PRENATAL CLINIC SERVICES PROVIDER TRAINING

Medicaid Issues for 2003

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

UNISYS

ABOUT THIS DOCUMENT

The implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has begun. HIPAA is being implemented in phases to minimize the impact on the Louisiana Medicaid provider community, the Department of Health and Hospitals (DHH) and Unisys.

This training packet was developed for presentation at the 2003 Louisiana Medicaid Provider Training Workshops and can be found on the DHH web-site, www.lamedicaid.com. The emphasis of these workshops is on changes occurring as a result of HIPAA and its effect on the Louisiana Medicaid Program.

This packet does not present general Louisiana Medicaid policy. The Fall 2002 Basic Medicaid Services training packet may be obtained by contacting Unisys Provider Relations.

POLICY CLARIFICATION ON PRIOR AUTHORIZED SERVICES

In the past, there has been some confusion within the provider community concerning the Louisiana Medicaid policy related to **emergency requests** for prior authorized services. Below is the policy. Please contact the Unisys Prior Authorization Unit (PAU) at 800/488-6334 with questions concerning this policy.

Emergency Requests

A request is considered an emergency if a delay in obtaining the medical service, equipment, appliance, or supplies would be life-threatening to the beneficiary. In addition, emergency request may be taken for services needed for a hospital discharge. Emergency request can be made for any of the Medicaid services that require prior authorization through the Unisys PA Unit.

The providers of emergency items must contact the PAU immediately by telephone and provide the following information:

- The beneficiary's name, age, and 13-digit identification number;
- The treating physician's name;
- The diagnosis;
- The time period of need for the item or service;
- A complete description of the item(s) or service(s) requested;
- The reason that the request is a medical emergency; and
- The cost of the item (only applies to Durable Medical Equipment).

The decision will be made by the PAU within two working days of the date the completed request is received, and the PAU will contact the provider by telephone. Then, the PAU will follow up with written confirmation of the decision.

Emergency Requests that are not truly emergencies will be denied as such and the provider must resubmit as a routine request.

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PRENATAL CLINICS

All new HIPAA standard procedure codes for prenatal clinics will be **effective for date of service October 1, 2003** and thereafter. All procedure codes being made non-payable will not be accepted on any claim with a date of service October 1, 2003 and thereafter. Claims submitted prior to this date will be billed and processed according to the policy in effect on the date of service.

DATES OF SERVICE PRIOR TO OCTOBER 1, 2003		DATE OF SERVICE OCTOBER 1, 2003 AND THEREAFTER	
LOCAL CODE	DESCRIPTION	HIPAA STANDARD CODE	DESCRIPTION
X0187	Consultation-Epsdt-Nurse	T1001	Nursing Assessment/ Evaluation
X0188	Consultation-Epsdt-Nutritionist	S9470	Nutritional Counsel, Dietician Visit
X0189	Consultation-Epsdt-Social Worker	99211 (AJ)	Office Visit, Estab Pt, Minimal Problem
X0548	Follow-Up Phone	99371 **THRU** 99373 (TD OR TE)	Telephone Call By Physician To Patient
X9007	Vision Screening	**NOT PAYABLE TO THIS PROVIDER TYPE**	
Z9001	Prenatal Lab Panel, 1-3 Tests	80055	Obstetric Profile
Z9002	Prenatal Lab Panel, 4-5 Tests		
Z9003	Prenatal Lab Panel, 6 Or More Tests		
Z9004	Initial Ob Care, New Or Estab Pt	99201 **THRU** 99205 (TH)	Office Visit, New Pt
Z9005	Prenatal Office Visit	99211 **THRU** 99215 (TH)	Office Visit, Established Pt
Z9006	Postpartum Visit	59430	Care After Delivery
Z9012	Sgot/Sma8 Blood Analysis For Live E	84450	UV-Assay Transaminase (SGOT)
Z9013	Injection, Benzathine Penicillin	J0530	Inj, Bicillin C-R, Up To 600,000
Z9015	Injection, Ceftriaxone Sodium	J0696	Inj, Ceftriaxone Sodium, Per 250 MG
Z9017	Tetracycline Hcl	J0120	Inj, Tetracycline, Up To 250 MG
Z9018	Ampicillin	J0290	Hemodialysis, Ampicillin Inj
		J0295	Ampicillin Sodium Per 1.5 GM
Z9019	Erythromycin Stertate	J1364	Erythromycin Lactobionate, 500 MG
Z9026	Injection, Capreomycin	**NOT PAYABLE**	
Z9027	Kanamycin	J1840	Inj, Kantrex, Kanamycin Sul
		J1850	Inj, Kantrex Pediatric Up To
ZZ034	Epsdt-Microscopic Exam Of Urine	81015	Microscopic Exam Of Urine
ZZ035	Epsdt Urine Culture Colony Count	87086	Urine Culture, Colony Count

OBSTETRICAL SERVICES

Maternity related services are exempt from the CommunityCARE referral process.

All obstetrical visit procedure codes must include procedure **modifier "TH"** to prevent them from being counted towards the twelve (12) outpatient visit maximum permitted per fiscal year for recipients age 21 or older.

INITIAL PRENATAL VISITS

Recipients will be allowed two initial prenatal visits per pregnancy (270 days). These two visits cannot be performed by the same provider.

The appropriate CPT code from the 99201-99205 section of ***Office or Other Outpatient Services*** range of codes should be billed for this service, as each pregnancy will be considered a new pregnancy whether or not the recipient is a new patient to the provider. Additionally, a pregnancy-related diagnosis must be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, **which must include procedure modifier "TH",** includes the routine dipstick analysis (CPT code 81002 or 81003), the examination, preparation of records, and health/dietetic counseling.

If medically necessary lab testing is needed at this visit, it may be billed separately.

If the pregnancy is not verified, or if the pregnancy test is negative, the appropriate level evaluation and management code from the 99201-99215 range of codes should be billed **without the "TH" modifier.**

FOLLOW UP PRENATAL VISITS

The appropriate CPT from the 99211-99215 section of *Office or Other Outpatient Services* range of codes should be billed for each follow-up prenatal office visit. The code for each of these visits **must include procedure modifier "TH".**

The reimbursement for this service includes payment for the routine dipstick urinalysis, the exam, routine fetal monitoring (excluding fetal non-stress test-CPT code 59025) and diagnosis and treatment of conditions both related to and unrelated to pregnancy.

POSTPARTUM CARE VISIT

CPT code 59430, which does not need to include a procedure modifier, should be billed for the postpartum care visit. The reimbursement for this service will include all the services (exam, routine dipstick urinalysis, weight and blood pressure checks, etc.) normally associated with releasing a patient from OB care.

Each recipient will be allowed one postpartum visit. Payment for a second medically indicated postpartum visit can be requested by submitting the 158A (extension form).

LABORATORY SERVICES

Obstetric panel code 80055 is payable only once per pregnancy. If payment for this code is billed on a specific day for a specific recipient, reimbursement for the components of this code cannot be billed the same billing or attending provider.

A complete urinalysis (CPT code 81000 or 81001) is payable only once per pregnancy per recipient per billing provider ***unless*** the primary diagnosis code for subsequent billings is within the CPT range of 590-599 (other disease of the Urinary System).

All lab work must be substantiated by appropriate diagnosis codes (e.g., urinalysis should be substantiated by a diagnosis for U.T.I).

INJECTIONS

Medically necessary Rhogam injections with justifying diagnosis(es) may be billed electronically using procedure code J2790.

ULTRASOUNDS

Three ultrasounds will be allowed per pregnancy. Payment for additional ultrasounds may be requested when medically necessary.

Reimbursement for CPT codes 76811 and 76812 is restricted to maternal-fetal specialists.

SOCIAL WORKER CONSULTATIONS

Providers should use procedure code X0189 for dates of service prior to October 1, 2203. Social worker consultations services provided on October 1, 2003 and thereafter should be submitted with procedure code 99211 with modifier **"AJ".**

PHYSICIAN PHONE CALLS TO PATIENTS

This service is payable only to the Office of Public Health (OPH).

Providers should use procedure code X0548 for services provided on dates of service prior to October 1, 2003. Services provided on October 1, 2003 and thereafter should be submitted with procedure code 99371, 99372, or 99373 and modifier **"TD"** (Registered Nurse) or **"TE"** (Licensed Practical Nurse) should be appended.

If the modifier "TD" or "TE" is not present, the claim will deny.

