UNISYS

NEMT PROVIDER TRAINING

Fall 2007

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

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 2007 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 recipient eligibility and ID cards, and third party liability. The 2006 Basic Training packet may be obtained by downloading it from the Louisiana Medicaid website, www.lamedicaid.com.

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES.
TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.
(See listing of numbers on attachment)

MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator 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. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.** Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828.

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED.
TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955
(or TTY 1-877-544-9544)

MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive Mental Health Rehabilitation Services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by mental health prior authorization unit.

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

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; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically 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 covered by Medicaid for recipients over the age of 21.

PERSONAL CARE SERVICES

Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. Personal Care 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 must be ordered by a physician. The PCS provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES

Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. *EARLYSTEPS* CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve 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.

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 in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544).
IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED,
CALL 1-888-758-2220 FOR ASSISTANCE.

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.

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)
*Support Coordination
*Speech and Language Evaluations and Therapies
*Occupational Therapy
*Physical Therapy
*Psychological Evaluations and Therapy
*Psychological and Behavior Services
*Podiatry Services
*Optometrist Services
*Hospice Services
*Extended Skilled Nurse Services
*Residential Institutional Care or Home and Community Based (Waiver) Services
*Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
*Immunizations
*Eyeglasses
*Hearing Aids
*Psychiatric Hospital Care
*Personal Care Services
*Audiological Services
*Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
*Appointment Scheduling Assistance
*Substance Abuse Clinic Services
*Chiropractic Services
*Prenatal Care
*Certified Nurse Midwives
*Certified Nurse Practitioners
*Mental Health Rehabilitation
*Mental Health Clinic Services

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

If you need a service that is not listed above call the referral assistance coordinator at KIDMED (toll free) 1-877-455-9955 (or TTY 1-877-544-9544). If they cannot refer you to a provider of the service you need call 225-342-5774.

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD Request for Services Registry, you may be eligible for support coordination services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office. If you are a Medicaid recipient under age 21, and it is medically necessary, you may be able to receive support coordination services immediately by calling SRI (toll free) at 1-800-364-7828.

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

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

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

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

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

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CSRAs

METROPOLITAN HUMAN SERVICES DISTRICT
Janise Monetta, CSRA
1010 Common Street, 5th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

CAPITAL AREA HUMAN SERVICES DISTRICT
Pamela Sund, CSRA
4615 Government St. – Bin#16 – 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Fee: 1-800-768-8824

REGION III
John Hall, CSRA
690 E. First Street
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

REGION IV
Celeste Larroque, CSRA
214 Jefferson Street – Suite 301
Lafayette, LA 70501
Phone (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

REGION V
Connie Mead, CSRA
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Phone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

REGION VI
Nora H. Dorsey, CSRA
429 Murray Street – Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
Rebecca Thomas, CSRA
3018 Old Minden Road – Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

REGION VIII
Deanne W. Groves, CSRA
122 St. John St. – Rm. 343
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
Marie Gros, CSRA
21454 Koop Drive – Suite 2H
Mandeville, LA 70471
Phone: (985) 871-8300
FAX: (985) 871-8303
Toll Free: 1-800-866-0806

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
Stephanie Campo, CSRA
Donna Francis, Asst CSRA
3300 W. Esplanade Ave. –Suite 213
Metairie, LA 70002
Phone (504) 838-5357
FAX: (504) 838-5400

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STANDARDS OF PARTICIPATION

Provider participation in Medicaid of Louisiana is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. These standards are listed as follows:

- Provider agreement and enrollment with the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH);

- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;

- Agreement to accept as payment in full the amounts established by the BHSF and refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.

- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services;

- **NOTE: Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, or the state Attorney General's Medicaid Fraud Control Unit.**

- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1978*, and, where applicable, *Title VII of the 1964 Civil Rights Act*.

Picking and Choosing Services

On March 20, 1991, Medicaid of Louisiana adopted the following rule:

> ***Practitioners who participate as providers of medical services shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by the provider as a Medicaid patient.***

This rule prohibits Medicaid providers from "picking and choosing" the services for which they agree to accept a client's Medicaid payment as payment in full for services rendered. Providers must bill Medicaid for **all** Medicaid covered services that they provide to their clients.

Providers continue to have the option of picking and choosing from which patients they will accept Medicaid. Providers are not required to accept every Medicaid patient requiring treatment.

Statutorily Mandated Revisions to All Provider Agreements

The 1997 Regular Session of the Legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437.14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

- comply with all federal and state laws and regulations;
- provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- have all necessary and required licenses or certificates;
- maintain and retain all records for a period of five (5) years;
- allow for inspection of all records by governmental authorities;
- safeguard against disclosure of information in patient medical records;
- bill other insurers and third parties prior to billing Medicaid;
- report and refund any and all overpayments;
- accept payment in full for Medicaid recipients providing allowances for copayments authorized by Medicaid;
- agree to be subject to claims review;
- the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- notification prior to any change in ownership;
- inspection of facilities; and,
- posting of bond or letter of credit when required.

MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive. The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify Provider Enrollment immediately that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.

Surveillance Utilization Review

The Department of Health and Hospitals' Office of Program Integrity, in partnership with Unisys, perform the Surveillance Utilization Review function of the Louisiana Medicaid program. This function is intended to combat fraud and abuse within Louisiana Medicaid and is accomplished by a combination of computer runs, along with medical staff that review providers on a post payment basis. Providers are profiled according to billing activity and are selected for review using computer-generated reports. The Program Integrity Unit of DHH also reviews telephone and written complaints sent from various sources throughout the state, including the fraud hotline.

☞ Program Integrity and SURS would also like to remind all providers that they are bound by the conditions of their provider agreement which includes but is not limited to those things set out in Medical Assistance Program Integrity Law (MAPIL) R.S. 46:437.1 through 440.3, The Surveillance and Utilization Review Systems Regulation (SURS Rule) Louisiana Register Vol. 29, No. 4, April 20, 2003, and all other applicable federal and state laws and regulations, as well as Departmental and Medicaid policies. Failure to adhere to these could result in administrative, civil and/or criminal actions.

Providers should anticipate an audit during their association with the Louisiana Medicaid program. When audited, providers are to cooperate with the representatives of DHH, which includes Unisys, in accordance with their participation agreement signed upon enrollment. Failure to cooperate could result in administrative sanctions. The sanctions include, but are not limited to:

- Withholding of Medicaid payments
- Referral to the Attorney General's Office for investigation
- Termination of Provider Agreement

Program Integrity and the Unisys Surveillance Utilization Review area remind providers **that a service undocumented is considered a service not rendered**. Providers should ensure their documentation is accurate and complete. All undocumented services are subject to recoupment. Other services subject to recoupment are:

- Upcoding level of care
- Maximizing payments for services rendered
- Billing components of lab tests, rather than the appropriate lab panel
- Billing for medically unnecessary services
- Billing for services not rendered
- Consultations performed by the patient's primary care, treating, or attending physicians

Fraud and Abuse Hotline

The state has a hotline for reporting possible fraud and abuse in the Medicaid Program. Providers are encouraged to give this phone number/web address to any individual or provider who wants to report possible cases of fraud or abuse.

Anyone can report concerns at (800) 488-2917 or by using the web address at http://www.dhh.state.la.us/offices/fraudform.asp?id=92

Deficit Reduction Act of 2005

Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC §1396(a)(68)), set forth in that subsection and as the Secretary of US Department of Health and Human Services may specify. As an enrolled provider, it is your obligation to inform all of your employees and affiliates of the provisions the provisions of False Claims Act. When monitored, you will be required to show evidence of compliance with this requirement.

- Effective July 1, 2007, the Louisiana Medicaid Program requires all new enrollment packets to have a signature on the PE-50 which will contain the above language.

- The above message was posted on LAMedicaid website, (https://www.lamedicaid.com/sprovweb1/default.htm), RA messages, and in the June/July 2007 Louisiana Provider Update

- Effective November 1, 2007, enrolled Medicaid providers will be monitored for compliance through already established monitoring processes.

- All providers who do $5 million or more in Medicaid payments annually, must comply with this provision of the DRA.

POLICY REMINDERS

Timeliness

Providers are responsible for picking up recipients in a timely manner to insure that they arrive at their appointments on time and are returned home within a reasonable amount of time. **If a provider accepts a trip, and then determines that he is unable to provide the service, the provider must notify the dispatch office immediately, provide an explanation, and notify the recipient.**

If a driver returns to pick up a recipient and cannot locate the recipient, the driver must determine if the recipient left the premises and make every attempt to locate the recipient. If the recipient cannot be located, the driver must notify his office immediately, and the provider must notify the dispatch office immediately. Failure on the part of the driver/provider to act responsibly may result in administrative sanctions, such as suspension from the program.

Efficient Trip Scheduling

Providers must transport as many recipients as the vehicles allow when there are individuals going to the same medical service during the same time period. However, when transporting recipients whose waiting time is excessive, recipients who are ready to leave should be taken home. The provider should either return later or send another vehicle to pick up recipients who had not completed their appointments.

