HOSPITAL
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.

***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).

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.

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NOTICE TO ALL PROVIDERS

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

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

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

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

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

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

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Services Available to Medicaid Eligible Children Under 21

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

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

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

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

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

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

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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

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.

GENERAL POLICY REMINDERS

DEFINITION OF INPATIENT DISCHARGE

A hospital patient is considered discharged from a hospital when:

1. The patient is formally released from the hospital
   OR
2. The patient dies in the hospital.

The above definition applies to both inpatient and outpatient discharges.

Non-medically necessary circumstances do not factor in determining the discharge time, and Louisiana Medicaid will not reimburse providers under these circumstances (ex: patient does not have a ride home; patient does not want to leave the facility; etc.).

If and when non-medically necessary circumstances arise and a recipient does not leave the hospital when he is discharged, the hospital may bill the recipient for these charges, **BUT ONLY AFTER HOSPITAL PERSONNEL INFORM THE PATIENT** that Louisiana Medicaid will not cover this portion of the stay.

ABORTED PROCEDURES

Regardless of the reason why the procedure was not performed, Louisiana Medicaid does not provide reimbursement for aborted procedures or for any charges related to the aborted procedure.

TIMELY FILING GUIDELINES

To be reimbursed for services rendered, all providers must comply with the following filing limits set by the Louisiana Medicaid Program.

- Straight Medicaid claims must be filed within **12** months of the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare Fiscal Intermediary within **12** months of the date of service in order to meet Medicaid's timely filing regulation. (Claims which fail to cross over via tape and have to be filed hard copy must be filed within **6** months of the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within **1** year from the date of service.)
- Claims with third-party payment must be filed within **12** months of the date of service.
- KIDMED claims must be filed within **60** days of the date of service.
- Claims for recipients with retroactive eligibility coverage, e.g., spend-down medically needy claims, should be sent to Unisys with a note of explanation **AND** a copy of Form 18-SSI (Medicaid Program Notice of Decision) or other official documentation from DHH

indicating the recipient's retroactive status within **12** months of the date retroactive eligibility was granted. The Unisys mailing address is as follows:

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

All claims for recipients with retroactive medical coverage will be forwarded to the Medicaid Program for review and authorization.

Medicaid claims received after the maximum timely filing date cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include:

- A Remittance Advice indicating that the claim was processed earlier (within the specified time frame).
- Correspondence from either the Medicaid Program or local Medicaid eligibility staff concerning the claim and/or the eligibility of the recipient.

NOTE: To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible. Documentation must reference the individual recipient and date of service.

CLAIMS FOR DATES OF SERVICE OVER TWO YEARS OLD

Claims with dates of service over two years old **are not** to be submitted to the Fiscal Intermediary (Unisys) or to the Medicaid Program for overriding of the timely filing edit **unless** one or more of the guidelines listed below is met:

- The recipient was certified for retroactive Medicaid benefits (e.g., spend-down medically needy, or the recipient won a Medicare or SSI appeal granting retroactive Medicaid benefits), and the provider submits the claim within **12** months of the date retroactive eligibility was granted.

- The claim was submitted to Medicaid within **12** months of the date of service and failure of the claim to pay was the fault of the Medicaid Program rather than the provider's fault **each** time the claim was adjudicated.

NOTE: Documentation of retroactive eligibility or your attempts to resolve the billing problem (e.g., copy of Remittance Advice) must be attached to the claim(s).

EMERGENCY ROOM SERVICES

Medicaid will approve three emergency room visits per calendar year per recipient who is 21 years of age or older or who is a foster care (category 15) child (Medicaid does not give extensions for use of the emergency room to hospitals). Although the use of the emergency room will deny after three, Medicaid will continue to reimburse the hospital for any other covered services (i.e.; lab, x-rays) which are medically necessary. Recipients under the age of 21 have unlimited emergency room visits as long as medical necessity for an emergency room visit is met.

Providers should use revenue codes 450 and 459 to bill for outpatient emergency room services, except when the patient is admitted as inpatient. In instances where patients are admitted from the emergency room, the provider should bill **all charges** associated with the emergency visit with revenue code 500, and include these on the inpatient bill.

This policy is applicable if the patient is admitted from the ER or if they have been seen in the ER within 24 hours before or after the inpatient stay.

NOTICE: Effective with DOS 7/1/00, the 3 visit limit on Emergency Room services has been removed for all CommunityCARE recipients. THIS IS FOR COMMUNITYCARE recipients ONLY.

BILLING REMINDER

There are limits placed on the number of line items that are allowed when filing claims.

Outpatient claims are limited to 23 total lines, including the line showing the total charges. Inpatient claims are limited to a total of 28 total lines, including the line showing the total charges. Please adhere to the following guidelines when submitting a two page UB-92 on inpatient claims:

- 1st page must indicate page 1 of 2
- 1st page should not include a subtotal and/or a total
- 2nd page must indicate page 2 of 2
- 2nd page should indicate the total of both pages only, not a subtotal
- Pages should be stapled together with the 1st page on top
- The total charges must not exceed $999,999.99

MAMMOGRAM BILLING

Medicaid does not cover screening mammograms for female recipients under the age of 40. Only one screening mammogram per year is covered for female recipients with a well diagnosis who are 40 years of age or older. However, there is no age restriction on a diagnostic mammogram. Mammograms are classified as diagnostic when there is an area of question, lump or history of breast cancer.

IV THERAPY

The state has also been made aware of a potential problem with regard to claims filing for IV Therapy. For example, some providers have been rendering IV therapy in an emergency room setting where the patient brings doctors' orders and receives treatment by a nurse without ever seeing an emergency room doctor. It is not appropriate to bill Revenue code 450 or any other "room" charge for patients receiving this type of treatment. Providers should be billing Revenue code 260 when rendering IV therapy in addition to other Revenue codes indicative of services received (e.g. pharmacy or supplies).

HOSPITAL OUTPATIENT PSYCHIATRIC SERVICES

Hospital outpatient psychological or psychiatric services are not covered under Louisiana Medicaid.

ORGAN TRANSPLANTS

When a Louisiana Medicaid recipient receives an organ transplant, all charges incurred with the transplant are to be included in the **recipient's** inpatient hospital charges. This includes all procedures involved in the harvest of the organ from the donor. All services must be included on the claim form using the appropriate revenue codes from the 300 and 800 range for the services provided.

Donor search costs are included in the recipient's inpatient bill and will not be paid on an outpatient basis. Testing for Bone Marrow donors (lab tests) can be billed on an outpatient claim.

Medicaid does not pay for harvesting of organs when a Louisiana Medicaid recipient is the donor to a non-Medicaid recipient.

PRIOR AUTHORIZATION REQUEST FOR TRANSPLANT PROCEDURES

All organ transplants must be authorized by the Prior Authorization Unit prior to the performance of the surgery. This policy also applies to out-of-state hospitals, including those located in trade areas. The Prior Authorization Request for Transplant Procedure(s) form (TP-01) must be completed and used by all Hospital Transplant Coordinators when requesting approval for transplant procedures. A copy of the form appears on the following page. The form should be completed and any documentation that supports medical necessity attached. The completed TP-01 form should be mailed to:

Unisys Prior Authorization
P.O. Box 14919
Baton Rouge, La. 70898-4919

Once the transplant has been approved, a letter will be sent to the hospital. The hospital must attach a copy of the approval letter to their PCF-01 request when pre-certification is requested for the inpatient admission. A copy of the organ transplant approval letter is provided for reference.

When billing for the transplant services, the hospital and all physicians involved must attach a copy of the approval letter, and a dated operative report to the claims. Hospitals should share a copy of the transplant approval letter with all other providers involved in the patient's transplant.

Prior Authorization Request For Transplant Procedure(s)

Louisiana Department of Health and Hospitals
Bureau of Health Services
Medical Assistance Program

Date of Request : ____/____/____ _____ Original Request _____ Re-Evaluation Request

1) Patient's Name _____ 2) Date of Birth: __/_____/_____

3) Patient's Medicaid Identification Number(13-digits): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

4) Type of Transplant : _____ 5) Primary Diagnosis :_____

6) Secondary Diagnosis: _____ 7) Procedure Description :_____

8) Prognosis (with and without transplant, specifying morbidity, mortality, life expectancy and any other considerations: _____

9) Patient's history of present illness is attached and includes the following: _____Yes _____No
__Pertinent social history, clinical findings, consults, and key test results (representing the patient's current status).

10) Copy of Transplant Selection Committee's Notes and/or Minutes is attached and signed by a Transplant Committee Physician and includes the following information: _____Yes _____No
__Listing of Committee members present (Name & Title) , their discussions including any psychosocial concerns, e.g., e.g., drug or alcohol abuse, on patient suitability, quality of life, and compliance.

11) Do Urgent or Emergency conditions exist? _____Yes _____No (If Yes, please attach explanation).

NOTE: For each item above, please attach additional information to support your request for transplant(s).

Emergency Requests can be submitted by faxing all documentation to:

UNISYS PRIOR AUTHORIZATION DEPARTMENT (EMERGENCY TRANSPLANT REQUEST) AT (225)-929-6803

I certify that the requested transplant is not investigational or experimental and is regarded as standard therapy by the medical community. This transplant program is in compliance with DHH Medicaid transplant registration and approval requirements for organ or tissue. Our transplant program will notify you if there are pertinent changes between approval and actual date of transplant that could necessitate reconsideration of th request. We are submitting or preparing to submit scientific documentation for recent applicable transplant developments.

12)_____
(Physician Name and Title , Please Print)

13) _____
(Physician Signature and Title)

14)_____
(Transplant Coordinator or Contact Person)

15)_____
(Telephone Number / Fax Number)

16)Site Where Transplant is to be Performed (Hospital Name & Address) _____

_____

_____

TP-01 FORM, Issued 04/97

Mail to: Unisys / La. Medicaid , Prior Authorization Dept., P.O. Box 14919, Baton Rouge, La. 70898-4919

Telephone Number for Unisys Prior Authorization Dept. (800) 488-6334 or (225) 928-5263

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

August 25, 2004

Reference:
ID#:
SS#:

Dear Ms.

This is to confirm that a kidney/pancreas transplant has been approved for to be done at Coverage is authorized for the evaluation, transplant and follow-up care.

The approval for this procedure is contingent upon your acceptance of Medicaid payment as payment in full and that you are a Louisiana Medicaid enrolled provider. To be reimbursed for services rendered, all providers must comply with timely filing guidelines set by the Louisiana Medicaid Program. Also, the client must be eligible for Medicaid on dates of services in order to receive reimbursement from Medicaid. If you have any questions regarding the reimbursement rate, you may call Ms. Darlene White at (225) 342-2119.

Please attach a copy of this letter to your claim form as your authorization when billing Unisys Corporation for this service and share this letter with all other providers associated with this transplant.

You have the right to appeal this decision. If you wish to do so, please write to the Department of Health and Hospitals, Bureau of Appeals, P. O. Box 4183, Baton Rouge, LA 70821-4183 within thirty (30) days of receipt of this letter.

Sincerely,

Darlene White

for Ben A. Bearden
Director

BAB/SG/sgw

cc: D. Gough
J. Womack
S. Guarino
P. Misner w/attachments

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE # 225/342-5774 • FAX # 225/342-3893
"AN EQUAL OPPORTUNITY EMPLOYER"

NEWBORN/NURSERY CHARGES

Current Medicaid policy requires that the baby's charges be included in the mother's claim while the mother and baby are both hospitalized. This policy includes those babies born in hospital emergency rooms, even when those facilities are not equipped with nurseries.

With the implementation of a Diagnosis Related Group (DRG) payment methodology on 07/01/2005, the Department will require separate claims to be submitted for mother/baby hospital stays. As this is a significant change, DHH and Unisys are currently working on this project and anticipate moving this phase into production 01/01/2005. However, current methods of reimbursement will remain in place and these claims will not be reimbursed under a DRG payment until full implementation of the DRG methodology in July 2005. Notification and instructions will be provided prior to the implementation of separating claims.

Providers should continue to complete the Eligibility Inquiry for Newborns (152-N) Form to facilitate the process of acquiring a Medicaid Identification Number for babies born to mothers who are Medicaid eligible. Refer to the Hospital Services Manual for complete instructions.

When providers bill for "baby only" charges, the baby assumes the mother's discharge date as it's admit date, and special billing instructions apply. On the UB-92 Form locators 19 and 20 must be completed as follows:

Form Locator 19 (Type of Admission) codes include the following:

1	Emergency	3	Elective
2	Urgent	4	Newborn

Providers should enter 4 to indicate newborn status

Form Locator 20 (Source of Admission) codes for newborn admissions are:

2 Premature Delivery
3 Sick Baby
4 Extramural Birth

Providers should always submit their claim hard copy if they encounter a situation where a newborn under the age of 4 days is being admitted to their facility. Pre-cert under the baby's name and Medicaid number is required. Failure to submit the claim hard copy will result in a denial.

NURSERY REVENUE CODES

170 General Classification
171 Nursery – Newborn
172 Nursery – Continuing care
173 Nursery – Intermediate Care
174 Neonatal Intensive Care Unit
179 Nursery – Other

Either revenue code 170 or 171 may be used to identify babies in the nursery during the mother's stay. Revenue code 174 is only used to bill for neonatal intensive care.

Revenue code 179 should only be used when none of the other codes for nursery are applicable.

There must be medical necessity for all hospital stays. Therefore, none of these revenue codes may be used to bill for a hospital stay of the newborn when medical necessity criteria for the stay is not met.

FREE-STANDING AND DISTINCT PART PSYCHIATRIC REIMBURSEMENT

Free-standing psychiatric hospitals and distinct part psychiatric units within acute care hospitals are recognized by Medicaid differently for reimbursement purposes if the unit/facility meets the Medicare criteria for exclusion from Medicare's Prospective Payment System (PPS excluded unit). This per diem is paid to all providers of inpatient psychiatric care, whether they are a distinct part psychiatric unit within an acute care general hospital or a free-standing psychiatric hospital. Distinct part psychiatric units are reimbursed for services provided to patients of any age. Free-standing psychiatric hospitals are reimbursed for services provided to patients either 21 years of age and under ***or*** 65 years of age and older.

Acute care general hospitals with a distinct part psychiatric unit which meets the Medicare criteria for designation as a PPS-exempt unit, must complete a new Medicaid provider enrollment form (PE-50) allowing the distinct part psychiatric unit to be enrolled separately and reimbursed in accordance with the prospective per diem rate for inpatient psychiatric care. This per diem includes payment for all services provided to an inpatient of such a unit, except for physician services, which should be billed separately. Reimbursement for the costs of all therapies (individual/group counseling or occupational therapy) is included in this per diem. The costs for services provided in the distinct part psychiatric units and free-standing psychiatric facilities are not subject to the cost settlement process.

The hospital must set up the distinct part psychiatric unit as a separate cost center and file it as a subprovider on the hospital's cost report. More information regarding this criteria may be obtained from the Bureau of Health Services Financing Health Standards Section at (225) 342-0148. Review of the hospital by the Health Standards Section for adherence to these guidelines is necessary prior to enrollment as a distinct part psychiatric unit.

Providers must bill on the hospital claim form (UB-92) for these services. In-state facilities will be reimbursed at the psychiatric per diem rate for in-state hospitals. Out-of-state facilities will be reimbursed at the lesser of the following:

- 60% of billed charges for patients under 21 years of age and 40% for patients ages 21 and older, or

- per diem. (Only facilities in bordering states are given a per diem rate. Facilities in all other states will be paid the appropriate percentage of charges.)

Note: The Louisiana Medicaid Program will only reimburse out-of-state hospitals for a maximum of a **two-day** psychiatric stay for Louisiana Medicaid recipients. The out-of-state facility must, if continued inpatient care is necessary, transfer the patient to a Louisiana psychiatric facility after two days.

INPATIENT PSYCHIATRIC SERVICES IN LONG TERM AND ACUTE CARE FACILITIES

When the primary diagnosis on the pre-certification file is in the 290-316 range, payment for each day of service will be made at the psychiatric per diem rate and not the long term or acute per diem rate.

