UNISYS

LONG TERM CARE PROVIDER TRAINING

Nursing Facilities and ICF-DDs

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 FOR 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.

ICF-DD FACILITIES

REIMBURSEMENT – (ICAP)

Private ICF-DD facilities are reimbursed under the ICAP reimbursement methodology. Reimbursement for private ICF-DD providers is based on a rate assigned to a resident, rather than a rate assigned to a facility. The Inventory for Client and Agency Planning tool will be used to determine the level of need of individual recipients.

The following revenue codes are to be used to bill services.

Revenue Code	Description	ICAP Score
193	Pervasive Level of Care	1-19
192	Extensive Level of Care	20-39
191	Limited Level of Care	40-69
190	Intermittent Level of Care	70-99

Should a recipient not have an ICAP level on file, providers will be paid at the Intermittent level of care until the ICAP level is established. All recipients must have an ICAP Assessment in their client records.

The ICAP level is submitted with the admissions packet to the Office for Citizens with Developmental Disabilities who oversee admissions to ICF-DD facilities. If a recipient's condition changes to the extent that the individual's ICAP level either increases or decreases, the new ICAP must to approved by the ICAP REVIEW COMMITTEE before the reimbursement level can be changed. To request a change in ICAP level, the provider must submit the updated ICAP and a cover letter with an explanation of why the individual's condition changed. An updated 90-L should also be submitted to the committee.

ICAP Review Committee
Waiver Compliance Section/ICF-DD Unit
628 N. 4th Street
Bienville Building, 7th Floor
Baton Rouge, LA 70802

Effective with date of service July 1, 2007, ICF-DD private facility rates were revised as indicated below. Audited cost reports from FY 2005 were used to calculate these rates. It should be noted that these rates include the provider fee of $14.30.

Peer Groups	Intermittent	Limited	Extensive	Pervasive
1-8 Beds	$165.94	$175.40	$191.47	$208.49
9-15 Beds	$158.09	$167.07	$182.34	$198.51
16-32 Beds	$144.72	$153.25	$167.76	$183.12
33 + Beds	$135.41	$142.65	$154.96	$168.00

Leave Days

A leave day is an absence from the facility for a 24 hour period or more. A leave of absence is broken only when the recipient returns to the facility for at least a 24 hour period. All qualified leave days must be recorded on the Medicaid bill **except for Special Event Leave Days for recipients in an ICF-DD.** Patients are limited as to how many leave days Medicaid will pay for per year.

- Reported **home** leave days are paid at **100%** of the per diem for the LTC facility.
- Reported **hospital** leave days are paid at **75%** of the per diem for the LTC facility.

An individual's direct transfer from one institution to another does not change the number of home leave days allowed per state fiscal year (July1-June 30) if cared for in an intermediate care facility for the handicapped.

Leave day limits do not exclude the recipient being **permitted** to take additional leave days. However, Medicaid **will not** pay for extra leave days. Arrangements for payment must be made with the recipient's responsible party. Such arrangements may include a charge by the facility to the family for the full Medicaid rate or for a reduced daily rate, or the facility may absorb the cost of non-covered days into its operating costs. **Except in the case where home leave days in an ICF-DD exceed 30 consecutive days; then, the recipient must be discharged on the 31st consecutive day of absence.**

Leave Day Limits

Home Leave Days

Recipients are limited to 45 days per **State fiscal year**, not to exceed 30 consecutive days. The recipient must be discharged on the 31st consecutive day of absence.

Hospital Leave Days

Recipients are limited to 7 days **per occurrence.**

Special Event Leave Days - ICF-DD Facilities ONLY

Leave days are also permitted under the following circumstances:

- Special Olympics
- Roadrunner sponsored events
- Louisiana planned conference
- Trial discharges
- Official State Holidays

These special event leave days are limited to 30 consecutive days per occurrence. If the recipient is absent from the facility for more than 30 consecutive days, the facility should discharge the recipient.

These special event leave days are not deducted from the 45 home leave days allowed per fiscal year. These leave days must be included in the recipient's plan of care, but are not to be reported when billing.

Approved Official State Holidays are found at the Division of Administration's website, (www.doa.louisiana.gov/employ_holiday.htm). These holidays will always fall on a week day. Official State Holidays should not be reported as leave days. Days preceding and following the Official State Holidays will not be excluded from the annual 45-day limit.

Non-Covered Days

The date of discharge (except discharge due to death) is not covered by Medicaid.

NURSING FACILITIES

Reimbursement

This reimbursement methodology is based on using the Medicare Minimum Data Set (MDS) to determine the level of needs of Medicaid recipients in nursing facilities and to assure that nursing facilities receive a level of reimbursement commensurate with the level of services needed for each resident. It requires that nursing facilities expend a set amount of funding received for the provision of direct care services. If expenditures for direct care are not at an acceptable level, the nursing facility must reimburse the department for a portion of the funding received. This methodology assures reasonable access to care for persons needing high levels of nursing facility care. A MDS documentation verification process was developed and implemented in 2002/2003 to assure compliance with requirements set in Act 694.

Nursing homes submit quarterly MDS information to DHH. A new facility rate is calculated on a quarterly basis.

Calculating Reimbursement

Full Month

[(Per diem rate X 365) ÷ 12] – Patient liability = Payment

Partial Month

(Per diem rate X Number of days) – A = Payment,
Where A = [(patient liability X12) ÷ 365] X number of approved days

(Round off numbers to the nearest penny.)

NOTE: A project has been initiated to re-evaluate this monthly rate calculation that has been the payment methodology for many years. Under review is a change to the payment system to implement calculating the monthly remittance amount as:

Days x Daily Rate – Patient Liability Amount = RA Payment

You will be notified by *Provider Update*, the LA Medicaid web site, RA messages and a letter from DHH Rate and Audit Department of when to expect the implementation of this change.

Leave Days

A leave day is an absence from the facility for a 24 hour period or more. A leave of absence is broken only when the recipient returns to the facility for at least a 24 hour period. All qualified leave days must be recorded on the Medicaid bill**.** Patients are limited as to how many leave days Medicaid will pay for per year.

- Reported **home** leave days are paid at **100%** of the per diem for the LTC facility.
- Reported **hospital** leave days are paid at **75%** of the per diem for the LTC facility.

An individual's direct transfer from one institution to another does not change the number of home leave days allowed per calendar year if they are cared for in a nursing home or in an intermediate care facility for the handicapped.

Leave day limits do not exclude the recipient being **permitted** to take additional leave days. However, Medicaid **will not** pay for extra leave days. Arrangements for payment must be made with the recipient's responsible party. Such arrangements may include a charge by the facility to the family for the full Medicaid rate or for a reduced daily rate, or the facility may absorb the cost of non-covered days into its operating costs.

Leave Day Limits

Home Leave Days

Recipients are limited to 15 days per **calendar year**.

Hospital Leave Days

Recipients are limited to 7 days **per occurrence.**

Non-Covered Days

The date of discharge (except discharge due to death) is not covered by Medicaid.

RUG-III CASE MIX REIMBURSEMENT SYSTEM FOR NURSING FACILITIES

Provider contacts for this process are as follows:

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

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

Provider Rates
All questions concerning provider rates

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

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

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

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

MDCN Helpdesk (800) 905-2069

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

Claims Billing Issues

Unisys Provider Relations (800) 473-2783 or (225) 924-5040
Unisys Long Term Care Unit (225) 216-6259

Medicaid Enrollment of Providers

Unisys Provider Enrollment (225)216-6370

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

DHH Regional Office (800) 834-3333

NURSING HOME RATE CHANGES

Effective for February 2007 the nursing home rates were increased to provide for a direct care service worker pay raise. The calculation for the rate adjustment reflects a $4.70 wage enhancement per patient day to the facility specific direct care component (prior to the case-mix adjustment). This enhancement is included in the direct care component floor.

Effective for July 1, 2007 the nursing home rate was modified to increase the provider fee to $8.02.

The nursing home rate also includes $.99 for Durable Medical Equipment.

Medicaid participating nursing facilities that install or extend fire sprinkler systems in accordance to Louisiana Administrative Code (LAC) 50:VII Chapter 13. Section 1317. (Reimbursement for Fire Sprinkler Systems and Two-Hour Rated Wall Installations) may receive Medicaid reimbursement for the cost of installation. The adjusted per diem cost shall be paid to each qualifying nursing facility as an additional component of the daily Medicaid rate over a five year period beginning July, 2007.

