LOUISIANA DEPARTMENT OF HEALTH

GENERAL INFORMATION AND ADMINISTRATION

Chapter One of the Medicaid Services Manual

Issued June 1, 2011

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. This includes ICD-10 surgical procedure codes for hospital claims. References in this manual to ICD-9 diagnosis/surgical procedure codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

State of Louisiana
Bureau of Health Services Financing

GENERAL INFORMATION AND ADMINISTRATION

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OVERVIEW

Manual Purpose and Organization

The Medicaid Services Manual has been developed to present useful information and guidance to providers participating in the Louisiana Medicaid program. The manual is divided into two major components, a general information and administration chapter and individual program chapters.

1. The "general information and administrative" chapter contains information to which **all** enrolled providers must adhere. It encompasses the universal terms and conditions for a provider to deliver medical services and supplies to beneficiaries of the Medicaid program and outlines the information and procedures necessary to file claims for reimbursement in accordance with Medicaid policy.

2. The other component is divided into the individual program chapters. Each chapter is dedicated to a specific program and outlines the policies, procedures, qualifications and limitations specific to that program.

Providers are encouraged to use this manual as a reference guide and training tool to assure that their employees have knowledge and understanding of, and access to, the pertinent information contained therein, and which is necessary to perform their duties.

Medicaid program policies and procedures are revised based on developing health care initiatives, state and federal directives. Providers are notified of these changes through publication of administrative rules, manual chapter revisions, ***Provider Update*** newsletters, remittance advice messages, correspondence, and/or training materials. These changes may also be posted to the Louisiana Medicaid website. All of these forms of communication shall constitute formal notice to providers.

Manual Revisions

To ensure that providers have current and accurate program information, changes or updates are made through quarterly manual revisions. A form titled the **Revision History Log (**Appendix C**)** will be issued with each manual chapter revision, as a means of documenting/cataloging each revision. It is the responsibility of the provider to become familiar with each revision upon issuance.

The Medicaid Program

The Medicaid program was created in 1965 with the passage of Title XIX of the Social Security Act "for the purpose of enabling each State…to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose income and resources are insufficient to meet the cost of necessary medical services".

Medicaid is governed by the regulations contained in Title 42 of the Code of Federal Regulations, Chapter IV, Subchapter C. These regulations describe the groups of people and the services a state must cover to qualify for federal matching payments. States must design their programs to meet these federal requirements, and to provide coverage and benefits to the groups specified under federal law. States must also establish the reimbursement rates paid to providers for delivering care to eligible beneficiaries.

Administration

Louisiana implemented its Medicaid program in 1966. The Louisiana Department of Health (LDH) administers the Medicaid program through the Bureau of Health Services Financing (BHSF). The BHSF is responsible for Medicaid eligibility determinations, licensure and certification of health care providers, payment to Medicaid providers, fraud and abuse investigations, and other administrative functions.

The Centers for Medicare and Medicaid Services (CMS) is the federal regulatory agency that administers the Medicaid program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state's Medicaid State Plan. It also enforces the general provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Eligibility

Individuals are determined eligible for Medicaid by BHSF field staff located in regional offices. Supplemental Security Income (SSI) eligible beneficiaries are determined Medicaid eligible by the Social Security offices.

Funding

Funding for the Medicaid program is shared between the federal government and the state. The federal government matches Louisiana's share of program funding at an authorized rate between 50 and 90 percent, depending on the program. The contribution for the federal government is adjusted annually based on the per capita income of the state comparative to the nation as a whole.

Service Coverage

The federal government requires that each state provides coverage of mandatory services in its Medicaid program in order to receive federal funding. In addition, states have the option to provide coverage of optional services that are recognized under federal regulations and approved by CMS.

States may also request approval from CMS to provide coverage for services that target a specific population through waivers. Waivers permit states more flexibility in providing services and coverage to individuals who, otherwise, would not be eligible for Medicaid.

Provider Participation

Providers supply health care services and/or medical equipment to Medicaid eligible beneficiaries. In order to receive reimbursement for these services and equipment, the provider must be enrolled to participate in Louisiana Medicaid, meet all licensing and/or certification requirements inherent to their profession and comply with all other requirements in accordance with the federal and state laws and BHSF policies.

The Fiscal Intermediary

The fiscal intermediary (FI) enters into a contract with LDH and BHSF to maintain the Medicaid Management Information System (MMIS), a computerized system with an extensive network of edits and audits for the effective processing and payment of all valid provider claims submitted to the Medicaid program. This system meets the requirements of the state and federal governments. Other functions of the FI include provider enrollment, technical assistance to providers on claim submission and processing, prior authorization of designated services, distribution of information, provider training, and on-site visits to providers. The FI's Provider Relations staff is also available to offer assistance and answer questions for providers when needed.

Provider Updates

The Medicaid Policy and Compliance Section publishes a monthly Medicaid newsletter which is distributed by the FI. This newsletter is published for enrolled providers as a mechanism to disseminate pertinent Medicaid and health care information and to clarify current program policy and procedures.

Notification of programmatic changes through a Rule, manual chapter revision, provider notice, or the newsletter is considered formal notification and the provider can be held accountable for information contained therein.

PROVIDER REQUIREMENTS

Provider participation in the Medicaid program is voluntary. When enrolled in the Medicaid program, a provider agrees to abide by all applicable state and federal laws, regulations and policies established by the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Department of Health (LDH). The provider manual assists providers with program operations and Medicaid reimbursement. The provider manual does not contain all Medicaid rules and regulations. In the event the manual conflicts with a Rule, the Rule prevails.

Providers are responsible for knowing the terms of the provider agreement, program standards, statutes and the penalties for violations. The providers' signature on the Provider Enrollment Packet (PE-50 Addendum - Provider Agreement) is an agreement to abide by all policies and regulations. This agreement also certifies that, to the best of the providers' knowledge, the information contained on the claim form is true, accurate and complete.

Providers agree to the following requirements:

1. Adhere to all the requirements of administrative rules governing the Medical Assistance Program found in the *Louisiana Register;*

2. Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

3. Comply with Title VI and Title VII of the *1964 Civil Rights Act* (where applicable), not to discriminate based on race, color, creed or national origin;

4. Comply with Section 504 of the *Rehabilitation Act of 1973*; and

5. Adhere to all federal and state regulations governing the Medicaid program including those rules regulating disclosure of ownership and control requirements specified in the 42 CFR 455, Subpart B.

Provider Agreement

The provider agreement is a contract between LDH and the provider that governs participation in the Louisiana Medicaid program. This contract is statutorily mandated by the Medical Assistance Program Integrity Law (MAPIL) and is voluntarily entered into by the provider.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in RS 46:437.11 - 46:437:14.

The provider must agree to terms and conditions imposed by MAPIL. The following list is not an all-inclusive:

1. Comply with all federal and state laws and regulations;

2. Provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;

3. Maintain all necessary and required licenses or certificates;

4. Allow for inspection of all records by governmental authorities, including, but not limited to, LDH, the State Attorney General's Medicaid Fraud Control Unit, and the Department of Health and Human Services;

5. Safeguard against the disclosure of information in the beneficiary's medical records;

6. Bill other insurers and third parties prior to billing Medicaid;

7. Report and refund any and all overpayments;

8. Accept the Medicaid payment as payment in full for services rendered to Medicaid beneficiaries, providing for the allowances for co-payments authorized by Medicaid. A beneficiary may be billed for services that have been determined as non-covered or exceeding the services limit for beneficiaries over 21 years of age. Beneficiaries are also responsible for all services rendered after their eligibility has ended;

9. Agree to be subject to claims review;

10. Accept liability for any administrative sanctions or civil judgments by the buyer and seller of a provider;

11. Allow inspection of the facilities; and

12. Post bond or a letter of credit, when required.

Note: In order to bill a beneficiary for a non-covered service, the beneficiary must be informed both verbally and in writing that they will be responsible for payment of the services.

The provider agreement provisions of MAPIL also grant authority to the Secretary to deny or revoke enrollment under specific conditions.

Disclosure of Ownership

Providers are required to update their ownership information using a web-based application available at www.lamedicaid.com. Providers without internet access may contact the fiscal intermediary's (FIs) Provider Enrollment Unit (PEU) for paper forms. Information must be disclosed on all owners with five percent or greater interest and all members of management/Board of Directors in the business/entity. Information includes, but is not limited to:

1. Name;
2. Social Security number (SSN);
3. Tax identification number (TIN); and
4. Address.

Acceptance of Beneficiaries

Providers are not required to accept every beneficiary requesting service. When a provider does accept a beneficiary, the provider cannot choose which services will be provided. Providers must treat Medicaid beneficiaries equally in terms of scope, quality, duration and method of delivery of services (unless specifically limited by regulation). The same services must be offered to a Medicaid beneficiary as those offered to individuals not receiving Medicaid, provided the services are reimbursable by the Medicaid program.

Confidentiality

All Medicaid beneficiary and applicant records and information are confidential. Providers are responsible for maintaining confidentiality of health care information, subject to applicable laws.

HIPAA

The **Health Insurance Portability and Accountability Act (HIPAA) of 1996** requires more standardization and efficiency in the health care industry. HIPAA requires providers to:

1. Use the same health care transactions, code sets and identifiers;

2. Prevent the release of patient protected health in formation (PHI) without knowledge or consent of the beneficiary (except as HIPAA regulations permit or require);

3. Provide safeguards to prevent unauthorized access PHI; and

4. Use a standard national provider number, called the National Provider Identifier (NPI), for identification on all electronic standard transactions.

National Provider Identifier

As a provision of HIPAA, providers must obtain and use their NPI number on all claims submissions. Providers who do not provide medical services are exempt from this requirement (i.e. non-emergency transportation, and some home and community-based waiver services). Although HIPAA regulations address only electronic transactions, Louisiana Medicaid requires both the NPI number and the legacy seven digit Medicaid provider number on hard copy claims.

Record Keeping

Providers must maintain and retain all medical, fiscal, professional and business records for services provided to all Medicaid beneficiaries for a period of five years from the date of service; however, if the provider is being audited, records must be retained until the audit is complete, even if the five years is exceeded. The records must be accessible, legible and comprehensible.

Any error made in the record must be corrected using the legal method, which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid or correction tape must never be used.
These records may be paper, magnetic material, film or electronic, except as otherwise required by law or Medicaid policy. All records must be signed and dated at the time of service. Rubber stamp signatures must be initialed.

Providers who fail to comply with the documentation and retention policy are subject to administrative sanctions and recoupment of Medicaid payments. Payments will be recouped for claims for services that are not accompanied by the required signatures and documentation.

NOTE: Upon agency closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements. LDH must be notified of the location of the records.

Electronic Records

Providers that maintain electronic records must develop and implement a policy to comply with applicable state and federal laws, rules and regulations to ensure each record is valid and secure.

Right to Review Records

Authorized state and federal agencies or their authorized representatives may audit or examine a provider's or facility's records without prior notice. This includes, but is not limited to, the following governmental authorities:

1. LDH;
2. State Attorney General's Medicaid Fraud Control Unit (MFCU); and
3. Department of Health and Human Services (DHHS).

Providers must allow access to all Medicaid beneficiary records and other information that cannot be separated from the records.

If requested, providers must furnish, at the provider's expense, legible copies of all Medicaid related information to the Bureau of Health Services Financing (BHSF), federal agencies or their representatives.

Destruction of Records

Records may be destroyed once the required record retention period has expired. Confidential records must be incinerated or shredded to protect sensitive information. Non-paper files, such as computer files, require special means of destruction. Disks or drives can be erased and reused, but care must be taken to ensure all data is removed prior to reuse. Commercially available software programs can be used to ensure all confidential data is removed.

In the event that records are destroyed or partially destroyed, and rendered unreadable and unusable in a disaster such as a fire, flood or hurricane, such records must be properly disposed of in a manner which protects beneficiary confidentiality. A letter of attestation must be submitted to the FI documenting the event/disaster and the manner in which the records were disposed.

Changes to Report

Providers have the responsibility to timely report all changes that may impact the provider's Medicaid enrollment status. Requests for changes to provider records must be submitted to the PEU in writing. Each change request requires the original signature of the individual provider or an authorized representative of an enrolled entity. Stamped signatures and initials are not accepted. Third party billers/agents cannot request changes to a provider's enrollment records.

