



UNISYS

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

February 14-26, 2008

**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:

Louisiana Medicaid

For Technical Support, call toll-free 1-877-598-8753.

Member ID Number 1234567890000
Date of Birth 01/01/1974
Sex Male

Health Benefit Plan Coverage

Benefit	Coverage Level	Insurance Type	Plan Coverage Description
Active Coverage	Individual	Medicaid	Eligible for Medicaid on Date of Service.
Benefit Description	Individual	Medicaid	This Recipient is Enrolled in LAHIPP.
Benefit Description	Individual	Medicaid	Recipient has Private Insurance.
Benefit Description	Individual	Medicaid	Preferred Language: English.

Other or Additional Payor

Coverage Level Individual
Service Type Medical Care

Warning: Unauthorized use of this site or the information contained herein is prohibited by the Louisiana Department of Health and Hospitals

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 not 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 but will no longer enter the contractual adjustment amount as a part of the TPL payment amount.

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 appropriate and accurate 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, www.lamedicaid.com, 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	<u>-40.00</u>
	- 3.87

Medicaid Payment	\$ 10.00
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(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

OR

Patient Responsibility (Co-Pay)	\$10.00
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EQUALS

Medicaid Payment -	\$ 0.00
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(Medicaid “zero pays” the claim. When cost-compared, the private insurance paid more than Medicaid's allowable for the procedure. When cost compared, the lesser of 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 Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid 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 Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid 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	Medicaid 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	Medicaid 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

<u>Procedure Code</u>	<u>Billed Charge</u>	<u>TPL Paid Amount</u>	<u>Medicaid Allowed Amount</u>	<u>Patient Responsibility</u>	<u>Medicaid Payment</u>
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

<u>Procedure Code</u>	<u>Billed Charge</u>	<u>TPL Paid Amount</u>	<u>Medicaid Allowed Amount</u>	<u>Patient Responsibility</u>	<u>Medicaid Payment</u>
<u>Code</u>	<u>Charge</u>	<u>TPL Paid</u>	<u>M'caid Allowed</u>	<u>Pt. Liability</u>	<u>M'caid Paid</u>
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 Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
HR259	1.10	0.33	0.33	1.10	1.10
HR450	291.39	87.71	87.71	22.11	22.11
HR450	99.22	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 Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
HR259	1.10	0.33	0.33	1.10	0.00
HR450	291.39	87.71	87.71	22.11	0.00
HR450	99.22	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

<u>Procedure Code</u>	<u>Billed Charge</u>	<u>TPL Paid Amount</u>	<u>Medicaid Allowed Amount</u>	<u>Patient Responsibility</u>	<u>Medicaid Payment</u>
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

<u>Procedure Code</u>	<u>Billed Charge</u>	<u>TPL Paid Amount</u>	<u>Medicaid Allowed Amount</u>	<u>Patient Responsibility</u>	<u>Medicaid 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

<u>Procedure Code</u>	<u>Billed Charge</u>	<u>TPL Paid Amount</u>	<u>Medicaid Allowed Amount</u>	<u>Patient Responsibility</u>	<u>Medicaid Payment</u>
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

<u>Procedure Code</u>	<u>Billed Charge</u>	<u>TPL Paid Amount</u>	<u>Medicaid Allowed Amount</u>	<u>Patient Responsibility</u>	<u>Medicaid Payment</u>
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 co-pay; 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:

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

(The deductible is paid for this LAHIPP recipient.)

Non-LAHIPP Recipient

<u>Procedure Code</u>	<u>Billed Charge</u>	<u>TPL Paid Amount</u>	<u>Medicaid Allowed Amount</u>	<u>Patient Responsibility</u>	<u>Medicaid Payment</u>
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 "0".)

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: _____

Medicaid ID

#: _____

Date of Birth: MM/DD/YYYY

Parish of

Residence: _____

Hospital Account #: _____

Date of Service: MM/DD/YYYY

Policy Information:

Policy Holder

Name: _____

Policy #: _____

Coverage Effective Date: MM/DD/YYYY

Carrier Code: _____

Please update the patient's medical file by **ADDING** the following insurance:

Insurance Name: _____

Address: _____

Please update the patient's medical file by **REMOVING** the following insurance:

Insurance Name: _____

Address: _____

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/re-disclosure, 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

