

Louisiana Part C Early Steps Provider Billing Manual



Effective 10/16/2003

Table of Contents

SECTION 1: INTRODUCTION.....	3
DHH.....	3
COVANSYS.....	3
CENTRAL FINANCE OFFICE.....	4
WEB ACCESS ENROLLMENT.....	4
SECTION 2: SERVICE AUTHORIZATION.....	5
BLANK FORMS	7
<i>Authorization Service – Blank.....</i>	<i>7</i>
<i>Transportation Authorization – Blank</i>	<i>8</i>
<i>Assistive Technology – Blank.....</i>	<i>9</i>
COMPLETED AUTHORIZATION SAMPLES.....	10
<i>Authorization Service – Service Coordination.....</i>	<i>10</i>
<i>Authorization Service – Service</i>	<i>11</i>
<i>Authorization Service – Transportation.....</i>	<i>12</i>
<i>Authorization Service – Assistive Technology.....</i>	<i>13</i>
<i>Discontinuation Notice.....</i>	<i>14</i>
<i>Cancellation Notice.....</i>	<i>15</i>
SECTION 3: BILLING INSTRUCTIONS	16
BILLING OPTIONS	17
<i>Option 1: Service Authorization/Billing Form.....</i>	<i>17</i>
Sample Bill #1: Service Coordination.....	19
Sample Bill #2: Service.....	20
<i>Option 2: HCFA 1500.....</i>	<i>21</i>
Sample HCFA Form	23
<i>Option 3. Electronic Billing & Claims Certification Statement.....</i>	<i>24</i>
EXPLANATION OF PROVIDER PAYMENT	29
RESUBMISSION OF REJECTED/DENIED CLAIMS.....	29
CLAIMS CORRECTIONS.....	29
EXPLANATION OF PROVIDER PAYMENT (EOP) EXAMPLE	31
SECTION 4: CALCULATION OF ENCUMBERED UNITS.....	32

CENTRAL FINANCE OFFICE – PROVIDER BILLING MANUAL

Section 1: Introduction

DHH

The Department of Health and Hospitals (DHH) is the Louisiana lead agency responsible for ensuring the provision of Early Steps services (Louisiana Early Steps) to eligible infants and toddlers with disabilities, birth to 36 months, and their families consistent with the requirements of Part C of the Individuals with Disabilities Education Act (IDEA). The Central Finance Office (CFO) is the financial system for payment of all Early Steps services. The CFO is connected through a child data system to a network of System Points of Entry (SPOE) throughout the state. The SPOE is responsible for entering child data during the referral, eligibility, and Individual Family Service Plan (IFSP) process. This data will generate service authorizations from the CFO.

Covansys

In 2003, Louisiana formed a working partnership with Covansys to implement an automated software system to capture the data for Part C of IDEA. The SPOE software application enables the system to capture information related to program eligibility determination, IFSP services, and provider authorizations for children served in Part C Early Steps. The CFO facilitates functions that determine appropriate reimbursement for providers.

Enrollment in the Central Finance Office

As a provider, you will need to first be enrolled with the Central Finance Office (CFO) by completing the enrollment process. After all enrollment forms are completed please mail them to Covansys' Provider Enrollment (PE) unit. Covansys can be contacted 866-305-4985 ext. 2 or by e-mail at laeiEnroll@pdainc.com.

Providers also need to complete a couple additional forms if they elect to communicate electronically with the CFO. These include the **Certification Statement for Providers Submitting Claims by Means Other Than Standard Paper** and the Trading Partner Profile. The TPA document outlines the provider elections on how they will communicate information with the CFO. With HIPAA legislation enacted, there are standardized file formats that must be followed when sending or receiving Protected Health Information electronically. This agreement is also available on the web site www.eikids.com/la/matrix/help/index.asp

******IMPORTANT NOTE******

Providers must be enrolled prior to being authorized to deliver services.

Central Finance Office

The Central Finance Office (CFO) design includes paying all providers from an interim-funding source based on the resulting submission of claims. The CFO then seeks reimbursement from an appropriate payment source such as state general revenue funds, Medicaid, Part C federal funds, Title V, etc.

The Central Finance Office at Covansys can be contacted 866-305-4985 Monday through Friday 8:00 a.m. to 5:00 p.m.

Claim submissions should be mailed to:

CENTRAL FINANCE OFFICE
C/O Covansys
PO Box 29134
Shawnee Mission, KS 66201-9134

Web Access Enrollment

The <http://la.eikids.com/> web page allows access to the forms the CFO/ PE office utilizes. The forms are in a pdf format for providers to download and print. It provides additional links to policy information and the email addresses to contact the CFO/Provider Enrollment Office. Once Provider Enrollment has received all of the requested, completed forms on the checklist from the provider, the enrollment process begins.

Web Access for Provider Enrollment

Provider enrollment information and forms are available on the web. Select the link for Provider Enrollment as shown below.

The web page above provides links to all of the documents and forms needed to enroll as a provider or to update provider information as an Early Steps provider.

