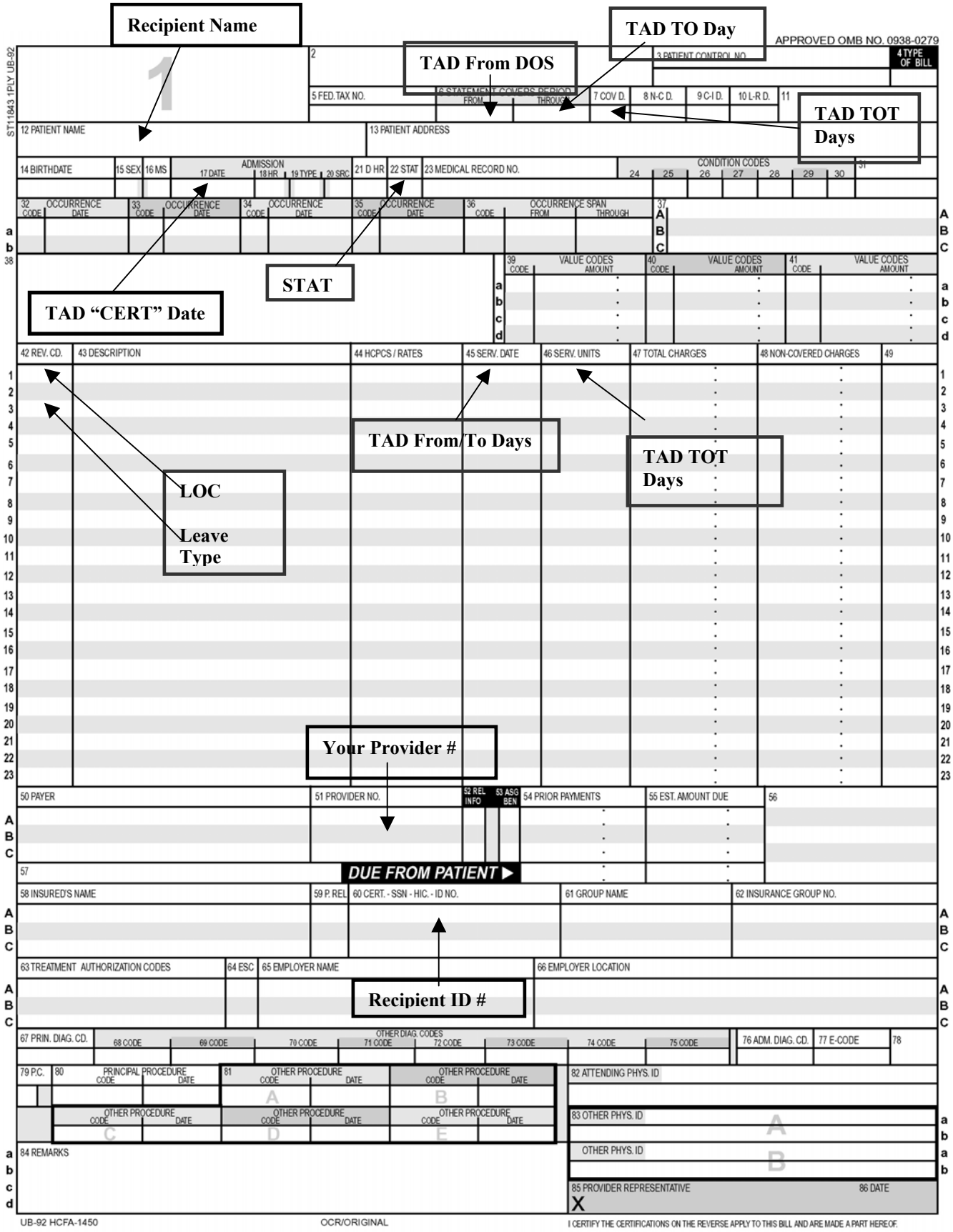
FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		inpatient care 06 Discharged/transferred to home under care of organized home health services organization 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of Home IV (Intravenous Therapy) provider 09 Admitted as inpatient to a hospital 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

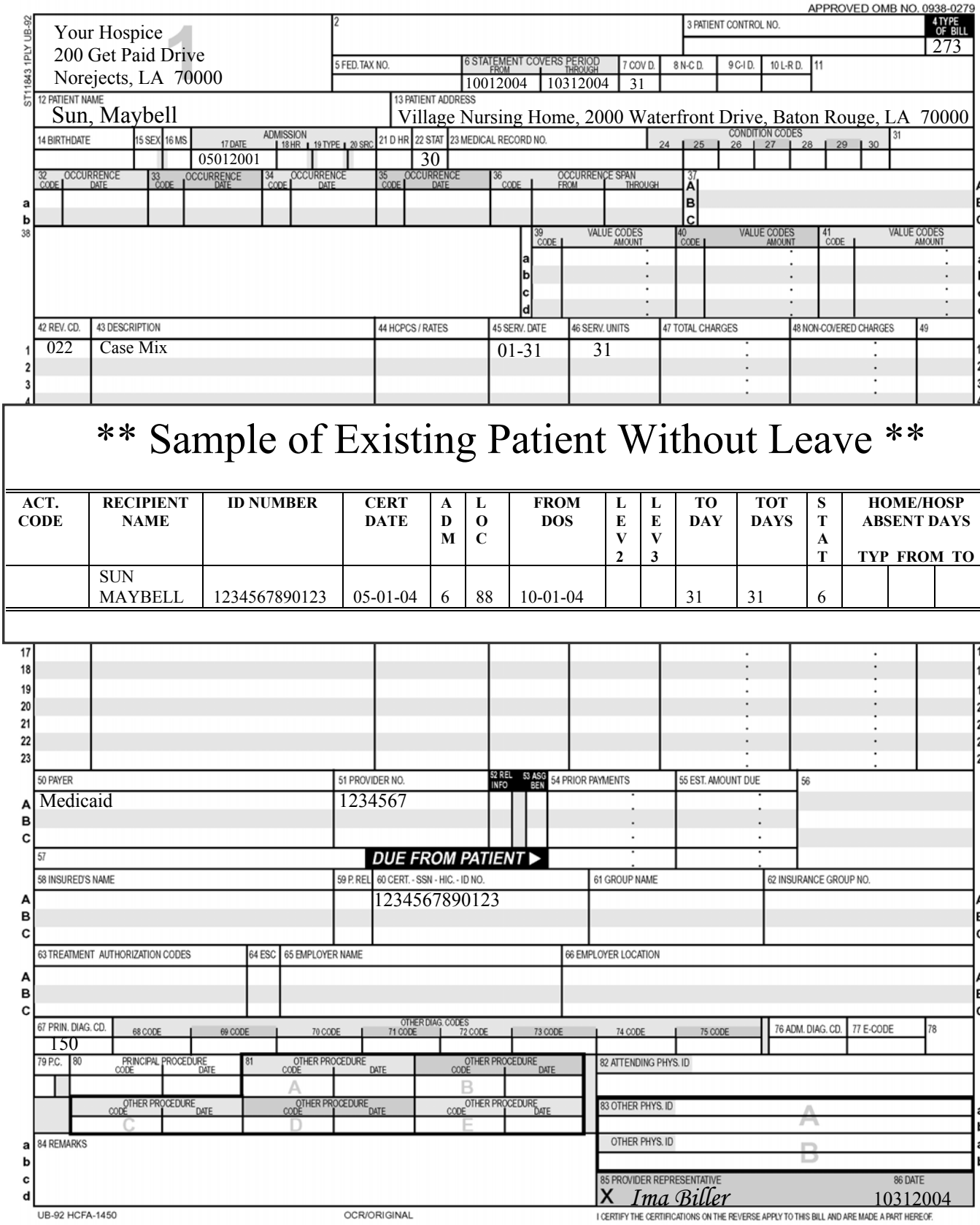
FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 42-43	REV CD/DESCRIPTION	**Required. 3-digit numeric** Enter the applicable revenue code(s) and description(s) that identify the service provided. Bill a Level of Care (LOC) Revenue Code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill LA Medicaid: Revenue Code & Description *Level of Care* 183 Leave of Absence – Subcategory Therapeutic *A* *Home Leave* 185 Leave of Absence – Subcategory Nursing Home (for Hospitalization) *B* *Hospital Leave* **FOR HOSPICE 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)* 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*
FIELD NO. 44	HCPCS/RATES	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
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. (Example 1: If SNF PPS care (Revenue Code 022) 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 06 – 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. **A Revenue Code indicating a specific LOC cannot be listed more than once.**)
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.). **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 on this claim by TPL or 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 4184562646500 02 Void: V 4205164253000 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 TO Day
TAD From DOS
TAD TOT Days
APPROVED OMB NO. 0938-0279
ST11843 1PLY UB-92
4 TYPE OF BILL
12 PATIENT NAME
13 PATIENT ADDRESS
TAD "CERT" Date
STAT
TAD From/To Days
TAD TOT Days
LOC
Leave Type
Your Provider #
DUE FROM PATIENT
Recipient ID #
UB-92 HCFA-1450
OCR/ORIGINAL
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 Your Hospice
200 Get Paid Drive
Norejects, LA 70000

