

# UNİSYS

# IMPLEMENTATION OF CHANGES IN PROCESSING AND PAYMENT METHODOLOGY FOR THIRD PARTY LIABILITY (TPL) CLAIMS PAYMENT

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LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

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#### THIRD PARTY LIABILITY OVERVIEW

Federal regulations and applicable state laws require that third-party resources be used before Medicaid is billed. *Third-party* refers to those payment resources available from other liable sources, including but not limited to both private and public health insurance, which can be applied toward the Medicaid recipient's medical and health expenses.

It is the responsibility of each provider to verify the recipient's eligibility prior to providing services. Information concerning other insurance coverage is presented in the eligibility response if it appears on that recipient's Medicaid file.

All insurance companies appearing on the Medicaid Resource file are assigned a TPL Carrier Code for billing purposes. When other insurance is present on the eligibility response, providers should obtain the TPL carrier code(s) for the name of the third-party insurance carrier from the TPL Carrier Code listing. The TPL carrier code listing is located on the LA Medicaid website at www.lamedicaid.com under "Forms/Files/User Guides".

If the insurance information provided in the eligibility response is not correct, the provider should:

- (1) Instruct the recipient to contact his/her parish worker to correct the file to either add or terminate the coverage if the insurance has been canceled; OR
- (2) Submit a request to the LA Medicaid TPL Unit to have the recipient's resource file updated.

Claims submitted for recipients with primary insurance will deny unless the applicable instructions are followed to indicate the insurance coverage information correctly on the claim.

In most cases it is the provider's responsibility to bill the third-party carrier prior to billing Medicaid. In those situations where the insurance payment is received after Medicaid has been billed and has made payment, the provider must reimburse Medicaid, not the recipient. Reimbursement must be made immediately to comply with federal regulations.

**NOTE**: The absence of other coverage on the eligibility response does not negate the provider's responsibility to ask the recipient if he/she has other insurance coverage.

**NOTE:** Once a recipient is accepted as a Medicaid recipient, the provider MAY NOT pick and choose the services he will bill to Medicaid, regardless of TPL payment/coverage or any other criteria. All Medicaid covered services must be billed to Medicaid.

#### **ELIGIBILITY DETERMINATION**

It is the provider's responsibility to always verify recipient eligibility prior to providing services.

All recipients enrolled in Louisiana's Medicaid Program are issued permanent **Plastic Identification Cards**. These permanent identification cards contain a card control number (CCN) which can be used by the provider to verify Medicaid eligibility. The Department of Health and Hospitals (DHH) offers several options to assist providers with verification of current eligibility. Use of these options will require provider verification. The following eligibility verification options are available:

- 1. e-MEVS, a web application accessed through www.lamedicaid.com
- 2. Medicaid Eligibility Verification System (MEVS), an automated eligibility verification system using a swipe card device or PC software through vendors.
- 3. Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system
- 4. Pharmacy Point of Sale (POS).

#### These eligibility verification systems provide confirmation of the following:

- Recipient eligibility
- Third Party (Insurance) Resources
- Service limits and restrictions
- CommunityCARE
- Lock-In

The eligibility response will not only confirm the recipient's eligibility and whether the recipient has other insurance, but it will also indicate any special information related to the recipient's enrollment.

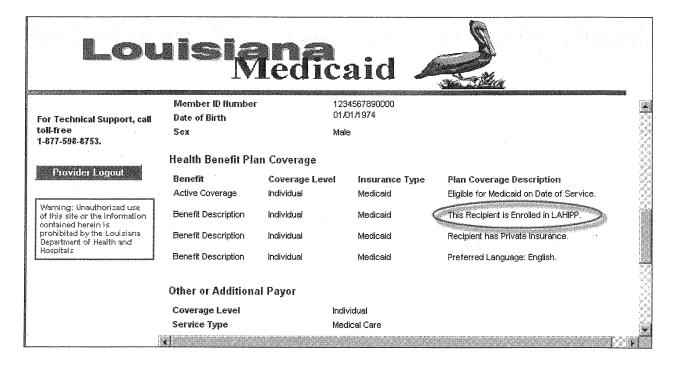
The focus of this training packet relates to changes to the processing and payment of Third Party Liability (TPL) claims, including changes related to revised payment of TPL claims for recipients enrolled through the Louisiana Health Insurance Premium Payment Program (LAHIPP). Under Section 1906 of the CMS regulations, LA Medicaid is required to pay the patient responsibility (co-pays, co-insurances, and deductibles) on TPL claims for these recipients. Of the estimated 46,000 Medicaid recipients with other insurance reported on the Medicaid files, approximately 2,200 (5%) are LAHIPP recipients.

LAHIPP eligibles will be identified by the response, "This recipient is enrolled in LAHIPP". This information will allow you to determine the payment methodology used to process and pay TPL claims.

