Louisiana Medicaid

Provider Update

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Universal Blood Lead Screening

The Department of Health and Hospitals, Office of Public Health would like to inform medical providers of changes made to state regulations pertaining to blood lead screening of children under 6 years of age in Louisiana. Low blood lead screening rates of children across the state (20% average) resulted in inadequate prevalence data to identify geographic high risk parishes. Therefore, in an effort to improve screening rates of children in Louisiana, the following amendments were made to the Lead Poisoning Prevention Program LAC 48:V. §7005, §7007, and §7009 effective October 20, 2008:

§7005. Mandatory Blood Lead Screening of Children in High Risk Geographical Areas

The amendment extends the designation of high-risk areas for childhood lead poisoning from Morehouse, Orleans, Tensas, and West Carroll to **ALL Parishes** in the state of Louisiana. Therefore, medical providers of routine primary care services to children ages 6 months to 72 months who reside or spend more than 10 hours per week in any Louisiana parish must have such children screened in accordance with practices consistent with the current Center for Disease Control and Prevention guidelines and in compliance with Louisiana Medicaid (KIDMED).

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All Providers

§7007. Mandatory Case Reporting by Health Care Providers

To ensure appropriate and timely follow-up, medical providers must now report a lead case, which is a blood lead level ≥15 micrograms per deciliter (ug/dL), to the Lead Poisoning Prevention Program, Office of Public Health **within 24 business hours** (instead of 48 hours) by fax to (504) 219-4452, and the original lead case reporting form shall be mailed within 5 business days to the Louisiana Childhood Lead Poisoning Prevention Program, Office of Public Health, Room 141, 3101 West Napoleon, Metairie, LA 70001.

§7009. Reporting Requirements of Blood Lead Levels by Laboratories AND Health Care Providers Performing Office-Based Blood Lead Analyses for Public Health Surveillance

All results of blood lead testing for children under 72 months of age must be reported to the Louisiana Lead Poisoning Prevention Program by electronic transmission regardless of the blood lead level.

The Louisiana Childhood Lead Poisoning Prevention Program (LACLPPP) needs your continued commitment to creating a lead safe environment for children and their families. If you have any questions, please contact LACLPPP at (504) 219-4413. Also, please visit the LACLPPP website at www.genetics.dhh.louisiana.gov for additional provider information and for educational booklets for families on lead poisoning prevention, which are available at no cost to providers.

Professional Services/RHC/FQHC Providers

Immunizations for Adults

Effective with date of service October 1, 2007, Louisiana Medicaid reimburses select CPT procedure codes specific to immunizations for influenza, pneumococcal, and human papillomavirus diseases (current codes: 90471, 90472, 90473, 90474, 90649, 90656, 90658, 90660, and 90732) as outlined by the *Current Procedural Terminology* (CPT) manual and delivered to adult recipients (age 21 and older) using the following guidelines:

- Providers should follow the recommendations (including age) of the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practice (ACIP) for these vaccines as identified in the current *Recommended Adult Immunization Schedule*. Providers are responsible for obtaining current copies of the schedule as the schedule is updated frequently. The current *Recommended Adult Immunization Schedule* can be found at www.cdc.gov/vaccines, following the link for 'Immunization Schedules'.

- Usual and customary charges should be used for the billed charges for all claim lines. Louisiana Medicaid reimburses for the vaccine administration as well as for the specific vaccine(s) administered, as identified in this policy. A fee schedule for Adult Immunizations is available at www.lamedicaid.com, following the Fee Schedules link.

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) should enter the appropriate immunization administration procedure code(s) as well as the vaccine procedure code(s) as encounter detail lines when submitting claims for these services. When billing a RHC or FQHC encounter, minimum requirements as identified in RHC or FQHC program policy must be met.

- **Billing For a Single/First Administration:**
  Providers should bill the appropriate CPT immunization administration code 90471 **or** 90473 for the first vaccine administration. The next line on the claim form must contain the specific CPT code for the vaccine that was administered.

    - Do not report CPT codes 90471 **and** 90473 on the same date of service for the same recipient.

- **Billing for Multiple Administrations:**
  When administering more than one immunization on the same date of service, providers should bill as described above for the first administration. The appropriate procedure code(s) for additional immunization administrations (90472 and/or 90474) should then be listed with the appropriate number of units for the additional vaccine(s). The specific CPT code(s) for the additional vaccine(s) administered should be listed on subsequent line(s) following the appropriate administration code. The number of specific vaccines listed after each immunization administration code should match the number of units listed for each administration code.

