UNISYS

HOSPICE PROVIDER TRAINING

Spring 2006

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

ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the Spring 2006 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as recipient eligibility, ID cards, and third party liability. Such information is presented only in the Basic Medicaid Information Training packet. This packet may be obtained by attending the Basic Medicaid Information workshop; by requesting a copy from Unisys Provider Relations; or by downloading it from the Louisiana MEDICAID website, www.lamedicaid.com.

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES.
TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.
(See listing of numbers on attachment)

MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.**

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED.
TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955
(or TTY 1-877-544-9544)

MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive Mental Health Rehabilitation Services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by mental health prior authorization unit.

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES
Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. PCS services do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. The PCS service provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES
Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT
If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. *EARLYSTEPS* CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

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

TRANSPORTATION
Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544).
IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED, CALL 1-888-758-2220 FOR ASSISTANCE.

OTHER MEDICAID COVERED SERVICES

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY

METROPOLITAN HUMAN SERVICES DISTRICT
1010 Common Street, 5th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660

CAPITAL AREA HUMAN SERVICES DISTRICT
4615 Government St. - Bin # 16 - 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-800-768-8824

REGION III
690 E. First Street
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

REGION IV
214 Jefferson Street - Suite 301
Lafayette, LA 70501
Phone: (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

REGION V
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Phone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

REGION VI
429 Murray Street - Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
3018 Old Minden Road
Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

REGION VIII
122 St. John St. - Room 343
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
21454 Koop Drive - Suite 2H
Mandeville, LA 70471
Phone: (985) 871-8300
FAX: (985) 871-8303
Toll Free: 1-800-866-0806

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
3101 W. Napoleon Ave – S140
Metairie, LA 70001
Phone: (504) 838-5357
FAX: (504) 838-5400

TABLE OF CONTENTS

STANDARDS FOR PARTICIPATION 1

PICKING AND CHOOSING SERVICES 1
STATUTORILY MANDATED REVISIONS TO ALL PROVIDER AGREEMENTS 2
SURVEILLANCE UTILIZATION REVIEW 3
FRAUD AND ABUSE HOTLINE 4

HOSPICE CARE 5

HOSPICE CLARIFICATIONS 6

WAIVER PATIENTS AND HOSPICE CHOICE 6
WAIVER OF PAYMENT FOR OTHER SERVICES 6
REVOKING/DISCHARGING RECIPIENTS WHEN RECIPIENT IS ADMITTED TO HOSPITAL 6

DIRECT HOSPICE CARE SERVICES 7

DOCUMENTATION REQUIREMENTS 7
Hospice Notice of Election (BHSF Form Hospice) *7*
Hospice Certification of Terminal Illness (BHSF Form Hospice – TI) *7*
Pending Medicaid Eligibles *7*

HOSPICE RECIPIENT ELECTION/CANCELLATION/DISCHARGE NOTICE 8

PURPOSE 8
ELECTION FORM 8
PREPARATION 8

HOSPICE CERTIFICATION OF TERMINAL ILLNESS 13

PURPOSE 13
THE CERTIFICATION FORM 13
SOURCES OF CERTIFICATION 14

SUBMISSION OF REQUIRED FORMS 16

FORMS SUBMISSION 16
Timeline for Signatures *16*
Fax Confirmations *16*

PRIOR AUTHORIZATION 19

HOSPICE BILLING AND EDIT CLARIFICATIONS 20

REIMBURSEMENT 20
CLAIM SUBMISSION 20
Recipients Residing In The Home *20*
Recipients Residing In A Long Term Care Facility *20*
REVENUE CODE CLARIFICATIONS 20
COMMUNITYCARE EXCLUSION 21
MEDICARE PART B ONLY RECIPIENTS 21
PROGRAM EDITS 22

BILLING HOSPICE SERVICES ON THE UB-92 23

ADJUSTMENTS AND VOIDS 30

LONG TERM CARE ROOM AND BOARD 32

REIMBURSEMENT 32
Calculating Reimbursement *32*

LEAVE DAYS 32
LEAVE DAY LIMITS 33
Home Leave Days *33*
Hospital Leave Days *33*
Special Event Leave Days *33*
NON-COVERED DAYS 34
BILLING 34
CLAIMS SUBMISSION SCHEDULE (ROOM AND BOARD ONLY) 34

UB-92 CLAIM FORM INSTRUCTIONS FOR ROOM AND BOARD 35

ADJUSTMENTS AND VOIDS 46

CLAIM ADJUSTMENTS/VOIDS USING THE UB-92 FORM 46
CLAIM ADJUSTMENT FORM 148 (PATIENT LIABILITY) 46

THE REMITTANCE ADVICE 49

THE PURPOSE OF THE REMITTANCE ADVICE 49
ELECTRONIC REMITTANCE ADVICES (ERAS) 50
REMITTANCE ADVICE BREAKDOWN 50
REMITTANCE SUMMARY 50
CLAIMS IN PROCESS 52
DENIED CLAIMS TURNAROUNDS (DTA) 52
TPL DENIED CLAIMS NOTIFICATION LIST 53

ELECTRONIC DATA INTERCHANGE (EDI) 54

CLAIMS SUBMISSION 54
CERTIFICATION FORMS 54
ELECTRONIC DATA INTERCHANGE (EDI) GENERAL INFORMATION 55
ELECTRONIC ADJUSTMENTS/VOIDS 56

HARD COPY REQUIREMENTS 57

IMPORTANT UNISYS ADDRESSES 58

CLAIMS PROCESSING REMINDERS 59

TIMELY FILING GUIDELINES 61

DATES OF SERVICE PAST INITIAL FILING LIMIT 61
SUBMITTING CLAIMS FOR TWO-YEAR OVERRIDE CONSIDERATION 62

LOUISIANA MEDICAID WEBSITE APPLICATIONS 63

PROVIDER LOGIN AND PASSWORD 63
WEB APPLICATIONS 64
ADDITIONAL DHH AVAILABLE WEBSITES 67

PROVIDER ASSISTANCE 68

PHONE NUMBERS FOR RECIPIENT ASSISTANCE 73

APPENDIX A – MSA CODES 74

MSA CODES FOR LOUISIANA MEDICAID HOSPICE SERVICES 74

APPENDIX B – 2006 LTC MONTHLY AND SUPPLMENTAL PROCESSING SCHEDULE 76

LTC MONTHLY PROCESSING SCHEDULE 76
LTC SUPPLEMENTAL/EMC/UB-92 BILLING SCHEDULE 77

STANDARDS FOR PARTICIPATION

Provider participation in Medicaid of Louisiana is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. These standards are listed as follows:

- Provider agreement and enrollment with the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH);

- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;

- Agreement to accept as payment in full the amounts established by the BHSF and refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.

- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services;

- **NOTE: Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, or the state Attorney General's Medicaid Fraud Control Unit.**

- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1978*, and, where applicable, *Title VII of the 1964 Civil Rights Act*.

Picking and Choosing Services

On March 20, 1991, Medicaid of Louisiana adopted the following rule:

> ***Practitioners who participate as providers of medical services shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by the provider as a Medicaid patient.***

This rule prohibits Medicaid providers from "picking and choosing" the services for which they agree to accept a client's Medicaid payment as payment in full for services rendered. Providers must bill Medicaid for **all** Medicaid covered services that they provide to their clients.

Providers continue to have the option of picking and choosing from which patients they will accept Medicaid. Providers are not required to accept every Medicaid patient requiring treatment.

Statutorily Mandated Revisions to All Provider Agreements

The 1997 Regular Session of the Legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437.14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

- comply with all federal and state laws and regulations;
- provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- have all necessary and required licenses or certificates;
- maintain and retain all records for a period of five (5) years;
- allow for inspection of all records by governmental authorities;
- safeguard against disclosure of information in patient medical records;
- bill other insurers and third parties prior to billing Medicaid;
- report and refund any and all overpayments;
- accept payment in full for Medicaid recipients providing allowances for copayments authorized by Medicaid;
- agree to be subject to claims review;
- the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- notification prior to any change in ownership;
- inspection of facilities; and,
- posting of bond or letter of credit when required.

MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive. The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify Provider Enrollment immediately that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.

Surveillance Utilization Review

The Department of Health and Hospitals' Office of Program Integrity, in partnership with Unisys, perform the Surveillance Utilization Review function of the Louisiana Medicaid program. This function is intended to combat fraud and abuse within Louisiana Medicaid and is accomplished by a combination of computer runs, along with medical staff that review providers on a post payment basis. Providers are profiled according to billing activity and are selected for review using computer-generated reports. The Program Integrity Unit of DHH also reviews telephone and written complaints sent from various sources throughout the state, including the fraud hotline.

☞ Program Integrity and SURS would also like to remind all providers that they are bound by the conditions of their provider agreement which includes but is not limited to those things set out in Medical Assistance Program Integrity Law (MAPIL) R.S. 46:437.1 through 440.3, The Surveillance and Utilization Review Systems Regulation (SURS Rule) Louisiana Register Vol. 29, No. 4, April 20, 2003, and all other applicable federal and state laws and regulations, as well as Departmental and Medicaid policies. Failure to adhere to these could result in administrative, civil and/or criminal actions.

Providers should anticipate an audit during their association with the Louisiana Medicaid program. When audited, providers are to cooperate with the representatives of DHH, which includes Unisys, in accordance with their participation agreement signed upon enrollment. Failure to cooperate could result in administrative sanctions. The sanctions include, but are not limited to:

- Withholding of Medicaid payments
- Referral to the Attorney General's Office for investigation
- Termination of Provider Agreement

Program Integrity and the Unisys Surveillance Utilization Review area remind providers **that a service undocumented is considered a service not rendered**. Providers should ensure their documentation is accurate and complete. All undocumented services are subject to recoupment. Other services subject to recoupment are:

- Upcoding level of care
- Maximizing payments for services rendered
- Billing components of lab tests, rather than the appropriate lab panel
- Billing for medically unnecessary services
- Billing for services not rendered
- Consultations performed by the patient's primary care, treating, or attending physicians

Fraud and Abuse Hotline

The state has a hotline for reporting possible fraud and abuse in the Medicaid Program. Providers are encouraged to give this phone number/web address to any individual or provider who wants to report possible cases of fraud or abuse.

Anyone can report concerns at (800) 488-2917 or by using the web address at http://www.dhh.state.la.us/offices/fraudform.asp?id=92

HOSPICE CARE

Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

A recipient must be terminally ill in order to receive Medicaid hospice care. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

Through the Hospice Program, Medicaid reimburses direct hospice care services as well as Long Term Care room and board charges for those recipients residing in a Long Term Care Facility.

Included in the packet are:

- election process;
- prior authorization process;
- hospice policy;
- billing procedures.

HOSPICE CLARIFICATIONS

WAIVER PATIENTS AND HOSPICE CHOICE

DHH has notified CMS of their intent to clarify the policy regarding the provision of waiver and hospice services. It has always been DHH's position that for patients with Medicaid only, the patient must choose between waiver and hospice services. DHH has allowed Medicare/Medicaid patients to receive both services since Medicare pays 100% of hospice and Medicaid pays no coinsurance or deductible.

However, after extensive discussions, DHH staff has concluded that the lack of Medicaid payment is not relevant. Regardless of the source, the hospice provider is paid for the provision of their services. **Therefore, please accept this as official notice of the intent of the Louisiana Department of Health and Hospitals to clarify our policy to Recipients, Hospice providers, Waiver providers, and Case Managers that recipients, whether Medicaid and/or dual eligibles must choose to receive either waiver or hospice services. They shall not receive both.**

It is the intention of DHH to require recipients forfeiting their wavier services for hospice services to have their case manager sign their Hospice Election forms. This will ensure that the recipient has made an informed choice.

WAIVER OF PAYMENT FOR OTHER SERVICES

For the duration of an election of hospice care, an individual waives all rights to Medicaid payments for:

- Hospice care provided by hospice other than the hospice designated by the individual;
- Any Medicaid services (including but not limited to Personal Care Services (PCS), Waiver services as described above, and Home Health) that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care, except for services provided by:
    - The individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

REVOKING/DISCHARGING RECIPIENTS WHEN RECIPIENT IS ADMITTED TO HOSPITAL

It has come to the attention of the Department that some hospice agencies are encouraging recipients to revoke hospice when they have an inpatient admission and re-elect hospice after discharge from the hospital. **THIS IS AGAINST MEDICAID HOSPICE POLICY**.

DIRECT HOSPICE CARE SERVICES

DOCUMENTATION REQUIREMENTS

Hospice Notice of Election (BHSF Form Hospice)

An election statement for hospice care must be filed by the recipient or by a person authorized by law to consent to medical treatment for the recipient. For dually eligible recipients, hospice care must be elected for both the Medicaid and Medicare programs simultaneously. **The provider must submit a copy of the BHSF Notice of Election Form (NOE) to the Bureau's Hospice Manager for every recipient who elects Medicaid Hospice.**

Hospice Certification of Terminal Illness (BHSF Form Hospice – TI)

Providers are required to complete a Certification of Terminal Illness (CTI). For dually eligible recipients, it is acceptable for providers to use Medicare's CTI.

Pending Medicaid Eligibles

The Notice of Election and Certification of Terminal Illness forms may be faxed to the State Hospice Unit for patients electing hospice who have "Pending" Medicaid. Providers enrolling patients with "Pending" status are assuming responsibility for those patients. If the patient becomes eligible for Medicaid and the effective date of eligibility is on or prior to the election date and the NOE and CTI were timely sent to the State Hospice Unit, the recipient will be entitled to hospice services with the protected election date. If the patient is not eligible for Medicaid, he is not eligible for hospice services.

- ☞ **To ensure optimal reimbursement providers should make every effort to submit the required documents in a timely fashion.**

HOSPICE RECIPIENT ELECTION/CANCELLATION/DISCHARGE NOTICE

PURPOSE

The Hospice Recipient Election/Cancellation/Discharge Notice is used to notify Department of Health & Hospitals, Bureau of Health Services Financing's Hospice Manager of a Medicaid hospice recipient's voluntary election or cancellation of the hospice services offered through Louisiana Medicaid. It is also used to update changes in the Medicaid hospice recipient's condition and status.

ELECTION FORM

The hospice must obtain the recipient's signed Election Form (BHSF – Hospice) and at least the verbal verification of the terminal illness (BHSF Form Hospice – TI) within two days of the admission date on the election form. Both forms must be submitted to the Bureau of Health Services Financing (BHSF) no later than 10 days from the admission date on the election form.

PREPARATION

The first section of the form is to be completed by the patient or legal representative. The signature of the patient or legal representative is required.

Detailed instructions for items required for the Notice of Election:

Admission/Election Date (Required):

Enter the admission/election date, which is the same date as the effective date of the hospice election or change of election.

Note: If the Notice of Election Form and the Certification of Terminal Illness are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date that BHSF receives the proper documentation.

EXAMPLE: The hospice election date (admission) is January 1, 2006. The physician's certification is dated January 3, 2006. The hospice date for coverage and billing is January 1, 2006. The first hospice benefit period ends 90 days from January 1, 2006.

Show the month, day, and year numerically as MM-DD-YYYY.

The admission date will change when the patient re-elects hospice anytime after a revocation or discharge.

Type of Bill (Required):

Enter the three-digit numeric type of bill code: 81A, B, C, D, or 82A, B, C, D, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure:

1st Digit - Type of Facility

8 - Special facility (hospice)

2nd Digit - Classification

1 - Hospice (Non-hospital based)
2 - Hospice (Hospital based)

3rd Digit - Frequency	Definition
A - Hospice Admission Notice	Use when the hospice is submitting Form as an Admission Notice.
B - Hospice Termination/ Revocation Notice	Use when the hospice is submitting Form as a notice of termination/revocation for a previously posted hospice election.
C - Hospice Change of Provider Notice	Use when Form is used as a Notice of Change to the hospice provider.
D - Hospice Election Void/Cancel	Use when Form is used as a Notice of a Void/Cancel of hospice election.
E - Hospice Change of Ownership	Use when Form is used as a Notice of Change in Ownership for the hospice.