Section 2: Service Authorization

Service Authorizations are initiated through the System Point of Entry (SPOE) based on receipt of a source documents. The system relies on prompt receipt of source documents from intake or family service coordinators. These sources include:

An Individualized Family Service Plan or IFSP
Authorization for Services (Not IFSP)
IFSP Review

Upon receipt of a source document the SPOE promptly enters the information into the electronic system, which captures sufficient information to generate authorizations for Early Steps services. Daily, or when information warrants, the SPOE connects electronically to the CFO and transfers this information triggering the CFO to print and mail an authorization to the enrolled service provider.

Once received by the CFO, service authorizations are printed and mailed daily and should be received by the service provider within 5 to 7 days. Authorizations are mailed to the site address identified on the Provider Enrollment Inquiry Form submitted as part of provider enrollment. Authorizations printed on any given day may be batched together and mailed to each site. Problems with missing authorizations could occur for any of the following reasons:

Provider not updating CFO of address changes
Internal mail routing problems within a provider organization
Problems or delays in SPOE transmissions of authorization data to the CFO

If you have not received expected authorizations, please check your organization's internal mail routing first, then please contact the SPOE to begin the verification process.

For Electronic Authorizations please check the File Distribution System (FDS) website before calling the CFO. The FDS is the website where HIPAA-compliant files are posted for the CFO. It can be accessed from the Service Matrix page after a successful login.

Authorizations are a reflection of the services identified on an Individualized Family Service Plan (IFSP). Authorizations will follow and should match the services specified on the IFSP including the dates of service, frequency, intensity, location and duration. Authorization start dates will be consistent with the start date identified on the IFSP even if mailed/or processed after service has started.

Authorizations that are inconsistent with the IFSP should be discussed with the Family Service Coordinator immediately. The child's Family Service Coordinator is identified on the IFSP and the authorization. Practitioners should pay close attention to the end dates of the IFSP and authorization and should not extend services beyond the end dates if no new IFSP or authorization has been received. Services, other than assessment/evaluation/IFSP development, not covered by an IFSP are not considered reimbursable services.

Providers should refer to the Early Steps Service Definitions for specific descriptions of requirements and of billable activities by individual Early Steps service. Services billed by time must be billed for the period of time that actual services were provided to the eligible child and/or family, and should not include time spent in travel to or from the setting. DHH has established a rate reimbursement policy that reflects a higher maximum rate of reimbursement for services provided in the child's natural setting.

Also, note that confirming copies of cancellation and discontinuation notices that are sent to providers should be kept for reference. Many providers use the authorization forms for billing. Please keep the original authorization and use copies of it for billings. Always verify that the authorization used for billing has not been cancelled or discontinued.

Sample Authorization Forms are included on the pages that follow and include:

Blank Samples


1) Service.....	Page 8
2) Transportation.....	Page 9
3) Assistive Technology.....	Page 10

Completed Samples

4) Service Coordination.....	Page 11
5) Service.....	Page 12
6) Transportation.....	Page 13
7) Assistive Technology.....	Page 14
8) Discontinuation Notice.....	Page 15
9) Cancellation Notice.....	Page 16

Blank Forms

Authorization Service – Blank

Central Finance Office		Service Authorization/Billing	
Client ID No.	Client's Name	Birthdate	Issue Date
Telephone No.	Head of Household	Authorization Service Dates to	
Include Address Here		Service Coordinator	
		Inquiries regarding service call: (888) 305-4985	
		Payment will be made to:	
Authorization Section: Subject to conditions on the IFSP, you are authorized to provide and bill for the services described below.			
EI Procedure	Description	Frequency	CPT Description
Billing Section: Please use this section of the form to bill for the services provided. Bills must be received within 60 days of service			
Authorization No.			
Date of Service			
Place Of Service Code			
CPT/HCPCS Code			
Line Charges			
Intensity In Minutes			
Place of Service Codes (Use in Column 2)			
Payee Tax ID No.			
Patient Account No.			
Total Charges			
Submit bills to: Central Finance Office c/o Covansys P.O. Box 29134 Shawnee Mission, KS 66201-9134			
Is this a resubmission of a claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I certify that the above billed services were provided in accordance with the child's Individualized Family Service Plan.			
_____ Provider's Signature			_____ Date

Assistive Technology – Blank

Central Finance Office



Assistive Technology
Authorization/Billing

Client ID No.	Client's Name	Birthdate	Issue Date
Telephone No.	Head of Household	Authorization Service Dates to	

Include Address Here

Service Coordinator
For inquiries regarding service call: (866) 305-4985
Payment will be made to:

Authorization No.							
Authorization Section					Billing Section		
HCPCS Code	Type	Description	QTY	Unit Price	Date	QTY	Billed Amount
Payee Tax ID No.		Patient Account No.				Total Charges	

Submit bills

Central Finance Office
c/o Covansys
P.O. Box 29134
Shawnee Mission, KS

Is this a resubmission of a claim? Yes No

I certify the above billed services were provided in accordance with the child's Individualized Family Service Plan.