- **Appropriate Use of CPT Evaluation/Management Codes with Immunization Administrations:**
  If a significant, separately identifiable medically necessary evaluation/management (E/M) service is performed, an appropriate E/M procedure code may be reported in addition to the vaccine and the immunization administration codes. This must be reflected in the medical record documentation.

Requests for Prior Authorization

The Dental Authorization Unit (DAU) located at the Louisiana State University (LSU) School of Dentistry has been back in New Orleans for approximately one year. All requests for prior authorization (PA) should be sent to the **LSU Medicaid Dental Unit, P.O. Box 19085, New Orleans, LA 70179-1085** for processing. The use of any other address will delay delivery and increase the amount of time to process the request.

Tips to expedite a request for prior authorization:

- Include two copies of each page of the American Dental Association (ADA) claim form;
- Place all radiographs behind the claim;
- Place the Department of Health and Hospitals Form 9-M (if required) on the top;
- Staple all pages of a single recipient's request together (using a single staple if possible);
- Do not use paper clips; and
- Resubmit returned requests to the DAU with the tan-colored response sheet on the top of the claim.

An additional tip for requesting PA is to group all of the items requiring PA on a single page of the claim. This reduces the possibility that a line item may be overlooked, and it also reduces the number of PA numbers that are associated with each recipient. While only a single PA number can be submitted on each form for reimbursement, the same PA number can be submitted multiple times as long as the claim items have different dates of service. Claims for reimbursement should never be stapled to each other nor should any attachments be included.

The DAU and Unisys continue to receive information not intended for their offices. Requests for authorization, which may include radiographs or other attachments, should be sent to the DAU. Requests for payment should be sent to Unisys. If a claim has a date stamp in the upper right-hand corner, this indicates that it was forwarded to the DAU from Unisys.

Complete information concerning the guidelines for prior authorization and for reimbursement can be downloaded at the www.lamedicaid.com website. Providers should also check the website regularly for updates and possible changes to the fee schedule. The ADA has released CDT 2009 for implementation effective January 1, 2009. If any changes are required due to procedure code modifications, providers will be notified through the website.

Providers who need to contact the DAU with questions regarding prior authorization may use the following telephone numbers:

- Toll-free (866)-263-6534
- Voice (504) 941-8206
- Fax (504) 941-8209

Hospice Providers

Hospice Program Reminders

Providers of the Hospice Program are reminded that revocation forms must be submitted to the Hospice Program within 3 working days of the revocation. Any requests for revocation submitted after the 3-day period will become effective on the date of receipt. The effective date of receipt will not be changed once it is entered into the system due to billing time frames of various entities.

The patient's or the authorized representative's signature is required whenever a patient revokes hospice. The patient must sign the form at the time of the revocation only, and not the time of the hospice election. Revocations cannot be back dated.

The revised Hospice Notice of Election form can be accessed at www.lamedicaid.com, and providers are not allowed to alter or revise this form. A legal representative who signs a Notice of Election form must indicate the relationship to the patient with a daytime telephone number. All legal representatives must sign and date the form. Hospice providers cannot date or predate the forms.

CommunityCARE Providers

CommunityCARE Utilization Reports

"CommunityCARE Utilization Reports" is a new web application available to CommunityCARE primary care physicians (PCPs) for use in managing the care of their enrollees. The utilization reports include detailed information on the enrollees' utilization of certain medical services, which is updated monthly using claims data for the previous month and calculated using paid claims per 100 enrollees linked to the PCP. CommunityCARE PCPs with fewer than 100 enrollees linked to their practice are not reflected on the report. PCPs can access the application, and obtain additional information and instructions, by logging into the secure provider application area of the Louisiana Medicaid web site (www.lamedicaid.com). For technical assistance regarding the web site and/or application, providers may call 1-877-598-8753.

