Louisiana Medicaid

EDI General Companion Guide

Version Number: 2.3

Revised 11/05

© 2003 CAQH and WEDI

"The Companion Guide is the copyrighted work of CAQH and WEDI. More information may be obtained by visiting the CAQH/WEDI website, http://www.wedi.org/snip/caqhimptools/, or by contacting WEDI and/or CAQH at these phone numbers:

Workgroup for Electronic Data Interchange (WEDI), Jim A. Schuping, Executive Vice President, 703-391-2716

Council for Affordable Quality Healthcare (CAQH), Robin Thomashauer, Executive Director, 202-861-1493

Preface

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content being requested when data is transmitted electronically to Louisiana Medicaid. Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are compliant with both X12N syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

Table of Contents

1 INTRODUCTION 5
1.1 Scope 5
1.2 References..... 5
1.3 Additional Information 6
2 GETTING STARTED 6
2.1 Trading Partner Registration..... 6
2.2 HIPAA Testing and Approval Overview 6
3 TESTING WITH THE PAYER 6
3.1 Software Vendor, Billing Agent, and Clearinghouse (VBC) List 7
3.2 HIPAA Testing Service..... 7
3.3 MMIS Parallel Testing 7
4 CONNECTIVITY WITH THE PAYER / COMMUNICATIONS 9
4.1 Supported Transactions 9
4.1.1 The HIPAA EDI BBS supports the following transactions: 9
4.2 Submitter IDs & Passwords 9
4.2.1 New Submitter or Changing Submitter 9
4.2.2 Test HIPAA Bulletin Board System (BBS) for Parallel Testing..... 9
4.2.3 Production HIPAA Bulletin Board System (BBS) 9
4.3 HIPAA Bulletin Board Dial-up Phone Numbers..... 10
4.3.1 Test..... 10
4.3.2 Production..... 10
4.4 Communication protocol specifications 10
4.4.1 Dial-Up Requirements..... 10
4.5 File Naming Conventions 11
4.5.1 Test File Names..... 11
4.5.2 Production File Names..... 12
4.6 How To Connect and Login To The Louisiana EDI BBS..... 12
4.6.1 How To Submit A File To The Louisiana EDI BBS 12
4.6.2 Single File Submission..... 13
4.6.3 How To Receive Responses and Download Files 13
5 BBS SCREEN SHOTS 14
5.1 BBS Login Screen..... 14
5.2 BBS Main Menu..... 14
5.3 BBS File Upload 16
5.4 BBS File Upload Review Y/N 17
5.5 BBS File Uploaded Review Y..... 17
5.6 BBS File Download Selection Screen..... 18
5.7 BBS File Download List..... 19
5.8 BBS File Download Screen Step 1 of 2..... 20
6 BBS RESPONSES..... 21
6.1 TA1 Interchange Acknowledgement..... 21

6.2 997 Functional Acknowledgement....22
6.3 835 Remittance Advice (also referred to as payment advice)....27
6.4 BBS Error Codes....27
6.4.1 Valid EDI Delimiters for Louisiana Medicaid....28
7 ACCEPTED PHYSICAL MEDIA....29
7.1 Media Labeling....29
7.2 Tape Specifications....29
7.3 5.25” & 3.5” Diskette Specifications....29
8 CONTACT INFORMATION....30
8.1 EDI Customer Service and Technical Assistance....30
8.2 Provider Service Number....30
9 TRADING PARTNER AGREEMENTS....31
9.1 EDI Agreement with Instructions....33
9.2 Medicaid Electronic Media Limited Power of Attorney....36
9.3 Provider Electronic Remittance Advice (835) Transaction Agreement with Instructions....37
9.5 Disclosure of Ownership and Control of Interest Statement (HCFA 1513) with Instructions....39
10 CERTIFICATION....43

1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs
- Protect Private Healthcare Information

1.1 Scope

The HIPAA EDI Transaction Standard Companion Guide explains the procedures necessary for Trading Partners of Louisiana Medicaid to send/transmit Electronic Data Interchange (EDI) transactions. Supported transactions for Louisiana Medicaid Bulletin Board System (BBS) are listed below:

Transaction Name Accepted by the LA Medicaid BBS	Version
Health Care Claim: Dental	ASC X12N 837-004010X097A1
Health Care Claim: Professional	ASC X12N 837-004010X098A1
Health Care Claim: Institutional	ASC X12N 837-004010X096A1
Health Care Claim Payment/ Advice	ASC X12N 835-004010X091A1
Functional Acknowledgement	ASC X12N 997
Interchange Acknowledgement	ASC X12N TA1

This Companion Guide does not to replace the X12N Implementation Guides; rather it is intended to be used in conjunction with them. Additionally, the Companion Guide is intended to convey information that is within the framework and structure of the X12N Implementation Guides and not to contradict or exceed them.

1.2 References

This section specifies additional documents useful to the reader.

Washington Publishing Company (WPC) Website - www.wpc-edi.com

All X12N Implementation Guides adopted for use under HIPAA and their corresponding Addenda are free when downloaded from this site.

WEDI SNIP Website - **www.wedi.org/snip/** - WEDI is an organization working to foster widespread support for the adoption of electronic commerce within healthcare and SNIP is a collaborative healthcare industry-wide process resulting in the implementation of standards and furthering the development and implementation of future standards. This website contains various resources on HIPAA administrative simplification.

Centers for Medicare and Medicaid Services (CMS) Website- www.cms.hhs.gov/hipaa/hipaa2/ The website provides answers to Frequently Asked

Questions, links to other HIPAA sites, and information on the law, regulations, and enforcement are located here.

1.3 Additional Information

Specific companion guides for the 837-I, 837-P, 837-D, and 835 transactions are available for download from www.lamedicaid.com web site. These companion guides outline specific payer requirements for LA Medicaid.

2 Getting Started

2.1 Trading Partner Registration

This section describes how to register as an EDI trading partner with Louisiana Medicaid

Current Electronic Claim Submitters:

Louisiana Medicaid trading partners who submit electronic claims currently in the old proprietary formats do not need to do any other registration with Louisiana Medicaid for HIPAA. Submitter numbers will remain the same.

However, if a new submitter ID is required or you are changing submitters (i.e. using a Clearinghouse) and need to have your provider number linked to a different submitter ID, contact Unisys Provider Enrollment at (225) 216-6370.

New Electronic Claim Submitters or those changing submitters;

Providers who wish to begin submitting claim electronically should complete the EMC/EDI Agreement and Power of Attorney (if applicable) and submit to Unisys Provider Enrollment, PO Box 80159, Baton Rouge, LA 70898-0159. For any questions on how to complete the forms, call Provider Enrollment at (225) 216-6370. **PLEASE NOTE: Enrollment forms are also located in Section 9.**

2.2 HIPAA Testing and Approval Overview

This section provides a general overview of the HIPAA testing and approval process.

- Testing
  - A provider's Software Vendor, Billing Agent or Clearinghouse must contact the EDI Department at 225.216.6000 #2 or email *hipaaedi@unisys.com for instructions to begin testing.

3 Testing with the Payer

This section contains a detailed description of the testing phase.

The following information will help you enable your software vendor, billing agent or clearinghouse to become HIPAA approved. Instructions are provided for those who do not have a software vendor, billing agent or clearinghouse.

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

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

3.1 Software Vendor, Billing Agent, and Clearinghouse (VBC) List

If you are a LA Medicaid provider AND
a. You do not have a Software Vendor, Billing Agent or Clearinghouse (VBC)

OR
b. Your VBC does not plan on becoming HIPAA ready

You should:
Go to the LA Medicaid website www.lamedicaid.com/hipaa and download the VBC List.

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

The list will be updated monthly.

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

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

3.2 HIPAA Testing Service

Once your VBC has contacted LA Medicaid, Your VBC must have a Submitter ID to test on the BBS. Companion Guides for the 837I, 837P, and 837D transactions and other necessary and useful documentation will be available for download from www.lamedicaid.com.

3.3 MMIS Parallel Testing

Please refer to the section on Connectivity with the Payer / Communications for instructions on how to gain access to our test HIPAA Bulletin Board System (BBS).

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

Listed below are the Parallel testing requirements:

1. Submitter must have an active submitter ID with Louisiana Medicaid.
2. Upload a copy of a production Electronic Medicaid Claim (EDI) file. The EDI copy must be uploaded within 7 days from the original submission to production. There are exceptions to this requirement, but they may lengthen the approval process. Positive results are required for promotion to production.
3. Upload a parallel HIPAA file that was constructed using the same production data in the copy of the original production EDI file. The HIPAA file cannot be more than 7 days older than the original production EDI file.

4. **NOTE:** For those submitters who have not previously sent proprietary electronic Medicaid claims, such a TAD, new to LA Medicaid, or paper billers, your parallel testing process will be slightly different. TAD and paper billers will consult their most recent remittance advice and construct a parallel HIPAA EDI file using the same claim data from the paper claims, which were reported on their most recent remittance advice. The HIPAA EDI file must be constructed and transmitted to the test HIPAA BBS within 7 days of receiving the remittance advice. There are exceptions to this requirement, but they may lengthen the approval process.

   These claims will be compared to the HIPAA file sent to the test BBS, which was generated from the same data. Any discrepancies will need to be resolved by your assigned EDI testing support person. If a tester does not have an assigned support person, please contact the EDI Unit, please email *hipaaedi@unisys.com (the * asterisk is part of the email address)or call 225.216.6000 #2
5. For each file that is uploaded, two reports (CP06 & CP090) will be posted to the BBS for download. The CP090 report will contain any errors/denials and the CP06 report will contain the detail payment information with a summary. (Error/denial code descriptions are available for download from within HIPAA Desk). The goal is for the HIPAA file and the EDI to process the same. Any discrepancies will need to be resolved by your assigned HIPAA EDI QA testing support person. If a tester does not have an assigned support person, please contact the EDI Unit, please email *hipaaedi@unisys.com (the * asterisk is part of the email address) or call 225-216.6000 #2
6. A member of the EDI Unit gives production approval. Approval is based on the success of a parallel test. Once approved, the submitter receives a status of “Approved” on the VBC list.