EDIT CODES

ERROR CODE	DESCRIPTION	CAUSE
671	INCLUDED IN PAID PRE- AND/OR POST-NATAL CARE VISIT – DO NOT RE-BILL	APPLICABLE IF PROVIDER SUBMITS A CLAIM FOR A SERVICE THAT IS CONSIDERED PAID WITHIN THE SCOPE OF PRENATAL OR POST-NATAL CARE

CLAIMS FILING

Professional services are billed on the CMS-1500 (formerly known as HCFA-1500) claim form. Items to be completed are either **required** or **situational. Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. **Situational** information may be required (but only in certain circumstances as detailed in the instructions below). Claims should be submitted to:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

1.	**REQUIRED**	Enter an "X" in the box marked Medicaid **(Medicaid #)**
***1A.**	**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 (MEVS) or through REVS.

NOTE: The recipients' 13-digit Medicaid ID number **must** be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable.

Note: If the 13-digit Medicaid ID 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.

***2.**	**REQUIRED**	Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through MEVS or REVS.
3.	**SITUATIONAL**	Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS or REVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.
4.	**SITUATIONAL**	Complete if appropriate, or leave blank
5.	**SITUATIONAL**	Print the recipient's permanent address
6.	**SITUATIONAL**	Complete if appropriate, or leave blank
7.	**SITUATIONAL**	Complete if appropriate, or leave blank
8.	**SITUATIONAL**	Leave blank
9.	**SITUATIONAL**	Complete if appropriate, or leave blank

9A.	**SITUATIONAL**	If recipient has no other coverage, leave blank. If there is other coverage, put the state assigned 6-digit TPL carrier code in this block-make sure EOB is attached to the claim.
9B.	**SITUATIONAL**	Complete if appropriate, or leave blank
9C.	**SITUATIONAL**	Complete if appropriate, or leave blank
9D.	**SITUATIONAL**	Complete if appropriate, or leave blank
10.	**SITUATIONAL**	Leave blank
11.	**SITUATIONAL**	Complete if appropriate, or leave blank
11A.	**SITUATIONAL**	Complete if appropriate, or leave blank
11B.	**SITUATIONAL**	Complete if appropriate, or leave blank
11C.	**SITUATIONAL**	Complete if appropriate, or leave blank
12.	**SITUATIONAL**	Complete if appropriate, or leave blank
13.	**SITUATIONAL**	Obtain signature if appropriate, or leave blank
14.	**SITUATIONAL**	Leave blank
15.	**SITUATIONAL**	Leave blank
16.	**SITUATIONAL**	Leave blank
17.	**SITUATIONAL**	Leave blank
17A.	**SITUATIONAL**	Leave blank
18.	**SITUATIONAL**	Leave blank
19.	**SITUATIONAL**	Leave blank
20.	**SITUATIONAL**	Leave blank
***21.**	**REQUIRED -**	Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.
22.	**SITUATIONAL**	Leave blank
23.	**SITUATIONAL**	Complete if required, or leave blank
***24A.**	**REQUIRED**	Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.

***24B. REQUIRED**	Enter the appropriate code from the approved Medicaid place of service code list (see Place of Service codes on pages 8-10).
24C. SITUATIONAL	Leave blank
***24D. REQUIRED**	Enter the procedure code(s) for services rendered.
***24E. REQUIRED**	Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a "1", "2", etc. More than one diagnosis may be related to a procedure. Do not enter ICD-9-CM diagnosis code.
***24F. REQUIRED**	Enter usual and customary charges for the service rendered.
***24G. REQUIRED**	Enter the number of units billed for the procedure code entered on the same line in 24D.
24H. SITUATIONAL	Leave blank, or Enter a "Y" if services were performed as a result of an EPSDT referral.
24I. SITUATIONAL	Leave blank
24J. SITUATIONAL	Leave blank
24K. SITUATIONAL	Leave blank
25. SITUATIONAL	Leave blank
26. SITUATIONAL	Enter the provider specific information assigned to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.
27. SITUATIONAL	Leave blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.
***28. REQUIRED**	Total of all charges listed on the claim.
29. SITUATIONAL	If block 9A is completed, indicate the amount paid; if no TPL, leave blank.
30. SITUATIONAL	If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from the billed charges.

*31.	**REQUIRED**	The claim form **MUST** be signed. The practitioner is not required to sign the claim form. However, the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. **If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned unprocessed.**
	Date	Enter the date of the signature
32.	**SITUATIONAL**	Complete as appropriate or leave blank
*33.	**REQUIRED**	Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid billing provider number must be entered in the space next to "Group (Grp) #."

Note: If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.

PLACE OF SERVICE CODES

Current codes and descriptions are maintained at posinfo@cms.hhs.gov.

Place of Service Code	Place of Service Name	Place of Service Description
01-02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
8	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09-10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility*	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services, including some health care and other services.
14	Group Home*	Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services, and that promotes rehabilitation and reintegration of residents into the community.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under the supervision of, physicians to patients admitted for a variety of medical conditions.

Place of Service Code	Place of Service Name	Place of Service Description
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do no require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Custodial Care Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic*	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services (including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility); 24-hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

Place of Service Code	Place of Service Name	Place of Service Description
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals, but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct pat of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility*	A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall, but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic**	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

- **New Place of Service code, effective October 1, 2003**

****Revised Place of Service code, effective October 1, 2003**

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM | DD | YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90). FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 5955515235563

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JONAS, GERRI

3. PATIENT'S BIRTH DATE: 12 26 74 SEX: M

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M | F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 6486 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 27 03	10 27 03	11		99213 TH		1	50 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ 50 00

29. AMOUNT PAID $

30. BALANCE DUE $ 50 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Shelly Kilroy 10/31/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

ABC PRENATAL CLINICS
123 SHILOH STREET

PIN# GRP# 1987653

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

ADJUSTMENT/VOID CLAIMS

THIS PROCESS HAS NOT CHANGED.

Claims paid on the CMS-1500 form are adjusted or voided using the Unisys 213 adjustment/void form. These may be ordered from Unisys at no cost.

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

Only a **paid** claim can be adjusted or voided. Denied claims must be corrected and resubmitted—not adjusted or voided.

Electronic submitters may electronically submit adjustment/void claims.

Only the paid claim's most recently approved control number can be adjusted or voided. For example:

1. A claim is paid on the RA dated 1-1-98, ICN 1234567890123.
2. The claim is adjusted on the RA dated 1/15/98, ICN 4567890123456.
3. If the claim requires further adjustment or needs to be voided, only ICN 4567890123456 may be used.

Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column.

To file a void, the provider must enter all the information from the original **claim exactly as it appeared on the original claim**. When the void claim is approved, it will be listed under the "void" column of the RA and a corrected claim may be submitted (if applicable).

INSTRUCTIONS FOR FILING ADJUSTMENT/VOID CLAIMS

*1. **ADJ/VOID**—Check the appropriate block

*2. **Patient's Name**

a. **Adjust**—Print the name exactly as it appears on the original claim if not adjusting this information

b. **Void**—Print the name exactly as it appears on the original claim

3. **Patient's Date of Birth**

a. **Adjust**—Print the date exactly as it appears on the original claim if not adjusting this information

b. **Void**—Print the name exactly as it appears on the original claim

*4. **Medicaid ID Number**—Enter the 13 digit recipient ID number

5. **Patient's Address and Telephone Number**

a. **Adjust**—Print the address exactly as it appears on the original claim

b. **Void**—Print the address exactly as it appears on the original claim

6. **Patient's Sex**

a. **Adjust**—Print this information exactly as it appears on the original claim if not adjusting this information

b. **Void**—Print this information exactly as it appears on the original claim

7. **Insured's Name**— Leave blank

8. **Patient's Relationship to Insured**—Leave blank

9. **Insured's Group No.**—Complete if appropriate or blank

10. **Other Health Insurance Coverage**—Complete with 6-digit TPL carrier code if appropriate or leave blank

11. **Was Condition Related to**—Leave blank

12. **Insured's Address**—Leave blank

13. **Date of**—Leave blank

14. **Date First Consulted You for This Condition**—Leave blank

15. **Has Patient Ever had Same or Similar Symptoms**—Leave blank

16. **Date Patient Able to Return to Work**—Leave blank

17. **Dates of Total Disability-Dates of Partial Disability**—Leave blank

18. **Name of Referring Physician or Other Source**—Leave this space blank

18a. **Referring ID number**—Enter the CommunityCARE authorization number if applicable or leave blank

19. **For Services Related to Hospitalization Give Hospitalization Dates**—Leave blank