REHABILITATION UNITS IN ACUTE CARE HOSPITALS

Medicaid does not issue separate provider numbers for Rehabilitation units. The Rehabilitation unit is considered part of the acute care hospital, and any billing for services provided in this unit should be billed with the acute care number. Reimbursement for inpatient stays in the Rehabilitation unit will be made at the same per diem as for the acute care part.

If you have been issued a provider number for the Rehabilitation unit by Medicare, which is not the same number assigned by Medicare for the acute care hospital part, you should report this number to our Provider Enrollment Unit at the address shown below. The Provider Enrollment Unit will then add this number to the MMIS crossover file so that your Medicare claims will correctly cross over for payment under your Medicaid provider number.

None of your Medicare crossover claims that have already been processed under the number assigned by Medicare for the Rehabilitation unit will be paid. After you have been notified by Provider Enrollment that the Medicare provider number assigned to the Rehab unit has been added to our crossover file, you may submit these claims to the Unisys Provider Relations Unit for payment by hardcopy. Be sure to include a copy of the Medicare EOB with each claim.

COMMUNITYCARE

Program Description

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

Recipients

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

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

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

Primary Care Physician

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

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

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

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

Non-PCP Providers and Exempt Services

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

When a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the patient's PCP to obtain the appropriate referral/authorization for any follow-up services the patient may need after discharge (i.e. Durable Medical Equipment (DME) or home health). Neither the home health nor DME provider can receive reimbursement from Medicaid without the appropriate PCP referral/authorization. **The DME and home health provider must have the referral/authorization in hand prior to rendering the services.**

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

Providers:

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

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

ACS - (877) 455-9955 - referral assistance

Recipients:
ACS - (800) 259-4444

HOSPICE

OVERVIEW

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

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

PAYMENT OF MEDICAL SERVICES RELATED TO THE TERMINAL ILLNESS

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

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

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

PAYMENT FOR MEDICAL SERVICES NOT RELATED TO THE TERMINAL ILLNESS

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

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

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

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

PHARMACY PRIOR AUTHORIZATION

Prior Authorization

The prescribing provider must request prior authorization for non-preferred drugs from the University of Louisiana – Monroe. Prior authorization requests can be obtained by phone, fax, or mail, as listed below.

Contact information for the Pharmacy Prior Authorization department:

Phone: (866) 730-4357 (8 a.m. to 6 p.m., Monday through Saturday)
FAX: (866) 797-2329

University of Louisiana – Monroe
School of Pharmacy
1401 Royal Avenue
Monroe, LA 71201

A copy of the "Request for Prescription Prior Authorization" form, as can be found on the LAMedicaid.com website under "Rx PA Fax Form".

Preferred Drug List (PDL)

The most current PDL is dated October 1, 2004, and can be found on the LAMedicaid.com website.

Monthly Prescription Service Limit

An eight-prescription limit per recipient per calendar month has been implemented in the LA Medicaid Pharmacy Program.

The following federally mandated recipient groups are exempt from the eight-prescription monthly limitation:

1. Persons under the age of twenty-one (21) years
2. Persons living in long term care facilities such as nursing homes and ICF-MR facilities
3. Pregnant women

If it is deemed medically necessary for the recipient to receive more than eight prescriptions in any given month, the provider must write "medically necessary" and the ICD-9-CM diagnosis on the script.

OUTPATIENT HOSPITAL SERVICES

OUTPATIENT HOSPITAL SERVICES

Diagnostic and therapeutic services which hospitals provide on an outpatient basis are covered by Medicaid. **This policy applies to all hospitals including charity facilities.** Federal regulations are specific in regard to the definition of both inpatient and outpatient services.

Louisiana Medicaid automatically deems a hospital stay of more than 24 hours in length inpatient. When outpatient duration of services exceed 24 hours, the services are deemed inpatient. Stays of less than 24 hours are NOT automatically considered outpatient. If a physician has formally admitted the patient, and the stay is less than 24 hours, the patient is deemed inpatient. Any outpatient services provided during the inpatient stay cannot be billed as outpatient, even if the stay is less than 24 hours. **All outpatient claims paid within 24 hours of the inpatient stay are subject to recoupment. Billing for outpatient services on a patient who is subsequently admitted as inpatient constitutes fraud.**

Clarification of the 24 Hour Rule

- All outpatient services performed within one (1) calendar day of the inpatient admission should be included in the inpatient stay.
- When a patient is treated in the emergency room and requires surgery which cannot be performed for several hours, the services may be billed as outpatient provided that the patient is not admitted as inpatient and that the duration from entry into the emergency room until release is less than 24 hours.
- When a patient is treated in an emergency room, released and returns to the hospital within 24 hours and is admitted, all emergency room charges should be included in the inpatient stay.
- When a patient has outpatient surgery and is observed for several hours after the surgery in an observation room, the services may be billed as outpatient, provided that the patient is not admitted as inpatient and the duration of the treatment from beginning to discharge is less than 24 hours.
- When an inpatient stay results in outpatient services being performed at another facility, all outpatient charges should be included and billed on the inpatient hospital's claim. The hospital in which the patient is an inpatient is responsible for reimbursing the facility for performing any outpatient services. Only services for the professional component should be billed separately by the provider of the service.

As stated prior, if a stay is less than 24 hours, the stay is deemed inpatient if any physician has formally admitted the patient. If no physician has admitted the patient, and the stay is less than 24 hours, then the stay would be outpatient. The patient's chart notes should indicate if any physician has admitted the patient for a particular stay. If the patient's records indicate that a physician has admitted the patient, **EVERYONE** including the hospital should bill the stay as inpatient, even if the stay is less than 24 hours.

OUTPATIENT LABORATORY SERVICES

Outpatient laboratory services are paid at a flat fee based on the Medicare fee schedule.

HOSPITAL LABORATORY SERVICES

When a hospital contracts with a freestanding standing laboratory for the performance of the technical service only, it is the responsibility of the hospital to pay the laboratory. The laboratory cannot bill Medicaid for these services.

PRENATAL LABORATORY PANELS

Obstetrical lab panels should be billed using CPT code 80055. Refer to the CPT-4 code book for tests included in this panel.

ULTRASOUNDS

Effective for dates of service on or after July 1, 2004, the reimbursement policy for ultrasounds during pregnancy has changed. Only 3 ultrasounds will be paid during a 270 day period, between both the Hospital Program and the Professional Services Programs. This includes ultrasounds performed in an acute care hospital on an outpatient basis.

OUTPATIENT REHABILITATION SERVICES

Hospitals are reimbursed for outpatient rehabilitation services including speech, occupational and physical therapies at a flat fee for service. These services are not cost settled. Hospitals are required to bill for these services using standard CPT codes. **Initial therapy and extended therapy plans require Prior Authorization.** Evaluation codes do not require prior authorization, but do have a limit of once per every 180 days.

The hospital rehabilitation services department must evaluate the recipient and complete a copy of the proposed plan of services, including the Request for Prior Authorization (PA-01) and Rehabilitation Services Request (PA-02) forms. Initial therapy and extended therapy plans must be submitted to the Unisys Prior Authorization Unit for approval prior to treatment of eligible Medicaid recipients. Completed requests are to be submitted to:

Unisys
Attn: Prior Authorization
P.O. Box 14919
Baton Rouge, La. 70898-4919

PA-01 and PA-02 forms must be completed in full when they are submitted for review. All initial requests for approval must have a copy of the physician's referral and the results of the evaluation of the patient which necessitates therapy attached. The request for therapy should be submitted within the first week of therapy, with an explanation and a request for approval from the start of therapy. In cases where delay of therapy would result in deterioration of the medical condition such as burn cases, accidents or surgery, the treatment may be instituted subject to later approval. Reimbursement for rehabilitation services provided without an approval plan for therapy will be dependent on the approval of the plan.

Requests for extensions should be submitted at least 25 days prior to the end of the approved period. This request should have current documentation attached that includes, but is not limited to, physical therapy notes, a current evaluation, goals and objectives, and a copy of the physician's referral.

If it is known that an inpatient recipient will require outpatient rehab services immediately following their discharge, a Prior Authorization request can be submitted prior to the outpatient rehab services using the patient's anticipated discharge date as the beginning date of service. This will help expedite the approval process.

NOTE: Durable Medical Equipment recommended by the physician, must be approved by the Prior Authorization Unit whether provided by the hospital or an independent durable medical equipment provider.

Description	Procedure Code
Speech/Language Evaluation	92506
Hearing Evaluation	92506
Speech/Lang/Hear Therapy – per 15 min	92507
Physical Therapy Evaluation	97001
Physical therapy – per 15 min	97110
Occupational Therapy Evaluation	97003
Occupational Therapy – per 15 min	97530

All services must be approved in advance by the Prior Authorization Unit except initial evaluations.

Note: Cardiac and Pulmonary/Respiratory therapy are not covered under Louisiana Medicaid. These services should not be prior authorized or billed using covered rehabilitation codes.

*****Please be aware that our Prior Authorization Unit is confirming medical necessity. Receiving an approved PA is not a guarantee that payment will be received.**

INSTRUCTIONS FOR COMPLETING PRIOR AUTHORIZATION FORM (PA-01)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS.

FIELD NO. 1 CHECK THE APPROPRIATE BLOCK TO INDICATE THE TYPE OF PRIOR AUTHORIZATION REQUESTED.

FIELD NO. 2 ENTER RECIPIENT'S 13-DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER.

FIELD NO. 3 ENTER THE RECIPIENT'S SOCIAL SECURITY NUMBER.

FIELD NO. 4 ENTER THE RECIPIENT'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON THEIR MEDICAID CARD.

FIELD NO. 5 ENTER THE RECIPIENT'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 6 ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER. IF ASSOCIATED WITH A GROUP, ENTER THE ATTENDING PROVIDER NUMBER ONLY.

FIELD NO. 7 ENTER THE BEGINNING AND ENDING DATES OF SERVICE IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 8 ENTER THE NUMERIC ICD9-DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION.

FIELD NO. 9 ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 10 ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES.

FIELD NO. 11 ENTER THE HCPCS / PROCEDURE CODE.

FIELD NO. 11A ENTER THE CORRESPONDING MODIFIERS (WHEN APPROPRIATE).

FIELD NO. 11B ENTER THE HCPCS/ PROCEDURE CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED.

FIELD NO. 11C ENTER THE NUMBER OF UNITS REQUESTED FOR EACH INDIVIDUAL HCPC/ PROCEDURE.

FIELD NO. 11D ENTER THE REQUESTED CHARGES FOR EACH INDIVIDUAL HCPC/ PROCEDURE WHEN IT IS APPROPRIATE FOR THE REQUESTED HCPC/ PROCEDURE.

FIELD NO. 12 ENTER THE LOCATION FOR ALL SERVICES RENDERED.

FIELD NO. 13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE.

FIELD NO. 14 **ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE RECIPIENT'S CASE MANAGER , IF AVAILABLE.**

FIELD NO. 15 **PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.**

FIELD NO. 16 **DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF FIELD IS NOT DATED.**

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS:

PRIOR AUTHORIZATION TOLL-FREE NO. IS 1-800-488-6334

PRIOR AUTHORIZATION UNIT NO IS 1- 225-928-5263

PRIOR AUTHORIZATION FAX NO. IS 1-225-929-6803

MAIL TO:
UNISYS / LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

FAX TO: (225) 929-6803

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

CONTINUATION OF SERVICES ____YES ____ NO

P.A. NUMBER

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2): 8 6 7 5 3 0 9 0 0 0 0 0 0

Social Security No. (3):

RECIPIENT LAST NAME: Firestone | FIRST: Andrew | MI (4):

DATE OF BIRTH (5): 05 27 1989

MEDICAID PROVIDER NUMBER (7- DIGIT) (6): 1 4 1 2 3 4 5

BEGIN DATE OF SERVICE (7) (MMDDYYYY): 12 08 2003

END DATE OF SERVICE (MMDDYYYY): 06 08 2004

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION
71942 Joint Pain/Up-arm
SECONDARY CODE & DESCRIPTION
71941 Joint Pain/Shoulder region

PRESCRIPTION DATE (9) (MMDDYYYY): 12 08 2004

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)
Dr. Cole James

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S
97110					Physical Therapy	384					

(12) PLACE OF TREATMENT: ____ RECIPIENT'S HOME ____ NURSING HOME ____ ICF-MR FACILITY ____ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: ABC Hospital
ADDRESS: P O Box 1234
CITY: Anytown STATE: LA ZIPCODE 70809
TELEPHONE: (337) 555 3825 FAX NUMBER: (337) 555 9680

(14) CASE MANAGER INFORMATION:
NAME:
ADDRESS:
CITY: STATE: ZIPCODE
TELEPHONE (____) ____ FAX NUMBER: (____) ____

(15) PROVIDER SIGNATURE: *Claire Belle*

(16) DATE OF REQUEST: 12/15/2003

PA-01 FORM

MAIL TO:
UNISYS / LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S

(12)
PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY ___ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE: (___) ___ ___ FAX NUMBER: (___) ___ ___

(14) CASE MANAGER INFORMATION:
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE (___) _____ FAX NUMBER: (___) ___ ___

(15) (16)

MAIL TO:
UNISYS / LA. MEDICAID
P.O. BOX 14919
Baton Rouge, La. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
REHABILITATION SERVICES REQUEST

Patient Name: Firestone, Andrew Age: 14 Provider Name: ABC Hospital

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: Week ending 9/26/2003

LIMITATIONS : X AMBULATORY ___ NON - AMBULATORY X YES ___ NO TRANSPORTATION AVAILABLE

AIDS NEEDED: ___ WALKER ___ CANE ___ WHEELCHAIR ___ LIMBS OR BRACES _____ OTHER

REHABILITATION PLAN

PLAN OF SERVICES: X INITIAL _____ EXTENSION

IF INITIAL , INITIAL EVALUATION DATA AND MD REFERRAL / PRESCRIPTION MUST BE ATTACHED

IF EXTENSION, PRIOR ATTENDANCE : _____ REGULAR _____ NON-REGULAR. MUST ALSO ATTACH PROGRESS REPORTS

REQUESTED SERVICES:	PROCEDURE CODE	DESCRIPTION	FREQUENCY	TIME / VISIT	TOTAL UNITS
PHYSICAL THERAPY:	97110	Physical Therapist	4Xwk		384
SPEECH THERAPY:					
OCCUPATIONAL THERAPY					

LENGTH OF PLAN SERVICE: FROM: 12 (MONTH) 08 (DAY) 2003 (YEAR) TO : 06 (MONTH) 08 (DAY) 2004 (YEAR)

DATE OF RE – EVALUATION: 06 (MONTH) 09 (DAY) 2004 (YEAR)

PROPOSED GOALS / COMMENTS: Increase ROM L Elbow

REQUESTED BY : *Mary Smith* DATE: *12/15/2003*

P.A 02 FORM (ISSUED 01/91)

MAIL TO:
UNISYS / LA. MEDICAID
P.O. BOX 14919
Baton Rouge, La. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
REHABILITATION SERVICES REQUEST

Patient Name: _____ Age: _____ Provider Name: _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: _____

LIMITATIONS : ___ AMBULATORY ___ NON - AMBULATORY ___ YES ___ NO TRANSPORTATION AVAILABLE

AIDS NEEDED: ___ WALKER ___ CANE ___ WHEELCHAIR ___ LIMBS OR BRACES _____ OTHER

REHABILITATION PLAN

PLAN OF SERVICES: _____ INITIAL _____ EXTENSION

IF INITIAL , INITIAL EVALUATION DATA AND MD REFERRAL / PRESCRIPTION MUST BE ATTACHED

IF EXTENSION, PRIOR ATTENDANCE : _____ REGULAR _____ NON-REGULAR. MUST ALSO ATTACH PROGRESS REPORTS

REQUESTED SERVICES: PROCEDURE CODE DESCRIPTION FREQUENCY TIME / VISIT TOTAL UNITS

PHYSICAL THERAPY: _____

SPEECH THERAPY: _____

OCCUPATIONAL THERAPY _____

LENGTH OF PLAN SERVICE: FROM: _____ TO : _____
MONTH DAY YEAR MONTH DAY YEAR

DATE OF RE – EVALUATION: _____
MONTH DAY YEAR

PROPOSED GOALS / COMMENTS: _____

REQUESTED BY : _____ DATE: _____

P.A 02 FORM (ISSUED 01/91)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 09/03/2004 RECIPIENT NAME
PRIOR AUTH. NBR RECIPIENT NUMBER