Recipient Freedom Of Choice

The recipient is entitled to freedom of choice. A medical provider cannot decide for the recipient which transportation provider will be used. The dispatch office assigns trips based on the least costly means of transportation available in the geographic area, with consideration given to the recipient's preference.

Requests for transportation must be made directly to the dispatch office, not to individual transportation providers.

Canceled Trips/Dry Runs

A provider must be able to receive cancellations between 8:00 a.m. and 4:30 p.m. Monday through Friday. A provider may not file a claim for a trip, which has been canceled, by the dispatch office.

No payment is made for a dry run. A dry run occurs when a provider is assigned a trip and the recipient is not at the pick up point, or the recipient canceled the medical appointment. In order for a service to be billed, a recipient must be transported.

Provider Service Area

A provider service area is the parish or parishes in which the transportation provider is authorized to operate. A minimum of one vehicle must be available per parish in the service area. Health Standards approves requests to serve a particular area, as well as expansions or reductions in authorized service areas or changes in a provider's capacity. As part of the approval process, the provider's record keeping and billing activity will be reviewed for accuracy and compliance. Expansions will not be approved for providers requiring corrective action until necessary changes are made. Requests for expansion within 60 days of enrollment (or the last review which revealed no problems) will be granted without another review.

The transportation provider must be authorized to transport within the recipient's parish of origin.

Minimum Liability Insurance Requirements

A provider is required to have minimum liability insurance coverage of $100,000 per person and $300,000 per accident, or a combined single limit of $300,000 at all times. **Providers authorized to transport recipients out of state must carry a minimum of $1,500,000 in automobile liability coverage.** Automobile liability must include coverage for owned, hired, and non-owned autos.

Each provider must be covered at all times by **general liability insurance** to cover the business entity and maintain a minimum coverage of $300,000 combined single Limit of Liability at all times.

Failure to comply with the minimum liability insurance coverage requirements on each vehicle and on the business entity is grounds for immediate suspension as a Medicaid transportation provider. Operation without the minimum liability insurance coverage is a violation of the provider enrollment and participation requirements. All payments made during the period of violation are subject to recoupment.

The dispatch office is immediately notified by Health Standards when a provider is suspended for failure to comply with insurance requirements. In accordance with DHH policy, the dispatch office is instructed to immediately cancel trips assigned to the provider, including capitated trips, and to attempt to reschedule the trips. There are situations when the provider fulfills the requirements in a short time and becomes reinstated. If this is the case, and the reinstated provider is informed by dispatch that the trips have already been rescheduled, the dispatch office will not cancel the second provider in order to re-schedule the original provider. This is DHH policy; **it is the responsibility of the provider to comply with the insurance requirements.** Under no circumstances will the dispatch office schedule a trip with a provider who is out of compliance. Dispatch must receive notification of reinstatement from Health Standards before scheduling can resume.

Attendants/Children

Medicaid does not pay for the transportation of an attendant or accompanying children. The provider may not bill Medicaid, or the recipient, or anyone else for the transport of an attendant or a child.

The dispatch office is required to inform the transportation provider if a recipient intends to be accompanied by a child or children. The transportation provider may refuse to transport the child or children, or may refuse to transport more than one child or attendant. The transportation provider may determine that an adult recipient requires an attendant, and may require an attendant to accompany the recipient.

The dispatch office is responsible for determining if an attendant is needed for a recipient.

A parent, legal guardian, or responsible person must accompany children under the age 17.

The attendant **MUST:**

1. Be age 17 or older; and
2. Be designated by the parent if the attendant is not the parent or legal guardian; and
3. Be able to authorize medical treatment and to care for the child; and
4. Accompany the child to and from the medical appointment.

The attendant **MUST NOT:**

5. Be a Medicaid provider or employee of a Medicaid provider that is providing services to the recipient being transported; or
6. Be a transportation provider or an employee of a transportation provider; or
7. Be an employee of a mental health or substance abuse clinic.

Capitated Trips

DHH has changed the policy regarding capitated trips. Effective July 1, 2007 providers must wait until the end of each month to bill for capitated trips. This change will bring NEMT billing into compliance with the Medical Assistance Program Integrity (MAPIL) and establish consistency with other programs where providers are paid capitated rates.

MT-3s

Providers must maintain copies of MT-3s for all trips provided, including every trip of capitated arrangements. When all trips are NOT provided under a capitated rate, the provider must document the reason why each trip was not made. This documentation must include the date of the scheduled trip and the reason why the trip was not completed. When a provider identifies that a recipient has missed three trips in a month or two consecutive trips, they must notify Medical Dispatch immediately. Trips may be re-scheduled from a capitated arrangement to approval for single trips.

Daily Logs

Providers must maintain a daily log of transports. This policy is outlined in your NEMT provider manual chapter.

REIMBURSEMENT

Non-profit providers may not receive capitated payments. Only for-profit providers may be reimbursed at capitated rates. Capitated payments are based on the number of trips and the distance traveled. Additional trips for medical appointments related to the service for which the capitated trips are scheduled are included in the capitated rate. **A provider who accepts a capitated payment is required to provide transportation for related medical appointments, and no additional payment for these trips may be made.**

NEMT NON-AMBULANCE RATES AND CODES

PROFIT PROVIDERS	PROCEDURE CODE	RATES
Flat Rate	Z5177 (0-66 miles)	$ 20.60 per recipient
Negotiated	Z5178	To be given by dispatch
Capitated (urban)	Z5179 (0-65 miles round trip)	$ 206.01 per month
Capitated (rural)	Z5180 (66-120 miles round trip)	$ 274.68 per month
Enhanced Capitated (5 trips or more per week)	Z5182 (5 trips or more per week)	$ 434.91 per month
Remote Capitated (>120 miles round trip)	Z5183 (> 120 miles round trip)	$ 412.02 per month
Wheelchair Capitated (rural)	Z5184 (66-120 miles round trip)	$ 343.35 per month
Wheelchair Capitated (urban)	Z5185 (0-65 miles round trip)	$ 247.21 per month
Wheelchair local	Z5186	$ 34.34 per recipient
Capitated-Negotiated	Z5188	Determined by state office

NON-PROFIT PROVIDERS	PROCEDURE CODE	RATES
Flat Rate	Z9498	$ 14.00 per trip
Negotiated	Z5176	To be given by dispatch
Wheelchair local	Z5187	$ 24.00 per recipient

Friends & Family PROVIDERS	PROCEDURE CODE	RATES
Flat Rate	Z9486	$ 7.50 per trip
Negotiated	Z5181	To be given by dispatch
Capitated (Urban)	Z9494	$ 75.00 per recipient
Capitated (Rural)	Z9495	$ 115.00 per recipient

Please Note: These rates and codes are effective for dates of service December 1, 2006, however rates and codes are subject to change.

A provider who accepts a capitated rate to transport a recipient to a series of medical appointments must be available on each day an appointment is scheduled. For example, if a recipient needs transportation to and from a dialysis center on Tuesday, Thursday, and Saturday, transportation must be provided on all three days. A provider may not choose the days he/she is available to transport the recipient to the center. Also, the transportation provider must transport the recipient to and from the appointments unless otherwise specified by the recipient.

NEMT INTRA-STATE RATES (based on round trip mileage)

MILES	RATE
0-65	$ 20.60
66-95	$ 25.75
96-125	$ 34.34
126-155	$ 42.92
156-185	$ 51.50
186-215	$ 60.09
216-245	$ 68.67
246-275	$ 77.25
276-305	$ 85.84
306-335	$ 94.42
336-365	$ 103.01
366-395	$ 111.59
396-425	$ 120.17
426-455	$ 128.76
456-485	$ 137.34
486-515	$ 145.92
516-545	$ 154.51
546-575	$ 163.09
576-605	$ 171.68
606-635	$ 180.26
636-665	$ 188.84
666-695	$ 197.43
696-725	$ 206.01
736-755	$ 214.59
756-785	$ 223.18
786-815	$ 231.76
816-845	$ 240.35
846-875	$ 248.93

DOCUMENTATION

A provider must maintain sufficient documentation to identify that recipients were transported. Such documentation consists of points of origin and destinations, driver qualifications, vehicle capabilities, and safety. Documentation must be maintained for five (5) years from the date on which the claim is paid.

Providers must maintain documentation to substantiate the driver's identification and vehicle certifications in their records. This policy is outlined in your NEMT provider manual chapter.

Daily Schedule Of Transports

A provider must maintain a daily schedule of transports by parish of origin. The schedules must be available for review of trips by parish and by date. The schedule must include the recipient's name, address (or point of origin), appointment time, assigned driver(s), assigned vehicle(s), and destination.

