NON-EMERGENCY TRANSPORTATION (NEMT) PROVIDER SERVICES

Emergency Billing Policy and Procedures for Hurricane Evacuees

Issue Date: August 27, 2005
Emergency Period Only

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

Prepared by: Unisys Technical Communications Group
Document Number 0042 Version 1.0

EMERGENCY BILLING POLICY AND PROCEDURES

PURPOSE

This packet is designed to furnish providers with billing policies and procedures for services rendered during the hurricane emergency period**. While some policies have been waived or altered for hurricane evacuees, others are current Louisiana Medicaid policy and remain unchanged.

**As of the date of publication, the Louisiana Department of Health and Hospitals defines those individuals considered Hurricane evacuees as recipients residing in the following Louisiana parishes:

Parish Name	Parish Number
Orleans	36
Jefferson (East and West)	26/65
St. Bernard	44
St. Tammany	52
St. Charles	45
St. John	48
LaFourche	29
Terrebonne	55
Tangipahoa	53
Plaquemines	38
Washington	59
St. James	47

PROVIDER ENROLLMENT

All providers rendering services for Louisiana Medicaid recipients must enroll with Louisiana Medicaid in order to receive reimbursement from the Louisiana Medicaid Program. Providers must complete and submit a Louisiana provider enrollment application. A link to the Hurricane Emergency Provider Enrollment Packets may be found on the home page for Louisiana Medicaid's website at www.lamedicaid.com. Once approved, providers will receive a Louisiana Medicaid 7-digit provider number assigned on a temporary basis. This number is to be used when verifying recipient eligibility and when submitting claims. While going through the enrollment process, providers may contact Provider Relations at 1-800-473-2783 to obtain temporary access codes necessary to verify eligibility. Once each provider receives a provider number, that number should be registered on the Louisiana Medicaid website at www.lamedicaid.com and used for any future eligibility inquiries.

RECIPIENT ELIGIBILITY VERIFICATION

The Department of Health and Hospitals (DHH) offers several options to assist providers with verification of current recipient eligibility. The following eligibility verification options are available: (1) Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system; (2) e-MEVS, a web application accessed through www.lamedicaid.com; and (3) Pharmacy Point of Sale (POS) for pharmacy providers only.

Before accessing the REVS and e-MEVS eligibility verification systems, providers should be aware of the following:

- In order to verify recipient eligibility through REVS and e-MEVS, inquiring providers must supply the systems with two (2) identifying pieces of recipient information.
- Specific dates of service must be requested. A date range in the date of service field on an inquiry transaction is not acceptable, and Provider Relations will not supply eligibility information for date ranges.

Recipient Eligibility Verification System (REVS)

The Recipient Eligibility Verification System (REVS) is a toll-free telephonic eligibility hotline that is used to verify Medicaid eligibility and is accessed through touch-tone telephone equipment using the Unisys toll-free telephone number **(800) 776-6323** or the local Baton Rouge area number **(225) 216-REVS (7387)**.

e-MEVS

Providers can verify eligibility for a Medicaid recipient using a web application accessed through www.lamedicaid.com.

Note: Providers must establish an online account to access eligibility information.

Pharmacy Point of Sale (POS)

For pharmacy claims being submitted through the POS system, eligibility is automatically verified as a part of the claims processing edits.

BILLING

- Medicaid is accepting only hard copy billing claim forms from all providers enrolled as "emergency" providers. Electronic claims submission will not be accepted from providers enrolled on this emergency basis.
- Claims must be submitted using the assigned 7-digit provider number received from Louisiana Medicaid.
- Some policies have been waived for evacuees only; however, other claims processing edits remain in place such as eligibility edits, procedure and diagnosis code edits, coverage edits, primary insurance edits, etc.
- More complete policy information can be found on the Louisiana Medicaid Website at www.lamedicaid.com.

The following emergency packet contains information on billing form completion instructions and sample forms, post office boxes for submitting claims, general policy information, and helpful phone numbers.

TABLE OF CONTENTS

OVERVIEW OF NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

DEFINITION OF NON-EMERGENCY, NON-AMBULANCE TANSPORTATION

Non-Emergency, Non-Ambulance Medical Transportation (NEMT) is defined as transportation provided for Medicaid recipients to and/or from a provider of Medicaid covered services. The Non-Emergency Medical Transportation Program is intended to provide transportation when all other reasonable means of free transportation have been explored and found to be unavailable.

Non-Emergency Medical Transportation is available without cost to the recipient on a uniform basis throughout the state when the recipient contacts the Transportation Dispatch Offices via toll-free telephone numbers.

The following are services for which transportation is **not** provided::

- Transportation to and from a pharmacy,
- Transportation from home to a nursing facility,
- Transportation from one nursing facility to another unless the recipient is transferring to a nursing facility in his medical service area because there were no beds originally available in his/her medical service area,
- Transportation for Nursing Home Residents, and,
- Transportation for rehabilitation services unless the rehabilitation services have been authorized by the Prior Authorization Unit**.**

Note: Transportation for the initial visit for an evaluation for the need of rehabilitation services will be approved by the Transportation Dispatch Office.

Effective August 1995, it became the responsibility of the nursing homes to transport their residents to the nearest available qualified provider of routine or specialty care within reasonable proximity to the facility. Any nursing home patient needing transportation for services capitated will not be authorized by the Transportation Dispatch Offices.

PROVIDER CLASSIFICATION

Profit Providers

This classification includes corporations, partnerships, or individuals who are certified by BHSF to provide non-emergency medical transportation to eligible recipients.

Non-profit Providers

This classification includes providers who are operated by or affiliated with a public organization such as state, federal, parish, or city entities, community action agencies, or parish Councils on Aging. If a provider qualifies as a non-profit entity according to IRS regulations, they may only enroll as non-profit providers.

RECIPIENT ELIGIBILITY FOR TRANSPORTATION SERVICES

NEMT services are available to all Medicaid recipients, with the exception of those listed below:

- Individuals who are eligible only for Medicare Supplemental Benefits (Pure QMB) with a '17' in the third and fourth digits of the Medicaid ID number
- Foster Care children with a '15' in the third and fourth digits of their Medicaid ID number

NEMT services for *Medicaid applicant's* **IS NOT** a covered service. Transportation providers, after being notified by the scheduling service that a Medicaid applicant is in need of transportation, agree to transport the Medicaid applicant with the understanding that an authorization number will be issued by the scheduling service only if the applicant becomes Medicaid eligible. An authorization number **WILL NOT** be issued and payment **WILL NOT** be made if the applicant does not become an eligible Medicaid recipient and determined eligible for the period the services provided.

TRANSPORTATION SCHEDULING

All NEMT services must be prior authorized by BHSF. All requests for NEMT services must be initiated through the Transportation Dispatch Offices because authorization for payment can only be issued through those offices.

- Calls to request transportation may be made by their recipients, Hemodialysis centers, the Louisiana KidMed staff, non-profit transportation providers or other DHH-approved sources.

  NOTE: Under no circumstances can profit transportation providers schedule trips on behalf of recipients

- The Transportation Dispatch Office will assign transportation on the basis of the least expensive means of transportation available in a geographic area with consideration given to the recipient's choice of provider. **Recipient's must take advantage of free transportation, and public transportation, when available.**
- The Transportation Dispatch Office will authorize transportation and assign the trip to the recipient's choice of provider.
  - The Transportation Dispatch Office will issue a ten-digit authorization number verifying that the service is approved to the transportation provider selected.
  - The transportation provider must use this authorization to bill for the service. Refer to the claims/billing section of this packet for further instructions on this process.
- Recipients and medical providers are asked to give at least 48 hours notice when calling to request transportation.
- When a recipient calls for same day service the Dispatch Office must make every effort possible to schedule the trip.

- When a recipient requires a second same day trip, the recipient's medical provider or the recipient must call the Transportation Dispatch Office to obtain authorization.

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 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, has expanded the Surveillance Utilization Review function of the Louisiana Medicaid Management Information System (LMMIS). Historically, this function has been a combination of computer runs, along with skilled Medical staff to review providers after claims are paid. Providers are profiled according to billing activity and are selected for review using computer-generated reports. The Program Integrity Unit of DHH reviews oral and written complaints sent from various sources throughout the state, including the fraud hotline.

As of July 1, 1998, the surveillance and utilization review capability of the LMMIS has been greatly expanded to review more providers than ever in the history of the Louisiana Medicaid Program. Additional controls in fraud and abuse measures have been added to include a personal computer-based Surveillance Utilization Review System with the full capability to provide:

- A powerful review tool at the desk-top level
- The ability to monitor more providers than ever under the previous system
- Enhanced exception processing
- Episode of care profiling
- A four-fold increase in review capability
- Significant expansion of field reviews and audits
- Higher focus on policy conformance issues.

If audited, providers should cooperate with the representatives of DHH, which includes Unisys representatives, in accordance with their provider agreement signed upon enrollment. Failure to cooperate could result in mild to severe 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

The members of the Surveillance Utilization Review team and Program Integrity would once again like to issue a reminder 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 on 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
- Inappropriate use of provider number (allowing someone who cannot bill the program to bill using your provider number).
- Consults performed by the patient's primary care, treating, or attending physicians.

This expansion also brings together the largest group of surveillance professionals in the state to combat fraud and abuse within this Medicaid program, along with the advanced technology to accomplish the goal.

PROVIDER WARNING

Entities not enrolled as Medicaid providers are prohibited from using enrolled physicians' Medicaid numbers in order to submit billing for their services. Physicians have unknowingly become involved in this fraudulent billing practice and risk being drawn into a long, complicated fraud investigation, and the unenrolled entities risk criminal prosecution.

- ☞ Program Integrity and SURS Teams 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.

FRAUD AND ABUSE HOTLINE

The state has a hotline for reporting possible fraud and abuse in the Medicaid Program. Anyone can report concerns at (800) 488-2917.

Providers are encouraged to give this phone number to any individuals or providers who want to report possible cases of fraud or abuse.

IDENTIFICATION OF ELIGIBLE RECIPIENTS

Recipients enrolled in Louisiana's Medicaid Program are issued Plastic Identification Cards; however, some hurricane evacuees may be issued a Temporary Letter. These permanent identification cards and temporary letters are issued as proof of Medicaid eligibility. Use of these cards and letters will require provider verification. The Department of Health and Hospitals (DHH) offers several options to assist providers with verification of current recipient eligibility. The following eligibility verification options are available: (1) Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system. (2) e-MEVS, a web application accessed through www.lamedicaid.com. (3) Pharmacy Point of Sale (POS).

These eligibility verification systems provide confirmation of the following:

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

Before accessing the REVS and e-MEVS eligibility verification systems, providers should be aware of the following:

- In order to verify recipient eligibility through REVS and e-MEVS inquiring providers must supply the system with two (2) identifying pieces of information about the recipient.
- Specific dates of service must be requested. A date range in the date of service field on an inquiry transaction is not acceptable, and Provider Relations will not supply eligibility information for date ranges.

RECIPIENT ELIGIBILITY VERIFICATION SYSTEM (REVS)

The Recipient Eligibility Verification System (REVS) is a toll-free telephonic eligibility hotline that is used to verify Medicaid eligibility and is provided at no additional cost to enrolled providers. REVS can be accessed through touch-tone telephone equipment using the Unisys toll-free telephone number **(800) 776-6323** or the local Baton Rouge area number **(225) 216-REVS (7387)**.

