CLAIMS FILING

EPSDT Health and IDEA-Related Services are billed electronically on the 837P transaction or hardcopy on the CMS-1500 claim form.

Items to be completed are either **required** or **situational.**

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:

Molina
P.O. Box 91020
Baton Rouge, LA 70821

CMS-1500 Claim Form and Instructions For EPSDT Health Services

*1. **REQUIRED -** Enter an "X" in the box marked Medicaid (Medicaid #)

*1a. **REQUIRED -** Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid swipe card (MEVS), e-MEVS, or through 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.

NOTE: If the 13-digit Medicaid ID number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.

*2. **REQUIRED -** Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through MEVS, e-MEVS or REVS

3. SITUATIONAL - Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, e-MEVS or REVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.

4. SITUATIONAL - Complete correctly if appropriate or leave blank

5. SITUATIONAL - Print the recipient's permanent address

6. SITUATIONAL - Complete if appropriate or leave blank

7. SITUATIONAL - Complete if appropriate or leave blank

8. SITUATIONAL - Leave Blank

9. SITUATIONAL - Complete if appropriate or leave blank

9a. SITUATIONAL - If recipient has no other coverage, leave blank. If there is other coverage, put the state assigned 6-digit TPL carrier code in this block - make sure the EOB is attached to the claim.

9b. SITUATIONAL - Complete if appropriate or leave blank

9c. SITUATIONAL - Complete if appropriate or leave blank

9d. SITUATIONAL - Complete if appropriate or leave blank

10. SITUATIONAL - Leave Blank

11. SITUATIONAL - Complete if appropriate or leave blank

11a. SITUATIONAL - Complete if appropriate or leave blank

11b. SITUATIONAL - Complete if appropriate or leave blank

11c. SITUATIONAL - Complete if appropriate or leave blank

12. SITUATIONAL - Complete if appropriate or leave blank

13. SITUATIONAL - Obtain signature if appropriate or leave blank

14. SITUATIONAL - Leave Blank

15. SITUATIONAL - Leave Blank

16. SITUATIONAL - Leave Blank

17. SITUATIONAL - If services are performed by a nurse practitioner or clinical nurse specialist, enter the name of the directing physician.

17a. SITUATIONAL - Leave Blank

17b. SITUATIONAL - Leave Blank

18. SITUATIONAL - Leave Blank

19. SITUATIONAL - Leave Blank

20. SITUATIONAL - Leave Blank

*21. **REQUIRED** - Enter the most specific ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.

22. SITUATIONAL - Leave Blank

23. SITUATIONAL - Complete if required or leave blank

*24a. **REQUIRED -** Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.

*24b. **REQUIRED -** Enter the appropriate code from the approved Medicaid place of service code list.

24c. SITUATIONAL - Leave Blank

*24d. **REQUIRED -** Enter the procedure code(s) for services rendered.

*24e. **REQUIRED -** Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a "1", "2", etc. More than one diagnosis may be related to a procedure. Do not enter ICD-9-CM diagnosis code

*24f. **REQUIRED -** Enter usual and customary charges for the service rendered

*24g. **REQUIRED -** Enter the number of units billed for the procedure code entered on the same line in 24D

24h. SITUATIONAL - Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral

24i. SITUATIONAL - Leave Blank

24j. SITUATIONAL - Leave Blank

25. SITUATIONAL - Leave Blank

26. SITUATIONAL - Enter the provider specific information assigned to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.

27. SITUATIONAL - Leave blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.

*28. **REQUIRED -** Total of all charges listed on the claim

29. SITUATIONAL - If block 9a is completed, indicate the amount paid; if no TPL, leave blank

30. SITUATIONAL - If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from the billed charges

*31. OPTIONAL – Signature is no longer required.

32. SITUATIONAL - Complete as appropriate or leave blank

*33. **REQUIRED -** Enter the provider name, address including zip code, and telephone number

*33a. **REQUIRED -** Enter the billing provider's 10- digit NPI number

*33b. **REQUIRED -** Enter the billing provider's 7-digit Medicaid ID number

NOTE: If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.