2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL: 273

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD: FROM 10012004 THROUGH 10312004 | 7 COV D.: 31 | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Sun, Maybell

13 PATIENT ADDRESS: Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000

14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION: 17 DATE 05012001 | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT: 30 | 23 MEDICAL RECORD NO. | CONDITION CODES: 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE / DATE | 33 OCCURRENCE CODE / DATE | 34 OCCURRENCE CODE / DATE | 35 OCCURRENCE CODE / DATE | 36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37

38

39 VALUE CODES CODE / AMOUNT | 40 VALUE CODES CODE / AMOUNT | 41 VALUE CODES CODE / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
022	Case Mix		01-31	31			

** Sample of Existing Patient Without Leave **

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
	SUN MAYBELL	1234567890123	05-01-04	6	88	10-01-04			31	31	6			

50 PAYER: Medicaid | 51 PROVIDER NO.: 1234567 | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 DUE FROM PATIENT ▶

58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO.: 1234567890123 | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.: 150 | OTHER DIAG. CODES: 68 69 70 71 72 73 74 75 | 76 ADM. DIAG. CD. | 77 E-CODE | 78

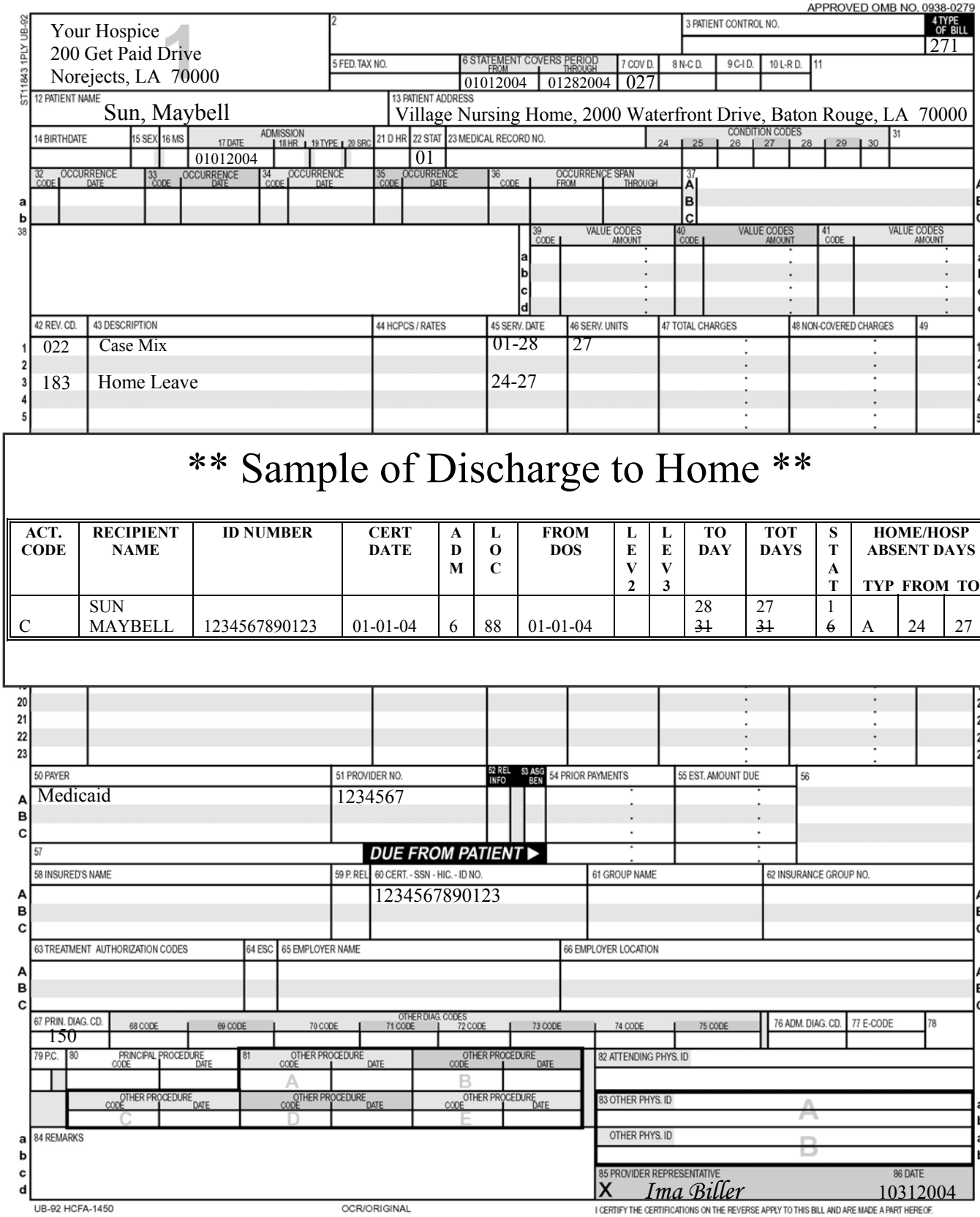
79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE (A) | OTHER PROCEDURE CODE / DATE (B) | OTHER PROCEDURE CODE / DATE (C) | OTHER PROCEDURE CODE / DATE (D) | OTHER PROCEDURE CODE / DATE (E)

82 ATTENDING PHYS. ID | 83 OTHER PHYS. ID | OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Ima Biller | 86 DATE: 10312004

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 Your Hospice
200 Get Paid Drive
Norejects, LA 70000

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL: 271

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM 01012004 THROUGH 01282004

7 COV D.: 027

8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Sun, Maybell

13 PATIENT ADDRESS: Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000

14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION 17 DATE: 01012004 | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT: 01 | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	022	Case Mix		01-28	27			
2								
3	183	Home Leave		24-27				
4								
5								
20								
21								
22								
23								

50 PAYER: Medicaid | 51 PROVIDER NO.: 1234567 | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 DUE FROM PATIENT ▶

58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO.: 1234567890123 | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.: 150 | OTHER DIAG. CODES 68 69 70 71 72 73 74 75 | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A | OTHER PROCEDURE CODE DATE B

OTHER PROCEDURE CODE DATE C | OTHER PROCEDURE CODE DATE D | OTHER PROCEDURE CODE DATE E

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID A

OTHER PHYS. ID B

84 REMARKS

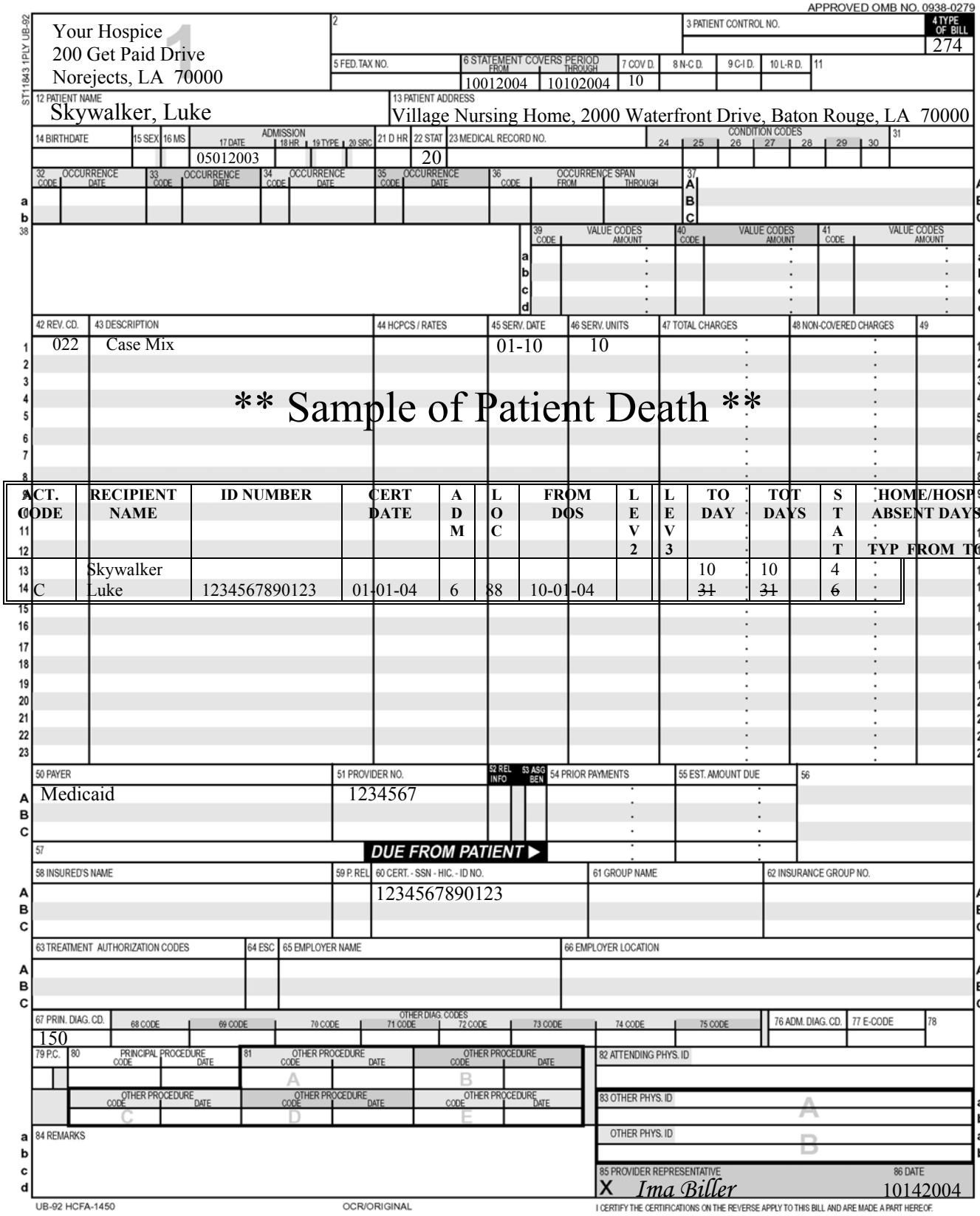
85 PROVIDER REPRESENTATIVE: X *Ima Biller* | 86 DATE: 10312004