4 Connectivity with the Payer / Communications

4.1 Supported Transactions

4.1.1 The HIPAA EDI BBS supports the following transactions:

Transaction Name	Version
Health Care Claim: Dental	ASC X12N 837-004010X097A1
Health Care Claim: Professional	ASC X12N 837-004010X098A1
Health Care Claim: Institutional	ASC X12N 837-004010X096A1
Health Care Claim Payment/ Advice	ASC X12N 835-004010X091A1
Functional Acknowledgement	ASC X12N 997
Interchange Acknowledgement	ASC X12N TA1

4.2 Submitter IDs & Passwords

4.2.1 New Submitter or Changing Submitter

Requests for a new submitter ID require form in Section 9 to be completed and mailed to the Provider Enrollment Unit. There is a 3-week turnaround for these request. Make these requests early so the submitter ID will be ready for parallel testing and production approval.
Note: A Submitter ID is required before a password can be issued for testing or submitting claim to Production. Refer to the section on Trading Partner Agreements for obtaining a Submitter ID. Parallel testing REQUIRES an active LA Medicaid submitter ID and a password.

4.2.2 Test HIPAA Bulletin Board System (BBS) for Parallel Testing

All providers and submitters who currently send electronic claims to LA Medicaid can use their existing Submitter IDs. They are still valid for HIPAA. However, you must be assigned a password to access the Test HIPAA BBS for parallel testing. To be assigned a password please contact the EDI Unit at 225.216.6000 #2.

4.2.3 Production HIPAA Bulletin Board System (BBS)

Submitter ID and Password for accessing the Production HIPAA bulletin board is the same as for the Test HIPAA bulletin board. The Production bulletin board will be updated with the information after approval is given.

4.3 HIPAA Bulletin Board Dial-up Phone Numbers

4.3.1 Test

Dial **225.927.4123** to access the test bulletin board system

To upload the following types of files to Test Select (A) SEND FILES

- 837 Institutional
- 837 Dental
- 837 Professional
- Proprietary claims files for parallel testing

To Download the following types of files Select (B) RECEIVE FILES

- TA1 Interchange Acknowledgement
- 997 Functional Acknowledgement
- 835 Payment Advice
- Testing Reports (CP06 & CP090 MMIS Reports for parallel testing)

4.3.2 Production

Dial **225.927.4326** to access the production bulletin board system.

To Upload the following types of files to Production Select (A) SEND FILES

- 837 Institutional
- 837 Dental
- 837 Professional

To Download the following type of files Select (B) RECEIVE FILES

- TA1 Interchange Acknowledgement
- 997 Functional Acknowledgement
- 835 Payment Advice

4.4 Communication protocol specifications

4.4.1 Dial-Up Requirements

- Windows
  - Dial-up Software that uses an asynchronous modem supporting Z-Modem protocol and a minimum baud rate of 9600 kbps
- Unix
  - Unisys will accept the BLAST protocol for asynchronous transmission at 14.4, 9.6, 4.8, 2.4 and 1.2 kbps.

4.5 File Naming Conventions

This section describes how files should be named for files uploaded to the BBS and those mailed on tape or disk.
In order to complete parallel testing, two files must be uploaded to the Test HIPAA BBS. One will be a copy of a production Electronic Media Claim (EMC) file named the same. Those names are listed in the table below. The other file will be a HIPAA parallel file using the same data as the production EDI file and the same name as for production.

4.5.1 Test File Names

The file names for test are in the table below.
To facilitate parallel testing, the following files are to be uploaded along with their HIPAA parallel counterpart. The file names below are the existing Electronic Medicaid Claims' file names.

Please replace the sample submitter number 4599999 with your own Medicaid submitter number.

Trxn.	Claim Type	Name	Extension	Sample file name
837D	11	Adult Dental	DNA	C4599999.DNA
837D	10	Dental-EPSDT	DNE	C4599999.DNE
837P	09	Durable Medical Equip.	DME	C4599999.DME
837P	04	Physician	PHY	C4599999.PHY
837P	05	Rehabilitation	REH	C4599999.REH
837P	07	Ambulance Trans	TRA	C4599999.TRA
837I	01 & 03	Hospital IP/OP	UB9	C4599999.UB9
837I	06	Home Health	HOM	C4599999.HOM
837D	11	Adult Dental	DNA	H4599999.DNA
837D	10	Dental-EPSDT	DNE	H4599999.DNE
837P	09	Durable Medical Equip.	DME	H4599999.DME
837P	04	Physician	PHY	H4599999.PHY
837P	05	Rehabilitation	REH	H4599999.REH
837P	07	Ambulance Trans	TRA	H4599999.TRA
837P	14	KIDMED/EPSDT	KID	H4599999.KID
837I	01 & 03	Hospital IP/OP	UB9	H4599999.UB9
837I	06	Home Health	HOM	H4599999.HOM
837I	02	Long Term Care	LTC	H4599999.LTC
837I	16	Adult Day Health Care	ADC	H4599999.ADC
278	03	Electronic Referral Authorization	ERA	H4599999.ERA

4.5.2 Production File Names

Please replace the sample submitter number 4599999 with your own Medicaid submitter number.

Trxn.	Claim Type	Name	Extension	Sample file name
837D	11	Adult Dental	DNA	H4599999.DNA
837D	10	Dental-EPSDT	DNE	H4599999.DNE
837P	09	Durable Medical Equip.	DME	H4599999.DME
837P	04	Physician	PHY	H4599999.PHY
837P	05	Rehabilitation	REH	H4599999.REH
837P	07	Ambulance Trans	TRA	H4599999.TRA
837P	14	KIDMED/EPSDT	KID	H4599999.KID
837I	01 & 03	Hospital IP/OP	UB9	H4599999.UB9
837I	06	Home Health	HOM	H4599999.HOM
837I	02	Long Term Care	LTC	H4599999.LTC
837I	16	Adult Day Health Care	ADC	H4599999.ADC
278	03	Electronic Referral Authorization	ERA	H4599999.ERA

4.6 How To Connect and Login To The Louisiana EDI BBS

- To login to the Louisiana EDI BBS, submitters must first have a valid Submitter ID and Password, see Trading Partner Registration or Agreements
- Configure the dialup software to dial the Louisiana EDI BBS using the appropriate phone numbers from the Bulletin Board Dial-Up Phone Numbers section. Once connected to the BBS, submitters should see the BBS Login Screen.
- Once connected to the BBS Login Screen, submitters must enter a valid Submitter ID and Password. Enter a Submitter ID and press the [Enter] Key. Then type the corresponding password and press the [Enter] key.
- At this point, press the [Y] key to complete the authentication process or press the [N] key to exit.
  - The BBS Main Menu should appear.

4.6.1 How To Submit A File To The Louisiana EDI BBS

- Login to the Louisiana EDI BBS using your Submitter ID and Password.
- At the BBS Main Menu press the [A] key to select the Send File(s) option of the Main Menu.
- The BBS File Upload screen will display
- An open dialog screen should appear. Consult your dial-up software documentation for details. Usually, there will be an option to upload/download through your software.
- After the file is uploaded to the BBS, the BBS File Upload Review Y/N will display.
- If you want to review the files and their edits, press the [Y] key and the BBS File Uploaded Review Y screen will display a list of uploaded files. To bypass the file review screen press the [N] key, you will be redirected back to the BBS Main Menu.

4.6.2 Single File Submission

A Single File Submission is an ASCII text file containing an X12N Transaction, *Proprietary EMC file. The following rules apply to the file.

- The file must have a valid file extension.
- The file must be an ASCII Text File.
- The file must be a valid X12N 837, or *Proprietary electronic claim.

*For parallel testing purposes, Louisiana proprietary file formats can be sent to the Test Louisiana HIPAA BBS.

Note: Proprietary files are never to be sent to the Production HIPAA BBS.

4.6.3 How To Receive Responses and Download Files

- Login to the BBS.
- From the BBS Main Menu, press the [B] key to retrieve files. The BBS File Download Selection Screen will display.
- Select a file type to download from the BBS File Download Selection Screen.
- The BBS File Download List will display a list of files available for download.
- Select the file to download. The BBS File Download Screen Step 1 of 2 screen will display giving a choice to compress the files before download. Choose [Y] to compress the file or [N] to download the file uncompressed.
- The BBS Receive File Step 2 of 2 screen will be displayed. A “Browse for Folder” dialog should be display on entry into the screen. Select a target location to download your file. If the dialog box is not displayed, manually start the download process. Consult you Dial-up Software documentation for details.
  - After the selected file or files are downloaded, the screen will navigate back to the BBS File Download Selection Screen.

5 BBS Screen Shots

5.1 BBS Login Screen

Screen Description: This screen allows a Submitter to login to the Louisiana EDI BBS.

```
Wildcat! Interactive Net Server (c) 1998-2002 Santronics Software, Inc.
Registration number: 09-3184  v5.6.450 (Nov 14 2002)  Node: 2

Connected with Local.  Ansi detected.

 You are connected to Louisiana EDI BBS:

        Node: 2
     Version: 1.1
   Baud Rate: Local                 (must be >= 9600)
    Protocol: No default            (must be ZMODEM)

 Enter Trading Parter ID: 4509999


 Enter Password:  [********                         ]
```

Once you have logged in to the BBS the following message will be displayed. Press **[Y]** to continue or **[N]** to logoff.

```
Press [Y] to continue or [N] to logoff...
```

Once authentication is complete, the BBS will navigate to the BBS Main Menu.

5.2 BBS Main Menu

Screen Description: The Louisiana EDI BBS Main Menu is the main entry point of the BBS.

