UNISYS

IMPLEMENTATION OF CHANGES IN PROCESSING AND PAYMENT METHODOLOGY FOR THIRD PARTY LIABILITY (TPL) CLAIMS PAYMENT

February 14-26, 2008

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

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THIRD PARTY LIABILITY OVERVIEW

Federal regulations and applicable state laws require that third-party resources be used before Medicaid is billed. ***Third-party*** refers to those payment resources available from other liable sources, including but not limited to both private and public health insurance, which can be applied toward the Medicaid recipient's medical and health expenses.

It is the responsibility of each provider to verify the recipient's eligibility prior to providing services. Information concerning other insurance coverage is presented in the eligibility response if it appears on that recipient's Medicaid file.

All insurance companies appearing on the Medicaid Resource file are assigned a TPL Carrier Code for billing purposes. When other insurance is present on the eligibility response, providers should obtain the TPL carrier code(s) for the name of the third-party insurance carrier from the TPL Carrier Code listing. The TPL carrier code listing is located on the LA Medicaid website at www.lamedicaid.com under "Forms/Files/User Guides".

If the insurance information provided in the eligibility response is not correct, the provider should:

(1) Instruct the recipient to contact his/her parish worker to correct the file to either add or terminate the coverage if the insurance has been canceled; OR
(2) Submit a request to the LA Medicaid TPL Unit to have the recipient's resource file updated.

Claims submitted for recipients with primary insurance will deny unless the applicable instructions are followed to indicate the insurance coverage information correctly on the claim.

In most cases it is the provider's responsibility to bill the third-party carrier prior to billing Medicaid. In those situations where the insurance payment is received after Medicaid has been billed and has made payment, the provider must reimburse Medicaid, not the recipient. Reimbursement must be made immediately to comply with federal regulations.

NOTE: The absence of other coverage on the eligibility response does not negate the provider's responsibility to ask the recipient if he/she has other insurance coverage.

NOTE: Once a recipient is accepted as a Medicaid recipient, the provider MAY NOT pick and choose the services he will bill to Medicaid, regardless of TPL payment/coverage or any other criteria. All Medicaid covered services must be billed to Medicaid.

ELIGIBILITY DETERMINATION

It is the provider's responsibility to always verify recipient eligibility prior to providing services.

All recipients enrolled in Louisiana's Medicaid Program are issued permanent **Plastic Identification Cards**. These permanent identification cards contain a card control number (CCN) which can be used by the provider to verify Medicaid eligibility. The Department of Health and Hospitals (DHH) offers several options to assist providers with verification of current eligibility. Use of these options will require provider verification. The following eligibility verification options are available:

1. e-MEVS, a web application accessed through www.lamedicaid.com

2. Medicaid Eligibility Verification System (MEVS), an automated eligibility verification system using a swipe card device or PC software through vendors.

3. Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system

4. Pharmacy Point of Sale (POS).

These eligibility verification systems provide confirmation of the following:

- Recipient eligibility
- Third Party (Insurance) Resources
- Service limits and restrictions
- CommunityCARE
- Lock-In

The eligibility response will not only confirm the recipient's eligibility and whether the recipient has other insurance, but it will also indicate any special information related to the recipient's enrollment.

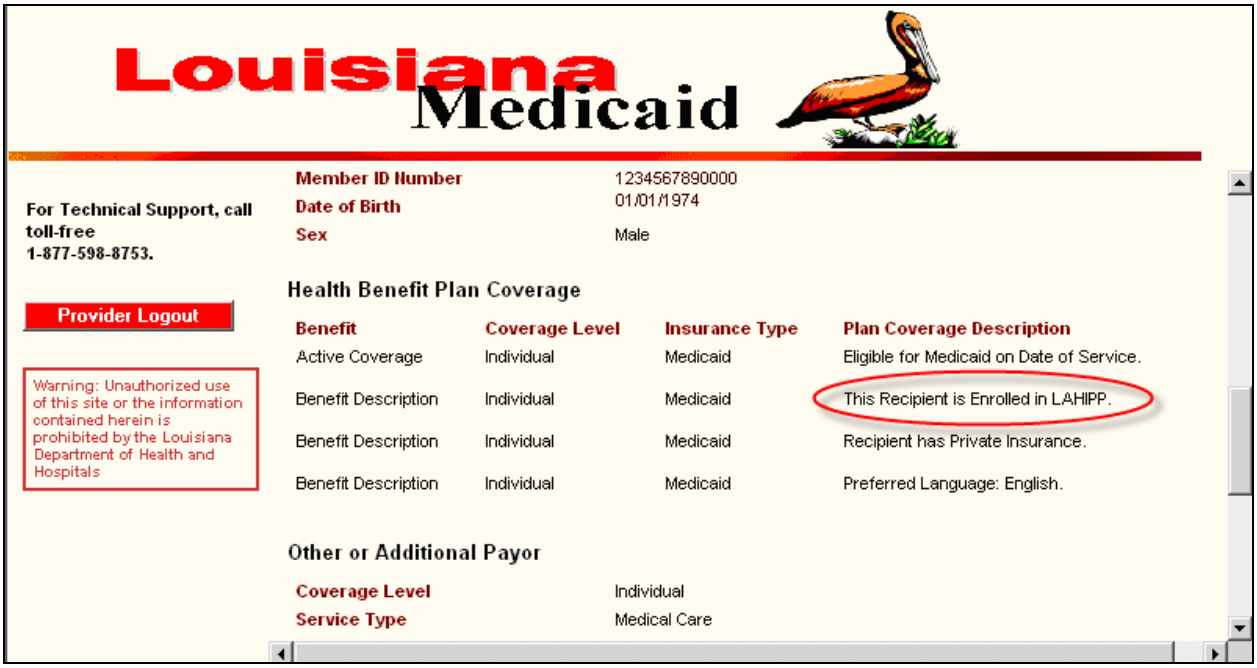
The focus of this training packet relates to changes to the processing and payment of Third Party Liability (TPL) claims, including changes related to revised payment of TPL claims for recipients enrolled through the Louisiana Health Insurance Premium Payment Program (LAHIPP). Under Section 1906 of the CMS regulations, LA Medicaid is required to pay the patient responsibility (co-pays, co-insurances, and deductibles) on TPL claims for these recipients. Of the estimated 46,000 Medicaid recipients with other insurance reported on the Medicaid files, approximately 2,200 (5%) are LAHIPP recipients.

LAHIPP eligibles will be identified by the response, **"This recipient is enrolled in LAHIPP".** This information will allow you to determine the payment methodology used to process and pay TPL claims.

SAMPLE OF MEVS ELIGIBILITY RESPONSE SCREEN

MEVS response screen formats may vary based on application used, vendors, etc. However, the response description for LAHIPP recipients will be presented as indicated above.

A sample response screen follows:



EXISTING TPL BILLING PROCEDURES AND PAYMENT METHODOLOGY

Until March 1, 2008, Louisiana Medicaid processes and pays TPL claims for recipients with private insurance using the following processes and payment methodology:

CLAIMS COMPLETION/PROCESSING:

When billing Medicaid after receiving an Explanation of Benefits (EOB) from a TPL carrier, the providers:

- Submit the claim hard copy.
- Attach a copy of the EOB, making sure any remarks/comments/edit descriptions from the other insurance company are legible and attached.
- Enter the six-digit carrier code assigned by Medicaid in the correct block on the claim form (except Medicare).
- Enter the amount the other insurance company paid (including contractual adjustments) in the appropriate block on the claim form (except for Medicare).
- The dates of service, procedure codes and total charges on the primary EOB **must match** the claim submitted to Medicaid or the claim will be rejected.
- All Medicaid requirements such as pre-certification or prior authorization **must** be met before payment will be considered.

NOTE: Claims submitted where the billing information does not match the EOB should be sent to the Provider Relations Correspondence Unit with a cover letter explaining the discrepancy.

PAYMENT METHODOLOGY

Until March 1, 2008, LA Medicaid uses a “spend-down” cost comparison methodology to process and pay TPL claims after reimbursement is made by the TPL carrier.

The TPL payment amount indicated on the TPL EOB is <u>not</u> applied by claim line item as the primary payor processed the claim. The total TPL payment amount indicated in “prior payments” on the claim form is applied against the Medicaid allowable for each procedure beginning with the first line on the claim form until it is “spent down”. Although the entire TPL payment is applied to the claim document, in many instances, the payment amount applied to the claim line by the primary payor is not the amount applied by Medicaid. This also allows some claim lines to be processed without application of appropriate payment, and Medicaid overpayments occur.

NOTE: This calculated payment methodology is not applied to certain types of claims.

IMPLEMENTATION OF NEW MEDICAID CLAIMS PROCESSING AND PAYMENT METHODOLOGY FOR TPL CLAIMS

CLAIMS COMPLETION/PROCESSING CHANGES FOR TPL CLAIMS

Effective with **processing date** March 1, 2008, Louisiana Medicaid will process TPL claims differently for all recipients, and the payment calculation will change. Initially, this change is effective for physician, hospital outpatient and inpatient claims, and DME claims. All other providers will be notified through RA messages and web notices when this change will be effective for them.

Only minor changes are being made to the claim completion process.

NOTE: This transition does not include Medicare Crossover, Pharmacy claims, or specific service claims such as immunizations that are paid at "0".

HARD COPY CLAIMS

As indicated above with existing processing, **providers must continue to**:

- Submit the claim hard copy
- Attach a copy of the EOB, making sure any remarks/comments/edit descriptions from the other insurance company are legible and attached.
- Enter the correct six-digit carrier code assigned by Medicaid in the correct block on the claim form (except Medicare).
- The dates of service, procedure codes and total charges on the primary EOB **must match** the claim submitted to Medicaid or the claim will be rejected.
- All Medicaid requirements such as pre-certification or prior authorization **must** be met before payment will be considered.

The change in claims completion follows:

- **Providers will continue to enter the total TPL payment amount in the "prior payments" field of the claim but will no longer enter the contractual adjustment amount as a part of the TPL payment amount.**

IMPORTANT NOTE: Providers must ensure that the correct, accurate EOB is attached to each TPL claim form; that EOB copies are clear, complete, and readable; and that the description of EOB edits is attached.

ELECTRONIC CLAIMS (EDI)

Effective with **processing date** April 1, 2008, Louisiana Medicaid will accept and process TPL claims submitted electronically by physician and DME providers. It will no longer be necessary for these providers to submit TPL claims hard copy with EOBs attached. This effective date is tentative for hospital inpatient and outpatient claims.

Providers must enter the appropriate and accurate information from the primary payor EOB for transmission electronically to Louisiana Medicaid for processing and payment. Post-payment reviews will be conducted to ensure that accurate information is being submitted by providers.

Detailed information concerning correct entry of TPL data in the 837 electronic specifications may be found in the Companion Guide(s) located on the Louisiana Medicaid web site, www.lamedicaid.com, link "HIPAA Billing Instructions and Companion Guides". Choose the appropriate Companion Guide applicable to the 837 transaction to be submitted. .

Questions concerning EDI transmissions may be directed to the Unisys EDI Department at (225) 216-6000, Option 2.

PAYMENT METHODOLOGY

With this transition, the processing procedures and payment methodology for calculating TPL claims will change. Unisys will process these claims **as processed by the primary payor**. The payment information indicated on the primary payor EOB will be used to process the claim.

Additionally, Medicaid TPL payments will be calculated differently for recipients enrolled through the Louisiana Health Insurance Premium Payment Program (LAHIPP).

