LOUISIANA MEDICAID PROGRAM

CHAPTER 32: NEW OPPORTUNTIES WAIVER

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CLAIMS FILING

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

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

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

Paper claims should be submitted to:

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

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers, or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

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

This appendix includes the following:

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

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CMS 1500 (02/12) INSTRUCTIONS FOR HOME AND COMMUNITY – BASED WAIVER SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	Situational – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	

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Locator #	Description	Instructions	Alerts
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabelled	Situational – Complete if applicable.	
17b	NPI	Situational – Complete if applicable.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

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Locator #	Description	Instructions	Alerts
21	ICD Ind. Diagnosis or Nature of Illness or Injury	Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM Required – Enter the most current ICD diagnosis code. NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable. Louisiana Medicaid currently accepts ICD-9-CM codes. The acceptance of ICD- 10-CM codes will be announced at a later date.
22	Resubmission Code	Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	Effective with date of processing 5/19/14 providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12). To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization Number	Required – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational	
24A	Date(s) of Service	Required Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	Required Enter the appropriate place of service code for the services rendered.	

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Locator #	Description	Instructions	Alerts
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	Required Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required . Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional .	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional . Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	

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

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

A sample form is on the following page

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SAMPLE WAIVER CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMI	ORM TTEE (NUCC) 02/12							
PICA								PICA
1. MEDICARE MEDICAID TRICARE (Medicare #) X (Medicaid #) (ID#/DoD#)	CHAMPVA (Member ID	HEALTH PLA	FECA AN BLKLUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. N 987654321012		(F	For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle		3. PATIENT'S BIRT	H DATE SEX		4. INSURED'S NAME		, First Name, Midd	le Inital)
JAYCO, TRAVIS 5. PATIENT'S ADDRESS (No., Street)		07 31	72 M X	F	7. INSURED'S ADDRE	SS /No S	froot)	
5. PATIENT 5 ADDRESS (No., STEET)		Self Spouse		ED her	7. INSURED SADDRE	:55 (140., 5)	2001)	
СПҮ	STATE	8. RESERVED FOR	NUCC USE		СПҮ			STATE
ZIP CODE TELEPHONE (Inclu	ide Area Code)				ZIP CODE		TELEPHONE (Ind	lude Area Code)
()							()	
9. OTHER INSURED'S NAME (Last Name, First Name	e, Middle Initial)	10. IS PATIENT'S	CONDITION RELATE	D TO:	11. INSURED'S POLIC	Y GROUP	OR FECA NUMBE	iR
a. OTHER INSURED'S POLICY OR GROUP NUMBER	R		(Current or Previous)		a. INSURED'S DATI MM DD			SEX
b. RESERVED FOR NUCC USE		YE b. AUTO ACCIDEN	ES NO T? PLA	.CE (State)	b. OTHER CLAIM ID (I	Designated	M by NUCC)	F
				(Olaro)				
C. RESERVED FOR NUCC USE		c. OTHER ACCIDE			c. INSURANCE PLAN	NAME OR I	PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		YES NO 10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHE	R HEALTH	BENEFIT PLAN?	
					YES NO <i>If yes</i> , complete items 9, 9a and 9c			is 9, 9a and 9d.
 PATIENT'S OR AUTHORIZED PERSON'S SIGNA' to process this claim. I also request payment of gove below. 	mment benefits either to	o myself or to the part	y who accepts assignm	nent	services described	below.	rtie undersigned p	ohysician or supplier for
SIGNED			\mathbf{F}	RN				
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ADJUSTING/VOIDING CLAIMS

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

<u>Only a paid claim can be adjusted or voided</u>. Denied claims must be corrected and resubmitted – <u>not adjusted or voided</u>.

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

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

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

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

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

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

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

Adjustments/Voids Appearing on the Remittance Advice

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.

LOUISIANA MEDICAID PROGRAM

ISSUED: 0 REPLACED: 0

04/30/14 03/01/11

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

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

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

A sample form is on the following page

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SAMPLE WAIVER CLAIM FORM ADJUSTMENT

	OT AN OLDAIN	COMMITTE	E (NUCC) 02/12								PICA
1. MEDICARE MEDICA		ICARE	CHAMPV	GROUP	FECA AN BLKLUN	OTHER	1a. INSURED'S	I.D. NUMBE	R	(Fo	or Program in Item 1)
(Medicare #) X (Medicaid		#/DoD#)	(Member I	D#) (ID#) 3. PATIENT'S BIR	(ID#)	(ID#) SEX	98765432 4. INSURED'S		Name First No	Middle	a Inifal)
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5. PATIENT'S ADDRESS (No.,	Street)			6. PATIENT RELA			7. INSURED'S	ADDRESS (N	lo., Street)		
СПҮ			STATE	8. RESERVED FOR		Other	СПҮ				STATE
				-			710.00.05				
ZIP CODE	(NE (Include A	rea Code)				ZIP CODE		(10 NE (Indu)	ude Area Code)
9. OTHER INSURED'S NAME	(Last Name, F	/ First Name, Mi	ddle Initial)	10. IS PATIENT'S	CONDITION REL	ATED TO:	11. INSURED'S	POLICY GR	OUP OR FEC	A NUMBER	R
								P DATE OF I			SEX
a. OTHER INSURED'S POLIC	F OR GROUP	NUMBER		a. EMPLOYMENT	? (Current or Previ /ES NO		a. INSURED MM	DD Y	Y	м	F
b. RESERVED FOR NUCC US	ε			b. AUTO ACCIDEI	NT?	PLACE (State)	b. OTHER CLA	IM ID (Design	nated by NUC	C)	
c. RESERVED FOR NUCC US	F			-	res NG	° — — —	c. INSURANCE	PLAN NAME	OR PROGR	AM NAME	
C NEGENVED FOR NOUG US	-			c. OTHER ACCIDI	ENT? (ES NO)		- served interval	_ stringen	and a scheme	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE			d. IS THERE A	NOTHER HE	ALTH BENEFI	IT PLAN?	
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 PATIENT'S OR AUTHORIZ to process this claim. I also re below. 	ED PERSON'S equest payment	S SIGNATUR nt of governme	E lauthorize the nt benefits either t	release of any med to myself or to the pa	ical or other inform rty who accepts as	ation necessary signment		medical bene scribed below		ersigned ph	nysician or supplier for
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17. NAME OF REFERRING PR		OTHER SOU	RCE 17a.			OIAL	18. HOSPITALI	I I	ES RELATED	TOCURRI	ENT SERVICES
			7 1b.	NPI			FROM			то	
19. ADDITIONAL CLAIM INFO	RMATION (De	sign ated by N	IUCC)				20. OUTSIDE L YES	AB? NO	\$	CHARGES	
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