NOTE: Faxes will not be accepted except for change of address and Clinical Laboratory Improvement Amendments (CLIA) status.

Correspondence must be mailed to the PEU. (Refer to Appendix B of this manual chapter for contact information).

Contact Information

Providers must notify the PEU when a mailing or physical address and/or telephone number changes. It is the provider's responsibility to keep all provider information current and accurate.

If the provider type requires a license, a copy of the updated license showing the new physical address must be submitted with the change request.

An individual Medicaid provider number may have only one pay-to address. This address **must** be the address where the provider wishes to receive all Medicaid documents related to claims billed under that particular provider number. For those providers who furnish services at multiple locations, the "pay –to" address must be the address of the provider's main location.

Failure to furnish accurate information for the provider file may result in closure of the Medicaid provider number. If mail is returned and the provider cannot be located, the provider number will be closed pending updated information. Once the number has been closed, a complete enrollment packet may be required to re-activate the number.

Changes in the Internal Operations

Providers must immediately notify the PEU of any changes in internal operations that affect the originally reported information. These include changes in administrators, board of directors or other major management staff for federally qualified health centers, rural health clinics, nursing facilities, hospitals and any other facilities or programs in which the provider is enrolled. The PEU must be notified in writing of these changes. Failure to timely notify the PEU could result in payment delays.

BHSF does not allow informal agreements between parties. The provider should contact the PEU for additional information regarding reporting changes in operational structure.

Change in Ownership

A new provider enrollment packet must be completed when a change in ownership (CHOW) or change in business organization (change from corporation to LLC, partnership, etc.) and a transfer of stock greater than five percent occurs. A change of five percent or more in stock ownership or profit sharing may require a new provider number. If the name of the company changes with no change in ownership or TIN, a CHOW is not considered to have occurred.

The new owner shall be subject to any restrictions, conditions, penalties, sanctions or other remedial action taken by the BHSF, any federal agency or other state agency against the prior owner or facility.

The following steps must be taken when reporting a CHOW:

1. Notify the PEU, in writing, 60 days prior to the anticipated date of the CHOW. Include the seven-digit Medicaid ID number and other identifying information;

2. For providers who are enrolled to participate in the Medicare program, notify LDH Health Standards 60 days prior to the anticipated date of the CHOW;

3. For providers who submit cost reports, notify the Rate Setting and Audit Section 60 days prior to the anticipated date of the CHOW; and

4. Submit the completed enrollment application and the required documentation to PEU immediately after the CHOW occurs. For those providers who are enrolled to participate in the Medicare Program, CMS approval must be received prior to submitting the application to PEU. The new provider agreement is subject, but not limited to prior statements of deficiencies cited by BHSF, including plans of compliance and expiration dates.

Failure to timely report a change in ownership may result in fines and/or recoupment of any and all payments made in the interim of the CHOW taking place and the agency approving the action.

Other Changes Required to be Reported

The following changes must be reported:

1. Decision to discontinue accepting Medicaid;

2. Business closure;

3. Change in licensing status (a copy of the updated license must be submitted with the change request);

4. Death of a provider. The Medicaid provider number of a deceased provider cannot be used for any reason;

5. Change in Medicare certification, provider number or status. A claim will not crossover unless the correct Medicare provider number is in the Medicaid Management Information System (MMIS);

6. Change in account information affecting Electronic Funds Transfer (EFT)/ (direct deposit);

   a. Changes must be submitted with a copy of a voided check (deposit slips are not accepted);

   b. Failure to update EFT information may result in payments being sent to incorrect accounts;

   c. A hardcopy check will not be reissued until the inappropriately routed funds are returned to the Department's account.

7. Change in the "pay to" mailing address. Official Medicaid documents, including any checks, are mailed to the provider's "pay to" address as listed on Medicaid files, not to the address written on a claim form. Therefore, it is imperative that any change in address be reported to the PEU immediately.
8. Change in provider name must be reported;

   a. Correspondence must include the current provider name, new provider name and the effective date of the change.

   b. If a license is required, the updated license must be submitted with the notification.

9. Change in telephone number. This telephone number must be a number where the provider or authorized agent may be contacted for questions. It must not be the corporate office unless all information is maintained at that location.

Linking Professionals to Group Practice

A request for linkage of an individual professional practitioner to a group practice provider number requires the submission of a completed provider enrollment (PE-50) form. If the provider has an active Medicaid provider number, a group linkage (LNK-01) form must be completed and must include the effective date of the linkage. The form must be signed by the professional practitioner who is officially enrolled under the number being linked. The PE-50 and the LNK-01 forms can be found at www.lamedicaid.com.

Professional practitioners who change group affiliation should notify the PEU to ensure payments are sent to the correct provider/group. Payments and remittance advices may be delayed due to incorrect mailing addresses on the Medicaid file. When submitting a change of address for linkage or office relocations, the request must include the following:

1. Request that the provider's file be updated with the current information;

2. Seven-digit provider number; and

3. Indication of whether the change is for a physical address and/or a "pay to" address.

Note: The request requires the original signature of the provider who is officially enrolled under the provider number. Stamped signatures and initials are not accepted.

Group Linkages Definitions

Refer to Appendix B for Group Linkages Definitions.

Taxpayer Identification

An Employer Identification Number (EIN), also known as a Federal Taxpayer Identification Number (FEIN), is assigned to a business by the Internal Revenue Service (IRS). The EIN must be exactly as it appears on the IRS file and the "pay to" name must be exactly how it appears on the Medicaid provider file. All individuals must report their Social Security number to the Bureau of Health Services Financing, but may also use a TIN for tax reporting purposes. The IRS considers the TIN incorrect if either the name or number shown on an account does not match a name or number combination in their files. The IRS sends the Department a tape identifying mismatches from our Medicaid provider files and the IRS files for previous years.

If appropriate action is not taken to correct the mismatches, the law requires the BHSF to withhold 31 percent of the interest, dividends, and certain other payments that are made to a provider's account. This is called backup withholding. In addition to backup withholding, a provider may be subject to a $50.00 penalty by the IRS for failing to give the correct name, TIN

and/or EIN combination.

Any change in the TIN must be reported to the PEU. Providers who obtain a new TIN must send a letter to PEU as notification of the new number and include any provider number affected by the change. Any pre-printed IRS document that shows the name and TIN is acceptable verification and should be forwarded to the PEU upon receipt. **W-9 forms are not acceptable.**

Electronic Funds Transfer/Direct Deposit

Electronic Funds Transfer (EFT), also referred to as direct deposit, is mandatory for the reimbursement of all Medicaid providers. All new applications will be returned if EFT information is not included. The EFT enrollment process requires that a voided check, or a letter from the bank identifying the provider's account and routing number, be submitted with the provider agreement papers. A deposit slip for the account will not be accepted.

It is the provider's responsibility to ensure that the information contained in their EFT record is accurate. The PEU must be notified prior to a change in the provider's bank account in order to ensure that payments are made to the appropriate account. EFT payments that are sent to incorrect accounts may result in extensive delays in the subsequent receipt of payments.

Providers should be aware that the processing time for information changes to the EFT is approximately two to three weeks. In the interim, paper checks are mailed to the provider's "pay-to" address.

Providers should review their monthly bank statement to identify payments made by the Department. The deposit account number on the bank statement consists of the middle five digits of the Medicaid provider number with two leading zeros, plus the remittance advice number. The amount of the deposit is the same as the total payment shown on the financial page of the remittance advice.

Providers should attempt to resolve deposit problems with their accounting department or bank before contacting the PEU. Providers should contact the PEU for inquiries regarding EFT and the Provider Relations Unit regarding missing checks. (Refer to Appendix B of this manual chapter for contact information).

BENEFICIARY ELIGIBILITY

The Bureau of Health Services Financing (BHSF), within the Louisiana Department of Health (LDH), is responsible for determining Medicaid eligibility.

Individuals may apply for Medicaid by mail, online, in person, or through a responsible authorized representative at any Medicaid office or application center.

Individuals certified for Medicaid are classified into various eligibility categories or groups based on specified criteria. These criteria may affect provider reimbursement.

The regulations contained in Title 42 of the Code of Federal Regulations define the groups of individuals and services a state must cover to qualify for federal matching payments. States define their programs to meet these federal requirements and coverage of groups and benefits, specified under federal law.

Categorically Needy

Beneficiaries classified as categorically needy must meet all requirements, including income and resource requirements. Payment for all covered services or equipment furnished to these beneficiaries and billed to BHSF shall be considered payment in full; however, beneficiaries are responsible for pharmacy co-payments.

Beneficiaries determined to be categorically needy include:

1. Families who meet low-income families with children (LIFC) eligibility requirements;

2. Pregnant women with family income at or below 200 percent of the Federal poverty level;

3. Children under age 19 with family income up to 250 percent of the Federal poverty level;

4. Caregivers (relatives or legal guardians who care for children under the age of 18, or 19 if still in high school);

5. Supplemental Security Income (SSI) beneficiaries; and

6. Individuals and couples who are living in medical institutions and who have a monthly income up to 300 percent of the SSI income standard (Federal benefit rate).

Medically Needy

Medically needy is an optional program; however, states that elect to include this program are required to include certain children under age 18 and pregnant women who would be eligible as categorically needy, if not for their income and resources.

Beneficiaries may qualify as regular **medically needy** or **spend-down medically needy**.

Regular medically needy beneficiaries are those individuals or families who meet all LIFC related categorical requirements and whose income is within the Medically Needy Income Eligibility Standard (MNIES).

Spend-down medically needy beneficiaries are those individuals or families who meet all LIFC or SSI related categorical requirements **and** whose resources fall within the medically needy resource limits, but whose income has been spent down to the MNIES.

Medically needy beneficiaries are identified on the Medicaid Eligibility Verification System (MEVS) and Recipient Eligibility Verification System (REVS). MEVS and REVS denote the appropriate eligibility information based on the provider type of the inquiring provider.

Service restrictions apply to medically needy benefits and eligibility for service coverage should be verified.

The following services are not covered in the Medically Needy program:

1. Adult dental services or dentures;
2. Mental health clinic services;
3. Home and community based waiver services;
4. Home health (nurse aide and physical therapy); and
5. Case management services.

Information detailing the other beneficiary categories and eligibility groups may be obtained by accessing the *Medicaid Eligibility Manual* on the LDH website.

Providers should refer beneficiaries with questions regarding eligibility to the Louisiana Medicaid and LaCHIP Assistance Line. (Refer to Appendix B for contact information).

Retroactive Eligibility

Beneficiaries may be eligible for benefits for the three months prior to the date of their Medicaid application provided they meet the eligibility criteria.

When a beneficiary has paid a provider for a service for which they would be entitled to have payment made under Medicaid, the provider may opt to refund the payment to the beneficiary and bill Medicaid for the service. The beneficiary must furnish a valid Medicaid identification card for the dates of services provided during the timely filing period. If a provider chooses not to refund the payment to the beneficiary, the beneficiary should be directed to the MMIS Retroactive Reimbursement Unit to request a refund (Refer to Appendix B for contact information).

Medicaid Verification

Medicaid Identification Cards

A plastic Healthy Louisiana identification card, with a unique identifying number, is issued to each eligible beneficiary by LDH.

These permanent identification cards contain a card control number (CCN) that is used by the provider to verify Medicaid eligibility. Eligibility information for that beneficiary, including third party liability and any restrictions, may be obtained by accessing information through MEVS or calling REVS.

Some types of Medicaid eligibility, such as Illegal/Ineligible Aliens (eligible for emergency services only) do not receive permanent identification cards. Their verification of eligibility is contained on the Notice of Eligibility Decision issued by the local Medicaid office. Providers should call the general information hotline (refer to Appendix B for contact information) to verify presumptive eligibility (PE).

Medicaid Eligibility Verification System

MEVS is an electronic system used to verify Medicaid beneficiary eligibility and third party liability (TPL). This information is accessed through personal computer (PC) software, an "eligibility card device", or computer terminal. MEVS is available seven days per week, 24 hours per day, except for occasional short maintenance periods.

Providers may also access MEVS by contracting with telecommunications vendors ("switch vendors") who will provide a magnetic card reader, PC software, or a computer terminal necessary for system access.

MEVS Access Data

Any two of the following identifying information may be used to access the system and receive eligibility information from MEVS:

1. CCN and card issue date;
2. Beneficiary name;
3. Beneficiary identification (ID) number;
4. Date of birth; and
5. Social security number (SSN).