Payment Changes for LAHIPP Claims

For recipients enrolled in LAHIPP, once the claim has been processed and paid by the primary carrier, LA Medicaid now processes and pays the full patient responsibility (co-pay, co-insurance, and/or deductible) - regardless of Medicaid's allowed amount, billed charges, or TPL payment amount. However, **recipients must follow the policies of the primary plan, and only in certain circumstances will Medicaid consider payment of claims that are denied by the primary payor.**

Payment of Non-LAHIPP Secondary Claims

Medicaid will use the revised cost comparison methodology to pay TPL claims for Non-LAHIPP recipients with primary insurance. TPL claims will be processed as processed by the primary payor, and TPL payment amount will be applied just as the primary payor indicates on the EOB. **If there is only a total TPL amount on the EOB, "spend down" methodology will continue to occur.**

The payment will be made based on the lesser of (1) Medicaid allowed amount minus TPL payment, OR (2) total patient responsibility amount (co-pay, co-insurance, and/or deductible).

NOTE: For all TPL claims, Medicaid will never pay more than the total co-pay, co-insurance and/or deductible. If co-pay, co-insurance and/or deductible are not owed, Medicaid will zero pay the claim.

An example of the difference between LAHIPP and Non-LAHIPP recipient payments follows.

Example of Claims Payment for LAHIPP vs. Non-LAHIPP Recipients

Procedure Code -	99213
Provider Billed Amount -	$ 70.00
Private Insurance Allowable -	$ 50.00
Private Insurance Payment -	$ 40.00
Patient Responsibility (Co-Pay) -	$ 10.00

LAHIPP Recipient

Medicaid Allowable	$ 36.13
TPL Payment	-40.00
	- 3.87
Medicaid Payment	$ 10.00

(Because this is a LAHIPP recipient, Medicaid pays the co-pay even though the private insurance payment is more than the Medicaid allowable. Medicaid pays the patient responsibility on Medicaid covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.)

Non-LAHIPP Recipient

Cost Comparison – The LESSER of:

Medicaid Allowable	$36.13
TPL Payment	- 40.00
	- 3.87
OR	
Patient Responsibility (Co-Pay)	$10.00
EQUALS	
Medicaid Payment -	$ 0.00

(Medicaid "zero pays" the claim. When cost-compared, the private insurance paid more than Medicaid's allowable for the procedure. When cost compared, the lesser of the Medicaid allowable minus the TPL payment OR the patient co-pay is the former; thus, no further payment is made by Medicaid. The claim is paid in full.)

NOTE: Providers must remember that the same procedure/service may be paid differently based on whether the recipient is LAHIPP or non-LAHIPP.

OTHER CLAIM EXAMPLES

See Appendix A of this packet for the claim examples that correspond with the scenarios presented below.

Please note that all information below, including the patient responsibility, can be found on the TPL EOB.

Professional Example #1

See pages 24-25 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medcaid Allowed Amount	Patient Responsibility	Medicaid Payment
99212	55.00	0	24.10	36.00 (Ded)	36.00
83655-QW	30.00	0	11.37	28.20 (Ded)	28.20
Totals	85.00	0	35.47	64.20 (Ded)	64.20

(Medicaid is required to pay the co-pay, co-insurance, and/or deductible for Medicaid covered services for LAHIPP recipients, regardless of Medicaid's allowable, billed charges, or TPL payment amount.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medcaid Allowed Amount	Patient Responsibility	Medicaid Payment
99212	55.00	0	24.10	36.00 (Ded)	24.10
83655-QW	30.00	0	11.37	28.20 (Ded)	11.37
Totals	85.00	0	35.47	64.20 (Ded)	35.47

(Medicaid pays the allowed amount minus TPL payment OR total patient responsibility amount (co-pay, co-insurance, and/or deductible) for Non-LAHIPP recipients. The Medicaid allowed amount minus the TPL paid amount is LESS THAN the Patient Responsibility; thus, the Medicaid allowed amount is the payment.)

Professional Example #2

See pages 26-27 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medcaid Allowed Amount	Patient Responsibility	Medicaid Payment
99436	250.00	49.50	0 (non-covered)	33.00 (Coins)	0
99433	65.00	20.46	45.00	13.64 (Coins)	13.64
99433	65.00	20.46	45.00	13.64 (Coins)	13.64
99238	115.00	44.88	28.80	29.92 (Coins)	29.92
Totals	495.00	135.30	118.80	90.20 (Coins)	57.20

(At this time, procedure code 99436 is not covered by LA Medicaid ; thus, Medicaid will pay nothing on this procedure even though this recipient is LAHIPP. The co-insurance is paid for procedures 99433 and 99238 because this is a LAHIPP recipient.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medcaid Allowed Amount	Patient Responsibility	Medicaid Payment
99436	250.00	49.50	0 (non-covered)	33.00 (Coins)	0
99433	65.00	20.46	45.00	13.64 (Coins)	13.64
99433	65.00	20.46	45.00	13.64 (Coins)	13.64
99238	115.00	44.88	28.80	29.92 (Coins)	0
Totals	495.00	135.30	118.80	90.20 (Coins)	27.28

(At this time, procedure code 99436 is not covered by LA Medicaid ; thus, Medicaid will pay nothing on this procedure. The co-insurance is paid for procedures 99433 because the Medicaid Allowed Amount minus the TPL payment is greater than the coinsurance amount. The LESSER is paid. Procedure 99238 is paid at zero because the Medicaid Allowed Amount minus the TPL payment is -16.08 which is less than the co-insurance amount of 29.92.)

Outpatient Example #1

See pages 28-29 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
HR270	99.25	74.44	22.04	0	0
HR450	316.25	137.19	70.24	100.00	100.00
Totals	415.50	211.63	92.28	100.00	100.00

(The 100.00 deductible for this claim is paid because this is a LAHIPP recipient.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment

Code	Charge	TPL Paid	M'caid Allowed	Pt. Liability	M'caid Paid
HR270	99.25	74.44	22.04	0	0
HR450	316.25	137.19	70.24	100.00	0
Totals	415.50	211.63	92.28	100.00	0

(This claim is paid at zero because the Medicaid Allowed Amount minus the TPL payment is LESS THAN the deductible.)

Outpatient Example #2

See pages 30-31 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
HR259	1.10	0.33	0.33	1.10	1.10
HR450	291.39	87.71	87.71	22.11	22.11
HR450	99.22	4.88	29.87	0.00	0.00
Totals	391.71	92.92		23.21	23.21

(In this example, the claim lines were bundled by the primary carrier and processed as one total. Therefore, Medicaid "spends down" the total payment and patient responsibility. The total payment is "spent down" (or applied) against the Medicaid allowed amount, and the total patient responsibility is "spent down" (or applied) against the billed charges. The 23.21 co-insurance for the total claim is paid because this is a LAHIPP recipient. It is paid by "spending it down" on each claim line until the entire 23.21 is paid. The last claim line is paid at "0" because the entire patient responsibility (co-insurance) is paid on the prior claim lines when processed by Medicaid.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
HR259	1.10	0.33	0.33	1.10	0.00
HR450	291.39	87.71	87.71	22.11	0.00
HR450	99.22	4.88	29.87	0.00	0.00
Totals	391.71	92.92		23.21	0.00

(This is a non-LAHIPP recipient. In this example, the claim lines were bundled by the primary carrier and processed as one total. Therefore, Medicaid "spends down" the total payment and patient responsibility. The total payment is "spent down" (or applied) against the Medicaid allowed amount, and the total patient responsibility is "spent down" (or applied) against the billed charges. On line one, the TPL Paid Amount applied is the 0.33 Medicaid Allowed Amount, and the patient responsibility applied is the 1.10 billed charges. The line is paid at zero because the Medicaid allowed amount minus the TPL paid amount is less than the patient responsibility. On line two, 87.71 of the TPL Paid Amount is applied and equals the Medicaid Allowed Amount. The remaining 22.11 of the patient responsibility is applied as it is less than the billed charges. The claim line is paid at 0.00 because the Medicaid allowed amount minus the TPL paid amount is less than the patient responsibility. On line three, the remaining TPL Paid Amount of 4.88 is "spent down." The claim line is paid at 0.00 because no patient responsibility remains.)

Inpatient Example #1

See pages 32-33 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR R & B	34,359.32	9,015.00	4,646.90	250.00	250.00

(The 250.00 patient deductible is paid for this LaHIPP recipient.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR R & B	34,359.32	9,015.00	4,646.90	250.00	0

(The claim is paid at zero because the Medicaid Allowable of 4646.90 minus the TPL payment of 9015.00 is less than the 250.00 patient deductible.)

Inpatient Example #2

See pages 34-35 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR HR 110 R & B	12,253.00	2,450.00	5,052.30	300.00 (co-pay)	300.00

(The co-pay is paid because this is a LAHIPP recipient and the services are a covered Medicaid service.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR	12,253.00	2,450.00	5,052.00	300.00 (co-pay)	300.00

(This is a Non-LAHIPP recipient. The Medicaid Allowed Amount minus the TPL payment is GREATER THAN the co-pay; thus, the co-pay is paid on this covered service.)

Inpatient Example #3

See pages 36-37 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient:

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR R & B	14,788.37	10,255.07	4,593.00	478.93	478.93

(The deductible is paid for this LAHIPP recipient.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR R & B	14,788.37	10,255.07	4,593.00	478.93	0

(This is a Non-LAHIPP recipient. The Medicaid Allowed Amount minus the TPL Payment Amount is LESS THAN zero; thus, the payment is "0".)

New Claim Edits Implemented for TPL

The following new claim edits will be implemented to assist with identifying payments for LAHIPP recipients:

Edit 928 – Paid Patient Responsibility Amount per The EOB

This edit will appear when the claim is paid by the Primary Carrier and Medicaid payment is the amount of the patient responsibility.

Edit 929 – Paid Medicaid Amount TPL Denied Claim

This edit will appear in circumstances when the claim is denied by the primary carrier and Medicaid pays as primary.

Edit 931 – Denied Per the TPL EOB Information

This edit will appear when the claim is denied by the primary carrier and Medicaid will not consider payment as primary.

It may be possible for providers to contact the primary carrier and resubmit to them with corrected information in order to have the claim reconsidered.

Important Reminders Concerning TPL Claims Processing and Payment

- At this time, It is necessary to submit paper TPL claims; however, electronic transmission of TPL claims is forthcoming, and paper claims will not be required once implemented.
- Do not include contract adjustments as prior payments on the claim.
- Until electronic transmission of TPL claims is accepted, providers must ensure that the correct, accurate EOB is attached to each TPL claim form and that EOBs are clear, complete, readable, and include descriptions of EOB edits.
- Other forms of incomplete documentation (payment registers, electronic reports, etc.) are not acceptable and will be rejected back to the provider.
- Once TPL claims are accepted electronically, providers must ensure that the appropriate and accurate information from the primary payor's EOB is entered correctly in the 837 transaction.
- Services that are not covered by LA Medicaid will not be considered for payment.
- Recipients must follow the policies of the primary plan, and only in certain circumstances will Medicaid consider payment of claims that are denied by the primary payor.
- Medicaid will never pay more than the total co-pay, co-insurance and/or deductible. If the TPL carrier pays the claim, and co-pay, co-insurance and/or deductible are not owed on a service covered by Medicaid, Medicaid will zero pay the claim.
- The same procedure/service may be paid differently based on whether the recipient is LAHIPP or non-LAHIPP.
- At this time, approximately 5% of the Medicaid recipients with primary insurance are enrolled through LAHIPP (about 2,200 recipients).
- Providers must verify recipient eligibility to ensure that the recipient is eligible on the date of service and to determine if TPL applies and how the recipient is enrolled.
- New claims edit codes are in effect to assist providers with claims payments or denials.

GENERAL REMINDERS

REQUESTS TO ADD OR REMOVE RECIPIENT TPL/MEDICARE COVERAGE

A request to add or remove TPL or Medicare coverage must include the cover sheet on the following page indicating the action requested; the claim; and the EOB or proof of coverage termination and should be sent to **Eligibility Special Services via fax (225) 342-1376*** or mailed to:

Eligibility Special Services
Third Party Liability
Medicaid Recovery Unit
543 Spanish Town Road
Baton Rouge, LA 70802

*Hardcopy claims must be originals, not faxes. If you are submitting a hardcopy claim with your request, use the mailing address above.

