Louisiana Medicaid

Provider Update

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Employee Education on the Deficit Reduction Act

The Deficit Reduction Act (DRA) of 2005 requires states to comply with the restriction on the use of contingency fees in contracts; encourages them to enact false claims acts; prohibits States from double billing the federal government for prescription drugs; mandates that certain employers conduct education campaigns for employees about false claims acts; appropriates funds for the Secretary of Health and Human Services to improve payment integrity in the Medicaid program; and clarifies the legal responsibility of third parties to pay for health care provided to Medicaid beneficiaries.

In part, Section 6032, entitled Employee Education about False Claims Recovery, requires that any entity that receives or makes payments of $5,000,000 under the Medicaid State Plan must:

- Establish a written policy for all contractors and employees (including management) that provides detailed information about the False Claims Act, any state laws pertaining to civil or criminal penalties for false claims and statements and provides whistleblower protections for preventing fraud and abuse in federal health care program (as defined in Section 1128B(f);
- Have written policies and procedures for detecting and preventing fraud, waste and abuse; and
- Include in all employee handbooks, the laws described in subparagraph (A) of this Act, the rights of employees to be protected as whistleblower and the policies and procedures for detecting and preventing fraud, waste and abuse.

As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act set forth in that subsection and as the Secretary of the US Department of Health and Human Services may specify. As an enrolled provider/entity, it is your obligation to inform all of your employees and affiliates of the provisions of the False Claims Act and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL). When monitored or audited, you will be required to show evidence of compliance with this requirement. Currently enrolled Medicaid providers will be monitored for compliance beginning November 1, 2007. This moni-

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toring will be conducted through established monitoring/auditing processes, i.e. desk audits, on-site monitoring, and/or random samples. At the time of monitoring/auditing, the Bureau of Health Services Financing will determine if the provider/entity is obligated to comply with the requirements of the Act. If the requirements of the Act are met, the provider/entity must demonstrate that it has met its responsibility regarding Employee Education about False Claims Recoveries, and any Louisiana laws and/or rules pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws and/or rules. A provider/entity that fails to demonstrate compliance at the time of the monitoring will be given a specific period of time to demonstrate compliance. Failure to demonstrate compliance, after written notice of noncompliance, will subject the provider/entity to sanctions.

New providers who enroll in the Louisiana Medicaid Program after July 1, 2007, must sign the PE-50 which will contain this requirement.

All Providers

NPI Implementation Delayed

To maintain accurate and timely payment to Louisiana Medicaid providers, the Department of Health and Hospitals did not implement the National Provider Identifier (NPI) system changes on May 23, 2007. Current Louisiana Medicaid Provider IDs will continue to be required on all paper claims, electronic claims, and pharmacy claims until further notice.

Continue to monitor the Louisiana Medicaid website (www.lamedicaid.com) for useful information, such as where to apply for an NPI and how to register that NPI with Louisiana Medicaid. Louisiana Medicaid is currently finalizing the implementation of the NPI. Updated information will be posted through the website, RA messages, provider notices and Provider Update articles. Refer to all provider publications and return to the website frequently to stay informed about the NPI implementation.

CMS 1500 Claims Filers

Revised CMS-1500 Claim Form for Professional, General Services, FQHCs and RHCs

Effective June 4, 2007, the Form CMS-1500 (12-90) was discontinued and only the Form CMS-1500 (08-05) shall be used. This includes all rebilling of claims even though earlier submissions may have been on the Form CMS-1500 (12-90).

Health plans, clearinghouses, and other information support vendors should be able to handle and accept the Form CMS-1500 (08-05) by June 4, 2007.

Instructions

Instructions for completing the CMS-1500 (08-05) are included with this edition of the *Provider Update*. Items to be completed are **required, situational, or optional**. Required information must be entered to process the claim. Claims submitted with missing or invalid information in these fields will be processed, but will appear on the RA as denied claims. **Situational** information may be required (but only in certain circumstances as detailed in the

enclosed instructions). **Optional** information is provided at the discretion of the provider. Claims should be submitted to:

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

Note: DME and Waiver providers must continue to write "DME" or "WAIVER"as appropriate in large letters at the top of the claim form.