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE		5. INSURED'S ADDRESS (No., Street)	
6. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS		9. INSURED'S POLICY GROUP OR FECA NUMBER	
10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S DATE OF BIRTH	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE	
24. A. DATE(S) OF SERVICE		25. TOTAL CHARGE	
26. PATIENT'S ACCOUNT NO.		29. AMOUNT PAID	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		30. BALANCE DUE	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PAY	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

HUMANA AUTOMATED REMITTANCE ADVICE

ANY QUESTIONS? PLEASE CONTACT:

HUMANA CLAIMS OFFICE
PO BOX 14801
LEXINGTON, KY 40512-4801

OR CALL 1-888-387-6767
OR VISIT WWW.HUMANA.COM

BENEFITS PAID TO THE FOLLOWING:

MEDICAL CENTER DR
ALEXANDRIA, LA 71301

PROVIDER ID: [REDACTED]
FEDERAL TAX ID: [REDACTED]
REMITTANCE ID: [REDACTED]
CHECK NUMBER: [REDACTED]

HUMANA

PAGE 1 OF 3
DATE 08/17/07

LINE #	DATE OF SERVICE FROM	SERVICE TO	CODE	CHARGE	EXCLUDED -AMOUNT	ALLOWED -DISCOUNT -AMOUNT	-DEDUCTIBLE	-COPAY	-COINSUR	BENEFIT =AMOUNT
PROVIDER NAME: ██████████						NBR ID: ██████████		CLAIM NUMBER: ██████████		
PATIENT NAME: ██████████						PAY DOB: ██████████		PAT ACCT: ██████████		
SUBSCRIBER NAME: ██████████						REL CO: ██████████		GROUP: ██████████		
001	07/06/07	07/06/07	99212	55.00	19.00	0.00	35.00	35.00	0.00	0.00
002	07/06/07	07/06/07	83855	30.00	1.80	0.00	28.20	28.20	0.00	0.00
CLAIM TOTALS				85.00	20.80	0.00	64.20	64.20	0.00	0.00
REMARK CODES HIPAA/HUMANA										
001 45 /580				1 2030 ↓ 85.00 TOTAL PAID 280570						
002 45 /580										
EST-MSR RESPONSIBILITY							0.00			

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in item 1)	
(Medicare #) <input type="checkbox"/> (Medicaid #) <input checked="" type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID) <input type="checkbox"/>		1234567891234	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Adalam, Mary		Adalam, Mary	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
123 Any Street		123 Any Street	
CITY		CITY	
Anytown		Anytown	
STATE		STATE	
LA		LA	
ZIP CODE		ZIP CODE	
70000		70000	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
(225) 555-5555		(225) 555-5555	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
N/A		1000000	
10. IS PATIENT'S CONDITION RELATED TO:		a. INSURED'S DATE OF BIRTH	
a. EMPLOYMENT? (Current or Previous)		MM DD YY M F	
b. AUTO ACCIDENT?		06 11 89 M F	
c. OTHER ACCIDENT?		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		Humana	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____ DATE _____		SIGNED _____ DATE _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	
MM DD YY		MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
PCP Auth # if applicable		FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by line)		22. MEDICAID RESUBMISSION CODE	
1. V70.0 3. 774.6		ORIGINAL REF. NO.	
2. 786.7		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	
From MM DD YY To MM DD YY		EMG OPTICPOS MODIFIER	
C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	
1. 07 24 07 21 99436 1 2 250.00 1 NPI 1234567		2. 07 25 07 21 99433 1 2 3 65.00 1 NPI 0987654321	
3. 07 26 07 21 99433 1 3 65.00 1 NPI 1234567		4. 07 27 07 21 99238 1 3 115.00 1 NPI 0987654321	
5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 00. 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78.			

22

UnitedHealthcare

A University Press Company

DATE: 04/20/00

THE

CONFIDENTIAL

REPORT MADE:

FREE INDEX: [REDACTED]

KEYSER AVE
NATCHITOCHE LA 71457

PROJECT	SEN. ID	PATIENT NAME	PAT REL	PATIENT ACCOUNT	MEMBER NAME	CONTROL NUMBER	DATE RECEIVED	PROVIDER OF SERVICE
CHFC	1-200-0000	XXXXXXXXXX	CH	XXXX	XXXXXXXXXX	0168267842-02	08/13/07	XXXXXXXXXX
CHFC	1-200-0000	XXXXXXXXXX	CH	XXXX	XXXXXXXXXX	0168267842-03	08/13/07	XXXXXXXXXX
CHFC	1-200-0000	XXXXXXXXXX	CH	XXXX	XXXXXXXXXX	0168000000-01	08/08/07	XXXXXXXXXX

