CLAIMS FILING

Hard copy billing of EPSDT Health and IDEA-Related Services are 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 process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider.
>
> **Situational** information may be required, but only in certain circumstances as detailed in the instructions below. Paper claims should be submitted to:

Paper claims should be submitted to:

Gainwell Technoligies
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
- The group provider number as the billing provider number.

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, 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 a sample of a completed CMS-1500 claim form; and

- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

CMS 1500 (02/12) INSTRUCTIONS FOR EPSDT AND IDEA-RELATED SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	**You must write "EPSDT & IDEA" at the top center of the Louisiana Medicaid claim form.**
1a	Insured's ID Number	**Required** – Enter the beneficiary's 13 digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through MEVS, eMEVS, or REVS. **NOTE:** The beneficiarys' 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 beneficiary's name in Block 2.	
2	Patient's Name	**Required** – Enter the beneficiary's last name, first name, middle initial.	
3	Patient's Birth Date Sex	**Situational** – Enter the beneficiary'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). Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	**Situational** – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the beneficiary'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.	

Locator #	Description	Instructions	Alerts
8	RESERVED FOR NUCC USE		
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If beneficiary has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is **required** in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	**Only the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.**
9b	RESERVED FOR NUCC USE	**Leave Blank.**	
9c	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:	**Situational** – Complete if appropriate or 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.	

Locator #	Description	Instructions	Alerts
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	**Optional.**	
15	OTHER DATE	**Leave Blank.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional**	
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	**Optional.**	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab?	**Optional.**	

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. 9 ICD-9-CM 0 ICD-10-CM **Required** – Enter the most current ICD diagnosis code. **NOTE**: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable. **ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.** **ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.** Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).

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: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	**Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).** **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	**Situational** – Complete if appropriate or leave blank. If the services being billed must be prior authorized, the PA number is required to be entered.	
24	Supplemental Information	**Leave Blank.**	
24A	Date(s) of Service	**Required --** Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	

Locator #	Description	Instructions	Alerts
24C	EMG	**Leave Blank.**	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). When a modifier(s) is required, enter the appropriate modifier in the correct field.	
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	**Required** -- 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	
24H	EPSDT Family Plan	**Leave Blank**.	
24I	ID. Qual.	**Optional**. If possible, leave blank for Louisiana Medicaid billing.	

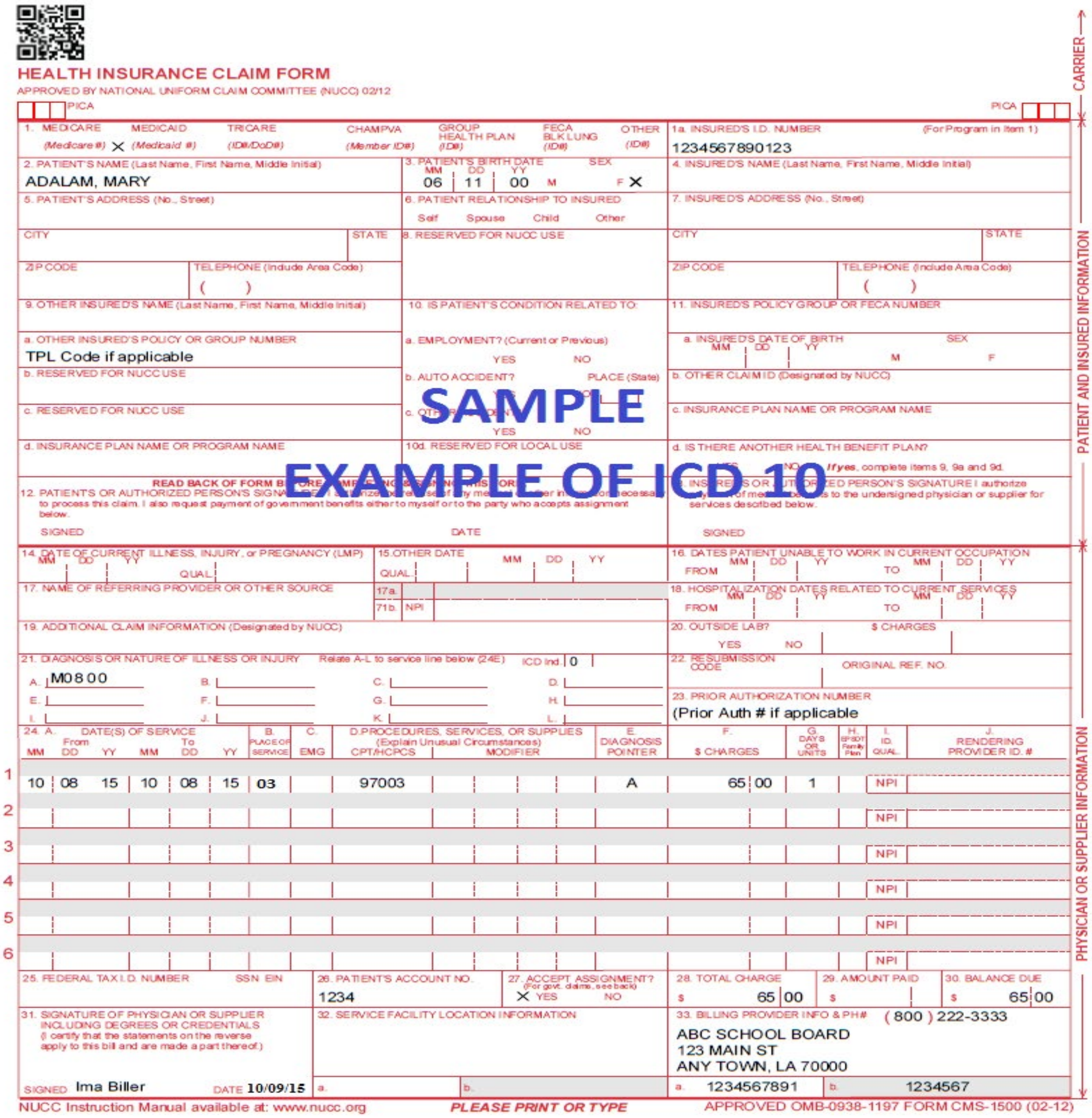
Locator #	Description	Instructions	Alerts
24J	Rendering Provider ID #	**Situational** – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required. **Optional**: Enter the Rendering Provider's NPI in the non-shaded portion of the block.	
25	Federal Tax ID Number	**Optional.**	
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the beneficiary. 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?	**Optional**. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. **Do not report Medicare payments in this field.**	
30	RESERVED FOR NUCC USE	**Leave Blank.**	

