

Public Health Services

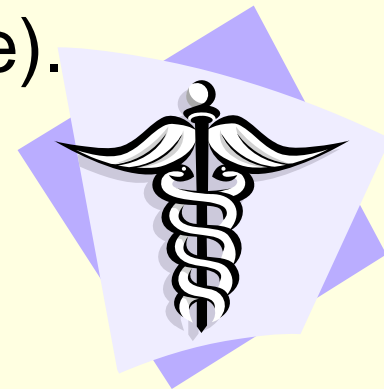
ACS Field Representatives:

**Denise Olson
&
Amy Buxton**

10/08/08

What are Public Health Clinic services?

- Public health clinic services are physician and mid-level practitioner services provided in a clinic designated by the Department of Health as a public health clinic.
- Services must be provided directly by a physician / nurse practitioner or by a public health nurse under a physician's immediate supervision (i.e., the physician has seen the client and ordered the service).
- Taxonomy – 251K00000X



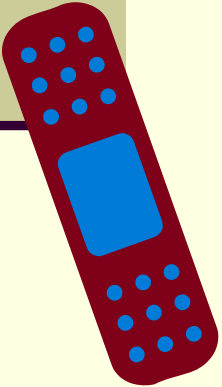
What types of services does EqualityCare reimburse for ?

- Public Health Service offices can bill for most services that a private practice nurse practitioner or physician can, within their legal scope of practice
- Primary services EqualityCare clients are seen for include:
 - Immunizations
 - LT101 evaluations
 - Acute illness examination and treatments
 - Breast pump purchase and rentals

Immunizations



- WyVIP program vaccines
 - Provided free of charge for EqualityCare eligible clients 18 years of age or younger
 - Billed with the SL modifier to indicate state supplied vaccine product
 - Billed with an appropriate vaccination administration code
 - ACS will pay \$0.00 on the vaccine product, and pay appropriate fee on the administration



Immunizations (con't)

- Private stock vaccinations
 - Necessary when:
 - WyVIP is out of stock and unable to supply a vaccine
 - The client is not age appropriate for the WyVIP program
 - The vaccine is not supplied through the WyVIP program

Immunizations (con't)

- Private stock vaccines
 - Bill the vaccine product without the SL modifier to indicate it was private stock
 - Bill the appropriate administration code
 - Include an invoice when applicable
 - ACS will pay either a pre-determined fee OR price the vaccine from the invoice, depending on the code, and pay appropriate fee on the administration code

LT101 Evaluations

- EqualityCare will pay for a non-binding LT101 evaluation to be completed on any referred client
- The LT101 evaluation form must be submitted to ACS prior to the claim for the LT101 evaluation being billed
- If the client is not on file with ACS, an ID number will be created under which the LT101 claim can be billed
- The newly created ID number can be obtained by calling the ACS AVR system with the client's SSN or through Provider Relations.
- ID numbers for clients without SSNs can be obtained by contacting Provider Relations at 800-251-1268.

Breast Pump Policy

- Breast pumps are covered for purchase or rental, depending on the needs of the mother and child
- Detailed bulletin with full policy available on the web site

Breast Pump Purchase

- Code E0603 – Breast pump, electric, any type
- Infant must have appropriate diagnosis to necessitate pump
- No prior authorization required
- Certificate of Medical Necessity should be kept on file
- Submit the claim with the infant's EqualityCare ID
- Submit claim with the invoice for the pump

Breast Pump Rental

- E0604 RR– Breast pump, heavy duty, hospital grade
- RR modifier indicates rental
- Mother must have appropriate diagnosis to necessitate temporary use of breast pump
- Prior authorization is required – submit Certificate of Medical Necessity and physician’s written order with PA request to ACS Bowers
- Submit the claim with the mother’s EqualityCare ID
- Coverage available for pump and for the breast pump starter kit for rentals (use the TH modifier for the kit)