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 Discharge to Home **

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	SUN MAYBELL	1234567890123	01-01-04	6	88	01-01-04			28 ~~31~~	27 ~~31~~	1 ~~6~~	A	24	27



APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 Your Hospice
200 Get Paid Drive
Norejects, LA 70000

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL: 274

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM 10012004 THROUGH 10102004

7 COV D.: 10

8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Skywalker, Luke

13 PATIENT ADDRESS: Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000

14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION 17 DATE: 05012003 | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT: 20 | 23 MEDICAL RECORD NO.

CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
022	Case Mix		01-10	10			

** Sample of Patient Death **

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
	Skywalker								10	10	4			
C	Luke	1234567890123	01-01-04	6	88	10-01-04			~~31~~	~~31~~	~~6~~			

50 PAYER: Medicaid | 51 PROVIDER NO.: 1234567 | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 DUE FROM PATIENT ▶

58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO.: 1234567890123 | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.: 150 | OTHER DIAG. CODES 68 69 70 71 72 73 74 75 | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A | OTHER PROCEDURE CODE DATE B | 82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE DATE C | OTHER PROCEDURE CODE DATE D | OTHER PROCEDURE CODE DATE E | 83 OTHER PHYS. ID A

84 REMARKS | OTHER PHYS. ID B

85 PROVIDER REPRESENTATIVE: X *Ima Biller* | 86 DATE: 10142004

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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 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 400012646500 02	Void: V 4000164253000 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.

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: ABC Provider

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
10012004	10312004	31	3000008100000	$175.00	30	

ADJUSTMENT

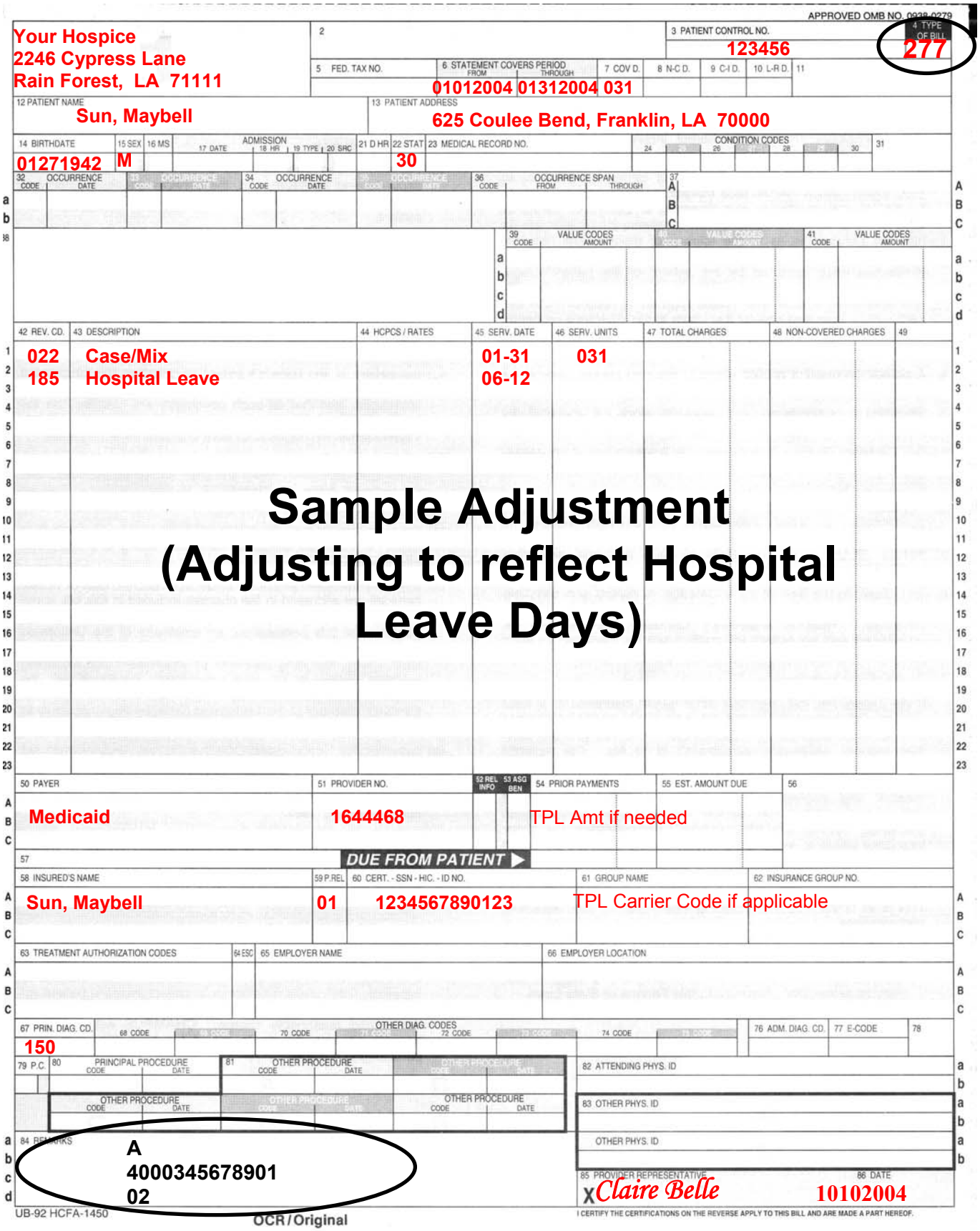
AUTHORIZED SIGNATURES

13. FACILITY Jane Friday DATE 11152004

14. PARISH OFS _____ DATE _____

FISCAL AGENT COPY

UNISYS 148/PLI


APPROVED OMB NO. 0938-0279
Your Hospice
2246 Cypress Lane
Rain Forest, LA 71111
3 PATIENT CONTROL NO.
123456
4 TYPE OF BILL
277
6 STATEMENT COVERS PERIOD
01012004 01312004 031
12 PATIENT NAME
Sun, Maybell
13 PATIENT ADDRESS
625 Coulee Bend, Franklin, LA 70000
14 BIRTHDATE
01271942
15 SEX
M
22 STAT
30
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
022
Case/Mix
01-31
031
185
Hospital Leave
06-12
Sample Adjustment
(Adjusting to reflect Hospital
Leave Days)
50 PAYER
51 PROVIDER NO.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
Medicaid
1644468
TPL Amt if needed
DUE FROM PATIENT
58 INSURED'S NAME
59 P.REL
60 CERT. - SSN - HIC. - ID NO.
61 GROUP NAME
62 INSURANCE GROUP NO.
Sun, Maybell
01
1234567890123
TPL Carrier Code if applicable
67 PRIN. DIAG. CD.
150
A
4000345678901
02
82 ATTENDING PHYS. ID
85 PROVIDER REPRESENTATIVE
X Claire Belle
86 DATE
10102004
UB-92 HCFA-1450
OCR/Original
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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, 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 (800) 339-9313
Questions concerning the RAVEN software

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

HOSPICE CARE

Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible. A recipient must be terminally ill in order to receive Medicaid hospice care. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

> It has come to the attention of the Department that some hospice agencies are encouraging recipients to revoke hospice when they have an inpatient admission and re-elect hospice after discharge from the hospital. **THIS IS AGAINST MEDICAID HOSPICE POLICY.**

Reimbursement

Medicaid reimbursement for hospice care is made at one of four predetermined per diem rates for each day in which a Medicaid recipient is under the care of the hospice (with the exception of payment for physician services). The rates are calculated based on the geographic location (Metropolitan Statistical Area – MSA) where the services are furnished.