Department of Health and Hospitals
Medicaid Recipient Insurance Information Update
Medicaid Recovery Unit Fax #: (225) 342-1376

Date of Submission:_____
Provider Name:_____ Phone #:(___)____-_____
Submitter Name:_____ Fax#:(___)____-_____

Recipient Information:	**Policy Information:**
Patient Name: _____ Medicaid ID #:_____ Date of Birth: MM/DD/YYYY Parish of Residence:_____ Hospital Account #:_____ Date of Service: MM/DD/YYYY	Policy Holder Name:_____ Policy #:_____ Coverage Effective Date: MM/DD/YYYY Carrier Code:_____

Please update the patient's medical file by **ADDING** the following insurance:
Insurance Name:_____
Address: _____
_____

Please update the patient's medical file by **REMOVING** the following insurance:
Insurance Name:_____
Address: _____
_____

PRIVACY AND CONFIDENTIALITY WARNING

This Fax may contain Protected Health Information, Individually Identifiable Health Information and other information which is protected by law. The information is intended only for the use of the intended recipient. If you are not the intended recipient, you are hereby notified that any review, disclosure/re-disclosure, copying, storing, distributing or the taking of action in reliance on the content of this Fax and any attachments thereto, is strictly prohibited. If you have received this Fax in error, please notify the sender immediately and destroy the contents of this Fax and its attachments by deleting any and all electronic copies and any and all hard copies regardless of where they are maintained or stored.

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MEDICAID PAYMENT ADJUSTMENTS OR REFUNDS

When errors in billing occur:

- **Providers shall initiate claim adjustments or voids**. The adjustment/void process is the most efficient and effective method for adjusting incorrect payments or refunding overpayments.

- **Adjustment/void claims shall be done initially.**

- Only in special circumstances where adjustments or voids can not be submitted shall providers submit refund checks. Refund checks shall be the last option.

When special circumstances occur and providers find it necessary to refund a payment by check, they must:

- Make checks payable to the Department of Health and Hospitals, Bureau of Health Services Financing. DO NOT make refund check payable to Unisys.

- Providers **MUST** attach a copy of the Remittance Advice page(s) to the refund check, and identify the payment line(s) being refunded.

- If the check and the attached RA(s) indicating payment information do not balance, all will be returned to the provider.

- Attach an explanation for the reason for the refund

- The Medicaid Provider Number must be clearly identified on requests.

- Mail the refunds to the following address:

Division of Fiscal Management
P. O. Box 91117
Baton Rouge, LA 70821-9117

- Allow additional time for processing, as this process takes a much longer time period to be completed and does not provide a clear audit trail as the adjustment/void process does.

PRENATAL AND PREVENTIVE PEDIATRIC CARE PAY AND CHASE

Louisiana Medicaid will continue to use the "pay and chase" method of payment for **prenatal and preventive care** for individuals with health insurance coverage. This means that most providers are not required to file health insurance claims with private carriers when the service meets the pay and chase criteria.

The Bureau of Health Services Financing seeks recovery of insurance benefits from the carrier within 60 days after claim adjudication when the provider chooses not to pursue health insurance payments.

HMO AND MEDICAID COVERAGE

Louisiana Medicaid has adopted the following policy concerning HMO and Medicaid coverage based on CMS (Centers for Medicare and Medicaid Services) clarification.

- **The recipient must use the services of the HMO that they freely choose to join.** These claims must be submitted hard copy with a copy of the HMO EOB from the carrier that is on file with the state.

- If the HMO denies the service because the service is not a covered service offered under the plan, the claim will be handled as a straight Medicaid claim and processed based on Medicaid policy and pricing.

- If the HMO denies the claim because the recipient sought medical care outside of the HMO network and without the HMO's authorization, Medicaid will deny the claim with a message that HMO services must be utilized.

- If the recipient uses out of network providers for emergency services and the HMO does not approve the claim, Medicaid will deny the claim with a similar edit.

NOTE: If the provider of the service plans to file a claim with Medicaid, copayments or any other payment cannot be accepted from the Medicaid recipient.

APPENDIX A – CLAIM FORM EXAMPLES

CLAIM FORM EXAMPLES

PROFESSIONAL

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567891234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Adalam, Mary

3. PATIENT'S BIRTH DATE: 06 11 89 SEX: M [ ] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Any Street

CITY: Anytown STATE: LA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Anytown STATE: LA

ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 555-5555

ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 555-5555

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 1000000

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 010101

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 06 11 89 SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Humana

d. INSURANCE PLAN NAME OR PROGRAM NAME: LA Medicaid

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: DATE:

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

SIGNED:

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

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 706.1 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 07 06 07	07 06 07	11		99212		1	55 00	1		NPI	1234567 0987654321
2 07 06 07	07 06 07	11		83655	QW	1	30 00	1		NPI	1234567 0987654321
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: H0000

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

28. TOTAL CHARGE: $ 85 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 85 00

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

Ima Biller 8/1/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (264) 555-0000

Angel Giggles, LLC

123 Smiley St.

Sunny, LA 70000

a. 1357901357 b. 1999999

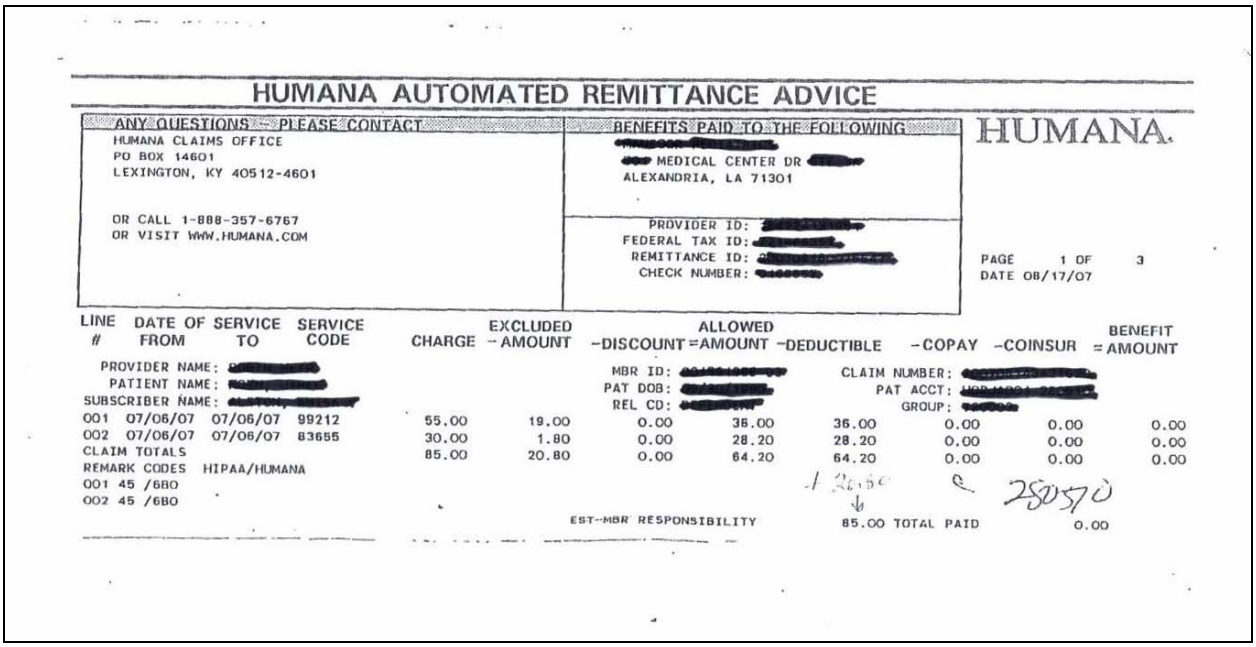
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)



HUMANA AUTOMATED REMITTANCE ADVICE

HUMANA.

ANY QUESTIONS - PLEASE CONTACT
HUMANA CLAIMS OFFICE
PO BOX 14601
LEXINGTON, KY 40512-4601

OR CALL 1-888-357-6767
OR VISIT WWW.HUMANA.COM

BENEFITS PAID TO THE FOLLOWING
[redacted] MEDICAL CENTER DR [redacted]
ALEXANDRIA, LA 71301

PROVIDER ID: [redacted]
FEDERAL TAX ID: [redacted]
REMITTANCE ID: [redacted]
CHECK NUMBER: [redacted]

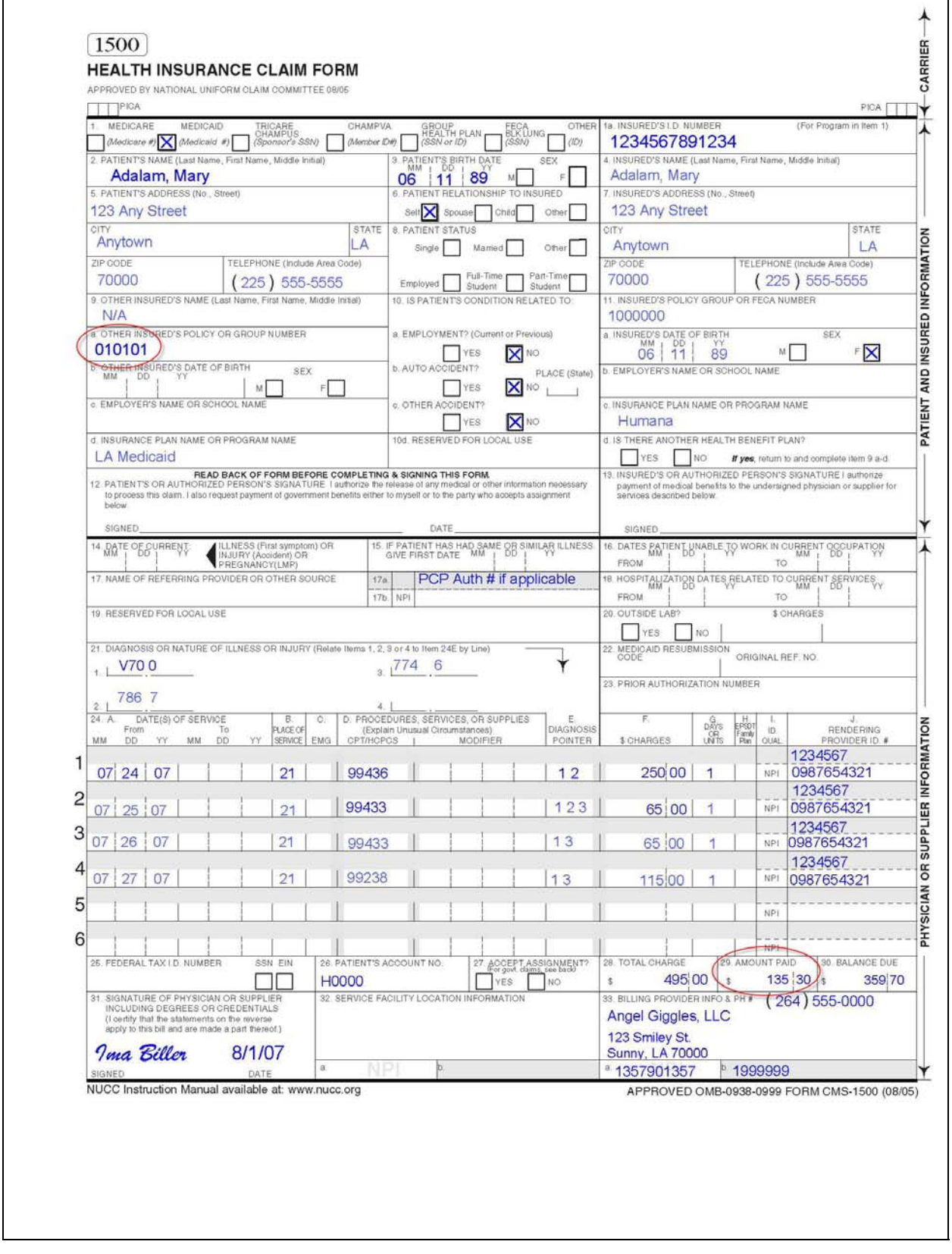
PAGE 1 OF 3
DATE 08/17/07

LINE #	DATE OF SERVICE FROM	TO	SERVICE CODE	CHARGE	EXCLUDED - AMOUNT	ALLOWED -DISCOUNT	=AMOUNT	-DEDUCTIBLE	-COPAY	-COINSUR	BENEFIT =AMOUNT
PROVIDER NAME: [redacted]						MBR ID: [redacted]		CLAIM NUMBER: [redacted]			
PATIENT NAME: [redacted]						PAT DOB: [redacted]		PAT ACCT: [redacted]			
SUBSCRIBER NAME: [redacted]						REL CD: [redacted]		GROUP: [redacted]			
001	07/06/07	07/06/07	99212	55.00	19.00	0.00	36.00	36.00	0.00	0.00	0.00
002	07/06/07	07/06/07	83655	30.00	1.80	0.00	28.20	28.20	0.00	0.00	0.00
CLAIM TOTALS				85.00	20.80	0.00	64.20	64.20	0.00	0.00	0.00