Service Hour Allocation of Resources Initiative

The Office of Aging and Adult Services has developed a new method of allocating services for Long Term-Personal Care Services (LT-PCS) and Elderly and Disabled Adult (EDA) Waiver recipients. This new method, SHARe (Service Hour Allocation of Resources), will use the assessment findings of the Minimum Data Set for Home Care (MDS-HC) to set a maximum number of hours per recipient per week. SHARe will also set the individual recipient's maximum dollar amount on his/her Comprehensive Plan of Care annual budget for EDA Waiver services and LT-PCS.

Time for LT-PCS will be approved in weekly amounts rather than the current method of assignment of time by individual task. This will allow for greater flexibility within each week, in order to meet the recipient's needs in a more person-centered manner. When SHARe is implemented, the Daily Level of Service Guide for assignment of time in LT-PCS will no longer be used.

Additionally, the prior authorizations (PAs) will be issued as weekly amounts for all services in LT-PCS and will be issued by Statistical Resources Incorporated (SRI). Service providers will be required to utilize the Louisiana Service Tracking System (LAST) software for input of service delivery in order to bill and receive payment.

Once implemented, SHARe will affect all new applications for LT-PCS and all new EDA linkages. Current recipients will be phased in during their annual reassessment over the twelve month period following implementation.

There will be mandatory training for all LT-PCS and EDA direct service provider agencies to discuss new documentation requirements. Details regarding training dates and locations will be forthcoming.

The tentative date for SHARe implementation is February 1, 2009. If the date of implementation changes, providers will be notified of the new date.

Vision Providers and Optical Suppliers

Billing for Eye Wear

Once a provider receives prior authorization for an eyewear request, services should be delivered as soon as possible within the authorized period. The provider may bill for the services rendered, after the eye wear is delivered to the patient. The actual date the eyewear is delivered is the date of service when filing a claim for payment. **Providers may neither require a payment/deposit for eye wear, nor may they withhold eyewear pending payment from Medicaid.**

Prosthetics and Orthotics Providers

Prosthetics and Orthotics Provider Accreditation

Effective for dates of service on or after January 1, 2009, all providers seeking Medicaid reimbursement for prostheses, orthoses, prosthetic services and orthotic services must be accredited by the American Board of Certification in Orthotics, Prosthetics and Pedorthics or by the Board of Certification/Accreditation, International.

A provider who is not accredited and provides prosthetic/orthotic services or devices to a recipient and accepts Medicaid reimbursement shall be fined $2,500 per violation and shall be required to reimburse the Medicaid program for the cost of the services(s) or device(s).

These accreditation provisions shall not apply to a licensed optometrist or a licensed ophthalmologist, and shall not prohibit a licensed occupational therapist or a licensed physical therapist from practicing within his scope of practice.

Long Term Care Providers

Barthelemy Update

In 2008, the Department of Health and Hospitals (DHH) entered into a supplemental settlement agreement with the plaintiffs in the *Barthelemy case*. The settlement emanates from a class action lawsuit brought in 2000 by the Advocacy Center that alleged that the state violated the rights of the elderly and disabled by not allowing them to live in the least-restrictive environment possible. Louisiana entered into the original settlement agreement in 2001, which outlined steps the state would take in providing more community and home-based care options.

Long Term Care Providers (cont.)

Key provisions of the 2008 supplemental settlement agreement include:

- Allowing DHH to lower maximum hours per week of Long Term-Personal Care Services (LT-PCS) from 56 to 42
- Allowing DHH to develop and implement new resource allocation methodology for LT-PCS and waiver services based on the acuity of the person
- Providing that consumers whose hours are reduced get appropriate notice of appeal rights
- Providing that any savings as a result of these changes will be used to fund additional offers and to reduce the EDA request for services registry
- Changing the priority (subject to the Centers for Medicare and Medicaid Services approval) for slot offers to target offers to persons in nursing homes, abuse/neglect cases, and persons not already receiving another HCBS service
- Providing that DHH report to plaintiffs on implementation impact on consumers
- Providing that, regardless of whether the 90-day waiting list objective in the current agreement is met, the suit will end December 31, 2009

KIDMED Providers

KIDMED Claims Processing System Changes

Effective with date of processing Monday, December 1, 2008, the KIDMED claims processing subsystem was merged into the Medicaid Management Information System (MMIS) claims processing system which processes all other Medicaid claims. This merger is beneficial for KIDMED providers and removed many of the problem areas related to processing KIDMED claims through a separate subsystem prior to the claims data being entered into MMIS for processing.