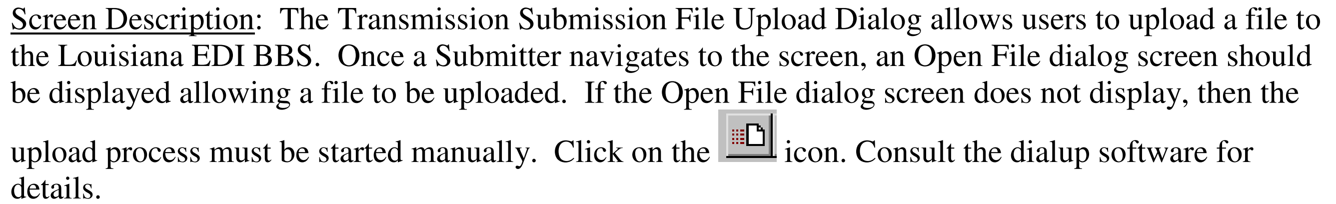
```
Version 1.1                                      TP: 4509999
Test                  Louisiana EDI BBS          Nm: Test Tradin
                         Main Menu               Dt: 2003/07/09
                                                 Tm: 12:31

             SEL  Description
             A    Send File(s)
             B    Retrieve File(s)
             Q    Logoff

             Enter Selection:
```

Screen Options

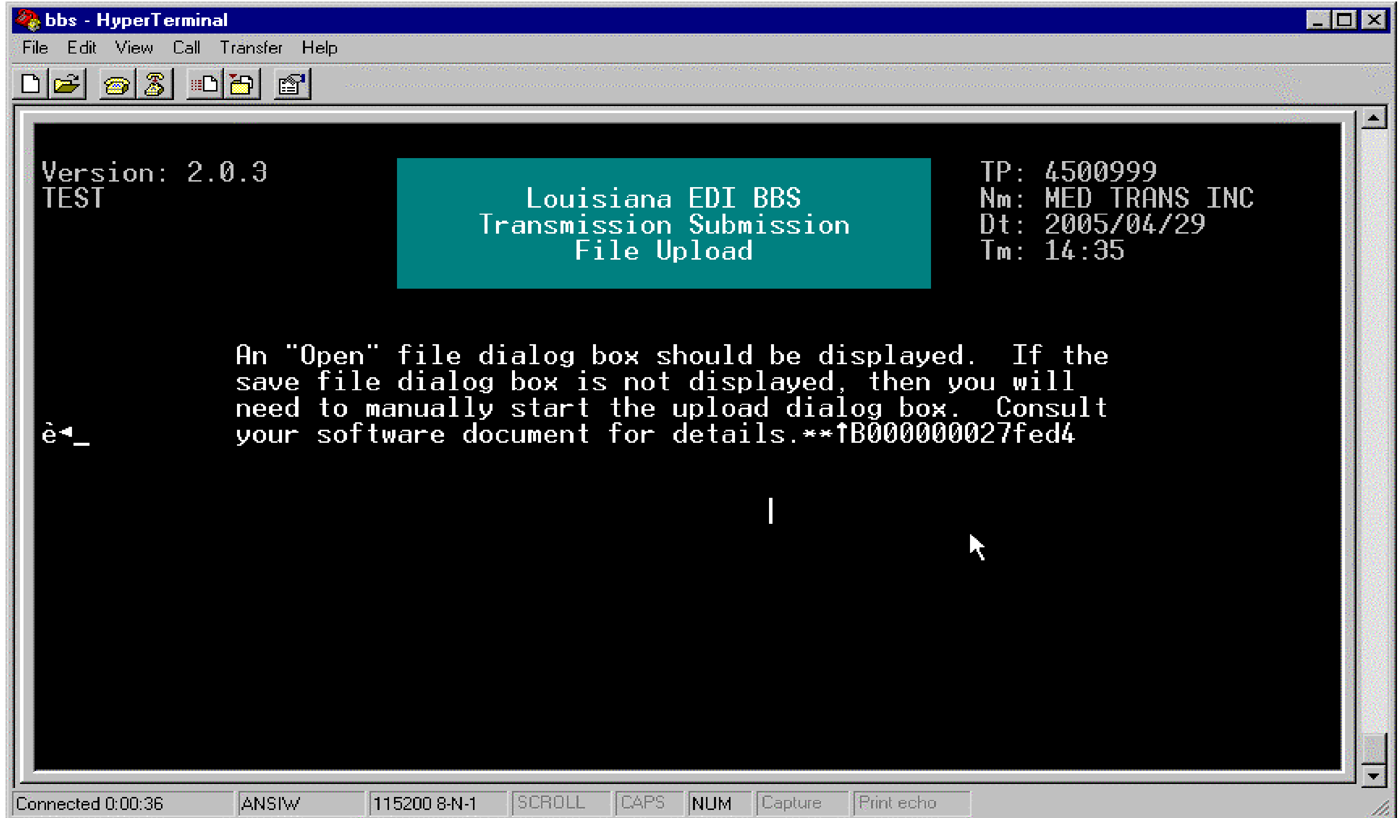
Option	***Name***	***Description***
A	Send File(s)	This option navigates to the File Upload Dialog.
B	Receive File(s)	This option navigates to the Transmission Retrieval screen, where Submitters can download response files from the Louisiana EDI BBS
Q	Logoff	This option allows a Submitter to logoff from the Louisiana EDI BBS.

Note: In the upper left hand corner of the screen, the version number and region appears. Before attempting to upload claims, verify that you are in the correct region.

5.3 BBS File Upload

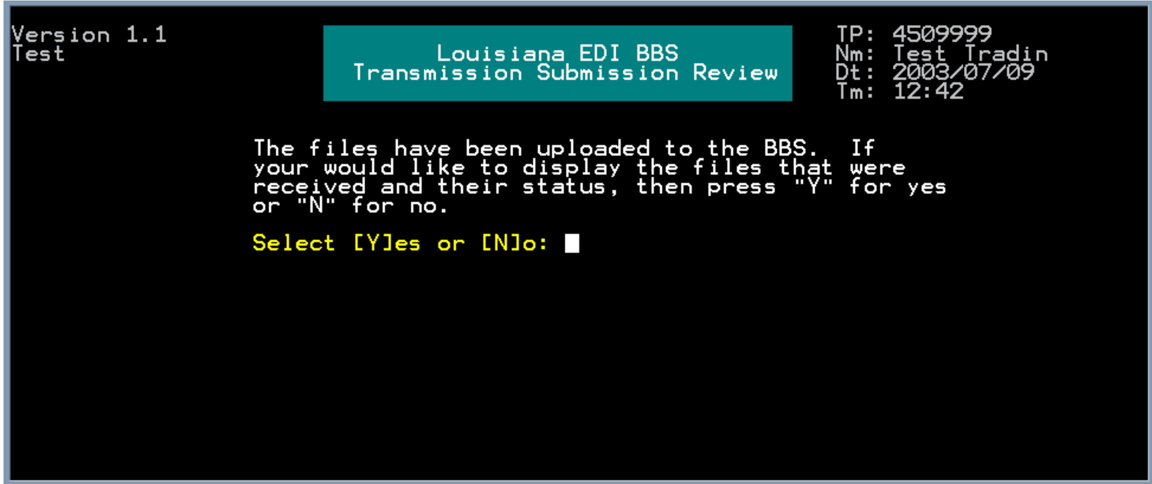


Screen Description: The Transmission Submission File Upload Dialog allows users to upload a file to the Louisiana EDI BBS. Once a Submitter navigates to the screen, an Open File dialog screen should be displayed allowing a file to be uploaded. If the Open File dialog screen does not display, then the upload process must be started manually. Click on the icon. Consult the dialup software for details.



5.4 BBS File Upload Review Y/N

Screen Description: The File Upload Review dialog screen allows Submitters to choose whether or not to review the files they have submitted and any edits that the file received.



5.4.1.1.1.1.1.1.1 Screen Options

Option	*Name*	*Description*
Y	Yes	This option navigates to the Louisiana BBS File Upload Review.
N	No	This option navigates to the Louisiana EDI BBS Main Menu.

5.5 BBS File Uploaded Review Y

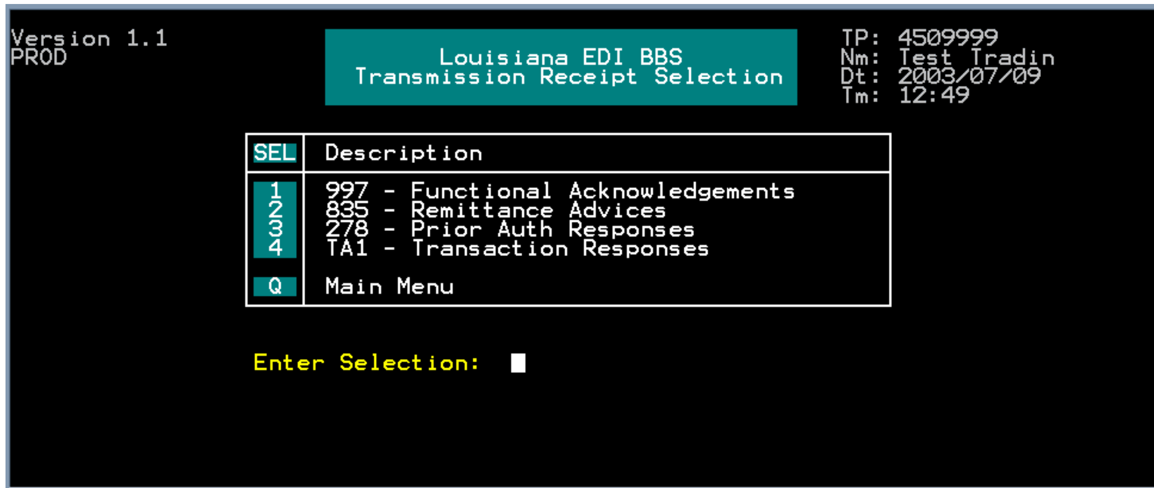
Screen Description: This screen displays the files that were uploaded to the Louisiana EDI BBS. Once this screen is displayed press the [ENTER] key to navigate to the Louisiana EDI BBS Main Menu.