Statement Covers Period:

This field should be used when filing an 81B/82B document only. The “From” date is the start date of the period from which the patient is revoking or being discharged. The “Through” date is the date of revocation or discharge.

Patient's Name (Required):

Enter the patient’s last name, first name, and middle initial.

Patient's Medicaid ID Number (Required):

Enter the recipient's 13-digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information obtained by "swiping" the plastic Medicaid ID card with MEVS, e-MEVS, or through REVS. Make certain that the last two digits are the correct individual suffix for your recipient. The number must match the recipient's name.

If the recipient has applied for Medicaid and no decision has been made on his application, the word "Pending" can be written in this field. If the patient becomes eligible for Medicaid, re-send the NOE with a line drawn through the word "Pending", and write in the 13-digit Medicaid ID number. If the original NOE and CTI were timely sent to the State Hospice Unit and the patient's effective date of eligibility is on or prior to the election date, the recipient will be entitled to hospice services. If the patient is not eligible for Medicaid, he is not eligible for hospice services. Providers enrolling patients with "Pending" ID numbers are assuming responsibility for those patients.

Patient's Address (Required):

Enter the patient's complete mailing address, including Zip code.

Patient's Date of Birth (Required):

Enter the month, day, and year of birth (MM-DD-YYYY) of patient. Example: 06121903 If the full correct date is not known, zero fill the field.

Patient's Medicare Number (Required, if applicable):

This field should only be used if the patient has Medicare. Enter the patient's Medicare health insurance number.

Principal Diagnosis Code (Required):

Use the most specific, and accurate numeric ICD-9-CM diagnosis code for the terminal illness that is current. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. CMS only accepts ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-l260, or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. **Use full ICD-9-CM diagnoses codes including all five digits where applicable.**

Other Diagnosis Codes (Required, if applicable):

Enter the full ICD-9 codes, including all five digits where applicable, for any other terminal diagnosis or related condition.

Hospice Name and Address:

Enter the following: Provider Name, Street Name and Number or P. O. Box Number, City, State, and ZIP code, Telephone Number Required, FAX number is optional.

Provider Number (Required):

Enter the seven (7) digit Medicaid provider identification number.

Attending Physician I.D and Name (Required):

Enter the seven (7) digit Medicaid provider identification number and name of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.

Other Physician I.D. (Required):

Enter the word "employee" or "non-employee" here to describe the relationship the patient's attending physician has with the hospice. "Employee" also refers to a volunteer under your jurisdiction.

Name of Nursing Facility or ICF-MR (Required, if applicable):

Enter the name of the facility in which the individual resides or intends to reside.
Medicaid field office staff handles long-term care cases.

BHSF Form Hospice
Issued 07/02

Medicaid Program
Hospice Recipient Election/Cancellation/Discharge Notice

TO BE COMPLETED BY PATIENT OR LEGAL REPRENTATIVE

I elect to receive Hospice from the provider named below effective _____
Admission Date

PATIENT'S DECLARATION

I understand and acknowledge:

- Medicaid Hospice consists of the following election periods:
  An initial 90-day period;
  a subsequent 90-day period; and
  subsequent periods of 60 days each.
- if I reach a point of stability, and am no longer considered terminally ill, that the Hospice will be unable to certify me, and I will return to the traditional Medicaid services, if applicable.
- by electing Medicaid Hospice, I waive all rights to Medicaid covered services related to the treatment of my terminal illness(es).
- if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit simultaneously with Medicaid Hospice.
- By this election, I have been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to my terminal illness(es).

_____ _____
Signature of Patient or Legal Representative Date signed

TO BE COMPLETED BY THE HOSPICE PROVIDER

_____ _____ _____
Type of Bill FROM THROUGH
Statement Covers Period

_____ _____
Patient's Name Patient's Medicaid ID Number

_____
Patient's Address

_____ _____
Patient's Date of Birth Patient's Medicare Number

_____ _____
Principal Diagnosis Code Other Diagnosis Codes

_____
Hospice Name and Address

_____ _____ _____
Provider Number Attending Physician I.D. & Name Other Physician I.D.

_____
Name of Nursing Facility or ICF-MR

_____ _____
Provider Representative Signature Date signed

HOSPICE CERTIFICATION OF TERMINAL ILLNESS

PURPOSE

The hospice must use the BHSF Form Hospice-TI (Certification of Terminal Illness Form) for documentation of written and verbal certification of terminal illness for Medicaid only recipients. A sample of this form follows. For dually eligible recipients, the form that is used for Medicare Certification of Terminal Illness, which also meets the requirements as detailed in this section, may be used.

The certification must specify that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. The certification shall be based on the physician's clinical judgment regarding the normal course of the individual's illness and must include the signature(s) of the physician(s). A stamped physician's signature is not acceptable on the certification.

If verbal certification is made, the referral from the physician must be received by a member of the hospice interdisciplinary group (IDG). The entry of the verbal certification in the patient's clinical record must include, at a minimum, the patient's name, physician's name, terminal diagnosis(es), prognosis, and the name and signature of the IDG member taking the referral.

Submission of the physician's Certification of Terminal Illness is required for the initial election period and for those periods requiring prior authorization. However, copies of certification forms for all election periods shall be made available to the Bureau upon request.

THE CERTIFICATION FORM

For the first 90 day period, the hospice must obtain Certification of Terminal Illness no later than 2 calendar days after hospice care is initiated (by the end of the third calendar day). If written certification is not obtained within 2 calendar days, verbal verification from the physician must be received by a interdisciplinary team member and the verbal verification section on the form must be completed and submitted to BHSF within 2 calendar days following the initiation of hospice care. Once the Certification of Terminal Illness has been obtained, BHSF Form Hospice – TI must be received by the Bureau of Health Services Financing (BHSF) within 8 days of the verbal verification.

NOTE: If the Notice of Election Form and the Certification of Terminal Illness are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date that BHSF receives the completed documentation. **Reimbursement is not available for the days prior to the certification, and reimbursement will be effective on the date that BHSF receives the completed TI Form.**

For the subsequent periods, a written certification must be on file in the recipient's record prior to the submission of a claim.

Hospice provider staff must make an appropriate entry in the patient's clinical record as soon as they receive an oral certification and file written certification in the clinical record.

Once the recipient hospice election and the Certification of Terminal Illness forms have been received by BHSF, the hospice election information will be loaded on the recipient's Medicaid

file. Claims will not process and pay until the hospice election segment is loaded on the Medicaid files. If a hospice claim is received prior to the Medicaid files being updated, the claim will pend for three (3) weekly RA cycles waiting for the files to be updated with the hospice election information. If the files are not updated within the three (3) weeks, the claim will then deny stating the recipient was not hospice eligible. After the hospice election information is loaded on the recipient's Medicaid file, BHSF will notify providers, both Hospice and Long Term Care if applicable, of the election date via letters.

NOTE: Please make sure that the Election Form, Certification of Terminal Illness and any necessary attachments are properly completed prior to submitting to BHSF. This will help ensure that recipient Medicaid files are updated timely.

- The hospice provider **MUST** obtain written certification of terminal illness **FOR EACH ELECTION PERIOD**. For the initial 90-day period and the subsequent 90-day period, the certification may be completed 2 weeks prior to the beginning of each election period. Once periods requiring PA begin, the certification may be completed at least 10 calendar days and up to 30 calendar days prior to the end of a preceding period.

If these requirements are not met, reimbursement is not available for the days prior to the certification. Reimbursement will be effective on the date that BHSF receives the completed TI Form.

For the subsequent periods, a written certification must be on file in the recipient's record prior to the submission of a claim.

Hospice staff must make an appropriate entry in the patient's clinical record as soon as they receive an oral certification and file written certification in the clinical record.

SOURCES OF CERTIFICATION

For the initial 90-day period, the hospice must obtain a completed certification form or documented receipt of a verbal certification statement, if applicable, from:

- the hospice's medical director or a physician member of the hospice's interdisciplinary group; and

- the recipient's attending physician if he/she has an attending physician. The attending physician must be a doctor of medicine or osteopathy and must be identified by the recipient, at the time of election for hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

For subsequent periods, the certification form may be completed by either the medical director of the hospice or the physician member of the hospice interdisciplinary group.

BHSF Form Hospice-TI
Issued 07/02

Medicaid Program
Hospice Certification of Terminal Illness

Patient's Name _____ Patient's Medicaid ID Number _____ Patient's Date of Birth _____

First Benefit Period (90 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Attending Physician _____ Signature of Hospice Medical Director or physician member of interdisciplinary group _____

Date signed _____ Date signed _____

Second Benefit Period (90 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Hospice Medical Director or physician member of interdisciplinary group _____ Date signed _____

Third Benefit Period (60 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Hospice Medical Director or physician member of interdisciplinary group _____ Date signed _____

Fourth Benefit Period (60 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Hospice Medical Director or physician member of interdisciplinary group _____ Date signed _____

Note: If additional periods are to be certified use an additional form

VERBAL VERIFICATION (within two days of election date)

I certify that on the date signed below a verbal verification was obtained from the physician named below, confirming that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

Physician's Name _____ Terminal diagnosis(es) _____

Name of IDG member taking referral _____ Signature of IDG member taking referral _____ Date signed _____

SUBMISSION OF REQUIRED FORMS

FORMS SUBMISSION

The original Hospice Election/Cancellation/Discharge Notice and Hospice Certification of Terminal Illness form must be kept by the provider. A copy of the forms must be mailed or faxed to the address/number below:

Hospice Manager
Louisiana Medicaid/Bureau of Health Services Financing
Program Operations, Bin # 24
P.O. Box 91030
Baton Rouge, LA 70821-9030
FAX: (225) 342-1411

Note: Fax is preferred due to the time frame involved.

Timeline for Signatures

Please make sure that the recipient does not sign the Notice of Election more than two weeks (calendar days) prior to the election. Also, make sure that the attending physician and medical director do not sign the Certification of Terminal Illness or give verbal certification no more than two weeks (calendar days) prior to the recipient's date of election.

Fax Confirmations

Please make sure that once you fax your Notice of Election and Certification of Terminal Illess that you keep a copy of your fax confirmation sheet for your own verification that you sent us the information. Please do not send a fax log of everything that you have faxed out but send a fax confirmation that has the confirmation at the top of the page and a copy of what was sent underneath it. Please see the following pages for a copy of an acceptable and unacceptable fax confirmation.

ACCEPTABLE CONFIRMATION

Transmission Log

Program Operations Friday, 2006-03-10 09:33 225-342-1411

Job #	Date	Time	Length	Speed	Station Name/Number	Type	Pgs	Status
14659	2006-03-10	09:32	0:29	14400	LA DHH	SCAN	1	OK -- ECM

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

Program Operations
Fax: 225-342-1411

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

DATE: 3-10-06 PAGE 1 OF 1

TO: Hospice Program Manager

LOCATION: DHH

FAX #: (225)342-1411

FROM: Hospice Provider

PHONE #: (555) 555-5555

COMMENTS: Re: Jane Doe - NOE and Completed CTI

CONFIDENTIALITY NOTICE

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PLEASE CALL IF YOU HAVE PROBLEMS RECEIVING THIS FAX OR IF PAGES ARE MISSING

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF HEALTH SERVICES FINANCING • PROGRAM OPERATIONS
1201 CAPITOL ACCESS ROAD • P.O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE #: 225-342-5774 • FAX #: 225-342-1411
"AN EQUAL OPPORTUNITY EMPLOYER"

UNACCEPTABLE CONFIRMATION

Receive Log

Program Operations Sunday, 2006-03-05 18:33 225-342-1411

Job #	Date	Time	Length	Speed	Station Name	Pgs	Status
14340	2006-03-03	11:31	1:28	14400		4	OK -- ECM
14341	2006-03-03	11:41	0:42	14400		2	OK -- ECM
14342	2006-03-03	11:47	1:04	14400		3	OK -- ECM
14343	2006-03-03	11:54	0:54	14400		2	OK
14344	2006-03-03	12:31	2:01	12000		3	OK -- ECM
14345	2006-03-03	12:38	0:35	14400		1	OK -- ECM
14346	2006-03-03	12:46	0:31	14400		1	OK -- ECM
14347	2006-03-03	12:55	0:33	14400		1	OK -- ECM
14348	2006-03-03	13:00	0:55	14400		3	OK -- ECM
14349	2006-03-03	13:06	0:44	14400		2	OK -- ECM
14350	2006-03-03	13:13	4:03	4800		3	OK -- ECM
14351	2006-03-03	13:19	2:06	12000		2	OK -- ECM
14352	2006-03-03	13:25	0:59	14400		3	OK -- ECM
14353	2006-03-03	14:11	1:16	14400		2	OK
14354	2006-03-03	15:06	1:02	14400		3	OK -- ECM
14355	2006-03-03	15:24	2:57	14400		10	OK -- ECM
14357	2006-03-03	15:34	0:26	14400		0	LINE DROP
14358	2006-03-03	15:36	1:39	14400		4	OK
14360	2006-03-03	16:18	1:08	12000		1	OK -- ECM
14361	2006-03-03	16:21	1:31	14400		4	OK -- ECM
14362	2006-03-03	16:32	2:21	14400		5	OK -- ECM
14363	2006-03-03	16:42	1:45	14400		4	OK -- ECM
14364	2006-03-03	16:45	1:44	14400		4	OK -- ECM
14365	2006-03-03	16:48	0:52	14400		2	OK -- ECM
14366	2006-03-03	16:49	0:51	14400		2	OK -- ECM
14367	2006-03-03	16:55	0:42	0		0	No Fax Detected
14368	2006-03-03	16:56	1:28	14400		4	OK -- ECM
14369	2006-03-03	17:01	0:47	14400		2	OK -- ECM
14370	2006-03-03	17:02	0:46	14400		2	OK -- ECM
14371	2006-03-03	17:06	1:50	14400		5	OK -- ECM
14372	2006-03-03	17:13	1:30	14400		4	OK -- ECM
14373	2006-03-03	17:15	1:36	14400		4	OK -- ECM
14374	2006-03-03	17:21	1:35	14400		3	OK -- ECM
14375	2006-03-03	17:26	0:46	14400		2	OK -- ECM
14376	2006-03-03	17:37	0:31	14400		1	OK -- ECM
14377	2006-03-04	13:01	0:59	14400		2	OK -- ECM
14378	2006-03-05	02:25	0:49	14400		2	OK -- ECM
14379	2006-03-05	15:18	1:25	14400		3	OK -- ECM
14380	2006-03-05	18:29	3:03	12000		4	OK -- ECM
14381	2006-03-05	18:32	0:49	14400		2	PRINTING

Total Pages: 111 Total Time: 52:43 Number of Errors: 1

PRIOR AUTHORIZATION

At this time, the PA-88 authorization form is not being used. Until you receive notice of the effective date of this form, providers requesting prior authorization (PA) of services should send the following: (1) a letter of request on hospice letterhead; (2) Certification of Terminal Illness form signed by the Hospice Medical Director or physician member of the interdisciplinary group for the period PA is being requested; (3) updated Plan of Care; (4) updated Physician's Orders; (5) Progress Notes for all services rendered; (6) Social Evaluation; and (7) any other documentation supporting the continuation of hospice services. The packet should be mailed to:

Hospice Program Manager
Bureau of Health Services Financing
Program Operations, Bin #24
P.O. Box 91030
Baton Rouge, LA 70821-9030

Prior authorization is required after the initial 180 days of hospice coverage. Prior authorization requests should be submitted 20-30 days before the end of the 180 days. If the PA is approved, it covers sixty (60) days. If another 60-day election period is required, the PA request should be submitted at least ten (10) days prior to the end of the current election period. This will ensure that requests are received and approved/denied before the preceding period ends.

Note: Prior authorization is not required for the initial 90-day election period or the subsequent 90-day election period. It is required for all subsequent 60-day election periods.

HOSPICE BILLING AND EDIT CLARIFICATIONS

The expansion of the Louisiana Medicaid Hospice Program on July 1, 2002, resulted in a number of changes in policy, procedures, and systems programming.