Provider's Signature

Date

Authorization Service – Service

Central Finance Office



Service Authorization/Billing

Client ID No.	Client's Name	Birthdate	Issue Date
0000-00000	Squirrel J Rocket	03/01/2002	09/18/2003
Telephone No.	Head of Household	Authorization Service Dates	
123-867-5309	Bull Winkle	11/01/2003 to 11/01/2004	

GENERAL HOSPITAL
SARAH SIMPSON
1234 ANYWHERE ST
NEW IBERIA, LA 70560

Service Coordinator

Dawnetta Simpson
123-456-7890

Inquiries regarding service call:

(866) 305-4985

Payment will be made to:

General Hospital
98-7654321

Authorization Section: Subject to conditions on the IFSP, you are authorized to provide and bill for the services described below.

EI Procedure	Description	Frequency	CPT	Description
8013	Speech Language Pathology-Direct Child Service (Home/none)	75 minutes 1/Week	92507	SPEECH/HEARING THERAPY

Authorization No.
A000000000-00

Date of Service	CPT/HCPCS Code	Line Charges	Intensity In Minutes
Payee Tax ID No.	Patient Account No.	Total Charges	
98-7654321			

Submit bills to:
Central Finance Office
c/o Covansys
P.O. Box 29134
Shawnee Mission, KS 66201-9134

Is this a resubmission of a claim? Yes No

I certify that the above billed services were provided in accordance with the child's Individualized Family Service Plan.

Provider's Signature

Date

Authorization Service – Assistive Technology

Central Finance Office



Assistive Technology
Authorization/Billing

Client ID No.	Client's Name	Birthdate	Issue Date
9100-00001	Joe Griffin	01/01/2003	09/09/2003
Telephone No.	Head of Household	Authorization Service Dates	
123-456-7890	Peter Griffin	06/01/2003 to 01/15/2004	

GENERAL HOSPITAL
Nice Provider
1234 ANYWHERE
NEW IBERIA, LA 70560

Service Coordinator
Tom Tucker 123-867-5309
For inquiries regarding service call:
(866) 305-4985
Payment will be made to:
General Hospital 98-7654321

Authorization No.
A910000000-1

Authorization Section						Billing Section	
HCPCS Code	Type	Description	QTY	Unit Price	Date	QTY	Billed Amount
L6650	Repair	Shoulder universal joint	2	49.99			
Payee Tax ID No. Patient Account No.						Total Charges	
98-7654321							

Submit bills

Central Finance Office
c/o Covansys
P.O. Box 29134
Shawnee Mission, KS

Is this a resubmission of a claim? Yes No

I certify the above billed services were provided in accordance with the child's Individualized Family Service Plan.

Provider's Signature

Date

Cancellation Notice

Central Finance Office
c/o Covansys
P.O. Box 29134
Shawnee Mission, KS 66201-9134



Notice Of Cancellation

Client ID No.	Client's Name	Birthdate	Issue Date
0000-00000	Squirrel Rocket	03/01/2002	09/18/2003
Telephone No.	Head of Household	Authorization	Service Dates
123-867-5309	Bull Winkle	11/01/2003	to 11/01/2004

GENERAL HOSPITAL
SARAH SIMPSON
1234 ANYWHERE ST
NEW IBERIA, LA 70560

For inquiries regarding
service call:

(866) 305-4985

EI Procedure	Description	Frequency
8013	Speech Language Pathology-Direct Child Service (Home/none)	60 minutes 2/Month
Authorization No.	A000000000-00	

This authorization has been canceled. You are not authorized to provide any services related to this authorization. Any claims submitted under this authorization will be denied payment. If this action was to correct or update the original authorization, a replacement authorization may be in process. Please contact the service coordinator or the local First Steps System Point of Entry for additional information.

Section 3: Billing Instructions

The Central Finance Office (CFO) will pay all Early Steps services authorized through the System Point of Entry (SPOE). The CFO will pay the claim, determine the appropriate funding source, and in turn seek reimbursement. The Central Finance Office (CFO) is the only Provider "payer" for any evaluation and service authorization generated for the Early Steps Part C Program. **Providers are not to bill Medicaid, private insurance, DHH, families or any other source for Early Steps services authorized through the SPOE/CFO.**

CFO Standard Timelines/Deadlines

Claims Processing Turnaround:

Claims processing and reimbursement timelines are available on the <http://la.eikids.com/> web site. Please consult this internet location for claims processing timelines.

Stale Checks:

Checks are void if not cashed within 6 months.

Claim Filing Deadline:

Claims must be submitted within 60 calendar days of the date of service.

Claim Resubmission Filing Deadline:

Previously submitted and rejected claims must be resubmitted within 180 days of the date of service.

Claim Resubmission (Incorrect Authorization) Filing Deadline:

Previously submitted and rejected claims can be resubmitted only after a corrected authorization is issued and must be resubmitted within 60 calendar days of the issue date of the corrected authorization.