Documentation Requirements

An election statement for hospice care must be filed by the recipient or by a person authorized by law to consent to medical treatment for the recipient. For dually eligible recipients, hospice care must be elected for both the Medicaid and Medicare programs simultaneously**. The provider must submit a copy of the BHSF Notice of Election Form (81A or 82A) to the Bureau's Hospice Manager for every recipient who elects Medicaid Hospice.** . Additionally, providers are required to complete a Certification of Terminal Illness (CTI). For dually eligible recipients, it is acceptable for providers to use Medicare's CTI.

☞ **To ensure optimal reimbursement providers should make every effort to submit the required documents in a timely fashion**.

HOSPICE NOTICE OF ELECTION AND CERTIFICATION OF TERMINAL ILLNESS FORMS

Election Form

The hospice must obtain the recipient's signed Election Form (BHSF – Hospice) and at least the verbal verification of the terminal illness (BHSF Form Hospice – TI) within 2 days of the recipient signature date on the election form. Both forms must be submitted to the Bureau of Health Services Financing (BHSF) no later than 2 days from the recipient signature date on the election form.

Certification of Terminal Illness

The hospice must obtain Certification of Terminal Illness no later than 2 calendar days after hospice care is initiated. If written certification is not obtained within 2 calendar days, verbal verification from the physician must be received by a interdisciplinary team member and the verbal verification section on the form must be completed and submitted to BHSF within 2 calendar days following the initiation of hospice care. Once the Certification of Terminal Illness has been obtained, BHSF Form Hospice – TI must be received by the Bureau of Health Services Financing (BHSF) within 8 days of the verbal verification.

Note: **If the Notice of Election Form and the Certification of Terminal Illness are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date that BHSF receives the completed documentation.**

Once the recipient hospice election and the Certification of Terminal Illness forms have been received by BHSF, the hospice election information will be loaded on the recipient's Medicaid file. Claims will not process and pay until the hospice election segment is loaded on the Medicaid files. If a hospice claim is received prior to the Medicaid files being updated, the claim will pend for three (3) weekly RA cycles waiting for the files to be updated with the hospice election information. If the files are not updated within the three (3) weeks, the claim will then deny stating the recipient was not hospice eligible.

NOTE: Please make sure that the Election Form, Certification of Terminal Illness and any necessary attachments are properly completed prior to submitting to BHSF. This will help ensure that recipient Medicaid files are updated timely.

- The hospice provider **MUST** obtain written certification of terminal illness **FOR EACH ELECTION PERIOD**. For the initial 90-day period and the subsequent 90-day period, the certification may be completed 2 weeks prior to the beginning of each election period. Once periods requiring PA begin, the certification may be completed at least 10 calendar days prior to the end of a preceding period.

Hospice Recipient Election/Cancellation/Discharge Notice BHSF Form Hospice

Purpose:

The BHSF Form Hospice is used to notify Department of Health & Hospitals, Bureau of Health Services Financing's Hospice Manager of a Medicaid hospice recipient's voluntary election or cancellation of the Hospice Program as provided by Louisiana Medicaid. It is also used to update changes in the Medicaid hospice recipient's condition and status.

Preparation:

The first section of the form is to be completed by the patient or legal representative. The signature of the patient or legal representative is required.

Admission/Election Date (Required):

Enter the admission/election date, which is the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days, and is the same as the certification date if the certification is not completed on time.

Note: **If the Notice of Election Form and the Certification of Terminal Illness are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date that BHSF receives the proper documentation.**

EXAMPLE: The hospice election date (admission) is January 1, 2004. The physician's certification is dated January 3, 2004. The hospice date for coverage and billing is January 1, 2004. The first hospice benefit period ends 90 days from January 1, 2004.

Show the month, day, and year numerically as MM-DD-YYYY.

The admission date will change when the patient re-elects hospice anytime after a revocation or discharge.

Detailed instructions for items required for the Notice of Election:

Type of Bill (Required):

Enter the three-digit numeric type of bill code: 81A, B, C, D, or 82A, B, C, D, as appropriate. 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:

1st Digit - Type of Facility

8 - Special facility (hospice)

2nd Digit - Classification

1 - Hospice (Non-hospital based)
2 - Hospice (Hospital based)

3rd Digit - Frequency	Definition
A - Hospice Admission Notice	Use when the hospice is submitting Form as an Admission Notice.
B - Hospice Termination/ Revocation Notice	Use when the hospice is submitting Form as a notice of termination/revocation for a previously posted hospice election.
C - Hospice Change of Provider Notice	Use when Form is used as a Notice of Change to the hospice provider.
D - Hospice Election Void/Cancel	Use when Form is used as a Notice of a Void/Cancel of hospice election.
E - Hospice Change of Ownership	Use when Form is used as a Notice of Change in Ownership for the hospice.

Statement Covers Period:

This field should be used when filing an 81B/82B document only. The “From” date is the start date of the period from which the patient is revoking. The “Through” date is the date of revocation.

Patient's Name (Required):

Enter the patient’s last name, first name, and middle initial.

Patient's Medicaid ID Number (Required):

Enter the recipient's 13-digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid "swipe" card, e-MEVS, or through REVS. Make certain that the last two digits are the correct individual suffix for your recipient. The number must match the recipient's name.

Patient's Address (Required):

Enter the patient's complete mailing address, including Zip code.

Patient's Date of Birth (Required):

Enter the month, day, and year of birth (MM-DD-YYYY) of patient. Example: 06121903 If the full correct date is not known, zero fill the field.

Patient's Medicare Number (Required, if applicable):

This field should only be used if the patient has Medicare. Enter the patient's Medicare health insurance number.

Principal Diagnosis Code (Required):

Use the most specific, and accurate numeric ICD-9-CM diagnosis code for the terminal illness that is current. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. CMS only accepts ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-I260, or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. **Use full ICD-9-CM diagnoses codes including all five digits where applicable.**

Other Diagnosis Codes (Required, if applicable):

Enter the full ICD-9 codes, including all five digits where applicable, for any other terminal diagnosis or related condition.

Hospice Name and Address:

Enter the following: Provider Name, Street Name and Number or P. O. Box Number, City, State, and ZIP code, Telephone Number Required, FAX number is optional.

Provider Number (Required):

Enter the seven (7) digit Medicaid provider identification number.

Attending Physician I.D and Name (Required):

Enter the seven (7) digit Medicaid provider identification number and name of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.

Other Physician I.D. (Required):

Enter the word "employee" or "non-employee" here to describe the relationship the patient's attending physician has with the hospice. "Employee" also refers to a volunteer under your jurisdiction.

Name of Nursing Facility or ICF-MR (Required, if applicable):

Enter the name of the facility in which the individual resides or intends to reside. Medicaid field office staff handles long-term care cases.

Mail or fax the original form to the address below. Fax is preferred due to the time frames involved.

Hospice Manager
Louisiana Medicaid/Bureau of Health Services Financing
Program Operations, Bin # 24
P.O. Box 91030
Baton Rouge, LA 70821-9030
FAX: (225) 342-1411

Medicaid Program
Hospice Recipient Election/Cancellation/Discharge Notice

TO BE COMPLETED BY PATIENT OR LEGAL REPRENTATIVE

I elect to receive Hospice from the provider named below effective _____
Admission Date

PATIENT'S DECLARATION

I understand and acknowledge:

- Medicaid Hospice consists of the following election periods:
  An initial 90-day period;
  a subsequent 90-day period; and
  subsequent periods of 60 days each.
- if I reach a point of stability, and am no longer considered terminally ill, that the Hospice will be unable to certify me, and I will return to the traditional Medicaid services, if applicable.
- by electing Medicaid Hospice, I waive all rights to Medicaid covered services related to the treatment of my terminal illness(es).
- if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit simultaneously with Medicaid Hospice.
- By this election, I have been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to my terminal illness(es).