As we have monitored these changes in Program activity and received feedback from the provider community, claims billing and processing issues were identified and addressed in the following areas:

REIMBURSEMENT

Medicaid reimbursement for hospice care is made at one of four predetermined per diem rates for each day in which a Medicaid recipient is under the care of the hospice (with the exception of payment for physician services). The rates are calculated based on the geographic location (Metropolitan Statistical Area – MSA) where the services are furnished.

CLAIM SUBMISSION

Recipients Residing In The Home

Hospice providers only bill for direct hospice services when a patient resides in the home, unless the recipient is dual eligible with Medicare Part A, then no bill should be submitted to Medicaid since Medicare Part A reimburses hospice services at 100 percent.

Recipients Residing In A Long Term Care Facility

Hospice providers bill for both direct **hospice** services and **room and board** when a recipient resides in a Nursing Facility, **unless** the recipient is dual eligible with Medicare Part A, then Hospice providers will bill only for room and board. Because Medicare Part A reimburses hospice services at 100 percent, no bill for direct hospice services should be submitted to Medicaid.

REVENUE CODE CLARIFICATIONS

Routine Home Care (Revenue Code 651) – use for the following situations:

1. The day of discharge when a recipient is discharged ALIVE from general inpatient care or respite care.
2. The recipient is in a non-contracted facility.
3. The recipient is in a facility for a reason unrelated to the terminal condition.
4. Fewer than 8 hours of continuous care are provided to the recipient.

Continuous Home Care (Revenue Code 652) – use for the following situations:

1. During brief periods of crisis when a recipient requires continuous care which is primarily nursing care. Homemaker and aide services may also be provided to supplement the nursing care.
2. A minimum of 8 hours of care must be provided during a 24-hour day which begins and ends at midnight.
3. The Continuous Home Care rate is divided by 24 hours in order to arrive at an hourly rate.
4. The provider should bill for the total number of hours and they should be listed in the units field next to revenue code 652.

Inpatient Respite Care (Revenue Code 655) – use for the following situations:

1. When a recipient is receiving care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home.
2. The day of admission to the inpatient facility.
3. The day of discharge when a recipient EXPIRES while receiving respite inpatient care.
4. A maximum of 5 consecutive days at a time including the date of admission, but not counting the date of discharge alive.

General Inpatient Care (Revenue Code 656) – use for the following situations:

1. The day of admission to the inpatient facility when the admission is related to the recipient's terminal diagnosis.
2. The day of discharge when a recipient EXPIRES while receiving general inpatient care.
3. When the recipient is in an inpatient facility that has a contract with the hospice agency.

Physician Services (Revenue Code 657) – use in the following situations:

1. When physician professional services are being provided to hospice patients; and the hospice is responsible for reimbursing the physician.
2. The physician can be an employee of the hospice, a volunteer, or a consultant.

COMMUNITYCARE EXCLUSION

Changes have been made in the programming logic to exclude Hospice services from requiring a CommunityCARE referral. Hospice claims are now exempt from the CommunityCARE system edits and should process without a CommunityCARE PCP referral.

MEDICARE PART B ONLY RECIPIENTS

Claims for recipients that have Medicare Part B ONLY on the recipient's Medicaid files (DO NOT have Medicare Part A on the recipient file) are now exempt from the Medicare 275 edit. The Medicaid Recipient Resource File must reflect this information for these claims to be excluded from this edit. If the file indicates the recipient has Medicare Part A (even if incorrect),

claims will not be excluded from this edit until the Medicare information is verified by Medicaid and the file is corrected.

PROGRAM EDITS

The following edits are now in place:

Edit 494 (Invalid MSA Code) This edit is received when the MSA code entered in the Value Code Fields 39-41 is not a valid MSA code. Please remember that the MSA code must appear to the left of the delimiter in the amount field, and double zeros (00) must appear to the right of the delimiter in the amount field.

Edit 495 (Not Hospice Eligible) The recipient file does not indicate the recipient has elected Hospice. These claims will pend systematically for three (3) weekly cycles before denying with this edit.

Edit 511 (Provider/Recipient Mismatch) If the claim submitted is for a Hospice provider, but that Hospice provider is not the provider linked to the recipient on the date of service billed, the billing Hospice provider will receive this edit denying the claim, because the provider ID number on the claim must match the provider ID number on the recipient's linkage file.

Edit 493 (Non-Hospice Provider) The hospice agency is responsible for either providing or paying for all covered services related to the treatment of the recipient's terminal illness. If claims are received from providers other than the hospice provider of record, those claims must have documentation attached to justify that the services were medically necessary and were not related to the terminal condition for which hospice care was elected. These claims will pend to the Unisys Medical Review Department to determine if the services being billed are not related to the hospice condition. If the services are not related to the hospice condition, the claims will be released for payment. If the services are related to the hospice condition, the claims will be denied with this edit. The servicing provider should obtain payment for these services from the hospice agency.

Edit 042 (Invalid UB-92 Bill Type Code) If hospice claims are received with a Bill Type that is not "81" or "82", the claims will deny for this edit.

Edit 085 (Invalid Units/Visits) If hospice claims are received with a correct Bill Type, but the dates of service and the units do not match, the claims will deny for this edit.

Edit 303 (Inpatient Respite Days Greater Than Five) Payment for respite care will be reimbursed for a maximum of five consecutive days at a time (including the date of admission but not including the date of discharge.) NOTE: Medicaid will pay for the date of death.

Edit 358 (No Valid Rate was found for LTC Level of Care) This edit is received when the Hospice recipient does not have a Nursing Home (LTC) provider number on the MMIS File. This edit will be resolved by DHH/BHSF.

Edit 356 (Total LTC Days Conflict with Sum of LTC LOC Days) This edit is received when the hospice bills for room & board and there is an error in one or more of the following fields on the claim: Field No. 4, 6, 7, 22, 46, and/or 47.

BILLING HOSPICE SERVICES ON THE UB-92

UB-92 billing for Hospice services has not changed. Instructions for completion of the REQUIRED Form Locators for Hospice services, as well as a sample claim form follow.

Field 1. (Untitled) - Provider Name, Address, and Telephone Number

Required. The minimum entry is the provider's name, City, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. This information is used to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Field 4. Type of Bill

Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.
Code Structure

1st Digit - Type of Facility
8 - Special facility (hospice).

2nd Digit - Classification
1 - Hospice (Non-hospital based)
2 - Hospice (Hospital based)

3rd Digit - Frequency	Definition
1 - Admit Through Discharge Claim	Use this code for a bill encompassing an entire course of hospice treatment for which you expect payment, i.e., no further bills will be submitted for this patient.
2 - Interim - First Claim	Use this code for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	Use this code when a payment bill for a hospice course of treatment has been submitted and further bills are expected to be submitted.
4 - Interim - Final Claim	Use this code for a payment bill which is the last of a series for a hospice course of treatment. The "Through" date of this bill (Field 6) is the discharge date or date of death.
7 - Replacement of Prior Claim	Use this code to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. Submit a code "7" (Replacement of Prior Claim) to show the corrected information.

Field 6. Statement Covers Period (From-Through)

Required. Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YYYY). Do not show days before the patient's entitlement began. The "From" date is used to determine timely filing. Be sure that the “From” date does not overlap with the “Through” date on your prior bill. A claim cannot span more than one month of service at a time.

Field 12. Patient's Name

Required. Enter the patient's last name, first name, and middle initial at the time services were rendered.

Field 13. Patient's Address

Required. Enter the patient=s full mailing address, including street number and name, post office box number, city, state (2-digit alpha), and valid zip code (minimum of 5 digits).

Field 14. Patient's Birth Date

Required. Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, zero fill the field.

Field 15. Patient's Sex

Required. Enter an "M" for male or an "F" for female.

Field 17. Admission Date

Required. Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. On the first claim, the date of admission should match the From date in the Statement Covers Period (Field 6). The date of admission may not precede the physician's certification by more than 2 calendar days.

Note: If the Notice of Election Form and the Certification of Terminal Illness are not received within 10 calendar days, the date of admission (election) will be the date that BHSF receives the proper documentation.

EXAMPLE: The hospice election date (admission) is January 1, 2006. The physician's certification is dated January 10, 2006. The hospice admission date for coverage and billing is January 8, 2006. The first hospice benefit period will end 90 days from January 8, 2006.

Show the month, day, and year numerically as MM-DD-YYYY.

Field 22. Patient Status

Required (maximum of 2 digits). This code indicates the patient's status as of the "Through" date of the billing period (Field 6).

Code Structure

01 Discharged to home or self care (routine discharge).
30 Still patient or expected to return for outpatient services.
40 Expired at home.
41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice.
42 Expired - place unknown.

Verify that patient’s status matches type of bill (Field 4).
Example: 811 or 821 bill types should have a patient status of 01, 40, 41, or 42.

Fields 32, 33, 34, and 35. Occurrence Codes and Dates

Required. Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YYYY). If there are more occurrences than there are spaces on the form, use Field 36 (occurrence span) or Field 84 (remarks) to record additional occurrences and dates.

Use the following codes where appropriate:

Code		Definition
27*	Date of Hospice Certification	Code indicates the date of written certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
42	Termination date	Enter code to indicate the date on which recipient terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.)

* This occurrence code must be present in order to show when certification occurred for each new benefit period. If the occurrence code 27 with a date is not present for each certification or re-certification of an individual, the claim will reject.

Claims that are submitted between certifications or prior to the due date of the next certification do not require occurrence code 27. Any claim that starts a new hospice period or that contains services that overlap the next hospice period must show the occurrence code 27 and the re-certification date.

Field 36. Occurrence Span Code and Dates

Not Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY. Use the following code where appropriate:

Code	Title	Definition
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients.

Note: If more than 1 episode of Inpatient Respite Care occurred during the billing period, record those episodes beyond the first episode in Field 84. Remarks

Fields 39-41. Value Code.

Required. Hospices are required to submit claims for payment for hospice care based on the geographic location where the service(s) was provided. The Value Code and Metropolitan Statistical Area (MSA) code/rural state code for each service are required for correct claim payment. (The current MSA code listing is found at the end of this packet in Appendix A.)

Value codes must be entered horizontally across the line to match the corresponding revenue codes listed vertically in Field 42. In other words, enter fields 39a, 40a, 41a before fields 39b, 40b, 41b, and so forth. (The first line of “a” codes is used before entering information in “b” codes.) Enter value code 61 in the “code” section of the field; the MSA code/rural state code in

the dollar portion of the “amount” section of the field; and double zeros (00) in the “cents” portion of the “amount” section of the field.

Multiple Occurrences of the Same Service: Enter the value codes/MSAs multiple times if there are multiple occurrences of the same service during the same month. (See further explanation under Fields 42 and 45.)

Note: Medicaid will continue to reimburse based on Metropolitan Statistical Area (MSA) Codes and will not use the Core Based Statistical Area (CSBA) Codes that Medicare has implemented. Please use the appropriate MSA codes as listed in this document.

Field 42. Revenue Code

Required. 3-digit numeric. Assign a revenue code for each service provided in order to be paid properly. Revenue codes should be listed vertically in ascending order. If more than one (1) occurrence of any hospice service occurs during the billing period list each occurrence of that revenue code on a separate line in ascending order. (See field 45 for instructions for associated dates of service.)

Example:	651 Routine Home Care	07/01/05
	651 Routine Home Care	07/08/05
	652 Continuous Home Care	07/06/05
	656 General Inpatient Care	07/31/05

Use these revenue codes to bill Medicaid:

Code	Description	Standard Abbreviation
651	Routine Home Care	RTN Home
652	Continuous Home Care	CTNS Home (A minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is reported as 1 hour.)
655	Inpatient Respite Care	IP Respite
656	General Inpatient Care	GNP IP
657	Physician Services	PHY Ser (must be accompanied by a physician procedure code)

NOTE: Revenue code 001 (Total Charges) MUST always be the final revenue code.

Field 43.--Revenue Description

Not Required. Enter a narrative description or standard abbreviation for each revenue code shown in Field 42 on the adjacent line in Field 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown under Field 42.

Field 44. HCPCS Rates

Required if applicable. When using Revenue Code 657 (Physician Services), enter the appropriate CPT-4 code for the physician's professional services. Procedure codes should be obtained from the physician providing the service and are required in order for the intermediary to make reasonable charge determinations when paying you for physician services.

Field 45. Service Date

Required. A service date MUST BE ENTERED for each revenue code indicated. The service date should be the first date that a service began.

Multiple Occurrences of the Same Service: If the same service occurs multiple times during a month of service (i.e., there is a break in the service dates for that service – not consecutive dates), that service must be entered multiple times on separate lines. In these cases, the initial date for that SEGMENT of that service should be used as the Service Date (see example under Field 42). In other words, if routine care is provided beginning the first day of the month of service for 5 days; the patient then has continuous care beginning the sixth day of the month for 2 days; followed by routine care again for the eighth day through the 30th of the month, the revenue code for routine care should be indicated twice – one entry with a service date of the first day of the month and one entry with a service date of the eight day of the month.

Field 46. Units of Service

Required. Enter the number of units of service for each type of service on the line adjacent to the revenue code, description, and service date.

Units of Revenue Code 651 (Routine Care) are measured in DAYS.
Units of Revenue Code 655 (Inpatient Respite Care) are measured in DAYS.
Units of Revenue Code 656 (General Inpatient Care) are measured in DAYS.
Units of Revenue Code 657 (Physician Service) are measured in PROCEDURES.
Units of Revenue Code 652 (Continuous Care) are measured in HOURS. (Remember that a minimum of 8 hours-not necessarily consecutive-in a 24-hour period is required. Less than 8 hours is considered routine care.)

PLEASE BE SURE THAT THE UNITS AND DATES BILLED FOR EACH OCCURRENCE MATCH.

Field 47. Total Charges

Required. Enter the total charges for the billing period by revenue code (Field 42) on the adjacent line in Field 47. The last revenue code entered in Field 42 ("000l") represents the grand total of all charges billed. The total is in Field 47 on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

Fields 50. Payer Identification

Required. If Medicaid is the primary payer, enter "Medicaid" on line A.

Field 51. Provider Number

Required. Enter the seven (7) digit Medicaid provider identification number.
It must be entered on the same line as "Medicaid" in Field 50.

Field 54. Prior Payments

Situational. If third party insurance is primary, enter the amount paid on this claim by TPL or 0 if nothing was paid.

Field 60. Patients Medicaid ID Number

Required. Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid "swipe" card, through e-MEVS or REVS. Make certain that the last two digits are the correct individual suffix for your recipient. If the number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.

Field 62. Insurance Group No.

Situational. If third party insurance is primary, enter the six-digit Louisiana-specific TPL carrier code assigned to the carrier in this field.

Field 67. Principal Diagnosis Code

Required. Use the most specific and accurate full ICD-9-CM diagnosis code for the terminal illness that is current. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. CMS only accepts ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-l260, or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Use full ICD-9-CM diagnoses codes including all five digits where applicable.

Field 68-75. Other Diagnostic Codes

(Required if applicable). Enter the full ICD-9-CM diagnosis codes, including all five digits where applicable, for any other terminal diagnoses or related conditions.

Field 82. Attending Physician I.D.

Required. Enter the seven (7) digit Medicaid provider identification number and name (last, first name and middle initial) of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.

Field 83. Other Physician.

Required. Enter the word "employee" or "non-employee" in reference to whether the attending physician entered in Field 82 is an employee of the hospice. If the attending physician volunteers for the hospice, he or she is considered an employee.

Field 84. Remarks

Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.

Field 85-86. Provider Representative Signature and Date

Required. A hospice representative verifies that the required physician's certification, and a signed hospice election statement are in the records before signing Form UB-92. A stamped signature is acceptable in field 85. Also enter the date the provider representative signed the form.

The UB-92 claim form is a proprietary form owned by the National Uniform Billing Committee (NUBC), and therefore cannot be provided by Unisys. Providers may purchase preprinted forms from most national form suppliers and office supply stores.

