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, link 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, link 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 from this web site, link Provider Enrollment. 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. A remittance advice 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 he or she was 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 REVS or 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 Beneficiary 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 (MCO or 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 the 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 remittance advice, 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. Effective with processing date March 1, 2008, 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, link "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 remittance advice 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 remittance advice (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, link – Weekly Remittance Advices, on Tuesdays of each week. This link is located on the secure web portal. 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 electronic remittance advice (RA) 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 a Remittance Advice 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 Remittance Advice, a corrected claim may be resubmitted (if applicable).

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

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 Remittance Advice under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

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

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

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