_____ _____
Signature of Patient or Legal Representative Date signed

TO BE COMPLETED BY THE HOSPICE PROVIDER

_____ _____ _____
Type of Bill FROM THROUGH
Statement Covers Period

_____ _____
Patient's Name Patient's Medicaid ID Number

_____
Patient's Address

_____ _____
Patient's Date of Birth Patient's Medicare Number

_____ _____
Principal Diagnosis Code Other Diagnosis Codes

_____
Hospice Name and Address

_____ _____ _____
Provider Number Attending Physician I.D. & Name Other Physician I.D.

_____ _____
Provider Representative Signature Date signed

CERTIFICATION OF TERMINAL ILLNESS

The hospice must obtain written certification of terminal illness for each of the election periods, even if a single election continues in effect for two or more periods. Written certifications may be completed two weeks before the beginning of each election period, except that for periods requiring prior approval, written certifications may be completed 20 to 30 calendar days prior to the end of a preceding election period.

> For the first 90-day period of coverage, the hospice must obtain certification of the terminal illness no later then 2 calendar days after hospice care is initiated (by the end of the third calendar day). If written certification is not obtained within 2 calendar days following the initiation of hospice care, a verbal certification must be received within 2 calendar days following the initiation of hospice care, with a written certification obtained no later then eight days after care is initiated. If these requirements are not met, reimbursement is not available for the days prior to the certification. Reimbursement will be effective on the date that BHSF receives the completed TI Form.

For the subsequent periods, a written certification must be on file in the recipient's record prior to the submission of a claim.

Hospice staff must make an appropriate entry in the patient's clinical record as soon as they receive an oral certification and file written certification in the clinical record.

THE CERTIFICATION FORM (BHSF FORM HOSPICE-TI)

The hospice must use the BHSF Form Hospice-TI (Certification of Terminal Illness Form) for documentation of written and verbal certification of terminal illness for Medicaid only recipients. A sample of this form is provided on the following page. For dually eligible recipients, the form that is used for Medicare Certification of Terminal Illness, which also meets the requirements as detailed in this section, may be used.

The certification must specify that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. The certification shall be based on the physician's clinical judgment regarding the normal course of the individual's illness and must include the signature(s) of the physician(s). A stamped physician's signature is not acceptable on the certification.

If verbal certification is made, the referral from the physician must be received by a member of the hospice interdisciplinary group (IDG), The entry of the verbal certification in the patient's clinical record must include, at a minimum, the patient's name, physician's name, terminal diagnosis(es), prognosis, and the name and signature of the IDG member taking the referral.

Submission of the physician's Certification of Terminal Illness is required for the initial election period and for those periods requiring prior authorization. However, copies of certification forms for all election periods shall be made available to the Bureau upon request.

SOURCES OF CERTIFICATION

For the initial 90-day period, the hospice must obtain a completed certification form or documented receipt of a verbal certification statement, if applicable, from:

- the hospice's medical director or a physician member of the hospice's interdisciplinary group; and

- the recipient's attending physician if he/she has an attending physician. The attending physician must be a doctor of medicine or osteopathy and must be identified by the recipient, at the time of election for hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

For subsequent periods, the certification form may be completed by either the medical director of the hospice or the physician member of the hospice interdisciplinary group.

BHSF Form Hospice-TI
Issued 06/02

Medicaid Hospice Program
Certification of Terminal Illness

Patient's Name | Patient's Medicaid ID Number | Patient's Date of Birth

First Benefit Period (90 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Attending Physician | Signature of Hospice Medical Director or physician member of interdisciplinary group

Date signed | Date signed

Second Benefit Period (90 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Hospice Medical Director or physician member of interdisciplinary group | Date signed

Third Benefit Period (60 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Hospice Medical Director or physician member of interdisciplinary group | Date signed

Fourth Benefit Period (60 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Hospice Medical Director or physician member of interdisciplinary group | Date signed

Note: If additional periods are to be certified use an additional form

VERBAL VERIFICATION (within two days of election date)

I certify that on the date signed below a verbal verification was obtained from the physician named below, confirming that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

Physician's Name | Terminal diagnosis(es)

Name of IDG member taking referral | Signature of IDG member taking referral | Date signed

PRIOR AUTHORIZATION

At this time, the PA-88 authorization form is not being used. Until you receive notice of the effective date of this form, providers requesting prior authorization (PA) of services should send the following: (1) a letter of request on hospice letterhead; (2) Certification of Terminal Illness form signed by the Hospice Medical Director or physician member of the interdisciplinary group for the period PA is being requested; (3) updated Plan of Care; (4) updated Physician's Orders; (5) Progress Notes for all services rendered; (6) Social Evaluation; and (7) any other documentation supporting the continuation of hospice services. The packet should be mailed to:

Hospice Program Manager
Bureau of Health Services Financing
Program Operations, Bin #24
P.O. Box 91030
Baton Rouge, LA 70821-9030

Prior authorization is required after the initial 180 days of hospice coverage. Prior authorization requests should be submitted 20-30 days before the end of the 180 days. If the PA is approved, it covers sixty (60) days. If another 60-day election period is required, the PA request should be submitted at least ten (10) days prior to the end of the current election period. This will ensure that requests are received and approved/denied before the preceding period ends.

Note: Prior authorization is not required for the initial 90-day election period or the subsequent 90-day election period. It is required for all subsequent 60-day election periods.

HOSPICE BILLING AND EDIT CLARIFICATIONS

The expansion of the Louisiana Medicaid Hospice Program on July 1, 2002 resulted in a number of changes in policy, procedures, and systems programming.

As we have monitored these changes in Program activity and received feedback from the provider community, claims billing and processing issues were identified and addressed in the following areas:

Revenue Code Clarifications

Routine Home Care Revenue Code 651 should be used for the following situations:

1. The day of discharge when a recipient is discharged ALIVE from general inpatient care or respite care.
2. The recipient is in a non-contracted facility.
3. The recipient is in a facility for a reason unrelated to the terminal condition.
4. Fewer than 8 hours of continuous care are provided to the recipient.

Continuous Home Care Revenue Code 652 should be used for the following situations:

1. During brief periods of crisis when a recipient requires continuous care which is primarily nursing care. Homemaker and aide services may also be provided to supplement the nursing care.
2. A minimum of 8 hours of care must be provided during a 24-hour day which begins and ends at midnight.
3. The Continuous Home Care rate is divided by 24 hours in order to arrive at an hourly rate.
4. The provider should bill for the total number of hours and they should be listed in the units field next to revenue code 652.

Inpatient Respite Care Revenue Code 655 should be used for the following situations:

1. When a recipient is receiving care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home.
2. The day of admission to the inpatient facility.
3. The day of discharge when a recipient EXPIRES while receiving respite inpatient care.
4. A maximum of 5 consecutive days at a time including the date of admission, but not counting the date of discharge alive.

General Inpatient Care Revenue Code 656 should be used for the following situations:

1. The day of admission to the inpatient facility when the admission <u>is related</u> to the recipient's terminal diagnosis.
2. The day of discharge when a recipient EXPIRES while receiving general inpatient care.
3. When the recipient is in an inpatient facility that has a contract with the hospice agency.

CommunityCARE Exclusion

Changes have been made in the programming logic to exclude Hospice services from requiring a CommunityCARE referral. Hospice claims are now exempt from the CommunityCARE system edits and should process without a CommunityCARE PCP referral.

Medicare Part B Only Recipients

Claims for recipients that have Medicare Part B ONLY on the recipient's Medicaid files (DO NOT have Medicare Part A on the recipient file) are now exempt from the Medicare 275 edit. The Medicaid Recipient Resource File must reflect this information for these claims to be excluded from this edit. If the file indicates the recipient has Medicare Part A (even if incorrect), claims will not be excluded from this edit until the Medicare information is verified by Medicaid and the file is corrected.

Program Edits

The following edits are now in place:

Edit 494 (Invalid MSA Code) This edit is received when the MSA code entered in the Value Code Fields 39-41 is not a valid MSA code. Please remember that the MSA code must appear to the left of the delimiter in the amount field, and double zeros (00) must appear to the right of the delimiter in the amount field.

Edit 495 (Not Hospice Eligible) The recipient file does not indicate the recipient has elected Hospice. These claims will pend systematically for three (3) weekly cycles before denying with this edit.

Edit 511 (Provider/Recipient Mismatch) If the claim submitted is for a Hospice provider, but that Hospice provider is not the provider linked to the recipient on the date of service billed, the billing Hospice provider will receive this edit denying the claim, because the provider ID number on the claim must match the provider ID number on the recipient's linkage file.

Edit 493 (Non-Hospice Provider) The hospice agency is responsible for either providing or paying for all covered services related to the treatment of the recipient's terminal illness. If claims are received from providers other than the hospice provider of record, those claims must have documentation attached to justify that the services were medically necessary and were not related to the terminal condition for which hospice care was elected. These claims will pend to the Unisys Medical Review Department to determine if the services being billed are not related to the hospice condition. If the services are not related to the hospice condition, the claims will be released for payment. If the services are related to the hospice condition, the claims will be denied with this edit. The servicing provider should obtain payment for these services from the hospice agency.