#### SAMPLE OF MEVS ELIGIBILITY RESPONSE SCREEN

MEVS response screen formats may vary based on application used, vendors, etc. However, the response description for LAHIPP recipients will be presented as indicated above.

A sample response screen follows:



## EXISTING TPL BILLING PROCEDURES AND PAYMENT METHODOLOGY

Until March 1, 2008, Louisiana Medicaid processes and pays TPL claims for recipients with private insurance using the following processes and payment methodology:

#### **CLAIMS COMPLETION/PROCESSING:**

When billing Medicaid after receiving an Explanation of Benefits (EOB) from a TPL carrier, the providers:

- Submit the claim hard copy.
- Attach a copy of the EOB, making sure any remarks/comments/edit descriptions from the other insurance company are legible and attached.
- Enter the six-digit carrier code assigned by Medicaid in the correct block on the claim form (except Medicare).
- Enter the amount the other insurance company paid (including contractual adjustments) in the appropriate block on the claim form (except for Medicare).
- 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.
- All Medicaid requirements such as pre-certification or prior authorization **must** be met before payment will be considered.

**NOTE**: Claims submitted where the billing information does not match the EOB should be sent to the Provider Relations Correspondence Unit with a cover letter explaining the discrepancy.

#### PAYMENT METHODOLOGY

Until March 1, 2008, LA Medicaid uses a "spend-down" cost comparison methodology to process and pay TPL claims after reimbursement is made by the TPL carrier.

The TPL payment amount indicated on the TPL EOB is <u>not</u> applied by claim line item as the primary payor processed the claim. The total TPL payment amount indicated in "prior payments" on the claim form is applied against the Medicaid allowable for each procedure beginning with the first line on the claim form until it is "spent down". Although the entire TPL payment is applied to the claim document, in many instances, the payment amount applied to the claim line by the primary payor is not the amount applied by Medicaid. This also allows some claim lines to be processed without application of appropriate payment, and Medicaid overpayments occur.

**NOTE:** This calculated payment methodology is not applied to certain types of claims.

## IMPLEMENTATION OF NEW MEDICAID CLAIMS PROCESSING AND PAYMENT METHODOLOGY FOR TPL CLAIMS

#### CLAIMS COMPLETION/PROCESSING CHANGES FOR TPL CLAIMS

Effective with **processing date** March 1, 2008, Louisiana Medicaid will process TPL claims differently for all recipients, and the payment calculation will change. Initially, this change is effective for physician, hospital outpatient and inpatient claims, and DME claims. All other providers will be notified through RA messages and web notices when this change will be effective for them.

Only minor changes are being made to the claim completion process.

**NOTE:** This transition does not include Medicare Crossover, Pharmacy claims, or specific service claims such as immunizations that are paid at "0".

#### HARD COPY CLAIMS

As indicated above with existing processing, providers must continue to:

- Submit the claim hard copy
- Attach a copy of the EOB, making sure any remarks/comments/edit descriptions from the other insurance company are legible and attached.
- Enter the correct six-digit carrier code assigned by Medicaid in the correct block on the claim form (except Medicare).
- 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.
- All Medicaid requirements such as pre-certification or prior authorization **must** be met before payment will be considered.

#### The change in claims completion follows:

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

IMPORTANT NOTE: Providers must ensure that the correct, accurate EOB is attached to each TPL claim form; that EOB copies are clear, complete, and readable; and that the description of EOB edits is attached.

#### **ELECTRONIC CLAIMS (EDI)**

Effective with **processing date** April 1, 2008, Louisiana Medicaid will accept and process TPL claims submitted electronically by physician and DME providers. It will no longer be necessary for these providers to submit TPL claims hard copy with EOBs attached. This effective date is tentative for hospital inpatient and outpatient claims.

Providers must enter the <u>appropriate and accurate</u> information from the primary payor 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, <a href="https://www.lamedicaid.com">www.lamedicaid.com</a>, link "HIPAA Billing Instructions and Companion Guides". Choose the appropriate Companion Guide applicable to the 837 transaction to be submitted.

Questions concerning EDI transmissions may be directed to the Unisys EDI Department at (225) 216-6000, Option 2.

#### PAYMENT METHODOLOGY

With this transition, the processing procedures and payment methodology for calculating TPL claims will change. Unisys will process these claims **as processed by the primary payor**. The payment information indicated on the primary payor EOB will be used to process the claim.

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

#### **Payment Changes for LAHIPP Claims**

For recipients enrolled in LAHIPP, once the claim has been processed and paid by the primary carrier, LA Medicaid now processes and pays the full patient responsibility (co-pay, co-insurance, and/or deductible) - regardless of Medicaid's allowed amount, billed charges, or TPL payment amount. However, recipients 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 payor.

#### Payment of Non-LAHIPP Secondary Claims

Medicaid will use the revised cost comparison methodology to pay TPL claims for Non-LAHIPP recipients with primary insurance. TPL claims will be processed as processed by the primary payor, and TPL payment amount will be applied just as the primary payor indicates on the EOB. If there is only a total TPL amount on the EOB, "spend down" methodology will continue to occur.