EVACUATION POLICY FOR NURSING FACILITIES AND ICF-DDS

When local conditions require evacuations of residents in Nursing Facilities and ICF-DD facilities, the following payment procedures apply:

- If clients are absent from the facility for less than 24 hours, the facility should charge for a service day.
- If the facility sends staff with the clients to the evacuation site, the facility should charge for a service day.
- **If the clients go to a family or friend's home at the facility's request, the facility should charge neither a service day nor a leave day.** The clients should be discharged from the facility the day they leave and be re-admitted to the facility the day they return. Providers billing on the UB-04 or 837I must submit two claims – one claim for services through the discharge date and another claim for services beginning with the re-admission date. Regardless of the billing method (UB-04 or 837I), no hard copy documents or attachments are required to substantiate the re-admission of these clients.

  In this circumstance, the facility should not collect patient liability.
- If the clients go home at the family's request or on their own initiative, the facility should charge a leave day.
- If a client evacuates to the hospital, the hospital should not charge Medicaid for a hospital day.

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

The following is a new policy that was published in the December 2006 Louisiana Register. Providers should refer to the rule for the complete policy.

ICF-DD and Nursing Homes must have:

A written plan describing the following elements:

a. The evacuation of residents to a safe place either within the facility or to another location;
b. The delivery of essential care and services to residents whether the residents are housed off-site or when additional residents are housed in the facility during an emergency;
c. The provision for management of staff, including distribution and assignment responsibilities and functions either within the facility or at another location;
d. A plan for coordinating transportation services required or evacuating residents to another location; and
e. The procedures to notify the resident’s family, guardian, or primary correspondent if the resident is evacuated to another location.
f. An annual activation and evaluation of the facility response for each shift.

DME IN ICF-DD AND NURSING FACILITIES

Louisiana Medicaid will not reimburse for DME services provided in a nursing home or intermediate care facility for the mentally retarded.

Unisys Prior Authorization Unit is instructed to deny all requests for DME and supplies for recipients residing in nursing home and ICF-DD's with the following **exceptions:**

- Certain Supplies to Medically Fragile Residents of ICF-DD Facilities – ICF-DD providers service medically fragile individuals may be reimbursed for certain medical supplies (Medical Add-On) as follows:

Ostomy Supplies	Enteral Feedings	Trach
Ostomy Bag	Formula	Tracheotomy Kit
	Feeding Bag	Tracheotomy Tubes
	Feeding Pump	Suction Catheter Kit
	G-Tube Extension	

  All of the above medical supplies must be approved by the ICAP Review Committee.

- Prosthetic and Orthotic Services (POS) for Residents of Nursing Facilities ONLY - Louisiana Medicaid **will pay** DME providers for prosthetic and orthotic devices supplied to residents of nursing homes only. These payments are included in the payment made to ICF-DD facilities. DME providers will bill Medicaid directly for these services.

Additionally edits are in place to prevent payment on claims for recipients who move into an ICF-DD or nursing home after authorization for DME or supplies has been given but prior to the delivery date.

IMPLEMENTATION OF NEW EDITS FOR RECIPIENT CERTIFICATION

In January 2007, DHH implemented edits on Long Term Care (LTC) payments to assure that provider billing agrees with the Medicaid recipient's LTC eligibility data maintained on Medicaid Eligibility Date System (MEDS).

Providers receive a copy of the decision notices when LTC eligibility is established, suspended, changed or terminated. Upon receipt of the eligibility decision notice, the provider should review the notice to ensure that it agrees with the provider's records. It is important that this be done as soon as the notice is received as the information on the eligibility notice is the information that is entered on MEDS. Special attention should be given to ensure the following information matches the provider records:

- Begin or end dates of LTC vendor payment eligibility; and
- Patient liability amount;
- Patient is linked to your provider number;
- For ICF-DD facilities, the ICAP Level of Care on Form 142.

Providers should immediately contact the local eligibility office if any discrepancies are found. With the implementation of electronic billing, the state will rely on the LTC recipient eligibility file as a cross check of billing and payment accuracy.

In order to ensure a smooth transition to the new payment routine, these new edits were initially implemented as educational edits on provider's remittance advices (RAs) when the claim conflicted with the information on the LTC eligibility recipient file. This has allowed providers an opportunity to establish procedures to coordinate recipient claims with the decision notices provided to them by the local eligibility office.

DHH plans to implement these edits as claim denials in the near future. Providers will be notified via letter, RA messages, web notices, and provider newsletter once the effective date for this change is finalized.

Once implemented, claims will be denied through the automated claims verification process within Unisys computer systems which compares and identifies discrepancies with those bills that are for recipients who are not on the LTC files or for services that do not agree with the information shown on the LTC recipient eligibility file. However, the impact should be minimal if providers have developed a procedure to carefully review the notices upon receipt from the local eligibility office to determine that:

- Residents are eligible for LTC vendor payment, not just Medicaid.
- Billing periods are proper.
- Bills are submitted only for the months of LTC vendor payment eligibility.
- Bills are adjusted when appropriate if there is a penalty period due to transfer of assets **OR** if Medicare is the primary payor during the first 100 days of a spell of illness.

Specific Claim Explanation of Benefits (EOB)

159 LTC PROVIDER NOT MATCHED: This EOB is generated when the LTC provider submitting the claim is not the LTC provider of record on the recipient's LTC eligibility file. When a recipient is certified for Medicaid LTC services, the provider number is entered into MEDS. Changes in patient liability, level of care/need, the beginning date and ending date of LTC vendor payment, and provider changes are also entered. The provider number on the billing document must agree with the provider number on the recipient's LTC eligibility file for the specific dates of service billed or the claim will be flagged with the this EOB code.

173 LEVEL OF NEED/LEVEL OF CARE NOT MATCHED: The recipient's level of care (LOC) on the billing document/file does not match the LOC on the recipient's LTC eligibility file for the dates of service billed. When recipients are certified for LTC services, an LOC for that individual is a part of the payment determination. The LOC must be indicated for each recipient before payment can be made, and the LOC on the bill must agree with the LOC on the LTC eligibility recipient file for the dates of service billed.

525 LEVEL OF NEED NOT ON RECIPIENT FILE: There is no LOC (Need) on the recipient's Medicaid file. This error applies to ICF-DD recipients ONLY. It occurs when the billing document includes a level of need that is not found on the recipient's LTC ligibility file. There must be an LOC on the recipient's LTC eligibility file before payment can be made.

568 NOT LTC ELIGIBLE: This error occurs when the provider has submitted a claim for services and there is no corresponding recipient LTC eligibility file on the claims payment system for the provider, dates of service, or both.

Providers must ensure that recipients are certified for LTC services under their provider number and for the time frame being billed.

NOTE: In the case of these specified EOBs, LTC providers must contact the appropriate local eligibility office to determine that the recipient's LTC eligibility file contains the correct:

1. **Provider Number**
2. **Level of Care**
3. **Patient Liability**
4. **Begin and End Dates of vendor payment eligibility for the service dates billed by the provider.**

BILLING ROOM AND BOARD ON THE UB-04

Billing

Providers bill for room and board using the standard 837 Institutional (837I) electronic claim transaction or the hardcopy UB-04 Form, regardless of the date of service. All supplemental billing must also be submitted electronically using the 837I format or on the UB-04 hard copy claim form. The 837I is the preferred method of claim submission.

A separate claim for room and board is billed for each recipient for each calendar month of service.

CLAIMS SUBMISSION SCHEDULE (ROOM AND BOARD ONLY)

Claims for room and board are processed according to a predetermined schedule set by DHH and is updated every calendar year. This schedule includes deadlines for initial monthly claim submissions as well as for monthly supplemental claim submissions. Claims received after the published deadline will be held and processed according to this schedule. The LTC room and board monthly processing schedule for the year 2007 can be found as an Appendix of this packet.

NOTE 1: Providers who bill hardcopy claims should continue to submit the initial monthly UB-04 forms in one package and may be hand delivered or mailed to the following address:

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

NOTE 2: When billing hard copy on the UB-04 form or the 837I electronic transaction, attachments are not required for LTC billing.