APPROVED OMB NO. 0938-0279

ST:11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Your Hospice 200 Get Paid Drive Norejects, LA 70000			813

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	10012005	10312005					

12 PATIENT NAME	13 PATIENT ADDRESS
Sun, Maybell	Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
01201919	F		05012005					30									

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a											A
b											B
											C

38

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	61	9919.00	61	9919.00		9919.00
b	61	7680.00				
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	651	Routine Home Care		10012005	5	450.00		
2								
3	651	Routine Home Care		10082005	23	900.00		
4								
5	652	Continuous Home Care		10062005	16	300.00		
6								
7	656	General Inpatient Care		10312005	1	200.00		
8								
9	657	Physician Services	99341	10302005	1	130.00		
10								
11								
12								
13	001	Total Charges				1980.00		
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

** Sample of Routine Home Care **

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Medicaid	1234567					
B						
C						

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A		1234567890123		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			
B			
C			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
9494											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		Dr. David Doe #7654321

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
C		D		E		Employee A

a	84 REMARKS	OTHER PHYS. ID
b		B
c		
d		

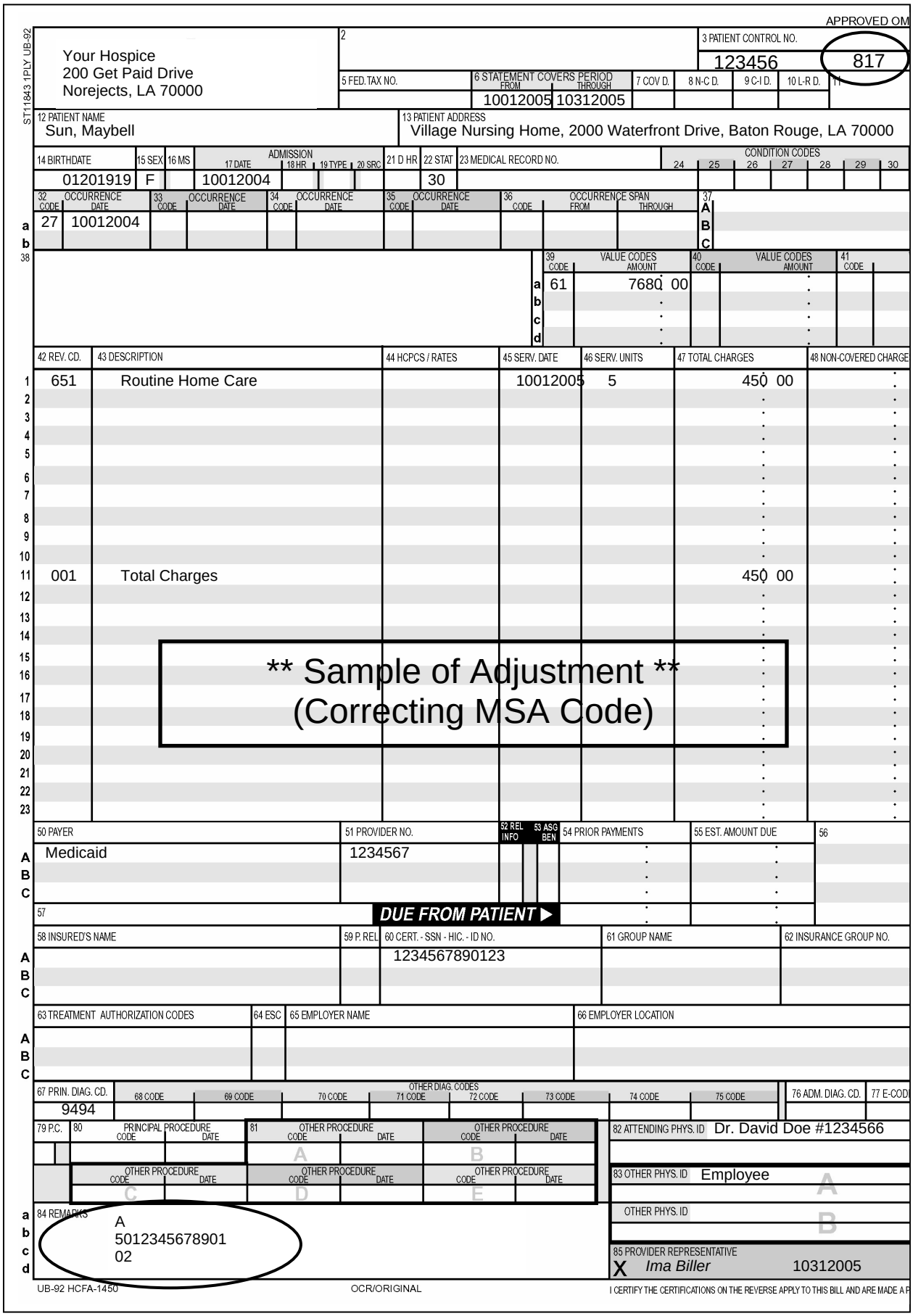
85 PROVIDER REPRESENTATIVE	86 DATE
X *Ima Biller*	10312005

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

ADJUSTMENTS AND VOIDS

Adjustments and voids must be submitted using the UB-92 or 837I electronic transaction. Adjustment and/or voids are completed only for paid claims. Adjustments/Voids are identified through the third digit the bill type (Field No. 4). The value “7” in the third digit indicates a claim adjustment, and “8” in the third digit indicates a voided claim. When submitting an adjustment or void, the following additional information is required in Field No. 84 (Remarks) of the UB-92:

UB-92 Field No. 84 (Remarks) Instructions for Adjustments/Voids	
Enter an" A" for an adjustment or a" V "for a void.	
Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.	
Enter one of the appropriate reason codes:	
Adjustments:	Voids:
01 - Third Party Liability Recovery 02 - Provider Correction 03 - Fiscal Agent Error 99 - Other - Please Explain	10 - Claim Paid for Wrong Recipient 11 - Claim Paid for Wrong Provider 00 - Other
Examples:	
Adjustment: A 500012646500 02	Void: V 5000164253000 00


APPROVED OM
ST11843 1PLY UB-92
Your Hospice
200 Get Paid Drive
Norejects, LA 70000
3 PATIENT CONTROL NO.
123456
817
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 10012005 THROUGH 10312005
12 PATIENT NAME
Sun, Maybell
13 PATIENT ADDRESS
Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000
14 BIRTHDATE 01201919
15 SEX F
17 DATE 10012004
22 STAT 30
32 OCCURRENCE CODE 27 DATE 10012004
39 VALUE CODES CODE 61 AMOUNT 7680 00
42 REV. CD. 43 DESCRIPTION 44 HCPCS / RATES 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGE
1 651 Routine Home Care 10012005 5 450 00
11 001 Total Charges 450 00
** Sample of Adjustment **
(Correcting MSA Code)
50 PAYER Medicaid
51 PROVIDER NO. 1234567
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
DUE FROM PATIENT ▶
58 INSURED'S NAME
60 CERT. - SSN - HIC. - ID NO. 1234567890123
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN. DIAG. CD. 9494
76 ADM. DIAG. CD.
77 E-COD
82 ATTENDING PHYS. ID Dr. David Doe #1234566
83 OTHER PHYS. ID Employee
84 REMARKS A 5012345678901 02
85 PROVIDER REPRESENTATIVE X Ima Biller 10312005
UB-92 HCFA-1450
OCR/ORIGINAL

LONG TERM CARE ROOM AND BOARD

REIMBURSEMENT

For hospice recipients residing in a Long Term Care (LTC) facility, including Nursing Facilities or ICF-MRs, Medicaid payment to the LTC facility for room and board is to be discontinued, and effective as of the date of the resident's hospice election, payment is made to the hospice to take into account the room and board furnished by the facility for a Medicaid recipient. The hospice must then reimburse the LTC facility for room and board. The Medicaid rate of reimbursement is 100 percent of the per diem rate that would have been paid to the LTC facility for that recipient, except that any Patient Liability Income (PLI) determined by the Bureau will be deducted from the payment amount. (It is the responsibility of the nursing facility or ICF-MR to collect the recipient's PLI.)

Note:

- Hospice providers can obtain appropriate LTC facility per diem rates by contacting the Rates and Audit section at DHH.

- Patient Liability Income (PLI) can obtain by contacting the parish office who issues eligibility for the recipient.

Calculating Reimbursement

Full Month

[(Per diem rate X 365) ÷ 12] – Patient liability = Payment

Partial Month

(Per diem rate X Number of days) – A = Payment,
Where A = [(patient liability X12) ÷ 365] X number of approved days

(Round off numbers to the nearest penny.)

LEAVE DAYS

A leave day is an absence from the facility for a 24 hour period or more. A leave of absence is broken only when the recipient returns to the facility for at least a 24 hour period. All qualified leave days must be recorded on the Medicaid bill except for Special Event Leave Days for recipients in an ICF-MR. Patients are limited as to how many leave days Medicaid will pay for per year.

- Reported home leave days are paid at 100% of the per diem for the LTC facility.

- Reported hospital leave days are paid at 75% of the per diem for the LTC facility.

An individual's direct transfer from one institution to another does not change the number of home leave days allowed per calendar year if cared for in a nursing home or in an intermediate care facility for the handicapped.

Leave day limits do not exclude the recipient being **permitted** to take additional leave days. However, Medicaid **will not pay** for extra leave days. Arrangements for payment must be made with the recipient's responsible party. Such arrangements may include a charge by the facility to the family for the full Medicaid rate or for a reduced daily rate, or the facility may absorb the cost of non-covered days into its operating costs. **Except in the case where home leave days in an ICF-MR exceed 30 consecutive days; then, the recipient must be discharged on the 31st consecutive day of absence.**

LEAVE DAY LIMITS

Home Leave Days

Nursing Facility

Recipients are limited to 15 days per calendar year.

ICF-MR Facility

Recipients are limited to 45 days per State fiscal year, not to exceed 30 consecutive days. The recipient must be discharged on the 31st consecutive day of absence.

Hospital Leave Days

Nursing Facility

Recipients are limited to 7 days **per occurrence**.

ICF-MR Facility

Recipients are limited to 7 days **per occurrence**.

Special Event Leave Days

ICF-MR Facilities ONLY

Leave days are also permitted under the following circumstances:

Special Olympics
Roadrunner sponsored events
Louisiana planned conference
Trial discharges
Official State Holidays

These special event leave days are limited to 30 consecutive days per occurrence. If the recipient is absent from the facility for more than 30 consecutive days, the facility should discharge the recipient.

These special event leave days are not deducted from the 45 home leave days allowed per fiscal year. These leave days must be included in the recipient's plan of care, but are not to be reported when billing.

NOTE: **Official State Holidays will always fall on a week day. They should not be reported as leave days. Days preceding and following the Official State Holidays will not be excluded from the annual 45-day limit.**

NON-COVERED DAYS

The date of discharge (except discharge due to death) is not covered by Medicaid.

BILLING

Hospice providers bill for room and board using the standard 837 Institutional (837I) electronic claim transaction or the hardcopy UB-92 Form, regardless of the date of service. All supplemental billing must also be submitted electronically using the 837I format or on the UB-92 hard copy claim form. The 837I is the preferred method of claim submission.

A separate claim for room and board is billed for each recipient for each calendar month of service.

> Note: Effective June 9, 2005 at noon, Unisys quit accepting any Long Term Care claims billed on a TAD. This billing change also applies to billing for prior dates of services.

CLAIMS SUBMISSION SCHEDULE (ROOM AND BOARD ONLY)

Claims for room and board are processed according to a predetermined schedule set by DHH and is updated every calendar year. This schedule includes deadlines for initial monthly claim submissions as well as for monthly supplemental claim submissions. Claims received after the published deadline will be held and processed The LTC room and board monthly processing schedule for the year 2005 can be found in Appendix B.

NOTE 1: Providers who bill hardcopy claims should continue to submit the initial monthly UB-92 forms in one package and may be hand delivered or mailed to the following address:

Kay Brue
Unisys LTC Unit
8591 United Plaza Blvd. Ste: 300
Baton Rouge, LA 70809

UB-92 CLAIM FORM INSTRUCTIONS FOR ROOM AND BOARD

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 1	PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER	**Required** Enter the provider's name, address, and phone number.
FIELD NO. 2	UNLABELED	Leave blank
FIELD NO. 3	PATIENT CONTROL NO.	**Situational** A patient control number may be entered using letters and/or numbers and may be a maximum of 16 characters.
FIELD NO. 4	TYPE OF BILL	**Required** Enter the 3-digit code indicating the specific type of facility, bill classification and frequency. This 3-digit code requires one digit each, in the following format: • The first digit identifies the type of facility. • The second classifies the type of care. • The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. Code Structure: **FOR HOSPICE PROVIDERS:** (Used for Nursing Facility Room and Board ONLY. Do not use for billing hospice services.) 1st Digit - Type of Facility 2 – Skilled Nursing (LOC = SNF/Hospice in Nursing Facility) (LOC = ICF I/Hospice in Nursing Facility) 2nd Digit - Classification 7 – Subacute Inpatient (SNF/Case Mix) Use for all service dates 3rd Digit – Frequency Definition 1 Admit Through Discharge Claim (Entire Claim) Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient.

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		2 Interim - First Claim Use this code for the first of an expected series of claims for a course of treatment. 3 Interim - Continuing Claim Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 Interim - Final Claim Use this code for a claim that is the last claim. The "Through" date of this bill (Field 6) is the discharge date or date of death. 7 Adjustment/ Replacement of Prior Claim Use this code to correct a previously submitted and paid claim. 8 Void/Cancel of a Prior Claim Use this code to void a previously submitted and paid claim.
FIELD NO. 5	FED. TAX NO.	Leave blank
FIELD NO. 6	STATEMENT COVERS PERIOD FROM/THROUGH	**Required** Enter the beginning and ending service dates of the period covered by this claim in numeric digits (MM-DD-YYYY).
FIELD NO. 7	COV D.	**Required** Enter the number of total covered days for the Statement Period. Covered days must equal the total number of units of service (Field 46) billed for **level of care** revenue codes. Note: For discharge due to death, the covered days and the statement through date in Field 6 should include the date of death. For all other discharges, the number of covered days will be one less than the Statement Covers Period From/Through (Field 6) which should include the discharge day.
FIELD NO. 8	N-C D.	Leave blank
FIELD NO. 9	C-I D.	Leave blank
FIELD NO. 10	L-R D.	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 11	UNLABELED	Leave blank
FIELD NO. 12	PATIENT NAME	**Required** Enter the recipient's name (last name, first name, and middle initial) exactly as it appears on the recipient's Medicaid ID card.
FIELD NO. 13	PATIENT ADDRESS	Leave blank
FIELD NO. 14	BIRTHDATE	Leave blank
FIELD NO. 15	SEX	Leave blank
FIELD NO. 16	MS	Leave blank
FIELD NO. 17	ADMISSION DATE	**Required** Enter the recipient's admission date to the facility. Show the month, day, and year numerically as MM-DD-YYYY.
FIELD NO. 18	ADMISSION HR	Leave blank
FIELD NO. 19	ADMISSION TYPE	Leave blank
FIELD NO. 20	ADMISSION SRC	Leave blank
FIELD NO. 21	D HR	Leave blank
FIELD NO. 22	STAT	**Required (maximum of 2 digits)** This code indicates the patient's status as of the "Through" date of the billing period (Field 6). **Code Structure:** 01 Discharged to home or self care (routine discharge) 02 Discharged/transferred to another short-term general hospital for inpatient care 03 Discharged/transferred to a skilled nursing facility (SNF) 04 Discharged/transferred to an intermediate care facility (ICF) 05 Discharged/transferred to another type of institution for inpatient care

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		06 Discharged/transferred to home under care of organized home health services organization 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of Home IV (Intravenous Therapy) provider 09 Admitted as inpatient to a hospital 20 Expired/Discharged Due to Death 30 Still a patient 61 Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 63 Discharged/transferred to a long term care hospital
FIELD NO. 23	MEDICAL RECORD NO.	**Situational** Facility may enter a patient's medical record number (up to 16 characters).
FIELD NO. 24 – 30	CONDITION CODES	Leave blank
FIELD NO. 31	UNLABELED	Leave blank
FIELD NO. 32 – 35	OCCURRENCE CODES/DATES	Leave blank
FIELD NO. 36	OCCURRENCE SPAN CODE, FROM/THROUGH	Leave blank
FIELD NO. 37A, B, C	UNLABELED	Leave blank
FIELD NO. 38	UNLABELED	Leave blank
FIELD NO. 39-41	VALUE CODES CODE (S)/AMOUNT	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 42-43	REV CD/DESCRIPTION	**Required. 3-digit numeric** Enter the applicable revenue code(s) and description(s) that identify the service provided. Bill a Level of Care (LOC) Revenue Code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill LA Medicaid: Revenue Code & Description **183** Leave of Absence – Subcategory Therapeutic **Home Leave** **185** Leave of Absence – Subcategory Nursing Home (for Hospitalization) **Hospital Leave** **FOR HOSPICE PROVIDERS:** Revenue Code & Description **022** Skilled Nursing Facility Prospective Payment System (RUGS) (For Dates of Service 01/01/03 and after) (LOC 88 -Case Mix (Formerly LOC 20, 21, 22))
FIELD NO. 44	HCPCS/RATES	Leave blank
FIELD NO. 45	SERV. DATE	**Required** A beginning and ending day of service (e.g., 01-31) MUST BE ENTERED for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided. (Example 1: If SNF PPS care (Revenue Code 022) is provided for the entire month of March, the Service Date should be entered 01-31. Example 2: If the recipient is on Hospital Leave (Revenue Code 185) from March 06 – 12, the Service Date should be entered 07-12, just as previously entered on the TAD.) **If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11).** (Note: The claim must reflect the total number of days billed at a particular Level of Care (LOC) corresponding to the Revenue Code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate Revenue Code for that LOC and the correct number of days indicated for that LOC for the month of service. A Revenue Code indicating a specific LOC cannot be listed more than once.)