FORM MT-3 AND INSTRUCTIONS FOR COMPLETION

The MT-3 provides verification that a medical appointment was kept. It is completed by the driver and signed by the recipient and the medical provider or representative to confirm that the trip was completed. If the recipient does not or will not sign the MT-3, an explanation must be given in the "remarks" section of the claim form (Form 106). Following are instructions for completion of the Form MT-3 and a sample MT-3 form.

Top Section of MT-3 Form:

Date of Transportation: complete space provided with the date the transportation is being provided.

Time of Appointment: complete space provided with the actual time of the medical appointment. Circle a.m. or p.m. as appropriate.

I. Recipient Verification of Medical Transportation

Transportation Provider Name: complete with provider's name.
Recipient's Name: complete with recipient's name as it appears on the medical eligibility card.
Recipient's ID #: complete with the recipient's 13-digit ID number.
Recipient's Address: complete with the recipient's complete address including zip code.

Signature and Date: the recipient must sign and date with that day's date. If the recipient signs with a mark, this mark must be witnessed by at least one person who can sign his/her name.

II. Driver Certification

The driver of the vehicle should sign and date the form, providing the name of the driver who picked up the recipient for the appointment and returned the recipient after the appointment.

III. Medical Service Provider Verification

The medical provider or his/her representative must complete section III.

If the recipient did not receive medical services, an explanation is required.

An office stamp is accepted, but the medical provider or his/her representative must also sign and give his/her title and date.

The MT-3 form may not be signed prior to the service being rendered.

The form should be returned to the transportation provider. Further information on the use of this form can be found in Section 7 of the Medicaid Transportation Services provider manual (issued January 20, 1998).

Reminders To NEMT Providers

- ✓ All fields on the Form MT-3 **MUST** be completed.

- ✓ Form MT-3 is to be signed on the day of transport. Neither the NEMT provider nor the Medical Service Provider should pre-date the form.

- ✓ All services for recipients are to be Prior Authorized. Recipients should not be transported without a Form MT-3.

- ✓ MT-3 forms submitted to Medical Dispatch AFTER transport will be denied.

- ✓ Weekend/after hours transports must have verbal authorization by paging Medical Dispatch.

- ✓ Providers refusing transports must fax the Prior Authorization request back to Medical Dispatch immediately so recipients can be rescheduled.

- ✓ MT-3 must be completed each time a recipient is transported (this includes capitated rates).

Form MT-3 (Revised 12/93)

DATE OF TRANSPORTATION 9 / 1 / 07
TIME OF APPOINTMENT 10:00 a.m./p.m.

I. RECIPIENT VERIFICATION OF MEDICAL TRANSPORTATION

Transportation Provider Name XYZ Medical Inc.

Recipient Name Faith Maebell ID # 0010600005421

Recipient Address 345 Now Dr. Happy LA 70020
Street City State Zip

Having no other form of transportation to receive medical treatment under the Medicaid Program, I have requested transportation services from the Department of Health and Hospitals. My signature below acknowledges that I am using transportation to keep a medical appointment. I understand that transportation services can only be used to receive medical services. I understand that if I do not sign this request for medical transportation and return it to the transportation provider, the Department of Health and Hospitals or a duly appointed representative may choose to contact me or the medical provider I am being transported to for verification that I have kept my medical appointment.

Faith Maebell 9/1/07
Signature Date

II. DRIVER CERTIFICATION

Check appropriate block(s)

☐ I certify that I was the driver who provided the above named recipient with transportation to the medical facility.

JR Walker 9/1/07
Signature Date

☐ I certify that I was the driver who provided transportation for the above named recipient from the medical facility to the recipient's home.

JR Walker 9/1/07
Signature Date

III. MEDICAL SERVICE PROVIDER VERIFICATION

This section must be completed by the medical service provider or his/her representative and returned to the transportation provider by the recipient when the recipient is picked up after the medical appointment. Completion of this section by the signature of anyone other than the medical provider or his/her representative who rendered the services is prohibited and may result in prosecution.

☐ I certify that the above named recipient had an appointment on 9 / 1 / 07 at 10:00 a.m./p.m. and received medical service.

☐ I certify that the above named recipient was in the office on ___/___/___ at _____ a.m./p.m. but did not receive medical services because_____

Provider Office Stamp

Do Right, MD 9/1/07
Signature and Title Date

Form MT-3 (Revised 12/93)

DATE OF TRANSPORTATION ___/___/____
TIME OF APPOINTMENT _____ a.m./p.m.

I. RECIPIENT VERIFICATION OF MEDICAL TRANSPORTATION

Transportation Provider Name_____

Recipient Name_____ ID #_____

Recipient Address_____

Street City State Zip

Having no other form of transportation to receive medical treatment under the Medicaid Program, I have requested transportation services from the Department of Health and Hospitals. My signature below acknowledges that I am using transportation to keep a medical appointment. I understand that transportation services can only be used to receive medical services. I understand that if I do not sign this request for medical transportation and return it to the transportation provider, the Department of Health and Hospitals or a duly appointed representative may choose to contact me or the medical provider I am being transported to for verification that I have kept my medical appointment.

_____ _____

Signature Date

II. DRIVER CERTIFICATION

Check appropriate block(s)

☐ I certify that I was the driver who provided the above named recipient with transportation to the medical facility.

_____ _____

Signature Date

☐ I certify that I was the driver who provided transportation for the above named recipient from the medical facility to the recipient's home.

_____ _____

Signature Date

III. MEDICAL SERVICE PROVIDER VERIFICATION

This section must be completed by the medical service provider or his/her representative and returned to the transportation provider by the recipient when the recipient is picked up after the medical appointment. Completion of this section by the signature of anyone other than the medical provider or his/her representative who rendered the services is prohibited and may result in prosecution.

☐ I certify that the above named recipient had an appointment on ___/___/___ at _____ a.m./p.m. and received medical service.

☐ I certify that the above named recipient was in the office on ___/___/___ at _____ a.m./p.m. but did not receive medical services because_____

_____

_____

Provider Office Stamp

_____ _____

Signature and Title Date

STATEWIDE DISPATCH SERVICE

REGIONAL TRANSPORTATION DISPATCH OFFICES Toll Free Numbers				
Region	**Parishes**		**Phone**	**Fax**
1-New Orleans	Orleans East Jefferson Plaquemines St. Bernard	St. Charles St. James St. John West Jefferson	Provider Line: (866) 272-5501	(800) 864-5226
2-Baton Rouge	Ascension Assumption East Baton Rouge East Feliciana Iberville Lafourche Livingston Pointe Coupee	St. Helena St. Tammany Tangipahoa Terrebonne West Baton Rouge Washington W. Feliciana	Provider Line: (866) 272-5501	(800) 864-5226
3-Lafayette	Acadia Evangeline Iberia Lafayette	St. Martin St. Mary Vermilion St. Landry	Provider Line: (866) 272-5501	(800) 864-5226
4-Lake Charles	Allen Beauregard Calcasieu	Cameron Jefferson Davis	Provider Line: (866) 272-5501	(800) 864-5226
5-Alexandria	Avoyelles Catahoula Concordia Grant	LaSalle Rapides Vernon Winn	Provider Line: (866) 272-5501	(800) 864-5226
6-Shreveport	Bienville Bossier Caddo Claiborne DeSoto	Natchitoches Red River Sabine Webster	Provider Line: (866) 272-5501	(800) 864-5226
7-Monroe	Caldwell East Carroll Franklin Jackson Lincoln Madison	Ouachita Richland Tensas Union West Carroll Morehouse	Provider Line: (866) 272-5501	(800) 864-5226

Complaints Against Dispatch

If provider has any complaints against the Dispatch Service, please forward a detailed description including:

1. Patient Name
2. Medicaid ID Number
3. Details of circumstances surrounding the complaint

Submit to:

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

CLAIMS FILING

Non-Emergency Medical Transportation claims are filed on the Unisys Form 106. Completed claims should be mailed to:

Unisys
P. O. Box 91022
Baton Rouge, LA 70821

- Normal, clean claims that go to the claims post office boxes should take no more than 30 calendar days from the date Unisys receives the claims to complete processing.

  Of course, claims that must pend will take longer to be paid. Nonetheless, these will appear in the provider's "claims in processing" RA section within the 30-day timeframe.

  - Voids are filed on the Unisys Form 206. **Non–Emergency, Non-Ambulance medical transportation claims <u>cannot</u> be adjusted, only voided.** If a claim was paid incorrectly, the payment must first be voided and then a correct 106 Form should be submitted to Unisys for payment consideration.

  Completed 206 forms should be mailed to the above address.

The following pages give the billing instructions for completing the 106 Form and the 206 Form. Also included are blank form copies and examples of a correctly completed Unisys 106 Form and 206 Form.

INSTRUCTIONS ON COMPLETING UNISYS FORM 106

1. Enter recipient's last name.

2. Enter recipient's first name.

3. Enter recipient's middle initial.

4. Enter the 13-digit Medicaid Identification number of the recipient. This information can be accessed by utilizing REVS, MEVS or e-MEVS.