Locator #	Description	Instructions	Alerts
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional**. The practitioner or the practitioner's authorized representative's original signature is no longer required. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI	**Optional.**	
32b	Unlabeled	**Situational** – Complete as appropriate or leave blank.	
33	Billing Provider Info & Phone #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Optional.**	
33b	Unlabeled	**Required** – Enter the billing provider's 7-digit Medicaid ID number. **ID Qualifier** – Optional – If possible, leave blank for Louisiana Medicaid billing.	**The 7-digit Medicaid Provider Number must appear on paper claims.**

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

Sample forms are on the following pages

SAMPLE EPSDT AND IDEA-RELATED CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR BEFORE 10/01/15)


HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SAMPLE
EXAMPLE OF ICD 10

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER — (Medicare #) X (Medicaid #)
1a. INSURED'S I.D. NUMBER: 1234567890123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ADALAM, MARY
3. PATIENT'S BIRTH DATE: 06 11 00 — SEX: F X
9a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if applicable
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY — ICD Ind. 0 — A. M0800
23. PRIOR AUTHORIZATION NUMBER: (Prior Auth # if applicable

	24A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	08	15	10	08	15	03		97003		A	65 00	1		NPI	
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

26. PATIENT'S ACCOUNT NO.: 1234
27. ACCEPT ASSIGNMENT?: X YES
28. TOTAL CHARGE: $ 65 00
30. BALANCE DUE: $ 65 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER: SIGNED Ima Biller DATE 10/09/15
33. BILLING PROVIDER INFO & PH #: (800) 222-3333
ABC SCHOOL BOARD
123 MAIN ST
ANY TOWN, LA 70000
a. 1234567891 b. 1234567

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Adjustments and Voids

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 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 Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the Remittance Advice

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.