REMARK CODES HIPAA/HUMANA
001 45 /6B0
002 45 /6B0

-1 22.50 ↓ 25057 0

EST-MBR RESPONSIBILITY 85.00 TOTAL PAID 0.00



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567891234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Adalam, Mary

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 89 SEX M [ ] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Any Street

CITY: Anytown STATE: LA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Anytown STATE: LA

ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 555-5555

ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 555-5555

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 1000000

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 010101

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 06 11 89 SEX M [ ] F [X]

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

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Humana

d. INSURANCE PLAN NAME OR PROGRAM NAME: LA Medicaid

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V70.0
2. 786.7
3. 774.6
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 07 24 07		21		99436		1 2	250 00	1		NPI	1234567 0987654321
2 07 25 07		21		99433		1 2 3	65 00	1		NPI	1234567 0987654321
3 07 26 07		21		99433		1 3	65 00	1		NPI	1234567 0987654321
4 07 27 07		21		99238		1 3	115 00	1		NPI	1234567 0987654321
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: H0000

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

28. TOTAL CHARGE: $ 495 00

29. AMOUNT PAID: $ 135 30

30. BALANCE DUE: $ 359 70

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

Ima Biller 8/1/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (264) 555-0000

Angel Giggles, LLC

123 Smiley St.

Sunny, LA 70000

a. 1357901357 b. 1999999

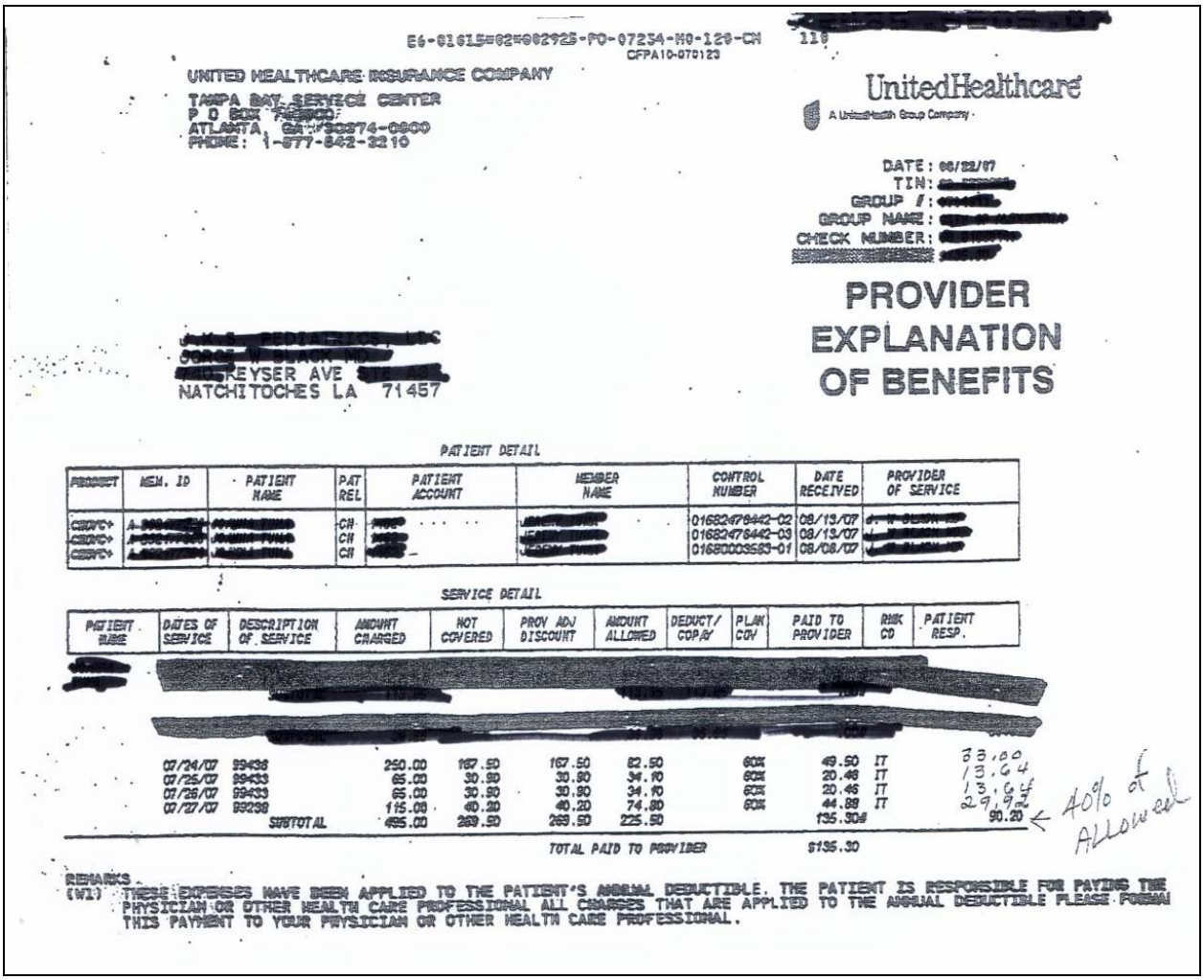
NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



E6-01615=02=002925-PO-07254-H0-120-CH 110
CFPA10-070123

UNITED HEALTHCARE INSURANCE COMPANY
TAMPA BAY SERVICE CENTER
P O BOX [redacted]
ATLANTA GA 30374-0600
PHONE: 1-877-842-3210

UnitedHealthcare
A UnitedHealth Group Company

DATE: 08/22/07
TIN: [redacted]
GROUP #: [redacted]
GROUP NAME: [redacted]
CHECK NUMBER: [redacted]

[redacted]
[redacted] KEYSER AVE [redacted]
NATCHITOCHES LA 71457

PROVIDER EXPLANATION OF BENEFITS

PATIENT DETAIL

PRODUCT	MEM. ID	PATIENT NAME	PAT REL	PATIENT ACCOUNT	MEMBER NAME	CONTROL NUMBER	DATE RECEIVED	PROVIDER OF SERVICE
CHPO	[redacted]	[redacted]	CH	[redacted]	[redacted]	01682478442-02	08/13/07	[redacted]
CHPO	[redacted]	[redacted]	CH	[redacted]	[redacted]	01682478442-03	08/13/07	[redacted]
CHPO	[redacted]	[redacted]	CH	[redacted]	[redacted]	01680003583-01	08/08/07	[redacted]

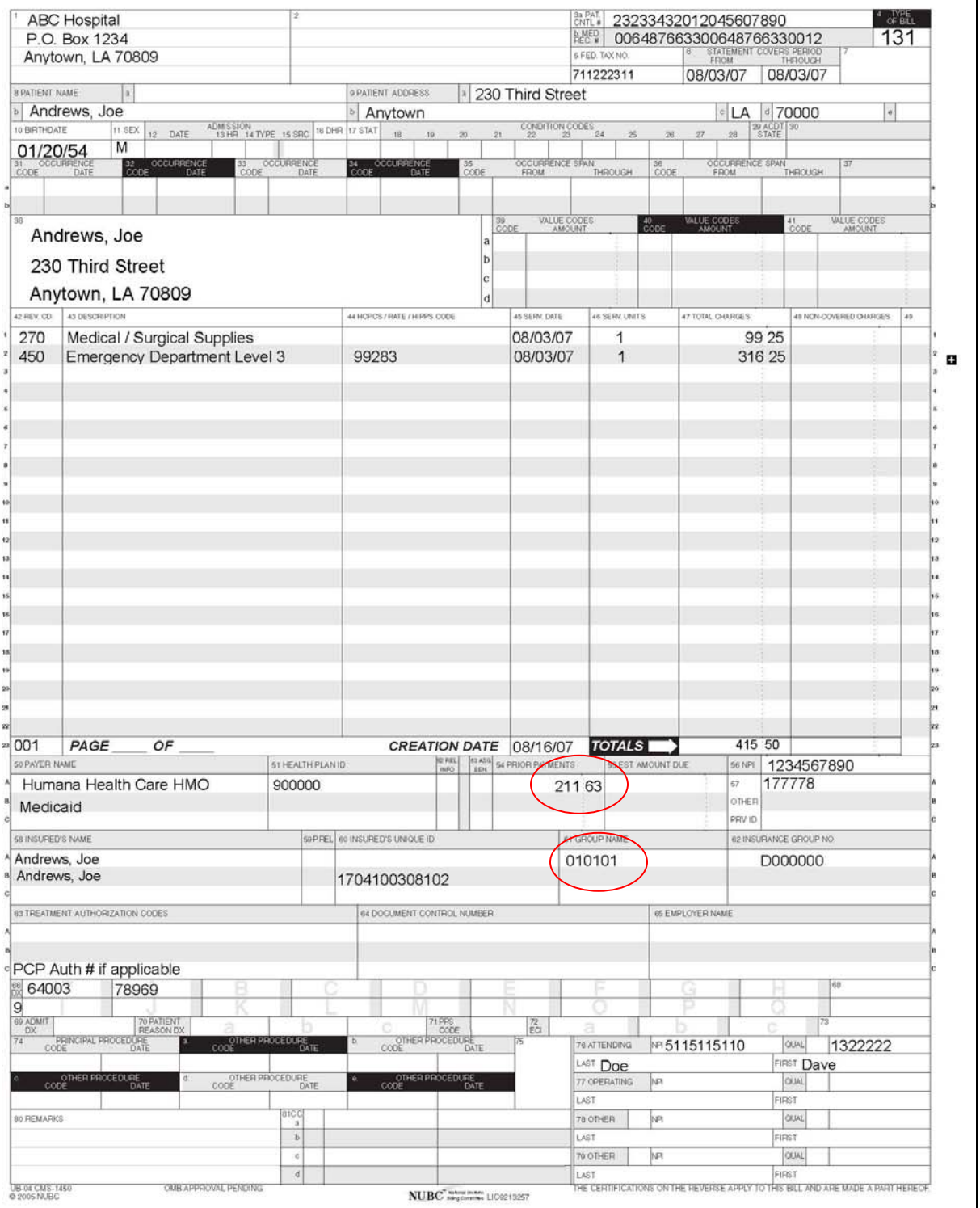
SERVICE DETAIL

PATIENT NAME	DATES OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT/ COPAY	PLAN COV	PAID TO PROVIDER	RMK CD	PATIENT RESP.	
[redacted]												
	07/24/07	99436	250.00	167.50	167.50	82.50		60%	49.50	IT	33.00	
	07/25/07	99433	65.00	30.80	30.80	34.20		60%	20.46	IT	13.64	
	07/26/07	99433	65.00	30.80	30.80	34.20		60%	20.46	IT	13.64	
	07/27/07	99238	115.00	40.20	40.20	74.80		60%	44.88	IT	29.92	
		SUBTOTAL	495.00	269.30	269.30	225.50			135.30#		90.20	← 40% of Allowed

TOTAL PAID TO PROVIDER $135.30

REMARKS
(W1) THESE EXPENSES HAVE BEEN APPLIED TO THE PATIENT'S ANNUAL DEDUCTIBLE. THE PATIENT IS RESPONSIBLE FOR PAYING THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL ALL CHARGES THAT ARE APPLIED TO THE ANNUAL DEDUCTIBLE PLEASE FORWARD THIS PAYMENT TO YOUR PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.