Special Event Leave Day Billing ICF-DD Only

Special Olympics, Roadrunner sponsored events, Louisiana planned conferences, trial discharges and official state holidays are not to be reported when billing. These leave days must be reported in the individuals' plan of care.

UB-04 CLAIM FORM INSTRUCTIONS FOR LTC PROVIDERS

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility.	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	**Expanded to 20 characters from 16 characters.**
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	**Expanded to 24 characters from 16 characters.**
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: ***FOR NURSING FACILITY PROVIDERS:*** *1st Digit - Type of Facility* 2 = Skilled Nursing (LOC = ICF I) (LOC = ICF II) (LOC = SNF) (LOC = SNF Technology Dependent Care) (LOC = SNF Infectious Disease) (LOC = NF Rehab) (LOC = NF Complex Care) Skilled Nursing/ Intermediate Care (LOC = Case Mix)	

Locator #	Description	Instructions	Alerts
		2nd Digit – Classification 1 = Skilled Nursing – Inpatient ***FOR ICF-DD PROVIDERS:*** *1st Digit - Type of Facility* 6 = Intermediate Care (LOC = ICF/MR) *2nd Digit - Classification* 5 = Intermediate Care Level I 6 = Intermediate Care Level II ***FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:*** *1st Digit - Type of Facility* 8 = Special Facility (LOC = Adult Day Health Care) *2nd Digit - Classification* 9 = Other (Adult Day Health Care - ADHC) ***FOR NURSING FACILITY, ICF-DD, AND ADHC PROVIDERS:*** *3rd Digit – Frequency Definition* 1 = Admit Through Discharge Claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 2 = Interim - First Claim. Use this code for the first of an expected series of claims for a course of treatment.	**2nd Digit "7" when used with 1st Digit "2" is reserved for assignment by NUBC. Use 2nd Digit "1" instead.**

Locator #	Description	Instructions	Alerts
		3 = Interim - Continuing Claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 = Interim - Final Claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death. 7 = Adjustment/ Replacement of Prior Claim. Use this code to correct a previously submitted and paid claim. 8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.	
5	Federal Tax No.	**Optional.**	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	**Leave blank.**	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	**Formerly entered in UB-92 Form Locator 12.**

Locator #	Description	Instructions	Alerts
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	**Formerly entered in UB-92 Form Locator 13.**
10	Patient's Birthdate	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 14.**
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	**Formerly entered in UB-92 Form Locator 15.**
12	Admission Date	**Required.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 17.**
13	Admission Hour	**Leave blank.**	
14	Type Admission	**Leave blank.**	
15	Source of Admission	**Leave blank.**	
16	Discharge Hour	**Leave blank.**	
17	Patient Status	**Required.** This code indicates the patient's status as of the "Through" date of the billing period (Field 6). **Code Structure** 01 = Discharged to home or self care (routine discharge) 02 = Discharged/transferred to another short-term general hospital for inpatient care 03 = Discharged/transferred to a skilled nursing facility	**Formerly entered in UB-92 Form Locator 22.** **Patient Status Code 08 (Discharge/Transfer to home care of Home IV provider) is no longer valid. Use Patient Status Code 01 instead.**

Locator #	Description	Instructions	Alerts
		(SNF) or an intermediate care facility (ICF) 04 = Discharged/transferred to another type of institution for inpatient care 06 = Discharged/transferred to home under care of home health services organization 07 = Left against medical advice or discontinued care 09 = Admitted as inpatient to a hospital 20 = Expired/Discharged Due to Death 30 = Still a patient 61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 63 = Discharged/transferred to a long term care hospital	
18-28	Condition Codes	**Leave blank.**	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Leave blank.**	
35-36	Occurrence Spans (Code and Dates)	**Leave blank.**	
37	Unlabeled	**Leave blank.**	
38	Responsible Party Name and Address	**Optional.**	
39-41	Value Codes and Amounts	**Required**. Enter the appropriate Value Code (listed below). *80 = Covered days 81 = Non-covered days 82 = Co-insurance days (required only for	**Formerly entered in Form Locator 7 of the UB-92. Covered Days is now reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04.**

Locator #	Description	Instructions	Alerts
		Medicare crossover claims) 83 = Lifetime reserve days (required only for Medicare crossover claims) *Enter the appropriate Value Code in the code portion of the field and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field. ***No other value code is required for processing LTC claims.**	**Please read the instructions carefully for entering the new number of days information in the Value Code fields.** **Value Codes 81, 82, and 83 are not used for Medicaid billing.**
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies the service provided. Bill a Level of Care (LOC) Revenue Code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill LA Medicaid: **FOR ALL PROVIDERS (Excluding ADHC Providers):** <u>Revenue Code & Description Leave of Absence</u> 183 = Leave of Absence – Subcategory Therapeutic (for Home Leave) 185 = Leave of Absence – Subcategory Nursing Home (for Hospitalization)	

Locator #	Description	Instructions	Alerts
		FOR NURSING FACILITIES: <u>Revenue Code & Description</u> <u>*(Corresponding Level of Care)*</u> 022 = Skilled Nursing Facility Prospective Payment System (RUGS) *(88 = Case Mix -- Formerly LOC 20, 21, 22)* 118 = Room & Board-Private Subacute Rehabilitation *(31 = NF Rehabilitation* *20 = SNF/Hospice in Nursing Facility* *21 = ICF I/Hospice in Nursing Facility* *22 = ICF II)* 193 = Subacute Care Level III (Complex Care) *(32 = NF Complex Care)* 194 = Subacute Care Level IV *(28 = SNF Technology Dependent Care)* 199 = Other Subacute Care *(30 = SNF Infectious Disease)* **FOR ICF-DDs**: <u>Revenue Code & Description</u> <u>*(Corresponding Level of Care)*</u> **ICAP Revenue codes to be used:** 193 = Pervasive Level of Care (ICAP Score 1-19) 192 = Extensive Level of Care (ICAP Score 20-39) 191 = Limited Level of Care (ICAP Score 40-69)	

Locator #	Description	Instructions	Alerts
		190 = Intermittent Level of Care (ICAP Score 70-99) **NOTE:** Providers will be paid at the Intermittent level of care should a recipient not have an ICAP level on file. All recipients must have an ICAP Assessment on file. **FOR ADULT DAY HEALTH CARE (ADHC):** Revenue Code & Description *(Corresponding Level of Care)* 932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day *(27 = Adult Day Health Care)*	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	**Leave blank.**	
45	Service Date	**Required.** Enter a beginning and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided. Example 1: If SNF TDC care	

Locator #	Description	Instructions	Alerts
		(Revenue Code 194) is provided for the entire month of March, the Service Date should be entered 01-31. Example 2: If the recipient is on Hospital Leave (Revenue Code 185) from March 6 – 12, the Service Date should be entered 07-12, -- **If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11).** **Note: The claim must reflect the total number of days billed at a particular Level of Care (LOC) corresponding to the Revenue Code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate Revenue Code for that LOC and the correct number of days indicated for that LOC for the month of service.** **Required**. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**
46	Units of Service	**Required.** Enter in DAYS the number of units of service for each Level of Care type on the line adjacent to the Level of Care revenue code, description, and service date. Example 1 above, Service Date 01-31 should indicate 31 units or days for Revenue	

Locator #	Description	Instructions	Alerts
		Code 194. **Note: Do not enter the actual number of units when billing for home or hospital leave days, only indicate the from and to days in Form Locator 45.** Example 2 above (Revenue Code 185), Service date 07-12, service units should be left blank. **Note: ADHC cannot exceed 23 days per month. Enter the number of days of service provided.**	
47	Total Charges	**Leave blank.**	
48	Non-Covered Charges	**Leave blank.**	
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	**The 7-digit Medicaid ID number is now located in Form Locator 57.**
52-A,B,C	Release of Information	**Optional.**	

Locator #	Description	Instructions	Alerts
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI FIELD	**Required.** Enter the provider's National Provider Identifier	**The 10-digit National Provider Identifier (NPI) must be entered here.**
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 must be entered here.**
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate. \	