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 46	SERV. UNITS	**Required** Enter in DAYS the number of units of service for each type of Level of Care service on the line adjacent to the Level of Care revenue code, description, and service date. (Example 1 above, Service Date 01-31 should indicate 31 units or days for Revenue Code 194. Example 2 above (Revenue Code 185), Service date 07-12, service units should be left blank**.). Do not enter the actual number of units when billing for home or hospital leave days, only indicate the from and to days in Field 45.**
FIELD NO. 47	TOTAL CHARGES	Leave blank
FIELD NO. 48	NON-COVERED CHARGES	Leave blank
FIELD NO. 49	UNLABELED	Leave blank
FIELD NO. 50	PAYER	**Required** Enter "Medicaid" on line “A”.
FIELD NO. 51	PROVIDER NO.	**Required** Enter the facility’s seven (7) digit Medicaid provider identification number on line “A”.
FIELD NO. 52	REL INFO	Leave blank
FIELD NO. 53	ASG BEN	Leave blank
FIELD NO. 54	PRIOR PAYMENTS	**Situational** If third party insurance is primary, enter the amount paid on this claim by TPL or 0 if nothing was paid.
FIELD NO. 55	EST. AMOUNT DUE	Leave blank
FIELDS NO. 56/57	UNLABELED	Leave blank
FIELD NO. 58	INSURED’S NAME	Leave blank
FIELD NO. 59	P REL	Leave blank
FIELD NO. 60	CERT. – SSN. – HIC. – ID NO.	**Required** Enter the recipient’s 13-digit Medicaid ID number.
FIELD NO. 61	GROUP NAME	Leave blank
FIELD NO. 62	INSURANCE GROUP NO.	**Situational** If third party insurance is primary, enter the six-digit Louisiana-specific TPL carrier code assigned to the carrier in this field.
FIELD NO. 63	TREATMENT AUTHORIZATION CODES	Leave blank
FIELD NO 64	ESC	Leave blank
FIELD NO. 65	EMPLOYER NAME	Leave blank

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
FIELD NO. 66	EMPLOYER LOCATION	Leave blank
FIELD NO. 67	PRIN. DIAG. CD.	**Required** Enter the ICD-9-CM diagnosis code for the principal diagnosis.
FIELD (S) NO. 68-75	OTHER DIAG CODES	**Situational** Enter the ICD-9-CM diagnosis codes for any other applicable diagnoses.
FIELD NO. 76	ADM DIAG CD	Leave blank
FIELD NO. 77	E – CODE	Leave blank
FIELD NO. 78	UNLABELED	Leave blank
FIELD NO. 79	P.C.	Leave blank
FIELD NO. 80	PRINCIPAL PROCEDURE CODE/DATE	Leave blank
FIELD NO. 81	OTHER PROCEDURE CODE/DATE	Leave blank
FIELD NO. 82	ATTENDING PHYS. ID	Leave blank
FIELD NO. 83	OTHER PHYS. ID	Leave blank
FIELD NO. 84	REMARKS	**Situational** Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment. For Adjustment/Void Claims: 1. Enter an" A" for an adjustment or a" V "for a void. 2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice. 3. Enter one of the appropriate reason codes: Adjustments: 01 - Third Party Liability Recovery 02 - Provider Correction 03 - Fiscal Agent Error 99 - Other - Please Explain Voids: 10 - Claim Paid for Wrong Recipient 11 - Claim Paid for Wrong Provider 00 - Other

FORM LOCATOR	FIELD NAME	DESCRIPTION/INSTRUCTIONS TO COMPLETE
		Examples: Adjustment: A 518456264650002 Void: V 520516425300000
FIELD NO. 85	PROVIDER REPRESENTATIVE	**Required** Enter the signature of the appropriate person at the facility who is authorized to submit Medicaid claims. (Stamped signatures must be initialed.)
FIELD NO. 86	DATE	**Required** Enter the date the claim was signed. The date should be in valid MMDDYY format and should be greater than the through date in Form Locator 6.

APPROVED OMB NO. 0938-0279

ST:11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Your Hospice 200 Get Paid Drive Norejects, LA 70000			273

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	10012005	10312005	31				

12 PATIENT NAME	13 PATIENT ADDRESS
Sun, Maybell	Village Nursing Home, 2000 Waterfront Drive, Baton Rouge, LA 70000

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
			05012001					30									

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a											A
b											B
											C

38

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	022	Case Mix		01-31	31			
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

** Sample of Existing Patient Without Leave **

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid	1234567					
B							
C							

57	DUE FROM PATIENT ▶		

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A			1234567890123		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

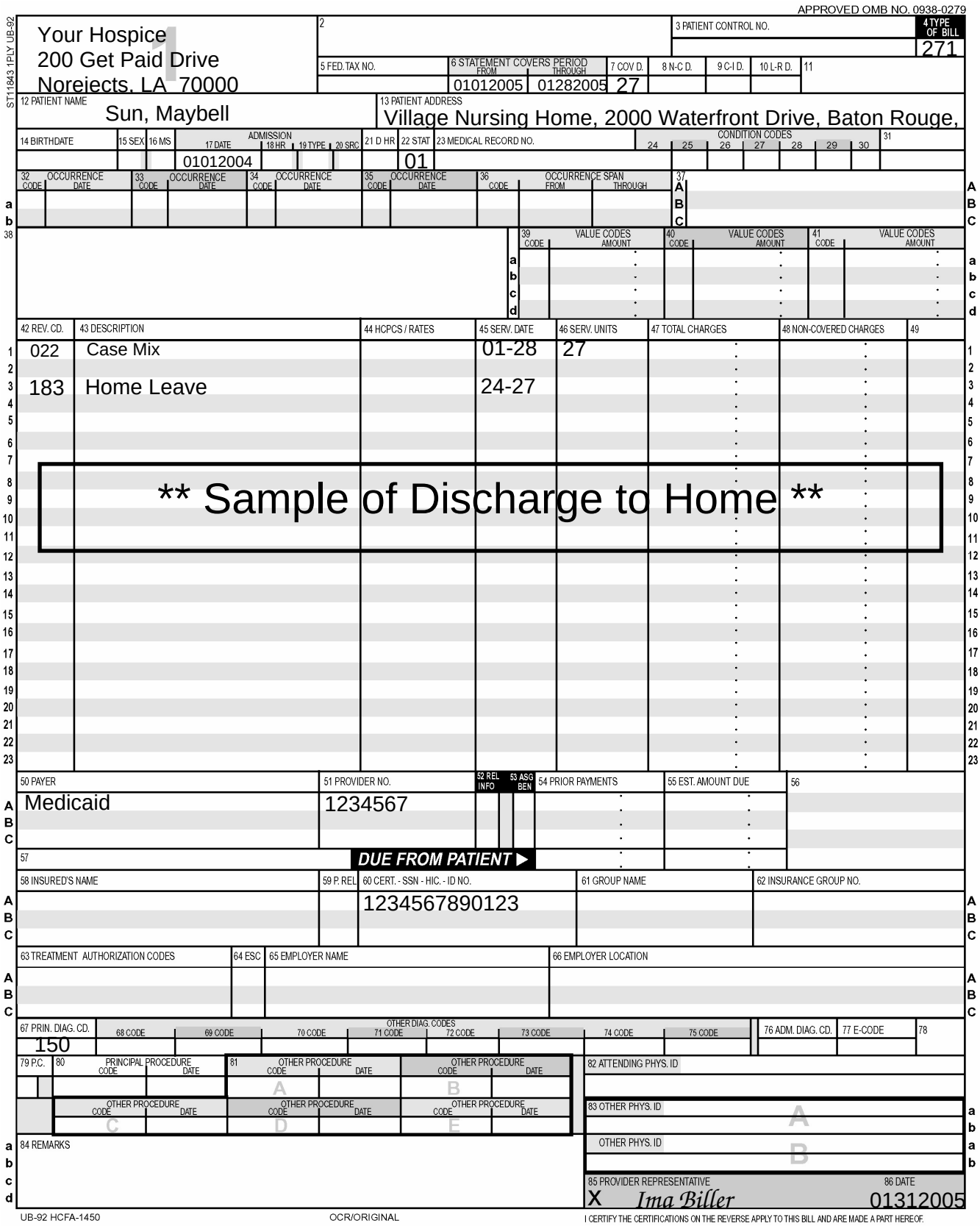
67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
150											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		

	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
	C		D		E		a A
							b
							OTHER PHYS. ID
							a B
							b

a	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
b		X *Ima Biller*	10312005
c			
d			

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

Your Hospice
200 Get Paid Drive
Norejects, LA 70000

4 TYPE OF BILL: 271

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM 01012005 THROUGH 01282005

7 COV D.: 27

12 PATIENT NAME: Sun, Maybell

13 PATIENT ADDRESS: Village Nursing Home, 2000 Waterfront Drive, Baton Rouge,

17 ADMISSION DATE: 01012004

22 STAT: 01

42 REV. CD.	43 DESCRIPTION	45 SERV. DATE	46 SERV. UNITS
022	Case Mix	01-28	27
183	Home Leave	24-27	

** Sample of Discharge to Home **

50 PAYER: Medicaid

51 PROVIDER NO.: 1234567

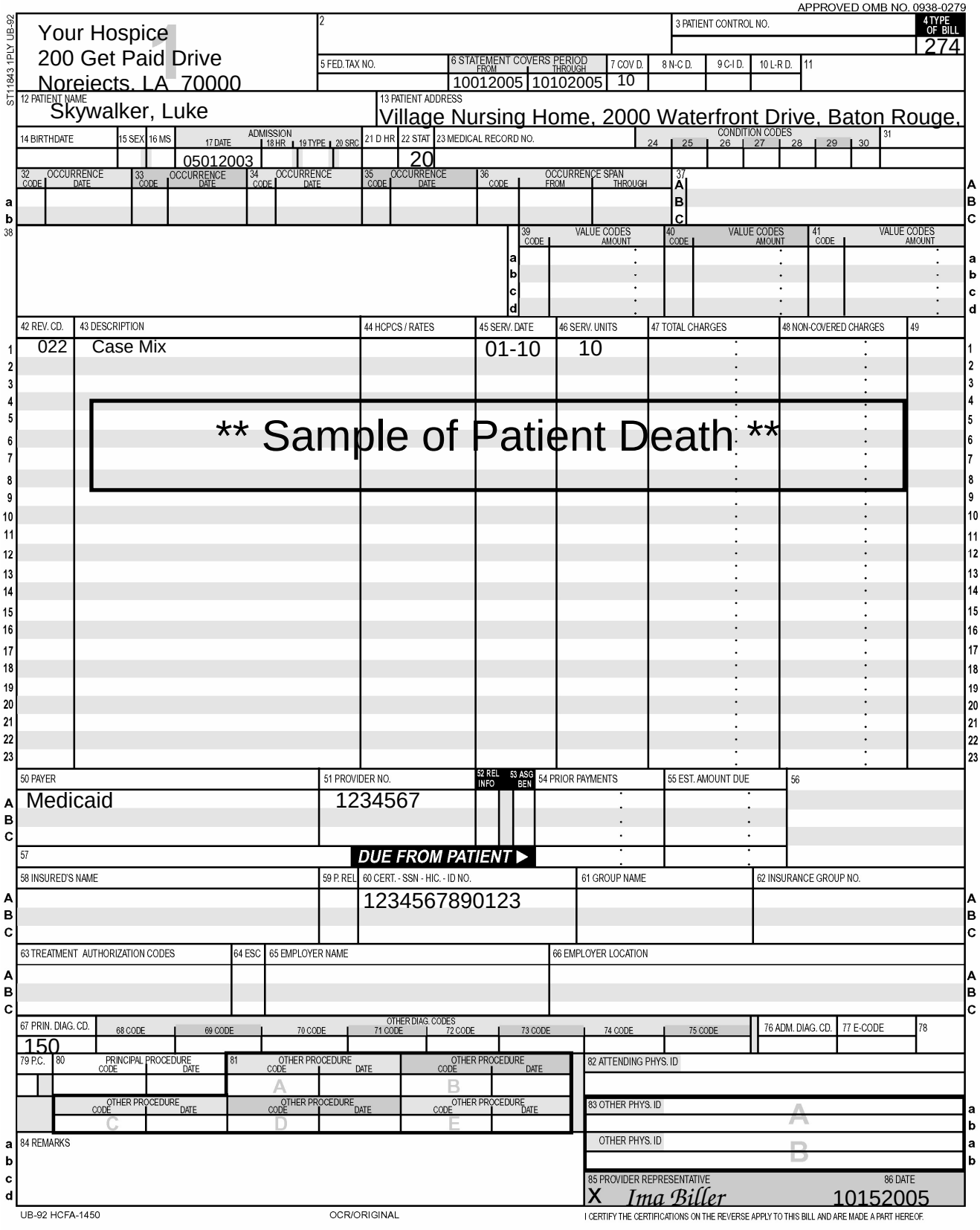
60 CERT. - SSN - HIC. - ID NO.: 1234567890123

67 PRIN. DIAG. CD.: 150

85 PROVIDER REPRESENTATIVE: X Ima Biller

86 DATE: 01312005

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 Your Hospice
200 Get Paid Drive
Norejects, LA 70000

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL: 274

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM 10012005 THROUGH 10102005

7 COV D.: 10

8 N-C D.

9 C-I D.

10 L-R D.

11

12 PATIENT NAME: Skywalker, Luke

13 PATIENT ADDRESS: Village Nursing Home, 2000 Waterfront Drive, Baton Rouge,

14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION 17 DATE 05012003 | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT 20 | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
022	Case Mix		01-10	10			

** Sample of Patient Death **

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	1234567					

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
		1234567890123		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD. 150 | OTHER DIAG. CODES 68 69 70 71 72 73 74 75 | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A | OTHER PROCEDURE CODE DATE B | 82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE DATE C | OTHER PROCEDURE CODE DATE D | OTHER PROCEDURE CODE DATE E | 83 OTHER PHYS. ID A

84 REMARKS | OTHER PHYS. ID B

85 PROVIDER REPRESENTATIVE: X *Ima Biller* | 86 DATE: 10152005

UB-92 HCFA-1450 OCR/ORIGINAL

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

ADJUSTMENTS AND VOIDS

CLAIM ADJUSTMENTS/VOIDS USING THE UB-92 FORM

LTC adjustments and voids must be submitted using the UB-92 or 837I electronic transaction.. Adjustment and/or voids are completed only for paid claims. Adjustments/Voids are identified through the third digit the bill type (Field No. 4). The value “7” in the third digit indicates a claim adjustment, and “8” in the third digit indicates a voided claim. When submitting an adjustment or void, the following additional information is required in Field No. 84 (Remarks) of the UB-92:

NOTE: The 212 Adjustment/Void Form is now obsolete. Adjustments or voids must be done on the UB-92 form or the 837I electronic transaction, regardless of the date of service.