Claim Overpayment Automated Refund Deadline:

In cases of overpayment, **providers will not refund payments manually through submission of checks.** The adjustments will be entered on the system against individual claims and the system will deduct the amount of overpayment on subsequent claim(s) payments processed. In cases of underpayments, adjustments will be entered on the system against individual claims and the system will augment the amount of the underpayment on the next claim payments processed.

Claim Overpayment Manual Refund Deadline:

Only when automated claims adjustment/offset is not a viable alternative the provider will be mailed two written notices (at 30 and 90 days from original overpayment date) to refund an overpayment discovered by CFO. All manual refunds must be made to CFO no later than 180 days from original overpayment date.

Automated Payment Adjustments/Offsets

The CFO has a system of automated claims adjustments/offsets to address providers for overpayments and /or underpayments caused by various procedures. When errors are discovered, adjustments will be entered on the system after receipt of proper documentation from providers.

Billing Options

Providers may bill using the Authorization form as the billing form. Electronic claims will be phased in and supported utilizing the required HIPAA 837P format.

Bills must be received within 60 calendar days of service delivery. Timely billing to the Central Finance Office is essential to your reimbursement.

Providers may choose from 3 billing options:

- a) using the bottom of the authorization form as the billing form
- b) the HCFA 1500 – paper form
- c) HIPAA 837P, X12 format

Bills must be received within 60 days of service delivery. Your timely billing to the Central Finance Office is essential to your reimbursement.

Option 1: Service Authorization/Billing Form

Choosing this billing option provides a reliable billing choice since most of the most critical information to process a claim is preprinted on the form. This will prove to be a highly effective billing choice that results in minimal rejections. Completed samples are provided in this document.

Date of service should be in the mm/dd/yy format (07/01/03) and must be after July 1, 2003. The CFO cannot pay claims for services that occurred prior to July 1, 2003. For service coordination only, the date on the claim form should be the last day of the month or the last day of the authorization - whichever occurs first.

The procedure code is either the code listed in the authorization section or a HCPCS code used in the Medicaid billing system for assistive technology claims. The HCPCS codes may be downloaded from the <http://la.eikids.com> web site under the "Help" tab.

If the same service is provided on the same day for the same child, the "76" modifier must be reported on all subsequent claim lines. The total number of units authorized cannot be exceeded in any combination of services performed. For Example: If a child is seen once in the morning and once in the afternoon for the same procedure, the first entry should report the CPT/HCPCS code, the second claim line would report the CPT/HCPCS code + "76".

Charges must reflect the total charges for that service encounter. For example, if your charges for speech therapy services in a special purpose center are \$16.00 per 15-minute increment, please put \$64 for charges for 60 minutes. Services must be in accordance with the provider's usual and customary charges. Payments will reflect the lesser of the provider's usual and customary charge or the Early Steps maximum rate.

Bill the actual time delivered in minutes. The system will round down to the nearest 15-minute increment.

The intensity should be referenced in minutes not in units. This column will be blank for service coordination.

The Patient account number is an optional field and is used at the provider's discretion. If included, this information will be returned on the Explanation of Provider Payment for ease in linking back to your accounts receivable system or practice management system.

Total charges should reflect the sum of line items on the claim. If the two do not match, the individual line items will take precedence.

A provider's original signature must be included.

The date must be after the latest date entered in the billing section of the claim.

Mail completed claims to:

CENTRAL FINANCE OFFICE
C/O Covansys
PO Box 29134
Shawnee Mission, KS 66201-9134
866-305-4985

Option 2: HCFA 1500

<u>Field.Number</u>	<u>Narrative Description</u>
---------------------	------------------------------

1a Insured's I.D. Number: This field should include the client ID # from the authorization received. While not a required field this information may be helpful particularly if other items do not match.

2 Patient's Name: Please use the child's name from the authorization document.

3 Patient's Birth Date/Sex: Enter the patient's birth date in a MM/DD/YY format, and enter an "X" or check mark in the appropriate sex block

Items 4 through 16 are either Not Applicable for Early Steps or Not Required.

19 Please add the therapist's name.

23 Prior Authorization Number - THIS FIELD MUST BE USED FOR THE CFO AUTHORIZATION NUMBER. This must be included.

24a The field Date(s) of Service should be in the mm/dd/yy format (07/02/01). **For service coordination only, the date on the claim form should be the last day of the month or the last day of the authorization whichever occurs first**

24b Place of service code must be listed. Acceptable codes are listed on the authorization forms. For service coordination use code "8" unless otherwise known.

24c Type of service: Not applicable

24d CPT/HCPCS Code is either the CPT code listed in the authorization **section** or a HCPCS code used in the Medicaid billing system. The Primary CPT code applicable to the EI Code the first CPT listed on the authorization form for easy identification. If multiple codes are related to the EI Code listed on the Authorization, a provider can select the code that describes the service performed. The total number of unit authorized cannot be exceeded in any combination of services performed.

24e Optional for EI

24f Charges must reflect the total charges for that service encounter. For example, if your charges for speech therapy services, on-site are \$16.00 per 15 minute increment please put \$64 for charges for 60 minutes. Services must be in accordance with the provider's usual and customary charges. Payments will reflect the lesser of the provider's usual and customary charge or the Early Steps maximum rate.