Beneficiary Eligibility Verification System

REVS is a telephonic system used to verify Medicaid beneficiary eligibility. It is available seven days per week, 24 hours per day, except for occasional short maintenance periods. REVS provides basic eligibility, service limits and restrictions, TPL, and program eligibility information. It is accessible through any touch-tone telephone equipment. (Refer to Appendix B for contact information).

REVS Access Data

Providers may access beneficiary eligibility by using the following identifying information:

1. CCN and date of birth;
2. CCN and SSN;
3. Medicaid ID number (valid during the last 12 months) and date of birth;
4. Medicaid ID number (valid during the last 12 months) and SSN; and
5. SSN and date of birth.

MEVS and REVS Reminders

Failure to comply with these procedures may result in problems with MEVS and REVS:

1. A valid eight-digit date of birth (mm/dd/yyyy) must be entered when using REVS or MEVS.

2. Eight-digit dates (mm/dd/yyyy) must be used when entering any dates through either system.

3. Where applicable, providers should listen to the menu and press the appropriate keys to obtain Lock-In information through REVS.

4. When using a beneficiary's 13-digit Medicaid ID number, remember that both systems carry only beneficiary numbers that are valid for the last 12 months. If you are entering an old number (valid prior to the last 12 months), you will receive a response that indicates the beneficiary is not on file.

5. When using a 13-digit Medicaid ID number or a 16-digit CCN for your inquiry into either system, you will receive the most current, valid 13-digit Medicaid ID number as part of the eligibility response.

6. Claims must be filed with the 13-digit Medicaid ID number.

Every effort is made to ensure that all beneficiaries' dates of birth are accurate on the Medicaid file. A REVS or MEVS reply of "beneficiary not on file" may be the result of an incorrect beneficiary date of birth on Medicaid files. In this situation, the provider should refer the beneficiary to their parish office or have the beneficiary call the General Hotline (Refer to Appendix B for contact information).

NOTE: **Eligibility is date specific.** It is important to confirm eligibility prior to providing the service. Providers who do not confirm eligibility risk the denial of reimbursement for services provided.

PROGRAM INTEGRITY

To maintain the programmatic and fiscal integrity of the Medicaid program, the federal government and state government have enacted laws, promulgated rules and regulations, and the Louisiana Department of Health (LDH) has established policies concerning fraud and abuse.

It is the responsibility of the provider to become familiar with these laws, rules, regulations, and policies. This section is not all-inclusive nor does it constitute legal authority; however, it was developed to assist the provider in becoming familiar with vital information around program integrity.

Providers, beneficiaries, and others may be subject to criminal prosecution, civil action, and/or administrative action for the violation of laws, rules, regulations, or policies applicable to the Medicaid program. Federal laws and regulations and state laws require that the Medicaid program establish criteria that are consistent with recognized principles that afford due process of law where there may be fraud, abuse or other incorrect practices. These laws and regulations also stipulate, as well as arrange for, the prompt referral to the proper authorities for investigation or review and authorize LDH to conduct reviews of claims before and after claims are paid.

Generally, suspected criminal activities are investigated and prosecuted by the Medicaid Fraud Control Unit (MFCU) of the Attorney General's (AG) Office. Civil actions are investigated and initiated by LDH and/or the AG's Office. Administrative actions are investigated and initiated by LDH. Depending on whether the action is criminal, civil, or administrative, different standards of proof and levels of due process apply.

Program Integrity Section

The purpose of the Program Integrity (PI) Section is to assure the programmatic and fiscal integrity of the Louisiana Medical Assistance program. In order for LDH to receive federal funding for Medicaid services, federal regulations mandate that LDH perform certain program integrity functions. The primary functions of PI include the following:

1. Provider enrollment;
2. Fraud and abuse detection;
3. Investigations;
4. Enforcement;
5. Administrative sanctions; and
6. Payment error rate measurement (PERM).

The mandates that direct the functions of the PI Section can be found in:

1. Federal laws and the Code of Federal Regulations;

2. RS 46:437.1 - 440.3, the Medicaid Assistance Program Integrity Law (MAPIL); and

3. Title 50, Part I, Subpart 5, Chapter 41 of the Louisiana Administrative Code (LAC 50:I.Chapter 41.) – the Surveillance Utilization Review System (SURS) Rule.

Provider Enrollment Unit

The FI is responsible for processing completed provider enrollment packets submitted by health care services providers requesting enrollment in the Medicaid program to provide specific types of services to Medicaid beneficiaries. If eligible for enrollment, a provider is assigned a separate Medicaid provider number for each specific type of service. Provider enrollment packets and other forms are available online under the Provider Enrollment link on the Louisiana Medicaid website. (Refer to the Appendix B for contact information).

Fraud and Abuse Detection

When providers bill Medicaid, claims are paid using the **Medicaid Management Information System (MMIS**). A monthly data extraction of the claims processing system information is put into a relational data base. This data is then "mined" to detect abnormal billing practices.

Complaints may also be used to detect fraud or abuse. Complaint procedures are designed for use by interested parties to bring problems encountered with providers to the attention of PI.

PI receives complaints from providers, private citizens, other agencies or offices within LDH through the fraud and abuse hotline, the LDH website or through written reports.

The state has a toll-free hotline for reporting possible fraud and abuse in the Medicaid program. Providers are encouraged to provide the hotline number to individuals who want to report possible cases of fraud or abuse. (Refer to the Appendix B for contact information).

Investigations

An investigation is a review process where documents are compared to the requirements established by law, regulations, written policies and directives for a particular service. An investigation is opened when questionable information is received as a result of data mining, or based on the information received from a complaint, or at the request of the Department.

PI requests additional information from the provider when an investigation is opened. The type of information requested is determined by the type of investigation.

Medicaid has an absolute right to the records that are related to Medicaid beneficiaries. If records are requested through written notification, the provider is responsible for the cost of copying and mailing the information to PI. If records are requested at an on-site review, the provider must make all requested records available to PI staff.

The following provider errors are commonly noted during investigations:

1. **Services not documented** – No documentation to support the billed services were ever provided to the beneficiary;

2. **Medical necessity not supported** – Documentation in the record does not support the medical necessity of the service billed;

3. **Inferior record keeping** – Provider records are not in compliance with the requirements of the Medicaid program;

4. **Up-coding** – Documentation in the record does not support the higher level of service billed; and

5. **Unbundling of services** – Services were billed individually when they should have been billed as part of a group of services.

Administrative Actions

Federal and state laws and regulations assign responsibility and authority to the Department to bring administrative actions against providers, beneficiaries, and others who engage in fraudulent, abusive and/or other incorrect practices.

Sanctions

To ensure the quality, quantity, and need for services, Medicaid payments may be reviewed either prior to or after payment is made by the Bureau of Health Services Financing (BHSF). Administrative sanctions may be imposed against any Medicaid provider who does not comply with laws, rules, regulations, or policies.

Sanctions refer to administrative actions taken by BHSF against a provider. Sanctions are designed to remedy inefficient and/or illegal practices that do not comply with the Department's policies and procedures, statutes, and regulations.

Sanctions which may be imposed through the administrative process include, but are not limited to the following actions:

1. Denial or revocation of enrollment;
2. Recommendation of revocation of licenses and/or certificates;
3. Withholding of payments;
4. Exclusion from the Medicaid program; and
5. Recovery of overpayments and imposition of administrative fines.

Grounds for Sanctioning Providers

The following are grounds under which BHSF may impose sanctions :

1. Non-compliance with the Department's policies, rules, and regulations, or the provider agreement that establishes the terms and conditions applicable to each provider's participation in the program;
2. Submission of a false or fraudulent application for provider status;
3. Licensing issues, including, not properly licensed or qualified, or a provider's professional license, certificate, or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated;
4. Engagement in a course of conduct; or has performed an act for which official sanction has been applied by the licensing authority, professional peer population, or peer review board or organization; or has continued the poor conduct after having received notification by a licensing or reviewing authority indicating that the conduct should cease;
5. Failure to correct deficiencies in the delivery of services or billing practices after having received written notice of these deficiencies from BHSF;
6. Exclusion from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142, or has been convicted of Medicaid fraud (Louisiana R.S. 14:70.1);

7. Conviction of a criminal offense relating to performance of a provider agreement with the State, to fraudulent billing practices, or to negligent practice resulting in death or injury to the provider's patient;

8. Presented false or fraudulent claims for services or merchandise for the purpose of obtaining greater compensation than that to which the provider is legally entitled;

9. Engaged in a practice of charging and accepting payment (in whole or in part) from beneficiaries for services for which Medicaid has already made a payment;

10. Rebated or accepted a fee or a portion of a fee for a patient referral;

11. Failure to repay or arrange to repay an identified overpayment or otherwise erroneous payment within ten working days after the provider receives written notice;

12. Failure, after having received a written request from BHSF, to keep or to make available for inspection and audit, copies of records regarding claims filed for payment for providing services;

13. Failure to furnish any information requested by BHSF or the fiscal intermediary regarding payments for providing goods and services;

14. Made, or caused to be made, a false statement or a misrepresentation of a material fact concerning the administration of the Louisiana Medicaid program;

15. Furnished goods or services to beneficiaries that are in excess of the beneficiary's needs, not medically necessary, harmful to the beneficiary, or of grossly inadequate or inferior quality. (This determination would be based upon competent medical judgment and evaluation);

16. Found in violation of or entering a settlement under MAPIL;

17. Failure to cooperate with BHSF, its fiscal intermediary or the investigation officer during the post-payment or pre-payment process, an investigatory discussion, informal hearing or the administrative appeal process or any other legal process;

18. Submission of bills or claims for payment or reimbursement to the Louisiana Medicaid on behalf of a person or entity which is serving out a period of exclusion from Medicaid, Medicare or any other publicly funded health care program;

19. Engagment in a systematic billing practice, which is abusive or fraudulent and which maximizes costs to the Louisiana Medicaid program after written notice to cease;

20. Failure to meet the terms of an agreement to repay or a settlement agreement entered into under MAPIL or the SURS rule;

21. A provider, or a person with management responsibility for a provider, an officer or person owning (either directly or indirectly) 5 percent or more of the shares of stock or other evidences of ownership in a corporation, an owner of a sole proprietorship, or a partner in a partnership that is found to fall into one or more of the following categories;

22. Previously barred from participation in the Medicaid program;

23. Was a person with management responsibility for a previously terminated provider during the time of conduct that was the basis for that provider's termination from participation in the Medicaid program;

24. Was an officer or owner (directly or indirectly) of five percent or more of the shares of stock or other evidences of ownership or owner of a sole proprietorship or a partner of a partnership that was a provider during the time of conduct that was the basis for that provider's termination from participation in the Medicaid program;

25. Engaged in practices prohibited by federal or state law or regulation;

26. Was a person with management responsibility for a provider at the time that the provider engaged in practices prohibited by state or federal law or regulation;

27. Previously convicted of Medicaid fraud under federal or state law or regulation;

28. Was a person with management responsibility for a provider at the time that the provider was convicted of Medicaid fraud under federal or state law or regulation;

29. Was an officer or owner (directly or indirectly) of five percent or more of the shares of stock or other evidences of ownership; or sole proprietorship or a partnership

that was a provider at the time the provider was convicted of Medicaid fraud under federal or state law or regulation; or

30. Was an owner of a sole proprietorship or partner in a partnership that was a provider at the time such a provider was convicted of Medicaid fraud under federal or state laws and regulations.

NOTE: The list above is not all-inclusive.

Federal laws and regulations also provide for administrative actions. Providers should refer to applicable federal laws and regulation and applicable sanctions.

Levels of Administrative Actions and Sanctions

BHSF may impose corrective actions and/or administrative sanctions against a Medicaid provider.

Corrective Action Plans

BHSF may at any time issue a notice of corrective action to a provider. The provider shall either comply with the corrective action plan within ten working days or request an informal hearing within that time. The purpose of the corrective action plan is to identify potential problem areas and correct them before they become significant discrepancies, deviations or violations.