Edit 042 (Invalid UB-92 Bill Type Code) If hospice claims are received with a Bill Type that is not "81" or "82", the claims will deny for this edit.

Edit 085 (Invalid Units/Visits) If hospice claims are received with a correct Bill Type, but the dates of service and the units do not match, the claims will deny for this edit.

Edit 303 (Inpatient Respite Days Greater Than Five) Payment for respite care will be reimbursed for a maximum of five consecutive days at a time (including the date of admission but not including the date of discharge.) **NOTE:** Medicaid will pay for the date of death.

Edit 358 (No Valid Rate was found for LTC Level of Care) This edit is received when the Hospice recipient does not have a Nursing Home (LTC) provider number on the Hospice Link File. This edit will be resolved by DHH/BHSF.

BILLING HOSPICE SERVICES ON THE UB-92

UB-92 billing for Hospice services has not changed. Instructions for completion of the claim form for Hospice services, as well as a sample claim form follow.

Field 1. (Untitled) - Provider Name, Address, and Telephone Number
Required. The minimum entry is the provider's name, City, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. This information is used to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Field 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. 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

1st Digit - Type of Facility
8 - Special facility (hospice).

2nd Digit - Classification
1 - Hospice (Non-hospital based)
2 - Hospice (Hospital based)

3rd Digit - Frequency	Definition
1 - Admit Through Discharge Claim	Use this code for a bill encompassing an entire course of hospice treatment for which you expect payment, i.e., no further bills will be submitted for this patient.
2 - Interim - First Claim	Use this code for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	Use this code when a payment bill for a hospice course of treatment has been submitted and further bills are expected to be submitted.
4 - Interim - Final Claim	Use this code for a payment bill which is the last of a series for a hospice course of treatment. The "Through" date of this bill (Field 6) is the discharge date or date of death.
7 - Replacement of Prior Claim	Use this code to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. Submit a code "7" (Replacement of Prior Claim) to show the corrected information.

Field 6. Statement Covers Period (From-Through)
Required. Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YYYY). Do not show days before the patient's entitlement began. The "From" date is used to determine timely filing. Be sure that the “From” date does not overlap with the “Through” date on your prior bill.

Field 12. Patient's Name
Required. Enter the patient's last name, first name, and middle initial at the time services were rendered.

Field 13. Patient's Address
Required. Enter the patient=s full mailing address, including street number and name, post office box number, city, state (2-digit alpha), and valid zip code (minimum of 5 digits).

Field 14. Patient's Birth Date
Required. Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, zero fill the field.

Field 15. Patient's Sex
Required. Enter an "M" for male or an "F" for female.

Field 17. Admission Date
Required. Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. On the first claim, the date of admission should match the From date in the Statement Covers Period (Field 6). The date of admission may not precede the physician's certification by more than 2 calendar days.

Note: **If the Notice of Election Form and the Certification of Terminal Illness are not received within 10 calendar days, the date of admission (election) will be the date that BHSF receives the proper documentation.**

EXAMPLE: The hospice election date (admission) is January 1, 2004. The physician's certification is dated January 10, 2004. The hospice admission date for coverage and billing is January 8, 2004. The first hospice benefit period will end 90 days from January 8, 2004.

Show the month, day, and year numerically as MM-DD-YYYY.

Field 22. Patient Status
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).
30	Still patient or expected to return for outpatient services.
40	Expired at home.
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice.
42	Expired - place unknown.

Verify that patient’s status matches type of bill (Field 4).
Example: 811 or 821 bill types should have a patient status of 01, 40, 41, or 42.

Fields 32, 33, 34, and 35. Occurrence Codes and Dates

Required. Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YYYY). If there are more occurrences than there are spaces on the form, use Field 36 (occurrence span) or Field 84 (remarks) to record additional occurrences and dates.

Use the following codes where appropriate:

Code		Definition
27*	Date of Hospice Certification	Code indicates the date of written certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
42	Termination date	Enter code to indicate the date on which recipient terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.)

* This occurrence code must be present in order to show when certification occurred for each new benefit period. If the occurrence code 27 with a date is not present for each certification or re-certification of an individual, the claim will reject.

Claims that are submitted between certifications or prior to the due date of the next certification do not require occurrence code 27. Any claim that starts a new hospice period or that contains services that overlap the next hospice period must show the occurrence code 27 and the re-certification date.

Field 36. Occurrence Span Code and Dates

Not Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY. Use the following code where appropriate:

Code	Title	Definition
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients.

Note: If more than 1 episode of Inpatient Respite Care occurred during the billing period, record those episodes beyond the first episode in Field 84. Remarks

Fields 39-41. Value Code.

Required. Hospices are required to submit claims for payment for hospice care based on the geographic location where the service(s) was provided. The Value Code and Metropolitan Statistical Area (MSA) code/rural state code for each service are required for correct claim payment. (The current MSA code listing is found at the end of this packet in Appendix A.)

Value codes must be entered horizontally across the line to match the corresponding revenue codes listed vertically in Field 42. In other words, enter fields 39a, 40a, 41a before fields 39b, 40b, 41b, and so forth. (The first line of “a” codes is used before entering information in “b” codes.) Enter value code 61 in the “code” section of the field; the MSA code/rural state code in the dollar portion of the “amount” section of the field; and double zeros (00) in the “cents” portion of the “amount” section of the field.

Multiple Occurrences of the Same Service: Enter the value codes/MSAs multiple times if there are multiple occurrences of the same service during the same month. (See further explanation under Fields 42 and 45.)

Field 42. Revenue Code

Required. 3-digit numeric. Assign a revenue code for each service provided in order to be paid properly. Revenue codes should be listed vertically in ascending order. If more than one (1) occurrence of any hospice service occurs during the billing period list each occurrence of that revenue code on a separate line in ascending order. (See field 45 for instructions for associated dates of service.)

Example:	651 Routine Home Care	07/01/04
	651 Routine Home Care	07/08/04
	652 Continuous Home Care	07/06/04
	656 General Inpatient Care	07/31/04

Use these revenue codes to bill Medicaid:

Code	Description	Standard Abbreviation
651	Routine Home Care	RTN Home
652	Continuous Home Care	CTNS Home (A minimum of 8 hours, **not necessarily consecutive,** in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is reported as 1 hour.)
655	Inpatient Respite Care	IP Respite
656	General Inpatient Care	GNP IP
657	Physician Services	PHY Ser **(must be accompanied by a physician procedure code)**

NOTE: Revenue code 001 (Total Charges) MUST always be the final revenue code.

Field 43.--Revenue Description

Not Required. Enter a narrative description or standard abbreviation for each revenue code shown in Field 42 on the adjacent line in Field 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown under Field 42.

Field 44. HCPCS Rates

Required if applicable. When using Revenue Code 657 (Physician Services), enter the appropriate CPT-4 code for the physician's professional services. Procedure codes should be obtained from the physician providing the service and are required in order for the intermediary to make reasonable charge determinations when paying you for physician services.

Field 45. Service Date
Required. A service date MUST BE ENTERED for each revenue code indicated. The service date should be the first date that a service began.

Multiple Occurrences of the Same Service: If the same service occurs multiple times during a month of service (i.e., there is a break in the service dates for that service – not consecutive dates), that service must be entered multiple times on separate lines. In these cases, the initial date for that SEGMENT of that service should be used as the Service Date (see example under Field 42). In other words, if routine care is provided beginning the first day of the month of service for 5 days; the patient then has continuous care beginning the sixth day of the month for 2 days; followed by routine care again for the eighth day through the 30th of the month, the revenue code for routine care should be indicated twice – one entry with a service date of the first day of the month and one entry with a service date of the eight day of the month.

Field 46. Units of Service
Required. Enter the number of units of service for each type of service on the line adjacent to the revenue code, description, and service date.

Units of Revenue Code 651 (Routine Care) are measured in DAYS.
Units of Revenue Code 655 (Inpatient Respite Care) are measured in DAYS.
Units of Revenue Code 656 (General Inpatient Care) are measured in DAYS.
Units of Revenue Code 657 (Physician Service) are measured in PROCEDURES.
Units of Revenue Code 652 (Continuous Care) are measured in HOURS.
(Remember that a minimum of 8 hours-not necessarily consecutive-in a 24-hour period is required. Less than 8 hours is considered routine care.)

Please be sure that the units and dates billed for each occurrence match.