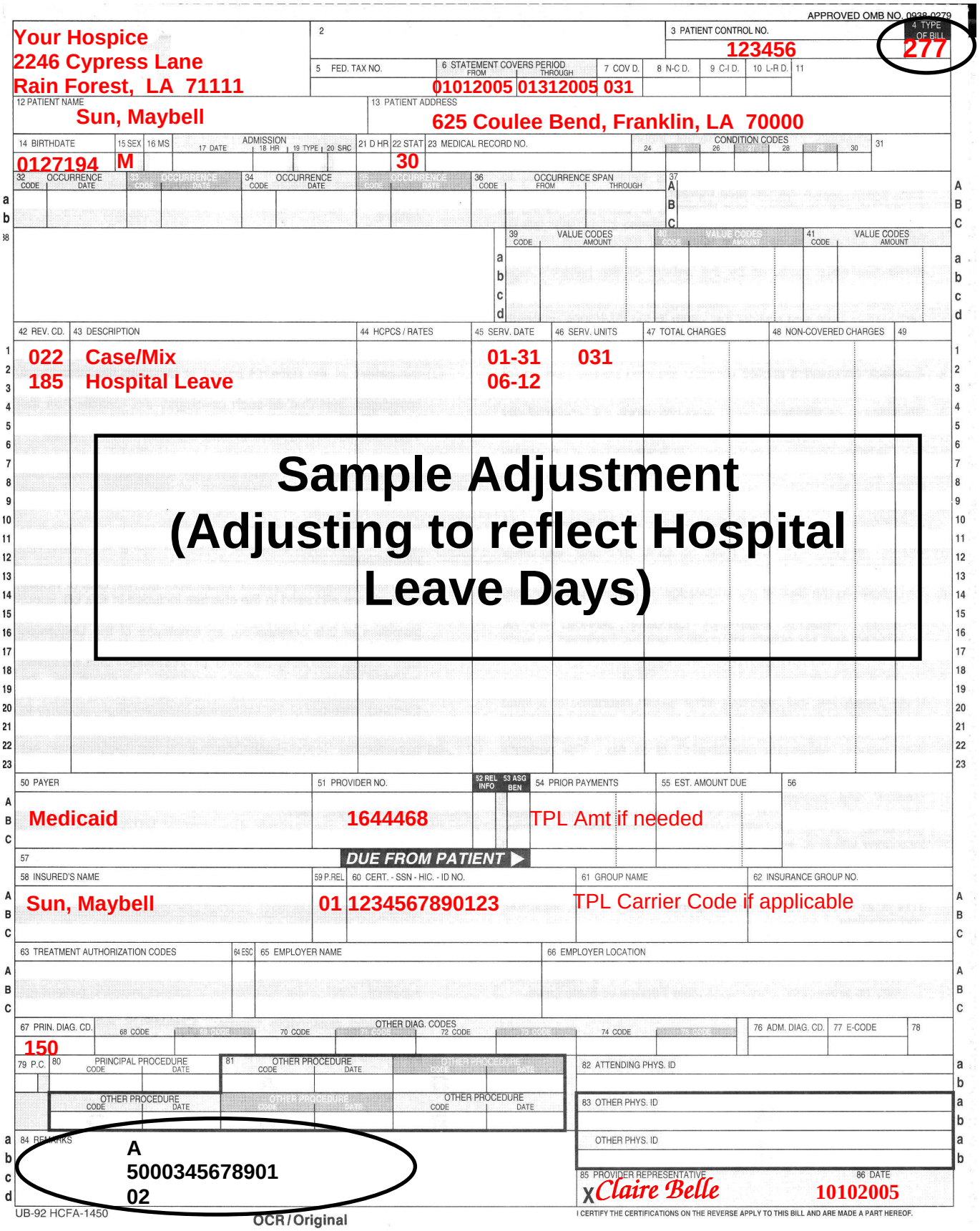
UB-92 Field No. 84 (Remarks) Instructions for Adjustments/Voids	
Enter an" A" for an adjustment or a" V "for a void.	
Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.	
Enter one of the appropriate reason codes:	
Adjustments:	Voids:
01 - Third Party Liability Recovery 02 - Provider Correction 03 - Fiscal Agent Error 99 - Other - Please Explain	10 - Claim Paid for Wrong Recipient 11 - Claim Paid for Wrong Provider 00 - Other
Examples:	
Adjustment: A 500012646500 02	Void: V 5000164253000 00

CLAIM ADJUSTMENT FORM 148 (PATIENT LIABILITY)

LTC adjustments billed when the recipient’s patient liability is changed retroactively are processed as 148/PLI adjustments. The Adjustment Reason Code included on this form is necessary to process these claims and calculate reimbursement correctly. This claim form will continue to be used with no changes in the submission process.

NOTE: (1) The Patient Status Code (block 12) should be the HIPAA standard 2-digit status code.

(2) The Level of Care (Block 5) should continue to indicate the locally assigned LOC code as opposed to the revenue code entered on the UB-92 form.


Your Hospice
2246 Cypress Lane
Rain Forest, LA 71111
3 PATIENT CONTROL NO.
123456
4 TYPE OF BILL
277
6 STATEMENT COVERS PERIOD
01012005 01312005
7 COV D.
031
12 PATIENT NAME
Sun, Maybell
13 PATIENT ADDRESS
625 Coulee Bend, Franklin, LA 70000
14 BIRTHDATE
0127194
15 SEX
M
22 STAT
30
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
022
Case/Mix
01-31
031
185
Hospital Leave
06-12
Sample Adjustment
(Adjusting to reflect Hospital
Leave Days)
50 PAYER
51 PROVIDER NO.
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
Medicaid
1644468
TPL Amt if needed
DUE FROM PATIENT
58 INSURED'S NAME
59 P.REL
60 CERT. - SSN - HIC. - ID NO.
61 GROUP NAME
62 INSURANCE GROUP NO.
Sun, Maybell
01
1234567890123
TPL Carrier Code if applicable
63 TREATMENT AUTHORIZATION CODES
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.
150
OTHER DIAG. CODES
76 ADM. DIAG. CD.
77 E-CODE
79 P.C.
80 PRINCIPAL PROCEDURE
81 OTHER PROCEDURE
82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
OTHER PHYS. ID
84 REMARKS
A
5000345678901
02
85 PROVIDER REPRESENTATIVE
XClaire Belle
86 DATE
10102005
UB-92 HCFA-1450
OCR / Original
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

MAIL TO:
UNISYS
P.O. BOX 91021
BATON ROUGE, LA 70821
(800) 737-8647
924-5040 (IN BATON ROUGE)

LONG TERM CARE
PATIENT LIABILITY ADJUSTMENT FORM

FOR OFFICE USE ONLY

TO: Medical Assistance

FROM: LTC Facility

1 PROVIDER NO.	2 RECIPIENT I.D. NUMBER	3 RECIPIENT LAST NAME	4 FIRST NAME
1234567	4004004001213	Holden	Hugh

5 LEVEL OF CARE	6 INITIATED BY
	☐ FACILITY ☐ PARISH OFS

7 FROM DATE OF SERVICE	8 TO DATE OF SERVICE	9 TOTAL DAYS	10 CONTROL NUMBER	11 CORRECT PATIENT LIABILITY	12 STATUS	SDC OFFICE USE ONLY
10/01/05	10/31/05	31	5000008100000	$175.00	30	

ADJUSTMENT

AUTHORIZED SIGNATURES

13. FACILITY *Jane Friday* DATE *11/15/05*

14. PARISH OFS _____ DATE _____

FISCAL AGENT COPY

UNISYS 148/PLI

THE REMITTANCE ADVICE

Unisys Provider Relations responds to inquiries concerning particular claims when the provider has reconciled the remittance advice (RA) and determined that the claims have denied, pended, paid or been rejected prior to entry into the system. It is not possible for Unisys Provider Relations or DHH to take the place of the provider's weekly RA by checking the status of numbers of claims on which providers, billers or collections agencies are checking. **All providers are responsible for reconciling their weekly remittance advices. Please reconcile your RA before calling DHH or Unisys concerning claims issues. Additionally, questions concerning claims denials should be directed to Unisys not DHH.**

The purpose of this section is to familiarize the provider with the design and content of the Remittance Advice (RA). This document plays an important communication role between the provider, the BHSF, and Unisys. Aside from providing a record of transactions, the Remittance Advice will assist providers in resolving and correcting possible errors and reconciling paid claims.

THE PURPOSE OF THE REMITTANCE ADVICE

The RA is the control document which informs the provider of the current status of submitted claims. It is sent out each week when the provider has adjudicated claims.

On the line immediately below each claim a code will be printed representing denial reasons, pended claim reasons, and payment reduction reasons. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. The only type of claim status which will not have a code is one which is paid as billed.

If the provider uses a medical record number (which may consist of up to 16 alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

At the end of each claim line is the 13-digit internal control number (ICN) assigned to that claim line. Each separate claim line is assigned a unique ICN for tracking and audit purposes. Following is a breakdown of the 13 digits of the ICN and what they represent:

Position 1	Last Digit of Current Year
Positions 2-4	Julian Date - ordinal day of 365-day year
Position 5	Media Code - 0 = paper claim with no attachments 1 = electronic claim 2 = systems generated 3 = adjustment 4 = void 5 = paper claim with attachments
Positions 6-8	Batch Number - for Unisys internal purposes
Positions 9-11	Sequence Number - for Unisys internal purposes
Positions 12-13	Number of Line within Claim - 00 = first line 01 = second line 02 = third line, etc.

Unisys Provider Relations responds to inquiries concerning particular claims when the provider has reconciled the RA and determined that the claim has denied, pended, paid or been rejected prior to entry into the system. It is not possible for Unisys Provider Relations to take the place of the provider's weekly RA by checking the status of numbers of claims on which providers, billers or collection agencies are checking.

In situations where providers choose to contract with outside billing or collection agencies to bill claims and reconcile accounts, it is the provider's responsibility to provide the contracted agency with copies of the RAs or other billing related information in order to bill the claims and reconcile the accounts.

When providers or contractors are attempting to reconcile old accounts, if RAs are not available through the provider, it is necessary for the provider to order a claim history, which is available through Unisys Provider Relations.

ELECTRONIC REMITTANCE ADVICES (ERAS)

The EDI Department now offers Electronic Remittance Advices (ERA's). This allows providers to have their Remittance Advices transmitted from Unisys and posted to accounts electronically. There is a minimal fee for this service. Further information may be obtained by calling the Unisys EDI Coordinator at (225) 216-6239.

REMITTANCE ADVICE BREAKDOWN

Claims presented on the RA can appear under one of several headings: Approved Original Claims (paid claims); Denied Claims; Claims in Process; Adjustment Claims; Previously Paid Claims; and Voided Claims. When reviewing the RA, please look carefully at the heading under which the claims appear. This will assist with your reconciliation process.

Always remember that claims appear under the heading "Claims in Process" to let the provider know that the claim has been received by the Fiscal Intermediary, and should not be worked until they appear as either "Approved Original Claims" or "Denied Claims." "Claims in Process" are claims which are pending in the system for review. Once that review occurs, the claims will move to a paid or denied status on the RA. If claims pend for review, they will appear on an initial RA as "Claims in Process" as they enter the processing system. After that point, they will appear only once a month under that heading until they are reviewed.

REMITTANCE SUMMARY

"Approved Original Claims" may appear with zero (0 dollar) payments. These claims are still considered paid claims. Claims pay a zero amount legitimately, based on other insurance payments, maximum allowable payments, etc.

When providers choose to return checks to adjust or void a claim rather than completing an adjustment/void form, the checks will initially appear as a financial transaction on the front of the RA to acknowledge receipt of that check. The provider's check number and amount will be indicated, as well as an internal control number (ICN) which is assigned to the check. If claims

associated with the check are processed immediately, they will appear on the same RA as the check financial transaction, under the heading of "adjustment or void" as appropriate, as well as the corresponding "previously paid claim." The amount of the check posted to the RA should offset the amount recouped from the RA as a result of the adjustment/void, and other payments should not be affected. However, if the adjustments/voids cannot be processed on the same RA, the check will be posted and appear on the financial page of the RA under "Suspense Balance Brought Forward" where it will be carried forward on forthcoming RA's until all adjustments/voids are processed. As the adjustments/voids are processed, they will appear on the RA and the amount of money being recouped will be deducted from the "Suspense Balance Brought Forward" until all claims payments returned are processed.

It is the responsibility of the provider to track these refund checks and corresponding claims until they are all processed.

When providers choose to submit adjustment/void forms for refunds, the following is an important point to understand. As the claims are adjusted/voided on the RA, the monies recouped will appear on the RA appropriately as "Adjustment Claims" or "Voided Claims." A corresponding "Previously Paid Claim" will also be indicated. The system calculates the difference between what has already been paid ("Previously Paid Claim") and the additional amount being paid or the amount being recouped through the adjustment/void. If additional money is being paid, it will be added to your check and the payment should be posted to the appropriate recipient's account. If money is being recouped, it will be deducted from your check amount. This process means that when recoupments appear on the RA, the paid claims must be posted as payments to the appropriate recipient accounts through the bookkeeping process and the recoupments must be deducted from the accounts of the recipients for which adjustment or voids appear. If the total voided exceeds the total original payment, a negative balance occurs, and money will be recouped out of future checks. This also includes state recoupments, SURS recoupments and cost settlements.

Below are the summary headings that may appear on the financial summary page and an explanation of each.

Suspense Balance Brought Forward	A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed.
Approved Original Claim	Total of all approved (paid) claims appearing on this RA.
Adjustment Claims	Total of all claims being adjusted on this RA.
Previously Paid Claim	Total of all previously paid claims which correspond to an adjustment or void appearing on this RA.
Void Claims	Total of all claims being voided on this RA.
Net Current Claims Transactions	Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process).
Net Current Financial Transactions	Total number of all financial transactions appearing on the RA.

Prior Negative Balance	If a negative balance has been created through adjustments or voids processed, the negative balance is carried forward to the next RA. (This also includes state recoupments, SURS recoupments and cost settlements.)
Withheld for Future Recoveries	Difference between provider checks posted on the RA and the deduction from those checks when associated claims are processed on the same RA as the posting of the check. (This is added to Suspense Balance Brought Forward on the next RA.)
Total Payments This RA	Total of current check.
Total Copayment Deducted This RA	Total pharmacy co-payments deducted for this RA.
Suspense Balance Carried Forward	Total of Suspense Balance Brought Forward and withheld for future recoveries.
Y-T-D Amount Paid	Total amount paid for the calendar year.
Denied Claims	Total of all denied claims appearing on this RA.
Claims in Process	Total of all pending claims appearing on this RA.

CLAIMS IN PROCESS

When the ICN of a claim appears on a remittance advice (RA), with a message of "Claim In Process," the claim is in the process of being reviewed. The claim has not been approved for payment yet, and the claim has not had payment denied. During the next week, the claim will be reviewed and will appear as a "paid" or "denied" claim on the next RA unless additional review is required. The "Claim In Process" listing on the RA appears immediately following the "Denied Claims" listing and is often confused with "Denied Claims."

Pended claims are those claims held for in-house review by Unisys. After the review is completed, the claim will be denied if a correction by the provider is required. The claim will be paid if the correction can be made by Unisys during the review.

Claims can pend for many reasons. The following are a few examples:
Errors were made in entering data from the claim into the processing system.
Errors were made in submitting the claim. These errors can be corrected only by the provider who submitted the claim.
The claim must receive Medical Review.
Critical information is missing or incomplete.

On the following pages are examples of remittance advice pages and a TPL denied claims notification list (this is normally printed at the end of the remittance advice).

DENIED CLAIMS TURNAROUNDS (DTA)

Denied claim turnarounds, also printed at the end of the remittance advice, are produced when certain errors are encountered in the processing of a claim. **(Not all denial error codes produce denied claim turnarounds.)** The denied claim turnaround document is printed to reflect the information submitted on the original claim. It is then mailed to the provider to allow

him to change the incorrect items and sign and return the document to Unisys. Once the document is received at Unisys, the correction is entered into the claims processing system and adjudication resumes for the original claim. Note, however, that the turnaround document must be returned to Unisys with appropriate corrections as soon as possible, as they are only valid for 30 days from the date of processing of the original claim.