The payment will be made based on the lesser of (1) Medicaid allowed amount minus TPL payment, OR (2) 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, co-insurance and/or deductible. If co-pay, co-insurance and/or deductible are not owed, Medicaid will zero pay the claim.

An example of the difference between LAHIPP and Non-LAHIPP recipient payments follows.

#### Example of Claims Payment for LAHIPP vs. Non-LAHIPP Recipients

Procedure Code -	99213
Provider Billed Amount -	\$ 70.00
Private Insurance Allowable -	\$ 50.00
Private Insurance Payment -	\$ 40.00
Patient Responsibility (Co-Pay) -	\$ 10.00

#### **LAHIPP** Recipient

Medicaid Allowable	\$ 36.13
TPL Payment	-40.00
	- 3.87

Medicaid Payment \$ 10.00

(Because this is a LAHIPP recipient, Medicaid pays the co-pay even though the private insurance payment is more than the Medicaid allowable. Medicaid pays the patient responsibility on Medicaid covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.)

#### Non-LAHIPP Recipient

#### Cost Comparison - The LESSER of:

Medicaid Allowable	\$36.13
TPL Payment	<u>- 40.00</u>
	- 3.87
<u>OR</u>	
Patient Responsibility (Co-Pay)	\$10.00
EQUALS	

Medicaid Payment - \$ 0.00

(Medicaid "zero pays" the claim. When cost-compared, the private insurance paid more than Medicaid's allowable for the procedure. When cost compared, the <u>lesser of</u> the Medicaid allowable minus the TPL payment OR the patient co-pay is the former; thus, no further payment is made by Medicaid. The claim is paid in full.)

NOTE: Providers must remember that the same procedure/service may be paid differently based on whether the recipient is LAHIPP or non-LAHIPP.

#### **OTHER CLAIM EXAMPLES**

See Appendix A of this packet for the claim examples that correspond with the scenarios presented below.

Please note that all information below, including the patient responsibility, can be found on the TPL EOB.

#### Professional Example #1

See pages 24-25 of Appendix A for the corresponding claim example and accompanying EOB.

#### LAHIPP Recipient

Procedure	Billed	TPL Paid	Medcaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	Payment
99212	55.00	0	24.10	36.00 (Ded)	36.00
83655-QW	30.00	0	11.37	28.20 (Ded)	28.20
Totals	85.00	0	35.47	64.20 (Ded)	64.20

(Medicaid is required to pay the co-pay, co-insurance, and/or deductible for Medicaid covered services for LAHIPP recipients, regardless of Medicaid's allowable, billed charges, or TPL payment amount.)

#### Non-LAHIPP Recipient

Procedure	Billed	TPL Paid	Medcaid Allowed Amount	Patient	Medicaid
Code	Charge	Amount		Responsibility	Payment
99212	55.00	0	24.10	36.00 (Ded)	24.10
83655-QW	30.00	0	11.37	28.20 (Ded)	11.37
Totals	85.00	0	35.47	64.20 (Ded)	35.47

(Medicaid pays the allowed amount minus TPL payment OR total patient responsibility amount (co-pay, co-insurance, and/or deductible) for Non-LAHIPP recipients. The Medicaid allowed amount minus the TPL paid amount is LESS THAN the Patient Responsibility; thus, the Medicaid allowed amount is the payment.)

#### Professional Example #2

See pages 26-27 of Appendix A for the corresponding claim example and accompanying EOB.

#### LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medcaid Allowed Amount	Patient Responsibility	Medicaid Payment
99436	250.00	49.50	0 (non-covered)	33.00 (Coins)	0
99433	65.00	20.46	45.00 `	13.64 (Coins)	13.64
99433	65.00	20.46	45.00	13.64 (Coins)	13.64
99238	115.00	44.88	28.80	29.92 (Coins)	29.92
Totals	495.00	135.30	118.80	90.20 (Coins)	57.20

(At this time, procedure code 99436 is not covered by LA Medicaid; thus, Medicaid will pay nothing on this procedure even though this recipient is LAHIPP. The co-insurance is paid for procedures 99433 and 99238 because this is a LAHIPP recipient.)

#### Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medcaid Allowed Amount	Patient Responsibility	Medicaid Payment
99436	250.00	49.50	0 (non-covered)	33.00 (Coins)	0
99433	65.00	20.46	45.00	13.64 (Coins)	13.64
99433	65.00	20.46	45.00	13.64 (Coins)	13.64
99238	115.00	44.88	28.80	29.92 (Coins)	0
Totals	495.00	135.30	118.80	90.20 (Coins)	27.28

(At this time, procedure code 99436 is not covered by LA Medicaid; thus, Medicaid will pay nothing on this procedure. The co-insurance is paid for procedures 99433 because the Medicaid Allowed Amount minus the TPL payment is greater than the coinsurance amount. The LESSER is paid. Procedure 99238 is paid at zero because the Medicaid Allowed Amount minus the TPL payment is -16.08 which is less than the co-insurance amount of 29.92.)