5.6 BBS File Download Selection Screen

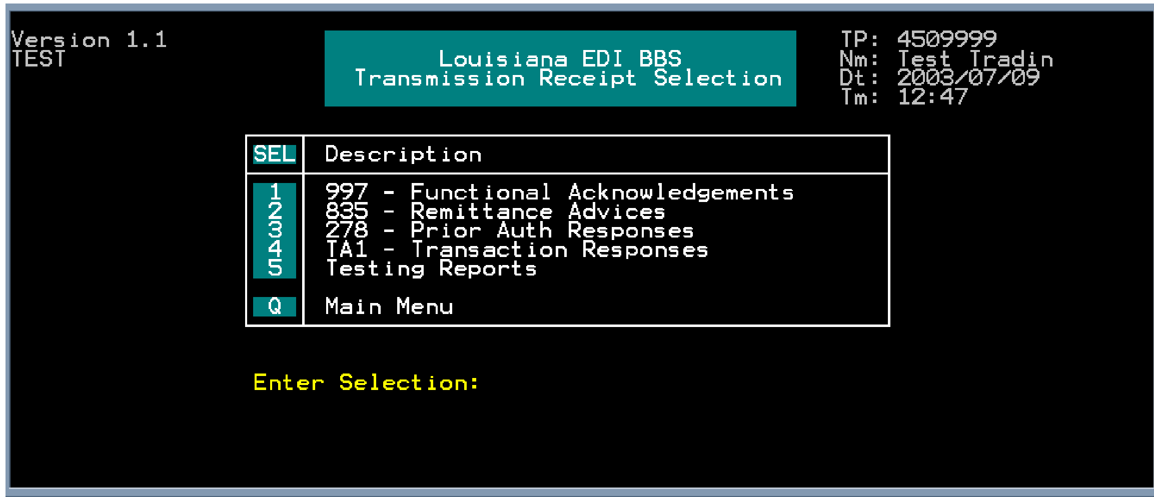
Screen Description: This screen allows Submitters to navigate to the File Download areas where the Responses can be downloaded.

Note: This screen differs depending on the Region. An image for each region is displayed below.

Screen Sample - **Production**



Screen Sample – **Test**



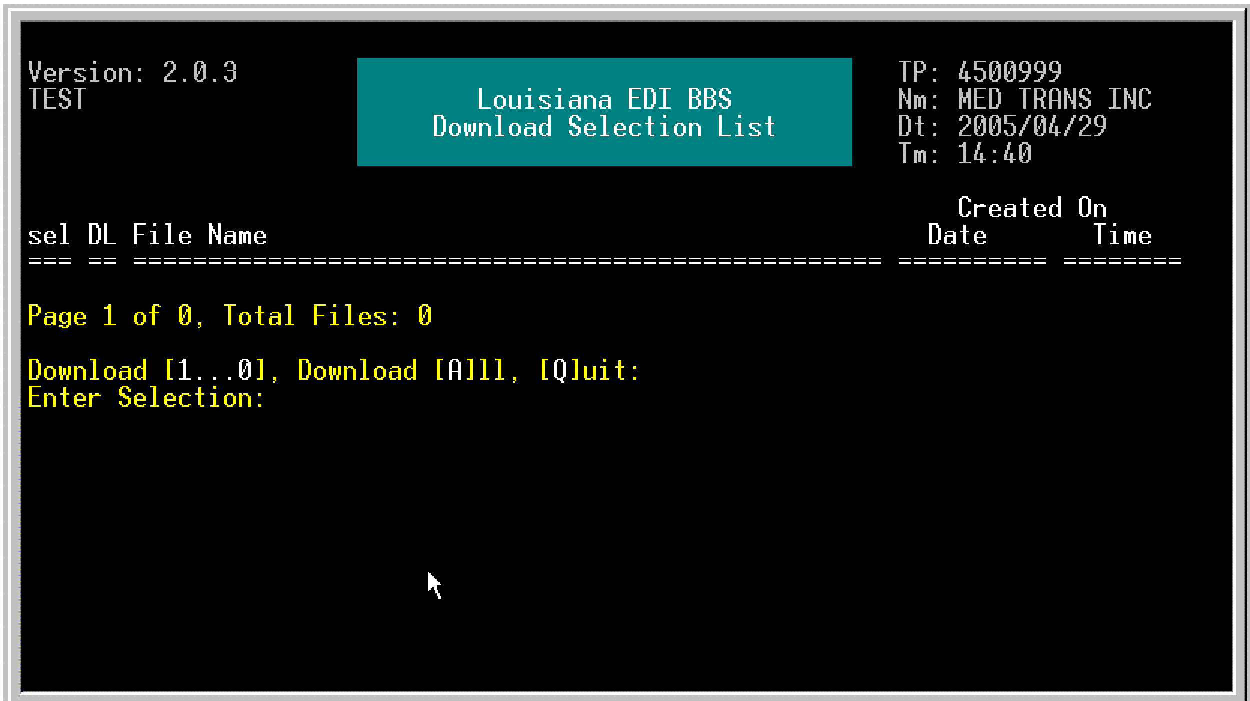
Screen Options

Option	Name	Description
1	997 – Functional Acknowledgements	This option navigates to the File download screen where Submitters can download 997 response files from the Louisiana EDI BBS.
2	835 – Remittance Advice	This option navigates to the File Download screen where Submitters can download 835 response files from the Louisiana

		EDI BBS.
3	278 – Prior Auth Responses	This option navigates to the File Download where submitters can download 278 response files from the Louisiana EDI BBS.
4	TA1 – Responses	This option navigates to the File Download screen where Submitters can download TA1 response files from the Louisiana EDI BBS.
5	Testing Reports **(Test Only)**	This option navigates to the File Download screen where Submitters can download Test Reports from the Louisiana EDI BBS.
Q	Quit	This option navigates to the Louisiana EDI BBS Main Menu.

5.7 BBS File Download List

Screen Description: This screen allows users to view and download of Response Files that reside on the Louisiana EDI BBS. Since there can be multiple files stored for a Submitter on the BBS, the files can be listed on several pages. The screen allows Submitters to scroll up or down pages of file listings.



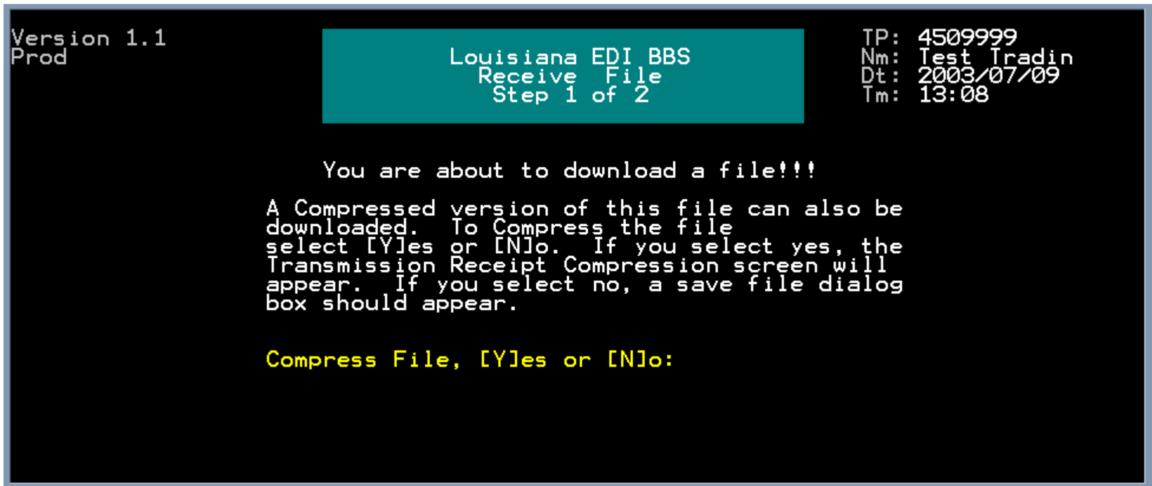
Screen Options

Option	*Name*	*Description*
P	Previous (Page)	This option scrolls to the previous page of files.
N	Next (Page)	This option scrolls to the next page of files.
1 thru 10	Download (file) [1…10]	This option allows Submitters to download a single file. After a user selects this option a Compress Dialog screen will be displayed allowing a user to compress the file before

		downloading.
A	Download All	This option allows a user to download all of the files from the particular download area. The files will be compressed and stored in a compressed file archive.
Q	Quit	Navigates to the BBS File Download Selection Screen.

5.8 BBS File Download Screen Step 1 of 2

Screen Description: This screen allows users to choose if the file to be downloaded is to be compressed. Once the selection is made, the Louisiana EDI BBS Receive File Step 2 of 2 screen will start the download process.



5.8.1.1.1.1.1.1.1 Screen Options

Option	***Name***	***Description***
Y	Yes	Compress the selected file or files before downloading.
N	No	Do not compress the selected file or files before downloading.

Please NOTE: The file will automatically load to your PCs default harddrive. If you are unsure about where your harddrive is located please consult your IT department or hardware vendor.

6 BBS Responses

6.1 TA1 Interchange Acknowledgement

The TA1 will be available on the BBS immediately after submission of an 837. Please note that LA Medicaid sends the TA1 report separate from the 997-Functional Acknowledgement.

This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly, the TA1 reflects a valid interchange, regardless of the validity of the contents of the data included inside the header/trailer envelope. The validity of the data contained within the actual transaction will be acknowledged in the 997.