TPL DENIED CLAIMS NOTIFICATION LIST

The TPL denied claims notification list is generated when claims for recipients with other insurance coverage are filed to Medicaid with no EOB from the other insurance and no indication of a TPL carrier code on the claim form. This list notifies the provider that third party coverage exists and gives the name and carrier code of the other insurance. Once the private insurance has been billed, the claim may be corrected and resubmitted to Unisys with the third party EOB.

ELECTRONIC DATA INTERCHANGE (EDI)

Claims Submission

Electronic data interchange submission is the preferred method of submitting Medicaid claims to Unisys. With electronic data, a provider or a third party contractor (billing agent) submits Medicaid claims to Unisys on a computer encoded magnetic tape, diskette or via telecommunications.

Each claim undergoes the editing common to all claims, e.g., verification of dates and balancing. Each type of claim has unique edits consistent with the requirements outlined in the provider manuals. All claims received via electronic data must satisfy the criteria listed in the manual for that type of claim.

Advantages of submitting claims electronically include increased cash flow, improved claim control, decrease in time for receipt of payment, automation of receivables information, improved claim reporting by observation of errors and reduction of errors through pre-editing claims information.

Certification Forms

Any submitter - individual providers, clearinghouse, billing agents, etc. - that submits at least one claim electronically in a given year is required to submit an Annual EDI Certification Form. This form is then kept on file to cover all submissions within the calendar year. It must be signed by an authorized representative of the provider and must have an original signature (no stamps or initials.)

Third Party Billers are required to submit a Certification Form including a list of provider(s) name(s) and Medicaid Provider numbers. Additionally, all Third Party Billers **MUST** obtain a "Professional, Pharmacy, Hospital or KIDMED Services Certification" form on which the provider has attested to the truth, accuracy and completeness of the claim information. These forms **MUST** be maintained for a period of five years. This information must be furnished to the agency, the DHH Secretary, or the Medicaid Fraud Control Unit upon request.

Required Certification forms may be obtained from lamedicaid.com under the EDI Certification Notices and Forms HIPAA Information Center link. The required forms are also available in both the General EDI Companion Guide and the EMC Enrollment Packet.

Failure to submit the Annual Certification Form will result in deactivation of the submitter number. Once the Cert is received, the number will be reactivated. There will be a delay if the number is deactivated thus preventing timely payment to your providers. Failure to correctly complete the Certification Form will result in the form being returned for correction.

To contact the EMC Department at Unisys, call (225) 216-6000 and select option 2. Providers may write to Unisys EMC Department, P.O. Box 91025, Baton Rouge, LA 70821.

Electronic Data Interchange (EDI) General Information

Please review the entire General EDI Companion Guide before completing any forms or calling the EMC Department.

The following claim types may be submitted as approved HIPAA compliant 837 transactions:

- Hospice
- Pharmacy
- Hospital Outpatient/Inpatient
- Physician/Professional
- Home Health
- Emergency Transportation
- Adult Dental
- Dental Screening
- Rehabilitation
- Crossover A/B
- Long Term Care

The following claims types may be submitted under proprietary specifications (not as HIPAA-compliant 837 transactions):

- Case Management services
- Non-Ambulance Transportation

Any number of claims can be included in production file submissions. There is no minimum number.

EDI Testing is required for all submitters (including KIDMED) before they are approved to submit claims for production unless the testing requirement has been completed by the Vendor. LTC providers must test prior to submission to production.

Case Management Services and Non-Ambulance Transportation submitters who file via modem MUST wait 24 hours, excluding weekends, between file submissions to allow time for processing.

Enrollment Requirements For EDI Submission

- **Submitters wishing to submit EDI 837 transactions without using a Third Party Biller** - complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS** (EMC Contract).

- **Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse** – complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS** (EMC Contract) **and** a Limited Power of Attorney.

- **Third Party Billers or Clearinghouses** (billers for multiple providers) are required to submit a completed HCFA 1513 – Disclosure of Ownership form and return it with a

completed EMC Contract and a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Enrollment Requirements For 835 Electronic Remittance Advices

- All EMC billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EMC billers to download their remittance advices weekly.

- 835 Transactions may not contain all information printed on the hardcopy RA, ex. blood deductible, patient account number, etc.

- To request 835 Transactions – Electronic Remittance Advice, contact Unisys EMC Department at (225) 216-6000 ext. 2.

Electronic Adjustments/Voids

Adjustments and voids can be submitted electronically. If your present software installation does not offer this option, please contact your software vendor to discuss adding this capability to your software.

SUBMISSION DEADLINES
Regular Business Weeks

Magnetic Tape and Diskettes	4:30 P.M. each Wednesday
KIDMED Submissions (All Media)	4:30 P.M. each Wednesday
Telecommunications (Modem)	10:00 A.M. each Thursday

Thanksgiving Week

Magnetic Tape and Diskettes	4:30 P.M. Tuesday, 11/21/06
KIDMED Submissions	4:30 P.M. Tuesday, 11/21/06
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/22/06

Important Reminders For EMC Submission

Denied claims may be resubmitted electronically unless the denial code states otherwise. This includes claims that have produced a denied claim turnaround document (DTA). Claims with attachments must be submitted hardcopy.

- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.

- The total amount of the submitted file must equal the amount indicated on the Unisys response file.

- **All claims submitted must meet timely filing guidelines.**

HARD COPY REQUIREMENTS

DHH has made the decision to continue requiring hardcopy claim submissions for all existing hardcopy attachments, as indicated in the table below.

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	**BILLING REQUIREMENTS**
Third Party/Medicare Payment - EOBs. (Includes Medicare adjustment claims)	Continue hardcopy billing
Retroactive Eligibility - copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing
Recipient Eligibility Issues - copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing - letter/other proof i.e., RA page	Continue hardcopy billing

IMPORTANT UNISYS ADDRESSES

Please be aware that **different post office boxes** are used for the various Medicaid programs. If you are submitting an original "clean" hard copy claim for payment or adjustments/voids, please utilize the following post office boxes and zip codes.

Type of Claim	P.O. Box	Zip Code
Pharmacy	91019	70821
CMS-1500 Claims Case Management Chiropractic Durable Medical Equipment EPSDT Health Services FQHC Hemodialysis Professional Services Independent Lab Mental Health Rehabilitation PCS Professional Rural Health Clinic Substance Abuse and Mental Health Clinic Waiver	91020	70821
Inpatient & Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long Term Care	91021	70821
Dental, Home Health, Rehabilitation, Transportation (Ambulance and Non-ambulance)	91022	70821
ALL Medicare Crossovers and All Medicare Adjustments and Voids	91023	70821
KIDMED	14849	70898

Unisys also has different post office boxes for various departments. They are as follows:

Department	P.O. Box	Zip Code
EMC, Unisys business & Miscellaneous Correspondence	91025	70898
Prior Authorization	14919	70898
Provider Enrollment	80159	70898
Provider Relations	91024	70821

CLAIMS PROCESSING REMINDERS

Unisys Louisiana Medicaid images and stores all Louisiana Medicaid paper claims on-line. This process allows the Unisys Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

If claims cannot be submitted electronically, prepare paper claim forms according to the following instructions to ensure appropriate and timely processing:

- Submit an original claim form whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.

- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.

- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. **DO NOT use a highlighter to draw attention to specific information.**

- Paper claims must be legible and in good condition for scanning into our document imaging system.

- **Don't forget to sign and date your claim form. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.**

- Continuous feed forms must be torn apart before submission.

- Use high quality printer ribbons or cartridges-black ink only.

- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.

- Do not use italic, bold, or underline features.

- Do not submit two-sided documents.

- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

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

Attachments

All claim attachments should be standard 81/2 x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper. If it is necessary to attach documentation to a claim, the documents must be placed directly behind each claim that requires this documentation. Therefore, it may be necessary to make multiple copies of the documents if they must be placed with multiple claims.

Changes to Claim Forms

Louisiana Medicaid policy prohibits Unisys staff from changing any information on a provider's claim form. Any claims requiring changes must be made prior to submission. Please do not ask Unisys staff to make any changes on your behalf.

Data Entry

Data entry clerks do not interpret information on claim forms-data is keyed as it appears on the claim form. If the data is incorrect, or **IS NOT IN THE CORRECT LOCATION**, the claim will not process correctly.

Rejected Claims

Unisys currently returns claims that are illegible or incomplete. These claims are not processed and are returned along with a cover letter stating why the claim(s) is/are rejected. During 2005, Unisys returned 273,291 rejected claims to providers. The most common reasons for rejection are listed as follows:

- A signature or handwritten initials were missing
- The recipient number was invalid or missing
- The provider # was missing or incomplete

The criteria for legible claims are:

- All claim forms are clear and in good condition
- All information is readable to the normal eye
- All information is centered in the appropriate block
- All essential information is complete

TIMELY FILING GUIDELINES

In order to be reimbursed for services rendered, all providers must comply with the following filing limits set by Medicaid of Louisiana:

- Straight Medicaid claims must be filed within 12 months of the date of service.
- KIDMED screening claims (KM-3 forms or 837P with K-3 segment) must be filed within 60 days from the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations.
- Claims which fail to cross over via tape and have to be filed hard copy MUST be adjudicated within six months from the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.
- Claims with third-party payment must be filed to Medicaid within 12 months of the date of service.

Dates of Service Past Initial Filing Limit

Medicaid claims received after the initial timely filing limits cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include the following:

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

OR

A Remittance Advice indicating that the claim was processed within the specified time frame.

OR

Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the recipient.

NOTE 1: All proof of timely filing documentation must reference the individual recipient and date of service. RA pages and e-CSI screen prints must contain the specific recipient information, provider information, and date of service to be considered as proof of timely filing.

NOTE 2: At this time Louisiana Medicaid **does not** accept printouts of Medicaid Electronic Remittance Advice (ERA) screens as proof of timely filing. Reject letters are not considered proof of timely filing as they do not reference a specific

individual recipient or date of service. Postal "certified" receipts and receipts from other delivery carriers are not acceptable proof of timely filing.

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

Submitting Claims for Two-Year Override Consideration

Providers requesting two-year overrides for claims with dates of service over two years old must provide proof of timely filing and must assure that each claim meets at least one of the three criteria listed below:

- The recipient was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted.
- The recipient won a Medicare or SSI appeal in which he or she was granted retroactive Medicaid Benefits.
- The failure of the claim to pay was the fault of the Louisiana Medicaid Program rather than the provider's each time the claim was adjudicated.

All provider requests for two-year overrides must be mailed directly to:

Unisys Provider Relations Correspondence Unit
P.O. Box 91024
Baton Rouge, La 70821

The provider must submit the claim with a cover letter describing the criteria that has been met for consideration along with all supporting documentation. Supporting documentation includes but is not limited to proof of timely filing and evidence of the criteria met for consideration.

Claims submitted without a cover letter, proof of timely filing, and/or supporting documentation will be returned to the provider without consideration. Any request submitted directly to DHH staff will be routed to Unisys Provider Relations.

LOUISIANA MEDICAID WEBSITE APPLICATIONS

The newest way to obtain general and specific Medicaid information is on our Louisiana Medicaid Provider Website:

www.lamedicaid.com

This website has several applications that should be used by Louisiana Medicaid providers. These applications require that providers establish an online account for the site.

Provider Login And Password

To ensure appropriate security of recipient's patient health information (PHI) and provider's personal information, the secure area of the web site is available to providers only. It is the responsibility of each provider to become "Web Enrolled" by obtaining a login and password for this area of the site to be used with his/her provider number. Once the login and password are obtained by the provider who "owns" the provider number, that provider may permit multiple users to login using the provider number. This system allows multiple individuals to login using the same login and password OR a provider may have up to 500 individual logins and passwords established for a single provider number. The administrative account rights are established when a provider initially obtains a login and password, and should remain with the provider or designated office staff employed by the provider.

A login and password may be obtained by using the link, Provider Web Account Registration Instructions. Should you need assistance with obtaining a login and password or have questions about the technical use of the application, please contact the Unisys Technical Support Desk at 877-598-8753.

☞ Unisys has received inquiries from billing agents/vendors attempting to access this web application. DHH and CMS Security Policy restrictions will not permit Unisys to allow access of this secure application to anyone except the owner of the provider number being used for accessing the site. In cases where an outside billing agent/vendor is contracted to submit claims on behalf of a provider, any existing business partner agreement is between the provider and the billing agent/vendor. Unisys may not permit anyone except the provider to receive or ask for information related to a login and password to access secured information.

Web Applications

There are a number of web applications available on the Medicaid website, however, the following applications are the most commonly used:

- Medicaid Eligibility Verification System (e-MEVS) for recipient eligibility inquiries; and
- Claims Status Inquiry (e-CSI) for inquiring on claims status; and
- Clinical Data Inquiry (e-CDI) for inquiring on recipient pharmacy prescriptions as well as other medical claims data; and
- Prior Authorization (e-PA) for requesting prior authorizations electronically.

These applications are available to providers 24 hours a day, 7 days a week at no cost.

e-MEVS:

Providers can now verify eligibility, primary insurance information, and service limits for a Medicaid recipient using this web application accessed through www.lamedicaid.com. This application provides eligibility verification capability in addition to MEVS swipe card transactions and REVS. An eligibility request can be entered via the web for a single recipient and the data for that individual will be returned on a printable web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Since its release, the application has undergone some cosmetic and informational changes to make it more user-friendly and allow presentation of more complete, understandable information.

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to remittance advices for this purpose. A LA Medicaid/HIPAA Error Code Crosswalk is available on this website by accessing the link, Forms/Files.

Once enrolled in the website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

e-CDI:

The e-CDI application provides a Medicaid recipient's essential clinical history information at the authorized practitioner's finger tips at any practice location.

The nine (9) clinical services information components are:

1. Clinical Drug Inquiry
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a six-month period. These updates are based on Medicaid claims history. A print-friendly version of the information on each of the web pages will be accessible and suitable for the recipient's clinical chart.

The major benefits of the use of e-CDI by the practitioner will include:

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by all providers that have provided services to each individual recipient.
2. Provides the practitioner rapid access to current clinical data to help him/her evaluate the need for "modifications" of an individual Medicaid recipient's health care treatment.
3. Promotes the deliberate evaluation by a practitioner to help prevent duplicate drug therapy and decreases the ordering of duplicate laboratory tests, x-ray procedures, and other services.
4. Supplies a list of all practitioner types providing health care services to each Medicaid recipient.
5. Assists the practitioner in improving therapeutic outcomes and decreasing health care costs.

e-PA

The Electronic Prior Authorization (e-PA) Web Application has been developed for requesting prior authorizations electronically. E-PA is a web application found on the www.lamedicaid.com website and provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. This application is currently restricted to the following prior authorization types:

01 – Inpatient
05 – Rehabilitation
06 – Home Health
09 – DME
14 – EPSDT PCS
99 - Other

Providers who do not have access to a computer and/or fax machine will not be able to utilize the web application. However, prior authorization requests will continue to be accepted and processed using the current PA hard-copy submission methods.

NOTE: Dental electronic Prior authorization (e-PA) Web Application to be implemented at a later date. In order to utilize the Dental e-PA Web Application, the dental provider will be required to obtain the services of a vendor to submit the electronic attachment information to Medicaid. Complete Dental e-PA instructions will be provided upon implementation of Dental e-PA.

Reminders:

PA Type 01: Outpatient Ambulatory Surgery performed Inpatient on the first or second day of the stay. This is only for State Operated hospitals and Out-of-State hospitals that have a DHH approval letter for the out of state stay. Use ICD-9-CM procedure codes.

PA Type 99: Outpatient Ambulatory Surgery (CPT procedures) performed Inpatient on the first or second day of the stay. The surgery was performed at a State Operated hospital and Out-of-State hospital that has a DHH approval letter for the out of state stay. This is also used for specialized CPT procedures. This is for professional services only.