PROVIDER NUMBER

DEAR PROVIDER,

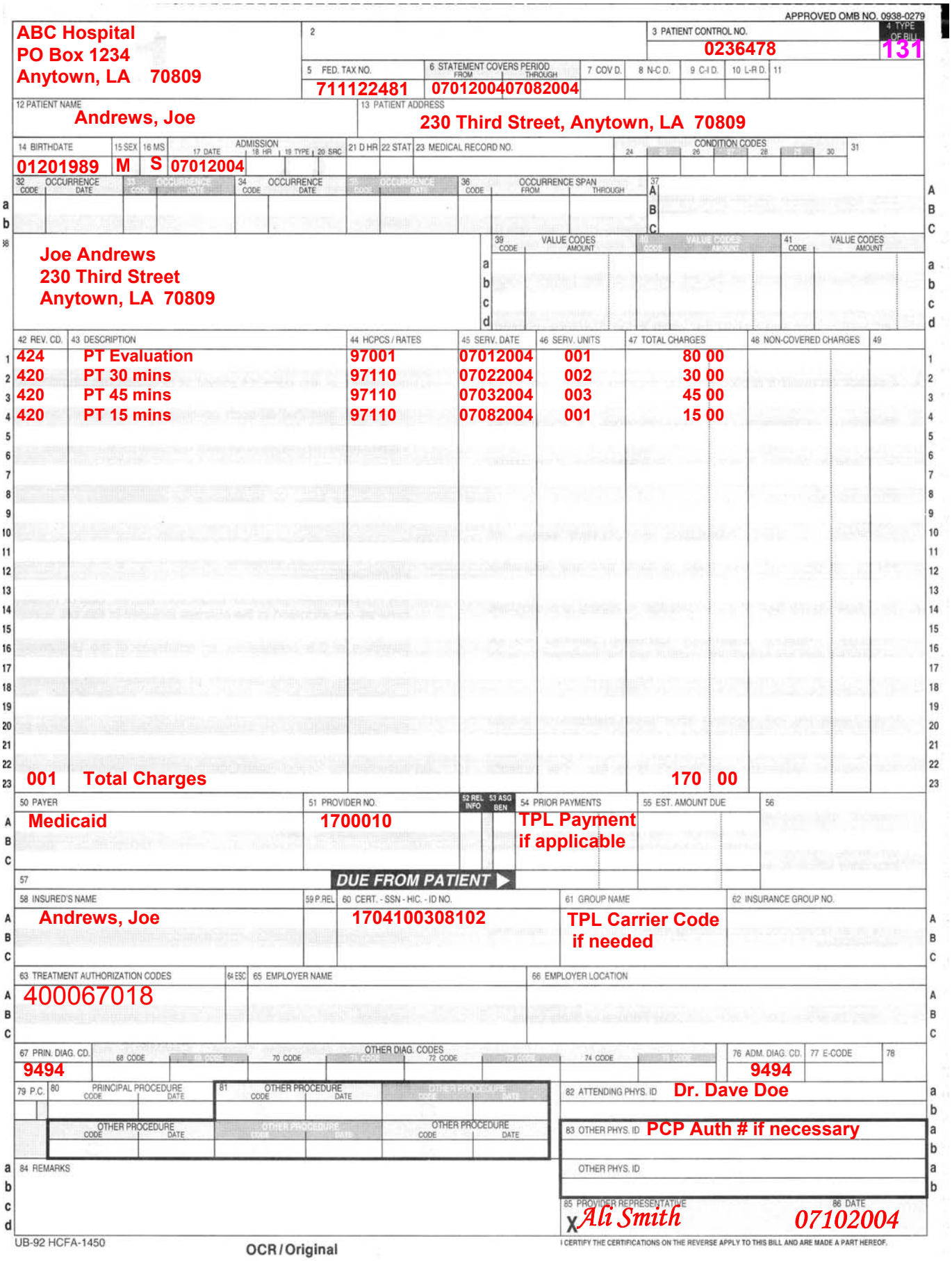
THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW. IF ANY OF THE APPROVED ASTERISKED(*) SERVICES ARE REQUIRED BEYOND THE APPROVED DATES OF SERVICE, YOU MUST FILE A REQUEST FOR A CONTINUATION OF APPROVED SERVICES BY 12/16/2004 (25 DAYS BEFORE THE END OF THE APPROVED SERVICE DATE). IF YOU FAIL TO SUBMIT A CONTINUATION OF SERVICES REQUEST BY 12/16/2004, THESE SERVICES WILL NOT BE CONTINUED.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
*92507 -TREATMENT OF SPEECH,LANGU	104	07/10/2004-01/10/2005	APPROVED

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY. PAYMENT ON A CLAIM WILL ONLY BE MADE WHEN THE CLAIM IS BILLED CORRECTLY AND ALL CONDITIONS FOR PAYMENT ARE MET.

ALL CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE APPROPRIATE REFERRALS TO BE PAID.


APPROVED OMB NO. 0938-0279
ABC Hospital
PO Box 1234
Anytown, LA 70809
3 PATIENT CONTROL NO.
0236478
4 TYPE OF BILL
131
5 FED. TAX NO.
711122481
6 STATEMENT COVERS PERIOD
0701200407082004
12 PATIENT NAME
Andrews, Joe
13 PATIENT ADDRESS
230 Third Street, Anytown, LA 70809
14 BIRTHDATE
01201989
15 SEX
M
16 MS
S
17 DATE
07012004
Joe Andrews
230 Third Street
Anytown, LA 70809
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
1 424 PT Evaluation 97001 07012004 001 80 00
2 420 PT 30 mins 97110 07022004 002 30 00
3 420 PT 45 mins 97110 07032004 003 45 00
4 420 PT 15 mins 97110 07082004 001 15 00
23 001 Total Charges 170 00
50 PAYER
Medicaid
51 PROVIDER NO.
1700010
54 PRIOR PAYMENTS
TPL Payment if applicable
57
DUE FROM PATIENT
58 INSURED'S NAME
Andrews, Joe
60 CERT. - SSN - HIC. - ID NO.
1704100308102
61 GROUP NAME
TPL Carrier Code if needed
63 TREATMENT AUTHORIZATION CODES
400067018
67 PRIN. DIAG. CD.
9494
76 ADM. DIAG. CD.
9494
82 ATTENDING PHYS. ID
Dr. Dave Doe
83 OTHER PHYS. ID
PCP Auth # if necessary
85 PROVIDER REPRESENTATIVE
X Ali Smith
86 DATE
07102004
UB-92 HCFA-1450
OCR / Original

COST – TO – CHARGE RATIO (CCR)

All Private Acute Care, Rehab and Long Term Care facilities will be assigned a specific CCR based on their last filed cost report. DHH quarterly adjusts the CCR as cost reports are filed. Annually, an average CCR will be assigned to those providers who have never filed a cost report. Notification will be mailed quarterly and annually to those providers who are affected. Final reimbursement for outpatient services will continue to be adjusted at cost settlement to 83% of the allowable costs documented in the cost report, except for lab services subject to a fee schedule and outpatient surgeries.

DHH urges Hospitals and Rehabs to include the CPT/HCPC information on all outpatient charges. The detailed billing on the claim form along with the cost reports will form the basis for future rate determination.

****Please remember to always include an 8-digit date of service for each outpatient line item being billed.**

OUTPATIENT SURGERY PROGRAM (AMBULATORY SURGERY)

Currently hospitals must bill all outpatient surgery charges with revenue code 490 for any ambulatory surgery. The pricing for services is based on the ICD-9 surgical procedure code reported. These same surgical procedures may be provided on an inpatient basis only under particular circumstances and only if prior authorization or precertification is obtained.

HIPAA regulations mandate that ICD-9 surgical procedure codes may no longer be used for billing hospital outpatient claims. Louisiana Medicaid is currently in the process of completing policy revisions that require the use of CPT/HCPCS codes for billing claims that previously required ICD-9 procedure codes. Providers would be required to use the most appropriate CPT/HCPCS code in Form Locator 44 to accompany revenue code 490. Only one CPT/HCPCS code can be entered in this field.

As before, all services performed in association with ambulatory surgical procedures will continue to be itemized and billed on the claim form. Medicaid will follow Medicare's Payment Grouping for Ambulatory Surgery. Pricing will be based on the nine (9) Medicare groups. **Clarification will be sent to all providers once a final decision has been made regarding implementation.**

Claims can continue to contain multiple revenue code 490's. However, if a claim contains more than one (1) revenue code 490, only the *approved* revenue code 490 with the highest group will be reimbursed. A provider will not be reimbursed for multiple groups filed on a claim.

MEDICARE/MEDICAID COVERAGE

Provided in this section is the Medicaid coverage criteria for Medicare/Medicaid recipients.

QUALIFIED MEDICARE BENEFICIARIES (QMBs)

QMBs are covered under the ***Medicare Catastrophic Coverage Act of 1988***. This act expands Medicaid coverage and benefits for certain persons aged 65 years and older as well as disabled persons who are eligible for Medicare Hospital Insurance (Part A) benefits and who:

- Have incomes less than 90 percent of the Federal poverty level,
- Have countable resources worth less than twice the level allowed for Supplemental Security Income (SSI) applicants,
- Have the general nonfinancial requirements or conditions of eligibility for Medical Assistance, i.e., application filing, residency, citizenship, and assignments of rights.

Individuals under this program are referred to as Qualified Medicare Beneficiaries (QMBs). The three groups of recipients under this category are: QMB Only, QMB Plus and Non-QMB.

QMBs	Status
QMB Only (Formerly Pure QMB)	Identified through the REVS and MEVS systems and are eligible only for Medicaid payment of deductibles and coinsurance for all Medicare covered services.
QMB Plus (Formerly Dual QMB)	Individuals who are eligible for both Medicare and traditional types of Medicaid coverage (SSI, etc). QMB Plus is identified by the REVS and MEVS systems and are eligible for Medicaid payment of deductibles and coinsurance for all Medicare covered services as well as for Medicaid covered services.
Non QMBs	Identified in the TPL segment of REVS. Non QMBs are eligible for only Medicare and Medicaid covered services.

In addition, for those persons who are eligible for Part A premium, but must pay for their own premiums, the State will now pay for their Part A premium, if they qualify as a QMB. The State will continue to also "buy-in" for Part B (Medical Insurance) benefits under Medicare for this segment of the population.

THE CROSSOVER PROCESS

The hospital should submit the claims for Medicare Part A inpatient charges and Medicare Part B ancillary charges to their Medicare intermediary for reimbursement. After Medicare makes their payment, the claims will cross over to Unisys for payment of the co-insurance and deductible. In the event that a hospital does not receive any reimbursement for crossover claims, the hospital should contact the Provider Relations Unit to ascertain that the correct Medicare provider number is indicated on the MMIS cross reference file. Although the Medicare register may indicate that a claim was crossed over, the claim may fail to appear on the Medicaid remittance advice in some instances.

Claims failing to automatically cross over for Medicaid reimbursement after Medicare pays have been a continuous problem. Unisys and DHH have applied much time and effort toward rectifying the situation. Some of the identified causes for claims not crossing over automatically are:

- Providers' Medicare and Medicaid numbers not properly cross-referenced on Medicaid files
- Error on recipient files (such as an incorrect Medicare number)
- Bad tapes received from Medicare intermediaries

However, some claims not crossing over cannot be explained.

Crossover claims must be tracked by the provider to ensure that Medicaid receives and processes them. If a Medicare claim does not appear on the hospital's Medicaid remittance advice within four weeks of the date of the Medicare Explanation of Benefits (EOB), the hospital must submit a paper claim with the Medicare EOB attached to Unisys to ensure compliance with the timely filing limitations.

Claims for recipients with Medicare and Medicaid absolutely must be filed to Medicare within one year from the date of service. If the claim is being filed to Medicaid after one year from the date of service, the claim must be filed within six months of the date on the Medicare Explanation of Benefits (EOB).

Should your claim fail to crossover electronically, you should be certain to file your claim to Unisys exactly as it was submitted to Medicare. Always attach a copy of the EOMB when filing claims hard copy. DHH has received many different versions of electronic EOMBs which have been generated from an "internal" program. Providers should ensure that the hard copy EOB submitted for consideration is an official Medicare EOB.

INPATIENT PART A CROSSOVERS

The Medicare payment will be compared to the number of days billed times the Medicaid inpatient per diem rate. If the Medicare payment is more than what the Medicaid payment would have been, Medicaid will approve the claim at "zero". If the Medicare payment is less, then Medicaid will pay on the Deductible and Coinsurance, up to what Medicaid would have paid as a Medicaid only claim not to exceed the coinsurance and deductible amounts.

These claims will be indicated on the Remittance Advice as "Approved Claims", with an error code of 996 ("deductible and or coinsurance reduced to max allowable"), and a reduced or zero payment. **These are considered paid claims and may not be billed to the recipient.**

Pre-certification Requirements (for recipients with Medicare and Medicaid)

Coverage	Pre-certification Required?
Medicare Part A Only – not exhausted	No
Medicare Part A Only – exhausted	Yes – must have Medicare EOB to show the days are exhausted (with PCF01). EOMB should show the first denial date of Medicare exhaust for days.
Medicare Part B Only	Yes
Medicare Parts A and B – Part A not exhausted	No
Medicare Parts A and B – Part A exhausted	Yes – must have Medicare EOB to show the days are exhausted (with PCF01).

Note: Remember that the provider has only 60 days from the notification date on the EOB to precert.

MEDICARE PART A AND B CLAIMS

The hospital should bill the Medicare intermediary for the inpatient portion covered by Part A and the ancillaries covered by Part B. The Medicare intermediary will make payment and cross the claims over to Unisys for payment up to co-insurance and deductible amounts.

MEDICARE PART A ONLY CLAIMS

If the recipient only has Medicare Part A coverage, then the hospital should submit an inpatient claim, including the ancillary charges, to its Medicare intermediary for reimbursement. The claim will cross over automatically to Medicaid for payment of the co-insurance and deductible amounts for the inpatient stay.

EXHAUSTED MEDICARE PART A CLAIMS

Occasionally Medicare/Medicaid recipients will exhaust not only their 90 days of inpatient care under Medicare Part A, but also their 60 lifetime reserve days. When this situation occurs, the hospital must submit a claim for the ancillary charges to its Medicare intermediary for reimbursement. Then the hospital must submit a paper claim with documentation of Medicare Part A being exhausted, e.g., a Notice of Medicare Claim Determination or the Medicare Part A EOB, and a copy of the Medicare Part B EOB to Unisys for processing.

The following items must be completed for the claim to be paid:

- **121 must be entered in form locator 4 as the type of bill.**
- **The amount in the Total Charges column of the Medicare EOB (the dollar amount billed to Medicare Part B, not what has been paid by Part B) must be entered in form locator 54 as a third party payment.**
- **"Medicare Part A Benefits Exhausted" should be written in form locator 84.**

The dates of service on the claim must match the dates of service on the Notice of Medicare Claim Determination or the Part A EOB to verify that Part A benefits have been exhausted. The exceptions to this rule are Medically Needy Spend-down claims where the effective date of Medicaid eligibility is after the date of admission and extended care claims from facilities designated as extended care hospitals by Medicaid.

MEDICARE PART B ONLY CLAIMS

If the recipient only has Medicare Part B coverage, then the hospital should submit a claim for the ancillary charges to its Medicare intermediary for reimbursement. After Medicare has made its payment, the hospital should submit a claim for the inpatient charges **(including ancillary charges)**, with the Medicare Part B EOB attached, to Unisys. The following items must be completed for the claim to be paid.