#### **Outpatient Example #1**

See pages 28-29 of Appendix A for the corresponding claim example and accompanying EOB.

#### **LAHIPP Recipient**

Procedure	Billed	TPL Paid	Medicaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	Payment
HR270	99.25	74.44	22.04	0	0
HR450	316.25	137.19	70.24	100.00	100.00
Totals	415.50	211.63	92.28	100.00	100.00

(The 100.00 deductible for this claim is paid because this is a LAHIPP recipient.)

#### Non-LAHIPP Recipient

Procedure	Billed	TPL Paid	Medicaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	Payment
Code	Charge	TPL Paid	M'caid Allowed	Pt. Liability	M'caid Paid
HR270	99.25	74.44	22.04	0	0
HR450	316.25	137.19	70.24	100.00	0
Totals	415.50	211.63	92.28	100.00	0

(This claim is paid at zero because the Medicaid Allowed Amount minus the TPL payment is LESS THAN the deductible.)

#### Outpatient Example #2

See pages 30-31 of Appendix A for the corresponding claim example and accompanying EOB.

#### LAHIPP Recipient

Procedure	Billed	TPL Paid	Medicaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	Payment
HR259	1.10	0.33	0.33	1.10	1.10
HR450	291.39	87.71	87.71	22.11	22.11
HR450	<u>99.22</u>	4.88	29.87	0.00	0.00
Totals	391.71	92.92		23.21	23.21

(In this example, the claim lines were bundled by the primary carrier and processed as one total. Therefore, Medicaid "spends down" the total payment and patient responsibility. The total payment is "spent down" (or applied) against the Medicaid allowed amount, and the total patient responsibility is "spent down" (or applied) against the billed charges. The 23.21 co-insurance for the total claim is paid because this is a LAHIPP recipient. It is paid by "spending it down" on each claim line until the entire 23.21 is paid. The last claim line is paid at "0" because the entire patient responsibility (co-insurance) is paid on the prior claim lines when processed by Medicaid.)

#### Non-LAHIPP Recipient

Procedure	Billed	TPL Paid	Medicaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	Payment
HR259	1.10	0.33	0.33	1.10	0.00
HR450	291.39	87.71	87.71	22.11	0.00
HR450	<u>99.22</u>	4.88	29.87	0.00	0.00
Totals	391.71	92.92		23.21	0.00

(This is a non-LAHIPP recipient. In this example, the claim lines were bundled by the primary carrier and processed as one total. Therefore, Medicaid "spends down" the total payment and patient responsibility. The total payment is "spent down" (or applied) against the Medicaid allowed amount, and the total patient responsibility is "spent down" (or applied) against the billed charges. On line one, the TPL Paid Amount applied is the 0.33 Medicaid Allowed Amount, and the patient responsibility applied is the 1.10 billed charges. The line is paid at zero because the Medicaid allowed amount minus the TPL paid amount is less than the patient responsibility. On line two, 87.71 of the TPL Paid Amount is applied and equals the Medicaid Allowed Amount. The remaining 22.11 of the patient responsibility is applied as it is less than the billed charges. The claim line is paid at 0.00 because the Medicaid allowed amount minus the TPL paid amount is less than the patient responsibility. On line three, the remaining TPL Paid Amount of 4.88 is "spent down." The claim line is paid at 0.00 because no patient responsibility remains.)

#### Inpatient Example #1

See pages 32-33 of Appendix A for the corresponding claim example and accompanying EOB.

#### **LAHIPP** Recipient

Procedure	Billed	TPL Paid	Medicaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	Payment
Multiple HR R & B	34,359.32	9,015.00	4,646.90	250.00	250.00

(The 250.00 patient deductible is paid for this LaHIPP recipient.)

#### Non-LAHIPP Recipient

Procedure	Billed	TPL Paid	Medicaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	<u>Payment</u>
Multiple HR R & B	34,359.32	9,015.00	4,646.90	250.00	0

(The claim is paid at zero because the Medicaid Allowable of 4646.90 minus the TPL payment of 9015.00 is less than the 250.00 patient deductible.)

#### Inpatient Example #2

See pages 34-35 of Appendix A for the corresponding claim example and accompanying EOB.

#### **LAHIPP Recipient**

Procedure	Billed TPL Paid		Medicaid	Patient	Medicaid	
Code	Charge Amount		Allowed Amount	Responsibility	Payment	
Multiple HR HR 110 R & B	12,253.00	2,450.00	5,052.30	300.00 (co-pay)	300.00	

(The co-pay is paid because this is a LAHIPP recipient and the services are a covered Medicaid service.)

#### Non-LAHIPP Recipient

Procedure	Billed	TPL Paid	Medicaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	Payment
Multiple HR	12,253.00	2,450.00	5,052.00	300.00 (co-pay)	300.00

(This is a Non-LAHIPP recipient. The Medicaid Allowed Amount minus the TPL payment is GREATER THAN the copay; thus, the co-pay is paid on this covered service.)