EqualityCare
Wyoming Department of Health
Certificate of Medical Necessity
Electric Breast Pump E0603, E0604

Section A CLIENT AND PROVIDER INFORMATION

Client Name _____	Prescribing Provider _____
Medicaid ID # _____	Provider ID # _____
Date of Birth _____	Telephone # _____

Section B CLINICAL INFORMATION (MUST BE COMPLETED BY THE PRESCRIBING PROVIDER)

DIAGNOSIS : INFANT

DIAGNOSIS : MOTHER

Section C—Applies to purchase of Single User Pump (E0603) through cooperative agreement with Women, Infant and Children (WIC) Program—SUBMIT CLAIM WITH INFANT’S MEDICAID ID #

Circle all that apply:

Y N 1. Breastfeeding is medically necessary for this infant AND

Y N 2. Mother has initiated contact with and will receive follow-up support from a community breastfeeding program such as WIC, La Leche or a community Public Health Nursing Office; or

Y N 3. You have provided Mother with education regarding health, nutritional, immunologic, developmental, psychological, social, economic and environmental benefits of breastfeeding; or

Y N 4. Infant is pre-term or low birth weight with increased nutritional needs; or

Y N 5. Infant requires hospitalization longer than the mother; or

Y N 6. Infant has diagnosis of cleft palate, cleft lip, Down’s Syndrome, cardiac problems, cystic fibrosis, PKU, neurological impairment, failure to thrive or other conditions that result in the inability to breastfeed; or

Y N 7. Infant has cranial facial abnormalities or is unable to suck adequately; or

Y N 8. Infant has severe feeding problem. Please describe:

Section D—For rental of breast pump, heavy duty, hospital grade (E0604) - up to 3 months only. SUBMIT CLAIM WITH MOTHER’S MEDICAID ID NUMBER AND PRIOR AUTHORIZATION #:

Circle all that apply:

Y N 1. Mother has diagnosis of breast abscess, mastitis, engorgement or other medical problem that necessitates short-term rental of breast pump; or

Y N 2. Mother is hospitalized due to illness or surgery on a short-term basis; or

Y N 3. Mother is to receive short-term treatment with medications that may be transmitted to the infant; or

Y N 4. Healthcare provider certifies that short-term use of this type of breast pump is medically necessary due to medical condition on infant. Please describe:

Section E—PRESCRIBING HEALTHCARE PROVIDER ORDER:

Section F—PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT SIGNATURE AND DATE:

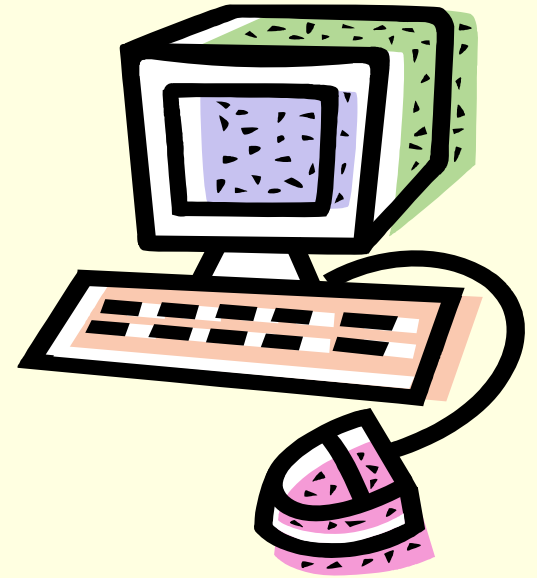
Signature of Prescribing Provider _____
Date

Additional Services

- Any other CPT or HCPCS procedure code for which the Public Health Services taxonomy is an allowed taxonomy code can be billed for an eligible client on an appropriate EqualityCare plan
- Please review the information on the ACS online fee schedule or contact Provider Relations to verify coverage of clients or codes