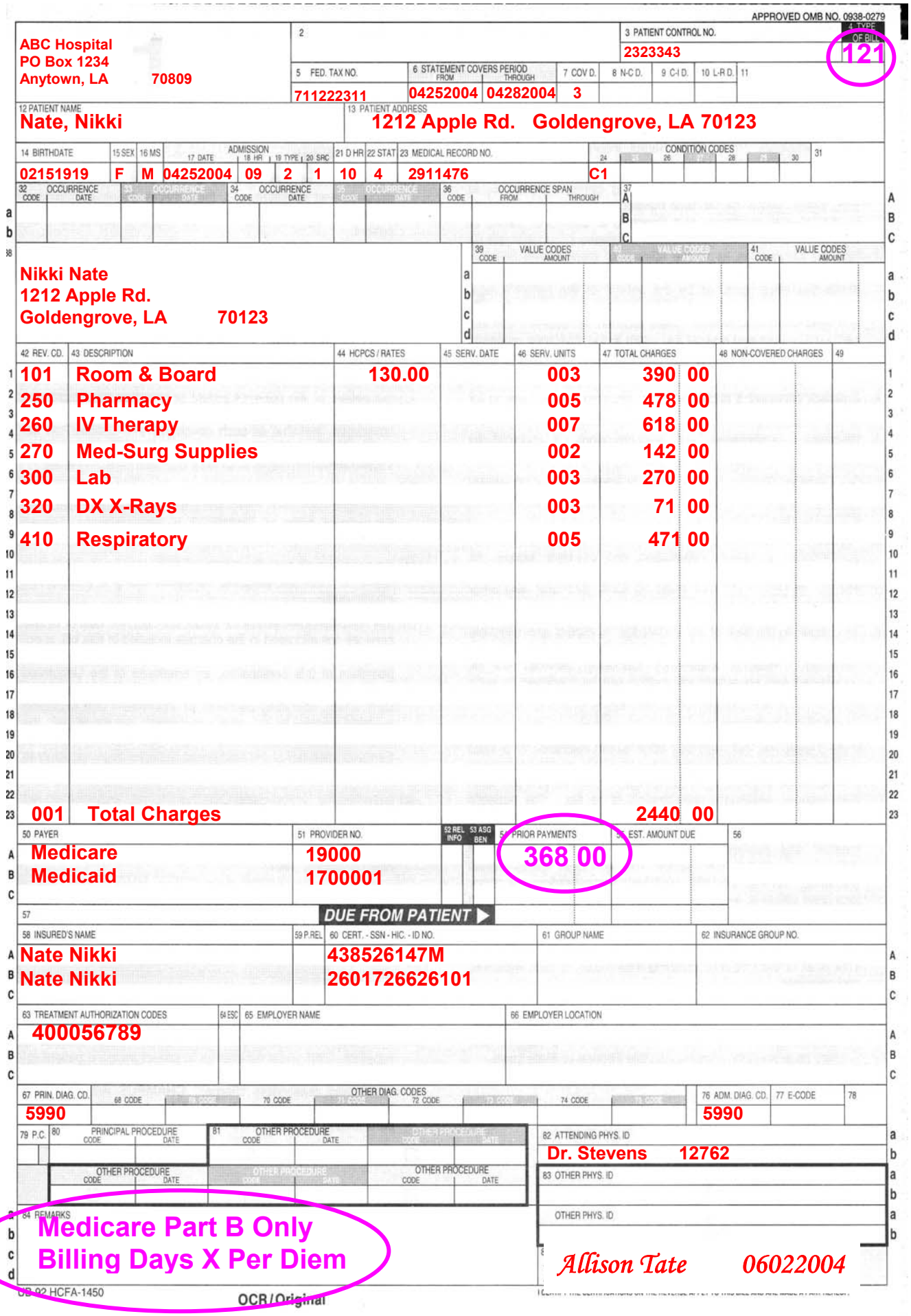
- **121 must be entered in form locator 4 as the type of bill.**

- **The amount in the Total Charges column of the Medicare EOB (the dollar amount billed to Medicare Part B, not what has been paid by Part B) must be entered in form locator 54.**

- "**Medicare Part B Only" must be written in form locator 84.**

Unisys will process the claim for the allowable days and multiply the number of days by the hospital's per diem rate. The total Part B charges indicated in form locator 54 would then be deducted to calculate the payment for the claim.

NOTE: When filing for coinsurance and deductible on the ancillary charges, make sure that total charges filed to Part B equal total charges being filed on the UB92. A copy of the Medicare Part B EOB must be attached to the claim.



APPROVED OMB NO. 0938-0279

ABC Hospital
PO Box 1234
Anytown, LA 70809

2

3 PATIENT CONTROL NO. 2323343

4 TYPE OF BILL 121

5 FED. TAX NO. 711222311

6 STATEMENT COVERS PERIOD FROM 04252004 THROUGH 04282004

7 COV D. 3

8 N-C D.

9 C-I D.

10 L-R D.

11

12 PATIENT NAME Nate, Nikki

13 PATIENT ADDRESS 1212 Apple Rd. Goldengrove, LA 70123

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 CONDITION CODES
02151919	F	M	04252004	09	2	1	10	4	2911476	C1

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

38

Nikki Nate
1212 Apple Rd.
Goldengrove, LA 70123

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	101	Room & Board	130.00		003	390 00		
2	250	Pharmacy			005	478 00		
3	260	IV Therapy			007	618 00		
4	270	Med-Surg Supplies			002	142 00		
5	300	Lab			003	270 00		
6	320	DX X-Rays			003	71 00		
7	410	Respiratory			005	471 00		
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	Total Charges				2440 00		

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

A Medicare — 19000 — 368 00
B Medicaid — 1700001

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 Nate Nikki — 438526147M
B Nate Nikki — 2601726626101

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

A 400056789

67 PRIN. DIAG. CD. 5990 — 68 CODE — 69 CODE — OTHER DIAG. CODES 70 CODE — 71 CODE — 72 CODE — 73 CODE — 74 CODE — 75 CODE — 76 ADM. DIAG. CD. 5990 — 77 E-CODE — 78

79 P.C. — 80 PRINCIPAL PROCEDURE CODE / DATE — 81 OTHER PROCEDURE CODE / DATE — OTHER PROCEDURE CODE / DATE — OTHER PROCEDURE CODE / DATE — OTHER PROCEDURE CODE / DATE — OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID Dr. Stevens 12762

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

Medicare Part B Only
Billing Days X Per Diem

Allison Tate *06022004*

UB-92 HCFA-1450 OCR/Original

RECOUPMENTS

RECOUPMENTS BY TPL COLLECTIONS CONTRACTOR PUBLIC CONSULTING GROUP

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

PCG identifies these claims and notifies the provider via letter with a claim report of Medicaid recipients whose claims paid as Medicaid primary when other resources were available. The providers are then allowed approximately 90 days to bill Medicare or the private insurance company. If Medicare is involved, this 90 days will allow the provider to VOID the payments and resubmit claims for consideration of co-insurance and deductible. If private insurance is involved, the provider can ADJUST the original Medicaid payment and include all required private insurance information including the TPL payment. At the end of the 90 days, information is sent to Unisys to recoup the claim payment for claims not already adjusted or voided. When a "P" appears at the beginning of the medical records number found on the Medicaid remittance advice, it is a PCG recoupment. For further information, the provider may call the PCG Provider Recoupment Team at (866) 567-6318 extension 10.

The following three pages are copies of the PCG letters

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

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

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

State of Louisiana
Department of Health and Hospitals

Month Day, Year

Dear Medicaid Provider:

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

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

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

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

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

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

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

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

Sincerely,

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

State of Louisiana
Department of Health and Hospitals

Month Day, Year

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

Dear Medicaid Provider:

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

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

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

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

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

Respectfully,

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

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

State of Louisiana
Department of Health and Hospitals

Month Day, Year

Dear Medicaid Provider:

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

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

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

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

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

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

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

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

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

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

Sincerely,

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

QUARTERLY MEDICARE RECOVERIES BY UNISYS

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

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

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

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

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

LAM2D012 CP-0-12C
RUN: 07/01/04

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

PROVIDER ID:

CYCLE: 06/30/04

MEDICARE RECOVERY PROJECT - CLAIM DETAIL LISTING

PAGE: 1

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

MEDICARE PLUS CHOICE CLAIMS

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

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

The Managed Care Plans currently participating in this program are: Ochsner (Ochsner 65), Tenet (Tenet 65 and Tenet PPO) and Sterling (Sterling Option One). These plans have been added to the Medicaid Third Party Resource File for the appropriate recipients with six-digit alpha-numeric carrier codes that begin with the letter "H".

When possible these plans will cross the Medicare claims directly to Medicaid electronically, just as Medicare carriers electronically transmit Medicare crossover claims. These claims will be processed just as claims crossing directly from a Medicare carrier. If claims do not cross electronically from the carriers within 30-45 days from the Medicare plan EOB date, providers must submit paper claims with the Medicare plan EOB attached to each claim.

NOTE: Sterling Option One will not electronically transmit claims to Unisys. Providers in the Sterling Option One network should submit claims hard copy to Unisys.

When it is necessary for providers to submit claims hard copy, the appropriate carrier code must be entered on each hard copy claim form in order for the claim to process correctly. The carrier codes follow:

Ochsner 65	H19510	Tenet 65	H19610
Tenet PPO	H19010	Sterling Option One	H50060

Hard copy claims submitted without the plan EOB and without a six-digit carrier code beginning with an "H" will deny 275 (Medicare eligible). Both the EOB and the correct carrier code are required for these claims to process properly.

Providers may not submit these claims electronically. Electronic submissions directly from providers will deny 966 (submit hard copy claim).

When it is necessary to submit these claims hardcopy, a Medicare Plus Choice institutional or professional cover sheet **MUST** be completed **for each claim** and attached to the top of the claim and EOB. Once finalized, these cover sheets will be available on the Louisiana Medicaid website for easy download. Claims received without this cover sheet will be rejected.

The calculated reimbursement methodology currently used for pricing Medicare claims will be used to price these claims. Thus, claims may price and pay a zero payment if the plan payment exceeds the Medicaid allowable for the service.

Timely filing guidelines applicable for Medicare crossover claims apply for Medicare Plus Choice claims.

OUT-OF-STATE HOSPITALS

OUT-OF-STATE HOSPITAL SERVICES

The Louisiana Medicaid Program only covers out-of-state hospital services provided to Louisiana Medicaid eligible recipients on an emergency basis. For reimbursement, the out-of-state provider must enroll as a Louisiana Medicaid Provider and must follow established timely filing guidelines in submitting claims.

Louisiana Medicaid will provide reimbursement to those out-of-state facilities approved to provide medically necessary services to Louisiana Medicaid recipients when the services are not available in Louisiana, upon approval by the Prior Authorization Unit (PAU) at Unisys. This includes requests for Transplants.

Non-emergency services are also covered when provided by bordering hospitals in Texas, Arkansas and Mississippi that are routinely used by Louisiana residents. It is important to remember that the hospital has been approved, not necessarily the stay itself.

OUT-OF-STATE HOSPITALS – OUTPATIENT SURGERY PERFORMED ON AN INPATIENT BASIS

Out-of-state providers requesting authorization for outpatient surgery performed on an inpatient basis must use the Prior Authorization request form (PA01) located on page 24. In addition, to expedite the review process, providers must continue to attach the appropriate medical data to substantiate the need for the service being provided in an inpatient setting. Documentation of extenuating circumstances should be submitted along with the request.

Medical authorization for the surgical procedure does not replace or in any way affect other policy requirements which may apply to surgical claims; e.g., sterilization consent requirements, recipient ineligibility for inpatient services and timely filing requirements. Medical authorization means only that the proposed procedure meets Louisiana Medicaid requirements of medical necessity for the service to be performed on an inpatient basis. If otherwise eligible for payment, a claim for the described services will be paid.

> **NOTE: When both the primary and secondary procedures require PA, all procedure codes must be listed on the PA01 request for authorization.**

Completed PA01 forms should be submitted to the address indicated on the form which is:

Unisys/Louisiana Medicaid
P.O. Box 14919
Baton Rouge, La. 70898-4919

The PA01 form should be submitted prior to the surgery; however, post authorization may be requested in certain instances. Approval for inpatient performance of these procedures will be granted only when one or more of the following exception criteria exist:

- The presence of documented medical condition(s) which make prolonged pre-and/or postoperative observation by a nurse or skilled medical personnel a necessity;
- The procedure is likely to be time consuming or followed by complication;
- An unrelated procedure is being done simultaneously which requires hospitalization;
- There is a lack of availability of proper postoperative care;
- It is likely that another major surgical procedure could follow the initial procedure, e.g., mastectomy;
- Technical difficulties as documented by admission or operative notes could exist; and/or
- The procedure carries high patient risk.

Note: Prior Authorization is not required if the procedure is performed on an outpatient basis.

Reimbursement to hospitals for surgical procedures approved for inpatient performance will be made in accordance with either the hospital's per diem rate or a percentage of billed charges based on the recipient's age.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

April 21, 2004

Reference:
ID#:
SS#:

Dear :

This is to confirm that out-of-state hospitalization for the above referenced recipient at has been approved.

The approval for this procedure is contingent upon your acceptance of the Medicaid payment as payment in full and that you are a Louisiana Medicaid enrolled provider. Reimbursement for inpatient hospitalizations will be made at the rate of 40% of billed charges for recipients age 21 and over or at the rate of 60% of billed charges for recipients under the age of 21. These rates are in accordance with our approved State Plan and therefore are non-negotiable.

Reimbursement for outpatient hospital services will be reimbursed at 31.04% of billed charges except for ambulatory surgical procedures, outpatient laboratory procedures, and rehabilitation services, which are reimbursed in accordance with a fee schedule. Physicians will be reimbursed in accordance with the physician fee schedule for the appropriate CPT code up to the maximum allowed amount. Also, the client must be eligible for Medicaid on dates of services in order to receive reimbursement from Medicaid. To be reimbursed for services rendered, all providers must comply with timely filing guidelines set by the Louisiana Medicaid Program.

Please attach a copy of this letter to your claim form as your authorization when billing Unisys Corporation for this service.

You have the right to appeal this decision. If you wish to do so, please write to the Department of Health and Hospitals, Bureau of Appeals, P. O. Box 4183, Baton Rouge, LA 70821-4183 within thirty (30) days of receipt of this letter.

Sincerely,

for Darlene White

Ben A. Bearden
Director

BAB/SG/sgw

cc: J. Womack
D. Gough
S. Guarino
P. Misner w/attachments

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE # 225/342-5774 • FAX # 225/342-3893
"AN EQUAL OPPORTUNITY EMPLOYER"

CONSENT FORM PROCEDURES

HYSTERECTOMIES

Federal regulations governing payment of hysterectomies prohibit Medicaid payment for a hysterectomy under the following circumstances:

- If the hysterectomy is performed solely for the purpose of terminating reproductive capability, or
- If there was more than one purpose for performing the hysterectomy, but the procedure would not have been performed except for the purpose of rendering the individual permanently incapable of reproducing.

According to Medicaid Program guidelines, if a hysterectomy is performed, payment can be made only if the patient is informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing and only if she has signed a written acknowledgment of receipt of this information. The acknowledgment statement that must be used by providers performing hysterectomies is BHSF Form 96-A. The Form 96-A must be signed and dated by the recipient on or before the date of the hysterectomy.

This regulation applies to all hysterectomy procedures, (with exception to special circumstances listed below) regardless of the woman's age, fertility, or reason for the surgery.

Providers may obtain the consent forms by calling (225) 342-1304 or by sending a written request to:

BHSF Program Operations
Attn: Physician Program Manager
P. O. Box 91030
Baton Rouge, LA 70821-9030

A Form 96-A is not necessary only in the following special circumstances:

1. The recipient was already sterile before the hysterectomy. The physician who performs the hysterectomy must certify in his own writing that the recipient was already sterile at the time of the hysterectomy and state the cause of sterility.

2. The recipient required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible. The physician must certify in his own writing that the hysterectomy was performed under these conditions and include in his narrative a description of the nature of the emergency.

3. The recipient was certified retroactively for Medicaid benefits, and the physician who performed the hysterectomy certifies in his own writing that one of the following conditions were met:

    a. The recipient was informed by the physician before the operation that the hysterectomy would make her permanently incapable of reproducing, or

    b. The recipient met one of the two other exceptions listed above. In this case the statement must describe the cause of the sterility or the nature of the emergency.

BHSF Form 96-A
Revised 07/94
Prior Issues Usable

Medicaid Program
Acknowledgement of Receipt of Hysterectomy Information

Recipient Name: _____
ID No.: _____
Physician Name: _____
Provider No.: _____

Payment by Louisiana's **Medicaid Program cannot** be authorized for the performance of **any** hysterectomy committed **solely** for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose for the procedure, the hysterectomy **would not** be performed but for the purpose of rendering the individual permanently incapable of reproducing.