OUTPATIENT



1 ABC Hospital
P.O. Box 1234
Anytown, LA 70809

3a PAT. CNTL # 23233432012045607890
b. MED REC. # 00648766330064876633 0012
4 TYPE OF BILL 131
5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 08/03/07 THROUGH 08/03/07

8 PATIENT NAME: b Andrews, Joe
9 PATIENT ADDRESS: a 230 Third Street; b Anytown; c LA; d 70000
10 BIRTHDATE: 01/20/54
11 SEX: M

38 Andrews, Joe
230 Third Street
Anytown, LA 70809

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
270	Medical / Surgical Supplies		08/03/07	1	99 25	
450	Emergency Department Level 3	99283	08/03/07	1	316 25	
001	PAGE ____ OF ____		CREATION DATE 08/16/07	TOTALS	415 50	

50 PAYER NAME: A Humana Health Care HMO; B Medicaid
51 HEALTH PLAN ID: 900000
54 PRIOR PAYMENTS: 211 63
56 NPI: 1234567890
57 OTHER PRV ID: 177778

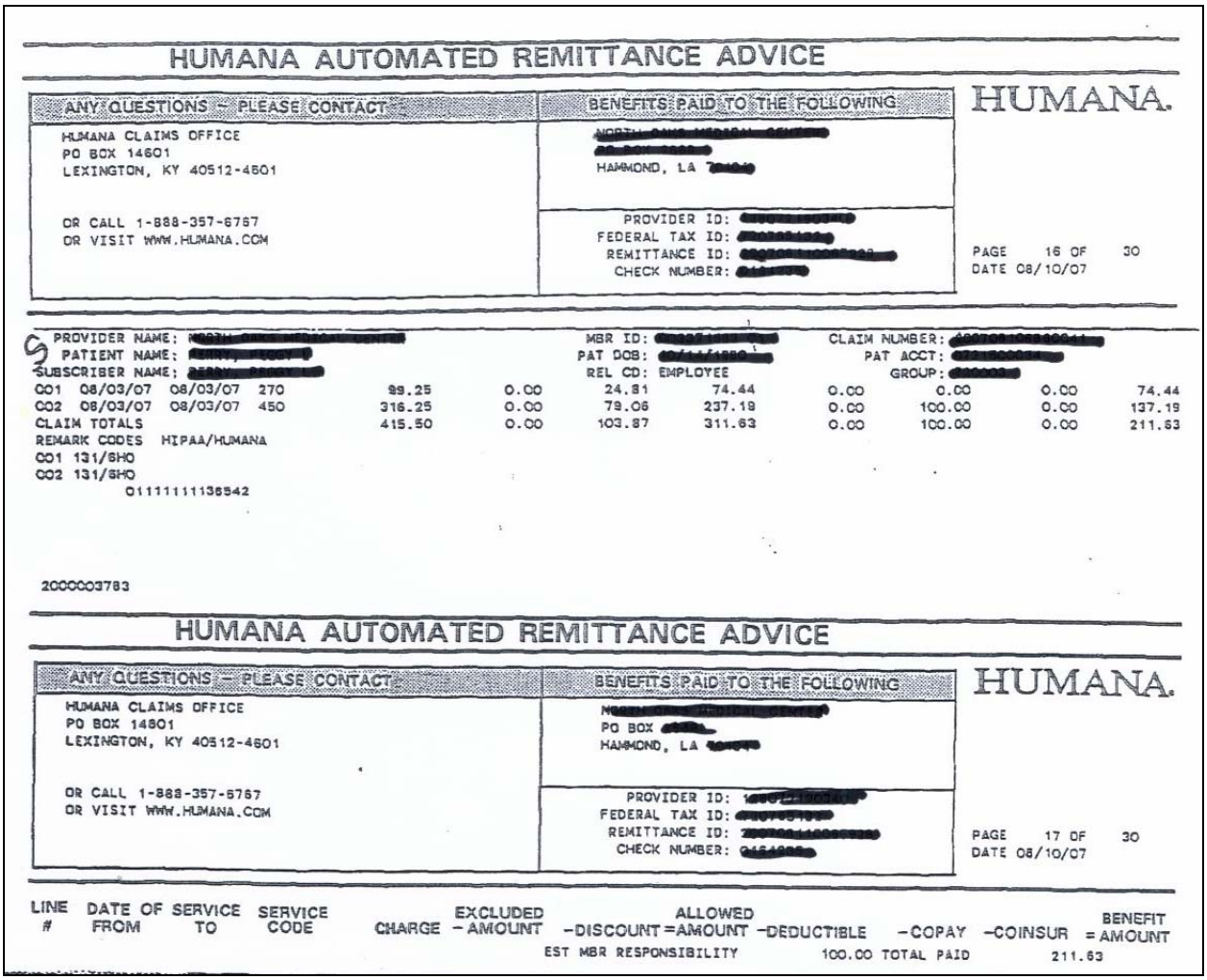
58 INSURED'S NAME: A Andrews, Joe; B Andrews, Joe
60 INSURED'S UNIQUE ID: 1704100308102
61 GROUP NAME: 010101
62 INSURANCE GROUP NO.: D000000

63 TREATMENT AUTHORIZATION CODES: C PCP Auth # if applicable

66 DX: 64003; 78969; 9

76 ATTENDING NPI 5115115110 QUAL 1322222
LAST Doe FIRST Dave

NUBC LIC9213257



HUMANA AUTOMATED REMITTANCE ADVICE

ANY QUESTIONS - PLEASE CONTACT	BENEFITS PAID TO THE FOLLOWING
HUMANA CLAIMS OFFICE PO BOX 14601 LEXINGTON, KY 40512-4601 OR CALL 1-888-357-6787 OR VISIT WWW.HUMANA.COM	[redacted] HAMMOND, LA [redacted] PROVIDER ID: [redacted] FEDERAL TAX ID: [redacted] REMITTANCE ID: [redacted] CHECK NUMBER: [redacted]

HUMANA.

PAGE 16 OF 30
DATE 08/10/07

PROVIDER NAME: [redacted] MBR ID: [redacted] CLAIM NUMBER: [redacted]
PATIENT NAME: [redacted] PAT DOB: [redacted] PAT ACCT: [redacted]
SUBSCRIBER NAME: [redacted] REL CD: EMPLOYEE GROUP: [redacted]

C01	08/03/07	08/03/07	270	99.25	0.00	24.81	74.44	0.00	0.00	0.00	74.44
C02	08/03/07	08/03/07	450	316.25	0.00	79.06	237.19	0.00	100.00	0.00	137.19
CLAIM TOTALS				415.50	0.00	103.87	311.63	0.00	100.00	0.00	211.63

REMARK CODES HIPAA/HUMANA
C01 131/SHO
C02 131/SHO
01111111136542

2000003783

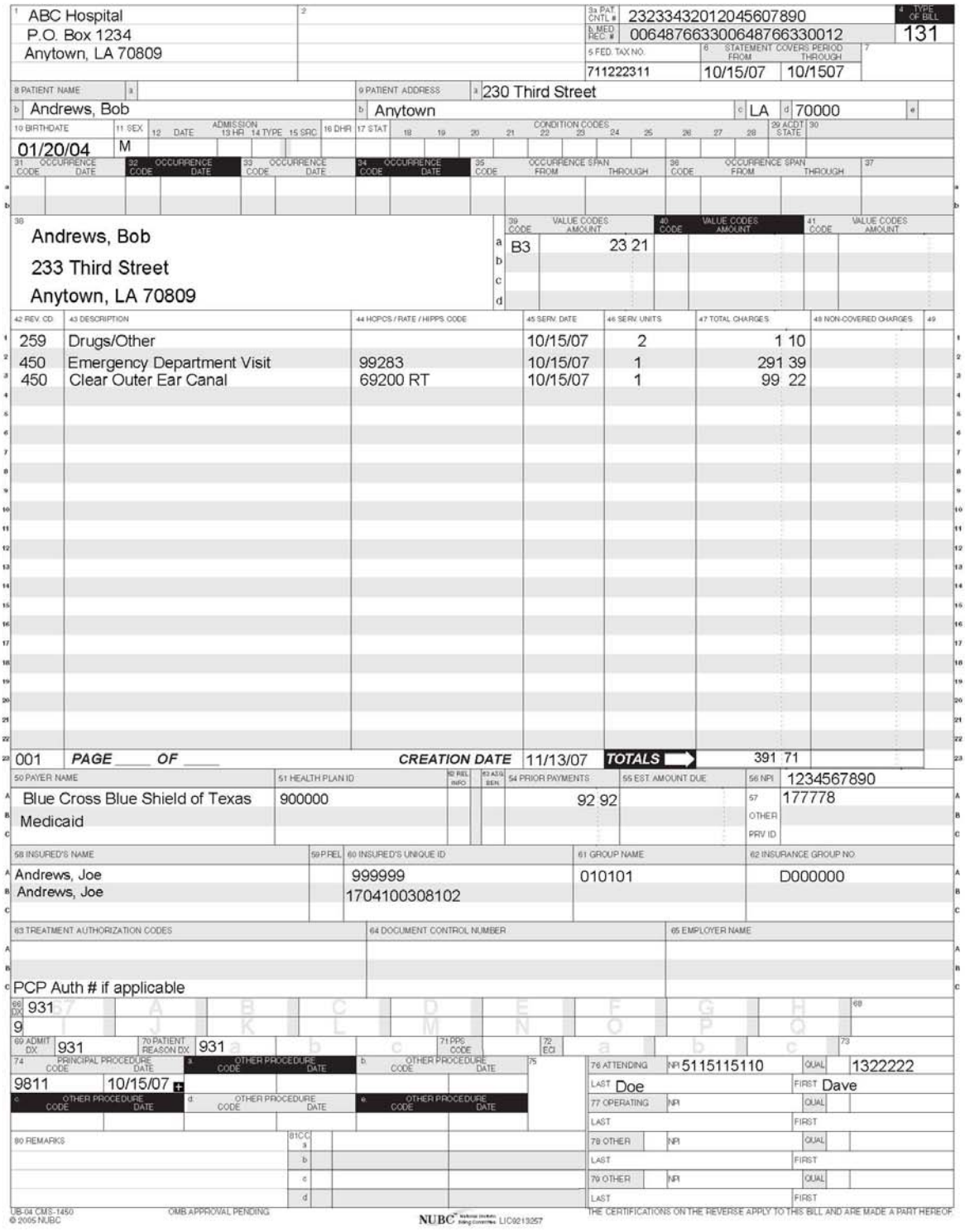
HUMANA AUTOMATED REMITTANCE ADVICE

ANY QUESTIONS - PLEASE CONTACT	BENEFITS PAID TO THE FOLLOWING
HUMANA CLAIMS OFFICE PO BOX 14601 LEXINGTON, KY 40512-4601 OR CALL 1-888-357-6787 OR VISIT WWW.HUMANA.COM	[redacted] PO BOX [redacted] HAMMOND, LA [redacted] PROVIDER ID: [redacted] FEDERAL TAX ID: [redacted] REMITTANCE ID: [redacted] CHECK NUMBER: [redacted]

HUMANA.