Website Fee Schedule Information

- Information is updated nightly
- Can search by code OR description
- Clearly shows if code is covered or not and current fee
- Indicates limitations such as age, sex, or number of units



Web Site Fee Schedule Example

1 record(s) returned where the Procedure Code= A4266

Procedure Code : A4266

Fee Schedule: M01 - Master Fee Schedule

Code Type: HCPCS Procedure Code

Description: DIAPHRAM FOR CONTRACEPTIVE USE

Rate Begin Date: 02/01/08

Conversion Factor Amt: N/A

Factor Code: M; Manual pricing usually requires invoice

RVU: N/A

Rate: 0.00

Prior Authorization : N

Follow Up Days: N/A

Min Age: 10

Max Age: 50

Max Units of Service: 1.00

ASC Group: N/A

OPPS Status Indicator: 03

Multiple Surgery: N

Medicare Covered: Y

Nursing Home Covered: Y

Valid Sex: B

Referral Indicator: N

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Eligibility Verification

- Services can only be billed to EqualityCare for eligible clients
- Contact ACS via the AVR to verify eligibility (800-251-1270)
 - AVR is available 24 hours a day, 7 days a week
 - AVR provides eligibility with client ID OR SSN
 - AVR provides limited TPL coverage information

Eligibility Verification (con't)

- Contact MediFax (Emdeon) or MEVSNET for information regarding verification systems using the swipe strip on the client's ID card
- MEVSNET – 1-800-333-4979
- MediFax (Emdeon) – 1-800-444-4336
- Refer to the EqualityCare web site for a comprehensive list of benefit plans and coverage details

Benefit Quick Reference

EqualityCare and State Healthcare Benefit Plans															
Plan Name	Plan Description	Eligibility Limitations	Coverage Types *												Coverage Limitations
			D	Rx	I	O	M	V	W	N	AP	BP	C/D		
KIDA	Standard Full Coverage Child Medicaid	Children only, under 21	X	X	X	X	X	X						X	No nursing facility coverage
QMB	Qualified Medicare Beneficiary												X	X	Limited to paying co-insurance and deductible on Medicare crossover claims
QMBP	Qualified Medicare Beneficiary with Prescriptions			X									X	X	Limited to 3 prescriptions per month, paying co-insurance and deductible on Medicare crossover claims, oxygen services not covered by Medicare and paying Medicare Part B premiums
SCM	Targeted Case Management	DD Eligibility Screenings					X								Limited to screening services for the Developmentally Disabled Waiver program
SHPS	State Licensed Shelter Care									X					Limited to nursing facility coverage
SLMB	Special Low-Income Medicare Beneficiaries												X		Limited to paying Medicare Part B premiums
SLMP	Special Low-Income Medicare Beneficiaries with Prescriptions			X									X		Limited to 3 prescriptions per month, oxygen services not covered by Medicare and paying Medicare Part B premiums
TBI	Tuberculosis Infected		X	X		X	X	X						X	No inpatient hospital coverage
WLTC	Wavier Long Term Care		X	X	X	X	X	X	X					X	No nursing facility coverage

*Key	
D	Dental
Rx	Prescriptions
I	Inpatient
O	Outpatient
M	Medical / CMS - 1500
V	Vision
W	Wavier
N	Nursing Home
AP	Part A Premiums
BP	Part B Premiums
C/D	Medicare Co-Insurance and Deductible

NDC / HCPCS Information

- Certain drug codes must be paired with appropriate NDC codes
- Crosswalk of required codes and appropriate NDC codes available on the website
- Currently, 21 codes require NDCs to be paired with them
- On CMS-1500 claim form, NDC is entered in the shaded area above the dates of service with an N4 qualifier
- If the same procedure code is used with more than one NDC, a KP modifier is used on the 1st line, and a KQ modifier is used on each additional line
- Detailed information available in the NDC/HCPCS informational bulletin on the EqualityCare website

CMS-1500 Billing Example

CMS-1500 (Version 08/05) Billing Instructions

To report a procedure code with an NDC on the CMS-1500 (08/05) claim form, enter the following NDC information into the shaded portion of field 24A:

- NDC qualifier of N4 [Required]
- NDC 11-digit numeric code [Required]

Do not enter a space between the N4 qualifier and the NDC. Do not enter hyphens or spaces within the NDC.