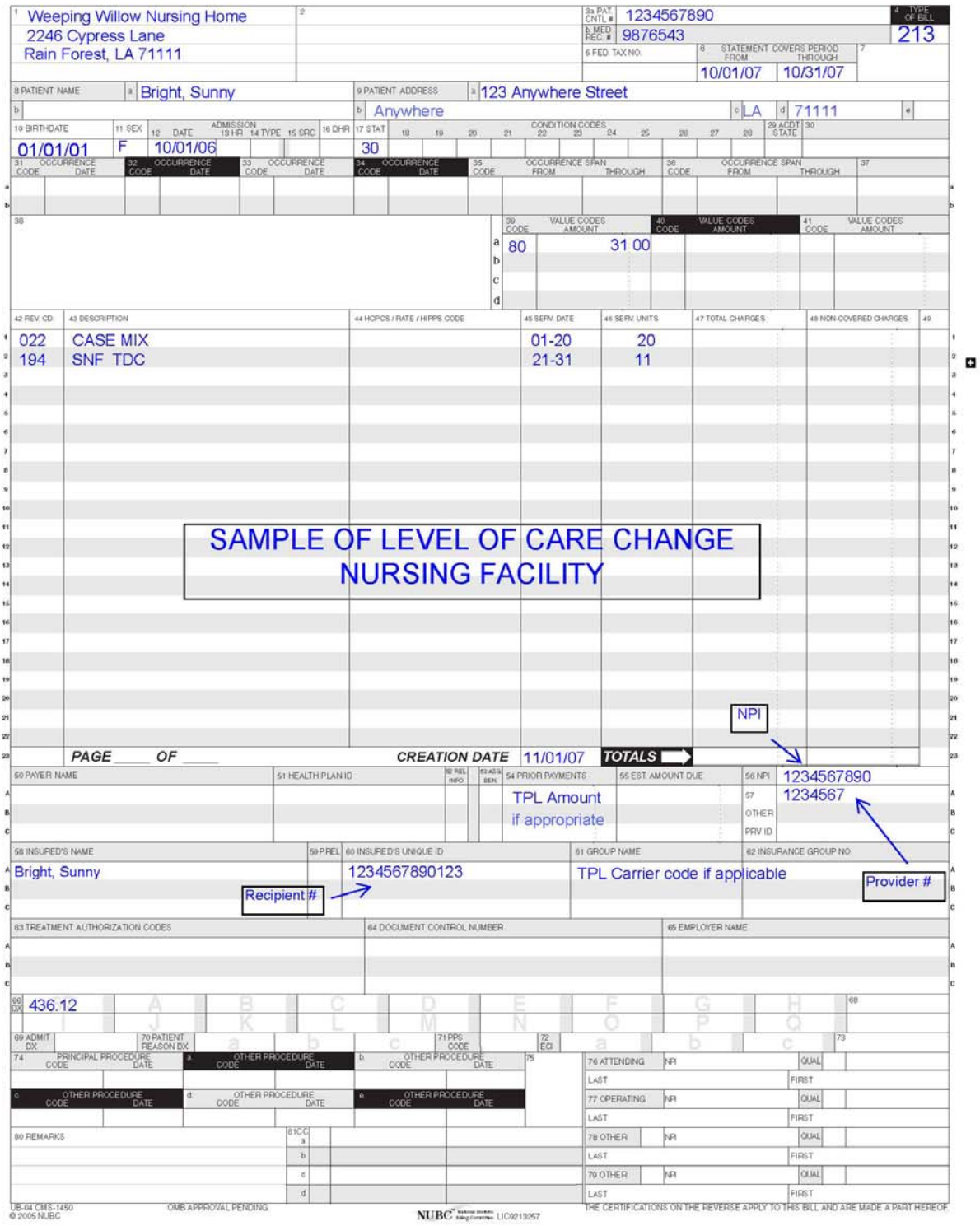
Locator #	Description	Instructions	Alerts
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	

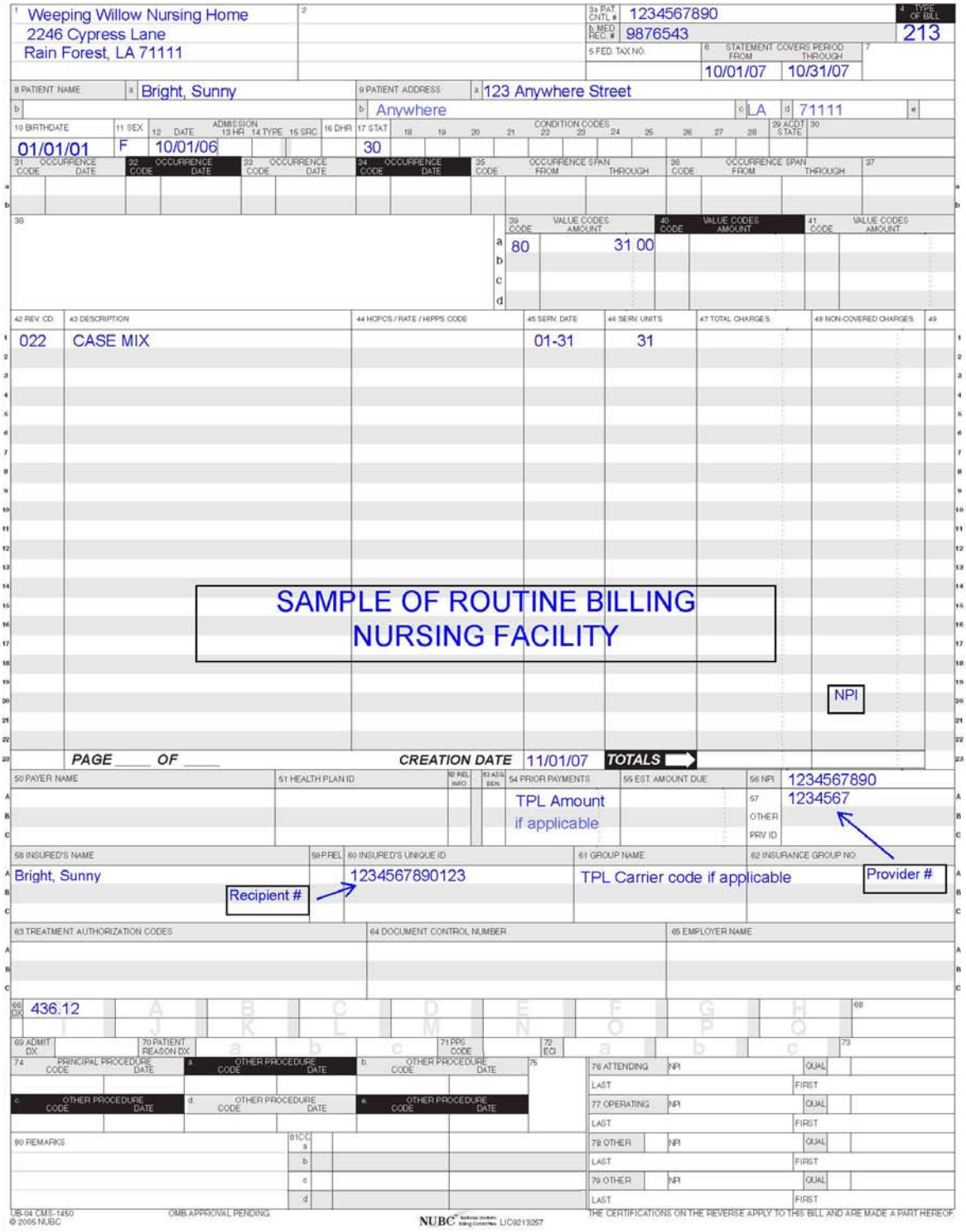
Locator #	Description	Instructions	Alerts
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Leave blank.**	
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other	**Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.** **To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.**