Sanctions

Sanctions may include:

1. Issuing a warning;

2. Requiring education and training at the provider's expense;

3. Limiting the services that may be provided or the individuals to whom the services are provided;

4. Requiring recoupment;

5. Requiring recovery;

6. Imposing judicial interest on outstanding recoveries or recoupment;

7. Imposing reasonable costs;

8. Excluding an individual or entity from participation;

9. Suspending an individual or entity from participation;

10. Requiring forfeiture of a posted bond;

11. Imposing an arrangement to repay;

12. Imposing monetary penalties not to exceed $10,000;

13. Imposing withholding of payments;

14. Requiring the provider receive prior authorization for any or all goods, services or supplies;

15. Imposing fines and costs; or

16. Requiring bonds or other forms of security.

NOTE: The list above is not all-inclusive.

The provider should refer to the laws and regulations related to sanctions for each program for which enrolled and should review the LAC 50:I., Chapter 41, Subchapter E.

Exclusions

Exclusion from the Medicaid program may be either mandatory or permissive. Health care fraud is a mandatory exclusion. Permissive exclusions include other crimes and activities as contained in the SURS Rule for which an individual and/or entity may be excluded from Medicaid.

Screenings for Exclusions and Sanctions

The Office of Inspector General (OIG), under its Congressional mandate, established a program to exclude individuals and entities affected by the various legal authorities, contained in Section 1128 and 1156 of the Social Security Act. The OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities.

Under the SURS Rule, providers have an obligation to ensure their employees are not and have not been excluded, restricted or convicted of a crime relative to a government funded health program. Providers should check the OIG and the Excluded Parties List System (EPLS) websites to determine if an individual has been excluded, restricted or convicted. (Refer to Appendix B for contact information).

Background Checks

Providers must perform background checks on all managers and employees in addition to contacting licensing boards at the time of hire and periodically thereafter. Failure to do these checks will result in the provider being sanctioned and subject to recovery, fines and possible exclusion from participating in Medicaid.

Fraud

Federal regulations and the SURS Rule prohibit individuals and/or entities that have been excluded from a government funded health program and/or convicted of health care fraud from participating in Medicaid or any other federally funded health care program.

Practice Restrictions

The SURS Rule mandates that when a restriction is placed on an individual or entity by another governing board, Medicaid will place a restriction on the individual or entity as well.

Informal Hearings and Appeals

An informal hearing is held at the request of a provider and is generally conducted byPI. This is not a court proceeding, but a discussion on what information and records were used in the review. Providers may opt to have legal representation, but it is not required.

After the informal hearing, providers receive a written notice of the results of the hearing and the recommended action to be taken. If the recommended action is accepted by the provider, the administrative process ends and the recommended action will be implemented. If the recommended action is rejected, the provider may initiate an appeal hearing. The hearings are scheduled by the Division of Administrative Law (DAL), Health and Hospitals Section.

The LDH offers an opportunity to have a hearing to any provider who feels that they have been unfairly sanctioned. The DAL, Health and Hospitals Section are responsible for conducting hearings for providers who have complaints. Requests for hearings should be made in writing and explain the reason for the request. All requests should be sent directly to the Division. (Refer to Appendix B for contact information).

Information regarding the appeals procedure may also be obtained by contacting the Division.

Criminal Fraud

Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. In criminal proceedings, the definition of fraud that governs between citizens and state government agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.1.

Legal action may be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142. Prosecution for fraud and the imposition of a penalty, if the individual is found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts.

All legal action is subject to due process of law and to the protection of the rights of the individual under the law.

Federal law also defines what is considered criminal conduct within federally funded programs. All providers should be aware of the applicable federal laws and regulations.

Provider Criminal Fraud

Cases involving one or more of the following situations shall constitute sufficient grounds for a provider fraud referral:

1. Billing for services, supplies, or equipment that are not rendered to, or used for, Medicaid patients;

2. Billing for supplies or equipment that are unsuitable for the patient's needs or are so lacking in quality or sufficiency as to be virtually worthless;

3. Claiming costs for non-allowable supplies, or equipment disguised as covered items;

4. Misrepresenting dates and descriptions of services rendered, the identity of the provider or of the beneficiary;

5. Submitting duplicate billing to the Medicaid program or to the beneficiary, which appears to be a deliberate attempt to obtain additional reimbursement; and

6. Arrangements made by providers with employees, independent contractors, suppliers, and others (through various devices such as commissions and fee

splitting) which appear to be designed primarily to obtain or conceal illegal payments, and/or additional or duplicate reimbursement from Medicaid.

NOTE: The above list is not all inclusive, but is rather illustrative of practices which may be considered criminal activities.

Beneficiary Criminal Fraud

Cases involving one or more of the following situations shall constitute sufficient grounds for a beneficiary fraud referral:

1. Misrepresentation of facts in order to become eligible, remain eligible or to receive greater benefits under the Medicaid program;

2. Transfer of a Medicaid eligibility card to a person not eligible to receive services or to a person whose benefits have been restricted or exhausted, thus enabling the person to receive unauthorized medical benefits; and

3. Unauthorized use of a Medical eligibility card by persons not eligible to receive medical benefits under Medicaid.

NOTE: The above list is not all inclusive, but is rather illustrative of practices which may be considered criminal activities.

Abuse and Incorrect Practices

Abuse by providers, beneficiaries, and others include practices that are not criminal acts, but still represent the inappropriate use of public funds.

Provider Abuse and Incorrect Practices

Cases involving one or more of the situations listed below may constitute sufficient grounds for investigation of a provider for incorrect practices or abuse. Abuse includes the following:

1. The unintentional misrepresentation of dates and descriptions of services rendered, of the identity of the beneficiary of the services, or of the individual who rendered the services and gained a larger reimbursement than is entitled; and

2. The solicitation or subsidization of anyone by paying or presenting any person with money or anything of value for the purpose of securing patients. Providers, however, may use lawful advertising that abides by BHSF's rules and regulations.

NOTE: This list is not all-inclusive, but is rather illustrative of practices that are abusive or improper.

Beneficiary Abuse

Cases involving one or more of the following situations may constitute sufficient grounds for a beneficiary abuse referral. Providers are required to report to BHSF suspected cases of beneficiary abuse related to the unnecessary or excessive use of the following:

1. Prescription medication benefits of the Medicaid program;

2. Physician benefits of the program; and

3. Other medical services and/or medical supplies that are benefits of the program.

Civil Causes of Action

MAPIL, RS 46:437.1-46:440.3 provides for civil causes of action that can be taken against providers and others who violate the provisions of MAPIL. MAPIL prohibits illegal remuneration, false claims, illegal acts regarding eligibility, and beneficiary lists among other things. These civil causes of action are set forth in RS 46:438.146:438.5. Individuals who are found by a court of law to have violated the provision of MAPIL are subject to triple damages, fines, cost, and fees.

Payment Error Rate Measurement

The Improper Payments Information Act of 2002 directed federal agencies to annually review programs that are susceptible to significant erroneous payments and report these improper payment estimates to Congress. The Centers for Medicare and Medicaid Services (CMS) uses a 17-state rotation for payment error rate measurement (PERM).

Each state is reviewed once every three years. This rotation allows states to plan for the review in advance. CMS is using a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection, and medical/data processing review of selected Medicaid and CHIP (Children's Health Insurance Program) fee-for-service (FFS) and managed care claims.

States are responsible for performing their own eligibility reviews using state and federal criteria. Reviews are made to determine the accuracy of beneficiary eligibility along with payments for services rendered. This information is then sent to CMS to be used to determine a state and national error rate.

GENERAL CLAIMS FILING

This section provides general information on the process of submitting claims for Medicaid services to the fiscal intermediary (FI) for adjudication. Program specific information for filing claims is provided in each program manual chapter.

Additionally, the FI offers support to providers, vendors, billing agents or clearinghouses (VBCs) in matters related to electronic data interchange (EDI). This includes providing support for transactions implemented as mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Hard Copy/Paper Claim Forms

The most current CMS-1500, UB-04, American Dental Association (ADA), and Pharmacy National Council for Prescription Drug Programs (NCPDP) claim forms are to be used when filing paper claims. These forms can be obtained through most business form vendors, some office supply stores, or by contacting the appropriate national claim form outlet. Some state- specific claim forms are also required for billing.

All paper claims are scanned and stored online. This process allows the Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

It is strongly encouraged that providers file claims electronically; however, if you cannot submit claims electronically, or if Medicaid policy does not allow the claim to be submitted electronically, prepare your paper claim forms according to the following instructions to ensure appropriate and timely processing:

1. Submit original claim forms (including resubmission of corrected claim forms);
2. Properly align forms in printer to ensure information is within the appropriate boxes;
3. Use high quality printer ribbons and cartridges – black ink only;
4. Use font types Courier 12, Arial 11, or Times New Roman, font sizes 10-12;
5. Do not use italic, bold, or underline features;

6. Do not submit two-sided documents;

7. Do not use marking pens. **Use a black ballpoint pen (medium point)**;

8. Do not use highlighters on claim forms. Providers who want to draw attention to a specific part of a report or attachment should circle that particular paragraph or sentence;

9. Do not submit carbon copies under any circumstances; and

10. Ensure that claim forms are standard size of 8 ½" x 11", not smaller or larger.

Attachments

Claims with attachments must be billed hard copy. All claim attachments should be standard 8.5 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.

Receiving and Screening Paper Claims

When a paper claim is received, it is screened for missing information. If the provider name, the provider number, beneficiary Medicaid identification number, and/or service dates are missing, the claim is rejected. The provider signature is optional on most claims. The Certification of Claims (paper and electronic) is signed by the provider at the time of enrollment in the Medicaid Program.

Claims with all the necessary items completed for claims processing will proceed to the next part of the claims processing cycle, in which the claim is microfilmed, given a unique 13- digit internal control number (ICN) and entered into the computer for processing.

Returned Claims

If the claim is rejected because of missing or incomplete items, the original claim will be returned accompanied by a "reject" letter. The reject letter will indicate why the claim has been returned. A returned claim will not appear on the Remittance Advice (RA), as it will not have entered the claims processing system. The claim will not be microfilmed and given an ICN before being returned to the provider and cannot be considered as proof of timely filing.

Changes to Claim Forms

It is the policy of the Medicaid program that the FI staff are not allowed to change any information on a provider's claim form; therefore, if changes are required on a claim, the provider or its billing agent must make those changes and resubmit the claim.

Data Entry

Data entry personnel do not make any attempts to interpret the claim form – they merely enter the data as found on the form. If the data is incorrect or is not in the correct location, the claim will not process correctly.

General Reminders

1. Signatures are optional on paper claim forms. Providers may choose to submit stamped or computer-generated signatures;

2. Continuous feed forms must be torn apart before submission; and

3. The beneficiary's 13-digit Medicaid ID number must be used to bill claims. **The 16- digit CCN number from the plastic ID card is NOT acceptable.**

The Medicaid program is required to make payment decisions based on the documentation submitted on the claim.

Electronic Claims

Providers are strongly encouraged to submit claims using the Electronic Data Interchange (EDI). Filing claims through EDI allows a provider or a third party contractor (vendor, billing agent or clearinghouse) to submit Medicaid claims to the FI via telecommunications (modem). A list of VBCs that provide electronic billing services is available on the Louisiana Medicaid web site, www.lamedicaid.com, HIPAA Information Center, VBC List.

Prior to billing electronically, providers must obtain a submitter ID number through the FI's Provider Enrollment Unit or contract with an approved submitter. Once the submitter number is loaded on the provider file, the FI will process test claims supplied by the provider to determine software formatting issues. Billing electronically requires software that complies with the HIPAA standards. Please refer to the HIPAA Transaction Companion Guide.

All claims received via electronic media must satisfy the criteria listed in the EDI Companion Guide for that type of service. Companion guides are located on the Medicaid web site.

Providers that submit claims electronically must complete an EDI certification form signed by the authorized Medicaid provider or billing agent. Failure to submit the required form will result in deactivation of the submitter number. If a number is deactivated, the certification form will have to be received hard copy (no faxes) in the fiscal intermediary EDI Department before the number is reactivated. This will result in a delay in payment for providers.

Providers should verify with their submitter that this requirement has been met in order to ensure no delays in claims payment.

Certification forms are located on the Louisiana Medicaid web site, EDI Information. Submitters must mail the annual certification forms to the FI. (Refer to the Appendix B for contact information).

Providers, who wish to submit claims electronically may download and complete an EDI packet. Providers should select the certification form in the packet applicable to their provider type and make copies as necessary for submission.