Field 47. Total Charges
Required. Enter the total charges for the billing period by revenue code (Field 42) on the adjacent line in Field 47. The last revenue code entered in Field 42 ("000l") represents the grand total of all charges billed. The total is in Field 47 on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

Fields 50. Payer Identification
Required. If Medicaid is the primary payer, enter "Medicaid" on line A.

Field 51. Provider Number
Required. Enter the seven (7) digit Medicaid provider identification number.
It must be entered on the same line as "Medicaid" in Field 50.

Field 60. Patients Medicaid ID Number
Required. Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid "swipe" card, through e-MEVS or REVS. Make certain that the last two digits are the correct individual suffix for your recipient. If the number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.

Field 67. Principal Diagnosis Code
Required. Use the most specific and accurate full ICD-9-CM diagnosis code for the terminal illness that is current. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. CMS only accepts ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-l260, or

CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Use full ICD-9-CM diagnoses codes including all five digits where applicable.

Field 68-75. Other Diagnostic Codes
(Required if applicable). Enter the full ICD-9-CM diagnosis codes, including all five digits where applicable, for any other terminal diagnoses or related conditions.

Field 82. Attending Physician I.D.
Required. Enter the seven (7) digit Medicaid provider identification number and name (last, first name and middle initial) of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.

Field 83. Other Physician.
Required. Enter the word "employee" or "non-employee" in reference to whether the attending physician entered in Field 82 is an employee of the hospice. If the attending physician volunteers for the hospice, he or she is considered an employee.

Field 84. Remarks
Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.

Field 85-86. Provider Representative Signature and Date
Required. A hospice representative verifies that the required physician's certification, and a signed hospice election statement are in the records before signing Form UB-92. A stamped signature is acceptable in field 85. Also enter the date the provider representative signed the form.

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.

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 Your Hospice
200 Get Paid Drive
Norejects, LA 70000

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL: 813

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM 10012004 THROUGH 10312004

7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Sun, Maybell

13 PATIENT ADDRESS: Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
01201919	F		10012004					30			

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a	27	10012004										A
b												B
												C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	61	9919 .00	61	9919 .00	61	9919 .00
b	61	7680. 00				
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	651	Routine Home Care		10012004	5	450.00		
2								
3	651	Routine Home Care		10082004	23	900.00		
4								
5	652	Continuous Home Care		10062004	16	300.00		
6								
7	656	General Inpatient Care		10312004	1	200.00		
8								
9	657	Physician Services	99341	10302004	1	130.00		
10								
11								
12								
13	001	Total Charges				1980.00		
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

** Sample of Routine Home Care **

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid	1234567					
B							
C							
57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A			1234567890123		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
9494											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID: Dr. David Doe #7654321

83 OTHER PHYS. ID: Employee (A)

OTHER PHYS. ID (B)

84 REMARKS

85 PROVIDER REPRESENTATIVE: X *Ima Biller*

86 DATE: *10312004*

UB-92 HCFA-1450 OCR/ORIGINAL

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

THE REMITTANCE ADVICE

Unisys Provider Relations responds to inquiries concerning particular claims when the provider has reconciled the remittance advice (RA) and determined that the claims have denied, pended, paid or been rejected prior to entry into the system. It is not possible for Unisys Provider Relations or DHH to take the place of the provider's weekly RA by checking the status of numbers of claims on which providers, billers or collections agencies are checking. **All providers are responsible for reconciling their weekly remittance advices. Please reconcile your RA before calling DHH or Unisys concerning claims issues. Additionally, questions concerning claims denials should be directed to Unisys not DHH.**

The purpose of this section is to familiarize the provider with the design and content of the Remittance Advice (RA). This document plays an important communication role between the provider, the BHSF, and Unisys. Aside from providing a record of transactions, the Remittance Advice will assist providers in resolving and correcting possible errors and reconciling paid claims.

THE PURPOSE OF THE REMITTANCE ADVICE

The RA is the control document which informs the provider of the current status of submitted claims. It is sent out each week when the provider has adjudicated claims.

On the line immediately below each claim a code will be printed representing denial reasons, pended claim reasons, and payment reduction reasons. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. The only type of claim status which will not have a code is one which is paid as billed.

If the provider uses a medical record number (which may consist of up to 16 alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

At the end of each claim line is the 13-digit internal control number (ICN) assigned to that claim line. Each separate claim line is assigned a unique ICN for tracking and audit purposes. Following is a breakdown of the 13 digits of the ICN and what they represent:

Position 1	Last Digit of Current Year
Positions 2-4	Julian Date - ordinal day of 365-day year
Position 5	Media Code - 0 = paper claim with no attachments 1 = electronic claim 2 = systems generated 3 = adjustment 4 = void 5 = paper claim with attachments
Positions 6-8	Batch Number - for Unisys internal purposes
Positions 9-11	Sequence Number - for Unisys internal purposes
Positions 12-13	Number of Line within Claim - 00 = first line 01 = second line 02 = third line, etc.

Unisys Provider Relations responds to inquiries concerning particular claims when the provider has reconciled the RA and determined that the claim has denied, pended, paid or been rejected

prior to entry into the system. It is not possible for Unisys Provider Relations to take the place of the provider's weekly RA by checking the status of numbers of claims on which providers, billers or collection agencies are checking.

In situations where providers choose to contract with outside billing or collection agencies to bill claims and reconcile accounts, it is the provider's responsibility to provide the contracted agency with copies of the RAs or other billing related information in order to bill the claims and reconcile the accounts.

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

ELECTRONIC REMITTANCE ADVICES (ERAS)

The EDI Department now offers Electronic Remittance Advices (ERA's). This allows providers to have their Remittance Advices transmitted from Unisys and posted to accounts electronically. There is a minimal fee for this service. Further information may be obtained by calling the Unisys EDI Coordinator at (225) 237-3239.

REMITTANCE ADVICE BREAKDOWN

Claims presented on the RA can appear under one of several headings: Approved Original Claims (paid claims); Denied Claims; Claims in Process; Adjustment Claims; Previously Paid Claims; and Voided Claims. When reviewing the RA, please look carefully at the heading under which the claims appear. This will assist with your reconciliation process.

Always remember that claims appear under the heading "Claims in Process" to let the provider know that the claim has been received by the Fiscal Intermediary, and should not be worked until they appear as either "Approved Original Claims" or "Denied Claims." "Claims in Process" are claims which are pending in the system for review. Once that review occurs, the claims will move to a paid or denied status on the RA. If claims pend for review, they will appear on an initial RA as "Claims in Process" as they enter the processing system. After that point, they will appear only once a month under that heading until they are reviewed.

REMITTANCE SUMMARY

"Approved Original Claims" may appear with zero (0 dollar) payments. These claims are still considered paid claims. Claims pay a zero amount legitimately, based on other insurance payments, maximum allowable payments, etc.

When providers choose to return checks to adjust or void a claim rather than completing an adjustment/void form, the checks will initially appear as a financial transaction on the front of the RA to acknowledge receipt of that check. The provider's check number and amount will be indicated, as well as an internal control number (ICN) which is assigned to the check. If claims associated with the check are processed immediately, they will appear on the same RA as the check financial transaction, under the heading of "adjustment or void" as appropriate, as well as the corresponding "previously paid claim." The amount of the check posted to the RA should offset the amount recouped from the RA as a result of the adjustment/void, and other payments should not be affected. However, if the adjustments/voids cannot be processed on the same RA, the check will be posted and appear on the financial page of the RA under "Suspense Balance Brought Forward" where it will be carried forward on forthcoming RA's until all adjustments/voids are processed. As the adjustments/voids are processed, they will appear on the RA and the amount of money being recouped will be deducted from the "Suspense Balance Brought Forward" until all claims payments returned are processed.

It is the responsibility of the provider to track these refund checks and corresponding claims until they are all processed.

When providers choose to submit adjustment/void forms for refunds, the following is an important point to understand. As the claims are adjusted/voided on the RA, the monies recouped will appear on the RA appropriately as "Adjustment Claims" or "Voided Claims." A corresponding "Previously Paid Claim" will also be indicated. The system calculates the difference between what has already been paid ("Previously Paid Claim") and the additional amount being paid or the amount being recouped through the adjustment/void. If additional money is being paid, it will be added to your check and the payment should be posted to the appropriate recipient's account. If money is being recouped, it will be deducted from your check amount. This process means that when recoupments appear on the RA, the paid claims must be posted as payments to the appropriate recipient accounts through the bookkeeping process and the recoupments must be deducted from the accounts of the recipients for which adjustment or voids appear. If the total voided exceeds the total original payment, a negative balance occurs, and money will be recouped out of future checks. This also includes state recoupments, SURS recoupments and cost settlements.

Below are the summary headings that may appear on the financial summary page and an explanation of each.