#### Inpatient Example #3

See pages 36-37 of Appendix A for the corresponding claim example and accompanying EOB.

#### **LAHIPP Recipient:**

Procedure	Billed	TPL Paid	Medicaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	Payment
Multiple HR	14,788.37	10,255.07	4,593.00	478.93	478.93

(The deductible is paid for this LAHIPP recipient.)

#### Non-LAHIPP Recipient

Procedure	Billed	TPL Paid	Medicaid	Patient	Medicaid
Code	Charge	Amount	Allowed Amount	Responsibility	Payment
Multiple HR R & B	14,788.37	10,255.07	4,593.00	478.93	0

(This is a Non-LAHIPP recipient. The Medicaid Allowed Amount minus the TPL Payment Amount is LESS THAN zero; thus, the payment is "O".)

#### New Claim Edits Implemented for TPL

The following new claim edits will be implemented to assist with identifying payments for LAHIPP recipients:

#### Edit 928 – Paid Patient Responsibility Amount per The EOB

This edit will appear when the claim is paid by the Primary Carrier and Medicaid payment is the amount of the patient responsibility.

#### Edit 929 - Paid Medicaid Amount TPL Denied Claim

This edit will appear in circumstances when the claim is denied by the primary carrier and Medicaid pays as primary.

#### Edit 931 – Denied Per the TPL EOB Information

This edit will appear when the claim is denied by the primary carrier and Medicaid will not consider payment as primary.

It may be possible for providers to contact the primary carrier and resubmit to them with corrected information in order to have the claim reconsidered.

## Important Reminders Concerning TPL Claims Processing and Payment

- At this time, It is necessary to submit paper TPL claims; however, electronic transmission of TPL claims is forthcoming, and paper claims will not be required once implemented.
- Do not include contract adjustments as prior payments on the claim.
- Until electronic transmission of TPL claims is accepted, providers must ensure that the correct, accurate EOB is attached to each TPL claim form and that EOBs are clear, complete, readable, and include descriptions of EOB edits.
- Other forms of incomplete documentation (payment registers, electronic reports, etc.) are not acceptable and will be rejected back to the provider.
- Once TPL claims are accepted electronically, providers must ensure that the appropriate and accurate information from the primary payor's EOB is entered correctly in the 837 transaction.
- Services that are not covered by LA Medicaid will not be considered for payment.
- Recipients 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 payor.
- Medicaid will never pay more than the total co-pay, co-insurance and/or deductible. If the TPL carrier pays the claim, and co-pay, co-insurance and/or deductible are not owed on a service covered by Medicaid, Medicaid will zero pay the claim.
- The same procedure/service may be paid differently based on whether the recipient is LAHIPP or non-LAHIPP.
- At this time, approximately 5% of the Medicaid recipients with primary insurance are enrolled through LAHIPP (about 2,200 recipients).
- Providers must verify recipient eligibility to ensure that the recipient is eligible on the date
  of service and to determine if TPL applies and how the recipient is enrolled.
- New claims edit codes are in effect to assist providers with claims payments or denials.

#### GENERAL REMINDERS

#### REQUESTS TO ADD OR REMOVE RECIPIENT TPL/MEDICARE COVERAGE

A request to add or remove TPL or Medicare coverage must include the cover sheet on the following page indicating the action requested; the claim; and the EOB or proof of coverage termination and should be sent to **Eligibility Special Services via fax (225) 342-1376\*** or mailed to:

Eligibility Special Services
Third Party Liability
Medicaid Recovery Unit
543 Spanish Town Road
Baton Rouge, LA 70802

\*Hardcopy claims must be originals, not faxes. If you are submitting a hardcopy claim with your request, use the mailing address above.

# Department of Health and Hospitals Medicaid Recipient Insurance Information Update Medicaid Recovery Unit Fax #: (225) 342-1376

Date of Submission:	
Provider Name:	Phone #:()
Submitter Name:	Fax#:( ) -
Recipient Information: Patient Name:	Policy Information: Policy Holder Name:
Medicaid ID	Policy #:
#:	Coverage Effective Date: MM/DD/YYYY
Date of Birth: MM/DD/YYYY	Carrier Code:
Parish of	
Residence:	
Hospital Account #:	
Date of Service: MM/DD/YYYY	
Please update the patient's medical file by ADD Insurance Name:  Address:	
	······································
Please update the patient's medical file by <b>REM</b> Insurance Name:	
Address:	
	the state of the s

#### PRIVACY AND CONFIDENTIALITY WARNING

This Fax may contain Protected Health Information, Individually Identifiable Health Information and other information which is protected by law. The information is intended only for the use of the intended recipient. If you are not the intended recipient, you are hereby notified that any review, disclosure/redisclosure, copying, storing, distributing or the taking of action in reliance on the content of this Fax and any attachments thereto, is strictly prohibited. If you have received this Fax in error, please notify the sender immediately and destroy the contents of this Fax and its attachments by deleting any and all electronic copies and any and all hard copies regardless of where they are maintained or stored.