20. **Name and Address of Facility Where Services Rendered (if other than home or office)**—Leave blank

21. **Was Laboratory Work Performed Outside of Office**—Leave blank

*22. **Diagnosis of Nature of Illness**

a. **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information

b. **Void**—Print the information exactly as it appears on the original claim

23. **Attending Number**—Enter the attending number submitted on original claim, if any,or leave this space blank

24. **Prior Authorization #**—Enter the PA number if applicable or leave blank

*25. **A through F**

a. **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information

b. **Void**—Print the information exactly as it appears on the original claim

*26. **Control Number**—Print the correct Control Number as shown on the Remittance Advice

*27. **Date of Remittance Advice that Listed Claim was Paid**—Enter MM DD YY from RA form

*28. **Reasons for Adjustment**—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary

*29. **Reasons for Void**—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary

*30. **Signature of Physician or Supplier**—All Adjustment/Void forms **must** be signed

*31. **Physician's or Supplier's Name, Address, Zip Code and Telephone Number**—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number ***The form will be returned if this information is not entered.***

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
3 PATIENT'S DATE OF BIRTH
4 MEDICAID ID NUMBER
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX MALE FEMALE
7 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
8 INSURED'S NAME
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES NO
B. AN AUTO ACCIDENT YES NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES NO CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1
2
3
23 ATTENDING NUMBER
23 PRIOR AUTHORIZATION NO.

24 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL

25 CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

26 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

27 REASONS FOR ADJUSTMENT
- ☐ 01 THIRD PARTY LIABILITY RECOVERY
- ☐ 02 PROVIDER CORRECTIONS
- ☐ 03 FISCAL AGENT ERROR
- ☐ 90 STATE OFFICE USE ONLY - RECOVERY
- ☐ 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

28 REASONS FOR VOID
- ☐ 10 CLAIM PAID FOR WRONG RECIPIENT
- ☐ 11 CLAIM PAID TO WRONG PROVIDER
- ☐ 99 OTHER - PLEASE EXPLAIN

29 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
30 YOUR PATIENT'S ACCOUNT NUMBER
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE

FISCAL AGENT COPY

UNISYS - 213
5/97

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): JONAS, GERRI
3 PATIENT'S DATE OF BIRTH: 12/26/74
4 MEDICAID ID NUMBER: 5955515235563
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [ ]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO
B. AN AUTO ACCIDENT YES [ ] NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO
15 DATE PATIENT ABLE TO RETURN TO WORK
16 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17A REFERRING ID NUMBER
18 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
19 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
20 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 6486
2
3
22 ATTENDING NUMBER
23 PRIOR AUTHORIZATION NO.

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
10 27 03	10 27 03	11	99214	TH	1	65 00	1		

25 CONTROL NUMBER: 3302159503002
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
26 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 11/4/2003

27 REASONS FOR ADJUSTMENT
[X] 01 THIRD PARTY LIABILITY RECOVERY
[ ] 02 PROVIDER CORRECTIONS
[ ] 03 FISCAL AGENT ERROR
[ ] 90 STATE OFFICE USE ONLY - RECOVERY
[ ] 99 OTHER - PLEASE EXPLAIN
Billed incorrect procedure code for services rendered

ADJUSTMENT

28 REASONS FOR VOID
[ ] 10 CLAIM PAID FOR WRONG RECIPIENT
[ ] 11 CLAIM PAID TO WRONG PROVIDER
[ ] 99 OTHER - PLEASE EXPLAIN

29 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Shelly Kilroy 11/7/03
30 YOUR PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
ABC PRENATAL CLINICS
123 SHILOH STREET
1987653

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UNISYS - 213
5/97

PREPARATION FOR HIPAA IMPLEMENTATION

HIPAA implementation will impact multiple areas of Louisiana Medicaid. Although HIPAA Regulations relate directly to electronic claims submission and code set requirements, the Department of Health and Hospitals (DHH) is requiring changes in additional areas of the Louisiana Medicaid Program in an effort to prepare for HIPAA implementation. **These changes will impact both electronic and hard copy billing.** This training packet addresses areas where changes are being made during the HIPAA preparation efforts that will impact the Louisiana Medicaid provider community.

Local Code Conversion

It is necessary to transition from the currently accepted Louisiana Medicaid local code sets to HIPAA accepted standardized code sets.

Billing Form/Instruction Changes

Some programs are required to transition from currently accepted billing claim forms to different claim forms. In some cases, currently accepted forms are being revised to require additional information, thus, requiring changes in billing instructions.

Prior Authorization

Some programs requiring prior authorization will begin using a revised prior authorization form to request PAs. Only minor changes have been made to the forms. Ultimately, providers will have the ability to submit PA requests electronically.

Electronic Data Interchange (EDI)

HIPAA requires that electronic billing transition from the currently accepted Louisiana Medicaid proprietary EMC specifications to the HIPAA standardized EDI specifications.

Claims Status Inquiry (CSI)

A new web application for claims status inquiry will be available later this year.

MEVS/REVS Upgrade

A new web application is available for MEVS, and MEVS inquiry responses will change.

Remittance Advices

Some changes were made in payment/denial descriptions on Electronic Remittance Advices. At this time, no changes will be made to paper remittance advices.

The following table contains the DHH implementation schedule and the required changes for HIPAA. **Note that exact dates are included only for the implementations occurring up to 10/01/2003. The schedule after that date is considered to be tentative.**

Implementation Title	Type	Date	Description
Pharmacy	Local Codes	01/21/03	Eliminate the use of LA specific pharmacy NDC codes for indwelling catheters
RA 835/U277	EDI	04/07/03	HIPAA transaction 835/U277 electronic remittance advice now available to those providers who request it.
Inpatient/Outpatient 837I	EDI	04/07/03	Begin accepting 837I inpatient/outpatient electronic institutional claims
Privacy	NA	04/14/03	The Privacy HIPAA Rule becomes effective.
Dental	EDI/Local Codes/ Claim Form	05/01/03	Begin accepting 837D electronic dental claims, elimination of LA specific dental codes, begin using CDT-4 dental procedure codes, and begin using the 2002 ADA paper dental claim form.
Hospital	Local Codes	05/01/03	Eliminate the use of LA specific codes.
Hemodialysis	Local Codes	05/01/03	Eliminate the use of LA specific codes. .
Rural Health/FQHC	Local Codes/ Claim Form	05/01/03	Eliminate the use of LA specific codes. Begin new payment methodology. Begin use of new billing instructions for KIDMED KM-3 paper claim form.
MEVS/REVS 270/271	EDI	06/28/03	Begin receiving recipient status requests and transmitting responses in the HIPAA standard electronic formats. End use of 3040 version.
Professional 837P	EDI	07/26/03	Begin accepting 837P electronic professional claims.
POS NCPDP V5.1	EDI	08/24/03	Begin use of NCPDP 5.1 real-time format for pharmacy Point of Sale claims. RA response codes for pharmacy claims upgraded to NCPDP version 5.1. End use of version 3.2.
Pharmacy NCPDP V1.1	EDI/Claim Form	08/24/03	Begin use of Universal Prescription Claim Form (UCF). Begin use of NCPDP 1.1 batch electronic format for pharmacy claims. End use of proprietary electronic format.
Transportation	Local Codes	10/01/03	Eliminate the use of LA specific codes for emergency transportation providers and begin use of standard code
Home Health	EDI/Local Codes/ Claim Form	10/01/03	Begin use of UB92 paper claim form and 837I electronic claims for this program. Eliminate use of LA specific codes and begin use of standard codes. End use of proprietary 101 paper forms.
Professional - Physicians *Ambulatory Surgical Center,* *Physician Services* *Lab & X-ray* *Transportation (ambulance)* *Prenatal Clinics* *Family Planning Clinics*	Local Codes	10/01/03	Eliminate the use of LA specific codes and begin use of standard codes. Begin use of new payment methodology for Anesthesia and Immunizations claims.
KIDMED Local Code *(EPSDT Screening Service)*	Local Codes/Claim Form	10/01/03	Begin using the revised KM-3 paper claim form with new billing instructions. Eliminate the use of LA specific codes and begin use of standard codes.
LTC/ICFMR/ADHC/Hospice 837I	EDI/Claim Form	10/01/03	Begin accepting UB92 paper claim form and 837I electronic institutional claims with standard codes.
Claims Status Inquiry (CSI) 276/277	EDI	TBD	Begin online provider Claim Status Inquiry (CSI)
Professional – Non-Physicians *TB Clinics* *STD Clinics* *EPSDT Health Services* *Mental Health Clinics* *Mental Health Rehab* *Rehab Centers* *Vision (Ophthalmologists, Optometrists)*	Local Codes	TBD	Eliminate the use of LA specific codes and begin use of standard codes.
Prior Authorization 278	EDI	TBD	Begin to accept prior authorization requests in the electronic 278 format.
DME/DME Pharmacy	Local Codes	TBD	Eliminate the use of LA specific codes and begin use of standard codes.
Waiver	Local Codes	TBD	Eliminate the use of LA specific codes and begin use of standard codes.