Physicians

DHH Expands Prenatal Care for Non-Citizens through LaCHIP

In an effort to expand better health care practices among low-income pregnant women, the Louisiana Department of Health and Hospitals (DHH) has enhanced its prenatal care program to provide eligibility for non-citizens who do not have access to Medicaid, including Medicaid pregnant woman benefits.

The new program, implemented as "Phase IV LaCHIP" under SCHIP, focuses on the prenatal care of the child and is open to non-citizen pregnant women regardless of immigration status. Specifically, Phase IV LaCHIP expands the accessibility beyond the limited emergency medical services traditionally utilized by this demographic group. Phase IV went into effect May 1, 2007, and a system for processing claims is currently in development. All Phase IV claims will be held as "pending" until programming has been finalized. Providers will be notified as soon as programming is completed, and payment of claims will move forward at that time.

The goal of Phase IV LaCHIP's increased availability of prenatal care is the ultimate reduction of premature deliveries and costly emergency care for drop-in deliveries. The program closely mirrors the benefits of the Medicaid Pregnant Woman Program, often referred to as LaMOMS, with the exception that this new group will not be eligible for sixty (60) days of postpartum care as a separate procedure or service because of federal regulations. However, postpartum care, as part of the reimbursement for the delivery, will be covered by this program. To take advantage of the Phase IV LaCHIP program, applicants must meet a number of eligibility criteria:

- Must be a Louisiana resident.
- Cannot be eligible for Medicaid benefits or any other Medicaid program.
- Must have a family income at or below 200 percent of the federal poverty level.
- Must be uninsured at the time of application (uninsured is defined as not having creditable health insurance that provides prenatal care services).
- Cannot be covered under a group health insurance plan.
- Cannot have access to a state employee health benefits plan.

Eligible applicants may be enrolled in the program as early as the month of conception. Coverage can extend through the month the pregnancy ends. Additionally, eligibility will end upon delivery or the month the participant moves out of state, dies, miscarries or is determined eligible for another Medicaid eligibility group.

Applicants previously eligible for emergency medical services only may now be considered for three months of retroactive coverage and their children may be deemed eligible for one year.

CMS Awards Grants to 13 States for Alternatives to Nursing Home Care

The following article is a press release from the U.S. Department of Health and Human Services.

Thirteen states and the District of Columbia will get more than $547 million in grants over five years to build Medicaid long-term care programs that will help keep people at home and out of institutions, Leslie V. Norwalk, Acting Administrator of the Centers for Medicare and Medicaid Services (CMS) announced recently.

These awards are the second round of grants, that will total $1.75 billion over five years (2007-2011), to help shift Medicaid's traditional emphasis on institutional care to a system offering greater choices that include home and community-based services.

This "Money Follows the Person" initiative was included in the Deficit Reduction Act of 2005 (DRA), currently being implemented by CMS. It is a component of the administration's New Freedom Initiative, a nationwide effort to remove barriers to community living for people of all ages with disabilities or chronic illnesses.

"There is more evidence than ever that people who need long-term care prefer to remain in their own homes and communities whenever possible," said Ms. Norwalk. "This new program will help states shift Medicaid's traditional emphasis on institutional care to a system offering greater choices that include home-based services. "States will also benefit by giving the elderly and people with disabilities more control over how and where they receive the Medicaid services they need." States expect to be able to move more than 14,000 people into community settings using these grant awards.

The Medicaid program traditionally pays for care for elderly and disabled individuals living in institutions who need help with activities of daily living. To fund home and community-based services, states must obtain waivers of normal program rules designed to pay for care in institutions.

"The concept of money following the person to the most appropriate setting improves beneficiary satisfaction while reducing Medicaid costs," Ms. Norwalk said. "We intend to keep taking steps to remove barriers and rebalance the options for Medicaid-funded long-term care."
States receiving grants (see list below) will design programs with four major objectives:

- Increase the use of home and community-based, rather than institutional, long-term care services;
- Eliminate barriers or mechanisms that prevent Medicaid-eligible individuals from receiving support for appropriate and necessary long-term services in the settings of their choice;
- Increase the ability of the state Medicaid program to assure continued provision of home and community based long-term care services to eligible individuals who choose to move from an institutional to a community setting; and
- Ensure that procedures are in place to provide quality assurance for individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

All states were eligible to participate in the five-year demonstration program and had to commit to provide demonstration services for at least two years. States receiving grant funds will qualify for a higher percentage of federal matching dollars to help cover the costs of moving people out of nursing homes and into community settings. The higher matching rate will be paid for one year after an individual moves out of an institution and into the community. The state must continue to provide community services after that period as long as the person needs community services and is Medicaid eligible.