Marked (*) items must be completed or form will be returned.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (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): Smith, Johnny

3. PATIENT'S BIRTH DATE MM DD YY: 01 18 97 SEX M [X] 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. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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: (TPL info here if applicable)

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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 MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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. 714.30

2.

3.

4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: (Prior Auth # if applicable)

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	4 20 07	4 20 07				97003		1	56 00	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 $ 56 00

29. AMOUNT PAID $(TPL Amt)

30. BALANCE DUE $ 56 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 5/15/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

ABC School Board
45 Oak Street
Sunny, LA 70000

a. 1111111111 b. 1111111

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)

213 Adjustment/Void Form and Instructions

*1. ADJ/VOID—Check the appropriate block

*2. Patient's Name
   a. Adjust—Print the name exactly as it appears on the original claim if not adjusting this information
   b. Void—Print the name exactly as it appears on the original claim

3. Patient's Date of Birth
   a. Adjust—Print the date exactly as it appears on the original claim if not adjusting this information
   b. Void—Print the name exactly as it appears on the original claim

*4. Medicaid ID Number—Enter the 13 digit recipient ID number

5. Patient's Address and Telephone Number
   a. Adjust—Print the address exactly as it appears on the original claim
   b. Void—Print the address exactly as it appears on the original claim

6. Patient's Sex
   a. Adjust—Print this information exactly as it appears on the original claim if not adjusting this information
   b. Void—Print this information exactly as it appears on the original claim

7. Insured's Name— Leave Blank

8. Patient's Relationship to Insured—Leave Blank

9. Insured's Group No.—Complete if appropriate or blank

10. Other Health Insurance Coverage—Complete with 6-digit TPL carrier code if appropriate or leave blank

11. Was Condition Related to—Leave Blank

12. Insured's Address—Leave Blank

13. Date of—Leave Blank

14. Date First Consulted You for This Condition—Leave Blank

15. Has Patient Ever had Same or Similar Symptoms—Leave Blank

16. Date Patient Able to Return to Work—Leave Blank

17. Dates of Total Disability-Dates of Partial Disability—Leave Blank

18. Name of Referring Physician or Other Source—Leave this space Blank

18a. Referring ID Number—SITUATIONAL

19. For Services Related to Hospitalization Give Hospitalization Dates—Leave Blank

20. Name and Address of Facility Where Services Rendered (if other than home or office)—Leave Blank

21. Was Laboratory Work Performed Outside of Office—Leave Blank

*22. Diagnosis of Nature of Illness
    a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information
    b. Void—Print the information exactly as it appears on the original claim

23. Attending Number—Leave Blank

24. Prior Authorization #—Enter the PA number if applicable or leave blank

*25. A through F
    a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information
    b. Void—Print the information exactly as it appears on the original claim

*26. Control Number—Print the correct Control Number as shown on the Remittance Advice

*27. Date of Remittance Advice that Listed Claim was Paid—Enter MM DD YY from RA form

*28. Reasons for Adjustment—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary

*29. Reasons for Void—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary

*30. Signature of Physician or Supplier—OPTIONAL

*31. Physician's or Supplier's Name, Address, Zip Code and Telephone Number—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. *The form will be returned if this information is not entered.*

32. Patient's Account Number—Enter the patient's provider-assigned account number.

Marked (*) items must be completed or form will be returned.

MAIL TO:
Molina
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) | 3 PATIENT'S DATE OF BIRTH | 4 MEDICAID ID NUMBER

5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO. | 6 PATIENT'S SEX MALE ☐ ☐ FEMALE | 7 INSURED'S NAME

8 PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ | 9 INSURED'S GROUP NO. (OR GROUP NAME)

10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER. | 11 WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO; B. AN AUTO ACCIDENT YES ☐ ☐ NO | 12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) | 14 DATE FIRST CONSULTED YOU FOR THIS CONDITION | 15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ ☐ NO

16 DATE PATIENT ABLE TO RETURN TO WORK | 17 DATES OF TOTAL DISABILITY FROM THROUGH | DATES OF PARTIAL DISABILITY FROM THROUGH