CMS-1500 (08/05) - One NDC Per Procedure Code

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	c. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
MM	From DD	YY	MM	To DD	YY			CPT/HCPCS	MODIFIER								
N460574411301																	
03	01	07	03	01	07	11		90378			13	500	00	2	N	NPI	0123456789

CMS-1500 (08/05) - Two NDCs Per Procedure Code

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	c. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
MM	From DD	YY	MM	To DD	YY			CPT/HCPCS	MODIFIER								
N460574411301																	
03	01	07	03	01	07	11		90378	KP		13	500	00	2	N	NPI	0123456789
N460574411401																	
03	01	07	03	01	07	11		90378	KQ		13	250	00	1	N	NPI	0123456789

NOTE: EqualityCare's instructions follow the National Uniform Claim Committee's (NUCC) recommended guidelines for reporting the NDC on the CMS-1500 (08/05) claim form. Provider claims that do not adhere to these guidelines will be returned unprocessed.

How do I bill EqualityCare?

- Paper Claims
 - CMS-1500 claim forms
- Electronic Claims
 - WINASAP 2003 software (free!)
 - Web Portal (free!)
 - Billing Agent
 - Clearing House

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1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA													
1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	0600123456															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith michelle B						3. PATIENT'S BIRTH DATE MM DD YY 05 15 1970		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)														
5. PATIENT'S ADDRESS (No., Street) 123 main ST						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)															
CITY Townville			STATE WY	8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY											STATE							
ZIP CODE 82111		TELEPHONE (Include Area Code) (307) 111-1111				Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	ZIP CODE											TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY OR FECA NUMBER																
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	10d. RESERVED FOR LOCAL USE	11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	10d. RESERVED FOR LOCAL USE	11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>															
c. EMPLOYER'S NAME OR SCHOOL NAME						10d. RESERVED FOR LOCAL USE	11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE	11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																
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. SIGNATURE: Signature on File DATE: 1-1-08												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE: Signature on File											
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				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 PROVIDER OR OTHER SOURCE						17a. NPI	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ CHARGES	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. V72.31 2. V25.49						22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. SPORT/Family Plan	I. ID.	J. RENDERING PROVIDER ID. #													
1 01 01 2008 01 01 2008		11	99212	1,2	50 00	1	NPI	261QA0005X	1112221113														
2 01 01 2008 01 01 2008		11	S4993	2	33 00	3	NPI	261QA0005X	1112221113														
3							NPI																
4							NPI																
5							NPI																
6							NPI																
25. FEDERAL TAX I.D. NUMBER 11-111111		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 1248		27. ACCEPT ASSIGNMENT? (For gnat. assign. only) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 83 00	29. AMOUNT PAID \$	30. BALANCE DUE \$ 83 00															
31. SERVICE FACILITY 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.) SIGNATURE: [Signature] DATE: 1-10-08						32. SERVICE FACILITY LOCATION INFORMATION Family Planning office 121 N. 3rd Ave Hertown WY 82101				33. BILLING PROVIDER INFO & PH # (307) 555-8655 Family Planning office 121 N. 3rd Ave Hertown WY 82101													
a. 1112221113		b. 261QA0005X		a. 1112221113		b. 261QA0005X																	

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Important tips: CMS-1500 claim form

- Box 1a – EqualityCare 10 digit client ID
- Box 17 – Referring physician information
- Box 21 – Diagnosis codes
- Box 24: Line item information
 - NDC / HCPCS information (if required)

Important tips: CMS-1500 claim form

- Box 28 – Total charges
- Box 29 – Third Party Liability payments
- Box 33 – Provider information
 - Box 33a – NPI number
 - Box 33b – Taxonomy code (251K00000X)
- <http://www.nucc.org> for more information on CMS-1500 claim instructions

WINASAP 2003 Software

(free!)