Bill the actual time delivered in minutes; the system will round down to the nearest 15-minute increment.

24g Days or Units must be referenced in minutes not in units. This column will be blank for service coordination. This is the most common problem on HCFA 1500 claim submissions and is the primary cause for payment delays or rejections.

- 25 Federal Tax I.D. Number - Is a required field and reflects the taxpayer ID of the payee.
- 26 Patient Account Number is an optional field and is used at the provider's discretion.
- 28 Total Charges: should reflect the sum of line items on the claim. If the two do not match the individual line items will take precedence.
- 29 Amount Paid: Less insurance or other applicable credits should be used when applicable.
- 30 Balance Due: Charges should be the result of subtracting "less amount paid" from "total charges". Required
- 31 A provider's signature must be included.
- DATE: Enter the date the claim was filed. Required. The date must be after the latest date entered in the billing section of the claim.
- 32 Name and Address of Facility where Services were rendered: While this field is optional, the information may be important for follow-up activity.
- 33 Physician's Supplier's Billing Name, Address, Zip Code & Phone: Enter the provider's Medicaid Number. Required.

Mail completed claims to:

Central Finance Office
c/o Covansys
PO Box 29134
Shawnee Mission, KS 66201-9134

HCFA 1500 is on the next page (page 24).

Sample HCFA Form

PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)	
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		11. INSURED'S POLICY GROUP OR FECA NUMBER	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17a. I.D. NUMBER OF REFERRING PHYSICIAN		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
19. RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER	
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE		F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PATIENT'S ACCOUNT NO.		28. TOTAL CHARGE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		29. AMOUNT PAID \$	
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		30. BALANCE DUE \$	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		PIN# _____ GRP# _____	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PHYSICIAN OR SUPPLIER INFORMATION

Option 3. Electronic Billing & Claims Certification Statement

The *Certification Statement for Providers Submitting Claims By Means Other Than Standard Paper* is to be used by providers/payee organizations with large batches of claims. It documents that the provider/payee organization certifies the accuracy of claims information submitted in batches whether paper or electronic.

If this signed and completed form is placed on file with the Central Finance Office, the provider or authorized official within a payee organization no longer has to sign each individual paper claim (See Billing Instructions Item 10).

Note: All providers/payee organizations intending to bill electronically are required to submit a signed, completed *Certification Statement for Providers Submitting Claims By Means Other Than Standard Paper*.

Instructions:

1. Fill in the provider/payee organization name.
2. Fill in the name of the provider or the official within the organization who has the authority to sign on behalf of the individual practitioner.
3. Fill in the title of the above individual.
4. Sign and date the signature.
5. Complete the Tax ID number of the provider/payee organization.
6. Place an "X" in the appropriate box to indicate if the certification form is being filed to cover batch submissions of paper and/or electronic claims.
7. If being filed to submit electronic claims please fill in the name and phone number of the contact person responsible for the submission of electronic claims.

Submit this signed and completed certification form to:

Central Finance Office
c/o Covansys
PO Box 29134
Shawnee Mission, KS 66201-9134
866-305-4985

Details regarding submitting claims electronically are found in the Companion Guide that is located on the www.eikids.com/la/matrix/help/index.asp. To activate the electronic billing option please read the Companion Guide, complete and mail the Trading Partner Agreement and the certification statement. After receipt of this information, contact the CFO about testing transmissions. Claim Rejection/Denial Reasons.

CERTIFICATION STATEMENT FOR PROVIDERS SUBMITTING CLAIMS BY MEANS OTHER THAN STANDARD PAPER

This is to certify that any and all information contained on any Early Steps billings submitted on my behalf by electronic, telephonic, and/or mechanical means of submission, shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information contained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (I. e. either by myself, my staff, and/or a third party acting in my behalf, such as a service bureau). I fully recognize that any billing intermediary or service bureau that submits billings to the Louisiana Department of Health and Hospitals (DHH) - Office of Public Health (OPH) or its Fiscal Agent Contractor is acting as my representative and not that of DHH/OPH or its Fiscal Agent Contractor. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for purposes of submission of Early Steps Central Finance Office claims.

I understand that payment and satisfaction of any claims that shall be submitted on my behalf will be from Federal and State funds, and that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable Federal and/or State law. The provider will hold harmless and indemnify DHH/OPH from any and all claims, actions, damages, liabilities, costs and expenses, including reasonable attorneys' fees and expenses, which arise out of or are alleged to have arisen out of or as a consequence of the submission of Early Steps Central Finance Office billings by the provider through electronic, telephonic, and/or mechanical means of submission unless the same shall have been caused by negligent acts or omissions of DHH/OPH.

I further acknowledge that submitting claims by means other than standard paper does not alter my continuing obligation to comply with all applicable requirements of the Central Finance Office Service Provider Agreement and Riders which I have signed including but not limited to those requirements pertaining to payments, billing timelines, records and records retention.