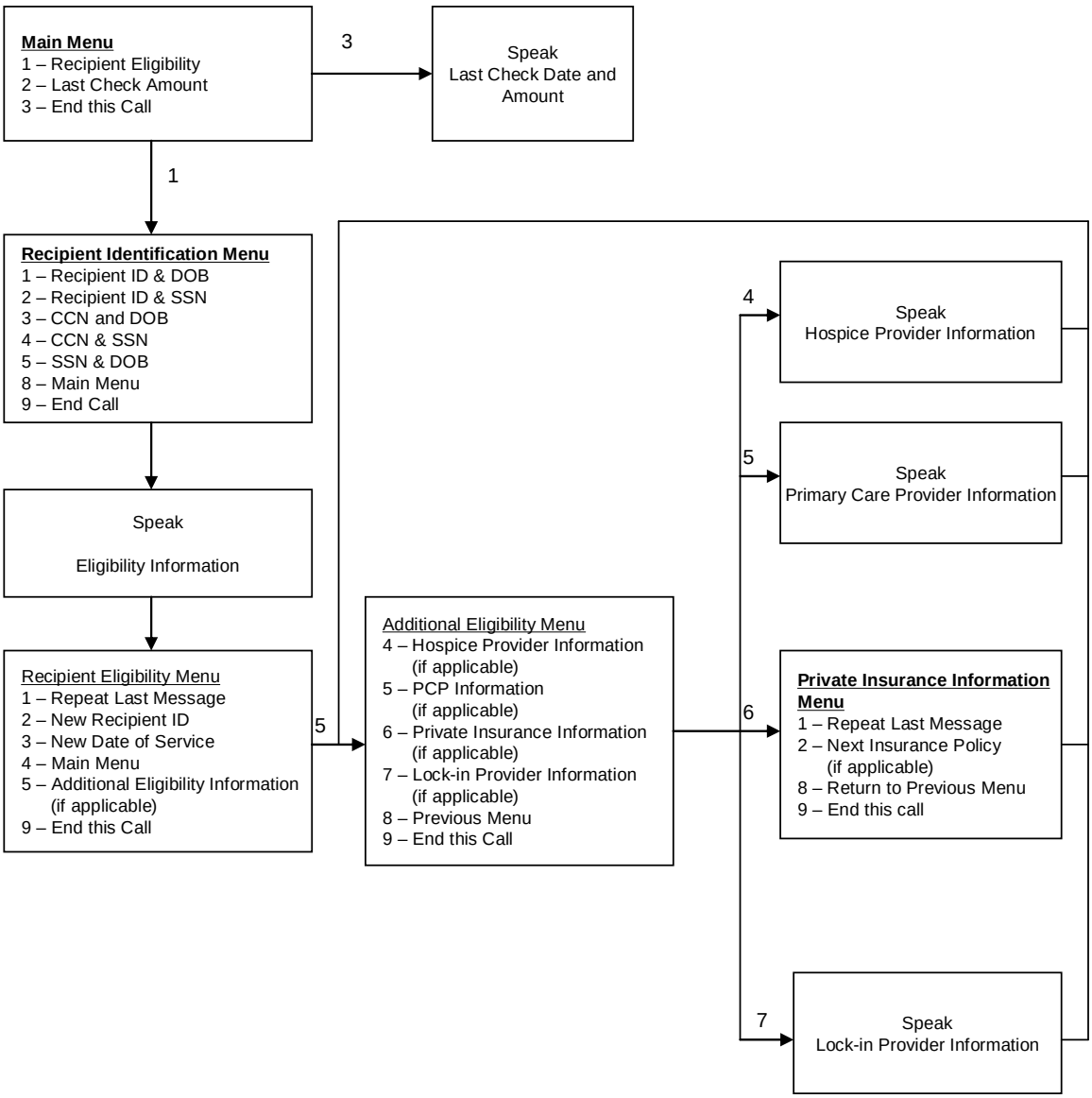
Accessing REVS

Enrolled providers may access recipient eligibility by using two (2) pieces of the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Medicaid ID number (valid during the last 12 months) and recipient birth date
- Medicaid ID number (valid during the last 12 months) and social security number
- Social Security number and recipient birth date

REVS MENU – (800) 776-6323

The 7-digit Louisiana Medicaid provider number must be entered to begin the eligibility verification process.



E-MEVS

Providers can verify eligibility and service limits for a Medicaid recipient using a web application accessed through www.lamedicaid.com. An eligibility request can be entered via the web for a single recipient and the eligibility and service limits data for that individual will be returned on a web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Accessing e-MEVS

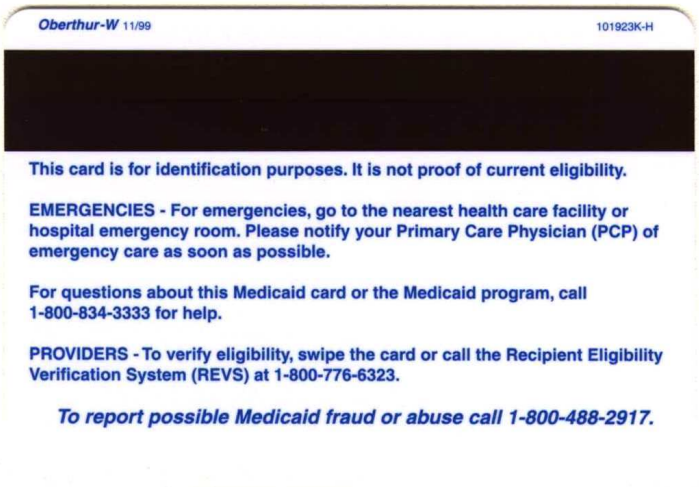
Enrolled providers may access recipient eligibility by using the following pieces of information:

- Card Control Number (CCN) and recipient birth date
- Card Control Number (CCN) and social security number
- Social security number and recipient birth date
- Recipient ID number and recipient birth date
- Recipient ID number and social security number
- Recipient ID number and recipient name
- Recipient name and recipient birth date
- Recipient name and social security number

PHARMACY POINT OF SALE (POS)

For pharmacy claims being submitted through the POS system, eligibility is automatically verified. Checking eligibility through REVS and e-MEVS is not necessary except in an instance of recipient retroactive eligibility.


HEALTH NETWORK for LOUISIANA
LOUISIANA
Department of HEALTH and HOSPITALS
Medicaid
CCN: 7779999999999101
Lou Z O'Ana
Issue Date: 03-01-1998
BIN 610551


Oberthur-W 11/99
101923K-H
This card is for identification purposes. It is not proof of current eligibility.
EMERGENCIES - For emergencies, go to the nearest health care facility or hospital emergency room. Please notify your Primary Care Physician (PCP) of emergency care as soon as possible.
For questions about this Medicaid card or the Medicaid program, call 1-800-834-3333 for help.
PROVIDERS - To verify eligibility, swipe the card or call the Recipient Eligibility Verification System (REVS) at 1-800-776-6323.
To report possible Medicaid fraud or abuse call 1-800-488-2917.

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

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

Date:_____

To Whom It May Concern:

This will serve as the Medicaid Eligibility Card for the persons listed below. These persons have been affected by Hurricane Katrina.

Claims for medical services covered by Louisiana Medicaid provided to these individuals will be processed and paid. For the period **September 1, 2005** and ending midnight **December 31, 2005**, these eligibles are exempt from hospital pre-certification and prescription limits.

Medicaid providers should maintain a copy of this letter in order to guarantee Medicaid payment.

Medical providers should contact 1-800-473-2783 for questions regarding claims submission.

ATTENTION Medicaid Eligibles: As soon as you get a permanent address, report it to Medicaid. At that time if you are still eligible, we can send you a plastic Medicaid card.

Name of Eligible Person	Medicaid ID Billing Number	Date of Birth

Sincerely,

Ben A Bearden
Medicaid Director

By: _____
Louisiana Medicaid Eligibility Representative

MEDICAL VENDOR ADMINISTRATION
1201 CAPITOL ACCESS ROAD • P.O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE #: 225/342-3891 • FAX #: 225/342-9508
"AN EQUAL OPPORTUNITY EMPLOYER"

THIRD PARTY LIABILITY

Federal regulations and applicable state laws require that third-party resources be used before Medicaid is billed. ***Third-party*** refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, which can be applied toward the Medicaid recipient's medical and health expenses. Providers should check the recipient's TPL segment to verify that the third-party liability (TPL) codes are accurate according to the TPL listing and the name of the third-party insurance carrier. (TPL carrier code listings can be found on the Medicaid website at www.lamedicaid.com under "Forms/Files" or by contacting Unisys Provider Relations at (800)473-2783 or (225)924-5040). If the TPL code is not correct, the provider should instruct the recipient to contact his/her parish worker to correct the file, especially if the insurance has been canceled. Claims submitted for payment will deny unless the insurance coverage is noted on the claim with the appropriate TPL code or unless a letter explaining the cancellation of the insurance from the carrier is attached to the claim.

NOTE: The lack of a third-party TPL code segment does not negate the provider's responsibility for asking the recipient if he/she has insurance coverage.

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

TPL BILLING PROCEDURES

When billing Medicaid after receiving an Explanation of Benefits (EOB) from a TPL, the provider must bill a hard copy claim and:

- Attach a copy of the EOB/EOMB, making sure any remarks/comments from the other insurance company are legible and attached.
- Enter the amount the other insurance company paid in the appropriate block on the claim form (except for Medicare).
- Enter the six-digit carrier code assigned by Medicaid in the correct block on the claim form (except Medicare).

  NOTE: The six-digit carrier code for traditional Medicare (060100) is not needed to process Medicare crossover claims. In fact, including the Medicare carrier code on these claims may cause processing errors. The Medicare EOB should be attached to each claim form. In addition, providers should not indicate the amount paid by Medicare on their claim forms.

Additionally, the dates of service, procedure codes and total charges **must match**, or the claim will deny. All Medicaid requirements such as precertification or prior authorization **must** be met before payment will be considered.

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

discrepancy. Such instances would include payment for dates not precertified by Medicaid and privately assigned procedure codes not recognized by Medicaid.

REQUESTS TO ADD OR REMOVE RECIPIENT TPL/MEDICARE COVERAGE

A request to add or remove TPL or Medicare coverage must include a cover letter indicating the action requested, the claim, and the EOB or proof of coverage termination and should be mailed to:

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

PAYMENT METHODOLOGY WHEN TPL IS INVOLVED

Medicaid payment is calculated by using cost comparison methodology after reimbursement is made from the TPL. The total payment to the provider from all resources will not be more than Medicaid allows for the service.

Example: A provider submits a claim to the private insurance company for procedure 99213 in the amount of $70.00. The private insurance allows $50.00 for this procedure, $10.00 is applied to the patient's deductible and the insurance payment to the provider is $40.00. When the claim and EOB are sent to Medicaid, the payment will be zero. Currently, Medicaid allows $36.13 for this procedure. The $40.00 insurance payment to the provider is more than the Medicaid allowable, thus the zero payment. This zero payment is considered an approved claim and is payment in full. The provider may not bill the recipient any remaining balance including co-payments and/or deductibles.

TPL carrier code listings can be found on the Louisiana Medicaid Website at www.lamedicaid.com under "Forms/Files" or by contacting Unisys Provider Relations at (800) 473-2783 or (225) 924-5040.

PRENATAL AND PREVENTIVE PEDIATRIC CARE PAY AND CHASE

Louisiana Medicaid uses the "pay and chase" method of payment for **prenatal and preventive care** for individuals with health insurance coverage. This means that most providers are not required to file health insurance claims with private carriers when the service meets the pay and chase criteria. The Bureau of Health Services Financing seeks recovery of insurance benefits from the carrier within 60 days after claim adjudication when the provider chooses not to pursue health insurance payments.

Service classes which do not require private health insurance claim filing by most providers are:

1. Primary prenatal diagnoses confined to those listed below. All recipients qualify. **Hospitals are not included and must continue to file claims with the health insurance carriers;**

V22.0	640.0 - 648.9
V22.1	651.0 - 658.9
V22.2	671.0 - 671.9
V23.0 - V23.9	673.0 - 673.8
V28.0 - V28.9	675.0 - 676.9

2. Primary preventive pediatric diagnoses confined to those listed below. Individuals under age 21 qualify. **Hospitals are not included and must continue to file claims with the health insurance carriers;**

V01.0 - V05.0	V77.0 - V77.7
V07.0 - V07.9	V78.2 - V78.3
V20.0 - V20.2	V79.2 - V79.3
V70.0	V79.8
V72.0 - V72.3	V82.3 - V82.4
V73.0 - V75.9	

3. EPSDT medical, vision, and hearing screening services (KIDMED screening services);

4. EPSDT dental services;

5. EPSDT services to children with special needs (formerly referred to as school health services) which result from screening and are rendered by school boards;

6. Services which are a result of an EPSDT referral, indicated by entering “Y” in block 24H of the CMS-1500 claim form or “1” as a condition code on the UB-92 (form locators 24 - 30).

7. Services for Medicaid eligibles whose health insurance is provided by an absent parent who is under the jurisdiction of the State Child Support Enforcement Agency. All providers and all services (regardless of diagnosis) qualify.

VOIDING ACCIDENT-RELATED CLAIMS FOR PROFIT

A provider who accepts Medicaid payment for an accident-related service or illness may not later void the Medicaid claim in order to pursue payment from an award or settlement with a liable third party. Federal regulations prohibit this practice. All providers enrolled in Louisiana's Medicaid Program are required to accept Medicaid payment as payment in full and are not to seek additional payment for any unpaid portion of the bill.

OUTGOING MEDICAL RECORDS STAMP

Providers who furnish medical information to attorneys, insurers, or anyone else must obtain a 3”x3” ANNOTATION STAMP and must assure that all outgoing medical information bears the stamp, which notifies the receiver that services have been provided under Louisiana's Medicaid Program (see example below).

Medicaid Provider No. (7 digits)
(Optional Control Number)

Services have been provided under Louisiana's Medicaid Program and are payable under R.S. 46:446:1 to:

DHH Bureau of Health Services Financing
P. O. Box 91030
Baton Rouge, LA 70821-9030
ATTN: Third Party Liability Unit

Any additional authorization needed may be obtained from DHH/BHSF's TPL Unit at (225) 342-9250.

TRAUMA DIAGNOSIS CODES

Providers are reminded to include the appropriate trauma diagnosis code when billing for accident-related injuries or illnesses. Provider cooperation is vital as trauma codes are used to help uncover instances of unreported third party liability.