5. Enter the recipient's address.

6. Enter the recipient's date of birth.

7. Enter the recipient's sex.

8. Enter the time, month, day, and year of the recipient's medical appointment.

9. Enter the origin of service.

10. Enter the destination of service.

11. Enter the 10-digit alphanumeric prior authorization number assigned by the dispatch office.

12. Check the appropriate block to indicate whether the scheduled service was one-way or two-way transport.

13. Leave blank.

14. This item serves as a reminder that all non-emergency medical transportation must be prior authorized by the dispatch office.

15. Leave blank.

16. Enter the name and address of the transportation provider providing the service.

17. Enter the provider's 7-digit Medicaid number.

18. Enter the name of the medical provider.

19. If applicable, enter the recipient's medical record number assigned by the medical service provider.

20. Leave blank.

21A. Enter the date the transportation service was rendered.

21B. Enter the correct origin code from those listed on the form to show where the trip began.

21C. Enter the correct destination code from those listed on the form to show where the trip ended.

21D. Enter the five-digit procedure code prior authorized by the dispatch office. Only one trip may be billed per claim form.

21E. Leave blank.

21F. Enter the monetary charge for the procedure code.

21G. Leave blank.

22. The provider or the provider's representative must sign and date the claim form. Stamped or computer-generated signatures will be accepted only if they are initialed by the provider or the provider's representative.

Note: The "remarks" section should be used to explain any unusual occurrences (i.e., the recipient or the medical provider refused to sign the MT-3 form).

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 SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 LAST NAME	2 FIRST NAME	3 MI	4 MEDICAL ASSISTANCE I.D. NUMBER
Faith	Maebell		1 2 3 4 5 6 7 8 9 0 1 2 3

5 PATIENT'S ADDRESS	6 DATE OF BIRTH	7 SEX	8 MEDICAL APPOINTMENT TIME
345 Now Drive	06 / 26 / 58	☐ M ☑ F	HOUR MO. DAY YEAR

9 ORIGIN OF SERVICE	10 DESTINATION OF SERVICE
Maebell, Faith (NAME)	Dr. Do Right (NAME)
345 Now Drive (STREET)	777 Do Right (STREET)
Happy, LA 70020 (CITY)	City of Gold, LA 72130 (CITY)

11	12 TRANSPORTATION AUTHORIZED IS	13 EPSDT REFERRAL
LL12345678	☐ ONE WAY ☒ TWO WAY	☐ YES ☐ NO

14 PRIOR AUTHORIZATION

I HEREBY CERTIFY THAT TRANSPORTATION FOR THIS RECIPIENT WAS MADE FOR A TITLE XIX COVERED SERVICE AND THAT ALL OTHER REASONABLE MODES OF TRANSPORTATION HAVE BEEN EXPLORED AND FOUND UNAVAILABLE.

15 SIGNATURE OF DHHR WORKER	TITLE	PARISH	DATE

TO BE COMPLETED BY TRANSPORTATION PROVIDER

16 PROVIDER NAME AND ADDRESS	17 PROVIDER NUMBER	18 TREATING PRACTITIONER'S NAME AND NUMBER
XYZ Medical Inc. 602 Yes Lane City of Gold, LA 72310	1234567	Dr. Do Right
	19 MEDICAL RECORD NUMBER	20 PAYMENT SOURCE OTHER THAN TITLE XIX ☐ YES ☐ NO TPL CARRIER CODES 1. 2. 3.

ORIGIN AND DESTINATION CODES

(1) INPATIENT HOSPITAL
(2) INTERMEDIATE CARE FACILITY
(3) OFFICE
(4) EMERGENCY ROOM
(5) CLINIC
(6) OUTPATIENT HOSPITAL
(7) HOME
(8) OTHER

21	A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
0	9 / 1 / 07	7	3	Z5177		20 60	
1							
2							
3							
	REMARKS:			TOTALS		$ 20 60	$

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

22 SIGNATURE OF PROVIDER	DATE SIGNED
J. Riddle	9/10/07

UNISYS 106
7/91

FISCAL AGENT COPY

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 SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 LAST NAME	2 FIRST NAME	3 MI	4 MEDICAL ASSISTANCE I.D. NUMBER

5 PATIENT'S ADDRESS	6 DATE OF BIRTH	7 SEX	8 MEDICAL APPOINTMENT TIME
		☐ M ☐ F	HOUR MO. DAY YEAR

9 ORIGIN OF SERVICE	10 DESTINATION OF SERVICE
NAME	NAME
STREET	STREET
CITY	CITY

11	12 TRANSPORTATION AUTHORIZED IS	13 EPSDT REFERRAL
	☐ ONE WAY ☐ TWO WAY	☐ YES ☐ NO

14 PRIOR AUTHORIZATION

I HEREBY CERTIFY THAT TRANSPORTATION FOR THIS RECIPIENT WAS MADE FOR A TITLE XIX COVERED SERVICE AND THAT ALL OTHER REASONABLE MODES OF TRANSPORTATION HAVE BEEN EXPLORED AND FOUND UNAVAILABLE.

15 SIGNATURE OF DHHR WORKER	TITLE	PARISH	DATE

TO BE COMPLETED BY TRANSPORTATION PROVIDER

16 PROVIDER NAME AND ADDRESS	17 PROVIDER NUMBER	18 TREATING PRACTITIONER'S NAME AND NUMBER
	19 MEDICAL RECORD NUMBER	20 PAYMENT SOURCE OTHER THAN TITLE XIX ☐ YES ☐ NO TPL CARRIER CODES 1. 2. 3.

ORIGIN AND DESTINATION CODES

(1) INPATIENT HOSPITAL
(2) INTERMEDIATE CARE FACILITY
(3) OFFICE
(4) EMERGENCY ROOM
(5) CLINIC
(6) OUTPATIENT HOSPITAL
(7) HOME
(8) OTHER

21	A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
0							
1							
2							
3							
				TOTALS		$	$

REMARKS:

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

22 SIGNATURE OF PROVIDER	DATE SIGNED

UNISYS 106
7/91

FISCAL AGENT COPY

INSTRUCTIONS ON COMPLETING UNISYS FORM 206

Non-Emergency, Non-Ambulance medical transportation claims may only be voided.. **Only a paid claim can be voided.** Providers submit their voids on the 206 form, which can be obtained by contacting Unisys Provider Relations. This form must be completed EXACTLY as it was filed initially**.**

1. Check "Void" box.
2. Enter recipient's last name.
3. Enter recipient's first name.
4. Enter recipient's middle initial.
5. Enter the 13-digit Medicaid Identification number of the recipient.
6. Enter the recipient's address.
7. Enter the recipient's date of birth.
8. Enter the recipient's sex.
9. Enter the time, month, day, and year of the recipient's medical appointment.
10. Enter the origin of service.
11. Enter the destination of service.
12. Enter transport authorization type.
13. Enter EPSDT referral.
14. Enter the name and address of the transportation provider providing the service.
15. Enter the provider's 7-digit Medicaid number.
16. Enter the name of the medical provider.
17. Enter the recipient's medical record number as assigned by the provider.
18. Leave blank.
19 Enter the information exactly as it appeared on the original claim form.
20. Remarks.
21. Enter the control number exactly as it appeared on the RA.
22. Enter the date of the Remittance Advice the claim paid.
23. Leave blank.
24. Check the appropriate box and write a brief narrative explaining the reason.
25. The provider or the provider's representative must sign and date the claim form.
26. Enter the date signed.

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 HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 ADJ [ ] VOID [X]

2 LAST NAME	3 FIRST NAME	4 MI	5 MEDICAL ASSISTANCE I.D. NUMBER
Faith	Maebell		1 2 3 4 5 6 7 8 9 0 1 2 3

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE)	7 DATE OF BIRTH	8 SEX	9 MEDICAL APPOINTMENT TIME
345 Now Drive	06 26 58	[ ] M [X] F	HOUR 10:00 MO. 8 DAY 28 YR. 07

10 ORIGIN OF SERVICE	11 DESTINATION OF SERVICE
Maebell Faith 345 Now Drive Happy, LA X	Dr. Do Right 777 Do Right Lane City of Gold, LA 72130

12 TRANSPORTATION AUTHORIZED IS [ ] ONE WAY [ ] TWO WAY

13 EPSDT REFERRAL [ ] YES [ ] NO

TO BE COMPLETED BY TRANSPORTATION PROVIDER

14 PROVIDER NAME AND ADDRESS	15 PROVIDER NUMBER	16 TREATING PRACTITIONER'S NAME AND NUMBER
XYZ Medical Inc. NAME 602 Yes Lane STREET City of Gold, LA 72310 CITY STATE ZIP	1234567 17 MEDICAL RECORD NUMBER	Dr. Do Right 18 PAYMENT SOURCE OTHER THAN TITLE XIX [ ] YES [ ] NO A. CARRIER B. POLICY NUMBER

ORIGIN OF DESTINATION
(01) INPATIENT HOSPITAL (03) OFFICE (05) CLINIC (07) HOME
(02) INTERMEDIATE CARE FACILITY (04) EMERGENCY ROOM (06) OUTPATIENT HOSPITAL (08) OTHER

19

A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
9/1/07	7	3	Z5177		20 60	
			TOTALS		$ 20 60	$

20 REMARKS:

21 CONTROL NUMBER
2234561234450

THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

22 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.
9/19/07

23 REASONS FOR ADJUSTMENT
[ ] 01 THIRD PARTY LIABILITY RECOVERY
[ ] 02 PROVIDER CORRECTIONS
[ ] 03 FISCAL AGENT ERROR
[ ] 90 STATE OFFICE USE ONLY - RECOVERY
[ ] 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

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

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

25 SIGNATURE OF PROVIDER	26 DATE SIGNED
Ima Biller	9/10/07

S.D.C.-206
1/93

FISCAL AGENT COPY

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 HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 ADJ ☐ VOID ☐

2 LAST NAME | 3 FIRST NAME | 4 MI | 5 MEDICAL ASSISTANCE I.D. NUMBER

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) | 7 DATE OF BIRTH | 8 SEX ☐ M ☐ F | 9 MEDICAL APPOINTMENT TIME HOUR MO. DAY YR.