PATIENT NAME	DATES OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT/CO-PAID	PLAN CD	PAID TO PROVIDER	RMC CD	PATIENT RESP.
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07/24/17	55435	255.00	75	157.50	001	49.50	IT	25.00
07/25/17	55433	255.00	75	30.00	001	20.46	IT	13.54
07/26/17	55433	115.00	35	40.00	001	20.46	IT	13.54
07/27/17	55235	115.00	35	40.00	001	44.58	IT	29.42
	SUBTOTAL	485.00	255.00	269.50		135.00		90.00

TOTAL PAID TO PROVIDER

\$13.50

THESE CHARGES HAVE BEEN APPLIED TO THE PATIENT'S ANNUAL DEDUCTIBLE. THE PATIENT IS RESPONSIBLE FOR PAYING THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL ALL CHARGES THAT ARE APPLIED TO THE ANNUAL DEDUCTIBLE. PLEASE FURNISH THIS PAYMENT TO YOUR PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.

40% of Allowed

OUTPATIENT

1 ABC Hospital P.O. Box 1234 Anytown, LA 70809		2		33 PAT CNTR # 23233432012045607890		4 FILE # 131	
5 PATIENT NAME Andrews, Joe		6 PATIENT ADDRESS 230 Third Street		7 STATEMENT COVERS PERIOD FROM 08/03/07 THROUGH 08/03/07		8	
9 BIRTHDATE 01/20/54		10 SEX M		11 DATE 08/03/07		12	
13 OCCURRENCE CODE		14 OCCURRENCE DATE		15 OCCURRENCE CODE		16 OCCURRENCE DATE	
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HUMANA AUTOMATED REMITTANCE ADVICE

ANY QUESTIONS - PLEASE CONTACT	BENEFITS PAID TO THE FOLLOWING	HUMANA
HUMANA CLAIMS OFFICE PO BOX 14801 LEXINGTON, KY 40512-4801	NO BENEFITS PAID TO THE FOLLOWING HUMANA CLAIMS OFFICE PO BOX 14801 LEXINGTON, KY 40512-4801	PAGE 16 OF 30 DATE 08/10/07
OR CALL 1-888-357-6767 OR VISIT WWW.HUMANA.COM	PROVIDER ID: [REDACTED] FEDERAL TAX ID: [REDACTED] REMITTANCE ID: [REDACTED] CHECK NUMBER: [REDACTED]	

PROVIDER NAME: [REDACTED] MBR ID: [REDACTED] CLAIM NUMBER: [REDACTED]
 PATIENT NAME: [REDACTED] PAT DOB: [REDACTED] PAT ACCT: [REDACTED]
 SUBSCRIBER NAME: [REDACTED] REL CD: EMPLOYEE GROUP: [REDACTED]

CO1	08/03/07	08/03/07	270	89.25	0.00	24.81	74.44	0.00	0.00	0.00	74.44
CO2	08/03/07	08/03/07	450	316.25	0.00	79.06	237.19	0.00	100.00	0.00	137.19
CLAIM TOTALS				415.50	0.00	103.87	311.63	0.00	100.00	0.00	211.63

REMARK CODES HIPAA/HUMANA
 CO1 131/SHO
 CO2 131/SHO
 01111111136542

2000003783

HUMANA AUTOMATED REMITTANCE ADVICE

ANY QUESTIONS - PLEASE CONTACT	BENEFITS PAID TO THE FOLLOWING	HUMANA
HUMANA CLAIMS OFFICE PO BOX 14801 LEXINGTON, KY 40512-4801	NO BENEFITS PAID TO THE FOLLOWING HUMANA CLAIMS OFFICE PO BOX 14801 LEXINGTON, KY 40512-4801	PAGE 17 OF 30 DATE 08/10/07
OR CALL 1-888-357-6767 OR VISIT WWW.HUMANA.COM	PROVIDER ID: [REDACTED] FEDERAL TAX ID: [REDACTED] REMITTANCE ID: [REDACTED] CHECK NUMBER: [REDACTED]	

LINE #	DATE OF SERVICE FROM TO	SERVICE CODE	CHARGE	EXCLUDED - AMOUNT	ALLOWED - DISCOUNT = AMOUNT	DEDUCTIBLE	COPAY	COINSUR	BENEFIT = AMOUNT
					EST MBR RESPONSIBILITY	100.00	TOTAL PAID	211.63	