PAGE 17 OF 30
DATE 08/10/07

LINE #	DATE OF SERVICE FROM	TO	SERVICE CODE	CHARGE	EXCLUDED - AMOUNT	-DISCOUNT	ALLOWED =AMOUNT	-DEDUCTIBLE	-COPAY	-COINSUR	BENEFIT = AMOUNT
						EST MBR RESPONSIBILITY		100.00	TOTAL PAID		211.63



1 ABC Hospital
P.O. Box 1234
Anytown, LA 70809

3a PAT CNTL # 232334320120456078900
b MED REC # 00648766330064876633001 2
4 TYPE OF BILL 131
5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 10/15/07 THROUGH 10/1507
7

8 PATIENT NAME
b Andrews, Bob
9 PATIENT ADDRESS a 230 Third Street
b Anytown c LA d 70000 e

10 BIRTHDATE 01/20/04
11 SEX M
12 ADMISSION DATE 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

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

38
Andrews, Bob
233 Third Street
Anytown, LA 70809

39 VALUE CODES CODE AMOUNT
a B3 23 21
b
c
d
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
259	Drugs/Other		10/15/07	2	1 10		
450	Emergency Department Visit	99283	10/15/07	1	291 39		
450	Clear Outer Ear Canal	69200 RT	10/15/07	1	99 22		
001	PAGE ____ OF ____	CREATION DATE	11/13/07	TOTALS	391 71		

50 PAYER NAME
A Blue Cross Blue Shield of Texas
B Medicaid
C
51 HEALTH PLAN ID
A 900000
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
A 92 92
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER PRV ID
A 177778

58 INSURED'S NAME
A Andrews, Joe
B Andrews, Joe
C
59 P REL
60 INSURED'S UNIQUE ID
A 999999
B 1704100308102
61 GROUP NAME
A 010101
62 INSURANCE GROUP NO.
A D000000

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
C PCP Auth # if applicable

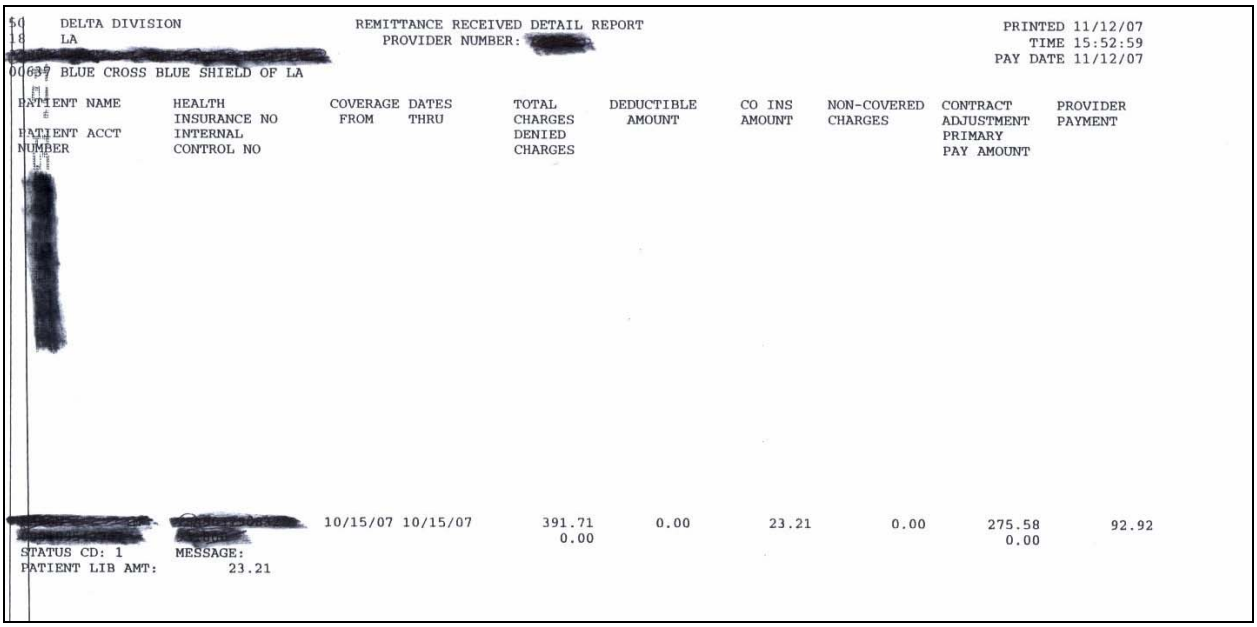
66 DX 931
9
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX 931
70 PATIENT REASON DX 931
a b c
71 PPS CODE
72 ECI
a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
9811 10/15/07
a OTHER PROCEDURE CODE DATE
b OTHER PROCEDURE CODE DATE
c OTHER PROCEDURE CODE DATE
d OTHER PROCEDURE CODE DATE
e OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 5115115110 QUAL 1322222
LAST Doe FIRST Dave
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC
a
b
c
d

UB-04 CMS-1450 © 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



50 DELTA DIVISION
18 LA
[redacted]
00639 BLUE CROSS BLUE SHIELD OF LA

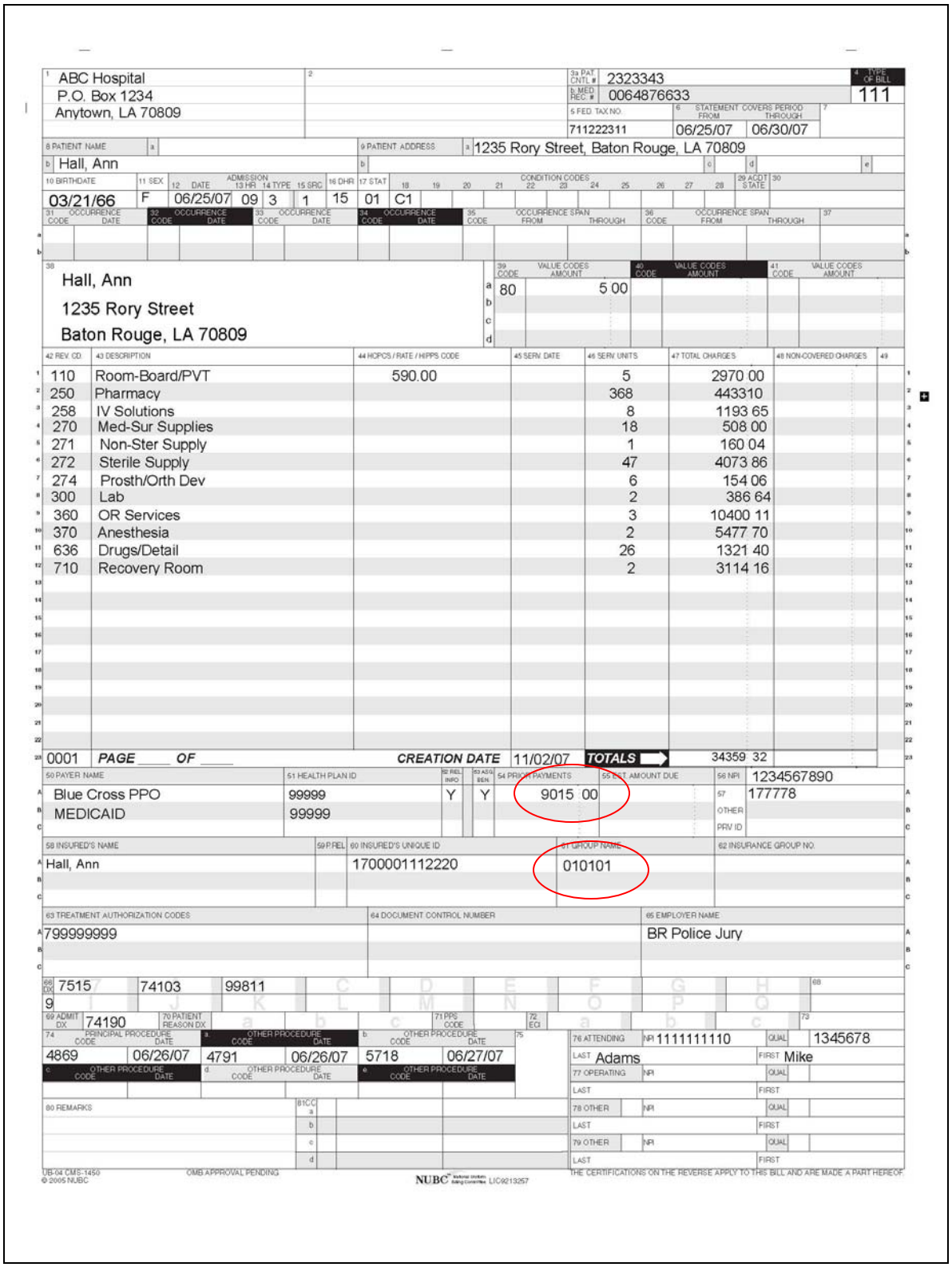
REMITTANCE RECEIVED DETAIL REPORT
PROVIDER NUMBER: [redacted]

PRINTED 11/12/07
TIME 15:52:59
PAY DATE 11/12/07

PATIENT NAME / PATIENT ACCT NUMBER	HEALTH INSURANCE NO / INTERNAL CONTROL NO	COVERAGE DATES FROM	THRU	TOTAL CHARGES / DENIED CHARGES	DEDUCTIBLE AMOUNT	CO INS AMOUNT	NON-COVERED CHARGES	CONTRACT ADJUSTMENT / PRIMARY PAY AMOUNT	PROVIDER PAYMENT
[redacted]	[redacted]	10/15/07	10/15/07	391.71 0.00	0.00	23.21	0.00	275.58 0.00	92.92

STATUS CD: 1 MESSAGE:
PATIENT LIB AMT: 23.21

INPATIENT



1 ABC Hospital
P.O. Box 1234
Anytown, LA 70809

3a PAT CNTL # 2323343
b MED REC # 0064876633
4 TYPE OF BILL 111
5 FED TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 06/25/07 THROUGH 06/30/07

8 PATIENT NAME: b Hall, Ann
9 PATIENT ADDRESS: a 1235 Rory Street, Baton Rouge, LA 70809

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18-28 CONDITION CODES	29 ACDT STATE	30
03/21/66	F	06/25/07	09	3	1	15	01	C1		

31-37 OCCURRENCE CODE / DATE; OCCURRENCE SPAN CODE / FROM / THROUGH

38 Hall, Ann
1235 Rory Street
Baton Rouge, LA 70809

39-41 VALUE CODES / AMOUNT
a 80 5 00

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
110	Room-Board/PVT	590.00		5	2970 00	
250	Pharmacy			368	443310	
258	IV Solutions			8	1193 65	
270	Med-Sur Supplies			18	508 00	
271	Non-Ster Supply			1	160 04	
272	Sterile Supply			47	4073 86	
274	Prosth/Orth Dev			6	154 06	
300	Lab			2	386 64	
360	OR Services			3	10400 11	
370	Anesthesia			2	5477 70	
636	Drugs/Detail			26	1321 40	
710	Recovery Room			2	3114 16	
0001	PAGE ____ OF ____		CREATION DATE 11/02/07	TOTALS	34359 32	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56 NPI	57 OTHER PRV ID
A Blue Cross PPO	99999	Y	Y	9015 00		1234567890	177778
B MEDICAID	99999						

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Hall, Ann		1700001112220	010101	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 799999999		BR Police Jury