Advantages of Electronic Claims

Submitting claims electronically has several advantages. The advantages include:

1. Increased cash flow and faster payment;
2. Improved claims control;
3. Automated receivables information;
4. Improved claim reporting by observation of errors; and
5. Reduced errors through pre-editing claims information.

Available Electronic Transactions

Available electronic transactions include the following documents:

1. Health Care Claim: Professional ASC X12N 837;

2. Health Care Claim: Institutional ASC X12N 837;

3. Health Care Claim: Dental ASC X12N 837;

4. Health Care Payment/Advice ASC X12N 835;

5. Health Care Claim Status Request and Response ASC X12N 276/277;

6. Health Care Eligibility Benefit Inquiry and Response ASC X12N 270/271;

7. Health Care Services Review: Request for Review and Response ASC X12N 278;

8. Transmission Receipt Acknowledgment ASC X12 997;

9. Payroll Deducted and Other Group Premium Payment for Insurance Products ASC X12N 820; and

10. Benefit Enrollment and Maintenance ASC X12N 834.

Timely Filing Guidelines

In order to be reimbursed for services rendered, providers must comply with the following timely filing guidelines established by Louisiana Medicaid:

1. "Medicaid only" claims must be filed within 12 months of the date of service;

2. 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;

3. For claims which fail to cross over electronically from Medicare, a hard copy must be submitted to Medicaid within six months from the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service; and

4. Claims with third-party payment must be filed with Medicaid within 12 months of the date of service.

Claims Exceeding the Initial Timely Filing Limit

Medicaid claims received after the initial one-year timely filing limit (one year from the date of service or date of retroactive certification) cannot be processed unless the provider is able to furnish documentation that verifies timely filing. Proof of timely filing may include one of the following:

1. An electronic Claims Status Inquiry (e-CSI) screen print indicating that the claim was processed within the specified time frame;

2. An RA indicating that the claim was processed within the specified timeframe; and

3. Correspondence from the state or parish office concerning the claim and/or the eligibility of the beneficiary.

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.

Louisiana Medicaid does not accept the following as proof of timely filing:

1. Printouts of Medicaid Electronic Remittance Advice (ERA) screens;

2. Rejection letters accompanying returned claims are not considered proof of timely filing as they do not reference a specific individual beneficiary or date of service; and

3. Post Office "certified" mail receipts and receipts from other delivery carriers.

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

Claims beyond the Two Year Timely Filing Limit

Claims with dates of service two years old must be submitted to Louisiana Department of Health (LDH) for review and must be submitted with proof of timely filing within the initial one-year filing limit. These claims must meet one of the following criteria:

1. The beneficiary was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date that retroactive eligibility was granted;

2. The beneficiary won a Medicare or SSI appeal in which they were granted retroactive Medicaid benefits; and

3. The failure of the claim to pay was the fault of the fiscal intermediary or the Louisiana Medicaid program, rather than the provider's fault, each time the claim was adjudicated.

In order to be considered for the 2-year override, requests must include a cover letter describing the criterion that has been met and supporting documentation. Requests received that do not meet these requirements will be returned to the provider.

Billing the Beneficiary

There are situations when the beneficiary cannot be billed for services rendered. The following is a list of situations when the beneficiary cannot be billed for services rendered. The list is not all inclusive:

1. Charges above the Medicaid maximum allowable fee amount;

2. Claims denied due to provider error;

3. Errors made by BHSF, the FI, or the Third Party Liability (TPL) collections contractor or changes in state and federal mandates;

4. Service(s) denied because the provider failed to request prior authorization or failed to meet procedural requirements;

5. Claim balances remaining after another third party source such as Medicare, health insurance, TRICARE, etc. has made payments;

6. Completion and submission of a Medicaid claim form;

7. Telephone calls and missed appointments; and

8. Costs associated with copying medical records.

Beneficiary's Responsibility

The following is a non-inclusive list of situations when a beneficiary may be billed for services rendered:

1. The Medicaid beneficiary was ineligible on the date of service;

2. The service is not covered under the scope of the Medicaid Program or exceeds the program benefit limitations; and

3. The beneficiary may be liable for the entire claim or a portion of the claim when it is determined that the services were not medically necessary.

NOTE: A provider can only bill a beneficiary for non-covered services, if the beneficiary was informed in advance, verbally and in writing, that the service(s) were not covered by Medicaid and the beneficiary agrees to accept the responsibility for payment. **The provider should obtain a signed statement or form which documents that the beneficiary was verbally informed of the out- of-pocket expense.**

Third Party Liability

Federal regulations and applicable state laws require that Third Party resources be used before Medicaid is billed. TPL refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, which can be applied toward the beneficiary's medical and health expenses **as** Medicaid, by law, is intended to be the payer of last resort. Providers should utilize Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS) to verify the beneficiary's eligibility, which will include information about TPL coverage if applicable. Information given includes the name and mailing address of the TPL carrier, the assigned TPL carrier code as well as any restrictions to or exclusions from the policy, if known. Providers may obtain an alpha or numeric listing of the TPL carrier codes to assist them in verifying the correct TPL carrier code for placement on their claims. The TPL Carrier Code Listings can be found on the Medicaid website at www.lamedicaid.com under "Forms/Files" or by contacting the FI.

The provider should submit the "Medicaid Recipient Insurance Information Update" form to Health Management Systems (HMS) requesting an update when the insurance and carrier code are incorrect, the insurance coverage has ended, and/or the beneficiary's insurance coverage is not on the file.

The form may be found on the Louisiana Medicaid website. A denial letter or explanation of benefits (EOB) from the TPL carrier should accompany these requests. HMS will verify the information and correct the beneficiary's file. The fax and email information may be found on lamedicaid.com along with follow up contact information.

When a TPL update is necessary, the associated claim(s) should not be submitted to the payer (managed care organization (MCO) or fee-for- service (FFS) Medicaid) for processing until the TPL update is made on beneficiary's file in the payer's system. Providers should re-verify updates through REVS or MEVS to confirm that the TPL update has occurred in thedicaid ie fee-for-service system when FFS is the payer, and re-verify updates through the MCO provider portal to confirm the TPL update has occurred when the MCO is the payer.

If the TPL insurance and carrier code is correct, the provider should enter the carrier code on the claim in the designated area, and submit the claim along with the TPL carrier's EOB if the claim is being billed hard copy to the FI for processing.

Louisiana Medicaid now accepts TPL claims billed electronically (via Electronic Data Interchange (EDI). Providers are no-longer required to bill TPL claims hard copy with the primary payer's **explanation of benefits** attached. The primary benefit of electronically submitting these claims is the expedition of processing and payment.

Providers are responsible for entering and transmitting the accurate and appropriate TPL information from the primary payer's EOB and the 6-digit carrier code into the 837 Electronic Data Interchange (EDI) transactions before submission to Louisiana Medicaid.

It is very important that providers notify their vendors, billing agents and clearinghouses (VBC's) of this important capability and to coordinate with them to make all the needed changes to their software which will allow these transactions to be processed correctly and timely. Providers may contact the FI for testing or other EDI questions.

Third Party Sources

If a payment is received from any source **prior to billing** Medicaid the provider is **required** to inform Medicaid of such payment. Medicaid **will reduce** the Medicaid allowable fee amount by the prior payment.

The following third parties must be billed prior to billing Medicaid. This list is not all inclusive:

1. Medicare Parts A and B;

2. Health insurance:

   a. Policies and indemnity policies that make payment when a medical service is provided and that restrict payment to the period of hospital confinement; and

   b. Policies that pay income supplements for lost income due to a disability or policies that make a payment for a disability, such as a weekly disability policy, are not included.

3. Major medical, drug, vision care and other supplements to basic health insurance contracts;

4. TRICARE – provides coverage for off base medical services to dependents of uniformed service personnel, active or retired;

5. Veteran Administration (CHAMP-VA) provides coverage for medical services to dependents of living and deceased disabled veterans;

6. Railroad Retirement;

7. Automobile medical insurance;

8. Worker's compensation;

9. Liability insurance – includes automobile insurance and other public liability policies, such as home accident insurance, etc.;

10. Family health insurance carried by an absent parent;

11. Black Lung Benefits; and

12. United Mine Workers of America Health and Retirement Fund, and donated funds.

Billing Medicare and Other Third Party Sources

Medicare/Medicaid Crossover

Dual Eligibles

Dual eligibles are beneficiaries who have Medicare and Medicaid coverage. Medicaid will reimburse the provider an amount up to the full amount of Medicare's statement of liability for co-insurance and deductible for Qualified Medicare Beneficiaries (QMB)

For claims in which Medicare's reimbursement exceeds the maximum allowable by Medicaid, **Medicaid will "zero" pay the claim. This means that the claim will be shown in the Approved Claims section of the RA with a "$0" shown in the payment column**. This claim is considered "paid in full" and the provider may not seek additional remuneration from the beneficiary.

Medicaid will pay up to the Medicare deductible and coinsurance on Medicare approved claims for non-Qualified Medicare Beneficiaries (non-QMB) receiving both Medicare and Medicaid, provided the procedure is covered by Medicaid. Medicaid will reimburse the provider an amount up to the full amount of Medicare's statement of liability for co-insurance and deductible as long as it does not exceed Medicaid's allowable reimbursement for the service. Medicaid will "zero' pay the claim when Medicare's reimbursement exceeds the maximum allowable by Medicaid.

If a beneficiary has both Medicare and Medicaid coverage, providers should file claims in the appropriate manner with the regional Medicare intermediary/carrier, making sure the beneficiary's Medicaid number is included on the Medicare claim form.

Once the Medicare intermediary/carrier has processed/paid their percentage of the approved charges, Medicare will electronically submit a "crossover" claim to the Medicaid FI that includes the co-insurance and/or deductible. If the "crossover" claim is denied by Medicare, the provider must submit a corrected claim to Medicare, if applicable. If the "crossover" claim is not received by the FI from Medicare, then the provider must submit a hard copy claim to the FI for payment of Medicaid's responsibility.

To process hard copy Medicare crossover claims, the provider must:

1. Make a copy of the claim filed to Medicare;

2. Put the Medicaid provider number and beneficiary Medicaid number in the appropriate form locators; and

3. Attach a legible copy of the Medicare EOB including edit/denial descriptions to the claim.

In addition, all of the EOB data, such as patient name and dates of service must match. Mail the hard copy Medicare crossover claim to the Medicaid FI. Once a claim is received, the claim will be processed, and reimbursement will be made to the provider.

NOTE: The provider should receive the Medicaid payment four to six weeks after receiving the Medicare payment.

If a provider's crossover claim does not appear on the RA within six weeks of the Medicare date of pay, the claim has failed to crossover electronically and must be filed hard copy.

Medicare Advantage Plan Claims

All beneficiaries participating in a Medicare Advantage Plan must have both Medicare Part A and Medicare Part B.

The Medicare Advantage Care Plans have been added to the Medicaid Third Party Resource File for the appropriate beneficiaries with six-digit alpha-numeric carrier codes that begin with the letter "H". A list of carrier codes can be accessed on the Louisiana Medicaid website.

Providers must submit hard copy claims with the Medicare Advantage Plan EOB attached and the six-digit carrier code entered correctly on the form in order for the claim to process correctly.

Hard copy claims submitted without the plan EOB and without a six-digit carrier code will not be processed.

A Medicare Advantage Plan institutional or professional cover sheet **MUST** be completed in its entirety **for each claim** and attached to the top of the claim and EOB. Claims received without this cover sheet will be rejected. A copy of these cover sheets may be obtained from the Louisiana Medicaid website at www.lamedicaid.com under "Forms/Files".

Discovery of Private Insurance Eligibility after Medicaid Payment

Recoupment of any Medicaid payments made prior to discovery of a beneficiary's private insurance eligibility is routinely handled by Health Management Systems (HMS), a TPL collections contractor. This private company is contracted by LDH to review payments and recoup any payment issued as Medicaid being the primary payer when the beneficiary had Medicare or private insurance.

HMS identifies these claims and notifies the provider via letter with an attached claim report of Medicaid beneficiaries whose claims paid as Medicaid primary when other resources were available.

One week after the letter is mailed; the provider is contacted to verify receipt of the letter, answer questions, and discuss documentation. Ten days prior to date of recoupment, the provider will again be contacted by HMS to ensure that they understood the requirements and confirm the required process. At the end of the 60 days, information is sent to the FI to recoup the payments.