1 ABC Hospital P.O. Box 1234 Anytown, LA 70809		3 PAT. ONT. # 23233432012045607890 4 FILE # 006487663300648766330012 5 FED. TAX NO 711222311 6 STATEMENT COVERS PERIOD FROM 10/15/07 THROUGH 10/15/07		7 131	
8 PATIENT NAME Andrews, Bob		9 PATIENT ADDRESS 230 Third Street LA 70000			
10 BIRTH DATE 01/20/04	11 SEX M	12 DATE	13 ADMISSION	14 ICD TYPE	15 DRG
16 STAT	17 ICD	18 ICD	19 ICD	20 ICD	21 ICD
22 ICD	23 ICD	24 ICD	25 ICD	26 ICD	27 ICD
28 ICD	29 ICD	30 ICD	31 ICD	32 ICD	33 ICD
34 ANDREWS, BOB 233 Third Street Anytown, LA 70809		35 VALUE CODES a B3 23 21 b c d			
36 REV. CODE	37 DESCRIPTION	38 HPOS / RATE / HIPPS CODE	39 SERV. DATE	40 SERV. UNITS	41 TOTAL CHARGES
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DELTA DIVISION LA		REMITTANCE RECEIVED DETAIL REPORT				PRINTED 11/12/07 TIME 15:52:59 PAY DATE 11/12/07			
00669 BLUE CROSS BLUE SHIELD OF LA		PROVIDER NUMBER: [REDACTED]							
PATIENT NAME	HEALTH INSURANCE NO	COVERAGE DATES FROM THRU		TOTAL CHARGES DEDUCTIBLE CHARGES	DEDUCTIBLE AMOUNT	CO INS AMOUNT	NON-COVERED CHARGES	CONTRACT ADJUSTMENT PRIMARY PAY AMOUNT	PROVIDER PAYMENT
PATIENT ACCT NUMBER	INTERNAL CONTROL NO								
[REDACTED]	[REDACTED]	10/15/07	10/15/07	391.71 0.00	0.00	23.21	0.00	275.58 0.00	92.92
STATUS CD: 1		MESSAGE:							
PATIENT LIB AMT:		23.21							

INPATIENT

1 ABC Hospital P.O. Box 1234 Anytown, LA 70809		2		3a PAT. CRTL. # 2323343		3b FID. # 0064876633		3c FID. # 111	
4 PATIENT NAME Hall, Ann		5 PATIENT ADDRESS 1235 Rory Street, Baton Rouge, LA 70809		6 FED. TAX NO. 711222311		7 STATEMENT COVER PERIOD 06/25/07 06/30/07		8	
9 BIRTH DATE 03/21/66		10 SEX F		11 DATE 06/25/07		12 TIME 09:31		13 STAT 01	
14 C1		15		16		17		18	
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22 OF 91

22 OF 91

BLUE CROSS/BLUE SHIELD OF LOUISIANA

[illegible]

PRO INPATIENT

04/20/07

70-85-10

[REDACTED]