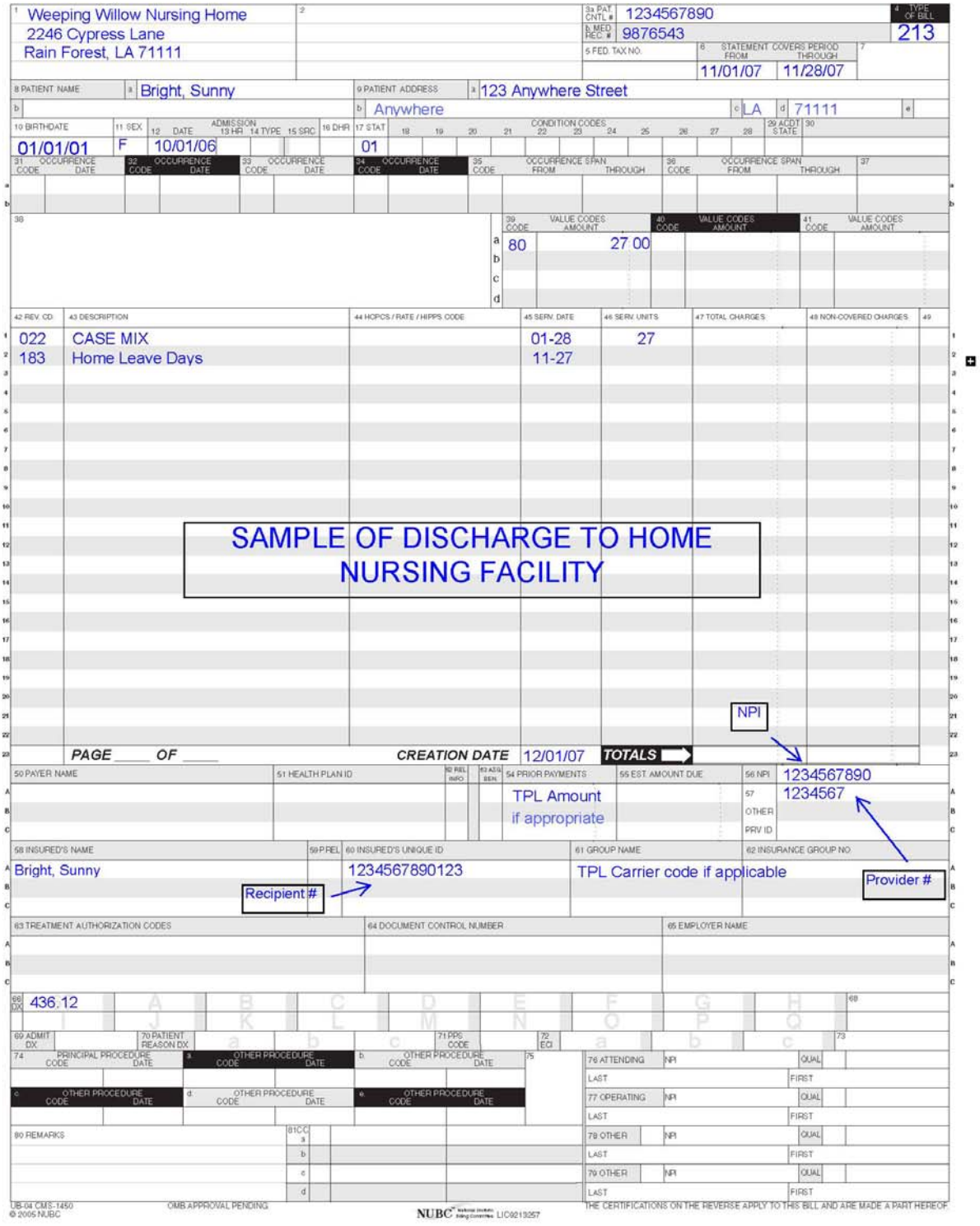
Locator #	Description	Instructions	Alerts
		Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Leave blank.**	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit subclassifications are provided, they must be assigned. A code is invalid if is has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	**The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.**
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	**Leave blank.**	
71	PPS Code	**Leave blank.**	

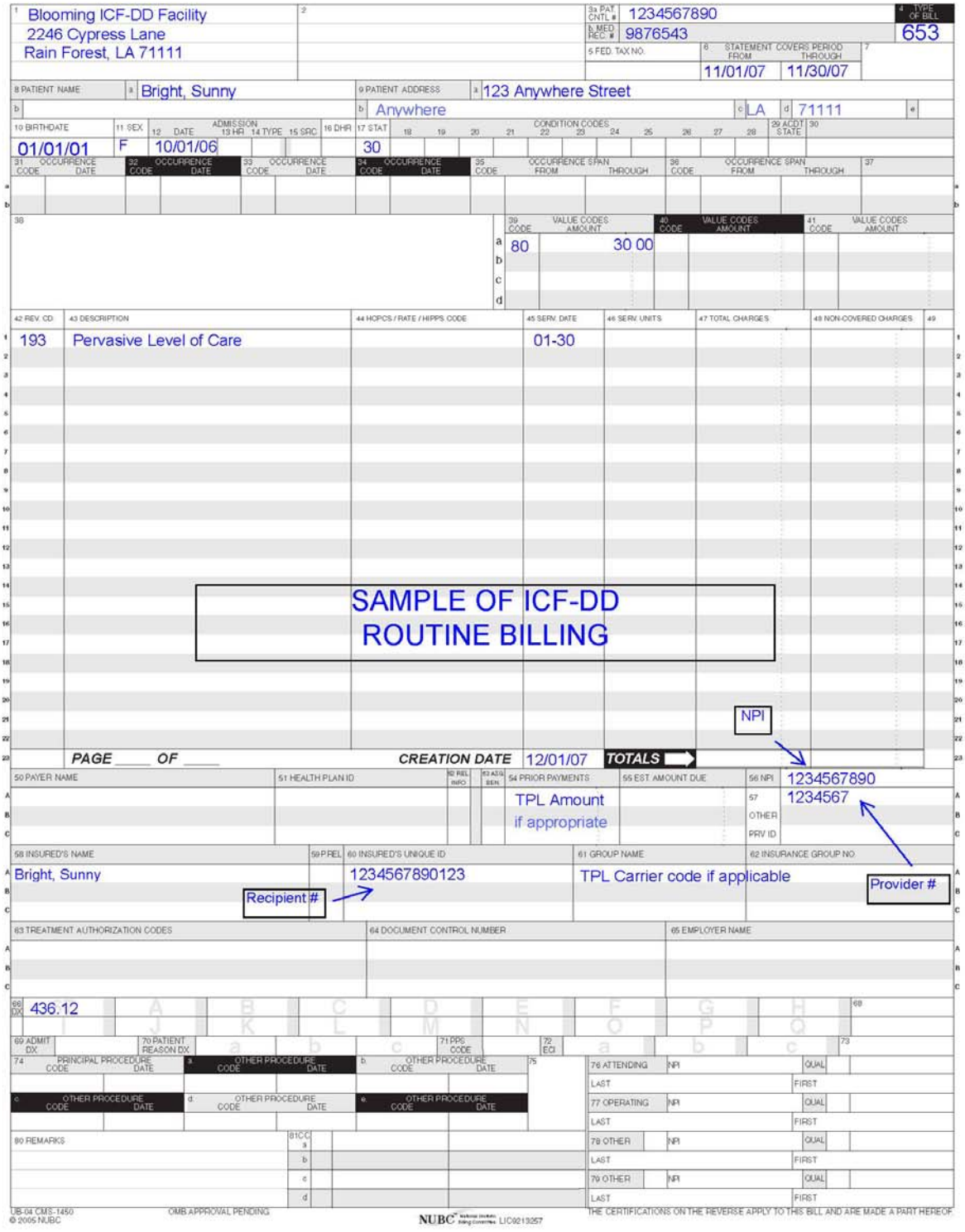
Locator #	Description	Instructions	Alerts
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank**.	
74 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank.**	
75	Unlabeled	**Leave blank.**	
76	Attending	**Leave blank.**	
77	Operating	**Leave blank.**	
78	Other	**Leave blank.**	
79	Other	**Leave blank**.	
80	Remarks	**Situational.** Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of the UB-04.**
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.


Weeping Willow Nursing Home
2246 Cypress Lane
Rain Forest, LA 71111
1234567890
9876543
213
10/01/07
10/31/07
Bright, Sunny
123 Anywhere Street
Anywhere
LA
71111
01/01/01
F
10/01/06
30
80
31 00
022
CASE MIX
01-20
20
194
SNF TDC
21-31
11
SAMPLE OF LEVEL OF CARE CHANGE
NURSING FACILITY
NPI
PAGE ____ OF ____
CREATION DATE
11/01/07
TOTALS
1234567890
TPL Amount
if appropriate
1234567
Bright, Sunny
Recipient #
1234567890123
TPL Carrier code if applicable
Provider #
436.12
OMB APPROVAL PENDING
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.