TA1

Interchange Acknowledgement

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 5

User Option (Usage): Required

Example: TA1*000568426*030615*0200*A*000~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
TA101	I12	**Interchange Control Number** **LA Medicaid:** *Will be the Interchange Control Number of the original Transaction being acknowledged.*	M	N0	9/9
TA102	I08	**Interchange Date** **LA Medicaid:** *Will be the date of the original Transaction being acknowledged. YYMMDD*	M	DT	6/6
TA103	I09	**Interchange Time** **LA Medicaid:** *Will be the time of the original Transaction being acknowledged. HHMM*	M	TM	4/4
TA104	I17	**Interchange Acknowledgement Code** **LA Medicaid:** *This will indicate if the envelopes are Accepted with no errors, Accepted with errors, or Rejected due to errors. See Implementation Guide for valid values.*	M	ID	1/1
TA105	I18	**Interchange Note Code** **LA Medicaid:** *This will display the error code indicating the error with the Interchange Control Structure. See Implementation Guide for valid values.*	M	ID	3/3

6.2 997 Functional Acknowledgement

The Functional Acknowledgement (997) transaction is used to report the results of the syntactical analysis of the functional groups of transaction sets, the 997 report the extent to which the syntax complies with the standards for transaction sets and functional groups. In addition, the 997 can be constructed to send information about the syntactical quality of the 837 transmission. The 997 is available within 24 hours of receipt of the file.

ISA

Interchange Control Header

Pos: **Max: 1**
Not Defined - Mandatory
Loop: N/A **Elements: 16**

User Option (Usage): Required
Example: ISA*00* **00** *ZZ*LA-DHH-MEDICAID*ZZ*4599999 *030423*0944*U*00401*000000001*1*T*:~

Element Summary: **ISA/GS**-These segments are the same as the inbound 837 with the exception of the Sender/Receiver Codes are reversed, as Louisiana has now become the Sender. Also, the GS01 is now 'FA'-Functional Acknowledgment, rather than 'HC'-Health Care Claim.

Ref	Id	Element Name	Req	Type	Min/Max
ISA01	I01	**Authorization Information Qualifier** **LA Medicaid:** *'00' will be used for this element*	M	ID	2/2
ISA02	I02	**Authorization Information** **LA Medicaid:** *Spaces will be used*	M	AN	10/10
ISA03	I03	**Security Information Qualifier** **LA Medicaid:** *'00' will be used for this element*	M	ID	2/2
ISA04	I04	**Security Information** **LA Medicaid:** *Spaces will be used*	M	AN	10/10
ISA05	I05	**Interchange ID Qualifier** **LA Medicaid:** *'ZZ' will be used for this element*	M	ID	2/2
ISA06	I06	**Interchange Sender ID** **LA Medicaid:** *'LA-DHH-MEDICAID' will be used for this element*	M	AN	15/15
ISA07	I05	**Interchange ID Qualifier** **LA Medicaid:** *'ZZ' will be used for this element*	M	ID	2/2
ISA08	I07	**Interchange Receiver ID** **LA Medicaid:** *Will be the 7 digit Unisys assigned submitter ID (i.e. 450XXXX) followed by spaces*	M	AN	15/15
ISA09	I08	**Interchange Date** **LA Medicaid:** *The date format is YYMMDD*	M	DT	6/6
ISA10	I09	**Interchange Time** **LA Medicaid:** *The time format is HHMM*	M	TM	4/4
ISA11	I10	**Interchange Control Standards Identifier** **LA Medicaid:** *Will be U for this element*	M	ID	1/1
ISA12	I11	**Interchange Control Version Number** **LA Medicaid:** *Will be 00401 for this element*	M	ID	5/5
ISA13	I12	**Interchange Control Number** **LA Medicaid:** *Will be identical to the interchange trailer IEA02. Will be unique for every transmission submitted.*	M	N0	9/9
ISA14	I13	**Acknowledgment Requested** **LA Medicaid:** *Will be 1 for this element*	M	ID	1/1
ISA15	I14	**Usage Indicator** **LA Medicaid:** *T = Test Data* *P = Production Data*	M	ID	1/1

ISA16	I15	**Component Element Separator** **LA Medicaid:** *Will be a colon : - ASCII x3A*	M		1/1

GS Functional Group Header

Pos: **Max: 1**
Not Defined - Mandatory
Loop: N/A **Elements: 8**

User Option (Usage): Required
Example: GS*FA*LA-DHH-MEDICAID*4599999*20030423*0944*1*X*004010X098A1~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
GS01	479	**Functional Identifier Code** **LA Medicaid:** *Will be the value 'FA' for this element*	M	ID	2/2
GS02	142	**Application Sender's Code** **LA Medicaid:** *Will be 'LA-DHH-MEDICAID' for this element*	M	AN	2/15
GS03	124	**Application Receiver's Code** **LA Medicaid:** *Will be identical to t he value in ISA06*	M	AN	2/15
GS04	373	**Date** **LA Medicaid:** *The date format is CCYYMMDD*	M	DT	8/8
GS05	337	**Time** **LA Medicaid:** *The time format is HHMM*	M	TM	4/8
GS06	28	**Group Control Number** **LA Medicaid:** *Assigned and maintained by the sender*	M	N0	1/9
GS07	455	**Responsible Agency Code** **LA Medicaid:** *Will be the value X for this element*	M	ID	½
GS08	480	**Version / Release / Industry Identifier Code** **LA Medicaid:** *Will be the value of the transaction version being validated by the 997. For Example, '004010X096A1', '004010X097A1', or '004010X098A1' for this element*	M	AN	1/12

ST TRANSACTION SET HEADER

Pos: 010 **Max: 1**
Heading - Mandatory
Loop: N/A **Elements: 2**

User Option (Usage): Required
Example: ST*997*0001~

Element Summary: **ST**-This segment identifies the start of the Transaction. The only difference between this ST and the 837 ST is the ST01 identifies the transaction as 997.

Ref	Id	Element Name	Req	Type	Min/Max
	143	**Transaction Set Identifier Code** **LA Medicaid:** *'997' will be used in the element*	M	ID	3/3

AK1 FUNCTIONAL GROUP RESPONSE HEADER

Pos: 020 **Max: 1**
Heading - Optional
Loop: N/A **Elements: 2**

User Option (Usage): Required
Example: AK1*HC*1~

Element Summary: **AK1**-This segment starts the acknowledgment group.

Ref	Id	Element Name	Req	Type	Min/Max
AK01	479	**Functional Identifier Code** **LA Medicaid:** *'HC' is the only valid value*	M	ID	2/2

AK2 TRANSACTION SET RESPONSE HEADER

Pos: 030 **Max: 1**
Heading - Optional
Loop: AK2 **Elements: 2**

User Option (Usage): Required
Example: AK2*837*000001~

Element Summary: **AK2**-The AK202 will display the same Transaction Set Control Number as the ST that is being acknowledged.

Ref	Id	Element Name	Req	Type	Min/Max
AK201	143	**Transaction Set Identifier Code** **LA Medicaid:** *837-Health Care Claim*	M	ID	3/3

AK3 Data Segment Note

Pos: 040 **Max: 1**
Heading - Optional
Loop: AK2/AK3 **Elements: 4**

User Option (Usage): Situational
Example: AK3*SV1*23**8~

Element Summary: **AK3**-This segment identifies which 837-segment contain an error.

Ref	Id	Element Name	Req	Type	Min/Max
AK301	721	**Segment ID Code** **LA Medicaid:** This is the two or three characters which occur at the beginning of a segment. This segment identifies which 837-segment contain an error.	M	ID	2/3
AK304	720	**Segment Syntax Error Code** **LA Medicaid:** This code is required if an error exists. See Implementation Guide for Valid Values	O	ID	1/3

AK4 Data Segment Note

Pos: 050 **Max: 99**
Heading - Optional
Loop: AK2/AK3 **Elements: 4**

User Option (Usage): Situational
Example: AK4*8**2~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
AK403	723	**Segment Syntax Error Code** **LA Medicaid:** This code is required if an error exists. See Implementation Guide for Valid Values	M	ID	1/3

AK5 TRANSACTION SET RESPONSE TRAILER

Pos: 060 **Max: 1**
Heading- Mandatory
Loop: N/A **Elements: 6**

User Option (Usage): Required
Example: AK5*R*5~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
AK501	717	**Transaction Set Acknowledgment Code** **LA Medicaid:** This element will indicate Acceptance or Rejection based on syntax edits. See Implementation Guide for Valid Values	M	ID	1/1
AK502	718	***Transaction Set Syntax Error Code*** **LA Medicaid:** This code is required if an error exists. See Implementation Guide for Valid Values	O	ID	1/3

AK9 FUNCTIONAL GROUP RESPONSE TRAILER

Pos: 070 **Max: 1**
Heading- Mandatory
Loop: AK2/AK3 **Elements: 9**

User Option (Usage): Required
Example: AK9*R*1*1*0~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
AK901	715	**Functional Group Acknowledgment Code** **LA Medicaid:** This element will indicate Acceptance or Rejection based on syntax edits. See Implementation Guide for Valid Values	M	ID	1/1
AK905	718	***Functional Group Error Code*** **LA Medicaid:** This code is required if an error exists. See Implementation Guide for Valid Values	O	ID	1/3

SE Transaction Set Trailer

Pos: 080 **Max: 1**
Heading - Mandatory
Loop: N/A **Elements: 2**

User Option (Usage): Required
Example: SE*422*0001~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
	721	**Segment ID Code** **LA Medicaid:** This is the two or three characters which occur at the beginning of a segment. This segment identifies which 837-segment contain an error.	M	ID	2/3
	720	**Segment Syntax Error Code** **LA Medicaid:** This code is required if an error exists. See Implementation Guide for Valid Values	O	ID	1/3

GE Functional Group Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required
Example: GE*1*1~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
GE01	97	**Number of Transaction Sets Included** **LA Medicaid:** *Number of transactions sets included*	M	N0	1/6
GE02	28	**Group Control Number** **LA Medicaid:** *Will be identical to the value in GS06*	M	N0	1/9

IEA Interchange Control Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required
Example: IEA*1*000000001~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
IEA01	I16	**Number of Included Functional Groups** **LA Medicaid:** *Number of included functional groups*	M	N0	1/5
IEA02	I12	**Interchange Control Number** **LA Medicaid:** *Will be identical to the value in ISA13*	M	N0	9/9

6.3 835 Remittance Advice (also referred to as payment advice)

Submitters who currently receive electronic remittance advice (ERA) from LA Medicaid should contact the EDI Unit 225.216.6000 #2 or email *hipaaaedi@unisys.com to request a Test 835.