Discovery of Medicare Eligibility after Medicaid Payment

Recoupment of any Medicaid payments made prior to discovery of a beneficiary's Medicare eligibility is routinely handled by the fiscal intermediary (FI) and HMS. Based on the information provided by LDH and the data from CMS with regard to Medicare retro-eligibility, the FI initiates a quarterly Medicare recoupment. HMS utilizes the same information and bills for any additional claims that they have identified. HMS identifies these claims and notifies the provider via letter with an attached claim report of Medicaid beneficiaries whose claims paid as Medicaid primary when other resources were available.

One week after the letter is mailed; the provider is contacted to verify receipt of the letter, answer questions, and discuss documentation. The providers are allowed approximately 30 days to bill Medicare. Ten days prior to date of recoupment, the provider will again be contacted by HMS to ensure that they understood the requirements and timeframes. At the end of the 30 days, information is sent to the FI to recoup the payments.

When an "H" appears at the beginning of the medical records number found on the Medicaid RA, it is a HMS recoupment. For further information, the provider may call the HMS Provider Recoupment Team (refer to Appendix B for contact information).

Resubmitting Claims Following HMS Recoveries

In instances where HMS has recovered payments from providers due to Medicare or private insurance coverage, providers have six months from the date of payment of the primary payer (Medicare or private insurance) to file the secondary claim to Louisiana Medicaid for consideration. These claims should be submitted to the fiscal intermediary for processing.

There are times when the timely filing limit for submitting an original claim to the private insurance payer has expired. In cases where the claim cannot be submitted to the primary payer for consideration due to filing deadlines, providers have six months from the recoupment of the Medicaid payment by Medicaid's TPL contractor to re-submit the claim to Medicaid for

reconsideration. The claim, along with documentation indicating that the timely filing limit has expired with the primary payer, must be submitted to HMS for reconsideration.

Third Party Payment or Denial

TPL claims must be billed to the FI. Louisiana Medicaid will process TPL claims differently for all beneficiaries, and the payment calculation will change.

Hardcopy Claims

Providers who bill hard copy claims must continue to do so and attach a copy of the EOB. In addition, remarks, comments, and/or edit descriptions from the TPL carrier must be legible and attached to the claim. With the exception of Medicare, the assigned six-digit carrier code must be entered correctly in the designated block/field/form locator of the claim form. The dates of service, procedure codes and total charges on the primary EOB must match the claim submitted to Medicaid or the claim will be rejected. In addition, all Medicaid requirements such as pre- certification or prior authorization **must** be met before payment will be considered.

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

Refer to the specific program manual for instructions on entering these key pieces of information on the claim form).

Electronic Claims

Louisiana Medicaid will accept and process TPL claims submitted electronically. It will no longer be necessary for providers to submit TPL claims hard copy with EOBs attached.

Providers must enter the appropriate and accurate information from the primary payer's EOB for transmission electronically to Louisiana Medicaid for processing and payment**.**

Post-payment reviews will be conducted to ensure that accurate information is being submitted by providers. Detailed information concerning correct entry of TPL data in the 837 electronic specifications may be found in the Companion Guide(s) located on the Louisiana Medicaid web site, HIPAA Billing Instructions and Companion Guides. Providers must choose the appropriate Companion Guide applicable to the 837 transaction that will be submitted.

Claims denied by the TPL carrier must be reconciled with the carrier before the claim is submitted

to Medicaid for processing.

Providers may contact the FI's EDI Department with questions concerning EDI transmissions (Refer to Appendix B for contact information).

Payment Methodology

When a beneficiary has other insurance, the beneficiary must follow any and all requirements of that insurance since it is primary. If a beneficiary does NOT follow their private insurance rules and regulations, Medicaid will not be responsible for considering payment of those services. Thus, the beneficiary is responsible for the payment of the services. Providers must determine prior to providing services, to which commercial plan the beneficiary belongs and if the provider of service is a part of the network of that particular plan.

Beneficiaries must be informed prior to the service that they will be responsible for the payment if they choose to obtain the services of an out-of-network provider and their commercial plan does not offer out-of-network benefits.

Louisiana Medicaid will process these claims as they were processed by the primary payer. The payment information indicated on the primary payer's EOB will be used to process the claim.

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

Claims Payment for LAHIPP Beneficiaries

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

Payment of Non-LAHIPP Secondary Claims

Medicaid will use a comparison methodology to pay TPL claims for non-LAHIPP beneficiaries with primary insurance. TPL claims must be processed by the primary payer, and TPL payment amount will be applied just as the primary payer indicates on the EOB. If there is only a total TPL amount on the EOB, "spend down" methodology will continue to be utilized. The payment will be made

based on the lesser of:

1. The Medicaid allowed amount minus TPL payment; or

2. The total patient responsibility amount (co-pay, co-insurance, and/or deductible).

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

Receipt of Duplicate Payments

If a provider receives payment from a third party carrier and a Medicaid payment for the same service, the amount of the Medicaid payment must be returned to Medicaid within 30 days.

Refund Process

When errors in billing occur (e.g., duplicate payments), instead of simply refunding payments, **providers should initiate claim adjustments or voids.** However, providers who find it necessary to refund a payment; should make checks payable to LDH, Bureau of Health Services Financing, and mail the refund with sufficient documentation to the Payment Management Section. **Refund checks should not be made payable to the FI.** (Refer to Appendix B for contact information).

To reconcile an account with the Department, providers must attach a copy of the RA to the return or refund check and indicate which claim payments are being refunded. In addition, providers must explain the reason for the return or refund payment.

To determine the amount of a refund, providers should consider the following rules:

1. Whenever a duplicate payment is made, the full amount of the second payment must be refunded; and

2. If another insurance company pays after Medicaid has made its payment, the full amount of the Medicaid payment must be refunded and the provider should file the claim with the EOB from the private insurance.

Note: Adjustment/voided claims should be the provider's initial consideration. A refund check should be a last option, as this process takes a much longer time period to be completed and does not provide a clear audit trail**.**

Trauma Recovery

A provider may not pursue a liable or potentially liable third party for payment in excess of the amount paid by Medicaid. (**LAC 50: I:8349**).

Request for Medical Information

Request from Beneficiary or Family Member or Insurance Company

If a provider receives a request for medical bills or other information from the beneficiary or someone acting on behalf of the beneficiary, such as an attorney, insurance company, etc., the information may be released with the proper authorization from the beneficiary. Information requested by an insurance company with whom a claim has been filed may be filed directly with the carrier.

Request from Attorneys

Providers must promptly comply with requests from a beneficiary's attorney when requested in cases of personal injuries. Providers should follow these procedures:

1. Obtain a signed authorization from the beneficiary before giving any report, verbal or written;

2. Compile the requested information. Forward this information to the attorney. A statement may be enclosed for copying the records; and

3. Mail a copy of the written request and authorization to the Bureau's TPL Trauma Unit.

Medical information concerning a beneficiary that is released by a provider must contain the following statements/information:

1. The person is a Medicaid beneficiary;

2. The beneficiary's Medicaid identification number; and

3. The bill has been paid by Medicaid or will be submitted to Medicaid for payment.

Providers who furnish medical information to attorneys, insurers, or anyone else must obtain a 3 x

3 ANNOTATION STAMP and must ensure that all outgoing medical information bears the stamp, which notifies the receiver that services have been provided under Louisiana's Medicaid program. A sample of this stamp is located on the Louisiana Medicaid website along with the notification form.

Methods of Payment for Child Support Enforcement Claims and Preventive Pediatric Care Pay and Chase

Louisiana Medicaid uses the "pay and chase" method of payment for **preventive pediatric care services and prescription drug services** for individuals with health insurance coverage. This means that most providers are not required to file health insurance claims with private carriers when the service meets the pay and chase criteria. The Bureau of Health Services Financing (BHSF) seeks recovery of insurance benefits from the carrier within 60 days after claim adjudication when the provider chooses not to pursue health insurance payments.

Service classes which do not require private health insurance claim filing by most providers are:

1. Primary preventive pediatric care diagnoses are confined to those listed here: Diagnosis Codes related to Preventive Pediatric Care Services. Individuals under 21 years of age qualify. **Hospitals are not included and must continue to file claims with the health insurance carriers**;

2. EPSDT (Early and Periodic Screening, Diagnostics and Treatment) medical, vision, and hearing screening services;

3. EPSDT dental services;

4. EPSDT services for children with special needs (formerly referred to as school health services) which result from screening and are rendered by school boards;

5. Services which are a result of an EPSDT referral, indicated by entering "Y" in block 24H of the HCFA-1500 claim form or "1" as a condition code on the UB-92 (form locators 24-30); and

6. Services for Medicaid eligibles whose health insurance is provided by an absent parent who is under the jurisdiction of the State Child Support Enforcement Agency are now subject to a "wait and see period." Payment for these claims can only be made after the required documentation is attached to a hard copy claim and submitted to the state's Fiscal Intermediary demonstrating that 100 days have elapsed since the provider billed

the responsible third party and the provider is still pending payment from the responsible third party.

NOTE: Documentation requirements can be found at: http://ldh.la.gov/assets/medicaid/MCPP/TPL/Wait_and_See_ProviderNotice_IBPayandChaseBBA.pdf

Recoupment of Payments

The provider must reimburse Medicaid in situations where the third party resource payment is received after Medicaid has been billed and made payment. Reimbursement must be made immediately to comply with regulations. This refund process is applicable to other claim situations in which an overpayment occurred and corrective action needs to be made. Providers should submit an adjustment/void either electronically or paper when adjusting/voiding claims within three years from the date of payment of the claim. Refund checks should be submitted when adjusting/voiding claims with dates of service three years or older.

Providers may reimburse Medicaid by forwarding a check identifying the claim or claims to which the refund is to be applied. Identifying claims will help to reduce additional correspondence. This information may be found on the RA as follows:

1. Provider number;
2. Date of payment;
3. Control number;
4. Beneficiary name and identification number;
5. Date of service;
6. Amount paid; and
7. Reason for refund.

In cases where the provider sends in one refund check for multiple beneficiaries/claims, providers should keep a current record of all claims associated with their refund check. The provider should closely monitor all subsequent RAs to ensure that all adjustments/voids associated with the one refund check have been posted and accounted for the provider.

Refunds should be made payable to LDH and mailed to the attention of LDH Payment Management Section. (Refer to Appendix B for contact information).

NOTE: Checks are not to be made payable to the FI.

Remittance Advice

The RA plays an important role in that it is the primary communication tool between the provider, the BHSF, and the FI. Aside from providing a record of transactions, the RA assists providers in resolving errors and recording or posting paid claims.

The RA is a computer generated document that informs the provider of the current status of submitted claims – approved, pended, or denied. RAs are generated weekly for all providers who have submitted claims for processing during a weekly cycle. RA's are posted online on the Louisiana Medicaid web site, www.lamedicaid.com, Weekly RAs, on Tuesdays of each week. Providers must register with each provider number under which they receive payment and must log in with the appropriate provider number and login information to view the RA. Once registered, providers may grant logon access to appropriate staff and/or any business partner entity representing them. Individuals who are allowed to access RAs will have the ability to download and save the documents or print the documents for reconciling accounts.

Providers are strongly encouraged to have the account administrator be either the actual provider or a management level staff member designated by the provider. Once registered, the administrator may create logons for others needing access to the secure information.

Standard RAs are only available online through the web site for five weeks (five payment cycles). Providers must implement procedures for appropriate individuals to access this information online and to print or download and save each RA for reconciling accounts for future reference, and to support the requirement to maintain Medicaid documents related to payment for a minimum of five years.

All providers with approved, denied, or pended claims receive an online RA whether billing hard copy or electronically.

Electronic Remittance Advice

The ERA is produced in the HIPAA-compliant format. All providers who bill electronically may elect to receive an electronic RA which contains all information regarding adjudicated (paid or

denied) claims. Information regarding pended claims is reported electronically in the 277 Unsolicited Claim Status format. Providers must contact the EDI Department or their EDI vendor to receive electronic RAs.