HIPAA UPGRADE FOR MEVS/REVS

To comply with HIPAA requirements, DHH and Unisys upgraded the Medicaid Eligibility Verification System (MEVS) and Recipient Eligibility Verification System (REVS) on June 28, 2003. This upgrade involved changing the current DHH approved inquiry responses to federally required standardized inquiry responses. The table on the following page represents a crosswalk of the previous DHH approved messages to the required, standardized messages for MEVS. There were only minor changes to the REVS responses.

REVS may be accessed by calling (800) 766-6323 or (225) 216-7387.

If you have an interest in MEVS access through a vendor, the current approved MEVS vendors will continue to provide this service for a fee. A list of the current vendors is located in the 2002 Basic Services training packet.

Additionally, a new MEVS web application is now available to providers by accessing the LA Medicaid web site at www.lamedicaid.com. Only one eligibility inquiry at a time may be made when using the web application.

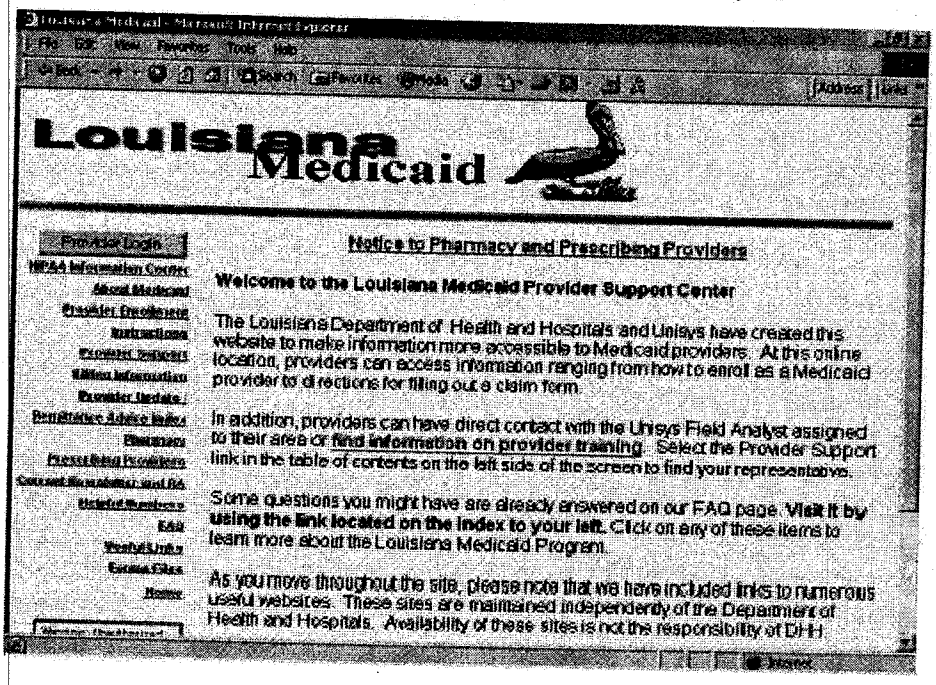
Screen prints of this new web application appear on pages 22-26.

MEVS INQUIRY RESPONSE CROSSWALK

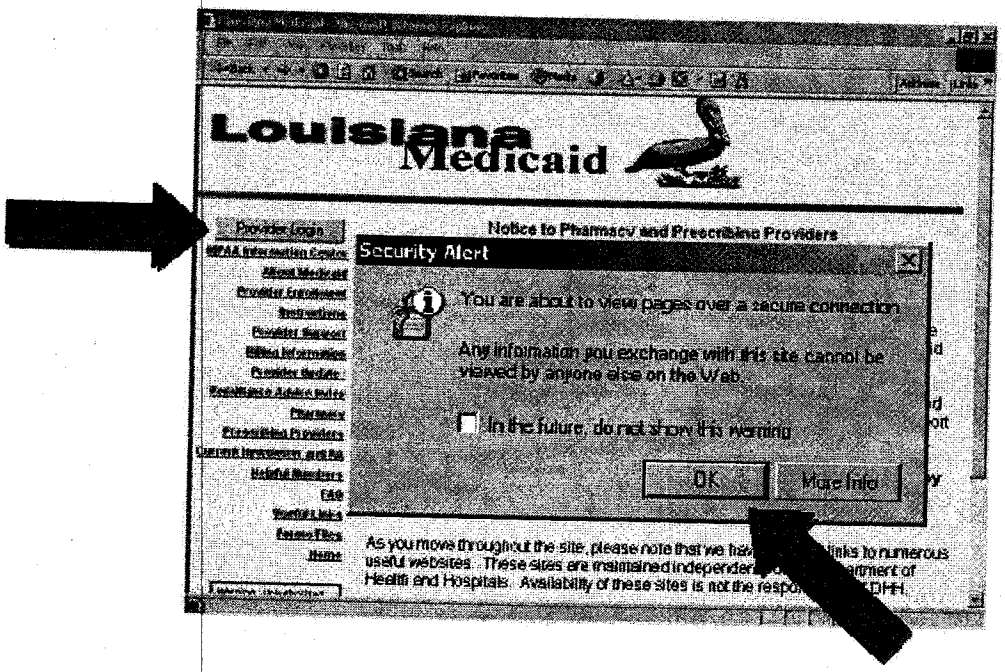
Field Name	Louisiana Medicaid Proprietary Responses	HIPAA Required Standardized Responses
Planned Unavailable	"Planned Unavailable" in clarification message	Unable to Respond at Current Time - Resubmission Allowed
Provider ID	Provider number missing or not numeric	Invalid/Missing Provider ID – Please Correct and Resubmit
Provider ID	Provider ID must begin with '1'	Invalid/Missing Provider ID – Please Correct and Resubmit
Provider ID	Provider/Attending provider not on file	Provider Not on File – Please Correct and Resubmit
Provider ID	Provider not eligible on dates of service	Provider Ineligible for Inquiries – Please Correct and Resubmit
Card Control #	Card control number missing/invalid	Invalid/Missing subscriber/insured ID – Please Correct and Resubmit
Card Issue Date	Card issue date missing/invalid	Inappropriate Date – Please Correct and Resubmit
Card Issue Date	Card may not be used prior to effective date	Inappropriate Date – Please Correct and Resubmit
Recipient ID	Recipient number invalid or less than 13 digits	Invalid/missing Patient ID – Please Correct and Resubmit
Last or First Name	Recipient name missing	Invalid/missing Patient Name – Please Correct and Resubmit
SSN	Social security number missing/invalid	Required application data missing – Please Correct and Resubmit
Date of Birth	Date of birth missing or invalid	Invalid/missing Date of Birth – Please Correct and Resubmit
Date of Birth	Date of birth must not be prior to year 1875	Invalid/missing Date of Birth – Please Correct and Resubmit
Service Date	Service date missing/invalid	Invalid/missing Date of Service – Please Correct and Resubmit
Service Date	Service more than 12 months old	Date of service Not Within Allowable Inquiry Period – Please Correct and Resubmit
Service Date	Service date may not exceed last day of current month	Date of service in Future – Please Correct and Resubmit
Recipient Query	Recipient not on file (this will be returned for any query combination that results in the recipient not found on Recipient table)	Patient Not Found – Please Correct and Resubmit
Date of Death	Recipient ineligible/deceased (when DOD < date of service)	Date of Death Precedes Date of Service – Please Correct and Resubmit
Eligibility Query	Recipient not eligible on date of service	Inactive
Eligibility Query	Dual Eligibility message in clarification message	Cannot Process - Overlapping Eligibility on DOS
Lock In Provider	"Unable to Respond - contact Unisys provider services" in clarification message (if Lock In Provider not on file)	Unable to Respond at Current Time – Resubmission Not Allowed
PCP Provider (CC)	"Unable to Respond - contact Unisys provider services" in clarification message (if PCP Provider not on file)	Unable to Respond at Current Time – Resubmission Not Allowed
Insurance Nbr, Company Name, Company Address, or Policy Holder Name	"Unable to Respond - contact Unisys provider services" in clarification message (if Insurance Number not on file)	Required application data missing – Resubmission Not Allowed