"These demonstration grants are a clear sign of our continued commitment to expand choice to all Medicaid beneficiaries as well as allowing them the independence to live at home and contribute to their communities," said Ms. Norwalk.

Waiver and LTC Providers

For more details about the New Freedom Initiative, of which this demonstration is part, visit the CMS web site at: http://www.cms.hhs.gov/newfreedom/.

2007 Money Follows the Person Rebalancing Demonstration Awards

State	Transitions	Year One Award Amount	Five Year Commitment
Delaware	100	$132,537	$5,372,007
District of Columbia	1110	$2,546,569	$26,377,620
Georgia	1,347	$480,193	$34,091,671
Hawaii	415	$231,250	$10,263,736
Illinois	3,357	$6,879,166	$55,703,078
Kansas	934	$102,483	$36,787,453
Kentucky	431	$4,973,118	$49,831,580
Louisiana	760	$524,000	$30,963,664
New Jersey	590	$230,000	$30,300,000
North Carolina	552	$16,055	$16,897,391

EDA Waiver Providers

Elderly and Disabled Waiver Code Approved

The Centers for Medicare and Medicaid Services has approved the Department ofg Health and Hospitals proposed wage increase for direct support staff that provider companion services under the Elderly and Disabled Adult (EDA) Waiver.

The increase for EDA Waiver procedure code S5135 was effective for dates of service on or after February 9, 2007. Providers must bill the procedure code that is appropriate for the date of service on which services were rendered.

Required Documents for Nursing Facility (NF) Admissions

For each nursing facility admission, the Office of Aging and Adult Services (OAAS) is requesting that only the required documents be sent to the OAAS Regional Offices. The required documents are:

1. Form 148
2. Statement of Medical Status (SMS)
3. Physicians Order for Admission
4. PASARR Level I Screen
5. LOCET/LISP

Should additional information be needed, the OAAS Regional Office will submit a request to the provider.

Please refer to the Quick Reference Guide at www.oaas.dhh.louisiana.gov to guide you on when and what information is needed to be sent to the OAAS Regional Office. Providers are encouraged to visit the OAAS website to obtain more information about this new process.

Procedure Code 36819 Payable Effective July 1, 2006, for Assistant Surgeons

Procedure code 36819 (Arteriovenous anastomosis, open; by upper arm basilic vein transposition) has been made payable effective July 1, 2006 for assistant surgeons. Claims for assistant surgeon services for this procedure for dates of service July 1, 2006 forward may be submitted to UNISYS for adjudication.

Update on Sterilization Consent Forms

The Office of Population Affairs (OPA) has updated the sterilization consent form available on their clearinghouse website which includes the revised expiration date of the form. Providers are strongly encouraged to use the most current sterilization consent form from this site.

The OPA website address is http://opa.osophs.dhhs.gov/pubs/publications.html. Lower case letters must be used to access this website.

Retrospective Drug Utilization Review: A Tool for Patient Care

By: Sandy Blake, PhD, ULM College of Pharmacy and Melwyn Wendt, PharmD, DHH/Medicaid Pharmacy Benefits Management

Issues

• OBRA '90 (Omnibus Budget Reconciliation Act of 1990)that mandated pharmacists counsel Medicaid patients, also required Medicaid agencies to develop drug utilization review (DUR) programs.

• You as a provider are an important part of the DUR process and your replies are used by the DUR committee to refine the process.

Introduction

Most healthcare providers are familiar with the OBRA '90 (Omnibus Budget Reconciliation Act of 1990), legislation that mandated pharmacists counsel Medicaid patients, but may not be aware that the same legislation required Medicaid agencies to develop drug utilization review (DUR) programs. States were allowed flexibility in program design and implementation within broad guidelines set by the Department of Health and Human Services (DHHS). However, all states were required to include the following components:

• Prospective DUR. In Louisiana, the prospective drug utilization review (ProDUR) occurs at the point of dispensing and is incorporated into the Medicaid Pharmacy Benefits Management Point-of-Sale (POS) system. Examples are: Drug-Drug Interactions, Early Refill, Pregnancy Precautions.