66 DX: 7515 | 74103 | 99811 | 9
67 A-Q
68
69 ADMIT DX 74190
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

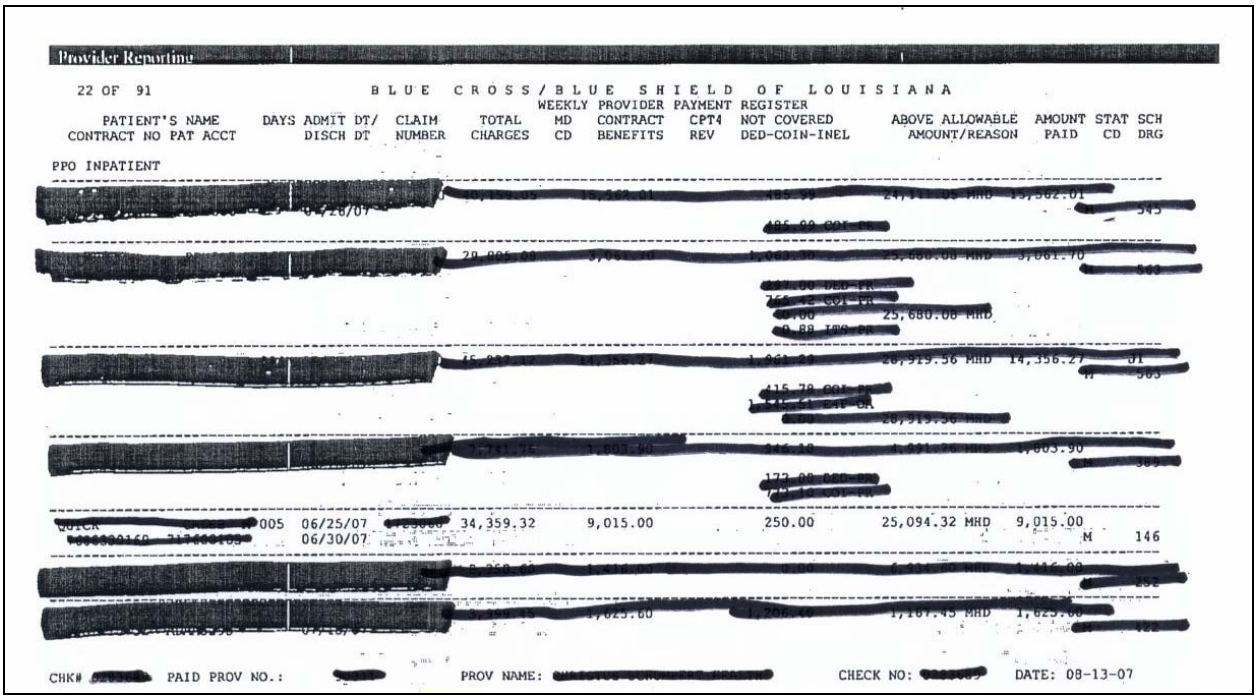
74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE
4869 06/26/07	4791 06/26/07	5718 06/27/07			

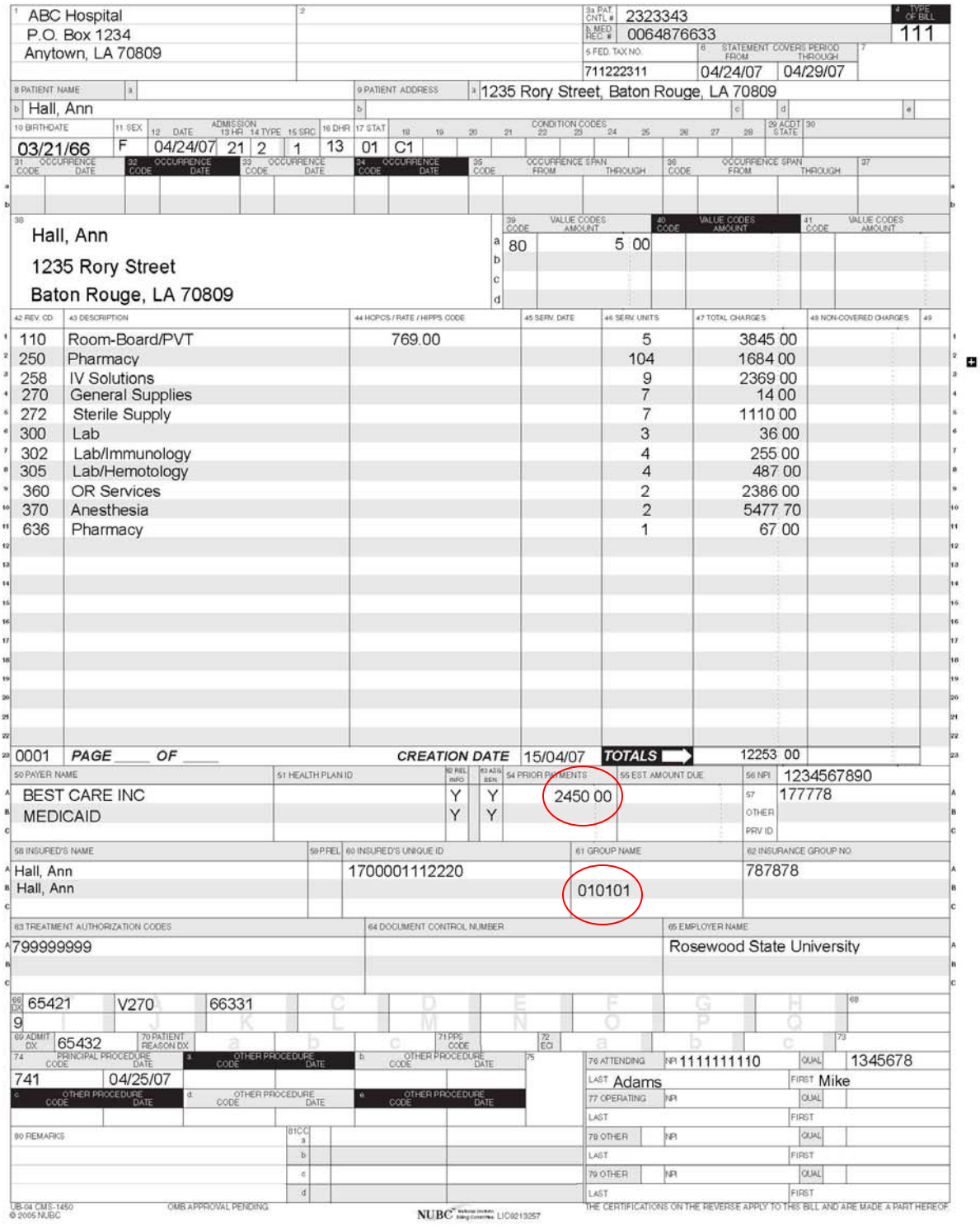
75

76 ATTENDING NPI 1111111110 QUAL 1345678 LAST Adams FIRST Mike
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81CC a b c d

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


Provider Reporting
22 OF 91
BLUE CROSS/BLUE SHIELD OF LOUISIANA
WEEKLY PROVIDER PAYMENT REGISTER
PATIENT'S NAME
CONTRACT NO PAT ACCT
DAYS ADMIT DT/ DISCH DT
CLAIM NUMBER
TOTAL CHARGES
MD CD
CONTRACT BENEFITS
CPT4 REV
NOT COVERED DED-COIN-INEL
ABOVE ALLOWABLE AMOUNT/REASON
AMOUNT PAID
STAT CD
SCH DRG
PPO INPATIENT
005 06/25/07 06/30/07 34,359.32 9,015.00 250.00 25,094.32 MHD 9,015.00 M 146
CHK#
PAID PROV NO.:
PROV NAME:
CHECK NO:
DATE: 08-13-07



ABC Hospital
P.O. Box 1234
Anytown, LA 70809

3a PAT CNTL # 2323343
b MED REC # 0064876633
4 TYPE OF BILL 111
5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 04/24/07 THROUGH 04/29/07

8 PATIENT NAME: Hall, Ann
9 PATIENT ADDRESS: 1235 Rory Street, Baton Rouge, LA 70809

10 BIRTHDATE 03/21/66
11 SEX F
12 ADMISSION DATE 04/24/07
13 HR 21
14 TYPE 2
15 SRC 1
16 DHR 13
17 STAT 01
CONDITION CODES C1

38 Hall, Ann
1235 Rory Street
Baton Rouge, LA 70809

39 VALUE CODES a 80 5 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
110	Room-Board/PVT	769.00		5	3845 00	
250	Pharmacy			104	1684 00	
258	IV Solutions			9	2369 00	
270	General Supplies			7	14 00	
272	Sterile Supply			7	1110 00	
300	Lab			3	36 00	
302	Lab/Immunology			4	255 00	
305	Lab/Hemotology			4	487 00	
360	OR Services			2	2386 00	
370	Anesthesia			2	5477 70	
636	Pharmacy			1	67 00	
0001	PAGE ____ OF ____		CREATION DATE 15/04/07	TOTALS	12253 00	

50 PAYER NAME
A BEST CARE INC
B MEDICAID
51 HEALTH PLAN ID
52 REL INFO: A Y, B Y
53 ASG BEN: A Y, B Y
54 PRIOR PAYMENTS: A 2450 00
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER PRV ID: A 177778

58 INSURED'S NAME
A Hall, Ann
B Hall, Ann
59 P REL
60 INSURED'S UNIQUE ID: A 1700001112220
61 GROUP NAME: A 010101
62 INSURANCE GROUP NO: A 787878

63 TREATMENT AUTHORIZATION CODES: A 799999999
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME: A Rosewood State University

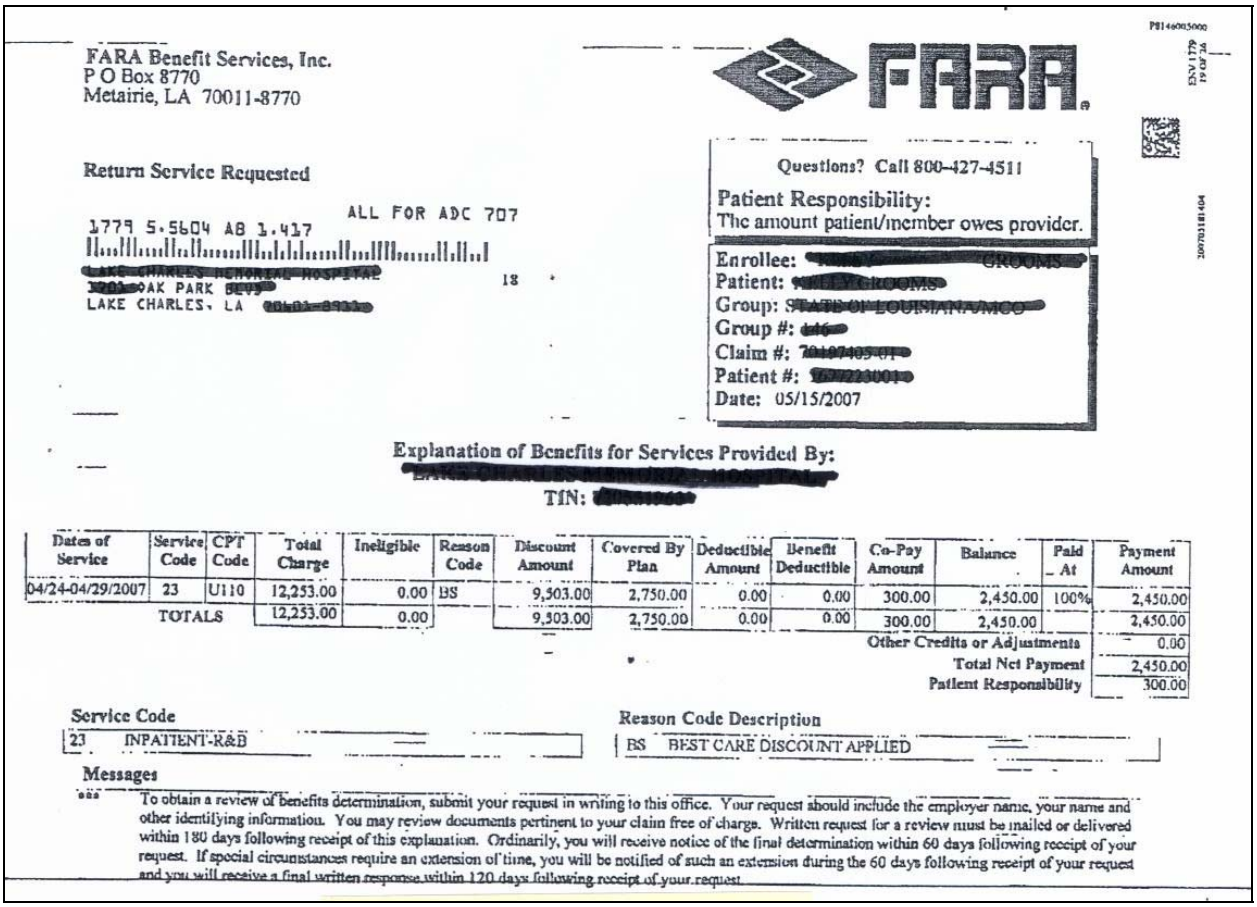
66 DX: 9 65421 V270 66331
67 ADMIT DX: 65432
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE 741 DATE 04/25/07
OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 1111111110 QUAL 1345678 LAST Adams FIRST Mike
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 National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