Suspense Balance Brought Forward	A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed.
Approved Original Claim	Total of all approved (paid) claims appearing on this RA.
Adjustment Claims	Total of all claims being adjusted on this RA.
Previously Paid Claim	Total of all previously paid claims which correspond to an adjustment or void appearing on this RA.
Void Claims	Total of all claims being voided on this RA.

Net Current Claims Transactions	Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process).
Net Current Financial Transactions	Total number of all financial transactions appearing on the RA.
Prior Negative Balance	If a negative balance has been created through adjustments or voids processed, the negative balance is carried forward to the next RA. (This also includes state recoupments, SURS recoupments and cost settlements.)
Withheld for Future Recoveries	Difference between provider checks posted on the RA and the deduction from those checks when associated claims are processed on the same RA as the posting of the check. (This is added to Suspense Balance Brought Forward on the next RA.)
Total Payments This RA	Total of current check.
Total Copayment Deducted This RA	Total pharmacy co-payments deducted for this RA.
Suspense Balance Carried Forward	Total of Suspense Balance Brought Forward and withheld for future recoveries.
Y-T-D Amount Paid	Total amount paid for the calendar year.
Denied Claims	Total of all denied claims appearing on this RA.
Claims in Process	Total of all pending claims appearing on this RA.

Claims in Process
When the ICN of a claim appears on a remittance advice (RA), with a message of "Claim In Process," the claim is in the process of being reviewed. The claim has not been approved for payment yet, and the claim has not had payment denied. During the next week, the claim will be reviewed and will appear as a "paid" or "denied" claim on the next RA unless additional review is required. The "Claim In Process" listing on the RA appears immediately following the "Denied Claims" listing and is often confused with "Denied Claims."

Pended claims are those claims held for in-house review by Unisys. After the review is completed, the claim will be denied if a correction by the provider is required. The claim will be paid if the correction can be made by Unisys during the review.

Claims can pend for many reasons. The following are a few examples:

- Errors were made in entering data from the claim into the processing system.
- Errors were made in submitting the claim. These errors can be corrected only by the provider who submitted the claim.
- The claim must receive Medical Review.
- Critical information is missing or incomplete.

On the following pages are examples of remittance advice pages and a TPL denied claims notification list (this is normally printed at the end of the remittance advice).

Denied Claims Turnarounds (DTA)
Denied claim turnarounds, also printed at the end of the remittance advice, are produced when certain errors are encountered in the processing of a claim. **(Not all denial error codes produce denied claim turnarounds.)** The denied claim turnaround document is printed to reflect the information submitted on the original claim. It is then mailed to the provider to allow him to change the incorrect items and sign and return the document to Unisys. Once the document is received at Unisys, the correction is entered into the claims processing system and adjudication resumes for the original claim. **Note, however, that the turnaround document must be returned to Unisys with appropriate corrections as soon as possible, as they are only valid for 30 days from the date of processing of the original claim.**

TPL Denied Claims Notification List
The TPL denied claims notification list is generated when claims for recipients with other insurance coverage are filed to Medicaid with no EOB from the other insurance and no indication of a TPL carrier code on the claim form. This list notifies the provider that third party coverage exists and gives the name and carrier code of the other insurance. Once the private insurance has been billed, the claim may be corrected and resubmitted to Unisys with the third party EOB.

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
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

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

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

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by all providers that have provided services to each 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

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

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. Staff in this unit also handles requests to update recipient files with correct eligibility and third party liability information.

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 the eligibility or TPL information, etc.). **A copy of the claim form with applicable corrections 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 updte 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 **are not** available to answer calls regarding eligibility, routine claim denials, 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 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) 237-3331
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 237-3342 or (225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 237-3342 or (225) 929-6803
Dental P.A. - LSU School of Dentistry		(504) 619-8589	(504) 619-8560
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 237-3370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Rate and Audit Review – DHH	(225) 342-6116	To obtain LTC Case Mix rates for Hospice Room and Board billing - call or e-mail: **mwisley@dhh.state.la.gov**
Division of Home and Community-Based Waivers - BCSS	(800) 660-0488	Providers and recipients may report complaints regarding waiver services provided to waiver recipients (does not include claim or billing problems or questions)
Regional Office – DHH	(800) 834-3333	Providers may request verification of eligibility for presumptively eligible recipients; recipients should contact to request a new card or to discuss eligibility issues
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address questions 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	(800) 455-9955	Provider or Recipient 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.
EarlySteps Program - OPH	(866) 327-5978	Providers and recipients may obtain information on the EarlySteps Program and services offered
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 Bureau of Health and Hospitals. They should be sent to the attention of the program manager for the provider's type or specialty at the following address:

ATTN: Hospice Program Manager
Department of Health and Hospitals
P. O. Box 91030
Baton Rouge, LA 70821

ELECTRONIC DATA INTERCHANGE

CLAIMS SUBMISSION

Electronic data interchange is the preferred method of submitting Medicaid claims to Unisys. With electronic media, 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 interchange 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.

Copies of required Certification forms are included in the 2004 Basic training packet and may also be obtained from lamedicaid.com under the HIPAA Information Center link. The required forms are available in both the General EDI Companion Guide and the EDI Enrollment Packet.

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

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

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

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

Electronic Date 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 claims type 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 DATA INTERCHANGE OF CLAIMS (EDI Contract).

- Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse – complete the PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE 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.

HARD COPY REQUIREMENTS

DHH has made the decision to continue requiring hardcopy claim submissions for all existing hardcopy attachments, as indicated in the table below.

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	BILLING REQUIREMENTS
Spend Down Recipient - 110MNP Spend Down Form	Continue hardcopy billing
Third Party/Medicare Payment - EOBs. (Includes Medicare adjustment claims)	Continue hardcopy billing
Failed Crossover Claims - Medicare EOB	Continue hardcopy billing
Retroactive Eligibility - copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing
Recipient Eligibility Issues - copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing - letter/other proof i.e., RA page	Continue hardcopy billing

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 8 1/2 x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper. If it is necessary to attach documentation to a claim, the documents must be placed directly behind each claim that requires this documentation. Therefore, it may be necessary to make multiple copies of the documents if they must be placed with multiple claims.

CHANGES TO CLAIM FORMS

Louisiana Medicaid policy prohibits Unisys staff from changing any information on a provider's claim form. Any claim 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

MSA Codes

MSA Code	Urban Area (Parishes)	Wage Index	Routine Home Care Adjusted Rate	Continuous Home Care Adjusted Hourly Rate	Inpatient Respite Care Adjusted Rate	General Inpatient Care Adjusted Rate
220	Rapides	0.8547	$ 109.95	$26.71	$122.37	$492.14
760	Ascen.	0.8959	$ 113.40	$27.55	$125.34	$506.45
760	E. B. R.	0.8959	$ 113.40	$27.55	$125.34	$506.45
760	Livingston	0.8959	$ 113.40	$27.55	$125.34	$506.45
760	W. B. R.	0.8959	$ 113.40	$27.55	$125.34	$506.45
3350	Lafourche	0.8258	$ 107.52	$26.12	$120.30	$482.11
3350	Terrebonne	0.8258	$ 107.52	$26.12	$120.30	$482.11
3880	Acadia	0.8728	$ 111.47	$27.08	$123.67	$498.43
3880	Lafayette	0.8728	$ 111.47	$27.08	$123.67	$498.43
3880	St. Landry	0.8728	$ 111.47	$27.08	$123.67	$498.43
3880	St. Martin	0.8728	$ 111.47	$27.08	$123.67	$498.43
3960	Calcasieu	0.8357	$ 108.35	$26.32	$121.01	$485.55
5200	Ouachita	0.8443	$ 109.07	$26.50	$121.63	$488.53
5560	Jefferson	0.9778	$ 120.28	$29.22	$131.22	$534.90
5560	Orleans	0.9778	$ 120.28	$29.22	$131.22	$534.90
5560	Plaq.	0.9778	$ 120.28	$29.22	$131.22	$534.90
5560	St. Bernard	0.9778	$ 120.28	$29.22	$131.22	$534.90
5560	St. Charles	0.9778	$ 120.28	$29.22	$131.22	$534.90
5560	St. James	0.9778	$ 120.28	$29.22	$131.22	$534.90
5560	St. John	0.9778	$ 120.28	$29.22	$131.22	$534.90
5560	St. Tammany	0.9778	$ 120.28	$29.22	$131.22	$534.90
7680	Bossier	0.9681	$ 119.46	$29.02	$130.53	$531.53
7680	Caddo	0.9681	$ 119.46	$29.02	$130.53	$531.53
7680	Webster	0.9681	$ 119.46	$29.02	$130.53	$531.53
9919	Nonurban	0.8	$ 105.36	$25.60	$118.44	$473.15

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: Hospice					

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.**