THIRD PARTY LIABILITY RECOVERY UNIT

Providers with questions about medical services to Medicaid recipients involved in accidents with liable third parties, and providers wishing to refer information about Medicaid recipients involved in accidents with liable third parties may contact the DHH Third Party Liability, Trauma/Health Recovery Unit at (225) 342-9250 or fax information to (225) 342-1376.

HMO TPL CODES

Providers must determine, prior to providing a service, to which HMO the recipient belongs and if the provider himself is approved through that particular HMO. (If the provider is not HMO approved, the recipient should be advised that he/she will be responsible for the bill and be given the option of seeking treatment elsewhere.)

Questions regarding HMOs should be referred to the DHH Third Party Liability/Medicaid Recovery Unit at (225) 342-3855. The fax number is (225) 342-2703.

HMO AND MEDICAID COVERAGE

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

- **The recipient must use the services of the HMO that they freely choose to join**. These claims must be submitted hard copy with a copy of the HMO EOB from the carrier that is on file with the state.

- If the HMO denies the service because the service is not a covered service offered under the plan, the claim will be handled as a straight Medicaid claim and processed based on Medicaid policy and pricing.

- If the HMO denies the claim because the recipient sought medical care outside of the HMO network and without the HMO's authorization, Medicaid will deny the claim with a message that HMO services must be utilized.

- If the recipient uses out of network providers for emergency services and the HMO does not approve the claim, Medicaid will deny the claim with a similar edit.

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

QUALIFIED MEDICARE BENEFICIARIES (QMBS)

QMBs are covered under the ***Medicare Catastrophic Coverage Act of 1988***. This act expands Medicaid coverage and benefits for certain persons aged 65 years and older as well as disabled persons who are eligible for Medicare Hospital Insurance (Part A) benefits and who:

- Have incomes less than 90 percent of the Federal poverty level,

- Have countable resources worth less than twice the level allowed for Supplemental Security Income (SSI) applicants,

- Have the general nonfinancial requirements or conditions of eligibility for Medical Assistance, i.e., application filing, residency, citizenship, and assignments of rights.

Individuals under this program are referred to as Qualified Medicare Beneficiaries (QMBs). The three groups of recipients under this category are: QMB Only, QMB Plus and Non QMB.

QMBS	STATUS
QMB Only (Formerly Pure QMB)	Identified through the REVS and e-MEVS systems and are eligible only for Medicaid payment of deductibles and coinsurance for all Medicare covered services.
QMB Plus (Formerly Dual QMB)	Individuals who are eligible for both Medicare and traditional types of Medicaid coverage (SSI, etc). QMB Plus is identified by the REVS and e-MEVS systems and are eligible for Medicaid payment of deductibles and coinsurance for all Medicare covered services as well as for Medicaid covered services.
Non QMBs	Identified in the TPL segment of REVS and e-MEVS. Non QMBs are eligible for only Medicaid covered services.

In addition, for those persons who are eligible for Part A premium, but must pay for their own premiums, the State will now pay for their Part A premium, if they qualify as a QMB. The State will continue to also "buy-in" for Part B (Medical Insurance) benefits under Medicare for this segment of the population.

MEDICARE CROSSOVER CLAIMS

If problems occur with Medicare claims crossing over electronically, please follow the steps listed below:

- If your Medicare claims are not crossing electronically, please call Unisys Provider Relations at (800) 473-2783 or (225) 924-5040. Be very specific with your inquiry. You should indicate whether **all** of your claims are not crossing over or only claims for certain recipients. Were the claims crossing over previously and suddenly stopped crossing, or is this an ongoing problem? The more information you can give, the better. The Unisys representative will check certain pieces of information against the provider and/or recipient files to determine if an identifiable file error exists. If a file update is required, the Unisys representative will route this information to the Unisys Provider Enrollment or Third Party Liability Unit to correct the Medicaid file. If a problem cannot be identified, you may be referred to the Third Party Liability Unit for further assistance.

- If you are not certain that you have supplied your Medicare provider number(s) to Unisys Provider Enrollment, please write to this unit to have your number(s) loaded correctly on your Medicaid provider file. Many Medicare providers have a primary provider number and one or more secondary provider numbers linked to this primary number. **Claims will cross electronically ONLY if the Medicare provider number(s) is cross-referenced to the Medicaid provider number.** If any or all of your Medicare provider numbers have not been reported to Unisys Provider Enrollment, please do so **immediately**.

Medicare adjusted claims **DO NOT** crossover. Providers must submit Medicaid adjustments with the Medicare adjustment EOB attached for corrected payment.

Providers are responsible for verifying on the Medicaid Remittance Advice that all Medicare payments have successfully crossed over. If Medicare makes a payment which is not adjudicated by Medicaid within 30 days of the Medicare EOB date, you should submit your crossover claim hard copy with the Medicare EOB attached. All timely filing requirements must be met even if a claim fails to cross over.

Also, if you are submitting a claim which Medicare has denied, the EOMB attached must include a complete description of the denial code.

MEDICARE ADVANTAGE

All recipients participating in Medicare Advantage must have both Medicare Part A and Medicare Part B.

The Managed Care Plans currently participating in this program are: Humana Gold Plus, Tenet (Tenet 65 and Tenet PPO) and Sterling (Sterling Option One). These plans have been added to

the Medicaid Third Party Resource File for the appropriate recipients with six-digit alpha-numeric carrier codes that begin with the letter “H”.

When possible these plans will cross the Medicare claims directly to Medicaid electronically, just as Medicare carriers electronically transmit Medicare crossover claims. These claims will be processed just as claims crossing directly from a Medicare carrier. If claims do not cross electronically from the carriers within 30-45 days from the Medicare plan EOB date, providers must submit paper claims with the Medicare plan EOB attached to each claim.

NOTE: Sterling Option One will not electronically transmit claims to Unisys. Providers in the Sterling Option One network should submit claims hard copy to Unisys.

When it is necessary for providers to submit claims hard copy, the appropriate carrier code must be entered on each hard copy claim form in order for the claim to process correctly. The carrier codes follow:

Humana Gold Plus	H19510	Tenet 65	H19610
Tenet PPO	H19010	Sterling Option One	H50060

Hard copy claims submitted without the plan EOB and without a six-digit carrier code beginning with an “H” will deny 275 (Medicare eligible). Both the EOB and the correct carrier code are required for these claims to process properly.

Providers may not submit these claims electronically. Electronic submissions directly from providers will deny 966 (submit hard copy claim).

When it is necessary to submit these claims hardcopy, a Medicare Advantage institutional or professional cover sheet **MUST** be completed **for each claim** and attached to the top of the claim and EOB. Once finalized, these cover sheets will be available on the Louisiana Medicaid website for easy download. Claims received without this cover sheet will be rejected.

The calculated reimbursement methodology currently used for pricing Medicare claims will be used to price these claims. Thus, claims may price and pay a zero payment if the plan payment exceeds the Medicaid allowable for the service.

Timely filing guidelines applicable for Medicare crossover claims apply for Medicare Advantage claims.

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.

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.
- 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.**

REJECTED CLAIMS

Unisys currently returns illegible claims. These claims have not been processed and are returned along with a cover letter stating what is incorrect.

The criteria for legible claims are:

1) all claim forms are clear and in good condition,
2) all information is readable to the normal eye,
3) all information is centered in the appropriate block, and
4) all essential information is complete.

ATTACHMENTS

All claim attachments should be standard 8½ 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. Make all changes to the claims 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.

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.
- 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 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 Remittance Advice indicating that the claim was processed earlier (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.

To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible. Proof of timely filing documentation must reference the individual recipient and date of service.

At this time Louisiana Medicaid **does not** accept printouts of Medicaid electronic remittance advice screens as proof of timely filing. Documentation **must** reference the individual recipient and date of service. Postal "certified" receipts and receipts from other delivery carriers are not acceptable proof of timely filing.

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:

1) The recipient was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted.

2) The recipient won a Medicare or SSI appeal in which he or she was granted retroactive Medicaid Benefits.

3) 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 to DHH staff will be routed to Unisys Provider Relations.

THE REMITTANCE ADVICE

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.

ELECTRONIC REMITTANCE ADVICES (E-RAS)

The EDI Department offers Electronic Remittance Advices (e-RAs). 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 Department.

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 RAs 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 provider's responsibility 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 which 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 CLAIM TURNAROUNDS (DTAS)

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.

PROFESSIONAL REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/09/2005 PAGE: 31
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE/ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
PPRO - 0	MAL CL S									
((1731	)/ S MD	3 4			650					
6! 4371 30	J SON JJ	1 041105		1	93325 26 DOPPLER COLOR FLOW VELOC	12500	3274	00	3274	52 36 361
((1731	)/ S MD	3 4			650					
6! 4371 30	J SON JJ	1 041305		1	93306 26 ECHO TRANSTHORACIC	12500	3705	00	3705	52 36 361
((1731	)/ S MD	3 4			650					
6! 4371 30	J SON JJ	1 041305		1	93321 26 DOPPLER ECHOCARDIOGRAPHY	3200	1800	00	1800	52 36 361
((1731	)/ S MD	3 4			650					
3! 0792 01	J SON M	1 070805		1	71020 26 X-RAY CHEST; TWO VIEWS	2500	1119	00	1119	52 15 147
((1741 -2	)/ S MD	1 5			650					
6! 0307 01	J SON RA	5 052005		1	99213 OFFICE,EST PT, EXPANDED,	9000	3613	00	3613	52 15 151
((1679 -3	)/ S MD	8 0			650					
1! 0891 30	J B P	04 120704		1	94010 26 SPIROMETRY WITH GRAPH, V	3500	1796	00	1796	52 15 171
((1741 -2	)/ S MD	1 5			650					
1! 0891 30	J B P	05 072005		1	88304 26 SURGICAL PATHOLOGY, COMP	3400	1281	00	1281	52 15 .21
((1746 -2	)/ S MD	2 0			650					
3! 0541 01	J S CL	05 072605		1	99241 OFF CONSULT,NEW PT,PRELM	9500	6750	00	6750	52 15 191
((1743 -2	)/ S MD	1 4			650					
4! 5646 36	J S WH	05 071805		1	99213 OFFICE,EST PT, EXPANDED,	9000	3613	00	3613	52 15 181
((1749 -2	)/ S MD	1 3			650					
3! 1371 01	J IS A	05 072205		1	93010 ECG; INTERPRETATION AND	3000	950	00	950	52 15 .61
((1746 -2	)/ S MD	2 1			650					
1! 5031 01	J IS JM	04 052404		1	99231 SUBSEQNT HOSP,PRBLM.STBT	7000	2584	00	2584	51 16 161
((1244	)/ S MD	1 7			071 650					
P 41613	9									
5! 0021 02	J ERSON S	05 071105		1	76811 26 ULTRASUND,PREG UTER,TRNS	21500	8875	00	8875	52 15 150
((1749 -2	)/ S MD	7 1			650					
3! 0049 39	J ERY D	05 050405		1	77470 26 SPECIAL TREATMENT PROCED	23400	14272	00	14272	51 16 .84
((1652	)/ S MD	3 0			280					
3! 0363 01	J INS M	05 080105		1	99213 OFFICE,EST PT, EXPANDED,	9000	3613	00	3613	52 15 191
((1748 -2	)/ S MD	3 5			650					
62 7822 68	J INGS HE	05 062305		1	88273 CYTOGENETICS, 10-30	22000	6440	00	6440	52 15 .34
((1748 -4	)/ S MD	1 9			650					
62 7822 68	J INGS HE	05 062305		1	88271 CYTOGENETICS, DNA PROBE	14300	2950	00	2950	52 15 .34
((1748 -4	)/ S MD	1 9			650					
62 7822 68	J INGS HE	05 062305		1	88291 CYTO/MOLECULAR REPORT	9600	554	00	554	52 15 .34
((1748 -4	)/ S MD	1 9			402 650					
6! 1372 20	J N E	05 063005		1	50394 51 INJECTION FOR KIDNEY X-R	41500	1303	00	1303	51 16 .27
((1718	)/ S MD	1 6			403 650 403 726 650					
6! 1373 02	J SON AM	05 071205		1	71020 26 X-RAY CHEST; TWO VIEWS	2500	1119	00	1119	52 .5 .72
((1743 -2	)/ S MD	1 8			650					
6! 1373 02	J SON AM	05 071105		1	99223 INITIAL HOSP,COMPRE, HIG	31000	5400	00	5400	52 .5 .63
((1746 -4	)/ S MD	1 8			650					
P 51943	7									
6! 1373 02	J SON AM	05 071205		1	99232 SBSQNT HOSP,XPANDED,MOD	11000	4280	00	4280	52 .5 .63
((1746 -4	)/ S MD	1 8			650					
P 51943	7									
6! 1373 02	J SON AM	05 071305		1	99238 HOSPITAL DISCHARGE DAY M	14000	2880	00	2880	52 .5 .63
((1746 -4	)/ S MD	1 8			650					
P 51943	7									