#### MEDICAID PAYMENT ADJUSTMENTS OR REFUNDS

When errors in billing occur:

- Providers shall initiate claim adjustments or voids. The adjustment/void process is the most efficient and effective method for adjusting incorrect payments or refunding overpayments.
- Adjustment/void claims shall be done initially.
- Only in special circumstances where adjustments or voids can not be submitted shall providers submit refund checks. Refund checks shall be the last option.

When special circumstances occur and providers find it necessary to refund a payment by check, they must:

- Make checks payable to the Department of Health and Hospitals, Bureau of Health Services Financing. DO NOT make refund check payable to Unisys.
- Providers **MUST** attach a copy of the Remittance Advice page(s) to the refund check, and identify the payment line(s) being refunded.
- If the check and the attached RA(s) indicating payment information do not balance, all will be returned to the provider.
- Attach an explanation for the reason for the refund
- The Medicaid Provider Number must be clearly identified on requests.
- Mail the refunds to the following address:

Division of Fiscal Management P. O. Box 91117 Baton Rouge, LA 70821-9117

 Allow additional time for processing, as this process takes a much longer time period to be completed and does not provide a clear audit trail as the adjustment/void process does.

#### PRENATAL AND PREVENTIVE PEDIATRIC CARE PAY AND CHASE

Louisiana Medicaid will continue to use the "pay and chase" method of payment for **prenatal** and **preventive care** 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 seeks recovery of insurance benefits from the carrier within 60 days after claim adjudication when the provider chooses not to pursue health insurance payments.

#### HMO AND MEDICAID COVERAGE

Louisiana Medicaid has adopted the following policy concerning HMO and Medicaid coverage based on CMS (Centers for Medicare and Medicaid Services) clarification.

- The recipient must use the services of the HMO that they freely choose to join.

  These claims must be submitted hard copy with a copy of the HMO EOB from the carrier that is on file with the state.
- If the HMO denies the service because the service is not a covered service offered under the plan, the claim will be handled as a straight Medicaid claim and processed based on Medicaid policy and pricing.
- If the HMO denies the claim because the recipient sought medical care outside of the HMO network and without the HMO's authorization, Medicaid will deny the claim with a message that HMO services must be utilized.
- If the recipient uses out of network providers for emergency services and the HMO does not approve the claim, Medicaid will deny the claim with a similar edit.

NOTE: If the provider of the service plans to file a claim with Medicaid, copayments or any other payment cannot be accepted from the Medicaid recipient.

#### APPENDIX A - CLAIM FORM EXAMPLES

### CLAIM FORM EXAMPLES

#### **PROFESSIONAL**

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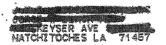
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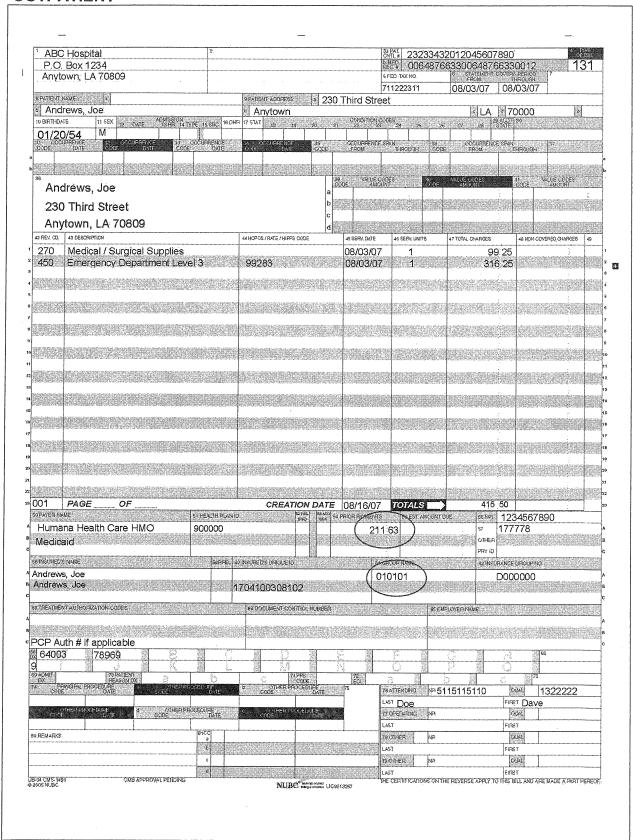
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#### HUMANA AUTOMATED REMITTANCE ADVICE