I understand that DHH/OPH or its designees are prepared to provide necessary technical assistance to assist new providers, or to correct technical problems which existing providers may experience. I realize that all communications regarding electronic, telephonic, or mechanical submission of claim shall be between the provider in whose name the claim is submitted and DHH/OPH or its Fiscal Agent Contractor. I further understand that this technical assistance shall consist of:

- Identification of data element requirements
- Identification of record layouts and other electronic specifications
- Identification of systematic problem areas and recommended solutions

I agree to notify either DHH/OPH or its Fiscal Agent Contractor of any changes in my provider name or address. Further, I agree to comply with such minimum substantive and procedural requirements for claims submission as may be required by DHH/OPH or its Fiscal Agent Contractor.

I certify that I am in compliance with the Central Finance Office Service Provider Agreement and Riders.

Fraud and abuse encompasses a wide range of improper billing practices that include misrepresenting or overcharging with respect to services delivered. Fraud generally involves a willful act; abuse involves actions that are inconsistent with acceptable fiscal, business or medical practices.

Frequently cited fraudulent or abusive practices include, but are not limited to, overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

Procedures and mechanisms employed in the claims and payment surveillance and audit program include, but are not limited to, the following:

- Review of recipient profiles of use of services and payment made for such
- Review of provider claims, Early Steps Program documentation or data and payment history for patterns indicating need for closer scrutiny
- Computer-generated listing of duplication of payments
- Computer-generated listing of conflicting dates of services
- Computer-generated over-utilization listingInternal and/or external checks on such items as procedures, quantity, duration, provider eligibility, recipient eligibility, etc.Staff review and application of established medical services parametersField-auditing activities conducted by the DHH/OPH or its representatives, which may include provider and recipient contacts or request for information.

In cases referred to law enforcement officials for prosecution, the DHH/OPH has the obligation, where applicable, to seek restitution and recovery of monies wrongfully paid even though prosecution may be declined by the enforcement officials.

Further I understand that violation of any of the provisions of this Certification Statement shall subject me to the actions set out in the DHH/OPH Policy on Central Finance Office Provider Dis-enrollment and shall make the billing privilege established by this document subject to immediate revocation at DHH/OPH's option.

THE UNDERSIGNED HAVING READ THIS CERTIFICATION STATEMENT AND UNDERSTANDING IT IN ITS ENTIRETY DOES HEREBY AGREE TO ALL OF THE STIPULATIONS, CONDITIONS AND TERMS STATED HEREIN.

Provider/Payee Organization Name

Provider/Authorized Official

Title

Provider/Authorized Official Signature Date

Provider/Payee Organization Tax ID

Place an "X" in the appropriate box below:

- This certification is being filed to cover the submission of unsigned batches of paper claims.
- This certification is being filed to cover the submission of electronic claims.

Name: Electronic claims contact: _____ Phone No: _____

Trading Partner Agreement General Information

The *Covansys* Trading Partner Agreement (TPA) establishes a formal relationship that allows *Covansys* and its trading partners to exchange electronic transactions. The TPA outlines the roles and responsibilities that bind both *Covansys* and its trading partner, to ensure secure electronic transmissions.

Any Early Steps provider that is a direct sender of batch electronic transmissions to *Covansys* must complete the *Covansys* Trading Partner Agreement. Trading partners must also complete the Certification Statement for Providers Submitting Claims by Means Other than Standard Paper form as part of this agreement. Copies of the Certification Statement for Providers Submitting Claims by Means Other than Standard Paper forms and instructions for their completion are found in the Louisiana Early Steps Provider Billing Manual.

A TPA is not required by HIPAA, but the ASC Insurance Subcommittee that was charged with developing the Implementation Guides for EDI transactions strongly recommends that trading partners have binding agreements to provide security and assurance in the transfer of electronic information (See Section 1.1.1 of any ASC X12 Implementation Guide). *Covansys* has made a business decision to make trading partner agreements a requirement for EDI transmission based on this recommendation.

After *Covansys* receives an original copy of the TPA, contact will be made with information about testing transmissions.

Covansys requires the execution of its own TPA with all entities that are sending us direct transmissions. The *Covansys* Trading Partner Agreement is comprehensive and should address any issues or legal concerns of our trading partners.

Covansys will accept up to 5000 claims per 837P batch file. The Implementation Guide recommends the creation of this limitation to avert circumstances where file size management may become an issue.

Covansys has determined the Electronic Transmitter Identification Number (ETIN), as used in the Implementation Guide, to be the Early Steps Provider number that was established at the time of credentialing.

EI Providers may send to *Covansys* the following files/transactions:

Transaction Set Number	Document Name/Description	Version Release
837	Health Care Claim: Professional	4010A1
276	Health Care Claim Status Request	4010A1

Covansys is prepared to send the following files/transactions to EI Providers:

Transaction Set Number	Document Name/Description	Version Release
835	Health Care Claim Payment/Advice	4010A1

277	Health Care Claim Status Response	4010A1
278	Health Care Services Review Response	4010A1

The following files/transactions will not be used at this time:

837	Health Care Claim: Institutional
837	Health Care Claim: Dental
834	Benefit Enrollment and Maintenance
820	Premium Payment for Insurance Products
278	Health Care Services Review Request
270	Health Care Eligibility Inquiry
271	Health Care Eligibility Response

Providers will see the following table in the Trading Partner Agreement. This allows an EI Provider to chose the transaction they will send electronically.