Requirements

- Uses an analog phone line and a dial up modem
- Must be separately installed on each computer from which it will be used

Advantages

- Stores client Ids, procedure codes, provider information, etc, for future use in claims building



WINASAP 2003 Software (free!)

Resources

- Website – <http://wyequalitycare.acs-inc.com>
 - Step by step tutorial
 - Found under WINASAP
- EDI Help Desk – 800-672-4959
 - Installation problems
 - File status
 - Rejected files



ACS Web Portal (free)

Requirements

- Uses your internet connection (dial-up, DSL or cable)

Advantages

- Allows you to enter claims from any computer connected to the internet
- Stores copies of submitted claims, but not individual client Ids or procedure codes
- Web Portal also grants access to current copies of Remittance Advices.

ACS Web Portal (free)

Resources

- Website – <http://wyequalitycare.acs-inc.com>
 - Step by step tutorials
 - Found under Web Portal Tutorials
- EDI Help Desk – 800-672-4959
 - Forgotten password
 - File status
 - Rejected files

EqualityCare Web Site

- Web Site – <http://wyequalitycare.acs-inc.com>
- Bulletins and Newsletters
- Fee Schedule, updated nightly
- Tutorials for Web Portal and WINASAP 2003
- Billing Manuals
- Payment Schedule Changes and Updates
- Important News and Policy Changes
- NDC/HCPSC Crosswalk
- Benefit Plan – Quick Reference

How to read an RA – Paid claims

REMITTANCE ADVICE
 WYMC8000-R001 (CP-O-12)
 AS OF 04/16/08

WYOMING DEPARTMENT OF HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 04/16/08

REMITTANCE ADVICE

TO: THE FAMILY PLANNING CLINIC R.A. NO.: 111222 DATE PAID: 04/16/08 PROVIDER NUMBER: 111111100/1234567890 PAGE: 1

TRANS-CONTROL-NUMBER	BILLED	MCARE	COPAY	OTHER	DEDUCT-	COINS	MCAID	WRITE	TREATING
LI SVC-DATE PROC/MODS	UNITS	PAID	AMT.	INS.	IBLE	AMT.	PAID	OFF	PROVIDER S PLAN

*** CLAIM TYPE: HCFA 1500

*** CLAIM STATUS: PAID

ORIGINAL CLAIMS:

* SMITH JANE RECIP ID: 0600123456 PATIENT ACCT #:000011111										
0-08094-33-706-0049-00		85.00	0.00	0.00	0.00	0.00	0.00	60.94	24.06	
01 10/17/07 81025 QW	1	20.00	0.00	0.00	0.00	0.00	0.00	0.00	1234567890 K MATR	
LINE EOB(S): 3										
PREVIOUS-DATE-PAID: 03/12/08 CONFLICTING-TCN: 3-08072-00-707-0000-01										
02 10/17/07 99213	1	65.00	0.00	0.00	0.00	0.00	0.00	60.94	4.06	1234567890 F MATR
* JONES ERICA RECIP ID: 0600181111 PATIENT ACCT #:000122221										
0-08102-33-701-0022-00		50.00	0.00	0.00	0.00	0.00	0.00	7.96	42.04	
01 02/27/08 99212	1	30.00	0.00	0.00	0.00	0.00	0.00	0.00	1234567890 K KIDA	
LINE EOB(S): 1										
PREVIOUS-DATE-PAID: 03/12/08 CONFLICTING-TCN: 0-08067-33-702-0044-00										
02 02/27/08 81025 QW	1	20.00	0.00	0.00	0.00	0.00	0.00	7.96	12.04	1234567890 F KIDA

What do I do if I need to correct a claim – or How do I do an adjustment?