MEVS WEB APPLICATION SCREENS

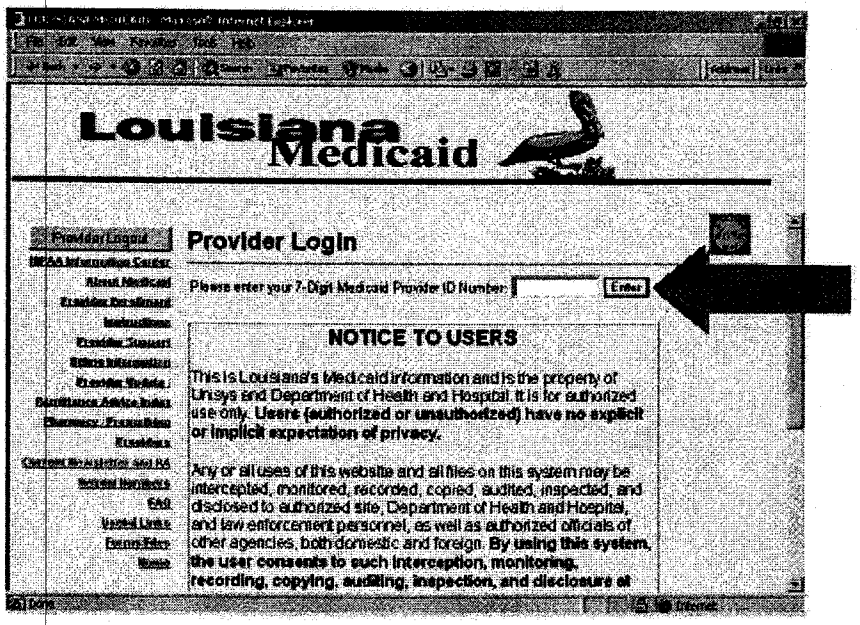
1. Open a web browser and enter the URL for the Louisiana Medicaid main menu – http://www.lamedicaid.com. The following screen will be displayed.



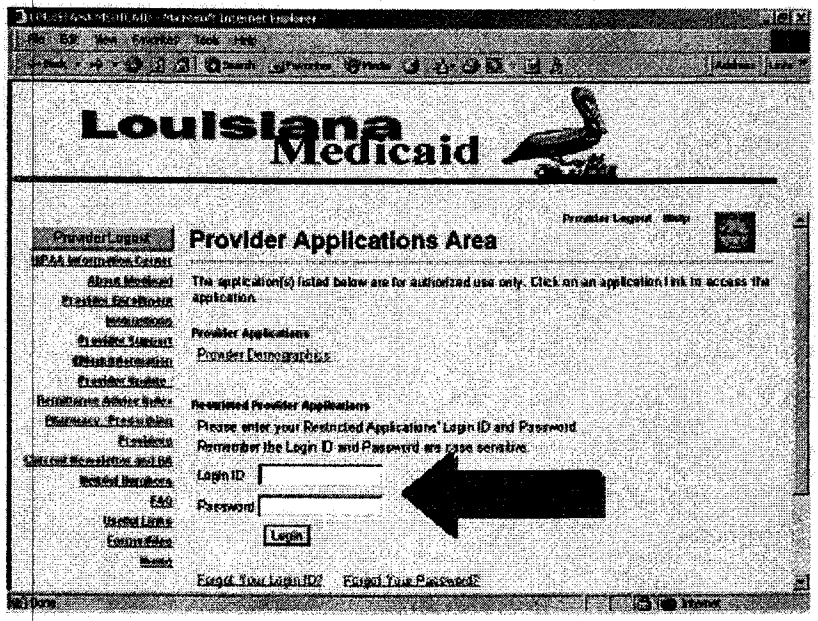
2. Click the **Provider Login** button on the left side; the following security message will appear.



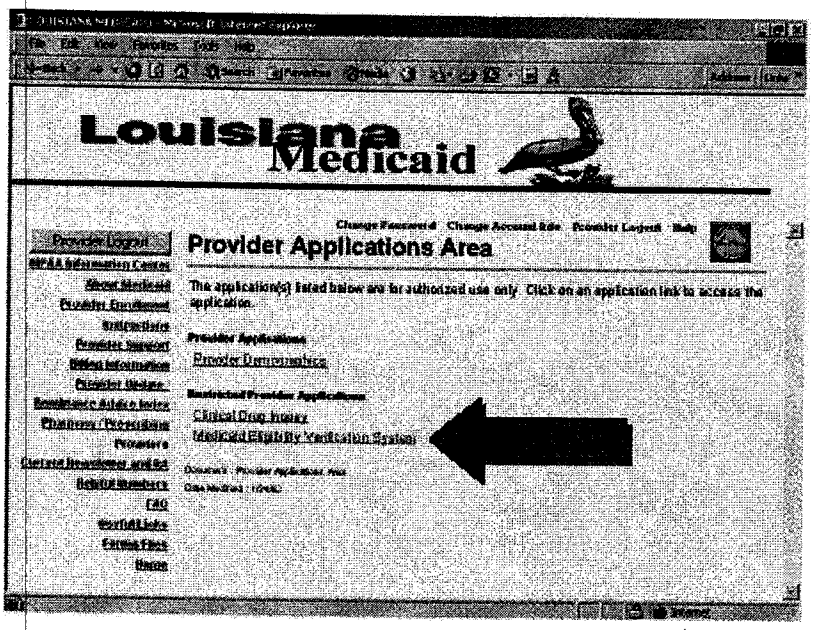
3. Click **OK.** The following screen is displayed.



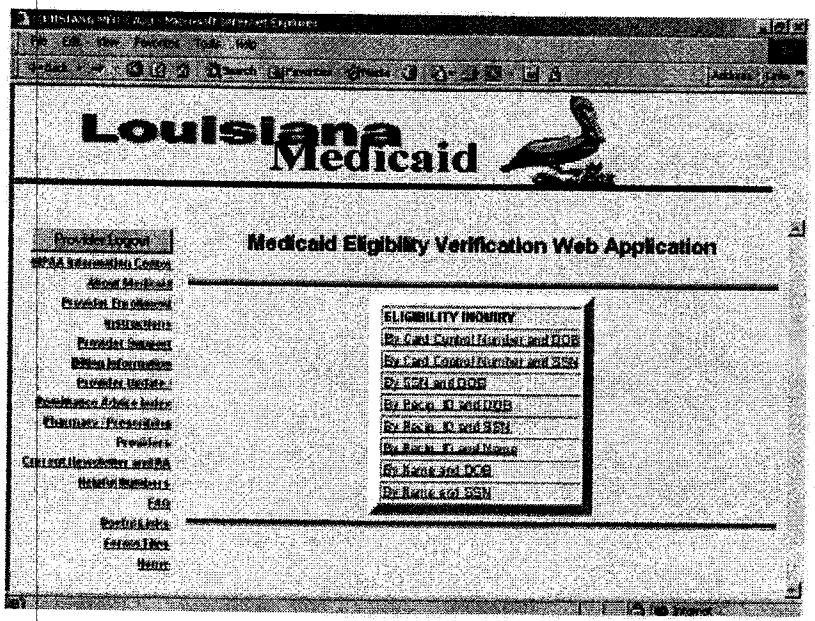
4. Enter your Provider ID Number in the area provided and click the **ENTER** button. The following screen is displayed.