• Educational. Clinical and educational articles published in the bimonthly *Louisiana Medicaid Provider Update* are part of the educational component of DUR. Past articles are available at http://www.lamedicaid.com/provweb1/Pharmacy/pharmacyindex.htm. Scroll down to the bottom of the page and click on **Provider Update newsletter educational programs**.

• Retrospective DUR is based on paid medical and pharmacy claims and is characterized by an intervention - a letter to the prescriber, primary care provider or dispensing pharmacy. Initially, RetroDUR was based on such topics as duplication of therapy, but has broadened into a disease/guidelinefocus.

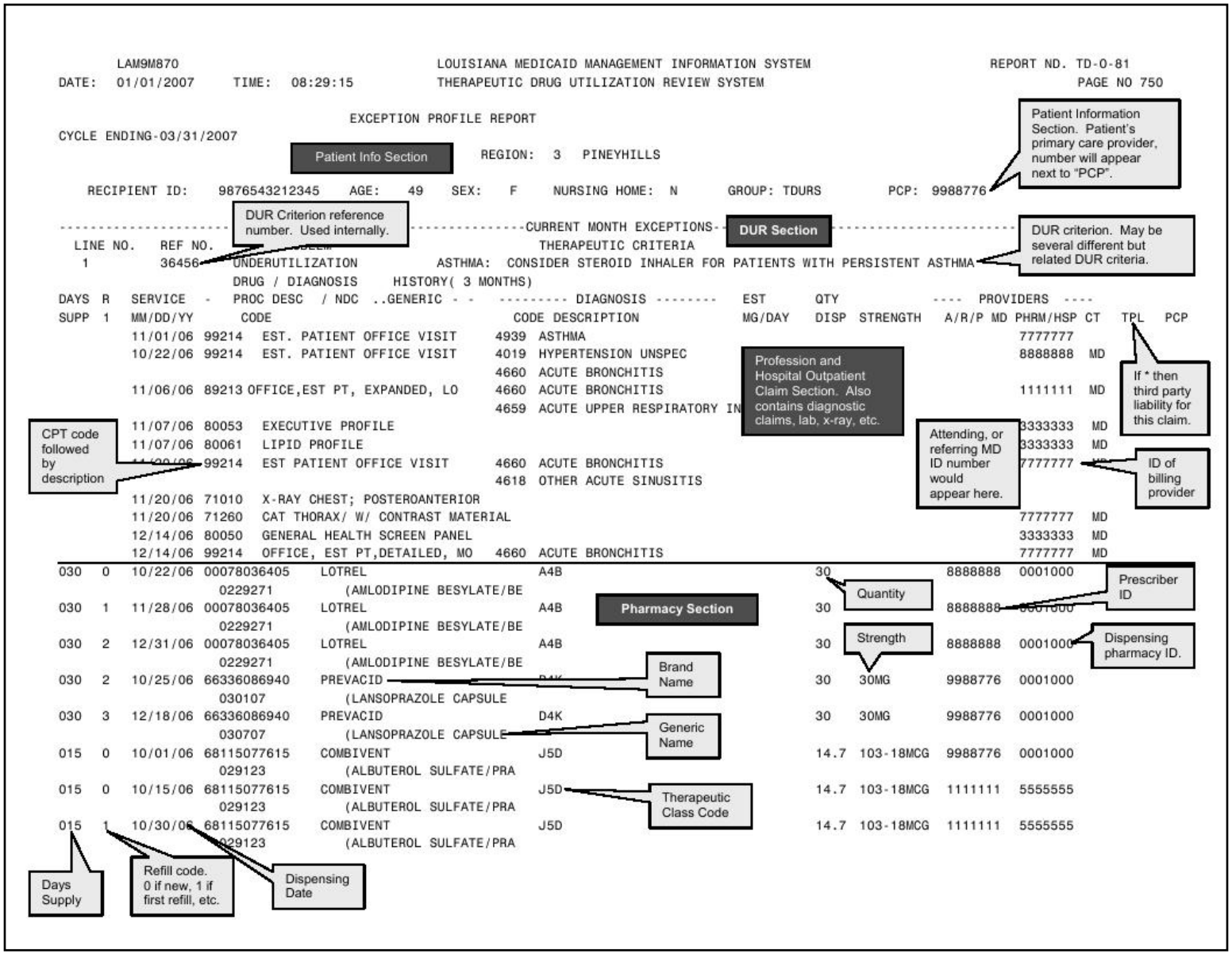
As Table 1 illustrates, RetroDUR is not a cost containment program; often providers are asked to consider adding drug therapy or order testing if they deem appropriate.