10 ORIGIN OF SERVICE | 11 DESTINATION OF SERVICE

12 TRANSPORTATION AUTHORIZED IS ☐ ONE WAY ☐ TWO WAY | 13 EPSDT REFERRAL ☐ YES ☐ NO

TO BE COMPLETED BY TRANSPORTATION PROVIDER

14 PROVIDER NAME AND ADDRESS
NAME
STREET
CITY STATE ZIP

15 PROVIDER NUMBER

16 TREATING PRACTITIONER'S NAME AND NUMBER

17 MEDICAL RECORD NUMBER

18 PAYMENT SOURCE OTHER THAN TITLE XIX ☐ YES ☐ NO
A. CARRIER
B. POLICY NUMBER

ORIGIN OF DESTINATION
(01) INPATIENT HOSPITAL (03) OFFICE (05) CLINIC (07) HOME
(02) INTERMEDIATE CARE FACILITY (04) EMERGENCY ROOM (06) OUTPATIENT HOSPITAL (08) OTHER

19

A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
			TOTALS		$	$

20 REMARKS:

21 CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

22 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.

23 REASONS FOR ADJUSTMENT

- ☐ 01 THIRD PARTY LIABILITY RECOVERY
- ☐ 02 PROVIDER CORRECTIONS
- ☐ 03 FISCAL AGENT ERROR
- ☐ 90 STATE OFFICE USE ONLY - RECOVERY
- ☐ 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

24 REASONS FOR VOID

- ☐ 10 CLAIM PAID FOR WRONG RECEIPIENT
- ☐ 11 CLAIM PAID TO WRONG PROVIDER
- ☐ 99 OTHER - PLEASE EXPLAIN

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

25 SIGNATURE OF PROVIDER | 26 DATE SIGNED

S.D.C.-206
1/93

FISCAL AGENT COPY

FREQUENTLY ASKED QUESTIONS

Q: If a recipient name is 3 characters and has a title, such as Jr. or Sr., we are receiving 217 denials (name/number mismatch). How do I get these paid?

A: Enter the name on the claim exactly as it appears on the recipient's Medicaid ID card and send the claim with a cover letter of explanation to the Provider Relations Correspondence Unit (P.O. Box 91024, Baton Rouge, LA 70821). Be sure to indicate in the cover letter why the claim denied. Unisys will special handle the claim so payment can be considered.

Q: Can we bill for services when the recipient doesn't sign the MT-3 form?

A: You may bill for services rendered if the recipient doesn't sign the MT-3 form. You must indicate the reason why the recipient did not sign the MT-3 form in the remarks section of the claim form.

Q: Can one parent be designated to ride as attendant for several children if other parents sign a permission slip?

A: No. Even if permission were granted, the attendant would be totally liable for each child. The Attendant/Children Policy is explained on page 3 of this document and is for the protection of the recipients and providers.

CLAIM DENIALS AND RESOLUTION

This section is designed to assist the provider in resolving claim denials. The most frequently encountered error codes are listed, with an explanation of each denial and how to correct it.

Hardcopy Claim Denial Resolution

The following explanations assume that, if the claim was filed hardcopy, no data entry errors occurred when the claim was entered into the computer system by Unisys. If the information on the remittance advice does not match the data on the claim (recipient ID number, date of service, procedure code, recipient name, charges, etc.), then a data entry error occurred. Providers may call Unisys Provider Relations department to report the problem and request that the claim be reprocessed.

For Further Information

The topics of recipient eligibility verification (using REVS, MEVS and e-MEVS), spend-down medically needy eligibility, timely filing guidelines, SURS, and others are discussed in detail in the 2004 Basic Medicaid Provider Training packet. Providers may obtain a copy of this document by attending a 2004 Basic Medicaid Provider Training workshop, by requesting the packet from Provider Relations or by downloading from the www.lamedicaid.com website.

General Claim Form Completion Error Codes

ERROR CODE 003 – RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS	
Cause:	The recipient ID number on the claim form was less than 13 digits in length or included letters or other non-numeric characters.
Resolution:	Verify the correct 13-digit recipient ID number using REVS, MEVS, or e-MEVS and enter this number where required on the claim form.

ERROR CODE 009 - SERVICE THRU DATE GREATER THAN DATE OF ENTRY	
Cause:	Unisys received the claim prior to one or more dates of service billed.
Resolution:	Correct the date span on the claim and rebill **OR** wait until all dates of service on the claim have passed and rebill.

ERROR CODE 028 - INVALID OR MISSING PROCEDURE CODE	
Cause:	**1.** No procedure code was entered in block 21D of the Unisys 106 claim form, **OR**
	2. The procedure code entered in block 21D of the Unisys 106 claim form is invalid (usually because it has fewer than five characters).
Resolution:	Enter the correct procedure code in block 21D of the claim form and resubmit.

Recipient Eligibility Error Codes

ERROR CODE 215 - RECIPIENT NOT ON FILE	
Cause:	The recipient ID number on the claim form is not in the Unisys eligibility files.
Resolution:	Verify the correct 13-digit recipient ID number using REVS, MEVS, or e-MEVS and enter this number where required on the claim form. If there is a printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and the printout to the Correspondence Unit with a cover letter stating the problem.

ERROR CODE 216 - RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE	
Cause:	The recipient ID number on the claim is in the Unisys eligibility files, but the recipient's eligibility does not cover the date of service filed on the claim.
Resolution:	Verify the recipient's eligibility using REVS, MEVS, or e-MEVS for all dates of service on the claim. If there is a printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and the printout to the Correspondence Unit with a cover letter explaining the problem.

ERROR CODE 217 - NAME AND OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD	
Causes:	**1.** The name on the claim form does not match the recipient ID number as recorded in the Unisys eligibility files. This is sometimes caused when a recipient marries and changes her surname, or if several family members have similar ID numbers, **OR**
	2. The first and last names have been entered in reverse order on the claim form.
Resolution:	Verify the correct spelling of the name via REVS, MEVS, or e-MEVS using the 13-digit recipient ID number. Ensure that the first and last names are entered in the correct order on the claim. Make corrections if necessary and resubmit.

Timely Filing Error Codes

ERROR CODE 272 - CLAIM EXCEEDS 1 YEAR FILING LIMIT	
Cause:	The date of service on the claim form is more than 1 year prior to the date the claim was received by Unisys.
Resolution:	Resubmit the claim with proof of timely filing attached. Proof of timely filing may be a copy of a RA page that shows the claim was processed within one year from the date of service
Note: When refiling claims over one year old, it is not enough for the provider to know or to believe that he has filed the claim to Unisys within one year from the date of service – proof of timely filing must be attached to the claim, or the claim will deny. A history can be ordered to assist in determining if payment has been made or if a claim has been filed timely. This may be done by calling the Provider Relations Telephone Inquiry Unit). The Field Analyst for your territory may also assist in placing the order.	

ERROR CODE 030 - SERVICE "THRU" DATE MORE THAN TWO YEARS OLD	
Cause:	The date of service on the claim form is more than two years prior to the date the claim was received by Unisys.
Resolution:	Timely filing guidelines dictate that, in general, claims with dates of service over two years old are not payable. Unisys staff does not have the authority to override such claims.

Duplicate Claim Error Code

ERROR CODE 833 - EXACT DUPLICATE ERROR: IDENTICAL NON-AMBULANCE CLAIMS	
Cause:	The claim is a duplicate of one that has already been paid by Unisys.
Resolution:	On the Remittance Advice, the denial refers the provider to the conflicting control number and adjudication date of the previously paid claim. Refer to the Remittance Advice date indicated to find the claim that has already been paid.