Medicaid payment for a medically indicated hysterectomy can be authorized **only** if:
(1) the individual and her representative*, if any, are informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing; **and**,
(2) the individual and her representative*, if any, have signed a written acknowledgement of receipt of that information. The written acknowledgement **must** be signed and dated prior to the operation and **must** be attached to the claim form which is submitted for payment.

* A representative is that person who has the legal authority to act for an individual. For purposes of this acknowledgement, a representative shall be defined as either the curator of an interdicted woman or the tutor or parent of an unmarried minor. A minor emancipated by marriage is deemed capable of acting for herself in the matter.

I hereby acknowledge that I have been informed orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom the procedure is performed permanently incapable of bearing children.

_____ _____
Signature of Recipient Date

_____ _____
Signature of Representative, if any Date

Physician's Copy

STERILIZATIONS

Effective March 8, 1979, federal regulations governing the payment for sterilizations under Title XIX were implemented requiring a 30-day waiting period after sterilization consent is signed before surgery can be performed in order to be reimbursed with Title XIX funds.

The federal regulations define sterilization as those medical procedures, treatments or operations which are performed for the purpose of rendering an individual permanently incapable of reproducing. The reason for which the individual (male or female) decides to take permanent and irreversible steps to prevent reproduction for the purpose of family size limitation is irrelevant. It may be for social, economic, or psychological reasons or because a pregnancy would be inadvisable for medical reasons. All procedures, which meet the above definition, are subject to the following requirements:

Eligibility Requirements for Sterilizations

In accordance with federal regulations, the following conditions must be met before Medicaid reimbursement can be made for sterilizations:

1. The patient must be at least 21 years of age when consent is obtained.
2. The patient is mentally competent. According to federal regulations an individual can be considered legally incompetent only if found to be so by a court of competent jurisdiction or so identified by virtue of a provision of state law. The Medicaid Program will not make reimbursement on behalf of an individual who is mentally incompetent or institutionalized in a mental facility.
3. The patient must have voluntarily given his or her informed consent by signing BHSF Form 96. This form must be signed at least 30 days, but no more than 180 days, before the sterilization is performed.

Exception:

If the patient has a premature delivery or requires emergency abdominal surgery within the 30 days of consent, and at least 72 or more hours have passed since the consent form was signed, sterilization can be performed at the time of the delivery or emergency abdominal surgery.

- In the case of premature delivery, the expected date of delivery must be given;

OR

- In the case of emergency abdominal surgery, the emergency must be described.

The patient must be given BHSF Form 96, written consent document, by the physician or clinic. No other form will be accepted.

The consent form must contain signatures of the following individuals:

- The individual to be sterilized;
- The interpreter, if one was provided;
- The person who obtained the consent; and
- The physician who performed the sterilization procedure.
  (If the physician who performs the sterilization procedure is the one who obtained the consent, he/she must sign both statements.)

A copy of the consent form must be attached to all claims for sterilization, including attending physician, assistant surgeon, anesthesiologist, and hospital claims.

The physician who signs the Form 96 (Consent Form) must be the physician listed in Items 82 and/or 83 of the UB-92.

CORRECTING THE OFS FORM 96

The only blanks on the form that cannot be changed after the form has been submitted are blanks 7, 8, 10, 11, 14, 15 **(old 96 Form – Revised 01/92)** and 7, 8, 10, 11, 13, 14 **(new 96 Form – Revised 06/00)**.

Errors in sections I, II, III, and IV can be corrected, but **only by the person over whose signature they appear**.

In addition, if either the recipient, the interpreter, or the person obtaining consent returns to the office to make a correction to his portion of the consent form, the medical record must reflect his presence in the office on the day of the correction.

To make a correction to the form, the individual making the corrections should line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction. Erasures, "writeovers," or use of correction fluid in making corrections are unacceptable.

Only the recipient can correct the date to the right of her signature. The same applies to the interpreter, to the person obtaining consent, and to the doctor. The corrections of the recipient, the interpreter, and the person obtaining consent must be made **before** the claim is submitted.

The date of the sterilization may be corrected either before or after submission by the doctor over whose signature it appears. However, the operative report must support the corrected date.

In addition, providers must remember that ***informed consent*** must be obtained and documented **prior to** the performance of the sterilization, not afterward. Therefore, corrections to blanks 7, 8, 10, 11, 14, 15 **(old 96 Form – Revised 01/92)** and 7, 8, 10, 11, 13, 14 **(new 96 Form – 06/00)** may not be made subsequent to the performance of the procedure.

Physicians and clinics are reminded to obtain valid, legible consent forms. Copies must be shared with any provider billing for sterilization services, including the assistant surgeon, hospital, and anesthesiologist. An invalid consent form will result in denial of all claims associated with the sterilization. Consent forms will be considered invalid if errors have been made in correctable sections but have not been corrected, if errors have been made in blanks that cannot be corrected, or if the consent form shows evidence of erasures, writeovers, or use of correction fluid.

SIGNATURES ON THE 96/96A

The Bureau of Health Services Financing has been informed that some Medicaid recipients have signed forms 96 and/or 96A with their first initials and full last names, rather than with their full first and last names. Signatures like these (first initial and last name) will not be accepted as legal and bona fide signatures by the Medical Review Unit at Unisys (and sterilization claims will not be paid) if the name on the recipient's medical card for the month in which the forms were signed is different. In other words, the name on the form that was signed in January and the name on the January card should be the same.

REQUESTS FOR OFS FORM 96 AND FORM 96-A

Provider requests for sterilization and hysterectomy consent forms should be sent to:

BHSF Program Operations
P.O. Box 91030
Baton Rouge, LA 70821

SAMPLE OFS FORM 96

On the following pages are facsimiles of OFS Form 96. The old version of the form is pictured on page 53, while the new version is shown on page 54. Louisiana Medicaid accepts both versions. Note that each blank and section is numbered on two of the completed forms. These numbers refer to policy on p. 48 regarding correction of the consent form.

One example illustrates a correctly completed form for sterilization completed less than 30 days after the consent was obtained. In this case, “premature delivery” is checked and the expected date of delivery is indicated in blank 21 on the **old 96 Form (Revised 01/92)** and blank 19 on the **new 96 Form (Revised 06/00)**. Note that the expected date of delivery was at least 30 days after the date of the recipient’s signature. In addition, at least 72 hours passed after consent was obtained and before sterilization was performed.

CONSENT FORMS AND NAME CHANGES

When billing for services that require an OFS Form 96 or Form 96A, the name on the recipient’s medical card for the month in which the forms were signed should be the same as the name signed at the time consent was obtained. If the name of the patient changes before the claim is processed for payment, the provider must attach a letter from the physician’s office from which the consent was obtained. The letter should be signed by the physician and should state that the patient’s name has changed and should include the patient’s social security number and date of birth. This letter should be attached to **all** claims requiring consent upon submission for claims processing.

Must be group or individual who gave information about sterilization procedure

BHSF Form 96
Rev. 01/92
Prior Issue Usable

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) Womans OB/GYN Group. When I first asked for *(doctor or clinic)* the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D. C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) tubal ligation. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (3) 12/06/1974 *Month Day Year*

I, (4) Mary Smith, hereby consent of my own free will to be sterilized by (5) Dr. T.A. Jones *(doctor)*

by a method called (6) tubal ligation. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Hospitals

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) Mary Smith *Signature* (8) 08/10/2004 *Date: Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

II ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) *Interpreter* (11) *Date*

III ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) Mary Smith *name of individual* signed the consent form, I explained to him/her the nature of the sterilization operation (13) tubal ligation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I expalined that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(14) Sue Andrews, R.N. *Signature of person obtaining consent* (15) 08/10/2004 *Date*

(16) Womans OB/GYN Group *Facility*

(17) 433 3rd St., Pine, LA *Address*

IV ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon (18) Mary Smith *Name of individual to be sterilized* on (19) 08/20/2004 *Date of sterilization*, I explained to him/her the nature of the *operation* sterilization operation (20) tubal ligation *specify type of operation*, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I expalined that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the Paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (Check applicable box and fill in information requested):

- ☒ Premature delivery
- ☒ Individual's expected date of delivery: (21) 09/15/2004
- ☐ Emergency abdominal surgery:

(describe circumstances):

(22) Dr. T. A. James *Physician*

Date (23) 10/01/2004

MUST MATCH

AT LEAST 30 DAYS

COMPLETE IF < 30 DAYS

SIGN AFTER SURGERY COMPLETE

PATIENT'S COPY

Must be group or individual who gave information about sterilization procedure

BHSF Fo
Rev. 06/00
Prior Issue Usable

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (1) Woman's OBGYN (Doctor or Clinic). When I first asked for the informa

that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as FITAP or Medicaid, that I am now getting or I become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO N BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the rejected these alternatives and have chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) tubal ligation. The discomforts, risks and bene with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time.

I am at least 21 years of age and was born on (3) 03/14/1974 (Month/Day/Year).

I, (4) Mary Smith, hereby consent of my own free will to be sterilized by (5) Dr. John Cutter (Doctor)

by a method called (6) tubal ligation. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: *Representatives of the Department of Health and Hospitals, programs or projects funded by that Department but only for determining if Federal laws were observed.*

I have received a copy of this form.

(7) *Mary Smith* (Signature) (8) 06/02/2004 (Date: Month/Day/Year)

You are asked to supply the following information, but it is not required: *Race and Ethnicity designation, please check.*

- ☐ American Indian or Alaska Native
- ☐ Black (not of Hispanic origin)
- ☐ Asian or Pacific Islander
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

MUST MATCH

AT LEAST 30 DAYS

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be s the person obtaining this consent. I have also read him/her the consent form in (9) language and explained i him/her. To the best of my (10) knowledge and belief he/she understood this explanation. (11)

II

(Interpreter Signature) (Date: Month/Day/Year)

STATEMENT OF PERSON OBTAINING CONSENT

Before (Name of Individual) signed the consent form, I explained to him/her the nature of the sterilization operation it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized t methods of birth control which are temporary are available. I explained that sterilization is different because it is permanent. I informed the ind to b that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and v requested to be sterilized and appears to understand the nature and consequence of the procedure.

(13) *Sue Andrews, RN* (14) 06/02/2004

III

(Signature of Person Obtaining Consent) (Date: Month/Day/Year)

(15) Woman's OBGYN Group 433 10th Street, Pine, LA 70001

(Name of Facility and Address)

COMPLETE IF <30 DAYS

PHYSICIAN'S STATEMENT (16) 06/02/2004

Shortly before I performed a sterilization operation upon (18) tubal ligation (Name of Individual to be Sterilized) on (Date: Month/Day/Year)

I explained to him/her the nature of the sterilization operation, (Specify Type of Operation), the fact that it is intended to be

irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of b which are temporary are available. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that this/he be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and v asked to be sterilized and appeared to understand the nature and consequence of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdo where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second para must be used. (Cross out the paragraph which is not used.)

(3) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(4) This sterilization was performed less than 30 days, but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (Check the appropriate box and fill in the requested information):

(19) ✓

- ✓ ☐ Premature delivery 08012004
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(Describe circumstances):

(20) *John Cutter, MD* (21) 07/06/2004

SIGN AFTER SURGERY COMPLETE

IV

(Physician's Signature) (Date: Month/Day/Year)

DELIVERIES WITH NON-PAYABLE STERILIZATIONS

Medicaid allows payment of an inpatient hospital claim for a delivery/c-section when a non-payable sterilization is performed during the same hospital stay. When a valid sterilization form has not been obtained, the procedure code for the sterilization and the diagnosis code associated with the sterilization should not be reported on the claim form, and charges related to the sterilization procedure should not be included on the claim form. In these cases, providers will continue to receive their per diem for covered charges.

Claims for these services will not require any prior or post-authorization (other than pre-cert) and may be billed to Unisys on paper or electronically.

PREGNANCY-RELATED PROCEDURES

ECTOPIC PREGNANCIES

In order to receive Medicaid reimbursement for the termination of an ectopic pregnancy, commonly known as a tubal pregnancy, hospitals must submit billing on hardcopy with a copy of the operative report attached.

Providers must use an appropriate ICD-9 surgical procedure code that denotes the termination of an ectopic pregnancy rather than a sterilization procedure. Use of an improper ICD-9 surgical procedure may cause the claim to deny.

MOLAR PREGNANCIES

A molar pregnancy results from a missed abortion; i.e., the uterus retains the dead and organized products of conception. The Medicaid Program covers the termination of molar pregnancies. To bill for the termination of a molar pregnancy, providers should use one of the following procedure codes with a diagnosis of molar pregnancy:

68.0 Hysterectomy with removal of hydatidiform mole
69.0 Dilation and curettage of uterus
69.02 D & C following delivery or abortion
69.52 Aspiration curettage following delivery or abortion
69.59 Other aspiration of uterus

Claims with diagnosis of missed, spontaneous, or threatened abortion must be submitted hard copy with the following attachments:

1) Medical records (chart notes for dates of service)
2) Pathology report (if products of conception are sent to lab)
3) Operative report (if a procedure is performed)

Unisys Provider Relations has received questions concerning the denial 478 (Send written sonogram results with operative report, pathology report, and history). When a D&C is done for an incomplete or missed abortion and error 478 is received, the review team must have documentation to substantiate that the fetus was not living at the time of the D&C; that is, that this was not an abortion for pregnancy termination. This documentation may be 1) a sonogram report showing no fetal heart tones, 2) a history showing passage of fetus at home, in an ambulance, or in the emergency room, 3) a pathology report showing degenerating products of conception, or 4) an operative report showing products of conception in the vagina. All reports are not needed. These are examples of the information needed to provide enough documentation to properly review the claim and substantiate payment.

STATE-OPERATED HOSPITALS

STATE-OPERATED HOSPITALS AND PHYSICIANS SERVICES AT STATE HOSPITALS

State-operated hospitals and physicians performing services at a state-operated hospital are not required to obtain pre-certification for inpatient hospital stays (except for state freestanding and distinct part psychiatric hospitals). These hospitals "are required" to obtain "prior authorization" as in accordance with our policy for outpatient surgical procedures performed on an inpatient basis.

OUTPATIENT SURGERY PERFORMED ON AN INPATIENT BASIS (STATE HOSPITALS ONLY)

Providers requesting authorization for outpatient surgery done on an inpatient basis must use the Prior Authorization request form (PA01). Copies of the PA-01 form follow on pages 59 and 60. In addition, to expedite the review process, providers must continue to attach the appropriate medical data to substantiate the need for the service being provided in an inpatient setting. Documentation of extenuating circumstances should be submitted along with the request.

Medical authorization for the surgical procedure does not replace or in any way affect other policy requirements which may apply to surgical claims; e.g., sterilization consent requirements, recipient ineligibility for inpatient services and timely filing requirements. Medical authorization means only that the proposed procedure meets Louisiana Medicaid requirements of medical necessity for the service to be performed on an inpatient basis. If otherwise eligible for payment, a claim for the described services will be paid.

NOTE: When both the primary and secondary procedures require PA, all procedure codes must be listed on the PA01 request for authorization.

Completed PA01 forms should be submitted to the address indicated on the form and as noted below:

Unisys/Louisiana Medicaid
P. O. Box 14919
Baton Rouge, LA 70898-4919

The PA01 form should be submitted prior to the performance of the surgery, however, post authorization may be requested in certain instances.

Approval for inpatient performance of these procedures will be granted only when one or more of the following exception criteria exists:

- The presence of documented medical condition(s) which make prolonged pre-and/or postoperative observation by a nurse or skilled medical personnel a necessity;
- The procedure is likely to be time consuming or followed by complication;
- An unrelated procedure is being done simultaneously which requires hospitalization;
- There is a lack of availability of proper postoperative care;
- It is likely that another major surgical procedure could follow the initial procedure, e.g., mastectomy;
- Technical difficulties as documented by admission or operative notes could exist; and/or
- The procedure carries high patient risk.

  NOTE: Authorization is not required if the procedure is performed on an outpatient basis.

Reimbursement to hospitals for surgical procedures approved for inpatient performance will be made in accordance with the hospital's per diem rate for the dates of service.