Once the test is complete then a request must be sent to the *hipaaedi@unisys.com email address to be moved to production.

A test 835 will be created for the submitter to evaluate.
Alert: The change from ERA to 835 is mutually exclusive. The 835 will replace the current ERA. Both cannot be generated in production. Once the switch is made to the 835 in production you cannot be switched back to the proprietary ERA.

In addition, the switch is performed at the submitter level. Therefore, all the providers who are linked to the submitter get their payment advice on an 835. So, the submitter requesting the 835 in production must be certain that their providers are prepared to handle the 835, or are not concerned with receiving it.

6.4 BBS Error Codes

Below are the description of any error codes returned by the BBS for and Invalid TA1.

Edit #	Edit Description
0	BBS Edit - Valid File
1	TA1 Edit 001 - The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
2	TA1 Edit 002 - This Standard as Noted in the Control Standards Identifier is Not Supported.
3	TA1 Edit 003 - This Version of the Controls is Not Supported
4	TA1 Edit 004 - The Segment Terminator is Invalid
5	TA1 Edit 005 - Invalid Interchange ID Qualifier for Sender
6	TA1 Edit 006 - Invalid Interchange Sender ID
7	TA1 Edit 007 - Invalid Interchange ID Qualifier for Receiver
8	TA1 Edit 008 - Invalid Interchange Receiver ID
9	TA1 Edit 009 - Unknown Interchange Receiver ID
10	TA1 Edit 010 - Invalid Authorization Information Qualifier Value
11	TA1 Edit 011 - Invalid Authorization Information Value
12	TA1 Edit 012 - Invalid Security Information Qualifier Value
13	TA1 Edit 013 - Invalid Security Information Value
14	TA1 Edit 014 - Invalid Interchange Date Value
15	TA1 Edit 015 - Invalid Interchange Time Value
16	TA1 Edit 016 - Invalid Interchange Standards Identifier Value
17	TA1 Edit 017 - Invalid Interchange Version ID Value
18	TA1 Edit 018 - Invalid Interchange Control Number Value

19	TA1 Edit 019 - Invalid Acknowledgment Requested Value
20	TA1 Edit 020 - Invalid Test Indicator Value
21	TA1 Edit 021 - Invalid Number of Included Groups Value
22	TA1 Edit 022 - Invalid Control Structure
23	TA1 Edit 023 - Improper (Premature) End-of-File (Transmission)
24	TA1 Edit 024 - Invalid Interchange Content (e.g., Invalid GS Segment)
25	TA1 Edit 025 - Duplicate Interchange Control Number
26	TA1 Edit 026 - Invalid Data Element Separator
27	TA1 Edit 027 - Invalid Component Element Separator
28	TA1 Edit 028 - Invalid Delivery Date in Deferred Delivery Request
29	TA1 Edit 029 - Invalid Delivery Time in Deferred Delivery Request
30	TA1 Edit 030 - Invalid Delivery Time Code in Deferred Delivery Request
31	TA1 Edit 031 - Invalid Grade of Service Code
90	BBS Edit - Invalid File Extension
91	BBS Edit - Invalid ISA Segment
92	BBS Edit - Invalid TA1
93	BBS Edit - Partially Received File
95	BBS Edit - File Received
96	BBS Edit - Compressed File Received
97	BBS Edit - Compressed File within a Compress File
98	BBS Edit - Invalid TXN Type for File Extension
99	BBS Edit - Invalid File Naming Convention

6.4.1 Valid EDI Delimiters for Louisiana Medicaid

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

7 Accepted Physical Media

7.1 Media Labeling

The following label information is required on all Tapes or Diskettes

LMMIS Tape, Disk, or CD Label	
1. Creation Date___________________	2. Submitter ID 450_________________
3. Reel Number_____________________	4. Provider or Company Name _______ ___________________________________ ___________________________________
5. Records_______________________	
6. Amount $_______________________	
7. Computer Used ________________	8. Claim Type ____________________
9. OP System ____________________	10. File Name _____________________

The billing date of the submission as it appears on the encoded claims and as it appears on the Submission Certification.

1. The submitter's ID number.
2. An external identifying number that makes the magnetic diskette unique - any six characters or digits the submitter wishes. This number must be unique to the submitter's tape/diskette/CD library and must be listed in Section I of the "Submission Certification."
3. The name of the provider, billing agent, or clearinghouse submitting the tape/diskette/CD.
4. The count of Medicaid claims contained on all the batches of the tape/diskette/CD.
5. The total dollar amount billed on the tape/diskette/CD for all the claims.
6. Type of machine used to create diskette/tape. Be specific, e.g., IBM 34, Series I, TRS 80, Kaypro, IBM PC.
7. The type(s) of claims encoded on the tape/diskette/CD, e.g., Pharmacy, Hospital Inpatient, Hospital Outpatient, and Physician/Professional.
8. Operating system used – e.g. CPM, CPM-86, PC-DOS, NECDOS, Turbodos, etc.
9. File Name - Directory name of internal file (left justify).

7.2 Tape Specifications

The following specifications must be adhered to when submitting tape input media.

- Tape - 9 track, 7" to 10 ½" reels with silver mylar reflector (standard reels).
- Recording Density - 1,600 bytes per inch required.
- Recording Code - Extended Binary Coded Decimal Interchange Code (EBCDIC).
- File Labels - None. The tape may have a leading tape mark and must have an end of file mark.
- Unfilled Final Block - Fill with spaces or use a short block. Do not fill the last block with 9s, high, or low values.
- Tapes must be an uncompressed format.

7.3 5.25" & 3.5" Diskette Specifications

IBM & IBM PC compatibles

- 5.25" Diskette

  - 96TPI
  - ASCII
  - MS-DOS, PC DOS
- 3.5” Diskette
  - 270 TPI 1.44 Megs
  - Double-sided high density
  - ASCII
  - MS-DOS, PC-DOS

8 Contact Information

8.1 EDI Customer Service and Technical Assistance

If you have questions in regards to this document please contact the EDI HIPAA QA group at *hipaaedi@unisys.com (the *asterisk is part of the email address) or (225) 216 6000 #2

8.2 Provider Service Number

For detailed information concerning the payment of claims, please contact Provider Relations @ (800) 473-2783 or (225) 924-5040

For enrollment as a new electronic submitter for Louisiana Medicaid, or to change submitter numbers, complete the Provider Enrollment Agreements and Power of Attorney (if applicable) found in Section 9 and submit to Provider Enrollment, PO Box 80159, Baton Rouge, LA 70898-0159.

Applicable websites / e-mail

Email *hipaaedi@unisys.com (the *asterisk is part of the email address) for all HIPAA EDI testing and support questions.

Louisiana Medicaid’s website for HIPAA information: www.lamedicaid.com/hipaa

9 Trading Partner Agreements

If you currently send electronic claims to Louisiana Medicaid, no additional agreements are required for HIPAA. However, if you are a new provider or a submitter that would like to submit electronically, complete the forms located in this section and submit to Provider Enrollment, PO Box 80159, Baton Rouge, LA 70898-0159.

Policies Affecting EDI Submissions and Submitters

The following policies are in addition to those outlined in the provider manuals for the individual claim types and in no way replace those publications.

1. The required edits, minimum submission standards, Letter of Certification requirements and data/keying specifications as outlined in the electronic media specification manuals must be fulfilled and maintained by all providers and billing agencies submitting claims electronically.
2. At any time, an authorized representative of the Louisiana Medicaid Program, Attorney General, U.S. Department of Health and Human Services, General Accounting Office, or Inspector General can request supportive documentation to ensure that all requirements are met, e.g. program listings, dumps, flow charts, file descriptions and accounting procedures. These regulatory agencies may also request actual information used to bill Louisiana Medicaid claims via electronic media, e.g. provider files, recipient files, reference files, pricing files, whether maintained on physical media, such as a computer listing or stored on automated media. All information thus obtained will be held in strictest confidence.
3. The individual provider is ultimately responsible for accuracy and valid reporting of all Medicaid claims submitted for payment. A provider utilizing the services of a billing agency must ensure through legal contract (a copy of which must be made available to the authorized agents of Louisiana Medicaid upon request) responsibility of an agency to report claim information as directed by the provider in compliance with all policies of the state. It is the responsibility of a billing agency to ensure that each provider has an original Medicaid Provider/Billing Agency Agreement and an original Medicaid Limited Power of Attorney form on file with BHSF/Unisys. Both the individual provider and the billing agency are required to maintain a record of all Medicaid claims submitted for payment.
4. All information supplied by BHSF/Unisys or collected internally within the computing and accounting systems of a provider or billing agency, e.g. master files, provider files, recipient files, reference files, statistical data, is considered confidential and may only be used in the accurate accounting of claims containing or referencing that information. Any redistribution or dissemination of that information for any purpose other than the accurate accounting of Medicaid claims is considered an illegal use of confidential information.
5. At any time, BHSF/Unisys can return, reject or disallow any claim, group of claims or submission received on electronic media pending correction or explanation.
6. No claim received on electronic media can have a date of service more than 365 days before the date of submission.
7. A provider or billing agency must contact Unisys before initial entry (test submission) of electronic claims, whether the submission is the first for the submitter or a new claim type for a submitter billing other claim types. This ensures that all editing is performed and that the submission is acceptable.
8. A submitter of electronic media, whether an individual provider encoding claims using an in-house system or a billing agency encoding claims for a number of providers, must have received authorization via a signed Provider’s Election To Employ Electronic Media Submission of Claims For Processing form from BHSF/Unisys for the type of claims submitted.
9. A billing agency must have on file with BHSF/Unisys an original Medicaid Electronic Media Claims Limited Power of Attorney form for each provider included in a submission. If a submission is received from a billing agency without the applicable forms on file, the claims for the unauthorized provider will not be processed.
10. A provider can utilize the services of only one billing agency per type of Medicaid claims during any calendar month service period.