Prior Authorization Error Codes

If there is **any** reason a prior authorization record sent to Unisys by the dispatch office does not download to the Unisys computer, then any claim filed with that prior authorization number would be denied. If the prior authorization record is re-transmitted to Unisys and is accepted, the claim for that service becomes payable.

Providers must bill services exactly as they are authorized by the dispatch office. The Medicaid computer system compares several items which must be the same on both the claim form and the prior authorization record: PA number, Medicaid recipient ID number, provider number, procedure code, and date of service. In addition, all claims must be filed with the correct PA number as indicated by the dispatch office.

The Remittance Advice reflects the PA number entered on each processed claim on the left-hand side of the document, just below the recipient name.

It is the responsibility of the Dispatch Office to assist the provider in processing claims that are denied for any reason having to do with prior authorization.

Several error codes pertain to the process the computer uses in matching items on the claim to items on the prior authorization record. An explanation of these error codes follows.

ERROR CODE 190 - PA NUMBER NOT ON FILE	
Cause:	The PA number on the claim is not in the Unisys computer system.
Resolution:	Check the PA number on the Remittance Advice for the denied claim. If the PA number on the Remittance Advice matches the PA number received from the dispatch office, contact the dispatch office. If the PA number on the claim does not match the PA number on the fax, correct the PA number on the claim and rebill.

ERROR CODE 191 – PROCEDURE REQUIRES PRIOR AUTHORIZATION	
Cause:	The claim was submitted with no PA number in block 11.
Resolution:	Verify the correct PA number using the faxed authorization from the dispatch office. Resubmit the claim with the correct PA number in block 11. Also, check to make sure the procedure code on the claim is the same code on the PA.

ERROR CODE 193 - DATE ON CLAIM NOT COVERED BY PA	
Cause:	The date of service on the claim does not match the covered dates for the PA number on the claim.
Resolution:	The accurate date of service should be determined. If the Remittance Advice reflects the correct date of service, call the dispatch office. If not, correct the date of service and rebill. Also, verify that the correct PA number was used on the claim. It is not acceptable to use the same authorization, which a trip is not made and then made at a later date.

ERROR CODE 194 - CLAIM EXCEEDS PRIOR AUTHORIZED LIMITS	
Cause:	The service indicated by the PA number on the claim has already been paid by Unisys.
Resolution:	Compare the authorization to the data submitted on the claim. Determine if the claim was already paid. Contact Dispatch to determine if they used the same authorization number for two different services.

ERROR CODE 196 - CLAIM RECIPIENT ID DOES NOT MATCH ID ON PRIOR AUTH FILE	
Cause:	The Medicaid ID number on the claim does not match the Medicaid ID number on the prior authorization record.
Resolution:	Correct the Medicaid ID number on the claim so that it matches the one on the PA.

ERROR CODE 197 – PA PROVIDER ID NOT SAME AS CLAIM PROVIDER ID	
Cause:	The provider number on the claim is not the provider on the PA file at Unisys.
Resolution:	Verify that the provider number on the claim is the same as the PA. If these do not match, contact Dispatch to ensure your correct provider number is on file.

ERROR CODE 198 - PA PROCEDURE NOT SAME AS CLAIM PROCEDURE	
Cause:	The procedure code on the claim is not the same as the procedure code on the PA file.
Resolution:	If the procedure code on the Remittance Advice matches the procedure code on the PA, call the dispatch office. If not, correct the procedure code and rebill.

ERROR CODE 199 - TRIP CANCELLED NON PAYABLE	
Cause:	The PA number billed on the claim form has been canceled by the dispatch office.
Resolution:	Ensure the claim is being billed with the correct PA number, as sometimes providers bill using a canceled PA number when a new PA number has been issued. Check records for a cancellation of the prior authorization number billed on the claim form. If the provider has not received a faxed cancellation or it is unclear why the PA was canceled, contact the dispatch office.

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
Recipient Eligibility Issues - copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing - letter/other proof i.e., RA page	Continue hardcopy billing

PLEASE NOTE: **When a provider submits a claim, which has more than one page of procedures and charges, each claim page must be totaled and attachments must be submitted with each page of the claim.**

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 www.lamedicaid.com web site; 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
- Prior Authorization (e-PA) for requesting prior authorizations electronically.

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

e-MEVS:

Providers can 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 one-year 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.

e-PA

The Electronic Prior Authorization (e-PA) Web Application has been developed for requesting prior authorizations electronically. E-PA is a web application found on the www.lamedicaid.com website and provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. This application is currently restricted to the following prior authorization types:

01 – Inpatient
05 – Rehabilitation
06 – Home Health
09 – DME
14 – EPSDT PCS
99 - Other

Providers who do not have access to a computer and/or fax machine will not be able to utilize the web application. However, prior authorization requests will continue to be accepted and processed using the current PA hard-copy submission methods.

NOTE: Dental electronic Prior authorization (e-PA) Web Application will be implemented at a later date. In order to utilize the Dental e-PA Web Application, the dental provider will be required to obtain the services of a vendor to submit the electronic attachment information to Medicaid. Complete Dental e-PA instructions will be provided upon implementation of Dental e-PA.

Reminders:

PA Type 01: Outpatient Ambulatory Surgery performed Inpatient on the first or second day of the stay. This is only for State Operated hospitals and Out-of-State hospitals that have a DHH approval letter for the out of state stay. Use ICD-9-CM procedure codes.

PA Type 99: Outpatient Ambulatory Surgery (CPT procedures) performed Inpatient on the first or second day of the stay. The surgery was performed at a State Operated hospital and Out-of-State hospital that has a DHH approval letter for the out of state stay. This is also used for specialized CPT procedures. This is for professional services only.

PA Type 05: Providers must always submit the PA02 Form with each request. Do not request authorization for the evaluation procedures, these do not require prior approval. Submit only units on the e-PA transaction, Do Not submit dollar amounts.

Home Health Providers submitting Rehab Services should use PA Type 05 and PA Type 09 when submitting DME Services.

PA Type 09: When submitting a request with a miscellaneous procedure code, the provider must submit a PA01 Form with the description of the item they are requesting.

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

RECONSIDERATION REQUESTS (RECONS) CAN BE SUBMITTED USING e-PA AS LONG AS THE ORIGINAL REQUEST WAS SUBMITTED THROUGH e-PA.

Additional DHH Available Websites

www.lamedicaid.com: Louisiana Medicaid Information Center which includes Field Analyst listing, RA messages, Provider Updates, Preferred Drug Listings, General Medicaid Information, Fee Schedules, and Program Training Packets

www.dhh.louisiana.gov: DHH website – LINKS (includes a link entitled "Find a doctor or dentist in Medicaid")

www.dhh.state.la.us: Louisiana Department of Health and Hospitals (DHH)

www.la-kidmed.com: KIDMED – Program Information, Frequently Asked Questions, Outreach Material ordering

www.la-communitycare.com: CommunityCARE – Program Information, PCP Listings, Frequently Asked Questions, Outreach Material ordering

https://linksweb.oph.dhh.louisiana.gov: Louisiana Immunization Network for Kids Statewide (LINKS)

www.ltss.dhh.louisiana.gov/offices/?ID=152: Division of Long Term Community Supports and Services (DLTSS)

www.dhh.louisiana.gov/offices/?ID=77: Office of Citizens with Developmental Disabilities (OCDD)

www.dhh.louisiana.gov/offices/?ID=334: EarlySteps Program

www.dhh.louisiana.gov/rar: DHH Rate and Audit Review (Information on Nursing Home, Adult Day Healthcare, Hospice, Administrative Claiming, Sub-Acute Care, PACE, and Assisted Living; Cost Reporting Information, Contacts and FAQ's.)

www.doa.louisiana.gov/osp/aboutus/holidays.htm: State of Louisiana Division of Administration site for Official State Holidays

PROVIDER ASSISTANCE

The Louisiana Department of Health and Hospitals and Unisys maintain a website to make information more accessible to LA Medicaid providers. At this online location, www.lamedicaid.com, providers can access information ranging from how to enroll as a Medicaid provider to directions for filling out a claim form.

Below are some of the most common topics found on the website:

New Medicaid Information
National Provider Identifier (NPI)
Disaster
Provider Training Materials
Provider Web Account Registration Instructions
Provider Support
Billing Information
Fee Schedules
Provider Update / Remittance Advice Index
Pharmacy
Prescribing Providers
Provider Enrollment
Current Newsletter and RA
Helpful Numbers
Useful Links
Forms/Files/User Guidelines

- ☞ The website also contains a section for Frequently Asked Questions (FAQ) that provide answers to commonly asked questions received by Provider Relations.

Along with the website, the Unisys Provider Relations Department is available to assist providers. This department consists of three units, (1) Telephone Inquiry Unit, (2) Correspondence Unit, and (3) Field Analyst. The following information addresses each unit and their responsibilities.

Unisys Provider Relations Telephone Inquiry Unit

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification; ordering printed materials; billing denials/problems; requests for Field Analyst visits; etc.