The process for submission of KIDMED claims by providers did not change. KIDMED claims are now treated like all other claims, and the standard weekly cut-off for submitting electronic claims is Thursday at 10:00 a.m. When a holiday falls on a Thursday, the cut-off date will be the preceding Wednesday.

Providers will no longer receive a CP-0-50 report. All KIDMED claims will now appear on the standard MMIS remittance advice, even if the claims are denied. The KIDMED claim edits that previously appeared on the Denied Claims List (CP-0-50) have been cross-referenced to the appropriate MMIS claims processing edits. A complete list has been posted on the Louisiana Medicaid website at http://www.lamedicaid.com/provweb1/newinformation/LMMIS_to_CCKM_Claims_Edits.pdf

In addition to the merge of the claims processing subsystem, Louisiana Medicaid implemented a series of RS-O-07 reports in late December to replace the single RS-O-07 report. This series of reports allows KIDMED providers to use data more effectively by identifying current, overdue and future screening dates. For additional information about these changes, go to http://www.lamedicaid.com/provweb1/newinformation/cckm_lmmis_trans.htm

Diabetes Self-Management Education (DSME): Past, Present, and Future

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Overview

Diabetes self-management education (DSME) is a critical component of care for individuals with diabetes and is necessary in order for patients to learn about diabetes and how to safely manage it on a daily basis. DSME is guided by evidence-based standards and is defined as the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care.[1] The objectives of DSME are to foster informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life.[1] Research indicates that self-management and patient education programs are effective in improving diabetes management, metabolic control, and quality of life.[6,7] Delivery of DSME programming has evolved from a lecture-based format to an interactive approach based on patient empowerment.[1] Empowerment is not a technique, but rather a patient-centered collaboration that guides patients to help themselves.[1]

A Look Back…

In the past, most health-care professional training was based on a medical model which provided acute, symptom-driven care.[2] As chronic illnesses such as diabetes became more prevalent, this model failed to shift from an acute care focus to a chronic care focus of keeping persons healthy. Patient education was provided prescriptively (for example, "Do as I say.") and therapeutic goals were set by the health-care professional.[2] The focus of the self-management plan was placed on the patient's diabetes rather than tailored to the patient. Patient education was designed to promote compliance or adherence as a motivation to change with the benefits of compliance outweighing the impact of these recommendations on the patient's quality of life.[2] The literature indicates that this approach was not effective in improving diabetes-related outcomes.[3]

Present and Future

Diabetes now affects nearly 24 million people in the United States, an increase of more than 3 million in approximately 2 years, according to 2007 prevalence data estimates released by the Centers for Disease Control and Prevention (CDC). This means that nearly 8 percent of the U.S. population has diabetes. In addition to the 24 million with diabetes, another 57 million people are estimated to have pre-diabetes, a condition that puts people at increased risk for diabetes. The estimated total costs (direct and indirect) of diabetes in the United States in 2007 was 174 billion dollars.[5]

Despite great strides in the treatment of diabetes, many patients continue to suffer devastating complications and less than optimal clinical and humanistic outcomes. Diabetes management has become a major challenge for the medical community.

A new approach was needed that recognizes and shifts the responsibility of diabetes care from the healthcare professional to the patient. This new approach should include intervention strategies that enable patients to make informed decisions about their daily self-management and to assume responsibility for their care.

One such model that incorporates the tenets of patient responsibility is the Empowerment Model· The Empowerment Model is based on three fundamental aspects of chronic illness care:[4]

1. Choices: The choices that patients make each day outweigh those made by the health professional.
2. Control: Once patients leave the office, they are in control of which recommendations they accept or ignore.
3. Consequences: The consequences from the decisions made accrue directly to the patient.

Patient empowerment is defined as helping patients discover and develop the inherent capacity to be responsible for one's own life.[8] Patient Empowerment:

- shifts the right and responsibility from the health professional to patients.
- facilitates patients' participation on their health care team.
- requires health professionals to help patients make informed decisions and overcome barriers.

Under this approach, diabetes care becomes a collaboration between equals; professionals bring knowledge and expertise about diabetes and its treatment, and patients bring expertise on their lives and what will work for them.[2]

DSME is the essential foundation for the Empowerment Model and is necessary for patients to effectively manage diabetes and to make informed decisions.[2] Approaches to patient education within the empowerment philosophy incorporate interactive teaching methods designed to involve patients in problem solving and to address their cultural and psychosocial needs.[2]

Interactive Teaching Methods

Engage participants in discussions by asking open-ended questions.