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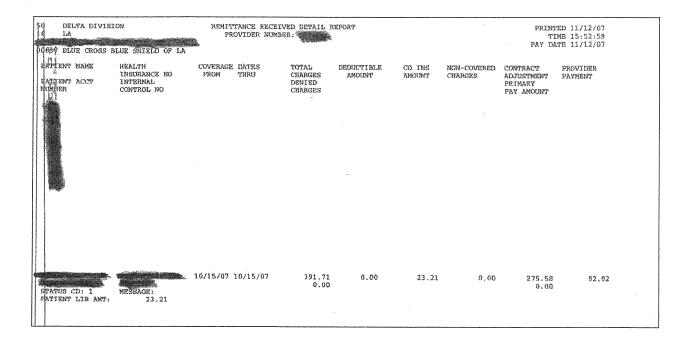
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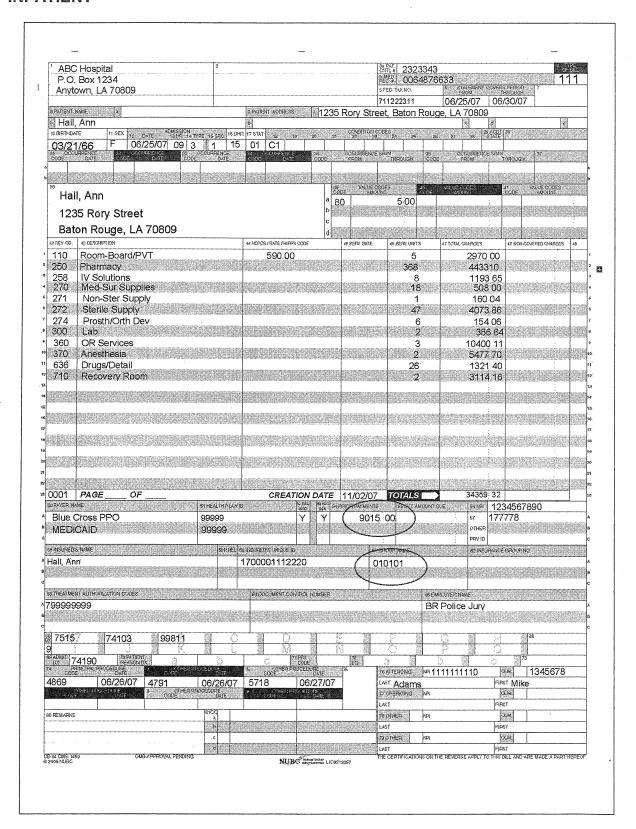
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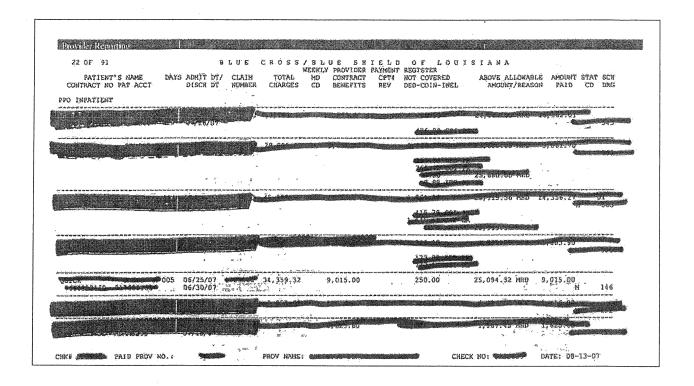
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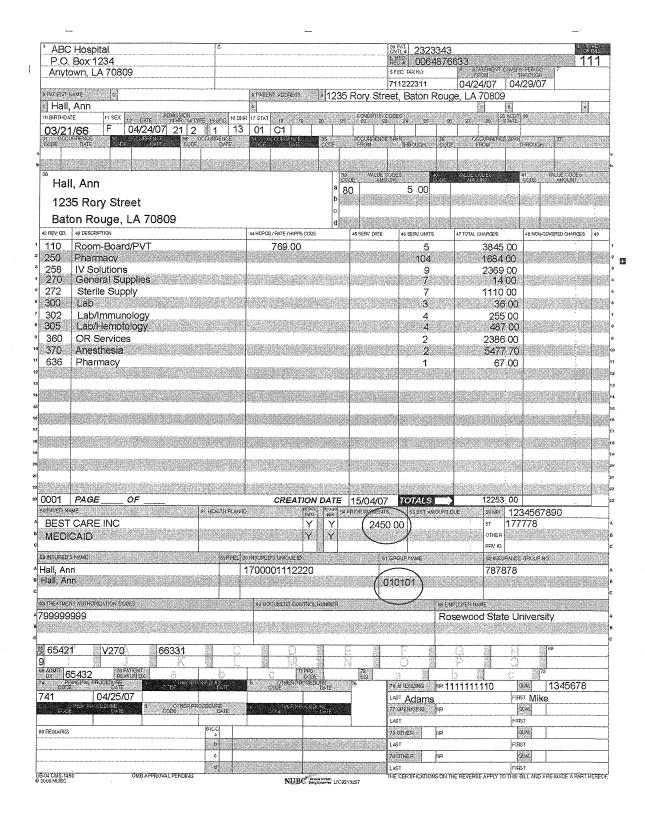
ABC Hospital 23233432012045607890 4 11 PE 59 E M 00648766330064876633001 131 P.O. Box 1234 Anytown, LA 70809 S FED. TAX NO 711222311 10/15/07 10/1507 S PATIENT NAME PATIENT ADDRESS 4 230 Third Street Andrews, Bob Anytówn LA | 70000 n BIRTHDATE 11 SEX 12 MISSION 18 HG 14 TYPE 15 SOC 16 DHR 17 STAT 18 27 25 M 01/20/04 Andrews, Bob ВЗ 23 21 233 Third Street Anytown, LA 70809 42 REV. CO. 43 DESCRIPTION 44 HCP CS / RATE / HIPPS. CODE 45 SERV DATE 46 SERV UNITS Drugs/Other 10/15/07 1 10 450 Emergency Department Visit 99283 10/15/07 291 39 450 Clear Outer Ear Canal 69200 RT 10/15/07 99: 22 001 PAGE 391 71 CREATION DATE 11/13/07 TOTALS ST HEALTH PLANID 56NPI 1234567890 Blue Cross Blue Shield of Texas 900000 177778 92:92 OTHER Medicaid SU INSURED'S NAME 62 INSURANCE GROUP NO 69 PREL 60 INSURED'S UNIQUE ID GI GROUP NAM Andrews, Joe 999999 010101 D000000 Andrews, Joe 1704100308102 do THEATMENT AUTHORIZATION GODES PCP Auth # if applicable PANENT 931 76 AT FENDING №5115115110 1322222 LAST Doe FIRST Dave 9811 10/15/07 77 OPEHATING QUAL LAST FIRST 80 FIEMARKS 78 OTHER CLAL b FIRST LAST QUAL 79 OTHE FIRST PLY TO THE CILL AND ARE MADE A PART HEREOF UB-04 CMS-1450 @ 2005 NUBC NUBC MANAGEMENT LIC9213257