- Print a copy of the Adjustment/Void form from the EqualityCare Website
- Fill out the form with the information from the incorrect claim
- Write a clear, concise description of what changes need to be made to the claim
- Indicate ALL changes that need to be made (i.e. units and amounts, if necessary)
- Attach a corrected paper claim or a copy of the RA with corrections made on it
- Mail to ACS, PO Box 547, Cheyenne, WY 82003
- Contact Provider Relations with questions!

Adjustment/void Request Form

EXHIBIT 6.9

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ADJUSTMENT/VOID REQUEST FORM																					
SECTION A: CHECK BOX 1a), 1b) OR 2)																					
<input type="checkbox"/> 1a) CLAIM ADJUSTMENT: Attach a copy of the claim with corrections made in red ink. DO NOT USE HIGHLIGHTER	<input type="checkbox"/> 2) CANCELLATION OF THE ENTIRE REMITTANCE ADVICE. Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances.																				
<input type="checkbox"/> 1b) VOID CLAIM: Attach a copy of the claim or Remittance Advice.	Complete Section C only. Attach RA and EqualityCare check																				
Complete Sections B and C. If attaching a check, the check should be payable to Office of Healthcare Financing.																					
SECTION B																					
TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:																					
1. 17-DIGIT TCN: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>																		2. PAYMENT DATE:			
3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>											4. PROVIDER NAME:										
5. 10-DIGIT CLIENT NUMBER: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>											6. 10-DIGIT PA NUMBER: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>										
7. REASON FOR ADJUSTMENT OR VOID:																					
SECTION C: SIGNATURE AND DATE REQUIRED																					
PROVIDER SIGNATURE: _____ DATE: _____																					
RETURN ALL REQUESTS TO: ACS P.O. BOX 547 CHEYENNE, WY 82003-0547																					
REMARKS/STATUS: _____ (FOR ACS USE ONLY)																					
CASH CONTROL NUMBER: _____																					
ADJUSTED BY: _____ DATE: _____																					

Adjustment/Void Form Instructions

Section	Field #	Field Name	Action
A	1a	Claim Adjustment	Mark this box if any adjustments need to be made to a claim. Attach a copy of the claim with corrections made in red ink. Sections B and C must be completed.
	1b	Void Claim	Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the Remittance Advice.
	2	Cancellation of the Entire Remittance Advice	Mark this box if an error or change would result in a complete refund of the EqualityCare payment. Attach a copy of the Remittance Advice and the EqualityCare check. Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances. (Skip to Section C)
B	1	17-digit TCN	Enter the 17-digit transaction control number assigned to each claim from the Remittance Advice.
	2	Date of Service	Enter the Date of Service
	3	9-digit Provider or 10-digit NPI Number	Enter your 9-digit EqualityCare provider number or 10-digit NPI number, if applicable.
	4	Provider Name	Enter your provider name.
	5	10-digit Client Number	Enter the client's 10-digit EqualityCare ID number.
	6	10-digit PA Number	Enter the 10-digit EqualityCare Prior Authorization number, if applicable.
	7	Reason for Adjustment or Void	Indicate if this is an adjustment or void. Enter the specific reason and any pertinent information that may assist ACS.
C		Provider Signature and Date	Signature of the provider or the provider's authorized representative and the date.