FARA Benefit Services, Inc.
P O Box 8770
Metairie, LA 70011-8770

FARA

Return Service Requested

1779 5.5604 AB 1.417 ALL FOR ADC 707

[redacted] 18

[redacted] OAK PARK [redacted]
LAKE CHARLES, LA [redacted]

Questions? Call 800-427-4511

Patient Responsibility:
The amount patient/member owes provider.

Enrollee: [redacted]
Patient: [redacted]
Group: [redacted]
Group #: [redacted]
Claim #: [redacted]
Patient #: [redacted]
Date: 05/15/2007

Explanation of Benefits for Services Provided By:

[redacted]

TIN: [redacted]

Dates of Service	Service Code	CPT Code	Total Charge	Ineligible	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Benefit Deductible	Co-Pay Amount	Balance	Paid At	Payment Amount
04/24-04/29/2007	23	U110	12,253.00	0.00	BS	9,503.00	2,750.00	0.00	0.00	300.00	2,450.00	100%	2,450.00
TOTALS			12,253.00	0.00		9,503.00	2,750.00	0.00	0.00	300.00	2,450.00		2,450.00
												Other Credits or Adjustments	0.00
												Total Net Payment	2,450.00
												Patient Responsibility	300.00

Service Code

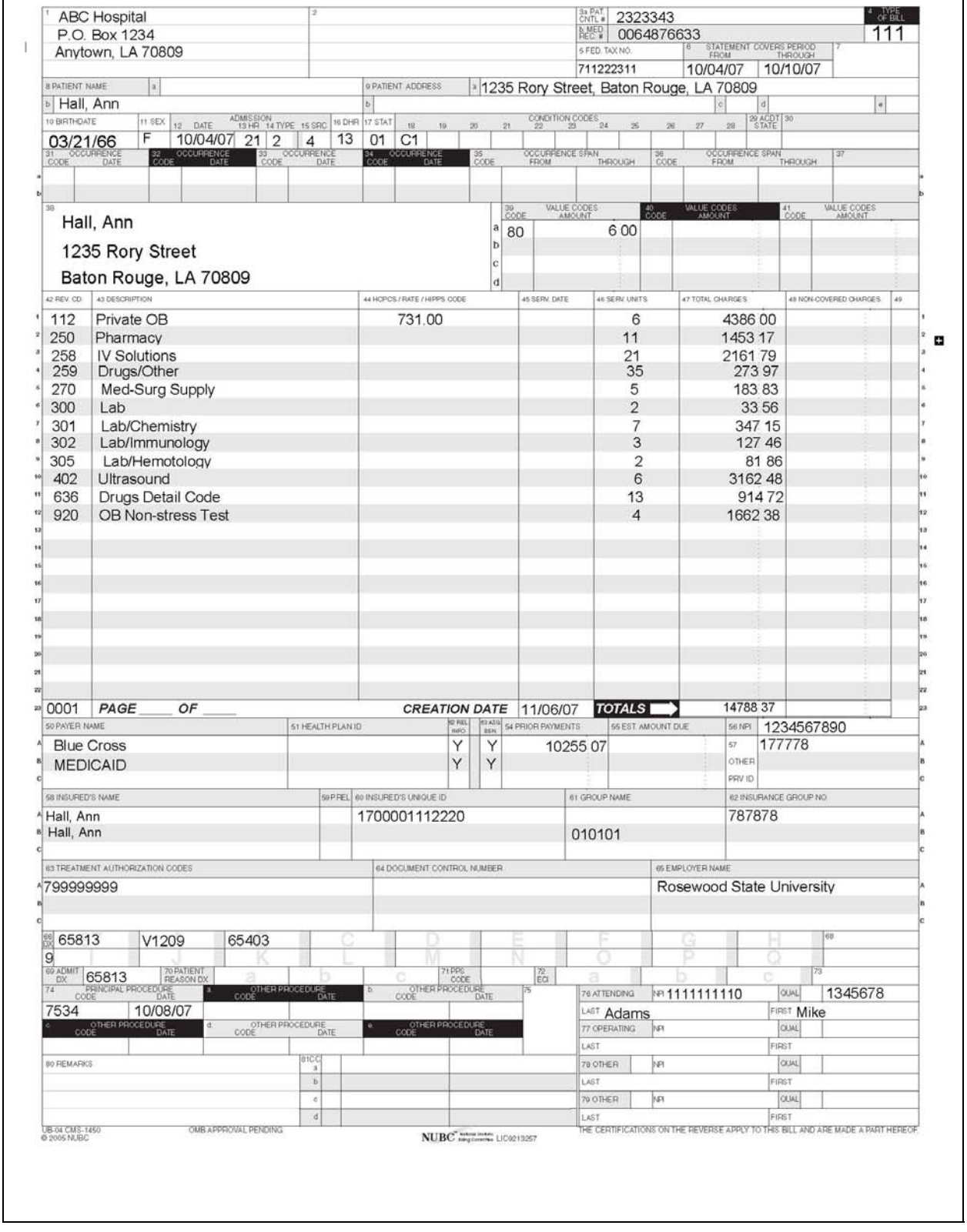
23 INPATIENT-R&B

Reason Code Description

BS BEST CARE DISCOUNT APPLIED

Messages

To obtain a review of benefits determination, submit your request in writing to this office. Your request should include the employer name, your name and other identifying information. You may review documents pertinent to your claim free of charge. Written request for a review must be mailed or delivered within 180 days following receipt of this explanation. Ordinarily, you will receive notice of the final determination within 60 days following receipt of your request. If special circumstances require an extension of time, you will be notified of such an extension during the 60 days following receipt of your request and you will receive a final written response within 120 days following receipt of your request.



1 ABC Hospital
P.O. Box 1234
Anytown, LA 70809

3a PAT CNTL # 2323343
b MED REC # 0064876633
4 TYPE OF BILL 111
5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 10/04/07 THROUGH 10/10/07

8 PATIENT NAME: Hall, Ann
9 PATIENT ADDRESS: 1235 Rory Street, Baton Rouge, LA 70809

10 BIRTHDATE 03/21/66
11 SEX F
12 ADMISSION DATE 10/04/07
13 HR 21
14 TYPE 2
15 SRC 4
16 DHR 13
17 STAT 01
CONDITION CODES C1
29 ACDT STATE

38 Hall, Ann
1235 Rory Street
Baton Rouge, LA 70809

39 VALUE CODES a 80 6 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
112	Private OB	731.00		6	4386 00	
250	Pharmacy			11	1453 17	
258	IV Solutions			21	2161 79	
259	Drugs/Other			35	273 97	
270	Med-Surg Supply			5	183 83	
300	Lab			2	33 56	
301	Lab/Chemistry			7	347 15	
302	Lab/Immunology			3	127 46	
305	Lab/Hemotology			2	81 86	
402	Ultrasound			6	3162 48	
636	Drugs Detail Code			13	914 72	
920	OB Non-stress Test			4	1662 38	
0001	PAGE ____ OF ____		CREATION DATE 11/06/07	TOTALS	14788 37	

50 PAYER NAME
A Blue Cross — 51 HEALTH PLAN ID — 52 REL INFO Y — 53 ASG BEN Y — 54 PRIOR PAYMENTS 10255 07 — 56 NPI 1234567890 — 57 OTHER 177778
B MEDICAID — 52 REL INFO Y — 53 ASG BEN Y — OTHER ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Hall, Ann		1700001112220		787878
B Hall, Ann			010101	

63 TREATMENT AUTHORIZATION CODES
A 799999999

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME
A Rosewood State University

66 DX 9
67 A 65813 B V1209 C 65403

69 ADMIT DX 65813

74 PRINCIPAL PROCEDURE CODE 7534 DATE 10/08/07

76 ATTENDING NPI 1111111110 QUAL 1345678
LAST Adams FIRST Mike
77 OPERATING
79 OTHER

80 REMARKS

81CC

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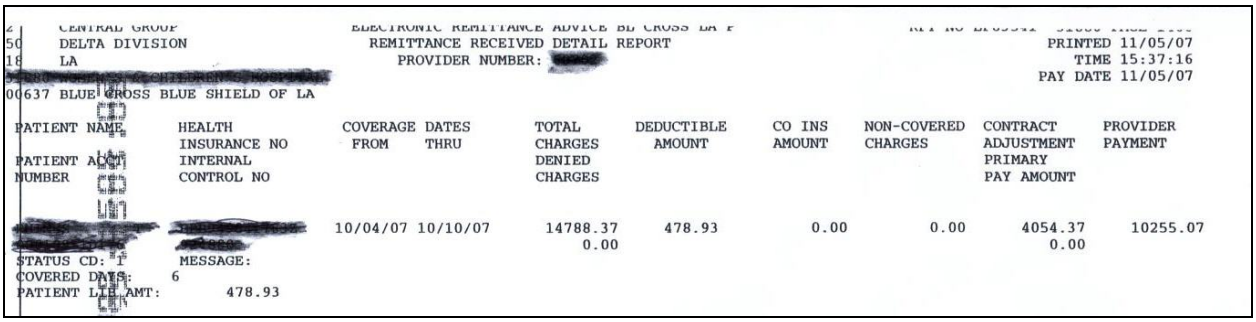

CENTRAL GROUP
50 DELTA DIVISION
18 LA
[redacted]
00637 BLUE CROSS BLUE SHIELD OF LA

ELECTRONIC REMITTANCE ADVICE BL CROSS LA P
REMITTANCE RECEIVED DETAIL REPORT
PROVIDER NUMBER: [redacted]

PRINTED 11/05/07
TIME 15:37:16
PAY DATE 11/05/07

PATIENT NAME / PATIENT ACCT NUMBER	HEALTH INSURANCE NO / INTERNAL CONTROL NO	COVERAGE DATES FROM	THRU	TOTAL CHARGES / DENIED CHARGES	DEDUCTIBLE AMOUNT	CO INS AMOUNT	NON-COVERED CHARGES	CONTRACT ADJUSTMENT / PRIMARY PAY AMOUNT	PROVIDER PAYMENT
[redacted]	[redacted]	10/04/07	10/10/07	14788.37 0.00	478.93	0.00	0.00	4054.37 0.00	10255.07

STATUS CD: I MESSAGE:
COVERED DAYS: 6
PATIENT LIE AMT: 478.93