18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 18A REFERRING ID NUMBER | 19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE) | 21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES ☐ ☐ NO CHARGES

22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1
2
3

23 ATTENDING NUMBER

24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. PROCEDURE	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $

26 CONTROL NUMBER

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

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT

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

ADJUSTMENT

29 REASONS FOR VOID

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

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE

32 YOUR PATIENT'S ACCOUNT NUMBER

Molina - 213
5/97

FISCAL AGENT COPY

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
- All essential information is complete

Correct Claims Submission

We have learned that some providers are incorrectly submitting claims directly to DHH at P.O. Box 91030 rather than correctly submitting claims to the FI to the appropriate post office box for the program type. Unless specifically directed to submit claims directly to DHH, providers should cease this practice and submit claims to the appropriate 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 Medicaid of Louisiana:

- Straight Medicaid claims must be filed within 12 months of the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations.
- Claims which fail to cross over via tape and have to be filed hard copy MUST be adjudicated within six months from the date on the 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 recipient.

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

NOTE 2: At this time Louisiana Medicaid **does not** accept printouts of Medicaid Electronic Remittance Advice (ERA) screens as proof of timely filing. Reject letters are not considered proof of timely filing as they do not reference a specific individual recipient or date of service. Postal "certified" receipts and receipts from other delivery carriers are not acceptable proof of timely filing.

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

Submitting Claims for Two-Year Override Consideration

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

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

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

Molina 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 DHH staff will be routed to Molina 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 Molina 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 Molina Provider Relations Department is available to assist providers. This department consists of three units, (1) Telephone Inquiry, (2) Correspondence, and (3) Field Analysts. The following information addresses each unit and their responsibilities.

Molina Provider Relations Telephone Inquiry Unit

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification; ordering printed materials; billing denials/problems; requests for Field Analyst visits; etc. 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 Molina 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, Molina 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 recipients. The telephone listing in Appendix E should be used to direct Medicaid recipient inquiries appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Molina. Recipients with a provider number may be able to obtain information regarding the provider (last

check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

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

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

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

Molina Provider Relations Correspondence Group

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

Providers, who wish to submit problem claims for research and want to receive a written response, **must submit a cover letter** explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). A copy of the claim form along with applicable corrections/and or attachments must accompany all resubmissions.

All requests to the Correspondence Unit should be submitted to the following address:

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 recipient files with correct eligibility. Staff in this unit does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

TPL File Updates: Requests to update Third Party Liability (TPL) should be directed to:

DHH-Third Party Liability
Medicaid Recovery Unit
P. O. Box 91030
Baton Rouge, LA 70821

"Clean" Claims: "Clean" claims should not be submitted to Provider Relations as this delays processing. Please submit "clean" claims to the appropriate P.O. Box. A complete list is available in 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 DHH established criteria, a detailed letter of explanation, the hard copy claim, and required supporting documentation must be submitted **in writing** to the Provider Relations Correspondence Unit at the address above. **These claims may not be submitted to DHH**

personnel and will not be researched from a telephone call to DHH or the Provider Inquiry Unit.

Molina Provider Relations Field Analysts

Provider Relations Field Analysts are available to visit and train new providers and their office staff on site, upon request. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However**, **since the Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for material, or other policy documentation. These calls should not be directed to the Field Analysts but rather to the FI Provider Relations Telephone Inquiry (see Appendix E).**

A current listing of the FI Provider Relations Field Analysts assigned by parish can be found on the Medicaid website, www.lamedicaid.com and following the link for Provider Support and Field Analysts.

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 Recipient's Medicaid ID number
    - The date of service
    - Any other information, such as procedure code and billed charge, that will help identify the claim in question
    - The Remittance Advice showing disposition of the specific claim in question
- Obtain the name of the phone representative you are speaking to in case further communication is necessary.
- 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 recipients.** The telephone listing in the "Recipient Assistance" section found in this packet should be used to direct Medicaid recipient inquires appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting FI. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

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

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

DHH Program Manager Requests

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

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