MAIL TO:
UNISYS / LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

FAX TO: (225) 929-6803

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

CONTINUATION OF SERVICES ____YES ____ NO

P.A. NUMBER

PRIOR AUTHORIZATION TYPE: (1)
✓ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2): 1 2 3 4 5 6 7 8 9 1 2 3 4

Social Security No. (3):

RECIPIENT LAST NAME: Smith | FIRST: Johnny | MI (4):

DATE OF BIRTH (5): 09 08 1978

MEDICAID PROVIDER NUMBER (7- DIGIT) (6): 1 7 2 0 0 0 0

BEGIN DATE OF SERVICE (7) (MMDDYYYY): 09 13 2004

END DATE OF SERVICE (MMDDYYYY): 09 14 2004

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION: 360.4 Degenerated Conditions of Globe

SECONDARY CODE & DESCRIPTION:

PRESCRIPTION DATE (9) (MMDDYYYY): 09 13 2004

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)
Dr. James Dean

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S
1149					Other Removal or Destruction of Corneal	1					

(12) PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY ___ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: We Care Charity Hospital
ADDRESS: 45 Oak St.
CITY: Sunny STATE: LA ZIPCODE 70000
TELEPHONE: (337) 555 3825 FAX NUMBER: (337) 555 9680

(14) CASE MANAGER INFORMATION:
NAME:
ADDRESS:
CITY: STATE: ZIPCODE
TELEPHONE (____) _____ FAX NUMBER: (____) _____

(15) PROVIDER SIGNATURE: *Claire Belle*

(16) DATE OF REQUEST: 09/01/2004

PA-01 FORM

MAIL TO:
UNISYS / LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

FAX TO: (225) 929-6803

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S

(12)
PLACE OF TREATMENT: ____ RECIPIENT'S HOME ___ NURSING HOME ____ ICF-MR FACILITY ____ OUTPATIENT HOSPITAL / CLINIC

(13)

PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE _____

TELEPHONE: (___) ___ ___ FAX NUMBER: (___) ___ ___

(14) CASE MANAGER INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE _____

TELEPHONE (___) ___ ___ FAX NUMBER: (___) ___ ___

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-01 FORM

HOSPITAL BASED PHYSICIANS

Hospital-Based Physicians (HBP) are those persons who are either contracted or employed by the hospital to perform professional services. This group may include emergency room physicians, pathologists, radiologists, dentists, certified registered nurse anesthetists (CRNAs) and other physician specialties. The hospital must bill for the services provided by the HBP group. These professional service providers cannot directly bill Medicaid for their services.

ENROLLMENT OF HOSPITAL-BASED PHYSICIANS

Louisiana Medicaid Program enrolls hospital-based physicians as providers separate from the hospital. Hospitals are required to complete a provider enrollment form to obtain a group physician number to bill services provided by all physicians currently under contract with the hospital who do not have an agreement to bill Medicaid directly.

Enrollment procedures are as follows:

- The hospital must complete a provider enrollment form to obtain the hospital's HBP group physician number;
- Each physician under contract without an agreement to bill Medicaid directly must submit a completed enrollment form with a copy of the contract to receive a Medicaid individual provider number and to show affiliation with the hospital; and
- Hospitals which contract with such organizations as National Emergency Room Physicians should not complete a PE-50 for the organization, but they must complete a PE-50 for each physician who provides services under this contract.

This enrollment process can be completed at the time the physician appears at the hospital to provide services under the contract. Federal requirements for Medicaid Management Information Systems (MMIS) mandate that each physician have an individual provider number.

Hospitals may not combine bill to Medicaid for the Professional component of services provided by contract physicians using inpatient/outpatient hospital claim forms. Claims for contract physician services must be submitted on the CMS-1500, and the hospital group number must be entered in Item 33. The individual physician's provider number must be entered in Item 24K to identify the treating physician or the physician providing the services billed.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789101

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Maureen

3. PATIENT'S BIRTH DATE MM DD YY: 06 01 1999 | SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 6-digit TPL Carrier Code (if applicable)

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

CommunityCARE Authorization# (if applicable)

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 00 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	09 01 2004 09 01 2004	23		99282		1	75 00	1				1333333
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ 75 00

29. AMOUNT PAID $ TPL Pmt. (if any)

30. BALANCE DUE $ 75 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Cole James 09042004

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Moon Medical Center
1020 Main St.
Sunny, LA 70821

PIN# GRP# 1790000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BILLING PROCEDURES

USE OF "V" AND "E" DIAGNOSIS CODES

Before the Pre-certification Department can make a determination that there is a legitimate medical reason for a hospital stay, they must have the specific ICD-9 classification from categories 001-999. "V" diagnosis codes are condition codes used for supplementary classification rather than true diagnosis codes. The medical reason for the hospital admit cannot be determined from these codes. A "V" code is useful to show what underlying cause or condition brought about the illness or immediate cause for hospitalization. In light of this information, a "V" code is acceptable only when pre-certifying a newborn born to a non-Medicaid mother.

"V" diagnosis codes ARE accepted for billing Louisiana Medicaid for inpatient or outpatient claims.

"**E" diagnosis codes <u>ARE NOT</u> accepted** for Louisiana Medicaid billing or precertification.

SPLIT BILLING

Split billing is permitted by the Louisiana Medicaid Program only in the following circumstances:

- Hospitals must split bill claims when the hospital changes ownership.
- Acute Care and State Operated Hospitals must split bill claims on June 30 - State's fiscal year.
- Hospitals must split bill claims at the end of the hospital's fiscal year.
- Hospitals may split bill neonatal, rehabilitation, cardiac, and extended care claims every 30 days.
- Distinct Part Hospitals must split bill at the end of the calendar year (December 31st).
- Due to total charges exceeding $999,999.99.

SPLIT BILLING PROCEDURES

Providers submitting a hospital claim which crosses the date for the fiscal year end, should complete the claim in two parts: through the date of the fiscal year end and for the first day of the new fiscal year. In addition, providers should enter a note in the Remarks section of the claim indicating that the claim is part of a split billing.

More specific instructions for split billing on the UB-92 claim form are provided below:

1. In the Type of Bill block (form locator 4), the hospital must enter code 112, 113, or 114 to indicate the specific type of facility, the bill classification, and the frequency for both the first part or the split billing interim and any subsequent part of the split billing interim.

2. In the Patient Status block (form locator 22), the hospital must enter a 30 to show that the recipient is "still a patient."
   When split billing, the hospital should never code the claim as a discharge.

3. In the remarks section of the claim form (form locator 84), the hospital must write in the part of stay for which it is split billing. For example, the hospital should write in "Split billing for Part 1," if it is billing for Part 1.

Example claims to follow.

APPROVED OMB NO.

ABC Hospital
PO Box 1234
Anytown, LA 70809

2

3 PATIENT CONTROL NO. 2323343

4 TYPE OF BILL 112

5 FED. TAX NO. 711222311

6 STATEMENT COVERS PERIOD FROM 08102004 THROUGH 08122004

7 COV D. 3

8 N-C D.

9 C-I D.

10 L-R D.

11

12 PATIENT NAME Hall, Ann

13 PATIENT ADDRESS 1235 Rory Street, Baton Rouge, LA 70809

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	31
03211966	F	S	08102004	11	3	1	99	30	0064876633	C1	

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

Ann Hall
1235 Rory Street
Baton Rouge, LA 70809

38

39 VALUE CODES CODE / AMOUNT — a: 0
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	214	CCU / Intermediate	650.00		3	1950 00		
2	250	Pharmacy				428 00		
3	258	IV Solutions				218 40		
4	270	Med-Sur Supplies				508 00		
5	301	Lab / Chemistry				837 00		
6	302	Lab / Immunology				192 75		
7	305	Lab / Hematology				100 00		
8	306	Lab / Bact. Micro				50 75		
9	320	DX X-Ray				131 00		
10	500	Emergency Room				270 00		
11	732	Telemetry				99 50		
12	990	PT Convenience				4 50		
13								
14								
15								
16								
17								
18								
19	001	Total Charges				4140 95		
20								
21								
22								
23								

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	1777778	Y	Y			

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Hall, Ann		1700001112220		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
400001781			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
24200	2765	30590	462	7850					462		

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE
9			

OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID 089987 Adams, Mike

83 OTHER PHYS. ID PCP Auth # if applicable

OTHER PHYS. ID

84 REMARKS

SPLIT BILLING FOR PART 1

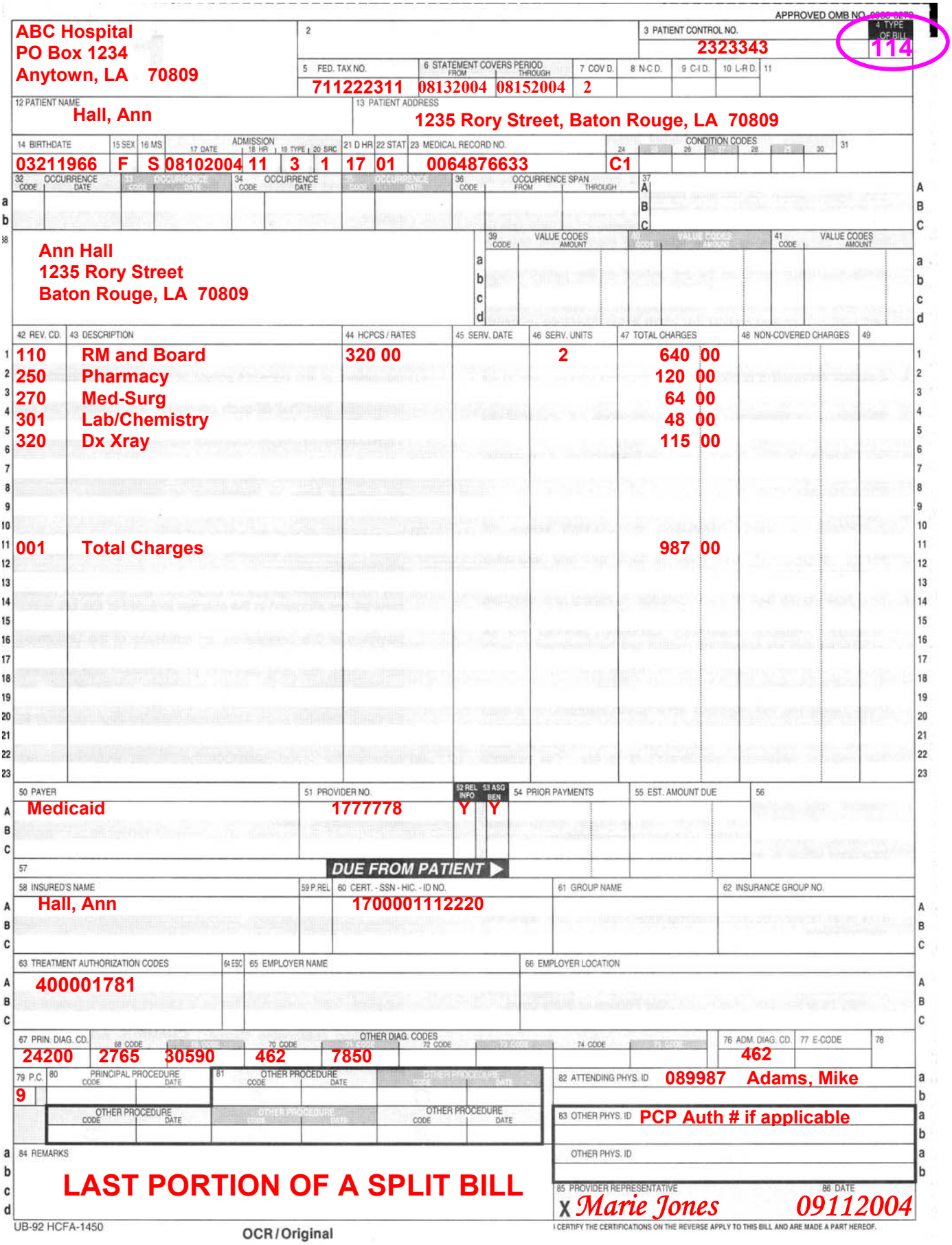
85 PROVIDER REPRESENTATIVE X Marie Jones

86 DATE 09112004

UB-92 HCFA-1450

OCR / Original

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



ABC Hospital
PO Box 1234
Anytown, LA 70809

APPROVED OMB NO.

3 PATIENT CONTROL NO. 2323343
4 TYPE OF BILL 114

5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 08132004 THROUGH 08152004
7 COV D. 2
8 N-C D.
9 C-I D.
10 L-R D.
11

12 PATIENT NAME Hall, Ann
13 PATIENT ADDRESS 1235 Rory Street, Baton Rouge, LA 70809

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 CONDITION CODES	31
03211966	F	S	08102004	11	3	1	17	01	0064876633	C1	

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
Ann Hall
1235 Rory Street
Baton Rouge, LA 70809

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	110	RM and Board	320 00		2	640 00		
2	250	Pharmacy				120 00		
3	270	Med-Surg				64 00		
4	301	Lab/Chemistry				48 00		
5	320	Dx Xray				115 00		
6								
7								
8								
9								
10								
11	001	Total Charges				987 00		
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

50 PAYER Medicaid
51 PROVIDER NO. 1777778
52 REL INFO Y
53 ASG BEN Y
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56

57 DUE FROM PATIENT

58 INSURED'S NAME Hall, Ann
59 P REL
60 CERT. - SSN - HIC. - ID NO. 1700001112220
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES 400001781
64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
24200	2765	30590	462	7850					462		

OTHER DIAG. CODES

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE
9			

OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID 089987 Adams, Mike
83 OTHER PHYS. ID PCP Auth # if applicable
OTHER PHYS. ID

84 REMARKS
LAST PORTION OF A SPLIT BILL

85 PROVIDER REPRESENTATIVE X Marie Jones
86 DATE 09112004
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450
OCR / Original

ADJUSTMENTS/VOIDS

A provider should initiate an adjustment or void immediately upon discovering an incorrect payment by Medicaid. To correct the payment, Unisys recommends filing a paper or electronic adjustment/void rather than sending a refund check. Adjusting or voiding is beneficial as it is faster and leaves a paper trail. Claims may only be adjusted or voided within two years of payment. Claims over two years old are dropped from Unisys history files and must be resolved via a refund check.

Recipient and Provider Numbers are items, which cannot be adjusted.

To adjust or void more than one claim line on an outpatient claim form, a separate UB92 form is required for each claim line since each line has a different Internal Control Number.

NOTE: If a TPL payment was not processed by the Fiscal Intermediary, an adjustment must be filed using reason code '01' (Third Party Liability Recovery).

When filing an adjustment or void on the UB92 Form Locator 84 "Remarks" and Locator 4 "Type of Bill" must be completed as follows:

UB-92 FORM LOCATOR 4

- Enter a three-digit code indicating the specific type of facility, bill classification and frequency.

- First Digit - Type Facility
  - 1 - Hospital
  - 8 - Special Facility

- Second Digit - Classification
  - 1 - Inpatient Medicaid and/or Medicare Part A or Parts A & B
  - 2 - Inpatient Medicaid and Medicare Part B Only
  - 3 - Outpatient or Ambulatory Surgical Center
  - 4 - Other - (Nonpatient)

- Third Digit - Frequency
  - 7 - Adjustment for Prior Claim
  - 8 - Void of Prior Claim

Example: Outpatient adjustment, type of bill would be 137.
Outpatient void, type of bill would be 138.