Table 1. Brief Summary of RetroDUR Process

- ✓ Drug Utilization Review Board develops DUR criteria based on clinical guidelines and research considering what information is available from claims data.
- ✓ Clinical profiles are created for recipients who fit the criteria.
- ✓ Regional DUR committees review the profiles and decide whether or not to send an intervention letter to the prescriber, primar y care provider or pharmacy.
- ✓ Intervention letters are mailed along with recipient profiles.
- ✓ Responses from prescriber, primary care provider or pharmacy are collected.
- ✓ Responses and comments are collected and presented to the DUR Board.
- ✓ Recipient outcomes are followed and reported to the DUR Board and in the federal annual report.
- ✓ Using feedback from responding providers, the DUR process is refined.

Underutilization is a major issue, i.e., in cardiovascular conditions, asthma, or diabetes. Nor is RetroDUR intended to replace your clinical judgment. Because the Medicaid program has access to all paid claims for that recipient, we may be able to provide information not accessible to you. This information, combined with clinical guidelines, is intended to be another resource for you in caring for your patient.

If you, as a provider, receive a DUR correspondence, there will be a brief introductory cover letter with a reply form on the back along with the patient's medical profile. This article will review the medical profile (See included profile), its organization and the information it contains, clarifying some of the coding used. The profile is organized into five broad sections. See the included fictitious sample profile for a brief discussion of each section.


LAM9M870 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEM REPORT ND. TD-O-81
DATE: 01/01/2007 TIME: 08:29:15 THERAPEUTIC DRUG UTILIZATION REVIEW SYSTEM PAGE NO 750
EXCEPTION PROFILE REPORT
CYCLE ENDING-03/31/2007
Patient Info Section
REGION: 3 PINEYHILLS
RECIPIENT ID: 9876543212345 AGE: 49 SEX: F NURSING HOME: N GROUP: TDURS PCP: 9988776
Patient Information Section. Patient's primary care provider, number will appear next to "PCP".
DUR Criterion reference number. Used internally.
DUR Section
CURRENT MONTH EXCEPTIONS
LINE NO. REF NO. THERAPEUTIC CRITERIA
1 36456 UNDERUTILIZATION ASTHMA: CONSIDER STEROID INHALER FOR PATIENTS WITH PERSISTENT ASTHMA
DUR criterion. May be several different but related DUR criteria.
DRUG / DIAGNOSIS HISTORY(3 MONTHS)
DAYS SUPP R SERVICE MM/DD/YY PROC DESC / NDC CODE ..GENERIC CODE DIAGNOSIS CODE DESCRIPTION EST MG/DAY QTY DISP STRENGTH PROVIDERS A/R/P MD PHRM/HSP CT TPL PCP
11/01/06 99214 EST. PATIENT OFFICE VISIT 4939 ASTHMA 7777777
10/22/06 99214 EST. PATIENT OFFICE VISIT 4019 HYPERTENSION UNSPEC 8888888 MD
4660 ACUTE BRONCHITIS
11/06/06 89213 OFFICE,EST PT, EXPANDED, LO 4660 ACUTE BRONCHITIS 1111111 MD
4659 ACUTE UPPER RESPIRATORY IN
Profession and Hospital Outpatient Claim Section. Also contains diagnostic claims, lab, x-ray, etc.
If * then third party liability for this claim.
11/07/06 80053 EXECUTIVE PROFILE 3333333 MD
11/07/06 80061 LIPID PROFILE 3333333 MD
CPT code followed by description
11/09/06 99214 EST PATIENT OFFICE VISIT 4660 ACUTE BRONCHITIS 7777777
4618 OTHER ACUTE SINUSITIS
Attending, or referring MD ID number would appear here.
ID of billing provider
11/20/06 71010 X-RAY CHEST; POSTEROANTERIOR
11/20/06 71260 CAT THORAX/ W/ CONTRAST MATERIAL 7777777 MD
12/14/06 80050 GENERAL HEALTH SCREEN PANEL 3333333 MD
12/14/06 99214 OFFICE, EST PT,DETAILED, MO 4660 ACUTE BRONCHITIS 7777777 MD
030 0 10/22/06 00078036405 0229271 LOTREL (AMLODIPINE BESYLATE/BE A4B 30 8888888 0001000
Pharmacy Section
Quantity
Prescriber ID
030 1 11/28/06 00078036405 0229271 LOTREL (AMLODIPINE BESYLATE/BE A4B 30 8888888
030 2 12/31/06 00078036405 0229271 LOTREL (AMLODIPINE BESYLATE/BE A4B 30 8888888 0001000
Strength
Dispensing pharmacy ID.
030 2 10/25/06 66336086940 030107 PREVACID (LANSOPRAZOLE CAPSULE D4K 30 30MG 9988776 0001000
Brand Name
030 3 12/18/06 66336086940 030707 PREVACID (LANSOPRAZOLE CAPSULE D4K 30 30MG 9988776 0001000
Generic Name
015 0 10/01/06 68115077615 029123 COMBIVENT (ALBUTEROL SULFATE/PRA J5D 14.7 103-18MCG 9988776 0001000
015 0 10/15/06 68115077615 029123 COMBIVENT (ALBUTEROL SULFATE/PRA J5D 14.7 103-18MCG 1111111 5555555
Therapeutic Class Code
015 1 10/30/06 68115077615 029123 COMBIVENT (ALBUTEROL SULFATE/PRA J5D 14.7 103-18MCG 1111111 5555555
Days Supply
Refill code. 0 if new, 1 if first refill, etc.
Dispensing Date