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1983-90

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100-443888-100

CHKN [REDACTED] PAID PROV NO.: [REDACTED] PROV NAME: [REDACTED] CHECK NO: [REDACTED] DATE: 08-13-07

1 ABC Hospital P.O. Box 1234 Anytown, LA 70809		3 PAT. CNTL # 2323343 REC # 0064876633 5 FED TAX NO 711222311		4 TYPE OF BILL 111 6 STATEMENT COVERS PERIOD FROM 04/24/07 THROUGH 04/29/07	
8 PATIENT NAME Hall, Ann		6 PATIENT ADDRESS 1235 Rory Street, Baton Rouge, LA 70809			
10 BIRTH DATE 03/21/66	11 SEX F	12 DATE OF ADMISSION 04/24/07	13 HLT 21	14 TYPE 2	15 DRG 1
16 ICD 13	17 STAT 01	18 C1	19 CONDITION CODES		
36 Hall, Ann 1235 Rory Street Baton Rouge, LA 70809					
37 VALUE CODES AMOUNT a 80		38 VALUE CODES AMOUNT b 5.00		39 VALUE CODES AMOUNT	
45 REV CD 110 Room-Board/PVT 44 HCPCS / RATE / HIPPS CODE 769.00 45 SERV DATE 46 SERV UNITS 5 47 TOTAL CHARGES 3845.00 48 NON-COVERED CHARGES					
250 Pharmacy 104 1684.00					
258 IV Solutions 9 2369.00					
270 General Supplies 7 14.00					
272 Sterile Supply 7 1110.00					
300 Lab 3 36.00					
302 Lab/Immunology 4 255.00					
305 Lab/Hematology 4 487.00					
360 OR Services 2 2386.00					
370 Anesthesia 2 5477.70					
636 Pharmacy 1 67.00					
0001 PAGE OF CREATION DATE 15/04/07 TOTALS 12253.00					
50 PAYER NAME BEST CARE INC MEDICAID		51 HEALTH PLAN ID		52 PRIOR PAYMENTS 2450.00	
53 INSURED'S NAME Hall, Ann		54 INSURED'S UNIQUE ID 170000112220		55 GROUP NAME 010101	
56 TREATMENT AUTHORIZATION CODES 7999999999		57 DOCUMENT CONTROL NUMBER		58 EMPLOYER NAME Rosewood State University	
59 ADMIT DX 65421		60 PATIENT REASON DX V270		61 PPS CODE 66331	
62 PRINCIPAL PROCEDURE 741		63 DATE 04/25/07		64 OTHER PROCEDURE 741	
65 DATE 04/25/07		66 OTHER PROCEDURE 741		67 OTHER PROCEDURE 741	
68 REMARKS		69 ICD 13		70 OTHER	
71 LAST		72 FIRST		73 QUAL	
74 LAST		75 FIRST		76 QUAL	
77 LAST		78 FIRST		79 QUAL	
80 LAST		81 FIRST		82 QUAL	

UB-04 CMS-1450
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ORIS APPROVAL PENDING

NUBC
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LIC 0219257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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



PH 14683000

EN 1177
10 of 20

Return Service Requested

1779 5-5604 AB 1.417 ALL FOR ADC 707
LAKE CHARLES, LA

Questions? Call 800-427-4511

Patient Responsibility:
The amount patient/member owes provider.

Enrollee: [REDACTED]
Patient: [REDACTED]
Group: [REDACTED]
Group #: [REDACTED]
Claim #: [REDACTED]
Patient #: [REDACTED]
Date: 05/15/2007

Explanation of Benefits for Services Provided By:

TIN: [REDACTED]

Dates of Service	Service Code	CPT Code	Total Charge	Ineligible	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Benefit Deductible	Co-Pay Amount	Balance	Paid At	Payment Amount
04/24-04/29/2007	23	U110	12,253.00	0.00	BS	9,303.00	2,750.00	0.00	0.00	300.00	2,450.00	100%	2,450.00
TOTALS			12,253.00	0.00		9,303.00	2,750.00	0.00	0.00	300.00	2,450.00		2,450.00
Other Credits or Adjustments													0.00
Total Net Payment													2,450.00
Patient Responsibility													300.00

Service Code

23 INPATIENT-R&D

Reason Code Description

BS BEST CARE DISCOUNT APPLIED

Messages

To obtain a review of benefits determination, submit your request in writing to this office. Your request should include the employer name, your name and other identifying information. You may review documents pertinent to 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 receive a final written response within 120 days following receipt of your request.

UB-04 CMS-1450
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21	CENTRAL GROUP	ADMINISTRATIVE REMITTANCE ADVISE BY CREDIT ADV		PRINTED 11/05/07				
50	DELTA DIVISION	REMITTANCE RECEIVED DETAIL REPORT		TIME 15:37:16				
18	LA	PROVIDER NUMBER: [REDACTED]		PAY DATE 11/05/07				
00637 BLUE CROSS BLUE SHIELD OF LA								
PATIENT NAME	HEALTH INSURANCE NO	COVERAGE DATES	TOTAL CHARGES	DEDUCTIBLE AMOUNT	CO INS AMOUNT	NON-COVERED CHARGES	CONTRACT ADJUSTMENT	PROVIDER PAYMENT
PATIENT ACCOUNT NUMBER	INTERNAL CONTROL NO	FROM THRU	DENIED CHARGES				PRIMARY PAY AMOUNT	
[REDACTED]	[REDACTED]	10/04/07 10/10/07	14788.37	478.93	0.00	0.00	4054.37	10255.07
STATUS CD: 1	MESSAGE: 6		0.00				0.00	
COVERED DATE:	PATIENT LTR AMT:							