(800) 473-2783 or (225) 924-5040
FAX: (225) 216-6334*

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

The following menu options are available through the Unisys Provider Relations telephone inquiry phone numbers. Callers should have the 7-digit LA Medicaid provider number available to enter the system. Please listen to the menu options and press the appropriate key for assistance.

Press #2 - To order printed materials only**
Examples: Orders for provider manuals, Unisys claim forms, and provider newsletter reprints. To choose this option, press "2" on the telephone keypad. This option will allow providers to leave a message to request printed materials **only**. Please be sure to leave (1) the provider name, (2) provider number, (3) contact person, (4) complete mailing address, (5) phone number and (6) specific material requested.

- ☞ Only messages left in reference to printed materials will be processed when choosing this option. Please review the other options outlined in this section for assistance with other provider issues.

- ☞ Fee schedules, TPL carrier code lists, provider newsletters, provider workshop packets and enrollment packets may be found on the LA Medicaid website. Orders for these materials should be placed through this option **ONLY** if you do not have web access.

- ☞ Provider Relations staff mail each new provider a current copy of the provider manual and training packet for his program type upon enrollment as a Medicaid provider. An enrolled provider may also request a copy of the provider manual and training packet for the Medicaid program in which he is enrolled. A fee is charged for provider manuals and training packets ordered for non-providers (attorneys, billing agents, etc.) or by providers wanting a manual for a program for which they are not enrolled. All orders for provider manuals and training packets should be made by contacting the Provider Relations Telephone Inquiry Unit. Those requiring payment will be forwarded to the provider once payment is received.

Provider Relations cannot assist recipients. The telephone listing in the "Recipient Assistance" section found on page 80 should be used to direct Medicaid recipient inquiries appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

Press #3 - To verify recipient or provider eligibility; Medicare or other insurance information; Primary Care Physician information; or service limits.

- Recipient eligibility
- Third Party (Insurance) Resources
- CommunityCARE
- Lock-In

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

Press #4 - To resolve a claims problem

Provider Relations staff are available to assist with resolving claim denials, clarifying denial codes, or resolving billing issues.

NOTE: Providers must use e-CSI to check the status of claims and e-CSI in conjunction with remittance advices to reconcile accounts.

Press #5 – To obtain policy clarification, procedure code reimbursement verification, request a field analyst visit, or for other information.

Unisys Provider Relations Correspondence Group

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

Providers who wish to submit problem claims for research and want to receive a written response, **must submit a 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.

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**: Many providers submit claims that do not require special handling to the Provider Relations Department hoping to expedite processing of these claims. However, this actually delays claim processing, as the claims must pass through additional hands before reaching the appropriate processing area. In addition, it diverts productivity that would otherwise be devoted to researching and responding to provider requests for assistance with legitimate claim problems. Providers are asked to send claims that do not require special handling directly to the appropriate post office box for that claim type.

Eligiblity File Updates: Provider Relations staff also handles requests to update recipient files with correct eligibility. Staff in this unit 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.

TPL File Updates: 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: "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". **CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.**

Claims Over Two Years Old: Providers are expected to resolve claims issues within two years from the date of service on the claims. The process through which claims over two years old will be considered for re-processing is discussed in this training packet under the section, Timely Filing Guidelines. In instances where the claim meets the DHH established criteria, a detailed letter of explanation, the hard copy claim, and required supporting documentation must be submitted **in writing** to the Provider Relations Correspondence Unit at the address above. **These claims may not be submitted to DHH personnel and will not be researched from a telephone call to DHH or the Provider Inquiry Unit.**

Unisys Provider Relations Field Analysts

Provider Relations Field Analysts are available to visit and train new providers and their office staff on site, upon request. 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 the Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for material, or other policy documentation. These calls should not be directed to the Field Analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

FIELD ANALYST	PARISHES SERVED	
Kellie Conforto (225) 216-6269	Jefferson Orleans Plaquemines	St. Bernard St. Tammany **(Slidell Only)**
Stacey Fairchild (225) 216-6267	Ascension Assumption Calcasieu Cameron Jeff Davis Lafourche St. Charles	St. James St. John St. Martin **(below Iberia)** St. Mary Terrebonne Vermillion Beaumont (TX)
Tracey Guidroz (225) 216-6201	West Baton Rouge Iberville Tangipahoa St. Tammany **(except Slidell**)	Washington Centerville (MS) McComb (MS) Woodville (MS)
Ursula Mercer (225) 216-6273	Bienville Bossier Caddo Caldwell Claiborne Catahoula Concordia East Carroll Franklin Jackson	LaSalle Lincoln Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Vicksburg (MS) Marshall (TX)
Kelli Nolan (225) 216-6260	East Baton Rouge East Feliciana Livingston	Pointe Coupee St. Helena West Feliciana
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin **(above Iberia)**
Sherry Wilkerson (225) 216-6306	Avoyelles Beauregard DeSoto Grant Natchitoches Rapides	Red River Sabine Vernon Winn Jasper (TX) Natchez (MS)

Provider Relations Reminders

The Unisys Provider Relations inquiry staff strives to respond to provider inquiries quickly and efficiently. There are a number of ways in which the provider community can assist the staff in responding to inquiries in an even more timely and efficient manner:

- Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:
    - The correct 7-digit LA Medicaid provider number
    - The 13-digit Recipient's Medicaid ID number
    - The date of service
    - Any other information, such as procedure code and billed charge, that will help identify the claim in question
    - The Remittance Advice showing disposition of the specific claim in question
- Obtain the name of the phone representative you are speaking to in case further communication is necessary.
- Because of the large volume of incoming provider calls, Telephone Inquiry staff are not allowed to be put on hold after answering a call.
- PLEASE review and reconcile the remittance advice before calling Provider Relations concerning claims issues. Some providers call Provider Relations frequently, asking questions that could be answered if the RA was reviewed thoroughly. However, providers are encouraged to call Provider Relations with questions concerning printed policy, procedures, and billing problems.
- **Provider Relations WILL NOT reconcile provider accounts or work old accounts for providers. Calls to check claim status tie up phone lines and reduce the number of legitimate questions and inquiries that can be answered. It is each provider's responsibility to establish and maintain a system of tracking claim billing, payment, and denial. This includes thoroughly reviewing the weekly remittance advice, correcting claim errors as indicated by denial error codes, and resubmitting claims which do not appear on the remittance advice within 30 - 40 days for hard copy claims and three weeks for EDI claims**.
- **Providers can check claim status through the e-CSI (Claim Status Inquiry) web application found in the secure area of the Louisiana Medicaid website at www.lamedicaid.com. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on e-CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the e-CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to e-CSI or hard copy remittance advices for this purpose. This includes provider's direct staff and billing agents or vendors. A LA Medicaid/HIPAA Error Code Crosswalk is available on the website by accessing the link, Forms/Files.**

- If a provider has a large number of claims to reconcile, it may be to the provider's advantage to order a provider history. Please see the Ordering Information section for instructions on ordering a provider history.

- **Provider Relations cannot assist recipients.** The telephone listing in the "Recipient Assistance" section found in this packet should be used to direct Medicaid recipient inquires appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

- Providers who wish to submit problem claims for a written response **must submit a cover letter** explaining the problem or question.

- Calls regarding eligibility, claim issues, requests for Unisys claim forms, manuals, or other policy documentation should not be directed to the Field Analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit.

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

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) 216-6334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 216-6381	(225) 216-6334
Electronic Media Claims (EMC) - Unisys		(225) 216-6000 option 2	(225) 216-6335
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 216-6342
Dental P.A. - LSU School of Dentistry		(225) 216-6470	(225) 216-6476
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 216-6370	
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) 925-6606	Providers may request verification of eligibility for presumptively eligible recipients; recipients may request a new card or discuss eligibility issues.
Eligibility Operations – **BHSF**	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information about the LaCHIP Program that expands Medicaid eligibility for children from birth to 19.
Office of Public Health - **Vaccines for Children Program**	(504) 838-5300	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Specialty Care Resource Line - **ACS**	(877) 455-9955	Providers and recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED. Providers may inquire about PCP assignment for CommunityCARE recipients and CommunityCARE monitoring/certification, and obtain information on KIDMED linkage, referrals, monitoring, and certification.
Louisiana Medicaid Nurse Helpline – **ACS**	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - **OCDD**	(866) 327-5978	Providers and recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4149	Providers may request termination as a recipient's lock-in provider.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (866) 758-5035	Providers and recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 342-0095 (866) 783-5553	Providers and recipients may request assistance regarding waiver services to waiver recipients.
Family Planning Waiver	(225) 219-4153	Providers may request assistance about the family planning waiver.
DHH Rate and Audit	(225) 342-6116	For LTC, Hospice, PACE, and ADHC providers to address rate setting and claims or audit issues.

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

Provider Relations cannot assist recipients. The telephone listing below should be used to direct recipient inquiries appropriately.