Remittance Advice Copy and History Requests

Provider participation in the Louisiana Medicaid Program is entirely voluntary. State regulations and policy establish certain requirements for providers who choose to participate in the program. **One of those requirements is the agreement to maintain any information regarding payments claimed by the provider for furnishing services for a period of five years. It is the responsibility of the provider to retain all RAs for five years.**

When it is necessary for a provider to request copies of RAs dated prior to November 1, 2011 (the effective date of online RAs) or claim histories, the FI will supply this information for a fee.

If providers are requesting RA prior to November 1, 2011 for multiple weeks or a large volume of RAs, the FI will determine whether RA copies or a claim history will be provided.

Requests for RAs or claims histories may be made through the Provider Relations Unit.

The provider name, number, address, date(s) of the RA being requested, and name of the individual requesting and authorizing the request must be included in the request. Upon receipt of the request, the provider will be notified of the number of pages to be copied and the cost of the request. The RA/claims history will be forwarded to the provider once payment is received.

A fee of $0.25 per page, which includes postage, is charged to any provider who requests an additional copy of an RA of one or more pages. Claims history fees may apply at the time of order.

Adjusting and Voiding Claims

An adjustment or void may be submitted electronically or paper. Refer to the specific program provider manual and the EDI Companion Guides (if billing electronically) for detailed billing information."

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 RA, 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:

1. 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; and

2. 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 RA 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 RA.

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES

TO REQUEST THEM - CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA (See listing of numbers on attachment)

Per Chisholm v Department of Health and Hospitals, it is required that the following language concerning services to persons under 21 and children with disabilities be published in this manual.

DEVELOPMENTAL DISABILITIES MEDICAID WAIVER SERVICES

The following services are available to children and youth with developmental disabilities. To apply for services, contact your local governing entity (LGE). Phone numbers are listed on the attachment or on the Louisiana Department of Health (LDH) website.

For those with developmental disabilities, who are able to live at home and not in an institution, waiver programs are available. To sign up for waiver programs that offer Medicaid and additional services to eligible persons, including individuals whose income may be too high for traditional Medicaid, you can request a screening to be added to the Developmental Disabilities Request for Services Registry (DDRFSR).

To sign up for waiver programs that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid programs), ask to be added to the DDRFSR. The **New Opportunities Waiver (NOW)** and the **Children's Choice (CC) Waiver** both provide services in the home, instead of in an institution, to persons who have intellectual disabilities and/or other developmental disabilities. Both waivers cover family support, center-based respite, environmental accessibility modifications, and specialized medical equipment and supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. Expanded dental benefits are available for adult NOW beneficiaries. The NOW is only available to individuals who cannot be supported in another Office for Citizens with Developmental Disabilities (OCDD) waiver (CC, Supports Waiver, or Residential Options Waiver (ROW)).

The **CC Waiver** also includes family training. Children remain eligible for the CC Waiver until their twenty-first birthday, at which time they are moved to an age-appropriate waiver for people with developmental disabilities.

The **Supports Waiver** provides specific, activity focused services rather than continuous custodial care. This waiver offers supported employment, day habilitation, pre-vocational services, respite, habilitation, permanent supportive housing stabilization, permanent supportive housing stabilization transition, personal emergency response systems, and expanded dental services for individuals age 18 and older.

The **ROW** is appropriate for those individuals of all ages whose health and welfare can be assured by the support plan with a cost limit based on their level of support need. This waiver offers community living supports, companion care, host home, shared living, one-time transitional services, environmental modifications, assistive technology/specialized medical equipment, personal emergency response systems, center-based respite, nursing, dental, professional (dietary, speech therapy, occupational therapy, physical therapy, social work, psychology), transportation-community access, supported employment, pre-vocational services, day habilitation, housing stabilization, housing stabilization transition services, monitored in home caregiving, and adult day health care (ADHC). Expanded dental benefits are available for adult ROW beneficiaries.

Although not a waiver, services are also available for children ages birth to 3 years. EarlySteps contacts for each parish are listed on this web page:
https://ldh.la.gov/index.cfm/directory/detail/609

SUPPORT COORDINATION

A support coordinator works with you to develop a full list of all the services you need and then helps you get them. This can include things like medical care, therapies, personal care services, equipment, social services and educational services. If you are a Medicaid beneficiary under the age of 21 and if support coordination is medically necessary, you may be eligible to receive support coordination services immediately. Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828. Support coordination is also provided through EarlySteps for eligible children.

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED

Transportation

Non-emergency medical transportation (NEMT) to and from medical appointments is covered under the Medicaid Managed Care program. Medicaid eligible children are enrolled in the Medicaid Managed Care program for their Medicaid transportation services even if they have Legacy Medicaid for their physical health services.

Arrangements for transportation should always be made at least 48 hours in advance by calling the numbers shown below.

Aetna Better Health	1-877-917-4150
AmeriHealth Caritas	1-888-913-0364
Healthy Blue	1-866-430-1101
Humana Healthy Horizons	1-844-613-1638
Louisiana Healthcare Connections	1-855-369-3723
UnitedHealthcare Community	1-866-726-1472

If you are not sure who your managed care organization (MCO) is, you can contact the Medicaid Managed Care Program Line at 1-855-229-6848 to find out under which MCO you are covered.

Applied Behavioral Analysis- Based Therapy Services (ABA)

ABA therapy is the design, implementation and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA-based therapies are based on reliable evidence of their success in alleviating autism and are not experimental. This service is available through Medicaid for persons 0 to 21 years of age. For Medicaid to cover ABA services through a licensed provider they must be ordered by a physician and be prior authorized by Medicaid.

ABA is accessed through your MCO. All Medicaid eligible children are enrolled in the Medicaid Managed Care program for their specialized behavioral health services, even if they may have Legacy Medicaid for their physical health services.

Aetna Better Health	1-855-242-0802
AmeriHealth Caritas	1-888-756-0004
Healthy Blue	1-844-406-2389
Humana Healthy Horizons	1-800-448-3810
Louisiana Healthcare Connections	1-866-595-8133
UnitedHealthcare Community	1-866-658-5499

If you are not sure who your MCO is, you can contact the Medicaid Managed Care Program Line at 1-855-229-6848 to find out under which MCO you are covered**.**

Mental Health and Substance Use Services

Children and youth may receive mental health and substance use services if it is medically necessary. These services include necessary assessments and evaluations; individual, group and/or family therapy; medication management; crisis services; community psychiatric support and treatment; psychosocial rehabilitation; multi-systemic therapy; functional family therapy; homebuilders; assertive community treatment for youth ages 18-20; therapeutic group home; psychiatric residential treatment facility; inpatient psychiatric treatment; and substance use disorder treatment services. In addition, eligible at-risk children and youth may access specialized services, including peer support, short-term respite, and independent living skills building, through the Coordinated System of Care (CSoC) program.

How to Access Mental Health and Substance Use Care

How a person gets these services depends on the type of coverage they have.

If the member is enrolled in a Medicaid Managed Care program, they can access services toll free by calling their plan using the numbers listed below. All Medicaid eligible children are enrolled in Medicaid Managed Care program for their specialized behavioral health services even if they may have Legacy Medicaid for their physical health services.

Aetna Better Health	1-855-242-0802
AmeriHealth Caritas	1-888-756-0004
Healthy Blue	1-844-521-6941
Humana Healthy Horizons	1-800-448-3810
Louisiana Healthcare Connections	1-866-595-8133
UnitedHealthcare Community	1-866-658-5499

If you are not sure who your MCO is you can contact the Medicaid Managed Care Program Line at 1-855-229-6848 to find out under which MCO you are covered.

If a member is part of the CSoC that helps at-risk children and youth who have serious behavioral health challenges, they can access services by contacting Magellan at 1-800-424-4489/TTY 1-800-424-4416. CSoC offers services and supports that help children and youth return remain at home. Services include youth support and training; parent support and training; independent living skill building services; and short-term respite, as well as all other Medicaid State Plan behavioral health services. Parents and guardians will be assisted in selecting a provider in their area to best meet the needs of the child or youth and the family. Members may apply for CSoC by contacting their MCO and requesting referral to CSoC. The MCO will transfer the caller to Magellan for a brief Child and Adolescent Needs Assessment (CANS) screening. If the youth screens positive on the brief CANS assessment, Magellan will connect you to the regional wraparound agency for further assessment.

The rest of your medical services will either be accessed through Legacy Medicaid if you have Legacy Medicaid for your physical health services or through your MCO if you chose to "opt in" to the Medicaid Managed Care program for your physical health services.

Chisholm Class members (Medicaid eligible children who are on the DDRFSR are allowed to participate in the Medicaid Managed Care program if they "opt in." For more information about these options, contact the Medicaid Managed Care program hotline toll free at 1-855-229-6848.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Exams and Checkups

Medicaid beneficiaries under the age of 21 are eligible for checkups ("EPSDT preventive screening"). These screenings include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; developmental screening; autism screenings; perinatal depression screening; and dental screenings. They are available both on a regular basis and whenever additional health treatment or services are needed.

EPSDT preventive screening may help to find problems which need other health treatment or additional services. Beneficiaries under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures covered under federal Medicaid statutes and regulations to correct or improve physical or mental conditions. Services may include those not otherwise covered by Louisiana Medicaid for beneficiaries age 21 and older, unless prohibited or excluded.

Personal Care Services

Personal care services (PCS) are provided by direct service workers (DSWs) and defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing,

locomotion, personal hygiene, and bladder or bowel requirements. PCS does not include medical tasks such as medication administration, tracheostomy care, or feeding tube or catheter management. The Medicaid Home Health program or Extended Home Health program provides those medical services. PCS must be ordered by a practitioner (physician, advance practice nurse, or physician assistant). The PCS provider must request approval for the service from Medicaid or the MCO.

Extended Skilled Nursing Services

Children and youth may be eligible to receive skilled nursing (over three hours per day) in the home. These services are provided by a home health agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid or the MCO.

Intermittent Nursing Services

Nursing visits to EPSDT individuals that do not exceed three hours per day may be provided without a prior authorization request unless more than one nursing visit a day is needed. These services must still be ordered by a physician and provided by a home health agency.

Pediatric Day Health Center

These centers serve medically fragile individuals under the age of 21, including technology dependent children, who require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition. These facilities offer an alternative or supplement to receiving in-home nursing care. Pediatric day health care (PDHC) may be provided up to seven days per week and up to 12 hours per day as documented by the beneficiary's plan of care (POC).

Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services

If a child or youth requires rehabilitation services such as physical, occupational or speech therapy, psychology, or audiology services, these services can be provided at school, through the EarlySteps early intervention program, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs.

For Medicaid to cover these services at school (ages 3 to 21), or through the early intervention program with EarlySteps (ages birth to 3), the services must be part of the Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid or the MCO.

For information on receiving these therapies contact your school or early intervention center or other providers. EarlySteps contacts for each parish are listed on this web page: https://ldh.la.gov/index.cfm/directory/detail/609. Call the Specialty Care Resource Line for referral assistance at 1-877-455-9955 for Legacy Medicaid or call your MCO using the contacts listed above under Mental Health to locate other therapy providers.

Medical Equipment and Supplies

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical equipment and supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid or the MCO.

If you need a service that is not listed above contact the Specialty Care Resource Line toll-free at 1-877-455- 9955 or TTY 1-877-544-9544 or the participant's MCO Member Services or Medicaid managed care case manager.

ACRONYMS/DEFINITIONS

Beneficiary - An individual who has been certified for medical benefits by the Medicaid Program.

Bureau of Health Services Financing (BHSF) - The division within the Department of Health and Hospitals responsible for the administration of the Medicaid program.

Center for Medicare and Medicaid Services (CMS) - The federal organization that administers the Medicare program and oversees and monitors the state Medicaid program.

Change in Ownership (CHOW) - Any change in the legal entity responsible for the operation of a provider agency.

Crossover Medicare/Medicaid Claims - Claims received on a Medicaid-eligible beneficiary who has both Medicare and Medicaid coverage.

Electronic Data Interchange (EDI) - The communication of data from one computer system to another computer system**.**

Electronic Funds Transfer (EFT) - The payment of Medicaid claims that are deposited directly into a provider's bank account.

Electronic Media Claims (EMC) - The process used to file claims electronically**.**

Employer Identification Number (EIN) - A number assigned to a business by the Internal Revenue Service (IRS). Also known as a Federal Taxpayer Identification Number (TIN).

Explanation of Benefits (EOB) - It provides detailed information about the services a person has used. It is not a bill.