5. Enter the Login ID and password.
6. Click the Login button. The following screen is displayed.

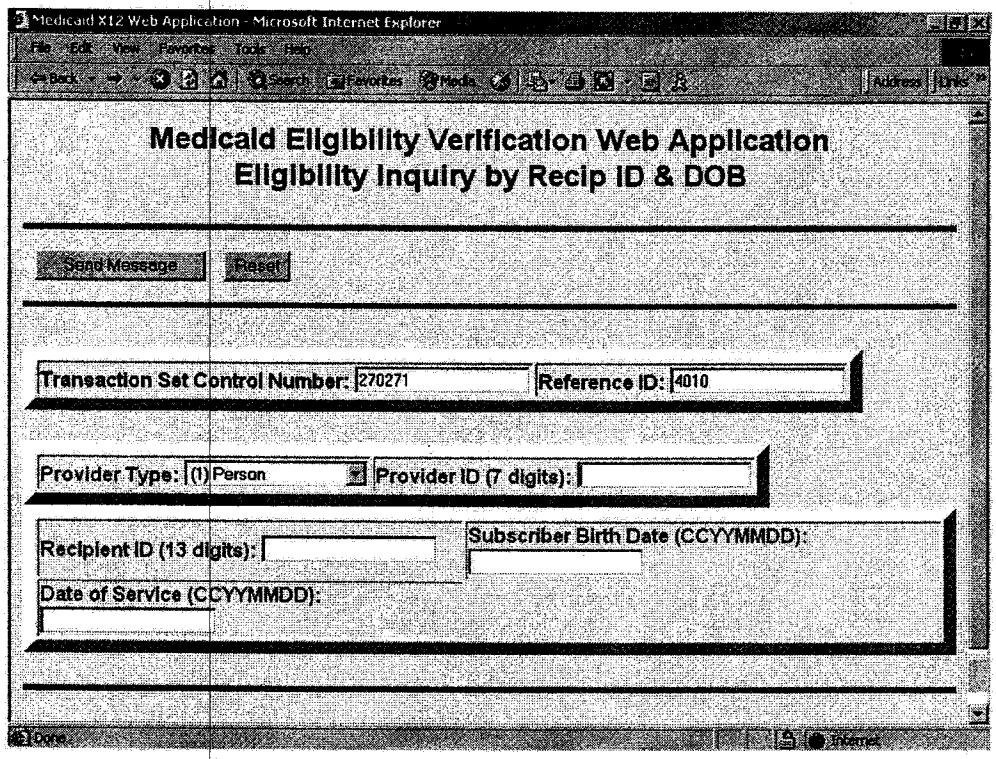


7. Click the ***Medicaid Eligibility Verification System*** hyperlink. The following screen is displayed.



MEVS inquiries can be requested using eight different methods.

This is the screen for Eligibility Inquiry by Recip ID & DOB:



Medicaid Eligibility Verification Web Application Response

Field ID	Field Title	Value
(ST02)	Transaction Set Control Number:	270271
(BHT03)	Reference ID:	4010
(HL03)	Hierarchical Level Code:	Information Source
(NM101)	Entity ID Code:	Payer
(NM103)	Last Name/Org. Name:	UNISYS LAMMIS
(NM108)	ID Code Qualifier:	Payor ID
(NM109)	ID Code:	610551
(HL03)	Hierarchical Level Code:	Information Receiver
(NM101)	Entity ID Code:	Provider
(NM103)	Last Name/Org. Name:	UNISYS PR STAFF TEST
(NM108)	ID Code Qualifier:	Service Provider Number
(NM109)	ID Code:	Provider Name
(REF01)	Reference ID Qualifier:	Contact Number
(REF02)	Reference ID:	2252373370
(HL03)	Hierarchical Level Code:	Subscriber
(TRN02)	Tracking Number:	200308070032403
(NM101)	Entity ID Code:	Insured or Subscriber
(NM103)	Last Name/Org. Name:	Recipient's Name
(NM104)	First Name:	
(NM105)	Middle Name:	
(NM108)	ID Code Qualifier:	Member ID Number
(NM109)	ID Code:	Recipient's Medicaid Id Number
(DMG02)	Birthdate:	DOB
(DMG03)	Gender Code:	Gender
(DTP01)	Date/Time Qualifier:	Service
(DTP03)	Date:	20030807
(EB01)	Eligibility or Benefit Information:	Benefit Description
(EB02)	Coverage Level Code:	Individual
(EB03)	Service Type Code:	Health Benefit Plan Coverage
(EB04)	Insurance Type Code:	Medicaid
(EB05)	Plan Coverage Description:	01ELIGIBLE FOR MEDICAID
(EB01)	Eligibility or Benefit Information:	Benefit Description
(EB02)	Coverage Level Code:	Individual
(EB03)	Service Type Code:	Health Benefit Plan Coverage
(EB04)	Insurance Type Code:	Medicaid
(EB05)	Plan Coverage Description:	11EPSDT ELIGIBLE
(EB01)	Eligibility or Benefit Information:	Benefit Description
(EB02)	Coverage Level Code:	Individual
(EB03)	Service Type Code:	Health Benefit Plan Coverage
(EB04)	Insurance Type Code:	Medicaid
(EB05)	Plan Coverage Description:	12PREFERRED LANGUAGE: ENGLISH
(EB01)	Eligibility or Benefit Information:	Benefit Description
(EB02)	Coverage Level Code:	Individual
(EB03)	Service Type Code:	Medical Care
(EB04)	Insurance Type Code:	Preferred Provider Organization (PPO)
(MSG01)	Message Text:	PCP MUST PROVIDE/AUTHORIZE SERVICES EXCEPT:
(MSG01)	Message Text:	ACUTE CARE HOSP PROV OR PHYSICIAN CAN PROVIDE ER SERV, POST AUTH REQ'D
(MSG01)	Message Text:	FAM PLANNING SERV PROV OR PROV SPECIALTIES CAN PROVIDE FAM PLANNING SERV
(NM101)	Entity ID Code:	Provider
(NM103)	Last Name/Org. Name:	Name of Recipient's PCP
(NM104)	First Name:	
(NM107)	Name Suffix:	
(PER01)	Contact Function Code:	Information Contact
(PER03)	Communication Number Qualifier:	Telephone
(PER04)	Communication Number:	Phone Number of Recipient's PCP

HIPAA ELECTRONIC DATA INTERCHANGE

The following information will assist your Software Vendor, Billing Agent or Clearinghouse to become HIPAA approved. For those who do not have a Software Vendor, Billing Agent or Clearinghouse to become HIPAA approved, instructions are also provided.

NOTE: If you currently submit claims electronically to LA Medicaid, your current method **WILL NOT** be **HIPAA** compliant without modifications by your Software Vendor, Billing Agent or Clearinghouse. The only exception to this statement is for electronic billing of Non-Ambulance Transportation and Case Management claims, which are exempt from HIPAA, and POS Pharmacy who will be approved through their switch vendors. All other claims are affected.

From this point on, a "Software Vendor", "Billing Agent", or "Clearinghouse" will be referred to collectively as a '**VBC**'.

SOFTWARE VENDOR, BILLING AGENT, AND CLEARINGHOUSE (VBC) LIST

If you are a LA Medicaid provider AND

a. You do not have a (VBC)

OR

b. Your VBC does not plan to become HIPAA ready

YOU SHOULD:

Subscribe to the weekly VBC list and HIPAA updates by e-mailing the HIPAA EDI group at ***hipaaedi@unisys.com** **(Note: * is part of the e-mail address).** Put **"subscribe to VBC list"** in the subject line. VBCs identified in the list are those that have enrolled with the LA Medicaid HIPAA testing service and are pursuing HIPAA readiness.

The list will include contact information, the types of X12N HIPAA transactions they support, and a status of "Enrolled", "Testing", "Parallel", or "Approved". The final "Approved" status means a provider can submit HIPAA EDI claims THROUGH the approved VBC to LA Medicaid.

The list will be updated and emailed weekly to subscribers as VBCs enroll and progress through the testing process.

LA Medicaid encourages all providers to be good consumers and use the VBC list to shop for a VBC that best suits their needs and their budget. The features, functions, and costs vary significantly between VBCs. ***Find the one that is right for you.***

Providers can also monitor the list to see how their VBC are progressing toward production approval.

The weekly VBC list will be e-mailed to those providers who have sent a subscription request to ***hipaaedi@unisys.com,** and will also be available on the web at **www.lamedicaid.com/hipaa.**

HIPAA DESK TESTING SERVICE ENROLLMENT

The first step towards HIPAA readiness is to have the VBC contact LA Medicaid and enroll in our testing service. As a provider who bills electronically, your VBC will be tasked with making your claims HIPAA ready. Therefore, the VBC **must** contact the LA Medicaid HIPAA EDI Group to enroll. (Providers who develop their own electronic means of submitting claims to LA Medicaid are considered the VBC).

The testing enrollment form is available on the web at **www.lamedicaid.com/hipaa**.

VBCs can also get an enrollment form by contacting the HIPAA EDI group by emailing a request for enrollment form to ***hipaaedi@unisys.com** or by calling **(225) 237-3318.**

The VBC must complete the form and return it by email to LA Medicaid.

A HIPAA EDI representative will issue the VBC login information for our testing service.