UB-92 FORM LOCATOR 84

- Enter an" A" for an adjustment or a" V "for a void.
- Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.
- Enter one of the appropriate reason codes:

Adjustments

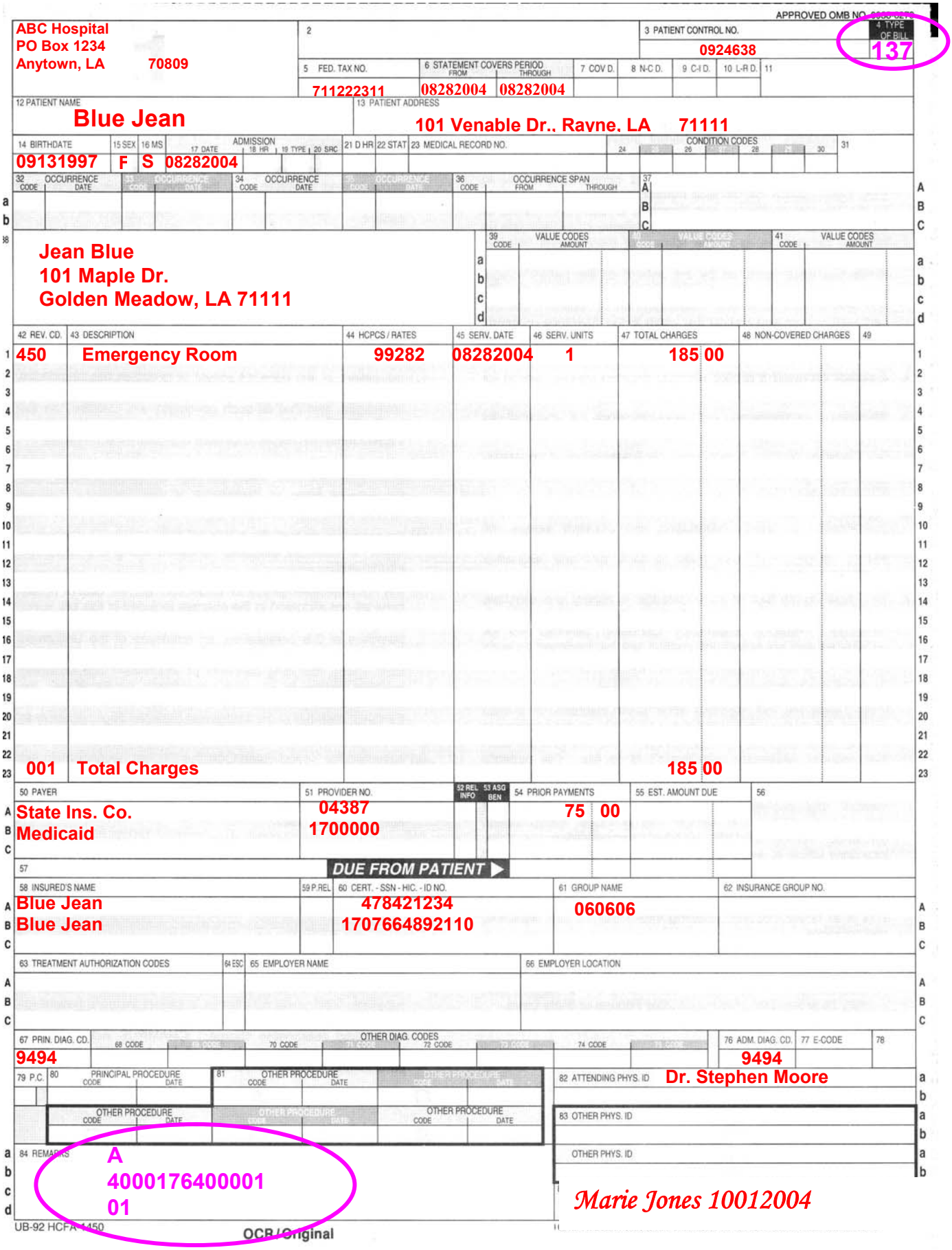
01 - Third Party Liability Recovery
02 - Provider Correction
03 - Fiscal Agent Error
90 - State Office Use Only - Recovery
99 - Other - Please Explain

Example: A
4000562646500
02

Voids

10-Claim Paid for Wrong Recipient
11-Claim Paid for Wrong Provider
00-Other

Example: V
4000164253000
00


APPROVED OMB NO.
ABC Hospital
PO Box 1234
Anytown, LA 70809
3 PATIENT CONTROL NO.
0924638
4 TYPE OF BILL
137
5 FED. TAX NO.
711222311
6 STATEMENT COVERS PERIOD
FROM 08282004
THROUGH 08282004
12 PATIENT NAME
Blue Jean
13 PATIENT ADDRESS
101 Venable Dr., Rayne, LA 71111
14 BIRTHDATE
09131997
15 SEX
F
16 MS
S
17 DATE
08282004
CONDITION CODES
Jean Blue
101 Maple Dr.
Golden Meadow, LA 71111
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
1
450
Emergency Room
99282
08282004
1
185 00
23
001
Total Charges
185 00
50 PAYER
51 PROVIDER NO.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
A
State Ins. Co.
04387
75 00
B
Medicaid
1700000
DUE FROM PATIENT
58 INSURED'S NAME
59 P.REL
60 CERT. - SSN - HIC. - ID NO.
61 GROUP NAME
62 INSURANCE GROUP NO.
A
Blue Jean
478421234
060606
B
Blue Jean
1707664892110
63 TREATMENT AUTHORIZATION CODES
64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.
9494
OTHER DIAG. CODES
76 ADM. DIAG. CD.
9494
77 E-CODE
79 P.C.
80 PRINCIPAL PROCEDURE
81 OTHER PROCEDURE
82 ATTENDING PHYS. ID
Dr. Stephen Moore
OTHER PROCEDURE
83 OTHER PHYS. ID
OTHER PHYS. ID
84 REMARKS
A
4000176400001
01
Marie Jones 10012004
UB-92 HCFA 1450
OCR/Original

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Smith, Maureen
3 PATIENT'S DATE OF BIRTH: 06011999
4 MEDICAID ID NUMBER: 1234567891011
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [X]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
6-digit TPL Carrier Code (if applicable)
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
CommunityCARE Auth# (if applicable)
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO [ ] CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 690.1
2
3
23 ATTENDING NUMBER: 1333333
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
09	02	2004	09	02	2004	23	99213		1	55 00	1		TPL Pmt. (if any)

26 CONTROL NUMBER: 400061287600
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 09/28/2004

28 REASONS FOR ADJUSTMENT
[ ] 01 THIRD PARTY LIABILITY RECOVERY
[X] 02 PROVIDER CORRECTIONS
[ ] 03 FISCAL AGENT ERROR
[ ] 90 STATE OFFICE USE ONLY - RECOVERY
[ ] 99 OTHER - PLEASE EXPLAIN
Billed wrong date of service in error

29 REASONS FOR VOID
[ ] 10 CLAIM PAID FOR WRONG RECIPIENT
[ ] 11 CLAIM PAID TO WRONG PROVIDER
[ ] 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Greta Biller 10/12/2004
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Downtown Medical Center
1020 Main St.
Sunny, LA 70808 1790000
32 YOUR PATIENT'S ACCOUNT NUMBER

FISCAL AGENT COPY

UNISYS - 213
5/97

ADDRESS FOR CLAIM / ADJUSTMENT SUBMISSIONS

Straight UB-92 claims and straight UB-92 adjustments and voids should be submitted to the following address:

Unisys
P.O. Box 91021
Baton Rouge, LA 70821

CMS-1500 claims and 213 adjustment/void forms for hospital-based physician services should be submitted to the following address:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

All crossover claims and Medicare adjustment and void claims should be submitted to:

Unisys
P.O. Box 91023
Baton Rouge, LA 70821

UB-92 BILLING INSTRUCTIONS

Hospitals should use the UB92 claim form to bill for hospital services provided to Medicaid recipients. The instructions used to complete the claim form follow the samples contained in this packet. In addition, a list of revenue codes hospitals need to complete the claim form is provided after the instructions. Fields noted with an * are required and claims will be denied if not entered.

Locator #	Description	Instructions
*1	Provider Name, Address, Telephone #	Required - Enter the name and address of the facility
2	Unlabeled Field (State)	Leave blank
3	Patient Control No.	Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 16 characters.
*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: a. First digit-type facility 1 Hospital 7 Clinic 8 Special Facility b. Second digit-classification 1 Inpatient Medicaid and/or Medicare Part A or Parts A & B 2 Inpatient Medicaid and Medicare Part B only 3 Outpatient or Ambulatory Surgical Center 4 Other (Non-patient) c. Third digit-frequency 0 Non-Payment claim 1 Admission through discharge 2 Interim-first claim 3 Interim-continuing 4 Interim-last claim 7 Replacement of prior claim 8 Void of prior claim
5	Federal Tax No.	Not required
*6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	Required - Enter the beginning and ending service
*7	Covered Days	**Required for inpatient -** Enter the number of days approved by the Utilization Review Committee as medically necessary. The

		number of covered days plus the number of non-covered days (Form Locator 8) must equal the number of days represented by the billing period in Form Locator 6. If the From and Through dates in Form Locator 6 are equal, enter "1" in "Covered Days."
8	Non-Covered Days	For inpatient, if applicable - Enter the number of days not approved by the Utilization Review Committee as medically necessary or leave days when not in the hospital for part of the stay. The number of non-covered days, plus the number of covered days (Form Locator 7), must equal the number of days represented by the billing period in Form Locator 6.
9	Co-Insurance Days	Required for Medicare Crossover.
10	Lifetime Reserve Days	Required for Medicare Crossover.
11	Patient's Phone No.	Not required - State Assigned.
*12	Patient's Name	Required - Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.
13	Patient's Address (City, State, Zip)	Enter patient's permanent address.
14	Patient's Birthdate	Enter the patient's date of birth using 8 digits (MMDDYYYY). If only one digit appears in a field, enter a leading zero.
15	Patient's Sex	Enter sex of the patient as M = Male F = Female U = Unknown
16	Patient's Marital Status	Not required
*17	Admission Date	Required for inpatient - Enter 6 digits for the date of admission (MMDDYY). If there is only one digit in a field, enter a leading zero.
*18	Admission Hour	Required for inpatient services - Enter the 2-digit code which corresponds to the hour the patient was admitted for inpatient care as: <u>Code Time</u> 00 12:00 - 12:59 midnight 01 01:00 - 01:59 A.M. 02 02:00 - 02:59 03 03:00 - 03:59 04 04:00 - 04:59 05 05:00 - 05:59 06 06:00 - 06:59 07 07:00 - 07:59 08 08:00 - 08:59 09 09:00 - 09:59 10 10:00 - 10:59 11 11:00 - 11:59 12 12:00 - 12:59 noon

		13 01:00 - 01:59 P.M. 14 02:00 - 02:59 15 03:00 - 03:59 16 04:00 - 04:59 17 05:00 - 05:59 18 06:00 - 06:59 19 07:00 - 07:59 20 08:00 - 08:59 21 09:00 - 09:59 22 10:00 - 10:59 23 11:00 - 11:59
*19	Type Admission	Required for inpatient - Enter one of the appropriate codes indicating the priority of this admission. 1 Emergency 2 Urgent 3 Elective 4 Newborn
20	Source of Admission	Required for inpatient - enter the appropriate code from the list of "Code Structure for Adult and Pediatrics: shown below. * Newborn coding structure must be used when the type of admission code in Form Locator 19 is "4" Valid codes if type of admission is 1, 2, or 3 1 Physician Referral 2 Clinic Referral 3 HMO Referral 4 Transfer from a Hospital 5 Transfer from a Skilled Nursing Facility 6 Transfer from Another Health Care Facility 7 Emergency Room **NOTE: 8 Court/Law Enforcement – is not a valid source of admission code.** *Valid code if type of admission is "4" 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth
21	Discharge Hour	Inpatient only - Enter the two-digit code which corresponds to the hour the patient was discharged. (See code structure under Admission Hour, Form Locator 19.)
*22	Patient Status	Required for inpatient - Enter the appropriate code to indicate patient status as of the Statement Covers through date. Valid codes are listed as follows: 01 Discharged (routine)

		02 Discharged to another short-term general hospital 03 Discharged to Skilled Nursing Facility 04 Discharged to Intermediate Care Facility 05 Discharged to another type of institution 06 Discharged to home under care of organized home health services 07 Left against medical advice 08 Discharge/Transfer to home care of Home IV provider 20 Expired 30 Still Patient * If interim billing, the patient status code must be "30", (frequency code 2 or 3 under type bill). Interim billing should only be submitted when the stay spans the hospital's fiscal year end.
23	Medical Record No.	Optional - Enter patient's medical record number (up to 16 characters)
*24-30	Condition Codes	Must be a valid code if entered. Valid codes are listed as follows: Insurance 01 Military service related 02 Condition is employment related 03 Patient is covered by insurance not reflected here 04 HMO Enrolled 05 Lien has been filed 06 End stage renal disease in first 18 months of entitlement covered by employer group insurance Accommodations 38 Semi-private room not available 39 Private room medically necessary 40 Same day transfer Special Program Indicators A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning PRO Approval C1 Approved as billed
31	Unlabeled Field	(National) Leave blank.
32-35	Occurrence Codes/Dates	a. Enter, if applicable.

		b. Each code must be two position numeric and have an associated date. c. Dates must be valid and in MMDDYY format. d. Valid codes are listed as follows: 01 Accident/Medical Coverage 02 Auto accident/no fault 03 Accident/tort liability 04 Accident/employment related 05 Accident/No Medical Coverage 06 Crime victim 21 UR/PSRO notice received 22 Date active care ended 24 Date insurance denied 25 Date benefits terminated by primary payer 40 Scheduled date of admission 41 Date of first test for pre-admission testing 42 Date of discharge when "Through" date in Form Locator 6 (Statement Covers Period) is **not** the actual discharge date **and** the frequency code in Form Locator 4 is that of final bill. A3,B3,C3 Benefits exhausted
36	Occurrence Span (Code and Dates)	Enter, if applicable - A code and related dates that identity an event that relates to the payment of the claim. Code and date must be valid. Date must be (MMDDYY) format. Valid codes are listed as follows: 72 First/Last visit 74 Non-covered Level of Care
37	A,B,C ICN/DCN # Original Bill	Not used for an adjustment of a Medicaid paid claim. Continue to use remarks section, Form Locator 84.
38	Responsible Party Name and Address	Not required.
*39-41	Value Codes and Amounts	**Required for benefit determination**. The value code structure is intended to provide reporting capability for those data elements that are routinely used but do not warrant dedicated fields. Value codes are listed as follows: 02 Hospital has no semi-private rooms. Entering the code requires $0.00 amount to be shown. 06 Medicare blood deductible 08 Medicare lifetime reserve first CY 09 Medicare coinsurance first CY

		10 Medicare lifetime reserve second year 11 Coinsurance amount second year 12 Working Aged Recipient/Spouse with employer group health plan 13 ESRD (End Stage Renal Disease) Recipient in the 12-month coordination period with an employer's group health plan 14 Automobile, no fault or any liability insurance 15 Worker's Compensation including Black Lung 16 VA, PHS, or other Federal Agency 30 Pre-admission testing - this code reflects charges for pre-admission outpatient diagnostic services in preparation for a previously scheduled admission. 37 Pints blood furnished 38 Blood not replaced - deductible is patient's responsibility 39 Blood pints replaced 80 Medicaid eligibility requirement that Medicare recipients utilize lifetime reserve days is not met. Recipient refuses to use available days. A1,B1,C1 Deductible A2,B2,C2 Coinsurance
*42	Revenue Code	**Required** - Enter the applicable revenue code(s) which identifies a specific accommodation and ancillary service. Accommodation codes require a rate in Form Locator 44. Revenue Codes 300-319 and 490 for outpatient also require a CPT/HCPCS procedure code in Form Locator 44. Must be a valid code. Must be in ascending sequence except for final entry for total charges (001). Revenue codes should be summed at the "zero" level (general classification) wherever possible. See Matrix for Revenue Codes to be used at detail line. If a revenue code is present, the amount charged must be present in Form Locator 47.
43	Revenue Description	For inpatient and outpatient claims. Enter the narrative description of the revenue code in the space preceding the dotted line.