Department	Phone	Purpose
Fraud and Abuse Hotline	(800) 488-2917	Recipients may anonymously report any suspected fraud and/or abuse.
Regional Office – DHH	(800) 834-3333 (225) 925-6606	Recipients may request a new card or discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Specialty Care Resource Line - ACS	(877) 455-9955	Recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED.
Louisiana Medicaid Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program – OCDD	(866) 327-5978	Recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Recipients may obtain immunization information.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (800) 660-0488	Recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 342-0095 (866) 783-5553	Recipients may request assistance regarding waiver services.
Family Planning Waiver	(225) 219-4153	Recipients may request assistance regarding family planning waiver services.

NOTE: Providers should not give their provider numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

BHSF REGIONAL TRANSPORTATION INSPECTORS

Provided below is a list of the contact telephone and fax numbers for BHSF Regional Medical Transportation Inspectors:

REGIONAL TRANSPORTATION INSPECTORS		
REGION	**PHONE**	**FAX**
New Orleans	(504) 568-7900	(504) 568-8335
Baton Rouge	(225) 922-2234	(225) 922-2620
Thibodaux	(504) 447-0860	(504) 447-0866
Lafayette	(318) 262-5264	(318) 262-5373
Lake Charles	(318) 491-2179	(318) 491-2287
Alexandria	(318) 487-5244	(318) 487-5722
Shreveport	(318) 832-9899	(318) 676-7420
Monroe	(318) 362-3324	(318) 362-3247
Mandeville	(504) 624-4177	(504) 624-4161

DHH Program Manager Requests

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

Program Manager - (i.e. NEMT)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

ELECTRONIC DATA INTERCHANGE (EDI)

Claims Submission

Electronic data interchange submission is the preferred method of submitting Medicaid claims to Unisys. With electronic data, a provider or a third party contractor (billing agent) submits Medicaid claims to Unisys on a computer encoded magnetic tape, diskette or via telecommunications.

Each claim undergoes the editing common to all claims, e.g., verification of dates and balancing. Each type of claim has unique edits consistent with the requirements outlined in the provider manuals. All claims received via electronic data must satisfy the criteria listed in the manual for that type of claim.

Advantages of submitting claims electronically include increased cash flow, improved claim control, decrease in time for receipt of payment, automation of receivables information, improved claim reporting by observation of errors and reduction of errors through pre-editing claims information.

Certification Forms

Any submitter - individual providers, clearinghouse, billing agents, etc. - that submits at least one claim electronically in a given year is required to submit an Annual EDI Certification Form. This form is then kept on file to cover all submissions within the calendar year. It must be signed by an authorized representative of the provider and must have an original signature (no stamps or initials.)

Third Party Billers are required to submit a Certification Form including a list of provider(s) name(s) and Medicaid Provider numbers. Additionally, all Third Party Billers **MUST** obtain a "Professional, Pharmacy, Hospital or KIDMED Services Certification" form on which the provider has attested to the truth, accuracy and completeness of the claim information. These forms **MUST** be maintained for a period of five years. This information must be furnished to the agency, the DHH Secretary, or the Medicaid Fraud Control Unit upon request.

Required Certification forms may be obtained from lamedicaid.com. Under the Provider Enrollment link, click on Forms to Update Existing Provider Information.

Failure to submit the Annual Certification Form will result in deactivation of the submitter number. Once the Cert is received, the number will be reactivated. There will be a delay if the number is deactivated thus preventing timely payment to your providers. 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) 216-6000 and select option 2. Providers may write to Unisys EDI Department, P.O. Box 91025, Baton Rouge, LA 70821.

Electronic Data Interchange (EDI) General Information

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

With the exception of Non-Ambulance Transportation, all claim types may be submitted as approved HIPAA compliant 837 transactions.

Non-Ambulance Transportation claims may be submitted under proprietary specifications (not as HIPAA-compliant 837 transactions).

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.

Non-Ambulance Transportation submitters who file via modem MUST wait 24 hours, excluding weekends, between file submissions to allow time for processing.

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) 216-6000 ext. 2.

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, 11/20/07
KIDMED Submissions	4:30 P.M. Tuesday, 11/20/07
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/21/07

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.**

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

TIMELY FILING GUIDELINES

In order to be reimbursed for services rendered, all providers must comply with the following filing limits set by Medicaid of Louisiana:

- Straight Medicaid claims must be filed within 12 months of the date of service.
- KIDMED screening claims (KM-3 forms or 837P with K-3 segment) must be filed within 60 days from 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 regulations.
- Claims which fail to cross over via tape and have to be filed hard copy MUST be adjudicated within six months from the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.
- Claims with third-party payment must be filed to Medicaid within 12 months of the date of service.

Dates of Service Past Initial Filing Limit

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

A Claims Status Inquiry (e-CSI) screen print indicating that the claim was processed within the specified time frame.

OR

A Remittance Advice indicating that the claim was processed within the specified time frame.

OR

Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the recipient.

NOTE 1: All proof of timely filing documentation must reference the individual recipient and date of service. RA pages and e-CSI screen prints must contain the specific recipient information, provider information, and date of service to be considered as proof of timely filing.

NOTE 2: At this time Louisiana Medicaid **does not** accept printouts of Medicaid Electronic Remittance Advice (ERA) screens as proof of timely filing. Reject letters are not considered proof of timely filing as they do not reference a specific

individual recipient or date of service. Postal "certified" receipts and receipts from other delivery carriers are not acceptable proof of timely filing.

To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible.

Submitting Claims for Two-Year Override Consideration

Providers requesting two-year overrides for claims with dates of service over two years old must provide proof of timely filing and must assure that each claim meets at least one of the three criteria listed below:

- The recipient was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted.
- The recipient won a Medicare or SSI appeal in which he or she was granted retroactive Medicaid Benefits.
- The failure of the claim to pay was the fault of the Louisiana Medicaid Program rather than the provider's each time the claim was adjudicated.

All provider requests for two-year overrides must be mailed directly to:

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

The provider must submit the claim with a cover letter describing the criteria that has been met for consideration along with all supporting documentation. Supporting documentation includes but is not limited to proof of timely filing and evidence of the criteria met for consideration.

Claims submitted without a cover letter, proof of timely filing, and/or supporting documentation will be returned to the provider without consideration.

Any request submitted directly to DHH staff will be routed to Unisys Provider Relations.

NOTE: Claims over two years old will only be considered for processing if submitted in writing as indicated above. These claims may be discussed via phone to clarify policy and/or procedures, but they will not be pulled for research or processing consideration.

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.

Electronic claims submission is the preferred method for submitting claims; however, 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. Claim forms **must be two sided** documents and include the standard information on the back regarding fraud and abuse. If a copy is submitted, it should be legible, and not too light or too dark.

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

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

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

- **Don't forget to sign and date your claim form <u>if the claim form requires a signature</u>. 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.

- Claims submitted should be two-sided documents and include the standard information on the back regarding fraud and abuse.

- **Do not use white out or a marking pen to omit claim line entries. To correct an error, draw a line through the error and initial it. 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.

Attachments

All claim attachments should be standard 81/2 x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper. If it is necessary to attach documentation to a claim, the documents must be placed directly behind each claim that requires this documentation. **Therefore, it may be necessary to make multiple copies of the documents if they must be placed with multiple claims**.

Changes to Claim Forms

Louisiana Medicaid policy prohibits Unisys staff from changing any information on a provider's claim form. Any claims requiring changes must be made prior to submission. Please do not ask Unisys staff to make any changes on your behalf. Claims with insufficient information are rejected prior to keying.

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, difficult to read, or **IS NOT IN THE CORRECT LOCATION**, the claim will not process correctly.

Rejected Claims

Each year, Unisys returns more than 250,000 claims that are illegible or incomplete. These claims are not processed and are returned along with a cover letter stating why the claim(s) is/are rejected. The most common reasons for rejection are listed as follows:

- A signature or handwritten initials were missing **(except UB-04 claim forms)**
- The provider number was missing or incomplete

The criteria for legible claims are:

- All claim forms are clear and in good condition
- All information is readable to the normal eye
- All information is centered in the appropriate block
- All essential information is complete

Correct Claims Submission

We have learned that some providers are incorrectly submitting claims directly to DHH at P.O. Box 91030 rather than correctly submitting claims to Unisys to the appropriate post office box for the program type. Unless specifically directed to submit claims directly to DHH, providers should cease this practice and submit claims to the appropriate Unisys post office box for processing. The correct post office boxes can be found on the following page of this packet and in training materials posted on the **Tracking** link of the www.lamedicaid.com website.

HOW DID WE DO?

I In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a Unisys 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					
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS REPRESENTATIVES					
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 question	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION:					

Do you have internet access in the workplace?_____

Do you use www.lamedicaid.com?_____

What topic was most beneficial to you?_____

Please provide us with your business email address:_____

Please specify your Provider Number so we can cross reference it with your email address:_____

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**