PROFESSIONAL REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/09/2005 PAGE: 82
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER / MEDICAL RECORD NO	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE/ACCOMODATION / DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
	SNIS LAIMS									
4(3164 01	LI(LL A	C 4	051304	4	95903 26	28800	00	00	00	520(4211
((1243	)/P	NO: 521			272					
4(3164 01	LI(LL A	0 4	051304	1	95934 26 50	6400	00	00	00	520(4211
((1243	)/P	NO: 1521			272					
4(3164 01	LI(LL A	0 04	051304	2	95904 26	18000	00	00	00	520(4211
((1243	)/P	NO: 1521			272					
2(3104 06	LI(IV AJ	0 05	070705	1	74020 26	3200	00	00	00	521(4892
((1743 -2	)/P	NO: 2951			242					
1(1704 56	LL(CA	0 05	062905	1	93010 ECG; INTERPRETATION AND	3000	00	00	00	521(4897
((1740 -2	)/P	NO: 0141			206					
3(1784 20	LO(JUDS BE	0(05	061705	1	73610 26 X-RAY EXAM OF ANKLE	2000	00	00	00	521(4414
((1744 -5	)/P	NO:1 1883			813					
					CONFLICTING CONTROL N(1(3 13500	ADJUDICATION(DATE:20050809				
1(3496 14	LO(L 07	05	072505	1	93010 ECG; INTERP 3 : AND	3000	00	00	00	521(4902
((1744 -3	)/P	NO:1 928			813					
					CONFLICTING CONTROL NO 1 1 32200	ADJUDICATION(DATE:20050809				
3(3506 01	LO(QM 05		053105	1	71010 26 X-RAY CHEST 0 1 ANTE	2100	00	00	00	521(4891
((1746 -2	)/P	NO:1 1			813					
					CONFLICTING CONTROL NO 8 1 70800	ADJUDICATION(DATE:20050705				
6 1208 93	LU(DE 01		010505	1	81002 ROUTINE URI A IS	400	00	00	00	521(4881
((1748 -7	)/P	NO:1 4			299 299					
4(3306 01	MAJ . TL	07	070705	1	76942 26 ECHO GUIDE 1 IV	7700	00	00	00	521(4344
((1742 -3	)/P	NO:1 1			813					
					CONFLICTING CONTROL NO 0 31700	ADJUDICATION(DATE:20050802				
4(3306 01	MAJ . TL 07		070705	1	36569 INSERT TUNN D ATH	19500	00	00	00	521(4344
((1742 -3	)/P	NO:15 1			813					
					CONFLICTING CONTROL NO 0 31701	ADJUDICATION(DATE:20050802				
2(3036 47	MAJ I AX	080	080305	1	76817 26 ULTRASOUND, EL , T	8500	00	00	00	521(4876
((1745 -2	)/P	NO:15 2			783					
2(1051 01	MAJ I KR	070	070705	2	71010 26 X-RAY CHEST OS 1 TE	4200	00	00	00	521(4892
((1743 -3	)/P	NO:15 1			813					
					CONFLICTING CONTROL NO: 14 1 600	ADJUDICATION(DATE:20050809				
2 1051 01	MAJ I KR	070	070805	1	71010 26 X-RAY CHEST; OS C TE	2100	00	00	00	521(4922
((1742 -2	)/P	NO:15 1			813					
					CONFLICTING CONTROL NO: 14 1 601	ADJUDICATION(DATE:20050809				
2 1791 42	MC(EM ZC	111	111604	60	00840 AA ANES;INTRAPE L 3 ED	77000	00	00	00	520(4135
((1691	)/P	NO:1 74			813					
					CONFLICTING CONTROL NO: 15 1 700	ADJUDICATION(DATE:20050802				
3 3681 01	MC(TD LA	02	021005	1	99233 SBSQNT HOSP, TA TD (I	15500	00	00	00	521(4881
((1551 -1	)/P	NO:1 78			730					
PA(13430										
3 3681 01	MC(TD LA 0		021205	1	99232 SBSQNT HOSP, AM),)	11000	00	00	00	521(4881
((1551 -1	)/P	NO: 78			813					
PA(13430										
					CONFLICTING CONTROL NO: 18 .800	ADJUDICATION(DATE:20050222				
3 3681 01	MC(TD LA C	;	021305	1	99232 SBSQNT HOSP, P 40D	11000	00	00	00	521(4881
((1551 -1	)/P	NO: 578			813					
PA(13430										
					CONFLICTING CONTROL N 252801	ADJUDICATION(DATE:20050222				
3 3681 01	MC(TD LA 0(	5	021505	1	99232 SBSQNT HOS. AD,MOD	11000	00	00	00	521(4881
((1551 -1	)/P	NO:1 578			813					
PA(13430					CONFLICTING CONTROL NO:50 .0	ADJUDICATION(DATE:20050308				

NON-INSTITUTIONAL TITLE XVIII REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE:08/09/2005 PAGE: 122
REMITTANCE NO:

M M D D Y Y

MEDIA: 1

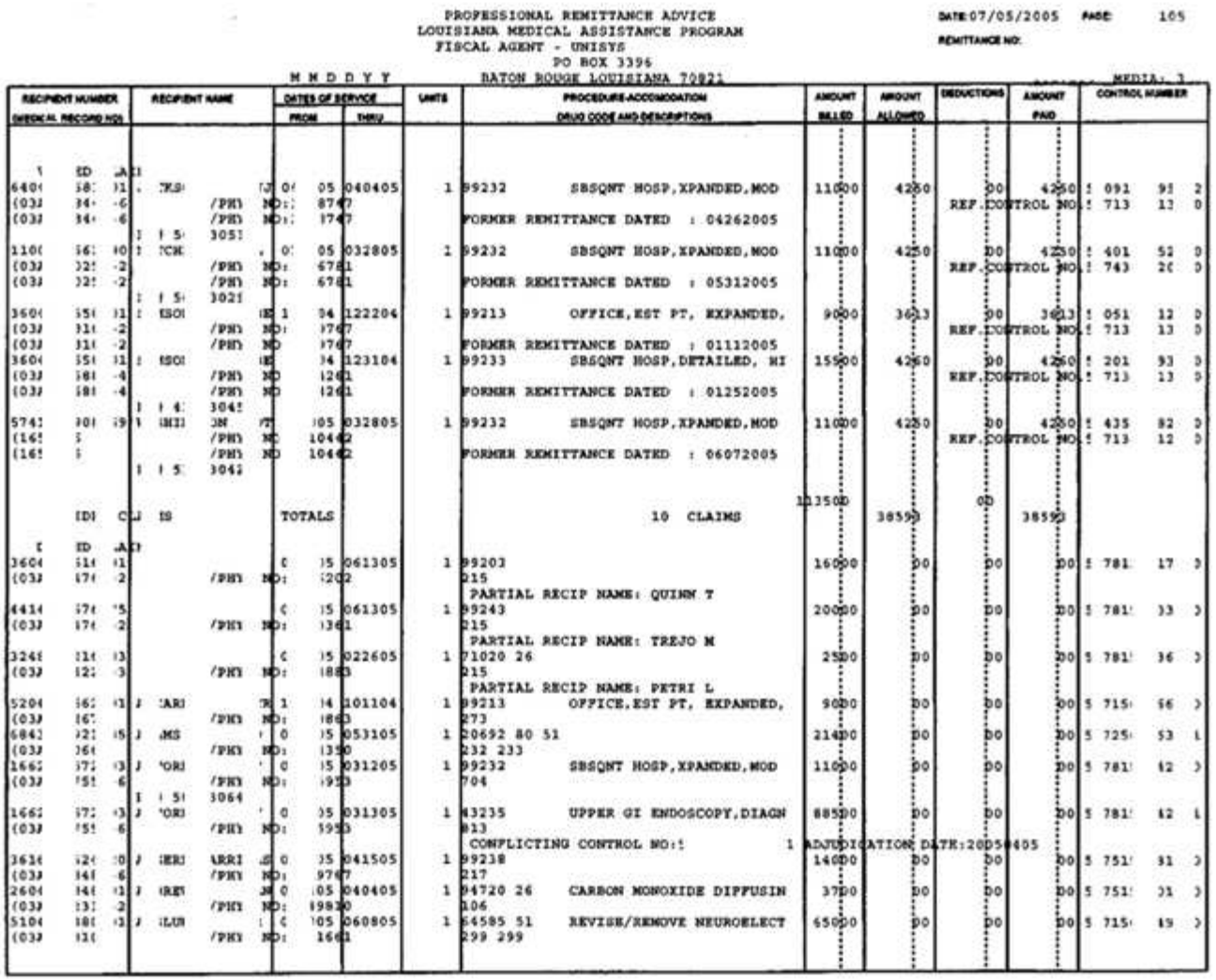
RECIPIENT NUMBER (SUBSIDIAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE/ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
MI LA MS										
1 02 01	SI PH	05	051005	1	35661 51 ARTERY BYPASS GRAFT 820 996 CONFLICTING CONTROL N 15401 ADJUDICATION DATE:20050705	323000	00	00	00	1 07 1
3 38 01	TA	0	060705	1	99212 24 232	6500	00	00	00	1 51 0
2 89 70	VE		061005	1	99232 SBSQNT HOSP,XPANDED,MOD 847 CONFLICTING CONTROL NO 00 ADJUDICATION DATE:20050809	11000	00	00	00	1 40 3
9 81 57	WA		070805	1	99213 217	9000	00	00	00	1 03 0
6 90 03	WE		062005	1	71010 26 X-RAY CHEST; POSTEROANTE 847 CONFLICTING CONTROL NO 00 ADJUDICATION DATE:20050802	2100	00	00	00	1 71 2
3 68 01	WH PH		052104	1	99252 217	14700	00	00	00	1 03 0
1 51 62	WI MS		061705	1	99204 OFFICE,NEW PT, COMPREHEN 907	22500	00	00	00	1 03 0
2 56 20	JA		011705	1	99214 799	13500	00	00	00	1 00 0
5 15 01	MC		062003	1	73510 RT 799	10500	00	00	00	1 00 0
0 27 59	OS	5	021805	1	99214 799	13500	00	00	00	1 00 0
DEN CLAI			LS		44 CLAIMS	1730000	00	00	00	
AIL N PRO										
3 38 01	CU PH		110204	1	50360 HOMOTRANSPLANT/IMPLANT G 280	490500	00	00	00	1 05 0
3 38 01	CU PH		110204	1	50200 BIOPSY OF KIDNEY 807 CONFLICTING CONTROL NO: ADJUDICATION DATE:20050802	41900	00	00	00	1 05 1
3 37 30	IV PH		051205	1	99213 293	9000	00	00	00	1 15 0
3 57 01	RE PH		050405	1	99213 293	9000	00	00	00	1 05 0
3 28 01	ST PH		052505	1	99213 216	9000	00	00	00	1 03 0
3 83 01	YO PH		011805	1	99213 293	9000	00	00	00	1 06 0
CL IN P	ISS	TOTALS			6 CLAIMS	558400	00	00	00	

PROFESSIONAL REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/16/2005 PAGE: 2
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
AP! VE ORIG AL CL IMS										MEDIA: 3
(36! '21 283),					650					
6 30! 01 PA[[S	080905	080905	1	99213 TH	OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5! 15265 0
(37('21 912),					650					
3 30(60 2 PA' [NM	080805	080805	1	99213 TH	OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5! 15270 0
(38('21 375),					650					
4 30(28 3 PRI TON RF	080505	080505	1	99213 TH	OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5! 15270 0
(21! '21 274),					650					
4 35! 95 5 RO! JN	080905	080905	1	99213 TH	OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5! 15265 0
(81! '21 177),					650					
6 31! 62 2 SE! \S KA	080905	080905	1	99213 TH	OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5! 15265 0
(96! '21 418),					650					
6 31! 62 1 SE! \S KR	080905	080905	1	99213 TH	OFFICE,EST PT, EXPANDED,	8259	3343	00	3343	5! 15265 0
(04! '21 181),					650					
J 'RO) ORI INAL AIMS	TOTALS				31 CLAIMS	83392	33195	00	33195	
AD! TM N CL(\S										
8 14! 92 5 SI! \S SE	070505	070505	1	J7302	MIRENA	6600	3843	00	3843	5! 36404 0
				650				REF.CONTROL NO.51!		64045
J 'US ENT (AIMS	TOTALS				1 CLAIMS	6600	3843	00	3843	
PRI OU (PA' CLA' \										
8 14! 92 5 SI! \S SE	070505	070505	1	J7302 51	MIRENA	6600	1922	00	1922	5! 56404 1
				FORMER REMITTANCE DATED : 08022005				REF.CONTROL NO.52!		64040
I 'VI SLY I ID CI IMS	TOTALS				1 CLAIMS	6600	1922	00	1922	
CL(IS PRO(\S										
0 03(70 2 AG! AR DL	072005	072005	1	99213 TH	OFFICE,EST PT, EXPANDED,	8259	00	00	00	5! 56405 0
(32!),					250					
(IM IN PI ESS	TOTALS				1 CLAIMS	8259	00	00	00	