11. BHSF/Unisys reserves the right to review the processing of Medicaid claims. This consists of an onsite validation of edit requirements through utilization of BHSF/Unisys test invoices with embedded errors.
12. A billing agency, which applies prices to Medicaid claims, must have on file a Medicaid pricing schedule for each provider. This schedule must be authorized in writing by each provider and be available upon demand. The schedule is not required for those Medicaid claims that are pre-priced on the individual source document by the provider.

9.1 EDI Agreement with Instructions

INSTRUCTIONS FOR COMPLETING THE **PROIVDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAID ASSISTANCE PROGRAM (PROVIDER AGREEMENT)**

The following must be completed by every submitter/provider who wants to submit claims electronically. The instructions are as follows:

Provider Agreement

The provider must provide the Medicaid provider number, submitter number (leave blank if requesting new number, provider name, type of medium for submission and name of billing agent or provider's name (if submitting claims for own billing.)

Provider Agreement, Paragraph

The provider must date, print his name and sign the agreement. Original signatures are required – no stamped signatures or initials are acceptable. The Medicaid Electronic Media Limited Power of Attorney form must be completed only if the provider elects to submit claims through a billing agency. If a provider is billing through a billing agency and decides to bill directly, or switch to another billing agency, the provider must submit a new agreement to Unisys Provider Enrollment.

Medicaid Electronic Media Limited Power of Attorney

If the provider will be using a Third Party Biller or Clearinghouse, a Limited Power of Attorney MUST be completed and notarized. Please complete the enclosed Limited Power of Attorney in its entirety to be mailed with your completed Electronic Media Agreement.

- The **Proivder's Election to Employ Electronic Media Submission of Claims for Processing in the Louisiana Medicaid Assistance Program (Provider Agreement)** MUST be completed in its entirety and forwarded to Provider Enrollment together. If you are electing to use a Third Party Biller, the **Medicaid Electronic Media Limited Power of Attorney** must also be completed, notarized, and returned with pages the **Provider Agreement**. Provider Enrollment will return any incomplete or inaccurate agreements or forms to you for correction.
- Third-party billing companies are required to submit a completed HCFA 1513 - Disclosure of Ownership form (included in this packet) and return it with a completed EDI Agreement for their first client to Unisys Provider Enrollment.

PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

Provider Number (7 digits)

4	5	0				

Submitter Number (7 digits)
(Leave blank if applying for new number)

Provider Name: ______________________________

Submission Medium: TAPE ☐; DISKETTE ☐; TELECOMMUNICATIONS ☐;

Name of Billing Agent or Name of Provider if submitting own claims: ______________________________

1. On the date of signature of this agreement, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 13 below. This is done in consideration for the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing's (hereinafter referred to as "State Agency") processing of provider claims, as well as other valuable considerations.
2. All specifications set forth in the "Specifications for Submitting Claims" on Electronic Media Manual," and as amended, shall be met as to every entry sought to be processed. The submission medium is indicated above.
3. The Provider, or his agent, shall be responsible for total compliance with said specifications. The Provider's data processing agent for submission of medical assistance claims is indicated above and any changes in the Provider's data processing agent shall be preceded by 30 days written notice to the State Agency.
4. The Provider shall provide upon request of the director of the State Agency supportive documentation to ensure that all technical requirements are being met, i.e. program listings, tape or diskette dumps, flow charts, file descriptions, accounting procedures and the like.
5. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to sign each certification as part of a transmittal document which must accompany every medical assistance claims submission. A copy of the said certification statement is attached and is hereby incorporated by reference into this paragraph.
6. It is expressly understood that the State Agency or its Fiscal Intermediary (Unisys) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
7. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to your provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
8. The State Agency and the Provider mutually agree that this Agreement may be amended by mutual consent of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement shall not be verbally amended.
9. The Provider agrees to submit to the State Agency, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
10. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
11. The Provider and the State Agency agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.

12. Further, for a period of five years, during the course of a federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested or produce such for examination and copying.

13. The Provider agrees that this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify the State Agency's limited obligations as set in a certain Provider Agreement between the State Agency and the Provider.

14. The Provider agrees to adhere to all requirements for submission and privacy as established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

______________________________	______________________________
Print Name of Person Completing Form	Provider's/Authorized Agent's Original Signature (Stamps, initials not acceptable)

____

Date of Provider/Authorized Agent's Signature

Issuance of submitter number or linkage of third-party billing number denotes acceptance of this agreement by the Louisiana Department of Health and Hospitals.

9.2 Medicaid Electronic Media Limited Power of Attorney

MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY

POWER OF ATTORNEY OR PROCURATION UNITED STATES OF AMERICA

Provider Number (7 digits)

4	5	0				

Submitter Number (7 digits)
(Leave blank if applying for new number)

Provider Name: ____________________

Billing Agent Name: ________________________

BE IT KNOWN, that on this day, BEFORE ME, A Notary Public duly commissioned and qualified in and for the Parish of ________________________________, State of Louisiana, therein residing and in the presence of the witness hereinafter named and undersigned:
PERSONALLY CAME AND APPEARED the above named provider, represented herein by the provider or its duly authorized representative who is of majority and a resident of and domiciled in the State shown under Provider Address above who declared unto me, Notary, that he does by these presents, name, constitute and appoint the above named Billing Agent, a person or entity with full legal capacity, to be his true and lawful agent and attorney-in-fact, to execute for him, and in his name, place and stand, the Louisiana Medical Assistance Program the applicable claims for the provider type for magnetic tape, diskette, or telecommunication submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

THUS DONE AND PASSED BEFORE ME, Notary, and the undersigned competent witnesses, in the City of , State of ____________________on the day of _________________________, 20___.

____
Provider Signature

____
Notary Public Signature

WITNESSES: (requires 2 witnesses)

____

____

Notary Seal (required)

9.3 Provider Electronic Remittance Advice (835) Transaction Agreement with Instructions

PLEASE NOTE: This form is completed only if the submitter is currently receiving a Production 835 and is linking new provider IDs to their submitter ID.

INSTRUCTIONS FOR COMPLETION OF PROVIDER ELECTRONIC REMITTANCE ADVICE (835) TRANSACTION AGREEMENT

Completion of this form indicates that the provider requests that Louisiana Medicaid remittance advice data be returned electronically to the submitter indicated. Once approved, this agreement will remain in effect until further written notice.

1. Enter the 7-digit Medicaid Provider Number.
2. Enter the 7-digit Medicaid Submitter Number of the entity that will receive the electronic remittance advice (835) transaction.
3. Enter the name of the provider requesting the electronic remittance advice.
4. Enter the provider address.
5. Enter the name of the entity to receive the electronic remittance advice (835) transaction. This is the name associated with the submitter number entered above.
6. Attach a copy of the testing acceptance verification letter stating that testing has been completed and you are now authorized to submit claims electronically. Failure to submit this verification will result in rejection of request.

This form must be signed and dated by the provider after reading the authorization request. Only an original, handwritten signature is acceptable. Faxed forms, stamped signatures or initials are not acceptable.

After completion, return the agreement, including a copy of the testing acceptance received from the Unisys EDI Department to the Unisys Provider Enrollment Unit at the address provided on the form.

Provider
Electronic Remittance Advice
(835) Transaction Agreement

Provider Number (7 digits)

4	5	0				

Submitter Number (7 digits)
(Of entity to receive electronic RA)

Provider Name: ______________________________

Provider Address: ______________________________

Name of entity to receive Electronic Remittance Advice (835 transaction) ______________________________

I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information; payment information; and bank account information, provided by me and currently on file if enrolled in **E**lectronic **F**unds **T**ransfer, to the submitter identified above. This authorization will remain in effect until discontinued by written request or changed by a future request.

______________________________ ______________________________

Provider Signature Date

The Provider must complete and submit this form to the Unisys Provider Unit, P.O. Box 80159, Baton Rouge, Louisiana 70898-0159. Processing time may require up to three (3) weeks. DO NOT submit this form prior to completion of required testing with Unisys EMC Department.

9.5 Disclosure of Ownership and Control of Interest Statement (HCFA 1513) with Instructions

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs. A full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All Title XX providers must complete Part II (a) and (b) of this form. Only those Title XX providers rendering medical, remedial or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

GENERAL INSTRUCTIONS

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V – 42CFR 51a.144
Title XVIII – 42CFR 420.200-206
Title XIX – 42CFR 455.100-106
Title XX – 45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed, use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files. This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I (a) Under identifying information, specify in what capacity the entity is doing business such as (DBA), example, name of trade of or corporation.

(b) For Regional Office Use Only. If the yes box is checked for Item VII, the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

Item II Self-explanatory

Item III List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing supplier. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health Program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices:

The ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the

by-laws, constitution, or other operating or management direction of the disclosing entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV – VII – Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VIII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV – (a&b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V – if the answer is yes, list name of the management form and employer identification number (EIN) or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI – if the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII – A chain affiliate is any free-standing health care facility that is either owned, controlled or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporation. Provider-based facilities such as hospital-based home health agencies are not considered to be chain affiliates.

Item VIII – if yes, list the actual number of beds in the facility now and the previous number.

Disclosure of Ownership and Control Interest Statement

I. Identifying Information

(a). Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

(b) (*To be completed by HCFA Regional Office*) Chain Affiliate No. ☐ ☐ ☐ ☐ ☐ LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX or XX?

☐ Yes ☐ No LB2

Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX or XX?