LAM9M870 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEM REPORT ND. TD-0-81
DATE: 01/01/2007 TIME: 08:29:15 THERAPEUTIC DRUG UTILIZATION REVIEW SYSTEM PAGE NO 750

EXCEPTION PROFILE REPORT

CYCLE ENDING-03/31/2007

REGION: 5 PINEYHILLS

RECIPIENT ID: 9876543212345 AGE: 49 SEX: F NURSING HOME: N GROUP: TDURS PCP: 8899988

DRUG / DIAGNOSIS HISTORY(3 MONTHS)

DAYS SUPP	R	SERVICE MM/DD/YY	PROC DESC / NDC CODE	..GENERIC	DIAGNOSIS CODE DESCRIPTION	EST MG/DAY	QTY DISP	STRENGTH	PROVIDERS A/R/P MD	PHRM/HSP	CT	TPL	PCP
015	2	11/11/06	68115077615	COMBIVENT	J5D		14.7	103-18MCG	1111111	5555555			
			029123	(ALBUTEROL SULFATE/PRA									
015	1	12/1/06	68115077615	COMBIVENT			14.7	103-18MCG	9988776	0001000			
			029123	(ALBUTEROL SULFATE/PRA									
030	0	10/22/06	66582031331	VYTORIN	M4F		30		9988776	5555555			
			0265051	(EXETIMIBE/SIMVASTATIN									
030	1	11/20/06	66582031331	VYTORIN	M4F		30		9988776	5555555			
			0265051	(EXETIMIBE/SIMVASTATIN									
030	2	12/21/06	66582031331	VYTORIN	M4F		30		9988776	5555555			
			0265051	(EXETIMIBE/SIMVASTATIN									
010	0	10/22/06	54569333505	AMOXICILLIN	W1A		30	500MG	8888888	5555555			
			008996	(AMOXICILLIN TRIHYDRATE CA									
007	0	12/14/06	00002306102	CECLOR	W1X		14	500MG	8888888	5555555			
			009104	CEFACLOR									

National Drug Code Number. unique to the chemical entity, manufacturer and strength.

HICL Code. Unique to the chemical entity.