Companion guides for the 837I, 837P, 837D, and 278 transactions are available for download from within the HIPAA Desk Testing Service.

Our testing service is now available 24 hours a day, 7 days a week.

Once your VBC has contacted LA Medicaid for enrollment in the LA Medicaid HIPAA testing service, advancement toward HIPAA readiness can begin.

Please have your VBC enroll early, even if they are not ready to send a test file. It is important that LA Medicaid understand that they intend on becoming HIPAA compliant.

In addition, LA Medicaid will communicate with all the VBCs primarily through the HIPAA Desk testing service so being enrolled early ensures that they are getting all the information they need.

HIPAA TESTING SERVICE

Once your VBC has contacted LA Medicaid and the enrollment form is processed, login information will be issued to the named testers on the enrollment form.

The testing service is a secure web based application that requires an internet connection and a web browser.

The testing service will have everything a VBC needs to test for HIPAA readiness with LA Medicaid. Companion Guides for the 837I, 837P, 837D, and 278 transactions and other necessary and useful documentation will be available for download from within the HIPAA Desk testing service.

There are several testing programs in the HIPAA Desk testing service that correspond with LA Medicaid claim types. VBCs will be enrolled into the testing programs according to the claim types indicated on their enrollment form.

Each testing program includes several tasks that must all be performed successfully to complete HIPAA Desk testing. Upon completion of HIPAA Desk testing, the VBC will begin MMIS Parallel Testing.

The testing service is comprehensive and evaluates SNIP 1-7 types of testing.

MMIS PARALLEL TESTING

Please refer to the section on Connectivity with the Payer/Communications in the Louisiana Medicaid General Companion Guide for instructions on how to gain access to our test HIPAA Bulleting Board System (BBS). This guide is also available for download from within the HIPAA Desk testing service.

Parallel testing will compare a current proprietary electronic claim file with a parallel HIPAA EDI file, both utilizing the same source data. Generally, the current proprietary and HIPAA EDI file should adjudicate the same.

NOTE: For those submitters who did not previously send proprietary electronic Medicaid claims, such as TAD billers, the parallel testing process will be slightly different. Instead of sending a copy of an EMC file to the BBS, you will email 25ICNs from paper-billed claims from your last remittance advice to your HIPAA EDI QA parallel testing support person. If there weren't 25 ICNs on your last remittance advice, email all the ICNs on your most recent weeks remittance advice and that will be acceptable. If a tester does not have an assigned support person, contact the HIPAA EDI QA Group at ***hipaaedi@unisys.com** or call **(225) 237-3318**.

These claims will be compared to the HIPAA file sent to the test BBS, which was generated from the same data.

Listed below are the Parallel testing requirements:

1. Submitter must have an active submitter ID number with Louisiana Medicaid

2. Upload a copy of a production Electronic Medicaid Claim (EMC) file. The EMC copy must be uploaded within 7 days from the original submission to production. Files that are not uploaded within the time requirement will void the parallel test results. Positive results are required for promotion to production.

3. Upload a parallel HIPAA file that was constructed using the same production data in the copy of the original production EMC file. The HIPAA file cannot be more than 7 days older than the original production EMC file. **Note: Both files may be uploaded in a compressed file using WINZIP or PKZIP.**

4. For each file that is uploaded, 2 reports will be posted to the BBS for download. One report will contain any errors/denials and the other will contain the detail payment information with a summary. (Error/Denial code descriptions are available for download from within HIPAA Desk testing service). The goal is for the HIPAA file and the EMC to process the same. Any discrepancies will need to be resolved by your assigned HIPAA EDI QA parallel testing support person. If a tester does not have an assigned support person, please contact the HIPAA EDI QA group at *hipaaedi@unisys.com or call **(225) 237-3318**.

5. A member of the parallel test team on the HIPAA EDI QA team gives production approval. Approval is based on the success of a parallel test. Once approved, the submitter will be given access to the production HIPAA BBS, and receive a status of "Approved" on the VBC list.

Below is a table that describes each EDI implementation.

Note that exact dates have been included here only for the implementations occurring up to 10/01/03. The schedule after that date is considered to be tentative.

Implementation Title	Type	Date	Description
RA 835/U277	EDI	04/04/03	HIPAA transaction 835/U277 electronic remittance advice now available to those providers that request it.
Inpatient/Outpatient 837I	EDI	04/07/03	Begin accepting 837I electronic claims.
Dental 837D	EDI	05/01/03	Begin accepting 837D electronic dental claims.
MEVS/REVS 270/271	EDI	06/28/03	Begin receiving recipient status requests and transmitting responses in the HIPAA standard electronic formats. End use of 3040 version.
Professional 837P	EDI	07/26/03	Begin accepting 837P electronic professional claims.
POS NCPDP V5.1	EDI	08/24/03	Begin use of NCPDP 5.1 real-time format for pharmacy Point of Sale claims. RA response codes for pharmacy claims upgraded to NCPDP version 5.1. End use of version 3.2.
Pharmacy NCPDP V1.1	EDI/ Claim form	08/24/03	Begin use of Universal Prescription Claim Form (UCF). Begin use of NCPDP 1.1 batch electronic format for pharmacy claims. End use of proprietary electronic format.
Prior Authorization 278	EDI	TBD	Begin accepting prior authorization requests in the electronic 278 format.
Claims Status Inquiry (CSI) 276/277	EDI	TBD	Begin online provider Claim Status Inquiry (CSI).

QUESTIONS TO ASK VENDORS, TPAs OR CLEARINGHOUSES

Deadline for Electronic Transactions and Code Sets is October 16, 2003

If you have determined you are a covered health care provider and must comply with HIPAA, it is important to communicate often with your software vendor about their progress towards HIPAA compliance. For instance, your vendor should supply you with upgraded software that will allow you to conduct electronic transactions according to HIPAA standards come October 16, 2003. They should also be testing their software with you and your payers. If you are using a clearinghouse, or billing service or third party administrator (TPA), it is equally important to stay abreast of their HIPAA activities. As the covered health care provider it is your responsibility to ensure that on or after October 16, 2003, the transactions you conduct electronically, or the TPA or clearinghouse conducts on your behalf, are compliant with HIPAA requirements.

Talk to your Vendor / TPA / Clearinghouse Now! Ask them these questions

1. Are you working on developing software to meet your HIPAA needs? Specifically:

- What HIPAA transactions does your product support? Claims and encounter information? Payment and remittance? Claims status inquiry? Eligibility inquiry? Referral and authorization inquiry?
- Which products do you now sell or support currently, which will not be supported after October 16th deadline or will not be HIPAA compliant.
- What software updates are needed for HIPAA compliance?
- Does my office need a particular release of your software to implement the HIPAA transactions or is an entire upgrade from our current version required?
- Can I upgrade to the various electronic transactions incrementally?
- What is the minimum hardware requirement for servers and workstations to run the HIPAA compliant version?
- When will the software updates be available?
- What training, support, and services are available to help my office?
- Do you charge extra for training and support services?
- How do you remain current on the latest HIPAA developments? Do you belong to any of the HIPAA-related workgroups?
- Who specifically can I contact for HIPAA electronic transaction questions?

IMPORTANT: Do not assume your vendor or clearinghouse is HIPAA compliant. Communicate with them often to determine their progress. Their HIPAA readiness will directly impact your HIPAA readiness!

2. Will your software be able to support HIPAA transactions and code set requirements? Specifically:

- ❑ Do you use the official Implementation Guides for the HIPAA transactions? Is your software using the latest version of the guides (4010A)?
- ❑ Do you have the companion guides for my payers with whom I file directly?
- ❑ How does your product support collecting the required and situational claim data?
- ❑ Will your software support the required HIPAA code sets for Medical and Non-Medical?
- ❑ Is there a process for cross-walking from current codes to the HIPAA mandated codes?
- ❑ What new data will I need to start collecting?
- ❑ Are there any edits built into your software?
- ❑ Do you have a price list for the various upgrades, or new version of software?
- ❑ (For Clearinghouses) How can we submit transactions directly to you? Are there any changes in connectivity?

3. What are your electronic transactions and code set testing plans?

- ❑ How much lead time is required to install and test the software?
- ❑ How will current claims processing with existing formats proceed while testing new ones?
- ❑ Has your testing process included all of the seven types recommended by WEDI SNIP?
- ❑ Has the software received third-party certification that it can generate HIPAA compliant transactions?
- ❑ Will you send me a testing schedule that includes internal testing, testing with Medicare, testing with
- ❑ commercial payers, and testing with a clearinghouse (if applicable)?
- ❑ Have you tested successfully with any of my payers? Which ones?
- ❑ What are your contingency plans if you cannot be ready on time?

