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### **CLAIMS FILING**

Hard copy billing of waiver services is billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

**Required** information must be entered in order for the claim to be processed. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

**Situational** information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

#### Molina Medicaid Solutions P.O. Box 91020 Baton Rouge, LA 70821

**NOTE:** Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid website at <u>www.lamedicaid.com</u>, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

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# CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

**APPENDIX E – CLAIMS FILING** 

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#### CMS 1500 (02/12) INSTRUCTIONS FOR ADULT DAY HEALTH CARE (ADHC) SERVICES EFFECTIVE WITH DATE OF SERVICE 4/1/16

# You must write "WAIVER" at the top center of the claim form!

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	Required – Enter the recipient's 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	<b>Required</b> – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	Situational – Enter the recipient's date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE		

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Locator #	Description	Instructions	Alerts
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
		Situational – If recipient has no other coverage, leave blank.	
9a	Other Insured's Policy or Group Number	If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number.	ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the
		Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	field.
9b	RESERVED FOR NUCC USE	Leave Blank.	
9с	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Leave Blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Leave Blank.	

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Locator #	Description	Instructions	Alerts
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Leave Blank.	
17	Name of Referring Provider or Other Source	Leave Blank.	
17a	Unlabeled	Leave Blank.	
17b	NPI	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Leave Blank.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Leave Blank.	

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Locator #	Description	Instructions	Alerts
21	ICD Indicator Diagnosis or Nature of Illness or Injury	Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM Required – Enter the ICD 10 diagnosis code Z76.89. NOTE: The ICD-10-CM "V", "W", "X", and "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	Diagnosis Code Z76.89 may be used on all ADHC claims.

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Locator #	Description	Instructions	Alerts
22	Resubmission Code	Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason 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 <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization (PA) Number	<b>Required</b> – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational - Complete if appropriate or leave blank.	
24A	Date(s) of Service	<ul> <li>Required Enter the date of service for each procedure. Bill one date of service per claim line.</li> <li>Either six-digit (MM DD YY) or eight digit (MM DD YYY) format is acceptable.</li> <li>A separate claim must be billed for each month if the recipient's dates of service cross the end of a calendar month.</li> </ul>	Note: Claims must be split billed at the end of each month.
24B	Place of Service	Required Enter the appropriate place of service code for the services rendered. 99 Other	
24C	EMG	Leave Blank.	

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Locator #	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s). S5100 – ADHC Services	
24E	Diagnosis Pointer	<b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block.	
24F	Amount Charged (\$ Charge)	<b>Required</b> Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required Enter the number of units billed for the procedure code entered on the same line in 24D NOTE: ADHC cannot exceed 10 hours (40 units) each day and 50 hours (200 units) per week.	Reminder: 1 Unit is equal to 15 minutes of service
24H	EPSDT Family Plan	Leave Blank.	
241	I.D. Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank.	
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the remittance advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	<b>Optional</b> . Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	

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Locator #	Description	Instructions	Alerts
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay.	
-		If TPL does not apply to the claim, leave blank.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	<b>Optional</b> The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Optional.	
33	Billing Provider Info & Phone #	<b>Required</b> Enter the provider name, address including zip code and telephone number.	
33a	NPI	<b>Required</b> – Enter the billing provider's 10-digit NPI number.	The 10-digit NPI must appear on paper claims.
33b	Unlabeled	<ul> <li>Required – Enter the billing provider's 7-digit Medicaid ID number.</li> <li>ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.</li> </ul>	The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

## REMINDER: MAKE SURE "WAIVER" IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

# Sample forms are on the following pages

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#### SAMPLE ADHC CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

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							set s	pouse	child 🗌	Other						
πγ						STATE 8.	RESERVED	FORINU	CC USE		СПҮ					STATE
PCODE		TEL	EPHO	NE (Induc	le Area	Code)					ZIP CODE		TELEPHO	NE (Ind)	ude Area (	Code)
		(		)									(	)		
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RESERVED F	OR NUCC US	BE					OTHER AC	CIDENT?	ihi		C. INSURANCE PLAN					
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#### ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

# Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted, not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided; thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

Adjustments/Voids Appearing on the Remittance Advice

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When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

#### Sample forms are on the following pages.

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#### SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