PROFESSIONAL REMITTANCE ADVICE
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE:07/05/2005 PAGE: 105
REMITTANCE NO:

M M D D Y Y

RECIPIENT NUMBER / MEDICAL RECORD NOS	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION / DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
6404 38 31		04 05	040405	1	99232 SBSQNT HOSP,XPANDED,MOD	11000	4250	00	4250	5 091 91 2
(033 34 -6	/PH) NO:	8747						REF.CONTROL NO:		5 713 12 0
(033 34 -6	/PH) NO:	1747			FORMER REMITTANCE DATED : 04262005					
1100 36 40		04 05	032805	1	99232 SBSQNT HOSP,XPANDED,MOD	11000	4250	00	4250	5 401 52 0
(033 32 -2	/PH) NO:	6781						REF.CONTROL NO:		5 743 20 0
(033 32 -2	/PH) NO:	6781			FORMER REMITTANCE DATED : 05312005					
3604 35 31		04	122206	1	99213 OFFICE,EST PT, EXPANDED,	9000	3613	00	3613	5 051 12 0
(033 31 -2	/PH) NO:	1747						REF.CONTROL NO:		5 713 13 0
(033 31 -2	/PH) NO	1747			FORMER REMITTANCE DATED : 01112005					
3604 35 31		04	123104	1	99233 SBSQNT HOSP,DETAILED, HI	15500	4250	00	4250	5 201 93 0
(033 38 -4	/PH) NO	1261						REF.CONTROL NO:		5 713 13 0
(033 38 -4	/PH) NO	1261			FORMER REMITTANCE DATED : 01252005					
5741 30 39		05	032805	1	99232 SBSQNT HOSP,XPANDED,MOD	11000	4250	00	4250	5 435 82 0
(165 5	/PH) NO	10462						REF.CONTROL NO:		5 713 12 0
(165 5	/PH) NO	10462			FORMER REMITTANCE DATED : 06072005					
						113500		00		
ID	CL	IS			TOTALS 10 CLAIMS		38590		38590	
3604 31 31		0	05	061305	1 99203	16000	00	00	00	5 781 17 0
(033 37 -2	/PH) NO:	1202			215					
					PARTIAL RECIP NAME: QUINN T					
4414 37 -5		0	05	061305	1 99243	20000	00	00	00	5 781 33 0
(033 37 -2	/PH) NO:	1361			215					
					PARTIAL RECIP NAME: TREJO M					
3261 31 -3		0	05	022605	1 71020 26	2500	00	00	00	5 781 36 0
(033 32 -3	/PH) NO:	1883			215					
					PARTIAL RECIP NAME: PETRI L					
5204 36 -1		1	04	101104	1 99213 OFFICE,EST PT, EXPANDED,	9000	00	00	00	5 715 56 0
(033 36	/PH) NO:	1883			273					
6842 32 -5		0	05	053105	1 20692 80 51	21400	00	00	00	5 725 53 1
(033 36	/PH) NO:	1350			232 233					
2662 37 -3		0	05	031205	1 99232 SBSQNT HOSP,XPANDED,MOD	11000	00	00	00	5 781 42 0
(033 35 -6	/PH) NO:	1923			704					
1662 37 -3		0	05	031305	1 43235 UPPER GI ENDOSCOPY,DIAGN	88500	00	00	00	5 781 42 1
(033 35 -6	/PH) NO:	5953			913					
					CONFLICTING CONTROL NO:1 1 ADJUDICATION DATE:20050405					
3616 32 -0		0	05	041505	1 99238	14000	00	00	00	5 751 91 0
(033 34 -6	/PH) NO:	9747			217					
2604 34 31		0	05	040405	1 94720 26 CARBON MONOXIDE DIFFUSIN	3700	00	00	00	5 751 01 0
(033 33 -2	/PH) NO:	19830			106					
5104 38 -3		0	05	060805	1 64585 51 REVISE/REMOVE NEUROELECT	65000	00	00	00	5 715 49 0
(033 33	/PH) NO:	1661			299 299					

REMITTANCE SUMMARY

LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

DATE: 08/09/2005 PAGE: 125
REMITTANCE NO:

MMDDYY

MEDIA: 1

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
				CURRENT NUMBER	TRANSACTIONS AMOUNT					
APPROVED ORIGINAL CLAIMS				2,241	132,047.31	LAST REMITTANCE NO:		DATED:	08/2/2005	
ADJUSTMENT CLAIMS				23	468.21					
PREVIOUSLY PAID CLAIMS				23	238.04-					
VOIDED CLAIMS				20	707.39-					
NET CURRENT CLAIM TRANSACTIONS				2,724	131,570.09					
NET CURRENT FINANCIAL TRANSACTIONS					.00					
PRIOR NEGATIVE BALANCE					.00					
RECOUPMENTS BYPASSED BY D.H.H.					.00					
TOTAL PAYMENT THIS REMITTANCE					$131,570.09	EFT NO:		DIRECT DEPOSIT DATE:	08/10/2005	
TOTAL COPAYMENT DEDUCTED THIS REMITTANCE					$.00					
YEAR-TO-DATE AMOUNT PAID					$4,249,992.86					
DENIED CLAIMS				372	102,781.20					
CLAIMS IN PROCESS				45	31,177.00					

REMITTANCE ADVICE CLAIM DENIAL RESOLUTION FOR LOUISIANA MEDICAID

This section is designed to assist providers in resolving some of the more general claim denials appearing on the Louisiana Medicaid Remittance Advices. When claims deny and appear on a remittance advice, a three-digit error code is given with the claim information. At the end of the remittance advice, all error codes received are listed with a narrative description that gives an explanation of the error code. The purpose of this explanation is to aid providers in correcting errors and resubmitting their claim(s) for processing.

Some of the more common error codes are listed in this section, along with an explanation of the denials and suggestions on how to correct them. These error codes are grouped by category, and apply to most Medicaid programs.

GENERAL CLAIM FORM COMPLETION ERROR CODES

ERROR CODE 003 – RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS
Cause: The recipient ID number on the claim form was less than 13 digits in length or included letters or other non-numeric characters.
Resolution: Verify the correct 13-digit recipient ID number using REVS or e-MEVS and enter this number where required on the claim form.

ERROR CODE 009 - SERVICE THRU DATE GREATER THAN DATE OF ENTRY
Cause: The claim was received by Unisys prior to one or more dates of service billed.
Resolution: Correct the date span on the claim and rebill OR wait until all dates of service on the claim have passed and rebill.

ERROR CODE 028 - INVALID OR MISSING PROCEDURE CODE
Cause: 1. No procedure code was entered on the claim form, OR
2. The procedure code entered on the claim form is invalid (e.g., usually because it has fewer than five characters).
Resolution: Enter the correct procedure code on the claim form and resubmit.

RECIPIENT ELIGIBILITY ERROR CODES

ERROR CODE 215 - RECIPIENT NOT ON FILE
Cause: The recipient ID number on the claim form is not in the State eligibility files.
Resolution: Verify the correct 13-digit recipient ID number using REVS or e-MEVS and enter this number where required on the claim form. If there is an e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 216 - RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE
Cause: The recipient ID number on the claim is in the State eligibility files, but the recipient's eligibility does not cover the date of service filed on the claim.
Resolution: Verify the recipient's eligibility using REVS or e-MEVS for all dates of service on the claim. If there is an e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter explaining the problem.
Note: Prior authorization does not override eligibility issues. Only dates of service during a recipient's eligibility will be reimbursed.

ERROR CODE 217 – NAME AND OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD
Causes: 1. The name on the claim form does not match the recipient ID number as recorded in the Unisys eligibility files. (This is sometimes caused when a recipient marries and changes her surname, or if several family members have similar ID numbers.) OR
2. The first and last names have been entered in reverse order on the claim form.
Resolution: Verify the correct spelling of the name via REVS or e-MEVS using the 13-digit recipient ID number. Ensure that the first and last names are entered in the correct order on the claim. Make corrections if necessary and resubmit.

ERROR CODE 222 – RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE (S)
Cause: The recipient ID number on the claim is in the State eligibility files, but the recipient's eligibility does not cover all dates of service filed on the claim.
Resolution: 1. Verify the recipient's eligibility using REVS or e-MEVS for all dates of service on the claim. If there is an e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.
2. If there is no verification of eligibility for the date of service, resubmit the claim for covered dates of service only.

ERROR CODE 223 – RECYCLED RECIPIENT NOT ON FILE
Cause: The recipient ID number on the claim form is not in the State eligibility files. The claim has been "recycled" a number of times looking for the ID number in the eligibility files.
Resolution: Verify the correct 13-digit recipient ID number using REVS or e-MEVS and enter this number where required on the claim form. If there is an e-MEVS printout that verified eligibility and was printed on the date of service in question, send a copy of the claim and a copy of the printout to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 364 – RECIPIENT INELIGIBLE/DECEASED
Cause: The State eligibility files indicate the recipient was deceased prior to the billed date of service.
Resolution: Verify the recipient's date of death with Unisys Provider Relations. If you have documentation proving the date of death on file is incorrect, submit the claim and your documentation, along with a cover letter explaining the problem, to Unisys Provider Relations Correspondence Unit.

TIMELY FILING ERROR CODES

ERROR CODE 272 – CLAIM EXCEEDS 1 YEAR FILING LIMIT
Cause: The date of service on the claim form is more than one year prior to the date the claim was received by Unisys. All such claims must be accompanied by proof of timely filing in order to be paid.
Resolution : Resubmit the claim with proof of timely filing attached. Proof of timely filing is usually a copy of an RA page that shows the claim was processed by Unisys within one year from the date of service. Such claims may be mailed with a cover letter requesting an override for proof of timely filing to the Unisys Correspondence Unit.
Note: When refiling claims over one year old, it is not enough for the provider to know or to believe that they have filed the claim to Unisys within one year from the date of service. The provider must attach proof of timely filing to the claim, or the claim will deny. A history can be ordered to assist in determining if payment has been made or if a claim has been filed timely. The Field Analyst for your territory may also assist in placing such an order.

ERROR CODE 030 – SERVICE "THRU" DATE MORE THAN TWO YEARS OLD
Cause: The date of service on the claim form is more than two years prior to the date the claim was received by Unisys.
Resolution: Timely filing guidelines dictate that, in general, claims with dates of service over two years old are not payable. Unisys staff does not have the authority to override such claims. In the case of retroactive eligibility, DHH must review the claim and approve any overrides for timely filing.

ERROR CODE 371 – ATTACHMENT REQUIRES REVIEW/FILING DEADLINE
Cause: The date of service on the claim form is more than one year prior to the date the claim was received by Unisys. The claim has pended in the Unisys computer system so that it can be checked for attached proof of timely filing.
Resolution: If the claim was submitted with proof of timely filing attached, no further action is required. If no proof of timely filing was attached to the claim form, attach proof of timely filing to the claim and mail it with a cover letter requesting an override for proof of timely filing to the Unisys Correspondence Unit.
Note: Code 371 is not a true "error" code, as the claim has not been denied. The message is to notify the provider why the claim is in process.

DUPLICATE CLAIM ERROR CODE

VARIOUS ERROR CODES SPECIFIC TO EACH PARTICULAR MEDICAID PROGRAM
Cause: The claim is a duplicate of one that has already been paid by Unisys.
Resolution: On the remittance advice, the denial refers the provider to the conflicting control number and adjudication date of the previously paid claim. Refer to the remittance advice date indicated to find the claim that has already been paid. Do not resubmit the claim if it has already been paid.

THIRD PARTY LIABILITY ERROR CODES

ERROR CODE 273 - 3RD PARTY CARRIER CODE MISSING - REFER TO CARRIER CODE LIST
Cause: No carrier code was indicated on the claim for a recipient with other insurance coverage.
Resolution: Verify the recipient's third party liability carrier code using REVS or e-MEVS. Resubmit the claim with the six-digit carrier code in the appropriate block and attach the EOB from the third party liability.
If you have verification that the recipient was not covered by other insurance for the date(s) of service, send a copy of the claim and the verification to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 290 - NO EOB ATTACHED FOR RECIPIENT WITH OTHER RESOURCE INDICATED
Cause: 1. No EOB from the other insurance was attached to the claim for a recipient with other insurance coverage, OR
2. There is a carrier code indicated on the claim form, but no EOB from the carrier is attached to the claim.
Resolution : Resubmit the claim with a copy of the EOB from the third party carrier.
If the carrier code was indicated on the claim form in error, remove it and resubmit the claim.
If you have verification that the recipient was not covered by other insurance for the date(s) of service, send a copy of the claim and the verification to the Unisys Correspondence Unit with a cover letter stating the problem.

ERROR CODE 292 - NO TPL AMOUNT INDICATED ON CLAIM/REQUIRES REVIEW
Cause: A carrier code was indicated on the claim form, but no TPL amount was entered on the claim.
Resolution: Indicate the amount paid by the third party carrier in the appropriate block on the claim form and resubmit the claim (including the third party carrier EOB).
If the carrier code was indicated on the claim form in error, remove it and resubmit the claim.