- How …?
- What …?

Facilitate patient-specific needs assessments.

- Encourage the patient to identify specific needs with regard to their diabetes management.
- Use the identified needs to assist the patient in setting their own goals and objectives.

Use visual aids to support discussion topics.

- Nutrition
- Long-term complications

Incorporate the teach-back method.†

- Blood glucose self-test
- Insulin administration

Play "What-If." Present scenarios and ask participants to engage in developing solutions through problem solving.

- What-If you have 2 different foods to choose from. How would you determine which one would be a better choice?
- What-If you have not met your physical activity goal for the week? What could you do different to meet your goal?

†During teach-back, the educator demonstrates a skill or technique and then asks the student to teach-back the skill or technique. This teaching method provides a built-in check for understanding.

Barriers in Making the Shift to the Empowerment Model

Patients and healthcare professionals may experience challenges in shifting to an empowerment model of care.

- **Role Change** - It is difficult for the provider and patient to change roles. The empowerment model transfers authority to the patient and promotes the development of a partnership between patient and provider.

- **Goal Setting** - Setting goals *with* the patient instead of *for* the patient can be difficult, especially if the goals set and priority of the goals differ from the provider's. When the provider realizes that the behavior of the patient is not their responsibility, the encounter can be focused on the patient as a whole, rather than just on diabetes.

- **Time Constraints** - A common concern expressed by providers is the limited time available to spend with their patients. There is a misconception that there is not enough time in a visit to address the emotional and psychosocial needs of the patient. However, Levsinon et al. reported that empowerment approaches may actually increase the efficiency of visits and decrease the time spent per visit.[10] Gains in efficiency accrue because of less time wasted on recommendations that will never be taken allowing more time to focus on patient-specific needs.

Attributes of a Quality DSME Program

The "National Standards for Diabetes Self-Management Education" was originally published in *Diabetes Care* 23:682-689, 2000. The American Association of Diabetes Educators and the American Diabetes Association convened a Task Force in 2006 to review and revise the previous version. Final approval was given in March 2007. (The updated standards are available at http://care.diabetesjournals.org/cgi/content/full/31/Supplement_1/S97.)

The Standards define quality DSME and can assist diabetes educators in providing evidence-based education.[1] Diabetes educators can use the Standards at any point during the life cycle of a DSME program. The Standards can provide guidance during DSME program development and implementation, can serve as indicators during continuous quality improvement activities, and/or can serve as outcome measures for DSME program evaluation.

The Standards contain 3 categories and 10 individual standards. (See table 1.) The first 4 Standards define the **structure** of a DSME entity. Standards 5 through 8 describe the recommended delivery **processes** for quality DSME. The last 2 Standards provide a guide to measure **outcomes**.

Table 1. National Standards for Diabetes Self-Management Education

Category	Standard	Description
Structure	1	The DSME entity will have documentation of its organizational structure, mission statement, and goals and will recognize and support quality DSME as an integral component of diabetes care.
Structure	2	The DSME entity shall appoint an advisory group to promote quality. This group shall include representatives from the health professions, people with diabetes, the community, and other stakeholders.
Structure	3	The DSME entity will determine the diabetes educational needs of the target population(s) and identify resources necessary to meet these needs.
Structure	4	A coordinator will be designated to oversee the planning, implementation, and evaluation of diabetes self-management education. The coordinator will have academic or experiential preparation in chronic disease care and education and in program management.
Process	5	DSME will be provided by one or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one of the instructors will be a registered nurse, dietitian, or pharmacist. A mechanism must be in place to ensure that the participant's needs are met if those needs are outside the instructors' scope of practice and expertise.
Process	6	A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the DSME entity. Assessed needs of the individual with pre-diabetes and diabetes will determine which of the content areas listed below are to be provided: • Describing the diabetes disease process and treatment options • Incorporating nutritional management into lifestyle • Incorporating physical activity into lifestyle • Using medication(s) safely and for maximum therapeutic effectiveness • Monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making • Preventing, detecting, and treating acute complications • Preventing, detecting, and treating chronic complications • Developing personal strategies to address psychosocial issues and concerns • Developing personal strategies to promote health and behavior change