SAMPLE EPSDT AND IDEA-RELATED CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

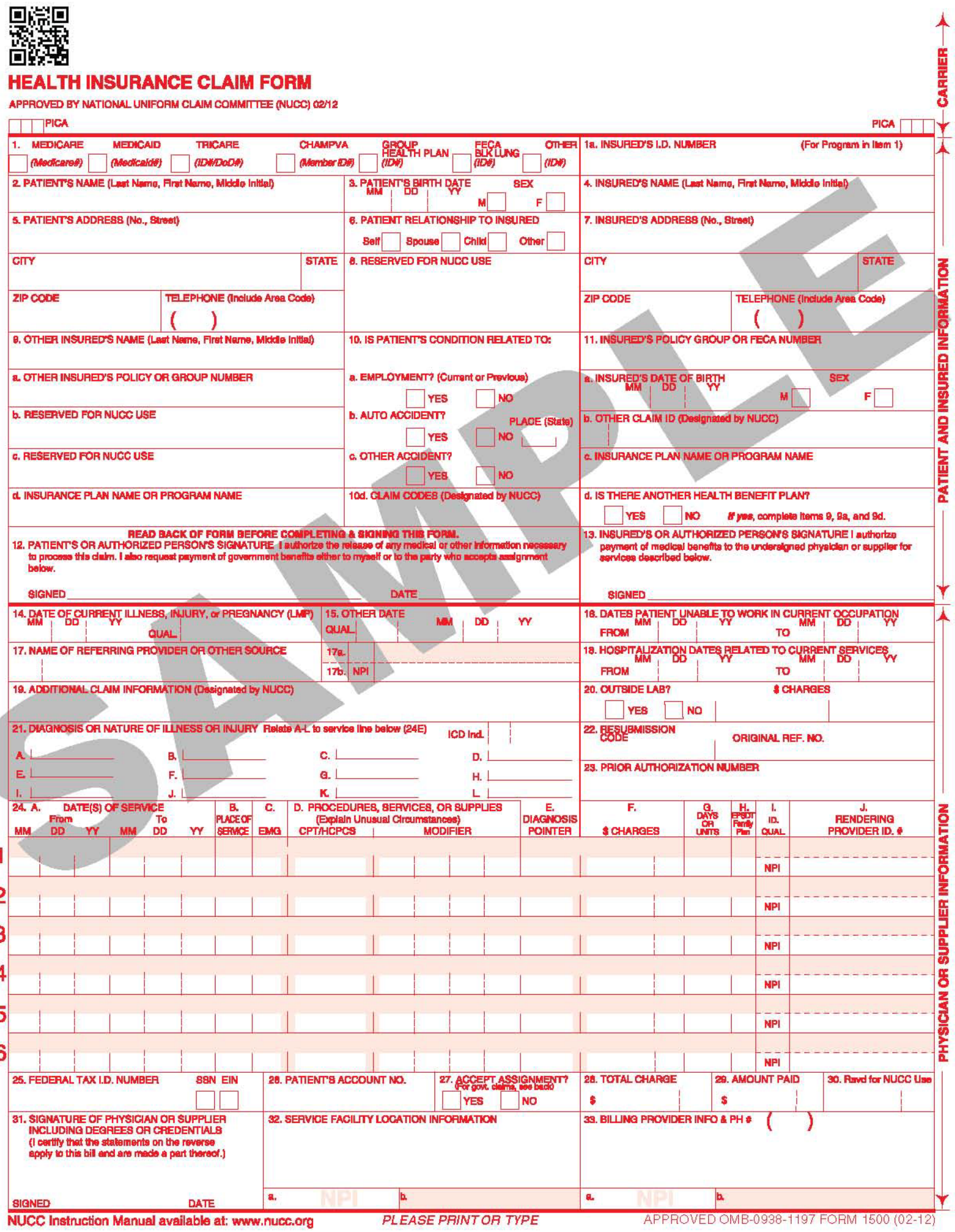
SAMPLE

EXAMPLE OF ICD 10

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	X (Medicaid #)
1a. INSURED'S I.D. NUMBER	1234567890123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	ADALAM, MARY
3. PATIENT'S BIRTH DATE / SEX	06 11 00 / F X
9a. OTHER INSURED'S POLICY OR GROUP NUMBER	TPL Code if applicable
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD Ind. 0)	A. M08 00
22. RESUBMISSION CODE / ORIGINAL REF. NO.	A 02 / 5299198561200
23. PRIOR AUTHORIZATION NUMBER	(Prior Auth # if applicable
26. PATIENT'S ACCOUNT NO.	1234
27. ACCEPT ASSIGNMENT?	X YES
28. TOTAL CHARGE	$ 65 00
30. BALANCE DUE	$ 65 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER	SIGNED Ima Biller DATE 10/09/15
33. BILLING PROVIDER INFO & PH #	(800) 222-3333 ABC SCHOOL BOARD, 123 MAIN ST, ANY TOWN, LA 70000
33a. / 33b.	1234567891 / 1234567