ERROR CODE 032 - EOB(S) ATTACHED/CARRIER CODE DOES NOT MATCH
Cause: The EOB attached to the claim does not appear to be from the third party carrier indicated on the State resource file for the recipient.
Resolution: Verify the recipient's third party liability carrier code using REVS or e-MEVS. Correct the carrier code if necessary and resubmit the claim (including the third party carrier EOB).
If the carrier code on the claim is correct, ensure that the EOB submitted with the claim is from the correct third party carrier. If not, attach the correct EOB if necessary and resubmit the claim. If the EOB submitted with the claim is from the correct third party carrier, submit the claim and the EOB to Unisys Provider Relations Correspondence Unit along with a cover letter explaining the problem.

ERROR CODE 918 – MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE
Cause: The amount paid by third party liability (as indicated on the claim form) has been subtracted from the amount Medicaid would usually pay.
Resolution: Ensure that the amount shown in the "deductions" column of the remittance advice is the same as the other insurance payment on the claim form. If the claim form was completed incorrectly, indicating an incorrect amount paid by other insurance, an adjustment must be filed to obtain correct payment.
Note: The message is to notify the provider why the payment is not the usual reimbursement amount.

MEDICARE/MEDICAID ERROR CODES

ERROR CODE 275 – RECIPIENT IS MEDICARE ELIGIBLE
Cause: The state files indicate that the recipient is eligible for Medicare. Since Medicaid is always the payer of last resort, it will be necessary to bill Medicare first and then submit the claim to Medicaid along with the EOMB.
Resolution: Submit the claim to Medicare. Once the Medicare EOB is received, attach it to the claim and send to Medicaid for adjudication.

ERROR CODE 330 - QMB NOT MEDICAID ELIGIBLE
Cause: The claim was filed for a recipient who is a QMB ONLY, meaning that Medicaid will only pay the co-insurance or deductible after Medicare has made payment. If the service is not a Medicare covered service or if Medicare did not make a payment on the claim (for whatever reason), Medicaid will not pay either. This type of recipient is not truly a Medicaid recipient. The recipient only has Medicaid coverage if Medicare has paid the claim and only co-insurance/deductible is owed.
Resolution: In general, recipients may be billed for services considered non-covered by Medicaid.

ERROR CODE 922 – MEDICARE EOMB INVALID/OR MISSING
Cause: 1. The claim was received by Unisys with no Explanation of Medicare Benefits (EOMB) attached; OR
2. The claim was received by Unisys with an EOMB which was invalid (missing date of service, recipient name, etc.).
Resolution: If no Medicare EOB was filed with the claim, resubmit the claim with the corresponding EOMB. If an invalid EOMB was attached to the claim, resubmit the claim with a corrected EOMB.

ERROR CODE 942 – DENIED BY MEDICARE, NOT COVERED BY MEDICAID
Cause: The billed service was denied by Medicare and so is not payable by Medicaid.
Resolution: Unless the recipient is a QMB plus, Medicaid is not required to make payment on services when Medicare denies payment. If the Medicare denial states the service was "not medically necessary," the service is not payable by Medicaid, even for QMB PLUS recipients. If the service is for a QMB PLUS and the denial is for other than medical necessity, the claim and EOMB should be submitted to the Correspondence Unit with a cover letter explaining the problem.

ERROR CODE 996 – DEDUCTIBLE & OR CO-INSURANCE REDUCED TO MAX ALLOWABLE
Cause: The Medicaid payment was reduced because of a Medicare payment.
Resolution: This claim has been approved and is considered paid in full. The provider cannot bill the patient for any remaining balance. In determining the Medicaid payment, the computer system will calculate the amount Medicaid would pay if there were no Medicare. If Medicare has paid more than that amount, the claim is considered approved at $0.00. Otherwise, Medicaid will pay the difference between the Medicaid allowable and what Medicare paid, up to the coinsurance and deductible amount.

ADJUSTMENT/VOID ERROR CODES

ERROR CODE 798 – HISTORY RECORD ALREADY ADJUSTED
Cause: An adjustment/void form has been submitted for an internal control number (ICN) that has already been adjusted or voided. Therefore, the ICN cannot be adjusted or voided again.
Resolution: Review previous RAs to determine all activity for the particular claim. Only the most recent paid claim (either original or adjustment) can be adjusted or voided. If an adjustment or void is still required, resubmit the adjustment/void form for the most recent paid ICN.
Note: Only paid claims can be adjusted or voided. It is impossible to process an adjustment or void of a denied claim.

ERROR CODE 799 – NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
Cause: An adjustment/void form has been submitted for an internal control number (ICN) that is not in the Unisys claim history.
Resolution: Review previous RAs to determine the correct ICN to be adjusted. If the ICN submitted on the adjustment/void form is incorrect, submit a corrected adjustment or void. If the ICN on the claim is correct, send a copy of the adjustment/void form and all related documentation to Unisys Correspondence Unit with a cover letter explaining the problem.
Note: Adjustments and voids may only be processed if the adjudication date (RA date) of the last paid claim is under two years old.

MISCELLANEOUS ERROR CODES

ERROR CODE 299 - PROCEDURE/DRUG NOT COVERED BY MEDICAID
Cause: The procedure code entered on the claim form is not a payable code.
Resolution: Review the claim that was filed, ensuring that the correct procedure code was entered on the claim form, including any modifiers that are appropriate. Make any necessary corrections and resubmit the claim.

ERROR CODE 232 - PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM
Cause: Usually this is caused by an error in entering the procedure code on the claim form (e.g., inadvertently reversing two digits of the procedure code).
Resolution: Verify that the procedure code entered on the original claim form is correct. If not, correct the procedure code and resubmit the claim. In addition, verify that the procedure code is one covered for your provider type.

Please be reminded that you cannot always bill the recipient for a service on which you have received a 299 or 232 denial.

Some CPT codes are in a non-payable status on our files because their services as described in CPT are included in other codes, which are covered.

When the denied service is not payable on the file because it is a component of a payable service, it cannot be billed to the recipient. For example, Code 92015 (determination of refractive state) cannot be billed to the recipient because its fee is included in the fee for the office visit. Therefore, Code 92015 cannot be billed to the recipient if denied with a 299 or 232.

PROVIDER ELIGIBILITY ERROR CODES

ERROR CODE 201 – PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
Cause: The billing provider number entered on the claim form is on the State provider files, but the provider's enrollment was not effective on the claim date(s) of service.
Resolution: Review the claim that was filed, ensuring that the correct Medicaid provider number was entered on the claim form. Make any necessary corrections and resubmit the claim.
Note: Providers must be enrolled as Medicaid providers in order to be reimbursed by Medicaid.

ERROR CODE 206 – BILLING PROVIDER NOT ON FILE
Cause: The billing provider number entered on the claim form is not on the State provider files.
Resolution: Review the claim that was filed, ensuring that the correct Medicaid provider number was entered on the claim form. Make any necessary corrections and resubmit the claim.
Note: Medicaid provider numbers are seven digits in length and begin with "1." All seven digits of the Medicaid provider number must be correct in order for the claim to be paid.

PROVIDER ASSISTANCE

The Louisiana Department of Health and Hospitals and Unisys maintain a website to make information more accessible to Medicaid providers. At this online location, www.lamedicaid.com, providers can access information ranging from how to enroll as a Medicaid provider to directions for filling out a claim form.

Below are some important links for Hurricane Katrina information found on the website:

Emergency Billing Policy and Procedures for Hurricane Katrina Evacuees
Emergency Provider Enrollment Packets
Emergency Telephone Numbers
Fee Schedules
Forms/Files
Hurricane Katrina Emergency Notices Provider Support
Pharmacy
Provider Update / Remittance Advice Index
Provider Web Account Registration Instructions

Along with the website, the Unisys Provider Relations Department is available to assist providers.

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

(800) 473-2783 or (225) 924-5040

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification.

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving claim denials and problems. Providers who wish to submit problem claims for research and want to receive a written response, **must submit a 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, etc.) to the Correspondence Unit at the following address:

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

IMPORTANT UNISYS ADDRESSES

Please be aware that **separate post office boxes** are used for the various Medicaid programs. If you are submitting an original "clean" hard copy claim 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 Independent Lab Mental Health Rehabilitation Professional Professional Services Rural Health Clinic Substance Abuse and Mental Health Clinic	91020	70821
Inpatient and 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 separate post office boxes for the 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

NEMT POLICY

TIMELINESS

Providers are responsible for picking up recipients in a timely manner to insure that they arrive at their appointments on time and are returned home within a reasonable amount of time. If a provider accepts a trip, and then determines that he is unable to provide the service, the provider must notify the dispatch office immediately, provide an explanation, and notify the recipient.

If a driver returns to pick up a recipient and cannot locate the recipient, the driver must determine if the recipient left the premises and make every attempt to locate the recipient. If the recipient cannot be located, the driver must notify his office immediately, and the provider must notify the dispatch office immediately. Failure on the part of the driver/provider to act responsibly may result in administrative sanctions, such as suspension from the program.

EFFICIENT TRIP SCHEDULING

Providers must transport as many recipients as the vehicles allow when there are individuals going to the same medical service during the same time period. However, when transporting recipients whose waiting time is excessive, recipients who are ready to leave should be taken home. The provider should either return later or send another vehicle to pick up recipients who had not completed their appointments.

RECIPIENT FREEDOM OF CHOICE

The recipient is entitled to freedom of choice. A medical provider cannot decide for the recipient which transportation provider will be used. The dispatch office assigns trips based on the least costly means of transportation available in the geographic area, with consideration given to the recipient's preference.

Requests for transportation must be made directly to the dispatch office, not to individual transportation providers.

CANCELED TRIPS/DRY RUNS

A provider must be able to receive cancellations between 8:00 a.m. and 4:30 p.m. Monday through Friday. A provider may not file a claim for a trip, which has been canceled, by the dispatch office.

No payment is made for a dry run. A dry run occurs when a provider is assigned a trip and the recipient is not at the pick up point, or the recipient canceled the medical appointment. In order for a service to be billed, a recipient must be transported.

PROVIDER SERVICE AREA

A provider service area is the parish or parishes in which the transportation provider is authorized to operate. A minimum of one vehicle must be available per parish in the service area. Health

Standards approves requests to serve a particular area, as well as expansions or reductions in authorized service areas or changes in a provider's capacity. As part of the approval process, the provider's record keeping and billing activity will be reviewed for accuracy and compliance. Expansions will not be approved for providers requiring corrective action until necessary changes are made. Requests for expansion within 60 days of enrollment (or the last review which revealed no problems) will be granted without another review.

The transportation provider must be authorized to transport within the recipient's parish of origin.

POLICY CLARIFICATION

Minimum Liability Insurance Requirements

A provider is required to have minimum liability insurance coverage of $100,000 per person and $300,000 per accident, or a combined single limit of $300,000 at all times. Providers authorized to transport recipients out of state must carry a minimum of $1,500,000 in automobile liability coverage. Automobile liability must include coverage for owned, hired, and non-owned autos.

Each provider must be covered at all times by general liability insurance to cover the business entity and maintain a minimum coverage of $300,000 combined single Limit of Liability at all times.

Failure to comply with the minimum liability insurance coverage requirements on each vehicle and on the business entity is grounds for immediate suspension as a Medicaid transportation provider. Operation without the minimum liability insurance coverage is a violation of the provider enrollment and participation requirements. All payments made during the period of violation are subject to recoupment.

The dispatch office is immediately notified by Health Standards when a provider is suspended for failure to comply with insurance requirements. In accordance with DHH policy, the dispatch office is instructed to immediately cancel trips assigned to the provider, including capitated trips, and to attempt to reschedule the trips. There are situations when the provider fulfills the requirements in a short time and becomes reinstated. If this is the case, and the reinstated provider is informed by dispatch that the trips have already been rescheduled, the dispatch office will not cancel the second provider in order to re-schedule the original provider. This is DHH policy; **it is the responsibility of the provider to comply with the insurance requirements**. Under no circumstances will the dispatch office schedule a trip with a provider who is out of compliance. Dispatch must receive notification of reinstatement from Health Standards before scheduling can resume.

Attendants/Children

Medicaid does not pay for the transportation of an attendant or accompanying children. The provider may not bill Medicaid, or the recipient, or anyone else for the transport of an attendant or a child.

The dispatch office is required to inform the transportation provider if a recipient intends to be accompanied by a child or children. The transportation provider may refuse to transport the child or children, or may refuse to transport more than one child or attendant. The transportation

provider may determine that an adult recipient requires an attendant, and may require an attendant to accompany the recipient.

The dispatch office is responsible for determining if an attendant is needed for a recipient.

A parent, legal guardian, or responsible person must accompany children under the age 17.

The attendant **MUST:**

1. Be age 17 or older; and
2. Be designated by the parent if the attendant is not the parent or legal guardian; and
3. Be able to authorize medical treatment and to care for the child; and
4. Accompany the child to and from the medical appointment.