#### **INPATIENT**







FARA Benefit Services, Inc. PO Box 8770 Metairie, LA 70011-8770



Return Service Requested

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TAKE CHARLES. LA

Questions? Call 800-427-4511 Patient Responsibility:

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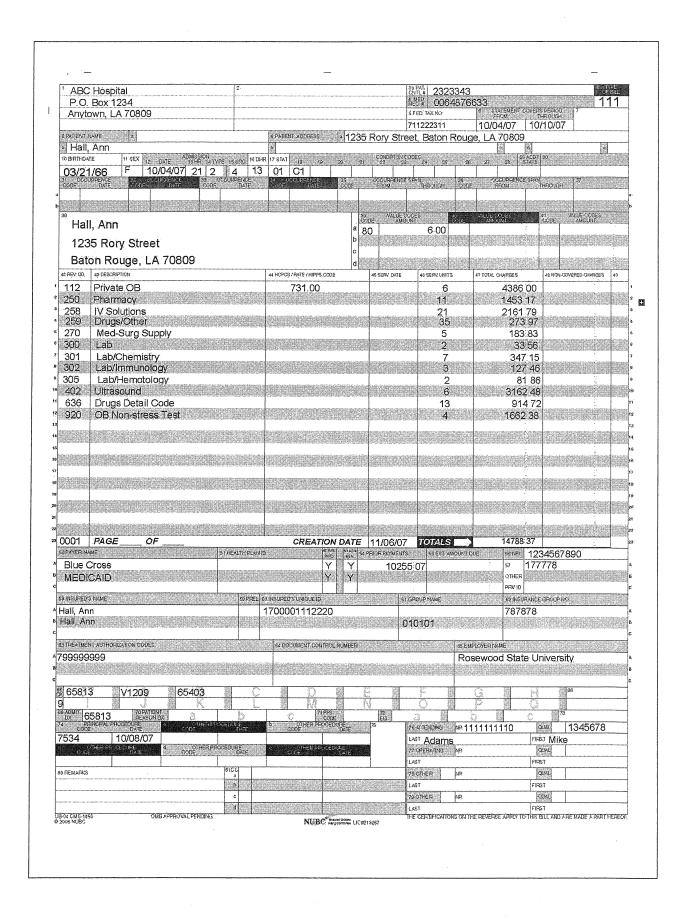
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BS BEST CARE DISCOVATE APPLIED

Messages

To obtain a review of benefits determination, submit your request in wraing to this office. Your request about include the employer name, your name and other identifying information. You may review documents pertinent in your claim free of charge. Written request for a review must be mailed or delivered within 180 days following receipt of this explanation. Ordinarily, you will receive notice of the final determination within 60 days following receipt of your request. If special circumstances require an extension of time, you will be notified of such an extension during the 60 days following receipt of your request and you will seeking a final aritten exposes, within 120 days following receipt of your request.



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