24.	A. From MM DD YY	To MM DD YY	B. Place of Service	C. EMG	D. CPT/HCPCS	Modifier	E. Diagnosis Pointer	F. $ Charges	G. Days or Units	H. EPSDT Family Plan	I. ID. Qual.	J. Rendering Provider ID. #
1	10 08 15	10 08 15	03		97003		A	65 00	1		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)



SAMPLE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. 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									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Attachments

All claim attachments should be standard 8 ½ 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 the fiscal intermediary staff from changing any information on a provider's claim form. Any claims requiring changes must be made prior to submission. 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

Claims that are illegible or incomplete are not processed. These claims are returned with a cover letter stating why the claim(s) is/are rejected. The most common reasons for rejection are listed as follows:

- 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; and
- All essential information is complete.

Correct Claims Submission

Unless specifically directed to submit claims directly to LDHthe Louisiana Department of Health (LDH), providers are to submit **ALL** claims to the appropriate FI post office box for processing. The correct post office boxes can be found on the following page of this packet and in Appendix E.

Timely Filing Guidelines

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

- Straight Medicaid claims must be filed within 12 months of the date of service.

- Claims for beneficiaries 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 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:

- An electronic-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 beneficiary.

NOTE 1: All proof of timely filing documentation must reference the individual beneficiary and date of service. RA pages and e-CSI screen prints must contain the specific beneficiary 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 beneficiary 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 beneficiary was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted.

- The beneficiary 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 <u>each</u> time the claim was adjudicated.

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

Gainwell Technoligies Provider Relations Correspondance Unit
P.O. Box 91024
Baton Rouge, Louisiana 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 LDH staff will be routed to Gainwell Technoligies 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 Gainwell Technoligies 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.

Listed 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 Gainwell Technoligies Provider Relations Department is available to assist providers. This department consists of three units: (1) Telephone Inquiry and (2) Correspondence. The following information addresses each unit and their responsibilities.

Gainwell Technoligies 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, etc. For more information, see Appendix E. 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 Gainwell Technoligies 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, Gainwell Technoligies 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.

- 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 beneficiaries. The telephone listing in Appendix E should be used to direct Medicaid beneficiary inquiries appropriately. Providers should not give their Medicaid provider billing numbers to beneficiaries for the purpose of contacting Gainwell Technoligies. Beneficiaries 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 beneficiary or provider eligibility, Medicare or other insurance information, primary care physician information, or service limits.

- Beneficiary eligibility
- Third Party (Insurance) Resources
- Lock-In

NOTE: Providers should access eligibility information via the web-based application, e-MEVS (electronic-Medicaid Eligibility Verification System) on the Louisiana Medicaid website or MEVS vendor swipe card devices/software. Providers may also check eligibility via the Beneficiary Eligibility Verification System (REVS) (see Appendix E). 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 for other information.

Gainwell Technoligies 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, beneficiary 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:

Provider Relations Correspondance Unit
P. O. Box 91024
Baton Rouge, Louisiana 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.

Eligibility File Updates: Provider Relations staff also handles requests to update beneficiary files with correct eligibility. Staff in this unit does not have direct access to eligibility files. Requests to update beneficiary 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:

LDH-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 Appendix E.

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 above in this section. In instances where the claim meets the LDH 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 LDH personnel and will not be researched from a telephone call to LDH or the Provider Inquiry Unit.**

Gainwell Technoligies Provider Relations

Provider Relations is available to visit and train new providers and their office staff on site, upon request. Providers are encouraged to request assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **These calls should be directed to the FI Provider Relations Telephone Inquiry (see Appendix E).**

Provider Relations Reminders

The FI 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 Beneficiary's Medicaid ID number ;
  - The date of service ;
  - Any other information, such as procedure code(s) and billed charge, that will help identify the claim in question; and
  - 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.
- Due of the large volume of incoming provider calls, Telephone Inquiry staff are not allowed to be put on hold after answering a call.
- 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. Refer to the Ordering Information section for instructions on ordering a provider history.

- **Provider Relations cannot assist beneficiaries.** The telephone listing in the "Beneficiary Assistance" section found in this packet should be used to direct Medicaid beneficiary inquires appropriately. Providers should not give their Medicaid provider billing numbers to beneficiaries for the purpose of contacting FI. Beneficiaries 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 Gainwell Technologies claim forms, manuals, or other policy documentation should be directed to the FI Provider Relations Telephone Inquiry Unit.

LDH 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:

Louisiana Department of Health
P.O. Box 91030
Baton Rouge, LA 70821