Explanation of Medicare Benefits (EOMB) - A notice sent to providers informing them of the services which have been paid by Medicare.

Fiscal Intermediary (FI) - The fiscal agent contracted by LDH to operate the Medicaid Management Information System. It processes Medicaid claims for services provided under the Medicaid Program and issues appropriate payment.

Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule - A federal regulation which is designed to establish uniformity and standards for transmission, storage and handling of data.

Internal Control Number (ICN) - The **unique** 13-digit number given to each claim for tracking purposes.

Louisiana Department of Health (LDH) - The state agency responsible for administrating the Medicaid Program and health and related services including public health, mental health, and developmental disabilities.

Mandatory Services - Services required by the federal government that each state must provide under Medicaid.

Medicaid - A federal-state medical assistance entitlement program provided under a State plan approved under Title XIX of the Social Security Act.

Medicaid Card - A medical eligibility card issued to each eligible beneficiary.

Medicaid Management Information System (MMIS) - The computerized claims processing and information retrieval system, which includes all providers eligible for participation in the Medicaid Program. This system is an organized method of payment for claims for all Medicaid services. It includes all Medicaid providers and beneficiaries.

Medical Assistance Program Law (MAPIL) - MAPIL outlines the provisions related to provider agreement.

Medically Needy - A medical program designed to provide Medicaid coverage when an individual's or family's income and/or resources are sufficient to meet basic needs in a categorical assistance program but not sufficient to meet medical needs according to Medically Needy Program standards.

Medicare - The health insurance program designed for aged and disabled under Title XVIII of the Social Security Act.

Optional Services - Services states choose to provide to Medicaid beneficiaries. These services must be approved by CMS.

Pay and Chase - Recovery of full or partial payment from a financially responsible third party after Medicaid has paid the claim.

Provider - Any individual or entity responsible for furnishing Medical services under a provider agreement with the Medicaid Program.

Provider Agreement - A contract between the provider of services and the Bureau of Health Services Financing that specifies responsibilities with respect to the provision of services and payment under the Title XIX Medicaid Program.

Provider Enrollment (PE) - The act of registering a licensed provider into the computerized system for payment of eligible services under the Medical Assistance Program. Enrollment includes the execution of the provider agreement and assignment of the provider number used for payment.

Remittance Advice - A list of all claims paid, pending, or denied during a particular payment period.

Revision Index - The form issued with each manual chapter to document chapter revisions.

Spend – Down - A term used to describe a group in the Medically Needy Program. The income for these Medicaid applicants/beneficiaries is above the Medically Needy Income Eligibility Standards but they may qualify for the Medically Needy Program on the basis that countable income has been spent or is obligated to pay unpaid medical expenses.

Third Party Liability (TPL) - Refers to the responsibility of another payer (Medicare, insurance, etc.) to pay benefits for services before Medicaid pays. Medicaid is generally the payer of last resort.

Group Linkages Definitions

Individuals who meet all enrollment requirements. This number is then used for billing purposes.

Professional Group Provider Number – a seven-digit Medicaid provider number issued to any professional group who meets all eligibility requirements. This number is then used for billing purposes.

Linkages of Professionals to Groups – an individual practitioner's provider number can be "linked" to a group provider number for purposes of billing services furnished through the relationship between the individual practitioner and the group. Claims submitted under the group number, with an individual's practitioner's provider number included as the attending provider, will be processed and the remittance will be sent directly to the group's pay-to address. It is not necessary for the individual practitioner's pay-to address to be the same as the group's pay-to address for these remittance advice notices to be sent to the group.

CONTACT/REFERRAL INFORMATION

Gainwell Technologies

The Medicaid program's fiscal intermediary, Gainwell Technologies can be contacted for assistance with the following:

TYPE OF ASSISTANCE	CONTACT INFORMATION
e-CDI technical support	Gainwell Technologies (877) 598-8753 (Toll Free)
Electronic Media Interchange (EDI) Electronic claims testing and assistance	P.O. Box 91025 Baton Rouge, LA 70898 Phone: (225) 216-6303 Fax: (225) 216-6335
Pre-Certification Unit (Hospital) Pre-certification issues and forms	P.O. Box 14849 Baton Rouge, LA 70809-4849 Phone: (800) 877-0666 Fax: (800) 717-4329
Pharmacy Point of Sale (POS)	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) **After hours, please call REVS*
Prior Authorization Unit (PAU)	Gainwell Technologies – Prior Authorization P.O. Box 14919 Baton Rouge, LA 70898-4919 Phone: (800) 488-6334 Fax: (225) 216-6476
Provider Enrollment Unit (PEU)	Gainwell Technologies-Provider Enrollment P. O. Box 80159 Baton Rouge, LA 70898-0159 Phone: (225) 216-6370 Fax: (225) 216-6392
Provider Relations Unit (PR)	Gainwell Technologies – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
Recipient Eligibility Verification (REVS)	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)

Louisiana Department of Health (LDH)

TYPE OF ASSISTANCE	CONTACT INFORMATION
General Medicaid Information	General Hotline (888) 342-6207 (Toll Free) www.lamedicaid.com
Division of Fiscal Management – Payment Management	P.O. Box 91117 Baton Rouge, LA 70821-9117 Phone: (225) 342-4163 Fax: (225) 342-4478
Health Standards Section (HHS) Licensing Standards	P.O. Box 3767 Baton Rouge, LA 70821 Phone: (225) 342-0138 Fax: (225) 342-5073 http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1623
Long Term Care Facility Care Home and Community-Based Care	P.O. Box 91030 Baton Rouge, LA 70821-9030 **Phone:** (877) 456.1146 **Fax:** (225) 342-9508 http://dhh.louisiana.gov/index.cfm/page/234
Louisiana Children's Health Insurance Program (LaCHIP)	(225) 342-0555 (Local) (877) 252-2447 (Toll Free) http://new.dhh.louisiana.gov/index.cfm/page/222
Medicaid /Card Questions	**Toll Free:** 1-800-834-3333 http://new.dhh.louisiana.gov/index.cfm/faq/category/72
MMIS Retroactive Reimbursement Unit	P.O. Box 91030 Baton Rouge, LA 70821-9030 **Phone:** (225) 342-1739 **Toll Free:** 1-866-640-3905 http://dhh.louisiana.gov/index.cfm/page/1202

LDH continued

Office of Aging and Adult Services (OAAS) Waiver Assistance and Complaints	P.O. Box 2031 Baton Rouge, LA 70821-2031 Phone: (866) 758-5035 Fax: (225) 219-0202 E-mail: OAASInquiries@dhh.la.gov http://dhh.louisiana.gov/index.cfm/subhome/12/n/327
Office of Behavioral Health	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: 225-342-2540 Fax: 225-342-1972 or 225-342-1973 Toll-free fax: 1-866-427-2148 http://www.mbhsla.org * See web MBHS website for additional contact information
Office for Citizens with Developmental Disabilities (OCDD)	P.O. Box 3117 Baton Rouge, LA 70821-3117 Phone: (225) 342-0095 (Local) Phone: (866) 783-5553 (Toll-free) E-mail: ocddinfo@la.gov http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8
OCDD – Region I - Metropolitan Human Services District (Serving Orleans, Plaquemines and St. Bernard parishes)	1010 Common Street, 5th Floor, Suite 550 New Orleans, LA 70112 **Phone:** (504) 599-0245 **Fax:** (504) 568-4660 **Toll Free:** 1-800-889-2975
OCDD – Region II - Capital Area Human Services District (Serving Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge and West Feliciansa parishes)	4615 Government St. – Building 2, Bin#16 Baton Rouge, LA 70806 **Phone:** (225) 925-1910 **Fax:** (225) 925-7080 **Toll Free:** 1-800-768-8824 www.cahsd.org
OCDD – Region III - South Central Human Services Authority (Serving Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne parishes)	1000 Plantation Road, Suite E Thibodaux, LA 70301 **Phone:** (985) 449-5167 **Fax:** (985) 449-5180 **Toll Free:** 1-800-861-0241

LDH Continued

OCDD – Region IV – Acadiana Area Human Service District (Serving Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermillion parishes)	302 Dulles Drive Lafayette, LA 70506-3008 **Phone**: (337) 262-5610 **Fax:** (337) 449-4761 **Toll Free:** 1-800-648-1484
OCDD – Region V – Imperial Calcasieu Human Services District (Serving Allen, Beauregard, Calcasieu, Cameron, and Jeff Davis parishes)	3501 Fifth Avenue, Suite C2 Lake Charles, LA 70607 **Phone:** (337) 475-8045 **Fax:** (337) 475-8055 **Toll Free:** 1-800-631-8810
OCDD – Region VI - Central Louisiana Human Services District (Serving Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn parishes)	429 Murray Street – Suite B Alexandria, LA 71301 **Phone:** (318) 484-2347 **Fax:** (318) 484-2458 **Toll Free:** 1-800-640-7494
OCDD – Region VII - Northwest Louisiana Human Services District (Serving Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, and Webster parishes)	3018 Old Minden Road – Suite 1211 Bossier City, LA 71112 **Phone:** (318) 741-7455 **Fax:** (318) 741-7487 **Toll Free:** 1-800-862-1409
OCDD - Region VIII - Northeast Delta Human Services Authority (Serving Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll parishes)	122 St. John St. – Rm. 202 Monroe, LA 71201 **Phone:** (318) 362-3396 **Fax:** (318) 362-5306 **Toll Free:** 1-800-637-3113
OCDD – Region IX - Florida Parishes Human Services Authority (Serving Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington parishes)	835 Pride Drive – Suite B Hammond, LA 70401 **Phone:** (985) 543-4730 **Toll Free:** 1-800-866-0806 www.fphsa.org

LDH Continued

OCDD – Region X - Jefferson Parish Human Services Authority (Serving Jefferson parish)	3610 S 1-10 Service Road Metairie, LA 70002 **Phone:** (504) 838-5357 **Fax:** (504) 838-5400
Office of Management and Finance (Bureau of Health Services Financing) - MEDICAID	P.O. Box 91030 Baton Rouge, LA 70810-9030 http://new.dhh.louisiana.gov/index.cfm/subhome/1
Provider Support Center	http://www.lamedicaid.com/provweb1/default.htm
Rate Setting and Audit Hospital Services	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: 225-342-0127 225-342-9462
Recovery and Premium Assistance TPL Recovery, Trauma	P.O. Box 3588 Baton Rouge, LA 70821 Phone: (225) 342-8662 Fax: (225) 342-1376
Take Charge Plus	P.O. Box 91030 Baton Rouge, LA 70821 Phone: (888) 342-6207 www.MakingMedicaidBetter.com
Take Charge (Family Planning Waiver)	P.O. Box 91278 Baton Rouge, LA 70821 Phone: (888) 342-6207 Fax: (877) 523-2987 medweb@la.gov http://new.dhh.louisiana.gov/index.cfm/page/232

Fraud Hotline

TYPE OF ASSISTANCE	CONTACT INFORMATION
To report fraud	Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://dhh.louisiana.gov/index.cfm/page/219

Appeals

TYPE OF ASSISTANCE	CONTACT INFORMATION
To file an appeal	Division of Administrative Law (DAL) - Health and Hospitals Section Post Office Box 4189 Baton Rouge, LA 70821-4189 Phone: (225) 342-0263 Fax: (225) 219-9823

Other Helpful Contact Information:

TYPE OF ASSISTANCE	CONTACT INFORMATION
Centers for Medicare and Medicaid	www.cms.hhs.gov
Excluded Parties List System (EPLS) Verification of exclusion or restriction from government funded health program	http://www.epls.gov/
Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP)	http://www.gohsep.la.gov
Health Management Systems (HMS) Third party liability collections contractor	Phone: (888) 831-2715 (214) 453-3000 http://www.hms.com/
Office of Inspector's General (OIG)	http://oig.louisiana.gov/
Office of Population Affairs (OPA) Clearinghouse	P.O. Box 30686 Bethesda, MD 20824-0686 Phone: 866-640-7827 Fax: 866-592-3299 E-mail: Info@OPAclearinghouse.org
Superintendent of Documents Forms	http://www.gpo.gov/ Phone: (202) 512-1800

REVISION HISTORY LOG

Revised/ Issued Date	Section #	Section Title	Page #	Reason for Revision
mm/dd/yy	3.0	Medicaid Identification Cards	5	Updated Take Charge ID card information
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