Common Reasons For Adjustments

- Incorrect dates of service
- Incorrect number of units
- Incorrect charges billed
- Incorrect client ID number used
- Third Party Liability payment made after claim has processed

How to read an RA – EOB codes

TO: THE FAMILY PLANNING CLINIC R.A. NO.: 111222 DATE PAID: 04/16/08 PROVIDER NUMBER: 111111100/1234567890 PAGE: 5

REMITTANCE TOTALS

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	6 -----	398.00	295.78
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	8 -----	1,435.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00	0.00
PENDEED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	6 -----	703.05	0.00
AMOUNT OF CHECK:	-----		295.78	

---	THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:	COUNT:
1	THIS IS AN EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM.	8
3	THE CLAIM IS IN POSSIBLE CONFLICT WITH A PREVIOUSLY PAID CLAIM.	1
45	THE LINE ITEM DIAGNOSIS CODE IS MISSING. CORRECT THE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.	7
81	SERVICE IS COVERED BY MEDICARE AND NO MEDICARE DENIAL ATTACHED OR MEDICARE DENIED AND MEDICAID DOES NOT COVER EITHER.	4
147	THE TREATING PROVIDER TYPE IS NOT VALID WITH THE PROCEDURE CODE.	1
171	A LAB CODE (80000-89999) CANNOT BE BILLED WITHOUT A VALID CLIA CERTIFICATE TYPE.	1
172	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE PROCEDURE CODE.	1
201	TWO OFFICE VISITS ON THE SAME DAY BY THE SAME PROVIDER REQUIRES DOCU-	6
243	YOUR NPI IS EITHER MISSING FROM THE CLAIM OR IS NOT ON FILE WITH ACS OR YOU NEED TO BILL WITH AN APPROPRIATE TAXONOMY CODE.	1
245	ONLY ONE UNIT OF SERVICE IS ALLOWED PER RECIPIENT EVERY 3 YEARS.	1
900	THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.	14

What do I do if a claim denies?

- Determine the reason for denial
- Correct the error
- Resubmit the claim
- Contact Provider Relations
 - Understanding EOB codes
 - Help correcting claim

Common denial reasons

- Client not eligible
 - Cannot bill for non-eligible client
- Exact duplicate of a previously paid claim
 - Review RA for TCN of previous payment, do adjustment if changes are necessary
- Incorrect provider NPI or taxonomy entered
 - Verify NPI is entered correctly before billing
- Invoice not included when necessary
 - Verify the invoice indicates the following:
 - Date of invoice is compatible with date of service
 - Item clearly marked on invoice
 - Clearly defined unit information
- LT101 claim submitted, however the client is not on file
 - Be sure to send the LT101 to ACS and obtain the client's ID number prior to billing
- Medicare or Third Party Liability eligibility present but not indicated on claim
 - EqualityCare is the payor of last resort, always bill Medicare or Third Party Liability sources first

How to read an RA – In process

TO: THE FAMILY PLANNING CLINIC R.A. NO.: 111222 DATE PAID: 04/16/08 PROVIDER NUMBER: 111111100/1234567890 PAGE: 4

TRANS-CONTROL-NUMBER	BILLED	MCARE	COPAY	OTHER	DEDUCT-	COINS	MCAID	WRITE	TREATING
LI SVC-DATE PROC/MODS	UNITS	AMT.	PAID	AMT.	INS.	IBLE	PAID	OFF	PROVIDER S PLAN

*** CLAIM TYPE: HCFA 1500

*** CLAIM STATUS: IN PROCESS

* CLAY D KIM RECIPIENT ID: 0600111777 PATIENT ACCT #:00055555

0-08102-33-701-0021-00		225.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
01 03/27/08 99212	1	30.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1234567890	KIDA
LINE EOB(S): 900											
02 03/27/08 99070	1	20.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1234567890	KIDA
LINE EOB(S): 900											
03 03/27/08 87110	1	95.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1234567890	KIDA
LINE EOB(S): 900											
04 03/27/08 99212	1	80.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1234567890	KIDA
LINE EOB(S): 900											

* HENRYE L MARY RECIPIENT ID: 0600128888 PATIENT ACCT #:000345875

0-08079-33-709-0029-00		17.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
01 03/10/08 S4993	1	17.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1234567890	
LINE EOB(S): 900											

What do I do if a claim is “In process”