PA Type 05: Providers must always submit the PA02 Form with each request. Do not request authorization for the evaluation procedures, these do not require prior approval. Submit only units on the e-PA transaction, Do Not submit dollar amounts.

Home Health Providers submitting Rehab Services should use PA Type 05 and PA Type 09 when submitting DME Services.

PA Type 09: When submitting a request with a miscellaneous procedure code, the provider must submit a PA01 Form with the description of the item they are requesting.

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

RECONSIDERATION REQUESTS (RECONS) CANNOT BE SUBMITTED VIA THE e-PA WEB APPLICATION AND SHOULD BE SUBMITTED USING THE EXISTING PROCESS.

Additional DHH Available Websites

www.lamedicaid.com: Louisiana Medicaid Information Center which includes field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, fee schedules, and program training packets

www.lamedicaid.com/provweb1/HIPAA/HIPAAindex.htm: Louisiana Medicaid HIPAA Information Center

www.dhh.louisiana.gov: DHH website – LINKS (includes a link entitled "Find a doctor or dentist in Medicaid")

www.dhh.state.la.us: Louisiana Department of Health and Hospitals (DHH)

www.la-kidmed.com: KIDMED – program information, Frequently Asked Questions, outreach material ordering

www.la-communitycare.com: CommunityCARE – program information, PCP listings, Frequently Asked Questions, outreach material ordering

https://linksweb.oph.dhh.louisiana.gov: Louisiana Immunization Network for Kids Statewide (LINKS)

www.ltss.dhh.louisiana.gov: Division of Long Term Community Supports and Services (DLTSS)

www.dhh.louisiana.gov/offices/?ID=77: Office of Citizens with Developmental Disabilities (OCDD)

www.dhh.louisiana.gov/offices/?ID=257: EarlySteps Program

www.dhh.state.la.us/offices/?ID=111: DHH Rate and Audit Review (nursing home updates and cost report information, Outpatient Surgery Fee Schedule, Updates to Ambulatory Surgery Groups, contacts, FAQ)

www.doa.louisiana.gov/employ_holiday.htm: State of Louisiana Division of Administration site for Official State Holidays

PROVIDER ASSISTANCE

Many of the most commonly requested items from providers including, but not limited to, the Field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, and program training packets are available online at www.lamedicaid.com.

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure/ information/clarification, ordering printed material, requesting a Field Analyst visit, etc., and may be reached by calling:

(800) 473-2783 or (225) 924-5040*
FAX: (225) 216-6334**

*Please listen to the menu options and press the appropriate key for assistance.

NOTE: Providers should access eligibility information via the Medicaid Eligibility Verification System (MEVS) or the automated Recipient Eligibility Verification System (REVS) at (800)776-6323 or (225)216-7387. Providers may also check eligibility by accessing the web-based application, e-MEVS, now available on the Louisiana Medicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

- **Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.**

Provider Relations will accept faxed information regarding provider inquiries on an **approved case by case basis. However, faxed claims **are not** acceptable for processing.

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims.

All requests to the Correspondence Unit should be submitted to the following address:

Unisys Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge, LA 70821

NOTE: All correspondence sent to Provider Relations, including recipient file updates, must include a separate cover letter explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). **A copy of the claim form along with applicable corrections and/or attachments must accompany all resubmissions.**

Provider Relations staff does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

Requests to update Third Party Liability (TPL) should be directed to:

DHH-Third Party Liability
Medicaid Recovery Unit
P.O. Box 91030
Baton Rouge, LA 70821

"Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box. A complete list is available in this training packet under "Unisys Claims Filing Addresses".

NOTE: CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

Upon request, Provider Relations Field Analysts are available to visit and train new providers and their office staff on site. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However, since Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

FIELD ANALYST	PARISHES SERVED	
Kellie Conforto (225) 216-6269	Assumption Calcasieu Cameron Jeff Davis Lafourche	St. Mary St. Martin (**below Iberia**) Terrebonne Vermillion
Martha Craft (225) 216-6306	Jefferson Orleans Plaquemines St. Bernard	St. Charles St. James St. John the Baptist St. Tammany (**Slidell only**)
Sharon Harless (225) 216-6267	East Baton Rouge (**Baker & Zachary only**) West Baton rouge Iberville Pointe Coupee	St. Helena East Feliciana West Feliciana Woodville (MS) Centerville (MS)
Erin McAlister (225) 216-6201	Ascension East Baton Rouge (**excluding Baker & Zachary**) Livingston	St. Tammany (**excluding Slidell**) Tangipahoa Washington McComb (MS)
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin (**above Iberia**) Beaumont (TX)
Kathy Robertson (225) 216-6260	Avoyelles Beauregard Caldwell Catahoula Concordia Franklin Grant LaSalle	Natchitoches Rapides Sabine Tensas Vernon Winn Natchez (MS) Jasper (TX)
Anna Sanders (225) 216-6273	Bienville Bossier Caddo Claiborne DeSoto East Carroll Jackson Lincoln Madison	Morehouse Ouachita Red River Richland Union Webster West Carroll Marshall (TX) Vicksburg (MS)

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

Department	Toll Free Phone	Phone	Fax
REVS - Automated Eligibility Verification	(800) 776-6323	(225) 216-7387	
Provider Relations	(800) 473-2783	(225) 924-5040	(225) 216-6334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 216-6381	(225) 216-6334
Electronic Media Claims (EMC) - Unisys		(225) 216-6000 option 2	(225) 216-6335
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 216-6342
Dental P.A. - LSU School of Dentistry		(225) 216-6470	(225) 216-6476
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 216-6370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline – Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – **DHH**	(800) 834-3333 (225) 342-9808	Providers may request verification of eligibility for presumptively eligible recipients; recipients may request a new card or discuss eligibility issues.
Eligibility Operations – **BHSF**	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - **Vaccines for Children Program**	(504) 838-5300	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Specialty Care Resource Line - **ACS**	(877) 455-9955	Providers and recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED. Providers may inquire about PCP assignment for CommunityCARE recipients and CommunityCARE monitoring/certification, and obtain information on KIDMED linkage, referrals, monitoring, and certification.
CommunityCARE Nurse Helpline – **ACS**	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - **OPH**	(866) 327-5978	Providers and recipients may obtain information on EarlySteps Program and services offered.
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4153	Providers may request termination as a recipient's lock-in provider.
Division of Long Term Supports and Services (DLTSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding waiver services to waiver recipients.

DHH PROGRAM MANAGER REQUESTS

Questions regarding the rationale for Medicaid policy, procedure coverage and reimbursement, medical justification, written clarification of policy that is not documented, etc. should be directed in writing to the manager of your specific program:

Program Manager - (i.e. DME, Hospital, etc.)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

The telephone listing below should be used to direct **recipient** inquiries appropriately.

Department	Phone	Purpose
Fraud and Abuse Hotline	(800) 488-2917	Recipients may anonymously report any suspected fraud and/or abuse.
Regional Office – DHH	(800) 834-3333 (225) 342-9808	Recipients may request a new card or discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Specialty Care Resource Line - ACS	(877) 455-9955	Recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED.
CommunityCARE Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - OPH	(866) 327-5978	Recipients may obtain information on EarlySteps Program and services offered.
LINKS	(504) 838-5300	Recipients may obtain immunization information.
Division of Long Term Supports and Services (DLTSS)	(225) 219-0200 (800) 660-0488	Recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 219-0200 (800) 660-0488	Recipients may request assistance regarding waiver services.

APPENDIX A – MSA CODES

MSA CODES FOR LOUISIANA MEDICAID HOSPICE SERVICES

MSA Code	Urban Area (Parishes)	Routine Home Care HR651 Adjusted Rate	Continuous Home Care HR652 Adjusted Hourly Rate	Inpatient Respite HR655 Adjusted Rate	General Inpatient Care HR656 Adjusted Rate
220	Rapides	$109.95	$26.71	$122.37	$492.14
19	Grant	$105.36	$25.60	$118.44	$473.15
760	Ascension	$113.40	$27.55	$125.34	$506.45
760	E. B. R.	$113.40	$27.55	$125.34	$506.45
760	Livingston	$113.40	$27.55	$125.34	$506.45
760	W. B. R.	$113.40	$27.55	$125.34	$506.45
19	E. Feliciana	$105.36	$25.60	$118.44	$473.15
19	Iberville	$105.36	$25.60	$118.44	$473.15
19	PointeCoupee	$105.36	$25.60	$118.44	$473.15
19	St.Helena	$105.36	$25.60	$118.44	$473.15
3350	Lafourche	$107.52	$26.12	$120.30	$482.11
3350	Terrebonne	$107.52	$26.12	$120.30	$482.11
3880	Acadia	$111.47	$27.08	$123.67	$498.43
3880	St. Landry	$111.47	$27.08	$123.67	$498.43
3880	Lafayette	$111.47	$27.08	$123.67	$498.43
3880	St. Martin	$111.47	$27.08	$123.67	$498.43
5560	St. James	$120.28	$29.22	$131.22	$534.90
3960	Calcasieu	$108.35	$26.32	$121.01	$485.55
19	Cameron	$105.36	$25.60	$118.44	$473.15
5200	Ouachita	$109.07	$26.50	$121.63	$488.53
19	Union	$105.36	$25.60	$118.44	$473.15
5560	Jefferson	$120.28	$29.22	$131.22	$534.90
5560	Orleans	$120.28	$29.22	$131.22	$534.90
5560	Plaquemine	$120.28	$29.22	$131.22	$534.90
5560	St. Bernard	$120.28	$29.22	$131.22	$534.90

MSA Code	Urban Area (Parishes)	Routine Home Care HR651 Adjusted Rate	Continuous Home Care HR652 Adjusted Hourly Rate	Inpatient Respite HR655 Adjusted Rate	General Inpatient Care HR656 Adjusted Rate
5560	St. Charles	$120.28	$29.22	$131.22	$534.90
5560	St.JohnBaptist	$120.28	$29.22	$131.22	$534.90
5560	St. Tammany	$120.28	$29.22	$131.22	$534.90
7680	Bossier	$119.46	$29.02	$130.53	$531.53
7680	Caddo	$119.46	$29.02	$130.53	$531.53
7680	Webster	$119.46	$29.02	$130.53	$531.53
19	DeSoto	$105.36	$25.60	$118.44	$473.15
9919	Nonurban	$105.36	$25.60	$118.44	$473.15

Note: Medicaid will continue to reimburse based on Metropolitan Statistical Area (MSA) Codes and will not use the Core Based Statistical Area (CSBA) Codes that Medicare has implemented. Please use the appropriate MSA Codes as listed in this document.

APPENDIX B – 2006 LTC MONTHLY AND SUPPLMENTAL PROCESSING SCHEDULE

LTC MONTHLY PROCESSING SCHEDULE

NOTE: It is **VERY IMPORTANT** that your EMC (837I) or UB92 claim form is submitted to Unisys no later than the scheduled deadline for billing (EMC/ UB92 CLAIMS RECEIVED AT UNISYS) in order to receive payment on the "check release (issue) date" shown on the schedule below. If your billing is received at Unisys after the deadline & if the regular monthly LTC check write is missed, the billing will be processed for payment with the next regular check write.

IF POSSIBLE SEND YOUR UB-92 CLAIMS VIA FEDERAL EXPRESS OR OVERNIGHT MAIL.

IN ORDER TO ASSURE THAT YOUR CLAIMS ARE DIRECTED TO THE PROPER PROCESSING UNIT, WRITE " ATTENTION LTC OR ATTENTION KAY BRUE " PROMINENTLY ON THE ENVELOPE, AS WELL AS ON A COVER SHEET WITH THE CLAIMS.

Once a provider is on direct deposit and paid in the regular check write, the funds will be available on the working day after the normal Tuesday check write date.

EMC/UB92 CLAIMS RECEIVED AT UNISYS	CHECK RELEASE (ISSUE) DATE	DAY	DIRECT DEPOSIT FUNDS AVAILABLE DATE	DAY
01/06/2006 12Noon	01/10/2006	Tuesday	01/11/2006	Wednesday
02/09/2006 12Noon	02/14/2006	Tuesday	02/15/2006	Wednesday
03/09/2006 12Noon	03/14/2006	Tuesday	03/15/2006	Wednesday
04/07/2006 12Noon	04/11/2006	Tuesday	04/12/2006	Wednesday
05/05/2006 12Noon	05/09/2006	Tuesday	05/10/2006	Wednesday
06/08/2006 12Noon	06/13/2006	Tuesday	06/14/2006	Wednesday
07/07/2006 12Noon	07/11/2006	Tuesday	07/12/2006	Wednesday
08/10/2006 12Noon	08/14/2006	Monday	08/15/2006	Tuesday
09/08/2006 12Noon	09/12/2006	Tuesday	09/13/2006	Wednesday
10/06/2006 12Noon	10/10/2006	Tuesday	10/11/2006	Wednesday
11/09/2006 12Noon	11/14/2006	Tuesday	11/15/2006	Wednesday
12/08/2006 12Noon	12/12/2006	Tuesday	12/13/2006	Wednesday

LTC SUPPLEMENTAL/EMC/UB-92 BILLING SCHEDULE

UB92'S/EMC RECEIVED AT UNISYS	DAY	CHECK RELEASE (ISSUE)	DAY	DIRECT DEPOSIT FUNDS AVAILABLE	DAY
JANUARY					
01/12/2006- 12NOON	THURSDAY	01/17/2006	TUESDAY	01/18/2006	WEDNESDAY
01/19/2006- 12NOON	THURSDAY	01/24/2006	TUESDAY	01/25/2006	WEDNESDAY
FEBRUARY					
02/16/2006- 12NOON	THURSDAY	02/21/2006	TUESDAY	02/22/2006	WEDNESDAY
MARCH					
03/16/2006- 12NOON	THURSDAY	03/21/2006	TUESDAY	03/22/2006	WEDNESDAY
APRIL					
04/13/2006- 12NOON	THURSDAY	04/18/2006	TUESDAY	04/19/2006	WEDNESDAY
04/20/2006- 12NOON	THURSDAY	04/25/2006	TUESDAY	04/26/2006	WEDNESDAY
MAY					
05/11/2006- 12NOON	THURSDAY	05/16/2006	TUESDAY	05/17/2006	WEDNESDAY
05/18/2006- 12NOON	THURSDAY	05/23/2006	TUESDAY	05/24/2006	WEDNESDAY
JUNE					
06/15/2006- 12NOON	THURSDAY	06/20/2006	TUESDAY	06/21/2006	WEDNESDAY
06/22/2006- 12NOON	THURSDAY	06/27/2006	TUESDAY	06/28/2006	WEDNESDAY
JULY					
07/13/2006- 12NOON	THURSDAY	07/18/2006	TUESDAY	07/19/2006	WEDNESDAY
07/20/2006- 12NOON	THURSDAY	07/25/2006	TUESDAY	07/26/2006	WEDNESDAY
AUGUST					
08/17/2006- 12NOON	THURSDAY	08/22/2006	TUESDAY	08/23/2006	WEDNESDAY
08/24/2006- 12NOON	THURSDAY	08/29/2006	TUESDAY	08/30/2006	WEDNESDAY
SEPTEMBER					
09/14/2006- 12NOON	THURSDAY	09/19/2006	TUESDAY	09/20/2006	WEDNESDAY
09/21/2006- 12NOON	THURSDAY	09/26/2006	TUESDAY	09/27/2006	WEDNESDAY
OCTOBER					
10/12/2006- 12NOON	THURSDAY	10/17/2006	TUESDAY	10/18/2006	WEDNESDAY
10/19/2006- 12NOON	THURSDAY	10/24/2006	TUESDAY	10/25/2006	WEDNESDAY
NOVEMBER					
11/16/2006- 12NOON	THURSDAY	11/21/2006	TUESDAY	11/22/2006	WEDNESDAY
DECEMBER					
12/14/2006- 12NOON	THURSDAY	12/19/2006	TUESDAY	12/20/2006	WEDNESDAY

IF YOU HAVE ANY QUESTIONS REGARDING ELECTRONIC BILLING, PLEASE CALL 225-216-6000, THEN PRESS OPTION 2.