1 Weeping Willow Nursing Home
2246 Cypress Lane
Rain Forest, LA 71111
3a PAT CNTL # 1234567890
b MED REC # 9876543
4 TYPE OF BILL 213
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 10/01/07 THROUGH 10/31/07
8 PATIENT NAME a Bright, Sunny
9 PATIENT ADDRESS a 123 Anywhere Street
b Anywhere
c LA
d 71111
10 BIRTHDATE 01/01/01
11 SEX F
12 ADMISSION DATE 10/01/06
17 STAT 30
39 VALUE CODES AMOUNT a 80 31.00
42 REV. CD. 022
43 DESCRIPTION CASE MIX
45 SERV. DATE 01-31
46 SERV. UNITS 31
SAMPLE OF ROUTINE BILLING
NURSING FACILITY
NPI
PAGE ____ OF ____
CREATION DATE 11/01/07
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
54 PRIOR PAYMENTS
TPL Amount
if applicable
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER 1234567
PRV ID
Provider #
58 INSURED'S NAME
Bright, Sunny
Recipient #
60 INSURED'S UNIQUE ID 1234567890123
61 GROUP NAME
TPL Carrier code if applicable
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX 436.12
67 A B C D E F G H I J K L M N O P Q
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
74 PRINCIPAL PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81CC
UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC LIC0213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF


1 Weeping Willow Nursing Home
2246 Cypress Lane
Rain Forest, LA 71111
3a PAT CNTL # 1234567890
b MED REC # 9876543
4 TYPE OF BILL 213
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 11/01/07 THROUGH 11/28/07
8 PATIENT NAME a Bright, Sunny
9 PATIENT ADDRESS a 123 Anywhere Street
b Anywhere
c LA
d 71111
10 BIRTHDATE 01/01/01
11 SEX F
12 ADMISSION DATE 10/01/06
17 STAT 01
39 VALUE CODES AMOUNT a 80 27.00
42 REV. CD. 43 DESCRIPTION 44 HCPCS / RATE / HIPPS CODE 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES
022 CASE MIX 01-28 27
183 Home Leave Days 11-27
SAMPLE OF DISCHARGE TO HOME NURSING FACILITY
NPI
PAGE ____ OF ____
CREATION DATE 12/01/07
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
54 PRIOR PAYMENTS
TPL Amount if appropriate
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER 1234567
PRV ID
58 INSURED'S NAME
60 INSURED'S UNIQUE ID
Bright, Sunny
1234567890123
Recipient #
61 GROUP NAME
TPL Carrier code if applicable
62 INSURANCE GROUP NO.
Provider #
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX 436.12
67 PRINCIPAL PROCEDURE CODE DATE
74 PRINCIPAL PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81CC
UB-04 CMS-1450 © 2005 NUBC
OMB APPROVAL PENDING
NUBC LIC0213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF


1 Blooming ICF-DD Facility
2246 Cypress Lane
Rain Forest, LA 71111
3a PAT. CNTL # 1234567890
b. MED. REC. # 9876543
4 TYPE OF BILL 653
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 11/01/07 THROUGH 11/30/07
8 PATIENT NAME a Bright, Sunny
9 PATIENT ADDRESS a 123 Anywhere Street
b Anywhere
c LA
d 71111
10 BIRTHDATE 01/01/01
11 SEX F
12 ADMISSION DATE 10/01/06
17 STAT 30
39 VALUE CODES AMOUNT a 80 30 00
42 REV. CD. 193
43 DESCRIPTION Pervasive Level of Care
45 SERV. DATE 01-30
SAMPLE OF ICF-DD
ROUTINE BILLING
NPI
PAGE ____ OF ____
CREATION DATE 12/01/07
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
54 PRIOR PAYMENTS
TPL Amount
if appropriate
56 NPI 1234567890
57 OTHER PRV ID 1234567
58 INSURED'S NAME A Bright, Sunny
60 INSURED'S UNIQUE ID 1234567890123
Recipient #
61 GROUP NAME TPL Carrier code if applicable
62 INSURANCE GROUP NO.
Provider #
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX 436.12
74 PRINCIPAL PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
UB-04 CMS-1450 © 2005 NUBC
OMB APPROVAL PENDING
NUBC LIC0213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

ADJUSTMENTS AND VOIDS

Claim Adjustments/Voids Using the UB-04 Form:

Adjustments and voids of claims data other that Patient Liability are submitted using the UB-04 claim form or 837I electronic transaction. Adjustments/Voids are identified through the third digit of the bill type (Form Locator #4). The value “7” in the third digit indicates a claim adjustment, and “8” in the third digit indicates a voided claim.

With the implementation of the revised UB-04 claim form, when submitting an adjustment or void the following information is required in Field #64 a, b, and c of the form. This is a change in the placement of this information and should be noted and implemented by providers in order to have adjustments/voids process properly.

UB-04 Form Locator 64 (a, b, & c) Instructions for Adjustments/Voids		
1. Enter an "A" for an adjustment or a "V" for a void in 64a		
2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice in 64b.		
3. Enter one of the appropriate reason codes in 64c:		
	Adjustments:	Voids:
	01 - Third Party Liability Recovery 02 - Provider Correction 03 - Fiscal Agent Error 99 - Other - Please Explain	10 - Claim Paid for Wrong Recipient 11 - Claim Paid for Wrong Provider 00 - Other
Examples:		
	Adjustment: A 718456264650002	Void: V 720516425300000

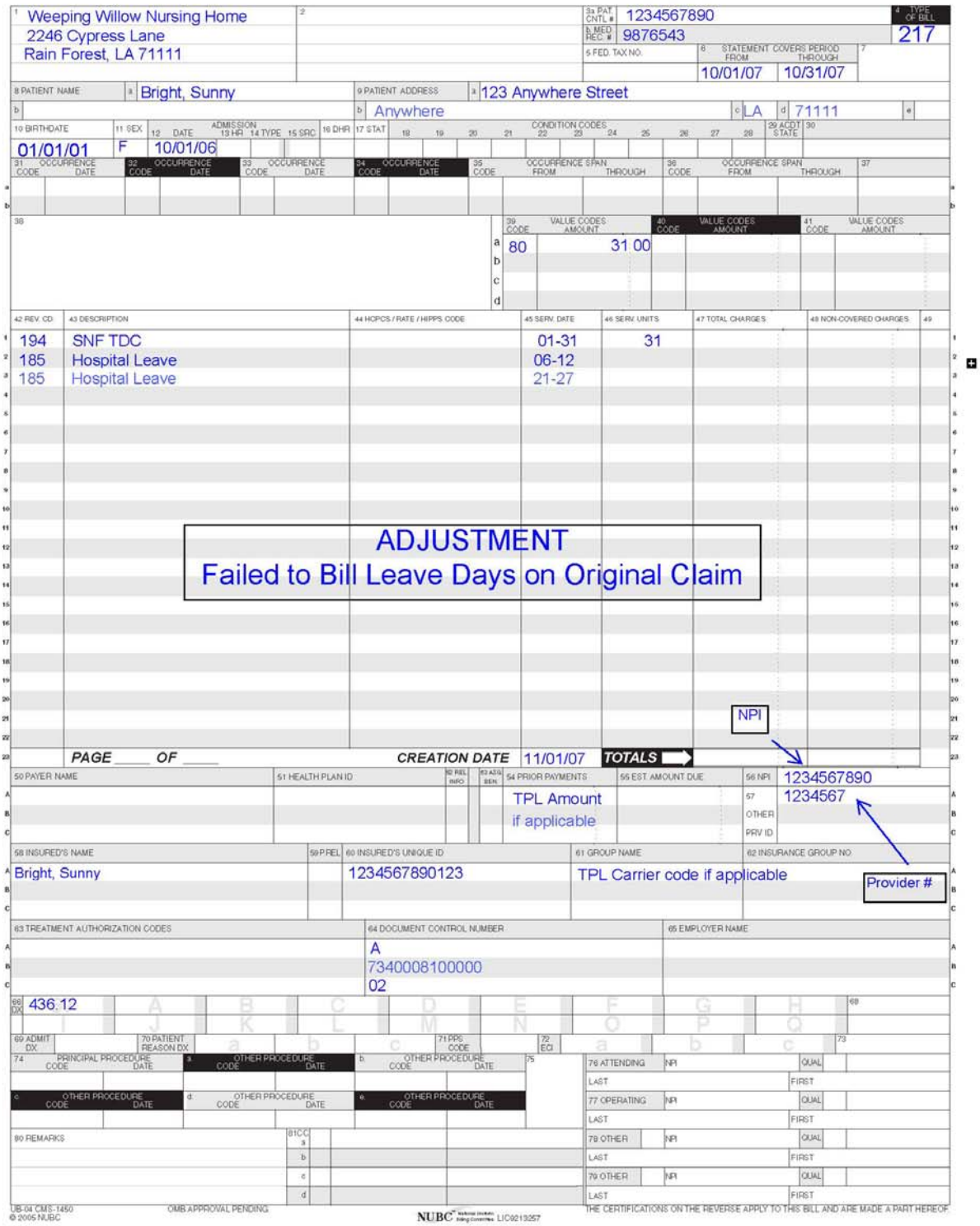
Claim Adjustment Form 148 (Patient Liability):