☐ Yes ☐ No LB3

Are there any individuals currently employed by the institution, agency or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or career within the previous 12 months?
(Title XVIII providers only)

☐ Yes ☐ No LB4

(a) List names, addresses for individuals or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under Remarks on page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
		LB5

(b) Type of Entity ☐ Sole Proprietorship ☐ Partnership ☐ Corporation LB6
☐ Unincorporated Associations ☐ Other (Specify)

© If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicaid/Medicare facilities? (Example, sole proprietor, partnership or members of Board of Directors.) Do you have other Medicaid/Medicare provider numbers? If yes, list names, addresses of individual and provider numbers

☐ Yes ☐ No LB7

Name	Address	EIN

IV. (a) Has there been a change in ownership or control within the last year? If yes, give date ___________________________	☐ Yes	☐ No	LB8
Do you anticipate any change of ownership or control within the year? If yes, when? ____________________________	☐ Yes	☐ No	LB9
©Do you anticipate filing for bankruptcy within the year? If yes, when? ___________________________	☐ Yes	☐ No	LB10
V. Is this facility operated by a management company or leased in whole or part by another organization? If yes, give date of change in operations ___________________________	☐ Yes	☐ No	LB11
VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?	☐ Yes	☐ No	LB12
VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)	☐ Yes	☐ No	LB13
Name EIN# Address			LB14
VII (b) Is the answer to Question VII (a) is No, was the facility ever affiliated with a chain? (If yes, list Name, Address of Corporation, and EIN)	☐ Yes	☐ No	LB18
Name EIN# Address			LB19
Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years? If yes, give year of change ________ Current Beds __________ LB16 Prior Beds ____________ LB17	☐ Yes	☐ No	LB15

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title
Signature	Date

Remarks

10 Certification

10.1 2005 Certification

Submitters of Electronic Claims to Louisiana Medicaid

RE: Change in Required Certification Process for Electronically Submitted Claims
IMMEDIATE ACTION REQUIRED

Dear Submitter:

Historically, all claims submitted electronically to Louisiana Medicaid have required a completed hardcopy Certification Form for each file transmitted to Unisys. Effective January 1, 2005, the individual certification forms will be replaced with an Annual Certification Form. These forms must be on file to allow ongoing submission of electronic claims. The first deadline for receipt of completed Annual Certification forms is May 31, 2005 and will be retroactive back to January 1, 2005.

Enclosed are the following forms:

- Annual Certification Form for calendar year 2005;
- Address/Telephone Update form.

ACTION NEEDED:
The enclosed forms MUST be completed and returned to the above address before April 15, 2005. Failure to submit a completed Certification form will result in closure of the submitter number and all electronic files will be dropped from the system **without being processed**.

PROVIDER RESPONSIBILITY:
It is the responsibility of each provider submitting electronic claims to Louisiana Medicaid to ensure that all rules and regulations are followed. The provider should submit an Annual Certification form to each billing agent/clearinghouse for their records. The provider should also ensure that all claims are true, accurate and complete.

THIRD PARTY BILLERS:
It is the responsibility of each third-party biller to ensure that similar certification forms are received from each provider for whom they submit electronic claims to Louisiana Medicaid. These forms must include language where the provider attests to the truth, accuracy and completeness of all claim information and that the provider understands that all claims are paid using Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. These provider Certification forms must be kept on file for a minimum of five (5) years.

FUTURE CERTIFICATION FORMS:
During the 4th Quarter of each year, correspondence will be mailed to all open submitters requesting updated information such as addresses, phone numbers, etc. and will include the Annual Certification Form. This form will have to be submitted by November 1st of each year. Failure to submit the updated Certification Form will result in termination of the submitter number thus preventing the ability to transmit electronic claims to Louisiana Medicaid.

Please contact the EMC/EDI Department at the number above regarding all questions.

Sincerely,

EMC/EDI Department

EMC/EDI ANNUAL CERTIFICATION OF ELECTRONICALLY-SUBMITTED MEDICAID CLAIMS
Certification Period: January 1, to December 31, 2005

Provider Number (7 digits) - If submission contains files for more than 1 provider, list ALL provider numbers and attach to this Certification.

4	5	0				

Submitter Number (7 digits)

Provider Name: ____________________

Submissions by Provider Rendering Services:

I certify that all services rendered during the above identified Certification Period were necessary, medically indicated and were rendered by me or under my personal supervision. I have reviewed the claims information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or otherwise required by law or regulation. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistant Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims 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 state laws.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

Submissions by Third Party Biller (Billing Agents/Clearinghouses):

I certify that the claim information submitted is an exact duplicate of information transmitted to me by the identified provider(s) and that no revisions or alterations have been made by me.
I also certify that the identified provider(s) have furnished me with an EMC/EDI Certification of Medicaid Claims Submitted Electronically Form on which the provider has attested to the truth, accuracy and completeness of the claim information and I agree to maintain these forms for a period of five (5) years.

Attach a list of provider(s) name(s) and identification numbers.

Identify all claim types that will be submitted during this Certification Period:

CLAIM TYPE ☐ 837P ☐ 837 I ☐ 837 D ☐ Non-Ambulatory Transportation ☐ Case Management ☐ Other:

DATE ____________________ PROVIDER SIGNATURE (ORIGINAL) ____________________

NOTE: Updated certification forms MUST be submitted annually. Failure to maintain a completed Certification Form on file will result in the closure of the submitter number without notice to subbmitter. All files submitted with closed submitter numbers will be dropped from the system without being processed.

ADDRESS CHANGE FORM FOR ELECTRONIC SUBMITTERS ONLY

COMPLETE THE FORM IN ITS ENTIRETY—See instructions before completing

1. YOUR MEDICAID PROVIDER NUMBER

2. YOUR MEDICAID SUBMITTER NUMBER (SEE INSTRUCTIONS)

3. SUBMITTER NAME (SEE INSTRUCTIONS)

4. TELEPHONE

FAX

EMAIL ADDRESS

5. PHYSICAL LOCATION STREET ADDRESS—INCLUDE SUITE INFORMATION—NO P.O. BOXES

6. PHYSICAL LOCATION – CITY

7. STATE

8. ZIP CODE

9. PAY-TO NAME*

10. OTHER (ATTN:, DBA, C/O, ETC.)

11. PAY-TO ADDRESS (MAILING ADDRESS FOR REMITTANCE ADVICES)

12. PAY-TO CITY (MAILING ADDRESS FOR REMITTANCE ADVICES)

13. PAY-TO STATE

14. ZIP CODE

15. PHYSICAL LOCATION PARISH

16. PARISH CODE

17. U (1) / R (2)

18. SSN:

19. TAX ID #

20. UPIN:

21. INDIVIDUALS ONLY – NOT APPLICABLE

22. DIRECT DEPOSIT INFORMATION - NOT APPLICABLE

23. ORIGINAL INDIVIDUAL PROVIDER SIGNATURE & DATE (NO STAMPS OR INITIALS)

______________________________	______________________________
Signature	**Date**

NOTE: Pages 48 and 49 contain the new 2006 Annual Certification.

Submitters of Electronic Claims to Louisiana Medicaid

Dear Submitter:

Effective January 1, 2006, all submitters must have a 2006 Annual Certification Form on file with Louisiana Medicaid. This form must be on file to allow ongoing submission of electronic claims. The deadline for the completed Annual Certification form is January 1, 2006

Enclosed is the following form:

- Annual Certification Form for calendar year 2006

ACTION NEEDED:

The enclosed form MUST be completed and returned to the above address before January 1, 2006. Failure to submit a completed Certification form will result in closure of the submitter number and all electronic files will be dropped from the system **without being processed.**

PROVIDER RESPONSIBILITY:

If the provider is submitting directly to Medicaid with their own submitter ID the provider must ensure that all rules and regulations are followed. If the provider is using a billing agent/clearinghouse for claims submission they must ensure a similar certification form is sent to their submitter for their records. The provider should also ensure that all claims are true, accurate and complete.

THIRD PARTY BILLERS:

It is the responsibility of each third-party biller to ensure that similar certification forms are received from each provider for whom they submit electronic claims to Louisiana Medicaid. These forms must include language where the provider attests to the truth, accuracy and completeness of all claim information and that the provider understands that all claims are paid using Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. These provider Certification forms must be kept on file for a minimum of five (5) years.

FUTURE CERTIFICATION FORMS:

During the 4th Quarter of each year, correspondence will be mailed to all open submitters requesting updated Annual Certification Form. This form will have to be submitted by January 1st of each year. Failure to submit the updated Certification Form will result in termination of the submitter number thus preventing the ability to transmit electronic claims to Louisiana Medicaid.

Please contact the EDI Department at the number above regarding all questions.

Sincerely,

EDI Department

Enc.

2006 ANNUAL CERTIFICATION FORM

EDI ANNUAL CERTIFICATION OF ELECTRONICALLY-SUBMITTED MEDICAID CLAIMS
Certification Period: January 1, to December 31, 2006

4	5	0			

Provider Number (7 digits) - If submission contains files for more than 1 provider, list ALL provider numbers and attach to this Certification.

Submitter Name: ______________________________

○ **Submissions by Provider Rendering Services Using their own Submitter ID:**

I certify that all services rendered during the above identified Certification Period were necessary, medically indicated and were rendered by me or under my personal supervision. I have reviewed the claims information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or otherwise required by law or regulation. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistance Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims 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 state laws.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

○ **Submissions by Third Party Biller (Billing Agents/Clearinghouses) Using their Submitter ID:**

I certify that the claim information submitted to Louisiana Medicaid is an exact duplicate of detailed claim line information received from the provider and has not been altered or revised except for translation to the current 837 transaction format. I certify that the information submitted in electronic format is true, accurate and complete and not materially changed by me. Additionally, I understand that payment of these claims will be from Federal and State funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

I also certify that the identified provider(s) have furnished me with an EDI Annual Certification of Medicaid Claims Submitted Electronically Form on which the provider has attested to the truth, accuracy and completeness of the claim information. If I do not have a direct relationship with submitting providers, I agree to obtain an/EDI Annual Certification Form from the individual(s) or entity(ies) with whom I maintain a contractual relationship. I agree to maintain these forms for a period of five (5) years.

Attach a list of provider(s) name(s) and identification numbers.

Identify all claim types that will be submitted during this Certification Period:

CLAIM TYPE ☐ 837P ☐ 837 I ☐ 837 D ☐ Non-Ambulatory Transportation ☐ Case Management ☐ Other:

______________________________ ______________________________

DATE SUBMITTER SIGNATURE (ORIGINAL)

NOTE: Updated certification forms MUST be submitted annually. Failure to maintain a completed Certification Form on file will result in the closure of the submitter number without notice to submitter. All files submitted with closed submitter numbers will be dropped from the system without being processed.