*44	HCPCS/Rates HCPCS/CPT Code (Outpatient DX Lab)	**Required for inpatient** - Enter the accommodation rate for any accommodation revenue codes entered in Form Locator 42. If present, must be numeric. For revenue codes 300-319, enter the appropriate CPT/ HCPCS procedure code describing each lab service. For revenue code 490, enter the appropriate HCPCS procedure code for Ambulatory Surgical Services.
*45	Date of Service (Outpatient Only)	Enter the date of service for outpatient services in the last six digits of the revenue description. The date must be a valid date in (MMDDYYYY) format.
*46	Units of Service	Enter the quantity of services rendered by Revenue Category for the recipient.
*47	Total Charges	**Required** - Enter the total charges pertaining to the related revenue codes. Must be numeric. Revenue Code "001" represents the total amount charged for this bill, and should be the last entry.
48	Non-Covered Charges	Indicate charges included in column 47 which are not payable under the Medicaid Program.
49	Unlabeled Field (National)	Leave blank.
50-A,B,C	Payer ID	Enter Medicaid on Line "A" and other payers on Lines "B" and "C". If another insurance company is primary payer, enter name of insurer. If the patient is a Medically Needy Spend-down recipient or has made payment for non-covered services, indicate the patient as payer and the amount paid. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period. Value codes for payer identification are M = Medicaid Z = Medicare 4 = All other TPL carriers (specify)
*51-A,B,C	Provider Number	Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program. If the Medicaid provider number is not on line A, circle or otherwise highlight this number so that it can readily be recognized and keyed.
52-A,B,C	Release of Information	Not required.
53-A,B,C	Assignment of Benefits Cert. Ind.	Not required.
*54-A,B,C	Prior Payments	Enter the amount the hospital has received

		toward payment of this bill from private insurance carrier noted in Form Locator 50 B,C. If the patient has Medicare Part B only, enter the amount billed to Medicare.
55-A,B,C	Estimated Amt. Due	Not required.
56 & 57	Unlabeled Fields (56 State/57 National)	Leave blank.
*58-A,B,C	Insured's Name	**Required** - Enter the name of the insured as it appears on the Medicaid identification card. Enter the last name first, first name, middle initial. If there is insurance coverage carried by someone other than the patient, enter the name of that individual to correspond with 50 A,B,C.
59-A,B,C	Pt's. Relationship Insured	Enter the patient's relationship to insured from Form Locator 50 A,B, and C that relates to the insured's name in Form Locator 58 A,B, and C. Acceptable codes are as follows: 01 Patient is insured 02 Spouse 03 Natural child/Insured has financial responsibility 04 Natural child/ Insured does not have financial responsibility 05 Step child 06 Foster child 07 Ward of the court 08 Employee 09 Unknown 10 Handicapped dependent 11 Organ donor 13 Grandchild 14 Niece/Nephew 15 Injured Plaintiff 16 Sponsored dependent 17 Minor dependent of minor dependent 18 Parent 19 Grandparent
*60-A,B,C	Insured's ID. No.	Enter the recipient/patient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60-A. If there are other payers, enter the recipient's identification number as assigned by the other payers.
*61-A,B,C	Insured's Group Name (Medicaid not Primary)	If there is third party insurance, enter carrier code of the insurance company indicated in 50, on the corresponding line.
62-A,B,C	Insured's Group No. (Medicaid not Primary)	Enter the number or code assigned by the carrier or administrator to identify the group under which the individual is covered.
*63-A,B,C	Treatment Auth. Code	For services, requiring prior authorization or

		pre-certification, enter the prior authorization or pre-certification number. Do not bill more than one treatment authorization code per UB-92 and bill only the services covered by that one prior authorization or pre-certification code.
64-A,B,C	Employment Status Code	To determine primary/secondary responsibility for the bill. Valid codes are listed as follows: 1 Employed full time 2 Employed part-time 3 Not employed 4 Self-employed 5 Retired 6 On active military duty 9 Unknown
65-A,B,C	Employer Name	Enter the name of the employer that may provide health coverage for the patient.
66-A,B,C	Employer Location	Not required.
*67	Principal Diagnosis Codes	**Required** - Enter the ICD-9-CM code for principal diagnosis. Codes beginning with "E" or "M" are not acceptable for any diagnosis code.
68-75	Other Diag. Codes	Codes for diagnoses other than the principal diagnosis are entered in Form Locators 68-75.
76	Admit Diag. Code	Inpatient only.
77	External Cause Injury Code	Not required.
78	Unlabeled Field (State)	Leave blank.
79	Procedure Coding Method Used	Not required.
*80	Principal Procedure Code and Date	**Required** for Inpatient. For Outpatient required on dates of service prior to 10/01/04 for all surgical procedures. Enter a valid ICD-9-CM VOL III code and date for principal procedure. Date must be (MMDD) format. Date must be within date period shown in Form Locator 6.
81-A-E	Other Procedure Codes and Dates	Enter codes other than principal procedure performed during billing period. Must be completed for Inpatient. For Outpatient must be completed for all surgical procedures for dates of service prior to 10/01/04.
82	Attending Physician ID	Enter the name and/or number which identifies the physician. This can be the Medicaid ID No., the Louisiana Licensing NO., or the UPIN. ***Note: For sterilization procedures, the surgeon's name must appear in item 82.***
*83	Other Physician ID	Enter any other physician's licensing number

		(other than attending physician), i.e., surgeon when surgical procedure(s) are performed. ***Note: If the recipient is in the CommunityCARE program, enter the seven-digit referral/ authorization number from the primary care physician in 83A.***
84	Remarks	If Admission Source is "4" (transfer from a hospital) enter the name of the hospital the patient was transferred from. If adjustment or void (Form Locator 4, third digit equal "6" or "8") enter the ICN of the paid Medicaid claim and an "A" or "V" to indicate whether adjustment or void. Also enter a reason code: **Adj.** — **Void** 01 TPL Recovery — 10 Claim paid for wrong recipient 02 Provider correct — 11 Claim paid to wrong provider 03 Fiscal Agency error — 00 Other 99 Other
*85	Provider Rep. Signature	Enter the signature and title of the appropriate person at the facility who is authorized to submit Medicaid billing (Stamped signatures must be initialed).
*86	Date Bill Submitted	Enter the date the bill was signed and submitted for payment. Must be a valid date (MMDDYY) format. Must be greater than the through date in Form Locator 6.

*** Required Fields** - If not completed the claim will be denied.

CMS 1500 CLAIMS FILING INSTRUCTIONS

Professional services are billed on the CMS-1500) claim form. Items to be completed are either **required** or **situational**. **Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. **Situational** information may be required (but only in certain circumstances as detailed in the instructions below). Claims should be submitted to:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

1.	REQUIRED	Enter an "X" in the box marked Medicaid (Medicaid #)
*1A.	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 (MEVS) or through REVS

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

Note: If the 13-digit Medicaid ID 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.

*2.	REQUIRED	Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through MEVS or REVS
3.	SITUATIONAL	Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS or REVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.
4.	SITUATIONAL	Complete correctly if appropriate or leave blank
5.	SITUATIONAL	Print the recipient's permanent address
6.	SITUATIONAL	Complete if appropriate or leave blank
7.	SITUATIONAL	Complete if appropriate or leave blank
8.	SITUATIONAL	Leave blank
9.	SITUATIONAL	Complete if appropriate or leave blank
9A.	SITUATIONAL	If recipient has no other coverage, leave blank. If there is other coverage, put the state assigned 6-digit TPL carrier code in this block-make sure the EOB is attached to the claim.

9B.	SITUATIONAL	Complete if appropriate or leave blank
9C.	SITUATIONAL	Complete if appropriate or leave blank
9D.	SITUATIONAL	Complete if appropriate or leave blank
10.	SITUATIONAL	Leave blank
11.	SITUATIONAL	Complete if appropriate or leave blank
11A.	SITUATIONAL	Complete if appropriate or leave blank
11B.	SITUATIONAL	Complete if appropriate or leave blank
11C.	SITUATIONAL	Complete if appropriate or leave blank
12.	SITUATIONAL	Complete if appropriate or leave blank
13.	SITUATIONAL	Obtain signature if appropriate or leave blank
14.	SITUATIONAL	Leave blank
15.	SITUATIONAL	Leave blank
16.	SITUATIONAL	Leave blank
17.	SITUATIONAL	If services are performed by a CRNA, enter the name of the directing physician If services are performed by an independent laboratory, enter the name of the referring physician If services are performed by a nurse practitioner or clinical nurse specialist, enter the name of the directing physician If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name
17A.	SITUATIONAL	If the recipient is linked to a PCP, the Primary Care Physician referral authorization number must be entered here.
18.	SITUATIONAL	Leave blank
19.	SITUATIONAL	Leave blank
20.	SITUATIONAL	Leave blank
*21.	REQUIRED -	Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.
22.	SITUATIONAL	Leave blank
23.	SITUATIONAL	Complete if required or leave blank

*24A.	REQUIRED	Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.
*24B.	REQUIRED	Enter the appropriate code from the approved Medicaid place of service code list.
24C.	SITUATIONAL	Leave blank
*24D.	REQUIRED	Enter the procedure code(s) for services rendered.
*24E.	REQUIRED	Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a “1”, “2”, etc. More than one diagnosis may be related to a procedure. Do not enter ICD-9-CM diagnosis code
*24F.	REQUIRED	Enter usual and customary charges for the service rendered
*24G.	REQUIRED	Enter the number of units billed for the procedure code entered on the same line in 24D
24H.	SITUATIONAL	Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral
24I.	SITUATIONAL	Leave blank
24J.	SITUATIONAL	Leave blank
24K.	SITUATIONAL	Enter the attending provider number if group number is indicated in block 33
25.	SITUATIONAL	Leave blank
26.	SITUATIONAL	Enter the provider specific information to assigned to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.
27.	SITUATIONAL	Leave blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.
*28.	REQUIRED	Total of all charges listed on the claim
29.	SITUATIONAL	If block 9A is completed, indicate the amount paid; if no TPL, leave blank
30.	SITUATIONAL	If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from the billed charges

*31.	REQUIRED	The claim form **MUST** be signed. The practitioner is not required to sign the claim form. However, the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned unprocessed.
	Date	Enter the date of the signature
32.	SITUATIONAL	Complete as appropriate or leave blank
*33.	REQUIRED	Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid billing provider number must be entered in the space next to "Group (Grp) #."

Note**: If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.**

INSTRUCTIONS FOR FILING UNISYS 213 ADJUSTMENT/VOID CLAIMS

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

***2.** Patient's Name

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

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

3. Patient's Date of Birth

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

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

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

5. Patient's Address and Telephone Number

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

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

6. Patient's Sex

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

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

7. Insured's Name**—** Leave blank

8. Patient's Relationship to Insured**—**Leave blank

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

10. Other Health Insurance Coverage**—**Leave blank

11. Was Condition Related to**—**Leave blank

12. Insured's Address**—**Leave blank

13. Date of**—**Leave blank

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

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

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

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

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

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

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

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

***22.** Diagnosis of Nature of Illness

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

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

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

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

***25.** A through F

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

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

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

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

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

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

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

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

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

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

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
Exhausted Medicare Part A- documentation of Medicare being exhausted (MEOB), note in FL 84 (Remarks)	Continue hardcopy billing
Office Visits over limit - Form 158A for extension of office visits	Continue hardcopy billing
Bilateral procedures-operative notes	Continue hardcopy billing
Modifiers 22, 47, 51, 52, 62, 66 - medical documentation	Continue hardcopy billing
Physician hospital visits to newborn - medical necessity, letter requesting precert edit override	Continue hardcopy billing
Physician claims for inpatient visits (not newborn) when no precert exists----Admit and discharge summary	Continue hardcopy billing
All unlisted procedures - medical documentation	Continue hardcopy billing
Sterilization procedures - Form 96 Sterilization Form	Continue hardcopy billing
Abortion procedures - Abortion Informed Consent Form, signed statement from recipient, treating physician statement, medical necessity	Continue hardcopy billing
Hysterectomy procedures - Form 96A Hysterectomy Form	Continue hardcopy billing
Multiple Anesthesia - graph and operative report	Continue hardcopy billing
High Risk Pregnancy - charts, physician notes	Continue hardcopy billing
Consultation by Physician of same specialty - medical documentation	Continue hardcopy billing
Regular OV during pregnancy - medical documentation	Continue hardcopy billing
Norplant if earlier than 5 years - medical documentation	Continue hardcopy billing
Breast Reconstruction procedures - medical documentation	Continue hardcopy billing
Reduction Mammography - pathology report & approval letter, photographs	Continue hardcopy billing

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	BILLING REQUIREMENTS
Pediatric Conscious Sedation codes (99141, 99142) - medical necessity and anesthesia report	Continue hardcopy billing
Anesthesia for arteriograms, cardiac catheterizations, CT Scans, Angioplasties, and MRIs (bill with appropriate CPT from CPT Guide)	Continue hardcopy billing
Codes 62310, 62311, 62318, 62319 - operative & history reports	Continue hardcopy billing
Anesthesia for Intraperitoneal procedures in lower abdomen (code 00851) - BHSF Form 96	Continue hardcopy billing
Transplants - DHH approval letter, operative report	Continue hardcopy billing
Infectious agent detection (code 87799) - description of test & methodology	Continue hardcopy billing
Critical Care services - medical necessity	Continue hardcopy billing
Enterolysis (code 44005) - operative report or history	Continue hardcopy billing
Pathology Consultations (codes 80500, 80502) - medical necessity, list of tests, test results, consult narrative	Continue hardcopy billing
Neurobehavioral testing (codes 96115, 96117) - interpretive report signed by correct specialty	Continue hardcopy billing
Incomplete Abortion - history, sonogram, discharge summary, treatment	Continue hardcopy billing
Keloid initial visit - chart notes, statement from physician	Continue hardcopy billing
Radionuclides (code 78990) – copy of invoice for the nuclide	Continue hardcopy billing
Operating Microscope (code 69990) - operative report	Continue hardcopy billing
Stereotactic Procedures – operative report, medical necessity	Continue hardcopy billing
Transmyocardial revascularization - see Provider Update, 11/99 issue	Continue hardcopy billing
Sonograms (codes 76815, 76816) - medical necessity, dated notes	Continue hardcopy billing
Anesthesia claims for less than 10 minutes or more than 224 minutes – graph	Continue hardcopy billing

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, FAQs)

PROVIDER ASSISTANCE

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

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

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

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

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

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

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

RECIPIENT HELPLINE (800) 834-3333

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

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

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

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

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

NOTE: All correspondence sent to Provider Relations, including recipient file updates, must include a separate cover letter explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). **A copy of the claim form along with applicable corrections and/or attachments must accompany all resubmissions.**

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

Requests to update Third Party Liability (TPL) should be directed to:

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

"Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box. A complete list is available in this training packet under "Unisys Claims Filing Addresses".

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

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

Upon request, Provider Relations Field Analysts are available to visit and train new providers and their office staff on site. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However, since Field Analysts routinely work in the field, they <u>are not</u> available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

FIELD ANALYST	PARISHES SERVED		
Martha Craft **(225) 237-3306**	Jefferson Orleans	St. Charles Plaquemines St. Bernard	
Open	Bienville Bossier Caddo Claiborne East Carroll Lincoln Madison Morehouse Vicksburg, MS	Ouachita Richland Union Webster West Carroll Marshall, TX	
Mona Doucet **(225) 237-3249**	Acadia Evangeline Iberia Lafayette	St. Landry St. Martin St. Mary Vermillion	
Open	Allen Beauregard Calcasieu Cameron	Jeff Davis Lafourche Terrebonne Vernon	Beaumont, TX Jasper, 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		
WEB Technical Support Hotline-Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

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

DHH PROGRAM MANAGER REQUESTS

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

Program Manager - Hospital
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

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

Electronic Adjustments/Voids

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

SUBMISSION DEADLINES
Regular Business Weeks

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

Thanksgiving Week

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

Important Reminders For EDI Submission

- Denied claims may be resubmitted electronically unless the denial code states otherwise. This includes claims that have produced a denied claim turnaround document (DTA). Claims with attachments must be submitted hardcopy.

- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.

- The total amount of the submitted file must equal the amount indicated on the Unisys response file.

All claims submitted must meet timely filing guidelines.

ELECTRONIC DATA INTERCHANGE (EDI) GENERAL INFORMATION

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

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

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

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

    - Case Management services
    - Non-Ambulance Transportation

Enrollment Requirements For EDI Submission

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

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

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

Enrollment Requirements For 835 Electronic Remittance Advices

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

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

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

UNISYS CLAIMS FILING ADDRESSES

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

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

CLAIMS PROCESSING REMINDERS

Unisys Louisiana Medicaid images and stores all Louisiana Medicaid paper claims on-line. This process allows the Unisys Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

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

- Submit an original claim 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.

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: HOSPITAL					

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.**