Provider Section

ID	NAME	TYPE	SPECIALTY		
0001000	ALPHA PHARMACY	26 PHARMACIES 1010 FIRST ST	87 ALL OTHER CITY	LA 71212	
1111111	BETA MEDICAL CLINIC	20 PHYSICIANS (MD) SERVICES 2020 SECOND ST	70 CLINIC OR OTHER GROUP PRACTICE TOWN	LA 71777	
3333333	GAMMA LABS	23 LAB SERVICES (PRIVATE) 3030 THIRD ST	69 INDEPENDENT LABORATORY (BILLING INDEPENDENTLY BIGCITY	LA 71888	
5555555	DELTA DRUGS	26 PHARMACIES 4040 FOURTH ST	87 ALL OTHER RURALVILLE	LA 71999	
7777777	WELBY MARCUS MD	20 PHYSICIANS (MD) SERVICES 5050 FIFTH ST	94 RURAL HEALTH CLINIC VILLAGE	LA 71888	
8888888	EPSILON FAMILY CLINIC	20 PHYSICIANS (MD) SERVICES 6060 SIXTH ST	70 CLINIC OR OTHER GROUP PRACTICE SMALLTOWN	LA 71999	
9988776	POWELL PAUL C MD	20 PHYSICIANS (MD) SERVICES 7070 70TH AVE	08 FAMILY PRACTICE MONROE	LA 71201	*

PCP Indicator

The Provider's Role in DUR

You as a provider are an important part of the DUR process and your replies are used by the DUR committee to refine the process. Perhaps you have prescribed a drug which the patient never filled. Or you may have ordered a test, such as an HbA1c test, but the profile suggests that the patient never received the lab work.

In addition to filing the letter and profile in the patient chart, please respond using the form provided. It contains the following 4 standard replies and a comment section:

_____ AWARE OF ISSUE / NO ACTION NEEDED

_____ PLAN TO TAKE ACTION (D/C DRUG, CHANGE DOSE, ORDER LAB)

_____ PLAN CONSULTATION (W/PATIENT, RPH, OR MD)

_____ DATA ACCURACY (PATIENT, MD OR DRUG HISTORY DATA).

A response of "DATA ACCURACY" is appropriate if you received this letter in error and are not one of the patient's providers/prescribers. If there are clinical issues, please include them in the "COMMENTS" section and they will be addressed by the DUR Board, keeping in mind that there are limitations to claims data.

Other suggestions on making the RetroDUR program relevant to your practice are welcome and will be given careful consideration. The goal of you, the Medicaid provider, and of the Medicaid Pharmacy Program is better patient outcomes. RetroDUR strives to use current resources to make more complete information available to you as providers to achieve that patient care goal.

Also available to Medicaid providers----

- For additional recipient information, the Electronic Clinical Data Inquiry (e-CDI) web-based clinical history information support system is easily accessible 24 hours a day on the lamedicaid.com website. Instructions for using the e-CDI can be found on the lamedicaid.com website or phone 1-800-648-0790.
- Profile information beyond 4 months can be obtained by contacting Dan Scholl, 225-216-6208.
- If in-depth clinical pharmacy research is needed, assistance is available by calling Greg Smith, RPh, Drug Information Service, ULM College of Pharmacy, at 318-342-1710.

UNISYS

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

PRSRT STD
U.S. POSTAGE PAID
BATON ROUGE, LA
PERMIT NO. 1037

FOR INFORMATION OR ASSISTANCE, CALL US!

Provider Enrollment	**(225) 216-6370**
Prior Authorization	
Home Health/EPSDT - PCS	**1-800-807-1320**
Dental	**1-504-619-8589**
DME & All Other	**1-800-488-6334**
	(225) 928-5263
Hospital Pre-Certification	**1-800-877-0666**
Provider Relations	**1-800-473-2783**
	(225) 924-5040
REVS Line	**1-800-776-6323**
	(225) 216-REVS (7387)
Point of Sale Help Desk	**1-800-648-0790**
	(225) 216-6381
General Medicaid Eligibility Hotline	**1-888-342-6207**
LaCHIP Enrollee/Applicant Hotline	**1-877-252-2447**
MMIS/Claims Processing/ Resolution Unit	**(225)342-3855**
MMIS/Recipient Retroactive Reimbursement	**(225)342-1739** **1-866-640-3905**
Medicare Savings Program Medicaid Purchase Hotline	**1-888-544-7996**
KIDMED & CommunityCARE ACS	**1-800-259-4444**
For Hearing Impaired	**1-877-544-9544**
Pharmacy Hotline	**1-800-437-9101**