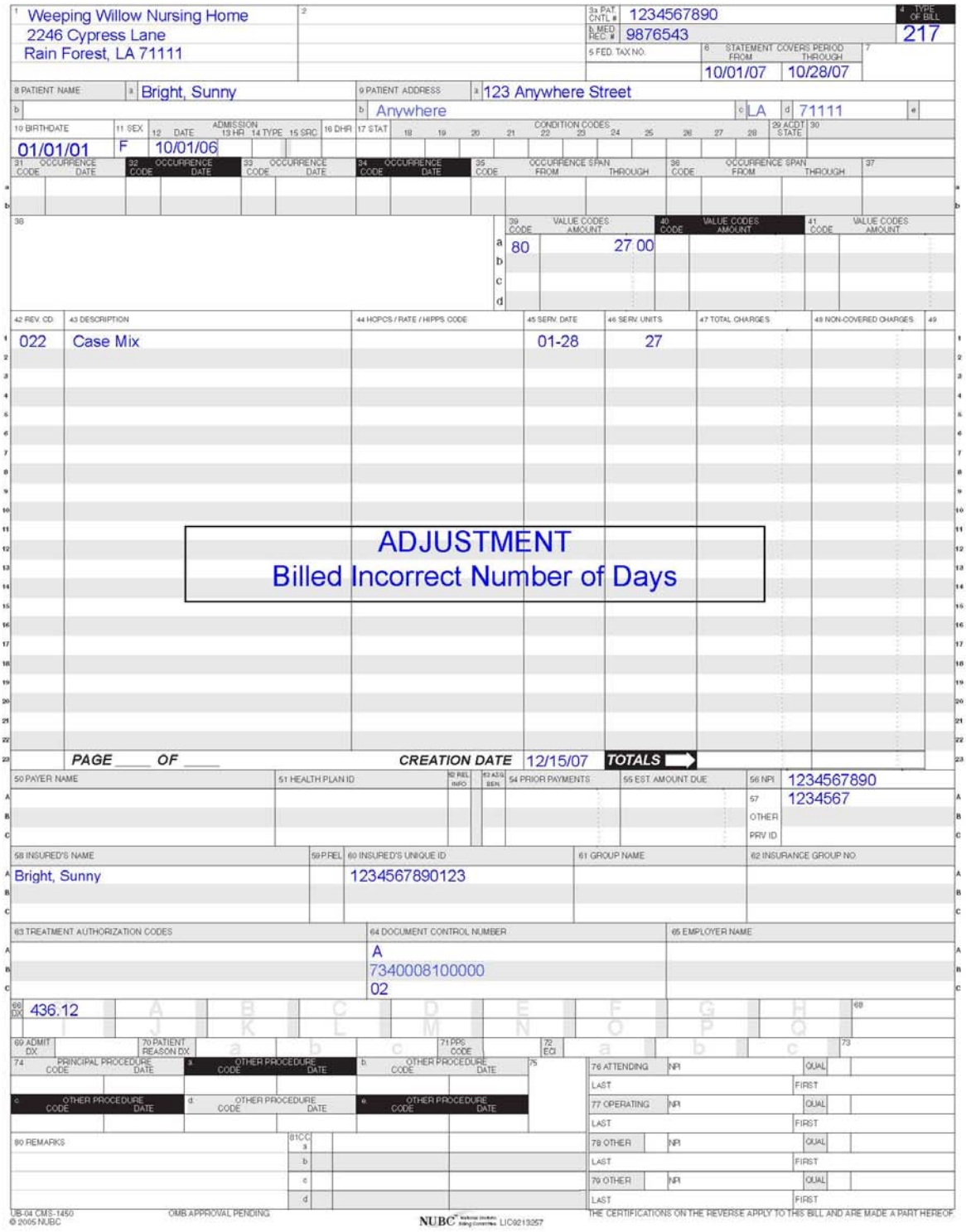
LTC adjustments billed when the recipient’s patient liability is changed retroactively are processed as 148/PLI adjustments. The Adjustment Reason Code included on this form is necessary to process these claims and calculate reimbursement correctly.

This claim form continues to be used with no changes in the submission process.

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

(2) The Level of Care (Block 5) must indicate the locally assigned LOC code as opposed to the revenue code entered on the UB-04 claim form.


Weeping Willow Nursing Home
2246 Cypress Lane
Rain Forest, LA 71111
1234567890
9876543
217
10/01/07
10/31/07
Bright, Sunny
123 Anywhere Street
Anywhere
LA
71111
01/01/01
F
10/01/06
80
31 00
194
SNF TDC
01-31
31
185
Hospital Leave
06-12
185
Hospital Leave
21-27
ADJUSTMENT
Failed to Bill Leave Days on Original Claim
NPI
PAGE ____ OF ____
CREATION DATE
11/01/07
TOTALS
1234567890
1234567
TPL Amount
if applicable
Bright, Sunny
1234567890123
TPL Carrier code if applicable
Provider #
A
7340008100000
02
436.12


Weeping Willow Nursing Home
2246 Cypress Lane
Rain Forest, LA 71111
3a PAT CNTL # 1234567890
b MED REC # 9876543
4 TYPE OF BILL 217
5 FED TAX NO.
6 STATEMENT COVERS PERIOD FROM 10/01/07 THROUGH 10/28/07
8 PATIENT NAME a Bright, Sunny
9 PATIENT ADDRESS a 123 Anywhere Street
b Anywhere c LA d 71111
10 BIRTHDATE 01/01/01
11 SEX F
12 ADMISSION DATE 10/01/06
42 REV. CD. 022
43 DESCRIPTION Case Mix
45 SERV. DATE 01-28
46 SERV. UNITS 27
ADJUSTMENT
Billed Incorrect Number of Days
PAGE ____ OF ____
CREATION DATE 12/15/07
TOTALS
50 PAYER NAME
56 NPI 1234567890
57 OTHER PRV ID 1234567
58 INSURED'S NAME Bright, Sunny
60 INSURED'S UNIQUE ID 1234567890123
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER A 7340008100000 02
65 EMPLOYER NAME
66 DX 436.12
76 ATTENDING
77 OPERATING
78 OTHER
79 OTHER
80 REMARKS
UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

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

LONG TERM CARE
PATIENT LIABILITY ADJUSTMENT FORM

FOR OFFICE USE ONLY

TO: **Medical Assistance**

FROM: **LTC Facility**

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

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

7 FROM DATE OF SERVICE	8 TO DATE OF SERVICE	9 TOTAL DAYS	10 CONTROL NUMBER	11 CORRECT PATIENT LIABILITY	12 STATUS	SDC OFFICE USE ONLY
10/01/07	10/31/07	31	7310008100000	$175.00	30	