EALTH INSURANCE CLAIM F			
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE			
MEDICARE MEDICAID TRICARE	CHAMPVA GROUP EECA OTHER	1a. INSURED'S I.D. NUMBER	PICA For Program in Item 1)
(Medicare#) 🗙 (Medicaid#) 🔄 (/D#/DcD#)	CHAMPVA GROUP HEALTH FLAN EEXLUNG OTHER (Member DØ (DØ) (DØ)	9876543210123	
PATIENT'S NAME (Last Name, First Name, Midde Initial		4. INSURED'S NAME (Last Name, First Name, Mo	(de Initial)
JAYCO, TRAVIS		7. INSURED'S ADDRESS (No., Street)	
	Set Spouse Child Other		
ITY	STATE 8. RESERVED FOR NUCC USE	СПТҮ	BTATE
IP CODE TELEPHONE (Include A	rea Code)		ndude Area Code)
OTHER INSURED'S NAME (Last Name, First Name, Mic	ble hillsal) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUM	3ER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EWPLOYMENT? (Oument or Previous)	a, INSURED'S DATE OF BIRTH MM   DD   YY M	SEX F
RESERVED FOR NUCC USE	Example of	b. OTHER CLAIM ID (Designated by NUCC)	
RESERVED FOR NUCCUSE	C. OTHER ACCIDENT?	C INSURANCE PLAN NAME OF PROGRAM NAM	ΛE
INSURANCE FLAN NAME OF PROGRAM NAME	<b>Adjustment Cl</b>		? Iems 9, 9a, and 9d.
2. PATIENT'S OF AUTHORIZED PERSON'S SIGNATURE	E COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary at cenerits either to myself or to the party who accepts assignment	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SI payment of medical benefits to the undersigned services described below.</li> </ol>	GNATURE I authorize
SIGNED	DATE.	SIGNED	
A. DATE OF CURRENT ILLNE BB, INJURY, & PREGNAN MM DD YY CUAL	CY (LMP) 15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CUP MM DD YY TO FROM   TO	
7. NAME OF RÉFERRING PROVIDER OR OTHER SOUP	ICE 178.	18. HOSPITALIZATION DATES RELATED TO CU MM DD FROM   TO	RRENT SERVICES
9. ADDITIONAL CLAIMINFORMATION (Designated by N.	JCC)	20. OUTSIDE LAB? \$ CHA	RGES
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY IR	elate A-L to service line below (24E) ICD Ind.   0	22. RESUBMISSION CODE . ORIGINAL REF.	NO
Z76.89		A 02 610519876	
F. L	а Царана на Ц	23. PRIOR AUTHORIZATION NUMBER 987654321	
J 4. A. DATE(S) OF SERVICE B. 0	K. L. L. L		J.
From To RLACEDF IM DD YY MM DD YY SBHIKCE EN	(Explain Unusual Choumstances) DIAGNOSIS (G. CPT/HCPCS MODIFIER POINTER	F. G. H. I. DAYS EPSOT OF Rendy \$CHARGES UNITS Pan QUAL	RENDERING PROVIDER ID. #
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5. FEDERALTAX I.D. NUMBER SSN EIN 2	26. PATIENT'S ACCOUNT NO. 27.	28. TOTAL CHARGE 29. AMDUNT PAID	SD. Revel.for NUCCU:
SIGNATURE OF PHYSICIAN OF SUPPLIER     INCLUDING DEGREES OF CREDENTIALS     0 perty that the statements on the reverse     apdry to this bit and are made a part hereot     OHN DOE 5/2/16	Image: Service Facility Location INFORMation	6         96,00         ₅           33. BLLING FROMDER INFO& PH#         (225           ADULT DAY CARE         9876 LOLLIPOP LANE           ANYWHERE, LA 71111         ANYWHERE, LA 71111	) 555-4957
	NDI	1234567890 1234567	

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#### SAMPLE CLAIM FORM

#care#)       (Medicald#)       (DMPDcO#)       (Member I)         NT'S NAME (Last Name, First Name, Middle Initial)       NT'S ADDRESS (No., Street)       STATE         #E       TELEPHONE (Include Area Code)       (/)         RVED FOR NUCC USE       Intervent Area Code)       (/)         #EAD BACK OF FORIM BEFORE COMPLETING       Entervent Area Code)       (/)         #EAD BACK OF FORIM DEFORE COMPLETING       (/)       (/)	a. PATIENT'S BIRTH DAT MMN DD  c. PATIENT'S BOUND  c. PATIENT RELATIONS Self	M F IIP TO INSURED Child Other C USE TION RELATED TO: nt or Previous) NO PLACE (State NO NO	A. INSURED'S NAME     A. INSURED'S NAME     7. INSURED'S ADDRE     CITY     ZIP CODE     11. INSURED'S POLIC     INSURED'S POLIC     INSURED'S DATE     O     D. OTHER CLAIN ID     C. INSURANCE PLAN     d. IS THERE ANOTHER	SS (No., Stre Y GROUP OI DE BIRTH Designated by	x) ELEPHONE ( ( NUCC)	(Include Area Code) ) WEER SEX F
NT'S ADDRESS (No., Street)  TELEPHONE (Include Area Code)  TEL	e. PATIENT RELATIONSH Belf Spouse      e. RESERVED FOR NUCC      10. IS PATIENT'S CONDIT      a. EMPLOYMENT? (Curre	M F IIP TO INSURED Child Other C USE TION RELATED TO: nt or Previous) NO PLACE (State NO NO	7. INSURED'S ADDRE CITY ZIP CODE 11. INSURED'S POLIC a. INSURED'S DATE C MM DD b. OTHER CLAIM ID ( c. INSURANCE PLAN	SS (No., Stre Y GROUP OI DE BIRTH Designated by	x) ELEPHONE ( ( NUCC)	(Include Area Code) ) WEER SEX F
	Self       Spouse         6. RESERVED FOR NUCC         10. IS PATIENT'S CONDIT         a. EMPLOYMENT? (Curre         b. AUTO ACCIDENT?         YES         c. OTHER ACCIDENT?         YEB         10d. CLAIM CODES (Dest	IIP TO INSURED Child Other ] 3 USE TION RELATED TO: nt or Previous) NO PLACE (State NO NO	CITY ZIP CODE 11. INSURED'S POLIC a. INSURED'S DATE ( MM DD b. OTHER CLAIM ID ( c. INSURANCE PLAN	Y GROUP OF BIRTH Sesignated by	ELEPHONE ( IFECA NUM M NUCC)	(Include Area Code) ) WBER SEX F
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ISSUED: REPLACED:

CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

**APPENDIX E – CLAIMS FILING** 

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Providers should refer to the General Information and Administration Provider Manual chapter of the Medicaid Services Manual located on the Louisiana Medicaid website for general information concerning topics relative to general claims filing. http://www.lamedicaid.com/provweb1/Providermanuals/GIA/GIA.pdf