Process	7	An individual assessment and education plan will be developed collaboratively by the participant and instructor(s) to direct the selection of appropriate educational interventions and self-management support strategies. This assessment and education plan and the intervention and outcomes will be documented in the education record.
Process	8	A personalized follow-up plan for ongoing self-management support will be developed collaboratively by the participant and instructor(s). The patient's outcomes and goals and the plan for ongoing self-management support will be communicated to the referring provider.
Outcomes	9	The DSME entity will measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention.
Outcomes	10	The DSME entity will measure the effectiveness of the education process and determine opportunities for improvement using a written continuous quality improvement plan that describes and documents a systematic review of the entities' process and outcome data.

Detailed information pertaining to the National Standards can be found at the ADA website:
http://care.diabetesjournals.org/cgi/content/full/31/Supplement_1/S97

Summary

Diabetes is a chronic disease that results in significant financial expenditures. Shifting DSME delivery from traditional directive models to theoretical empowerment models is an effective approach to patient education. Implementing the Empowerment Model within the framework of the National Standards for DSME creates patient-centered practices which foster beneficial partnerships between patients and providers. An important benefit for the patient is better communication with providers. Open communication centered on patient-specific clinical and psychosocial needs is often associated with improvements in clinical and quality-of-life outcomes along with concomitant increases in patient satisfaction. When providers incorporate the empowerment approach into care processes, visit efficiency is increased, therapeutic relationships are strengthened, and outcomes of care are optimized. Additionally, providers can use the National Standards as a template for evidenced-based DSME and as indicators in continuous quality improvement activities.

References

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Attention Medicaid Providers!

'HELP' is available for your asthma patients!

Do you find it difficult to find time for asthma education?
Do you have asthma patients that need additional education to reinforce what they've learned in your office?
Do you wonder if your asthma patients are using their devices correctly?
If you answered 'Yes' to one or more of these questions, we've got a solution for you!

Asthma HELP
Asthma Health Education by Louisiana Pharmacists

- *Free educational program for Louisiana Medicaid recipients diagnosed with asthma*
- *Recipients are assigned their own personal Certified Asthma Educator pharmacist*
- *Services provided:*
  - ✓ *Telephone counseling*
  - ✓ *Educational materials, such as brochures, children's books, and videos*
  - ✓ *Toll-free HELP line for asthma-related questions*
- *Any Louisiana Medicaid recipient with asthma is eligible! To refer a patient, complete the bottom portion of this page and fax it to (318) 410-4367.*

Provider Name	
Provider Prescriber ID No.	
Provider Phone	
Recipient Name	
Recipient Medicaid ID No.	
Recipient Phone	
Recipient DOB	
Notes	

Fax completed form to (318) 410-4367- Attn: Asthma HELP Program

Asthma HELP is not intended to replace regular provider care, but complements it with additional asthma education. Sponsored by the Louisiana Medicaid Pharmacy Benefits Management Program and the University of Louisiana at Monroe College of Pharmacy.

UNISYS

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

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FOR INFORMATION OR ASSISTANCE, CALL US!

Provider Enrollment	**(225) 216-6370**	**General Medicaid Eligibility Hotline**	**1-888-342-6207**
Prior Authorization			
Home Health/EPSDT - PCS	**1-800-807-1320**	**LaCHIP Enrollee/Applicant Hotline**	**1-877-252-2447**
Dental	**1-866-263-6534** **1-504-941-8206**		
DME & All Other	**1-800-488-6334** **(225) 928-5263**	**MMIS/Claims Processing/ Resolution Unit**	**(225) 342-3855**
Hospital Pre-Certification	**1-800-877-0666**	**MMIS/Recipient Retroactive Reimbursement**	**(225) 342-1739** **1-866-640-3905**
Provider Relations	**1-800-473-2783** **(225) 924-5040**	**Medicare Savings Program Medicaid Purchase Hotline**	**1-888-544-7996**
REVS Line	**1-800-776-6323** **(225) 216-REVS (7387)**	**KIDMED & CommunityCARE ACS**	**1-800-259-4444**
		For Hearing Impaired	**1-877-544-9544**
Point of Sale Help Desk	**1-800-648-0790** **(225) 216-6381**	**Pharmacy Hotline**	**1-800-437-9101**