ADJUSTMENT

AUTHORIZED SIGNATURES

13. FACILITY *Jane Friday* DATE *11/15/07*

14. PARISH OFS _____ DATE _____

FISCAL AGENT COPY

UNISYS 148/PLI

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

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

LONG TERM CARE
PATIENT LIABILITY ADJUSTMENT FORM

FOR OFFICE USE ONLY

TO: _____

FROM: _____

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

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

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

ADJUSTMENT

AUTHORIZED SIGNATURES

13. FACILITY _____ DATE _____

14. PARISH OFS _____ DATE _____

FISCAL AGENT COPY

UNISYS 148/PLI

DENIAL CODES/EDITS

ICF-DD Only

Edit Codes

Edit 525 Level of Care Not on Recipient File

Edit 173 Level of Care/Level of Need Not Matched

Nursing Facility and ICF-DD

Current Denial Codes Associated With Room & Board Billing

Edit 042 Invalid Bill Type

Edit 045 Patient Status Invalid or Missing

Edit 093 Revenue Code Missing or Invalid

Edit 356 To Day/Tot/Status Conflict

Edit 373 Invalid Leave Date

Edit 395 Hospital Leave Days Exceed 7

Edit 853 Duplicate Claim

Denial Codes Associated With Edits For Recipient Certification

Edit 159 LTC Provider Not Matched

Edit 173 Level of Need/Level of Care Not Matched
ICF-DD ONLY

Edit 525 Level of Need Not on Recipient File

Edit 568 Not LTC Eligible

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.**

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
Third Party/Medicare Payment – EOBs. (Include Medicare adjustment Claims)	Continue hardcopy billing
Retroactive eligibility – copy of ID card or letter from parish office BHSF staff	Continue hardcopy billing
Recipient Eligibility Issues – Copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing – letter/other proof (i.e., RA page, e-CSI printout)	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.

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.

IMPORTANT UNISYS ADDRESSES

Please be aware that **different post office boxes** are used for the various Medicaid programs. If you are submitting an original "clean" hard copy claim for payment or adjustments/voids, please utilize the following post office boxes and zip codes.

Type of Claim	P.O. Box	Zip Code
Pharmacy	91019	70821
CMS-1500 Claims Case Management Chiropractic Durable Medical Equipment EPSDT Health Services FQHC Hemodialysis Professional Services Independent Lab Mental Health Rehabilitation PCS Professional Rural Health Clinic Substance Abuse and Mental Health Clinic Waiver	91020	70821
Inpatient & Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long Term Care	91021	70821
Dental, Home Health, Rehabilitation, Transportation (Ambulance and Non-ambulance)	91022	70821
ALL Medicare Crossovers and All Medicare Adjustments and Voids	91023	70821
KIDMED	14849	70898

Unisys also has different post office boxes for various departments. They are as follows:

Department	P.O. Box	Zip Code
EMC, Unisys business & Miscellaneous Correspondence	91025	70898
Prior Authorization	14919	70898
Provider Enrollment	80159	70898
Provider Relations	91024	70821

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.

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 - (i.e. Professional, DME, Hospital, etc.)
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.

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

APPENDIX A – LTC SCHEDULES

Listed below is the LTC MONTHLY PROCESSING SCHEDULE FOR THE YEAR 2007.

NOTE: It is VERY IMPORTANT that your EDI (837I) or UB claim form is submitted to Unisys no later than the scheduled deadline for billing (EDI/ UB CLAIMS RECEIVED AT UNISYS) in order to receive payment on the "check release (issue) date" shown on the schedule below. If your billing is received at Unisys after the deadline & if the regular monthly LTC check write is missed, the billing will be processed for payment with the next regular check write.
IF POSSIBLE SEND YOUR UB CLAIMS VIA FEDERAL EXPRESS OR OVERNIGHT MAIL.

IN ORDER TO ASSURE THAT YOUR CLAIMS ARE DIRECTED TO THE PROPER PROCESSING UNIT, WRITE " ATTENTION LTC OR ATTENTION KAY BRUE " PROMINENTLY ON THE ENVELOPE, AS WELL AS ON A COVER SHEET WITH THE CLAIMS.

Once a provider is on direct deposit and paid in the regular check write, the funds will be available on the working day after the normal Tuesday check write date.

EDI/UB CLAIMS RECEIVED AT UNISYS	CHECK RELEASE (ISSUE) DATE	DAY	DIRECT DEPOSIT FUNDS AVAILABLE DATE	DAY
01/11/2007 12Noon	01/16/2007	Tuesday	01/17/2007	Wednesday
02/08/2007- 12Noon	02/13/2007	Tuesday	02/14/2007	Wednesday
03/08/2007 12Noon	03/13/2007	Tuesday	03/14/2007	Wednesday
04/12/2007 12Noon	04/16/2007	Monday	04/17/2007	Tuesday
05/10/2007 12Noon	05/15/2007	Tuesday	05/16/2007	Wednesday
06/08/2007 12Noon	06/12/2007	Tuesday	06/13/2007	Wednesday
07/12/2007 12Noon	07/16/2007	Monday	07/17/2007	Tuesday
08/09/2007 12Noon	08/14/2007	Tuesday	08/15/2007	Wednesday
09/07/2007 12Noon	09/11/2007	Tuesday	09/12/2007	Wednesday
10/11/2007 12Noon	10/15/2007	Monday	10/16/2007	Tuesday
11/08/2007 12Noon	11/13/2007	Tuesday	11/14/2007	Wednesday
12/07/2007 12Noon	12/11/2007	Tuesday	12/12/2007	Wednesday

Year 2007 LTC Supplemental / EDI / UB Billing Schedule

EDI/UB RECEIVED AT UNISYS	DAY	CHECK RELEASE (ISSUE) DATE	DAY	DIRECT DEPOSIT FUNDS AVAILABLE	DAY
JANUARY					
01/18/2007 – 12 NOON	THURSDAY	01/23/2007	TUESDAY	01/24/2007	WEDNESDAY
FEBRUARY					
02/15/2007 – 12 NOON	THURSDAY	02/20/2007	TUESDAY	02/21/2007	WEDNESDAY
MARCH					
03/15/2007 – 12 NOON	THURSDAY	03/20/2007	TUESDAY	03/21/2007	WEDNESDAY
03/22/2007 – 12 NOON	THURSDAY	03/27/2007	TUESDAY	03/28/2007	WEDNESDAY
APRIL					
04/19/2007 – 12 NOON	THURSDAY	04/24/2007	TUESDAY	04/25/2007	WEDNESDAY
MAY					
05/17/2007 – 12 NOON	THURSDAY	05/22/2007	TUESDAY	05/23/2007	WEDNESDAY
05/24/2007 – 12 NOON	THURSDAY	05/29/2007	TUESDAY	05/30/2007	WEDNESDAY
JUNE					
06/14/2007 – 12 NOON	THURSDAY	06/19/2007	TUESDAY	06/20/2007	WEDNESDAY
06/21/2007 – 12 NOON	THURSDAY	06/26/2007	TUESDAY	06/27/2007	WEDNESDAY
JULY					
07/19/2007 – 12 NOON	THURSDAY	07/24/2007	TUESDAY	07/25/2007	WEDNESDAY
AUGUST					
08/16/2007 – 12 NOON	THURSDAY	08/21/2007	TUESDAY	08/22/2007	WEDNESDAY
08/23/2007 – 12 NOON		08/28/2007	TUESDAY	08/29/2007	WEDNESDAY
SEPTEMBER					
09/13/2007 – 12 NOON	THURSDAY	09/18/2007	TUESDAY	09/19/2007	WEDNESDAY
09/20/2007 – 12 NOON	THURSDAY	09/25/2007	TUESDAY	09/26/2007	WEDNESDAY
OCTOBER					
10/18/2007 – 12 NOON	THURSDAY	10/23/2007	TUESDAY	10/24/2007	WEDNESDAY
NOVEMBER					
11/15/2007 – 12 NOON	THURSDAY	11/20/2007	TUESDAY	11/21/2007	WEDNESDAY
DECEMBER					
12/13/2007 – 12 NOON	THURSDAY	12/18/2007	TUESDAY	12/19/2007	WEDNESDAY

IF YOU HAVE ANY QUESTIONS REGARDING ELECTRONIC BILLING, PLEASE CALL 225-216-6000, THEN PRESS OPTION 2.

HOW DID WE DO?

In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a 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:_____

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