Transaction Set Number	Document Name/Description	Version Release	Method (Paper/electronic)
837	Health Care Claim: Professional	4010A1	
276	Health Care Claim Status Request	4010A1	

Providers will see the following table in the Trading Partner Agreement. This allows an EI Provider to chose the transaction they will receive electronically.

Transaction Set Number	Document Name/Description	Version Release	Method (Paper/electronic)
835	Health Care Claim Payment/Advice	4010A1	
277	Health Care Claim Status Response	4010A1	
278	Health Care Services Review Response	4010A1	

Explanation of Provider Payment

The CFO generates an Explanation of Payment (EOP) detailing the information on the claims submitted and processed. The EOP includes the claim number assigned to a particular claim processed as well as amounts paid or not covered. When claims are rejected in part or in full the EOP will include a rejection code for the provider information in taking corrective action. Please see an example of an EOP on the last page of this section.

The HIPAA standard 835, remittance advice, is also available for the providers who elect to communicate electronically.

Resubmission of Rejected/Denied Claims

Resubmission of a previously denied claim must be marked as a '**Resubmission**'. If the claim was denied and a correction is required on the authorization please contact the Family Service Coordinator. Corrections to authorizations require verification with the Individualized Family Service Plan. Required billing corrections may be done by the provider and marked as such on the resubmitted form.

Claims Corrections

Corrections to previously submitted and paid claims should be marked as '**Correction**' when submitted to the Central Finance Office.

Billing Examples

Example # 1- Not enough service billed:

Provider bills and receives payment for services that represent 60 minutes when **actual services for that day were 90 minutes**. Provider submits an additional claim, marked as "correction" on the face of the claim form, for the incremental 30 minutes of service. In addition, please place an X in the "yes" block indicating this is a resubmission of a claim, and make a note on the face of the claim form indicating this is for additional minutes.

Example # 2- Too much service billed:

Provider bills and receives payment for services that represent 60 minutes when **actual services for that day were 30 minutes**. Provider submits an additional claim, marked as "correction" on the face of the claim form for the reduction of 30 minutes of service. The reduction should be noted with a minus sign or in brackets for both the time and the charges. In addition, please place an X in the yes block indicating this is a resubmission of a claim. Make a note on the face of the claim form indicating the minutes billed and this needs to be set up as an overpayment.

Automated Payment Adjustments/Offsets:

CFO has implemented a system of automated claims adjustments/offsets to address provider overpayments/underpayments caused by various improper/erroneous billing procedures. When errors

are discovered, adjustments will be entered on the system after receipt of proper documentation from providers.

In cases of overpayment **providers will not refund payments manually through submission of checks.** The adjustments will be entered on the system against individual claims and the system will deduct the amount of overpayment on subsequent claim(s) payments processed. In cases of underpayments adjustments will be entered on the system against individual claims and the system will augment the amount of the underpayment on the next claim payments processed.

Manual Overpayment Refund:

Only when automated claims adjustment/offset is not a viable alternative the provider will be mailed two written notices (at 30 and 90 days from original overpayment date) to refund an overpayment discovered by CFO. All manual refunds must be made to CFO no later than 180 days from original overpayment date.

When submitting manual claims corrections for overpayment please make the refund check out to:

Central Finance Office
c/o Covansys

and mail to:

Central Finance Office
c/o Covansys
PO Box 29134
Shawnee Mission, KS 66201-9134

Explanation of Provider Payment (EOP) Example

Central Finance Office
 c/o Covansys
 P.O. Box 29134
 Shawnee Mission, KS 66201-9134



Explanation of Provider Payment

Payee: A Nice Agency
 P.O. Box 1
 COLFAX, LA 71417

Date: 10/24/03
 Check #: 1234
 Statement Date: 10/24/03
 Amount: \$264.00

Provider ID: 12 3456789 0000
 Provider Name: A Provider
 Program: Early Steps

Service Category	Service Dates	Amount Billed	Amount Denied	See Note	Amount Disallowed	Paid Previously	Amount Paid
Patient: Patient One		SSN:		Claim: 00000-00-0			
Account:		Parent/Guardian: Mom One		ID: 1000-00001			
Service Coordination	7/1/03	66.00	0.00		0.00	0.00	66.00
Service Coordination	8/1/03	66.00	0.00		0.00	0.00	66.00
Service Coordination	9/1/03	66.00	0.00		0.00	0.00	66.00
Sub-Totals		\$198.00	\$0.00		\$0.00	\$0.00	
Paid to Provider:							\$198.00
Patient: Patient Two		SSN: 111-11-1111		Claim: 00000-00-1			
Account:		Parent/Guardian: Mom Two		ID: 1000-00002			
Service Coordination	9/15/03	66.00	0.00		0.00	0.00	66.00
Sub-Totals		\$66.00	\$0.00		\$0.00	\$0.00	
Paid to Provider:							\$66.00
Provider Totals		\$264.00	\$0.00		\$0.00	\$0.00	
Total Paid to Provider							\$264.00

Grand Totals:	
Previous Balance:	\$0.00
Provider Claims:	\$264.00
Payee Transactions:	\$0.00
Check Amount:	\$264.00
Check #:	1234

Section 4: Calculation of Encumbered Units

This document is provided to assist providers with the management of services delivered and billed.