The attendant **MUST NOT:**

5. Be a Medicaid provider or employee of a Medicaid provider that is providing services to the recipient being transported; or
6. Be a transportation provider or an employee of a transportation provider; or
7. Be an employee of a mental health or substance abuse clinic.

REIMBURSEMENT

Reimbursement to NEMT providers is based on the type of trip made and the type of provider rendering the service. This section will list the different types of trips and the reimbursement rates paid to each type of provider.

TYPES OF TRIPS

Single Trip

A single trip is a completed trip in which the recipient is picked up from home or an indicated point of origin, taken to the medical appointment, and returned to the point of origin or another drop off point.

Wheelchair Trip

A wheelchair trip is one transporting non-ambulatory and wheelchair bound recipients to non-emergency medical appointments.

> NOTE: Wheelchair accessible vehicles must have a wheelchair restraint and appropriate wheelchair lift.

Capitated Trips

Capitated trips are trips to regular, predictable, and continuing medical services such as Hemodialysis, chemotherapy or rehabilitation therapy.

Non-profit providers may not receive capitated payments. Only for-profit providers may be reimbursed at capitated rates. Capitated payments are based on the number of trips and the distance traveled. Additional trips for medical appointments related to the service for which the capitated trips are scheduled are included in the capitated rate. A provider who accepts a capitated payment is required to provide transportation for related medical appointments, and no additional payment for these trips may be made.

Dry Runs

The term dry run is applied when a provider is assigned a trip for the transport of an eligible recipient, and the provider discovers that the recipient is not at the pick up point or did not choose to keep the medical appointment. **No payment is made for dry runs. A recipient must be transported for a service to be billed.**

Second Trip - Same Day

A second trip - same day is one in which the recipient has two separate appointments on the same day. The second trip requires prior authorization by the Dispatch Office. A separate authorization code must be given before payment may be made to the provider.

NEMT NON-AMBULANCE RATES AND CODES

PROFIT PROVIDERS	PROCEDURE CODE	RATES
Flat Rate	Z5177	$ 18.00 per recipient
Negotiated	Z5178	To be given by dispatch
Capitated (urban)	Z5179	$ 180.00 per month
Capitated (rural)	Z5180	$ 240.00 per month
Enhanced Capitated (5 trips or more per week)	Z5182	$ 360.00 per month
Remote Capitated (>120 miles round trip)	Z5183	$ 360.00 per month
Wheelchair Capitated (rural)	Z5184	$ 300.00 per month
Wheelchair Capitated (urban)	Z5185	$ 216.00 per month
Wheelchair local	Z5186	$ 30.00 per recipient
Capitated-Negotiated	Z5188	Determined by state office

NON-PROFIT PROVIDERS	PROCEDURE CODE	RATES
Flat Rate	Z9498	$ 14.00 per trip
Negotiated	Z5176	To be given by dispatch
Wheelchair local	Z5187	$ 24.00 per recipient

Please Note: These rates and codes are effective for dates of service August 1, 2003, however rates and codes are subject to change.

A provider, who accepts a capitated rate to transport a recipient to a series of medical appointments, must be available on each day an appointment is scheduled. For example, if a recipient needs transportation to and from a dialysis center on Tuesday, Thursday, and Saturday, transportation must be provided on all three days. A provider may not choose the days he/she is available to transport the recipient to the center. Also, the transportation provider must transport the recipient to and from the appointments unless otherwise specified by the recipient.

NEMT INTRA-STATE RATES (BASED ON ROUND TRIP MILEAGE)

MILES	RATE
0-65	$ 18.00
66-95	$ 22.50
96-125	$ 30.00
126-155	$ 37.50
156-185	$ 45.00
186-215	$ 52.50
216-245	$ 60.00
246-275	$ 67.50
276-305	$ 75.00
306-335	$ 82.50
336-365	$ 90.00
366-395	$ 97.50
396-425	$ 105.00
426-455	$ 112.50
456-485	$ 120.00
486-515	$ 127.50
516-545	$ 135.00
546-575	$ 142.50
576-605	$ 150.00
606-635	$ 157.50
636-665	$ 165.00
666-695	$ 172.50
696-725	$ 180.00
736-755	$ 187.50
756-785	$ 195.00
786-815	$ 202.50
816-845	$ 210.00
846-875	$ 217.50

DOCUMENTATION

A provider must maintain sufficient documentation to identify that recipients were transported. Such documentation consists of points of origin and destinations, driver qualifications, vehicle capabilities, and safety. Documentation must be maintained for five (5) years from the date on which the claim is paid.

DAILY SCHEDULE OF TRANSPORTS

A provider must maintain a daily schedule of transports by parish of origin. The schedules must be available for review of trips by parish and by date. The schedule must include the recipient's name, address (or point of origin), appointment time, assigned driver(s), assigned vehicle(s), and destination.

MT-3 FORM AND COMPLETION INSTRUCTIONS

The MT-3 provides verification that a medical appointment was kept. It is completed by the driver and signed by the recipient and the medical provider or representative to confirm that the trip was completed. If the recipient does not or will not sign the MT-3, an explanation must be given in the "remarks" section of the claim form (Form 106). Following are instructions for completion of the Form MT-3 and a sample MT-3 form.

Top Section of MT-3 Form:

Date of Transportation: complete space provided with the date the transportation is being provided.

Time of Appointment: complete space provided with the actual time of the medical appointment. Circle a.m. or p.m. as appropriate.

I. Recipient Verification of Medical Transportation

Transportation Provider Name: complete with provider's name.
Recipient's Name: complete with recipient's name as it appears on the medical eligibility card.
Recipient's ID #: complete with the recipient's 13-digit ID number.
Recipient's Address: complete with the recipient's complete address including zip code.

Signature and Date: the recipient must sign and date with that day's date. If the recipient signs with a mark, this mark must be witnessed by at least one person who can sign his/her name.

II. Driver Certification

The driver of the vehicle should sign and date the form, providing the name of the driver who picked up the recipient for the appointment and returned the recipient after the appointment.

III. Medical Service Provider Verification

The medical provider or his/her representative must complete section III.

If the recipient did not receive medical services, an explanation is required.

An office stamp is accepted, but the medical provider or his/her representative must also sign and give his/her title and date.

The MT-3 form may not be signed prior to the service being rendered.

The form should be returned to the transportation provider. Further information on the use of this form can be found in Section 7 of the Medicaid Transportation Services provider manual (issued January 20, 1998).

REMINDERS TO NEMT PROVIDERS

- √ All fields on the Form MT-3 **MUST** be completed.

- √ Form MT-3 is to be signed on the day of transport. Neither the NEMT provider nor the Medical Service Provider should pre date the form.

- √ All services for recipients are to be Prior Authorized. Recipients should not be transported without a Form MT-3.

- √ MT-3 forms submitted to Medical Dispatch AFTER transport will be denied.

- √ Weekend/after hour's transports must have verbal authorization by paging Medical Dispatch.

- √ Providers refusing transports must fax the Prior Authorization request back to Medical Dispatch immediately so recipients can be rescheduled.

Form MT-3 (Revised 12/93)

DATE OF TRANSPORTATION 10/02/05
TIME OF APPOINTMENT 10:00 a.m./p.m.

I. RECIPIENT VERIFICATION OF MEDICAL TRANSPORTATION

Transportation Provider Name XYZ MEDICAL INC.

Recipient Name FAITH MAEBELL ID # 0010600005421

Recipient Address 345 NOW DR. (Street) HAPPY, (City) LA (State) 70020 (Zip)

Having no other form of transportation to receive medical treatment under the Medicaid Program, I have requested transportation services from the Department of Health and Hospitals. My signature below acknowledges that I am using transportation to keep a medical appointment. I understand that transportation services can only be used to receive medical services. I understand that if I do not sign this request for medical transportation and return it to the transportation provider, the Department of Health and Hospitals or a duly appointed representative may choose to contact me or the medical provider I am being transported to for verification that I have kept my medical appointment.

Faith Maebell (Signature) 10/02/05 (Date)

II. DRIVER CERTIFICATION

Check appropriate block(s)

☐ I certify that I was the driver who provided the above named recipient with transportation to the medical facility.

JR Walker (Signature) 10/02/05 (Date)

☐ I certify that I was the driver who provided transportation for the above named recipient from the medical facility to the recipient's home.

JR Walker (Signature) 10/02/05 (Date)

III. MEDICAL SERVICE PROVIDER VERIFICATION

This section must be completed by the medical service provider or his/her representative and returned to the transportation provider by the recipient when the recipient is picked up after the medical appointment. Completion of this section by the signature of anyone other than the medical provider or his/her representative who rendered the services is prohibited and may result in prosecution.

☐ I certify that the above named recipient had an appointment on 10/02/05 at 10:00 a.m./p.m. and received medical service.

☐ I certify that the above named recipient was in the office on ___/___/___ at _____ a.m./p.m. but did not receive medical services because_____

Provider Office Stamp

Do Right, MD (Signature and Title) 10/02/05 (Date)

Form MT-3 (Revised 12/93)

DATE OF TRANSPORTATION ____ ____ ____
TIME OF APPOINTMENT _____ a.m./p.m.

I. RECIPIENT VERIFICATION OF MEDICAL TRANSPORTATION

Transportation Provider Name_____ _____

Recipient Name_____ ID #_____

Recipient Address_____

Street City State Zip

Having no other form of transportation to receive medical treatment under the Medicaid Program, I have requested transportation services from the Department of Health and Hospitals. My signature below acknowledges that I am using transportation to keep a medical appointment. I understand that transportation services can only be used to receive medical services. I understand that if I do not sign this request for medical transportation and return it to the transportation provider, the Department of Health and Hospitals or a duly appointed representative may choose to contact me or the medical provider I am being transported to for verification that I have kept my medical appointment.

_____ _____

Signature Date

II. DRIVER CERTIFICATION

Check appropriate block(s)

☐ I certify that I was the driver who provided the above named recipient with transportation to the medical facility.

_____ _____

Signature Date

☐ I certify that I was the driver who provided transportation for the above named recipient from the medical facility to the recipient's home.

_____ _____

Signature Date

III. MEDICAL SERVICE PROVIDER VERIFICATION

This section must be completed by the medical service provider or his/her representative and returned to the transportation provider by the recipient when the recipient is picked up after the medical appointment. Completion of this section by the signature of anyone other than the medical provider or his/her representative who rendered the services is prohibited and may result in prosecution.

☐ I certify that the above named recipient had an appointment on ___/___/___ at _____ a.m./p.m. and received medical service.

☐ I certify that the above named recipient was in the office on ___/___/___ at _____ a.m./p.m. but did not receive medical services because_____

_____

_____

Provider Office Stamp

_____ _____

Signature and Title Date

STATEWIDE DISPATCH SERVICE

REGIONAL TRANSPORTATION DISPATCH OFFICES Toll Free Numbers				
Region	**Parishes**		**Phone**	**Fax**
1-New Orleans	Orleans East Jefferson Plaquemines St. Bernard	St. Charles St. James St. John West Jefferson	Provider Line: (866) 272-5501	(800) 864-5226
2-Baton Rouge	Ascension Assumption East Baton Rouge East Feliciana Iberville Lafourche Livingston Pointe Coupee	St. Helena St. Tammany Tangipahoa Terrebonne West Baton Rouge Washington W. Feliciana	Provider Line: (866) 272-5501	(800) 864-5226
3-Lafayette	Acadia Evangeline Iberia Lafayette	St. Martin St. Mary Vermilion St. Landry	Provider Line: (866) 272-5501	(800) 864-5226
4-Lake Charles	Allen Beauregard Calcasieu	Cameron Jefferson Davis	Provider Line: (866) 272-5501	(800) 864-5226
5-Alexandria	Avoyelles Catahoula Concordia Grant	LaSalle Rapides Vernon Winn	Provider Line: (866) 272-5501	(800) 864-5226
6-Shreveport	Bienville Bossier Caddo Claiborne DeSoto	Natchitoches Red River Sabine Webster	Provider Line: (866) 272-5501	(800) 864-5226
7-Monroe	Caldwell East Carroll Franklin Jackson Lincoln Madison	Ouachita Richland Tensas Union West Carroll Morehouse	Provider Line: (866) 272-5501	(800) 864-5226

***** Out of state providers should call the Dispatch Office Number closest to their location.****

CLAIMS FILING

Non-Emergency Medical Transportation claims are filed on the Unisys Form 106. Completed claims should be mailed to:

Unisys
P. O. Box 91022
Baton Rouge, LA 70821

- Normal, clean claims that go to the claims post office boxes should take no more than 30 calendar days from the date Unisys receives the claims to complete processing.

  Of course, claims that must pend will take longer to be paid. Nonetheless, these will appear in the provider's "claims in processing" RA section within the 30-day timeframe.

- Voids are filed on the Unisys Form 206. **Non–Emergency, Non-Ambulance medical transportation claims <u>cannot</u> be adjusted, only voided.** If a claim was paid incorrectly, the payment must first be voided and then a correct 106 Form should be submitted to Unisys for payment consideration.