Need Help? CMS has many resources to help you prepare for October 16, 2003

- **Have you read our ten-part information series on electronic transactions and code sets? It is available to download for free at: http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/**
- **Or, View our webcast at: http://www.eventstreams.com/cms/tm_001/**
- **Visit us on the web at: http://www.cms.hhs.gov/hipaa/hipaa2**
- **Send us an e-mail at askhipaa@cms.hhs.gov or call us toll-free at 866-282-0659**

PROVIDER ASSISTANCE

The newest way to obtain general Medicaid information is on our Provider Website –

www.lamedicaid.com

Many of the most commonly requested items from providers including, but not limited to, Field Analyst listing, RA messages, Provider Updates, preferred drug listings, general information, etc. are available online.

Louisiana Medicaid HIPAA information can be found on this web-site by clicking on the HIPAA Information Center link.

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) 237-3334*

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. Questions regarding an eligibility response may be directed to Provider Relations.

NOTE: UNISYS cannot assist recipients. If recipients have problems, please direct them to the Parish Office or the number on their card:

RECIPIENT HELPLINE (800) 834-3333

*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. Staff in this unit also handles requests to update recipient files with correct eligibility and third party liability information.

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 the eligibility or TPL information, etc.). **A COPY OF THE CLAIM FORM WITH APPLICABLE CORRECTIONS 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.

"Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box.

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, Field Analysts ARE NOT available to answer calls regarding eligibility, routine claim denials, 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	
Cora Burks (225) 237-3306	Jefferson Orleans	St. Charles Plaquemines St. Bernard
Steven Carr (225) 237-3273	Bienville Bossier Caddo Caldwell Claiborne East Carroll Franklin Lincoln Vicksburg, MS	Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Marshall, TX
Gwen Gros (225) 237-3272	Allen Beauregard Calcasieu	Cameron Jeff Davis Lafourche Terrebonne
Mona Doucet (225) 237-3249	Acadia Evangeline Iberia Lafayette	St. Landry St. Martin St. Mary Vermillion
Sharon Harless (225) 237-3267	Avoyelles Iberville West Baton Rouge	East Feliciana West Feliciana Woodville/Centerville (MS) Pointe Coupee
Erin McAlister (225) 237-3201	Ascension Assumption Livingston St. Helena St. James	St. John the Baptist St. Tammany Tangipahoa Washington McComb (MS)
Courtney Patterson (225) 237-3269	East Baton Rouge	
Kathy Robertson (225) 237-3260	Catahoula Concordia DeSoto Grant Jackson LaSalle Natchitoches	Rapides Red River Sabine Vernon Winn Natchez (MS) Jasper, TX

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) 237-3334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 237-3381	(225) 237-3334
Electronic Media Claims (EMC) - Unisys		(225) 237-3200 option 2	(225) 237-3334
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 237-3342 or (225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 237-3342 or (225) 929-6803
Dental P.A. - LSU School of Dentistry		(504) 619-8589	(504) 619-8560
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 237-3370	
Fraud and Abuse Hotline (for use by providers and recipients) - DHH	(800) 488-2917		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – DHH	(800) 834-3333 (225) 925-7948	Providers may request verification of eligibility for presumptively eligible recipients; recipients should contact to request a new card or to discuss eligibility issues
Eligibility Operations –BHSF	(888) 342-6207	Recipients may address questions concerning eligibility issues
LaCHIP Program	(877) 252-2447	Providers and recipients may obtain information regarding the LaCHIP program, which expands Medicaid eligibility for children from birth to 19
Office of Public Health - Vaccines for Children Program	(504) 483-1900	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program
Referral Assistance - ACS	(877) 455-9955	Provider or Recipient may use this phone number for referral assistance.
KIDMED Provider Hotline – ACS	(800) 259-8000	Providers may obtain information on KIDMED linkage, referrals, monitoring, certification, and names of PCA/PCS agencies to provide EPSDT PCS services
KIDMED Recipient Hotline – ACS	(800) 259-4444	Recipients request enrollment in KIDMED program and obtain information on KIDMED linkage
CommunityCARE Provider Hotline – ACS	(800) 609-3888	Providers inquire about PCP assignment for CommunityCARE recipients and about CommunityCARE monitoring/certification
CommunityCARE Recipient Hotline – ACS	(800) 359-2122	Recipients may choose a change in PCP, inquire about CommunityCARE program policy or procedures, and express complaints concerning the CommunityCARE program.
Division of Home and Community-Based Waivers - BCSS	(800) 660-0488	Providers and recipients may report complaints regarding waiver services provided to waiver recipients **(does not include claim or billing problems or questions)**

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 Department of Health and Hospitals, P. O. Box 91030, Baton Rouge, LA 70821. They should be sent to the attention of the program manager for the provider's type or specialty (e.g., ATTN: Physician Program Manager, ATTN: Home Health Program Manager, etc.).

WEBSITES AVAILABLE

www.lamedicaid.com: General information regarding Medicaid. Not provider specific

www.lamedicaid.com/HIPAA: Louisiana Medicaid HIPAA Information Center

www.la-communitycare.com: DHH website with CommunityCARE program information, provider listings, FAQ's, etc.

www.la-kidmed.com: DHH website with KIDMED program information, provider listings, FAQ's, etc.

UNISYS CLAIMS FILING ADDRESSES

To expedite payment, providers should send "clean" claims directly to the appropriate Post Office Box as listed below. All Post Office Boxes are for Unisys Corporation, Baton Rouge, LA.

Type of Claim or Department	Post Office Box
The zip code for the following P.O. Boxes is 70821:	
Pharmacy (original claims and adjustment/voids)	91019
HCFA-1500, including services such as Professional, Independent Lab, Substance Abuse and Mental Health Clinic, Hemodialysis Professional Services, Chiropractic, Durable Medical Equipment, Mental Health Rehabilitation, EPSDT Health Services, Case Management, FQHC, and Rural Health Clinic (original claims and adjustment/voids)	91020
Inpatient and Outpatient Hospitals, Long Term Care, Hospice, **Hemodialysis Facility**, Freestanding Psychiatric Hospitals (original claims and adjustment/voids)	91021
Dental, Transportation (Ambulance and Non-ambulance), Rehabilitation, Home Health (original claims and adjustment/voids)	91022
All Medicare Crossovers and All Medicare Adjustments and Voids	91023
Provider Relations	91024
EMC, Unisys Business, and Miscellaneous Correspondence	91025
The zip code for the following P.O. Boxes is 70898:	
Provider Enrollment	80159
Prior Authorization	14919
KIDMED	14849

CLAIMS PROCESSING GENERAL REMINDERS

All Louisiana Medicaid paper claims are now scanned and stored 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.

Electronic submission of claims is the most efficient and gives the provider a quicker turnaround on payment.

If you cannot submit claims electronically, prepare your 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.
- Use high quality printer ribbons or cartridges – black ink only.
- Use 10 – 12 point font sizes. We recommend font styles Courier 12, Arial 11, or 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).

Note: *We currently return illegible claims. The criteria for legible claims are: (1) claim forms are clear and in good condition; (2) all information is readable to the normal eye, (3) information is centered in the appropriate block, and (4) that essential information is complete.*

ATTACHMENT SIZE

All claim attachments should be standard 8 ½ x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper.

HIGHLIGHTING SPECIFIC INFORMATION

Do not use highlighters on the claim form. Providers who want to draw attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence.

CHANGES TO CLAIM FORMS

It has always been Louisiana Medicaid policy that Unisys staff is not allowed to change any information on a provider's claim form. We want to remind providers of this policy and use this avenue to again inform you that if changes are required on a claim before it can be resubmitted, you must make those changes and resubmit the claim. Please do not ask Unisys staff to make any changes on your behalf.

DATA ENTRY

Data entry clerks do not make any attempt to interpret the claim form - they merely enter the data as found on the form. If the data is incorrect, or **IS NOT IN THE CORRECT LOCATION**, the claim will not process correctly.

SIGNING CLAIM FORMS

Don't forget to sign and date your claim form. Unisys will accept stamped or computer generated signatures, but authorized personnel must initial them.

CONTINUOUS FEED FORMS

Continuous feed forms must be torn apart before submission.

The recipient's 13-digit Medicaid ID number must be used to bill paper claims. The 16-digit CCN number from the plastic ID card is NOT acceptable.