It is the responsibility of providers to monitor the utilization of services they have been authorized to deliver and it is essential that they receive information on the process by which the total units on an authorization are calculated.

The majority of authorization types are addressed by the information below. However, in the case of Assistive Technology, authorizations are based on fixed dollar amounts for specific items.

Background

The CFO Claims system determines the maximum usage of many types of authorization based on a calculated number of units authorized. For example, an authorization for a service to be rendered 3 times for 1 hour each time would have a total "units authorized" of 12 units (4 15-minute units x 3 visits).

Once all units authorized have been paid, claims are denied with reason code 12, "authorized limit exceeded." The total number of units authorized and the number of units paid to date is available to providers who call the CFO in order to determine how many more units are available for payment for a particular authorization.

The SPOE software has enormous flexibility in the specification of an authorization's number of units. An authorization can be written for x units, y times per z time period, from a start date to an end date. This flexibility adds a great deal of complexity when calculating the maximum number of units intended to be authorized.

Most of the calculation is fairly simple. Some differences in total units authorized result from a variance of plus or minus a week or month and is relatively minor. In some cases, the difference can be quite large, particularly when the authorization is written on a per-month, per-quarter or per-year basis.

Examples:

4 units, 8 times per month from 3/10/01 to 5/25/01 totals

- 96 units, if the date range is rounded to 3 months
- 64 units, if the date range is rounded to 2 months
- 48 units, if the date range is prorated to 1.5 months

2 units, 52 times per year from 2/1/00 to 1/12/01 totals

- 104 units, if rounded to 1 year
- 208 units, if rounded to 2 years
- 99 units, if prorated to 0.95 years

Solution

An algorithm for converting a specified date range into a number of weeks, months or years was implemented. An effort was made to keep the algorithm as simple as possible, because the number of units authorized must be calculated each time a claim is edited to determine whether it can be paid.

In order to address the above requirements and considerations the following algorithm has been implemented in the claims system:

Two intermediate values are coded.

U = the number of units authorized per single time period. In example A, above, U = 32 (4 units x 8 times per single month). In example b, U = 104 (2 units x 52 times per single year). In finding U, the start and end dates of the authorization and the exact time period specified are ignored. For any authorization, U is an integer that is easily determined.

T = the number of time periods falling between the authorization start date and end date. It is not rounded, and it is determined as follows:

If start date = end date or the time period is "per auth," then T = 1.

Else T = the number of days between start date and end date, inclusive, divided by 1, 7, 30, 90, or 365, for authorizations per day, per week, per month, per quarter and per year, respectively.

Total Units Authorized = U x T. The number of units per time period multiplied by the number of periods between the start date and end date gives the final answer. When any remainder exists, the number of units is always rounded up to the next whole number. For instance, 14.01 units should be paid up to 15 units.

This algorithm effectively prorates the units authorized according to the number of days in the authorization's date range, giving the third answer in the previous examples.

In Summary:

The last section above describes the calculation, which simply put is this:

$U \times T$

where U = the number of units per time period (per auth, per week, per year,...) and T = the number of time periods during the auth, based on the number of days from start date to end date, divided by 7, 30, 90, or 365 to determine weeks, months, quarters, or years, as appropriate.

If the result of U x T is not an integer (0 to the right of the decimal), the value is always bumped up to the next whole unit.

The following are examples:

A. 45 minutes 2 times **per week**, from April 1 to May 31

U = 6 (3 units x 2 times per)

T = 8.7142857... (61 days / 7 days per week)

U x T = 52.2857 ...
Units Authorized = 53

B. 60 minutes 2 times **per month**, from February 1 to May 31 U = 8 (4 units x 2 times per)
T = 4.0 (120 days / 30 days per month)
U x T = 32.0
Units Authorized = 32

C. 30 minutes 5 times **per auth**, from January 1 to December 31 U = 10 (2 units x 5 times per)
T = 1.0 (time period is per auth)
U x T = 10.0
Units Authorized = 10

D. 90 minutes 1 time **per quarter**, from January 1 to January 31 U = 6 (6 units x 1 time per)
T = 0.34444... (31 days / 90 days per quarter)
U x T = 2.06666...
Units Authorized = 3

In order to calculate how many units you have for a given authorization, you can find an Encumbered Units Calculator at this link <http://la.eikids.com> and click "Help". The required information for the Encumbered Units Calculator may be found by information obtained from the authorization. The calculator will display the total number of units for that given authorization.