  Completed 206 forms should be mailed to the above address.

The following pages give the billing instructions for completing the 106 Form and the 206 Form. Also included are blank form copies and examples of a correctly completed Unisys 106 Form and 206 Form.

INSTRUCTIONS ON COMPLETING UNISYS FORM 106

1. Enter recipient's last name.

2. Enter recipient's first name.

3. Enter recipient's middle initial.

4. Enter the 13-digit Medicaid Identification number of the recipient. This information can be accessed by utilizing REVS, MEVS or e-MEVS.

5. Enter the recipient's address.

6. Enter the recipient's date of birth.

7. Enter the recipient's sex.

8. Enter the time, month, day, and year of the recipient's medical appointment.

9. Enter the origin of service.

10. Enter the destination of service.

11. Enter the 10-digit alphanumeric prior authorization number assigned by the dispatch office.

12. Check the appropriate block to indicate whether the scheduled service was one-way or two-way transport.

13. Leave blank.

14. This item serves as a reminder that all non-emergency medical transportation must be prior authorized by the dispatch office.

15. Leave blank.

16. Enter the name and address of the transportation provider providing the service.

17. Enter the provider's 7-digit Medicaid number.

18. Enter the name of the medical provider.

19. If applicable, enter the recipient's medical record number assigned by the medical service provider.

20. Leave blank.

21A. Enter the date the transportation service was rendered.

21B. Enter the correct origin code from those listed on the form to show where the trip began.

21C. Enter the correct destination code from those listed on the form to show where the trip ended.

21D. Enter the five-digit procedure code prior authorized by the dispatch office. Only one trip may be billed per claim form.

21E. Leave blank.

21F. Enter the monetary charge for the procedure code.

21G. Leave blank.

22. The provider or the provider's representative must sign and date the claim form. Stamped or computer-generated signatures will be accepted only if they are initialed by the provider or the provider's representative.

Note: The "remarks" section should be used to explain any unusual occurrences (i.e., the recipient or the medical provider refused to sign the MT-3 form).

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 SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 LAST NAME	2 FIRST NAME	3 MI	4 MEDICAL ASSISTANCE I.D. NUMBER
Faith	Maebell		1 2 3 4 5 6 7 8 9 0 1 2 3

5 PATIENT'S ADDRESS	6 DATE OF BIRTH	7 SEX	8 MEDICAL APPOINTMENT TIME
345 Now Drive	06 26 58	☐ M ☒ F	HOUR MO. DAY YEAR

9 ORIGIN OF SERVICE	10 DESTINATION OF SERVICE
Maebell Faith (NAME)	Dr. Do. Right (NAME)
345 Now Drive (STREET)	777 Do Right Lane (STREET)
Any City, State Zip (CITY)	Any City, State Zip (CITY)

11	12 TRANSPORTATION AUTHORIZED IS	13 EPSDT REFERRAL
LL1234567	☐ ONE WAY ☒ TWO WAY	☐ YES ☐ NO

14 PRIOR AUTHORIZATION

I HEREBY CERTIFY THAT TRANSPORTATION FOR THIS RECIPIENT WAS MADE FOR A TITLE XIX COVERED SERVICE AND THAT ALL OTHER REASONABLE MODES OF TRANSPORTATION HAVE BEEN EXPLORED AND FOUND UNAVAILABLE.

15 SIGNATURE OF DHHR WORKER	TITLE	PARISH	DATE

TO BE COMPLETED BY TRANSPORTATION PROVIDER

16 PROVIDER NAME AND ADDRESS	17 PROVIDER NUMBER	18 TREATING PRACTITIONER'S NAME AND NUMBER
XYZ Medical Inc. 602 Yes Lane Any City, State Zip	1234567	Dr. Do Right
	19 MEDICAL RECORD NUMBER	20 PAYMENT SOURCE OTHER THAN TITLE XIX ☐ YES ☐ NO TPL CARRIER CODES 1. 2. 3.

ORIGIN AND DESTINATION CODES

(1) INPATIENT HOSPITAL
(2) INTERMEDIATE CARE FACILITY
(3) OFFICE
(4) EMERGENCY ROOM
(5) CLINIC
(6) OUTPATIENT HOSPITAL
(7) HOME
(8) OTHER

21

	A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
0	10 05 05	7	3	Z5177		18. 00	
1							
2							
3							
	REMARKS:			TOTALS		$ 18. 00	$

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

22 SIGNATURE OF PROVIDER	DATE SIGNED
J.RIDDLE	10/15/05

UNISYS 106
7/91

FISCAL AGENT COPY

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 SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 LAST NAME	2 FIRST NAME	3 MI	4 MEDICAL ASSISTANCE I.D. NUMBER

5 PATIENT'S ADDRESS	6 DATE OF BIRTH	7 SEX	8 MEDICAL APPOINTMENT TIME
		☐ M ☐ F	HOUR MO. DAY YEAR

9 ORIGIN OF SERVICE	10 DESTINATION OF SERVICE
NAME	NAME
STREET	STREET
CITY	CITY

11	12 TRANSPORTATION AUTHORIZED IS	13 EPSDT REFERRAL
	☐ ONE WAY ☐ TWO WAY	☐ YES ☐ NO

14 PRIOR AUTHORIZATION

I HEREBY CERTIFY THAT TRANSPORTATION FOR THIS RECIPIENT WAS MADE FOR A TITLE XIX COVERED SERVICE AND THAT ALL OTHER REASONABLE MODES OF TRANSPORTATION HAVE BEEN EXPLORED AND FOUND UNAVAILABLE.

15 SIGNATURE OF DHHR WORKER	TITLE	PARISH	DATE

TO BE COMPLETED BY TRANSPORTATION PROVIDER

16 PROVIDER NAME AND ADDRESS	17 PROVIDER NUMBER	18 TREATING PRACTITIONER'S NAME AND NUMBER
	19 MEDICAL RECORD NUMBER	20 PAYMENT SOURCE OTHER THAN TITLE XIX ☐ YES ☐ NO TPL CARRIER CODES 1. 2. 3.

ORIGIN AND DESTINATION CODES

(1) INPATIENT HOSPITAL
(2) INTERMEDIATE CARE FACILITY
(3) OFFICE
(4) EMERGENCY ROOM
(5) CLINIC
(6) OUTPATIENT HOSPITAL
(7) HOME
(8) OTHER

21	A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
0							
1							
2							
3							
				TOTALS		$	$

REMARKS:

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

22 SIGNATURE OF PROVIDER	DATE SIGNED

UNISYS 106
7/91

FISCAL AGENT COPY

INSTRUCTIONS ON COMPLETING UNISYS FORM 206

Non-Emergency, Non-Ambulance medical transportation claims may only be voided. **Only a paid claim can be voided.** Providers submit their voids on the 206 form, which can be obtained by contacting Unisys Provider Relations. This form must be completed EXACTLY as it was filed initially.

1. Check “Void” box.
2. Enter recipient’s last name.
3. Enter recipient’s first name.
4. Enter recipient’s middle initial.
5. Enter the 13-digit Medicaid Identification number of the recipient.
6. Enter the recipient’s address.
7. Enter the recipient’s date of birth.
8. Enter the recipient’s sex.
9. Enter the time, month, day, and year of the recipient’s medical appointment.
10. Enter the origin of service.
11. Enter the destination of service.
12. Enter transport authorization type.
13. Enter EPSDT referral.
14. Enter the name and address of the transportation provider providing the service.
15. Enter the provider’s 7-digit Medicaid number.
16. Enter the name of the medical provider.
17. Enter the recipient’s medical record number as assigned by the provider.
18. Leave blank.
19. Enter the information exactly as it appeared on the original claim form.
20. Remarks.
21. Enter the control number exactly as it appeared on the RA.

22. Enter the date of the Remittance Advice the claim paid.

23. Leave blank.

24. Check the appropriate box and write a brief narrative explaining the reason.

25. The provider or the provider's representative must sign and date the claim form.

26. Enter the date signed.

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 HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 ADJ [ ] VOID [X]

2 LAST NAME	3 FIRST NAME	4 MI	5 MEDICAL ASSISTANCE I.D. NUMBER
Faith	Maebell		1 2 3 4 5 6 7 8 9 0 1 2 3

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE)	7 DATE OF BIRTH	8 SEX	9 MEDICAL APPOINTMENT TIME
345 Now Drive	06 26 58	[ ] M [X] F	HOUR 10:00 MO. 9 DAY 30 YR. 05

10 ORIGIN OF SERVICE	11 DESTINATION OF SERVICE
Maebell Faith 345 Now Drive Any City, State Zip	Dr. Do Right 777 Do Right Lane Any City, State Zip

12 TRANSPORTATION AUTHORIZED IS [ ] ONE WAY [X] TWO WAY

13 EPSDT REFERRAL [ ] YES [ ] NO

TO BE COMPLETED BY TRANSPORTATION PROVIDER

14 PROVIDER NAME AND ADDRESS	15 PROVIDER NUMBER	16 TREATING PRACTITIONER'S NAME AND NUMBER
XYZ Medical Inc. 602 Yes Lane (NAME) Any City, State Zip (STREET / CITY / STATE / ZIP)	1234567	Dr. Do Right

17 MEDICAL RECORD NUMBER

18 PAYMENT SOURCE OTHER THAN TITLE XIX [ ] YES [ ] NO
A. CARRIER
B. POLICY NUMBER

ORIGIN OF DESTINATION
(01) INPATIENT HOSPITAL (03) OFFICE (05) CLINIC (07) HOME
(02) INTERMEDIATE CARE FACILITY (04) EMERGENCY ROOM (06) OUTPATIENT HOSPITAL (08) OTHER

19

A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
9/30/05	7	3	Z5177		18.00	
			TOTALS		$ 18.00	$

20 REMARKS:

21 CONTROL NUMBER
5234561234450

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

22 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.
10/10/05

23 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

24 REASONS FOR VOID
- [X] 10 CLAIM PAID FOR WRONG RECEIPIENT
- [ ] 11 CLAIM PAID TO WRONG PROVIDER
- [ ] 99 OTHER - PLEASE EXPLAIN

Claim filed for wrong DOS; will void payment and then rebill corrected 106 form.

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

25 SIGNATURE OF PROVIDER *Ima Biller*

26 DATE SIGNED 11/1/05

S.D.C.-206
1/93

FISCAL AGENT COPY

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 HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 ADJ ☐ VOID ☐

2 LAST NAME | 3 FIRST NAME | 4 MI | 5 MEDICAL ASSISTANCE I.D. NUMBER

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) | 7 DATE OF BIRTH | 8 SEX ☐ M ☐ F | 9 MEDICAL APPOINTMENT TIME HOUR MO. DAY YR.

10 ORIGIN OF SERVICE | 11 DESTINATION OF SERVICE

12 TRANSPORTATION AUTHORIZED IS ☐ ONE WAY ☐ TWO WAY | 13 EPSDT REFERRAL ☐ YES ☐ NO

TO BE COMPLETED BY TRANSPORTATION PROVIDER

14 PROVIDER NAME AND ADDRESS
NAME
STREET
CITY STATE ZIP

15 PROVIDER NUMBER

16 TREATING PRACTITIONER'S NAME AND NUMBER

17 MEDICAL RECORD NUMBER

18 PAYMENT SOURCE OTHER THAN TITLE XIX ☐ YES ☐ NO
A. CARRIER
B. POLICY NUMBER

ORIGIN OF DESTINATION
(01) INPATIENT HOSPITAL (02) INTERMEDIATE CARE FACILITY (03) OFFICE (04) EMERGENCY ROOM (05) CLINIC (06) OUTPATIENT HOSPITAL (07) HOME (08) OTHER

19

A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
			TOTALS		$	$

20 REMARKS:

21 CONTROL NUMBER

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

22 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.

23 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

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

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

25 SIGNATURE OF PROVIDER | 26 DATE SIGNED

S.D.C.-206
1/93
FISCAL AGENT COPY

FREQUENTLY ASKED QUESTIONS

Q: If a recipient name is 3 characters and has a title, such as Jr. or Sr., we are receiving 217 denials (name/number mismatch). How do I get these paid?

A: Enter the name on the claim exactly as it appears on the recipient's Medicaid ID card and send the claim with a cover letter of explanation to the Provider Relations Correspondence Unit (P.O. Box 91024, Baton Rouge, LA 70821). Be sure to indicate in the cover letter why the claim denied. Unisys will special handle the claim so payment can be considered.

Q: Can we bill for services when the recipient doesn't sign the MT-3 form?

A: You may bill for services rendered if the recipient doesn't sign the MT-3 form. You must indicate the reason why the recipient did not sign the MT-3 form in the remarks section of the claim form.

Q: Can one parent be designated to ride as attendant for several children if other parents sign a permission slip?

A: No. Even if permission were granted, the attendant would be totally liable for each child. The Attendant/Children Policy is explained on page 3 of this document and is for the protection of the recipients and providers.