- Do NOT resubmit the claim
- Do NOT adjust the claim
- Wait for your next RA and review the claim status
- Be patient, some claims may take up to 30 days to resolve
- Claims “In Process” are not yet paid or denied

Top Reasons Claims are “In Process”

- Items on the claim need to be manually priced from an invoice
- Client does not currently have eligibility for the date of service
- Possible conflict or duplicate claim
- Client has primary insurance
- Procedure requires review of attachments

Customer Service

- AVR – 800-251-1270
 - Eligibility, check status, lock-in status, insurance information
- Provider Relations – 800-251-1268, option 2
 - Questions concerning claims, codes, eligibility, payments, Remittance Advices, enrollment, etc
- EDI Help Desk – 800-672-4959
 - EDI enrollment, technical support for electronic billing
- ACS Bowers – 800-230-1791
 - Breast pump rental prior authorization



Pregnant by Choice – A Family Planning Wavier Program

- What is Pregnant by Choice?
 - **Program begins 1/1/2009!**
 - Pregnant By Choice is a new program that provides family planning services to women who have received Medicaid benefits through the Pregnant Women program. This program extends family planning options to women who would typically lose their Medicaid benefits two months postpartum.
 - Family planning services help women to reduce the incidence of closely spaced pregnancies and decrease the number of unintended pregnancies. This, in turn, leads to healthier babies, better birth outcomes, and improved child health.

Pregnant by Choice (con't)

- What is the eligibility criteria for the program?
 - Must be transitioning from the Pregnant Women program
 - Must not be eligible for another Medicaid program
 - Must not have health insurance
 - Must not have not have had a medical procedure to prevent pregnancy
 - Must meet U.S. Citizen/Immigration Status
 - Must be a Wyoming resident
 - Must be Age 19 through the age of 44
 - Must be at or below 133% of the Federal Poverty Level
 - Must not be pregnant

Pregnant by Choice (con't)

- What is the application process?
 - The Department of Family Services (DFS) will send a review form to women eligible for the Pregnant Women program, while in the 60 day postpartum period, to determine if they are interested in the program.

Pregnant by Choice (con't)

■ What services are covered?

- Approved family planning methods and products approved by the Food and Drug Administration (FDA). This program will not cover sterilization reversals, infertility treatment or abortions.
- Family planning services including education about reproductive health, abstinence and methods of contraception. The following medically prescribed services and supplies are proposed for coverage in the family planning waiver program benefit package:
 - Initial physical exam and health history, including patient education and counseling relating to reproductive health and family planning options, including a pap smear and testing for sexually transmitted infections
 - Annual follow-up exam for reproductive health/family planning purposes, including a pap smear and testing for sexually transmitted infections when indicated
 - Brief and intermediate follow up office visits related to family planning
 - Necessary family planning/reproductive health-related laboratory procedures and diagnostic tests
 - Contraceptive management including drugs, devices and supplies
 - Insertion, implantation, or injection of contraceptive drugs or devices
 - Removal of contraceptive devices
 - Sterilization services and related laboratory services (when properly completed sterilization consent form has been submitted) and
 - Medications required as part of a procedure done for family planning purposes.

Pregnant by Choice (con't)

- Where can I get more information?
 - If you would like more information on EqualityCare programs including Pregnant By Choice, please visit the EqualityCare website at:
<http://wdh.state.wy.us/healthcarefin/medicaid/eligibility.html>

Pregnant by Choice (con't)

- Where can services be provided?
 - Family Planning Clinics
 - Primary Care Physicians (MDs and DOs) in public and private practice
 - Certified Nurse Midwives
 - Nurse Practitioners
 - Physician Assistants
 - Pharmacies
 - Laboratories
 - Outpatient Departments of Hospitals (as appropriate)
 - Federally Qualified Health Centers
 - Rural Health Clinics
 - Tribal Health Centers
 - Wyoming Title X and non-Title X publicly funded family planning agency and its sub-grantees, to include participating local public health departments

Questions?
