Louisiana Medicaid | Provider UPDATE

Volume 34, Issue 6 | June 2018

Drug Therapy Updates

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Updated Recommendations for the Treatment of Seasonal Allergic Rhinitis (SAR)

The 2017 Joint Task Force on Practice Parameters, comprised of representatives of the American Academy of Allergy, Asthma and Immunology (AAAAI) and the American College of Allergy, Asthma and Immunology (ACAAI), recently updated recommendations regarding medications used to treat seasonal allergic rhinitis (SAR). Evidence was reviewed to provide guidance on the initial pharmacologic treatment of SAR in patients aged 12 years or older.

Key recommendations:

- For initial treatment of SAR in persons aged 12 years or older, routinely prescribe monotherapy with an intranasal corticosteroid rather than an intranasal corticosteroid in combination with an oral antihistamine.
- For initial treatment of SAR in persons aged 15 years or older, recommend an intranasal corticosteroid over a leukotriene receptor antagonist.
- For treatment of moderate to severe SAR in persons aged 12 years or older, the clinician may recommend the combination of an intranasal corticosteroid and an intranasal antihistamine for initial treatment.

In addition, it was suggested that healthcare providers utilize their professional judgement to assist patients in evaluating the most appropriate treatment choice for SAR. This should be accomplished through shared decision making, with consideration of the potential benefits versus harms of combination therapy. Patients should be allowed to discuss their values and preferences and should participate in the decision-making process.

Reference: Wallace DV, Dykewicz MS, Oppenheimer J, Portnoy JM, Lang DM. Pharmacologic Treatment of Seasonal Allergic Rhinitis: Synopsis of Guidance From the 2017 Joint Task Force on Practice Parameters. *Annals of Internal Medicine*. 2017; 167:876–881. doi: 10.7326/M17-2203

PPIs May Decrease Effectiveness of Direct-Acting Antiviral (DAA) Agents

According to a comprehensive review published in the *Journal of Clinical and Translational Hepatology,* sustained virologic responses (SVRs) were lower in patients with hepatitis C taking direct-acting antiviral (DAA) agents with proton pump inhibitors (PPIs) compared to those not receiving PPIs.

It is estimated that hepatitis C virus (HCV) affects over 185 million people across the globe and is a leading cause of cirrhosis. DAA agents are used for the treatment of chronic HCV infection. These agents can achieve sustained virologic response (SVR) defined as the absence of detectable virus 12 weeks after completion of treatment. An SVR is indicative of a cure for HCV infection. Proton pump inhibitors are indicated for the treatment of acid-related disorders, such as peptic ulcer and gastroesophageal reflux disease, and are some of the most frequently prescribed medications worldwide for these conditions. DAA agents can interact with PPIs through the effects of PPIs on both gastric pH and DAA bioavailability. This interaction leads to sub- therapeutic levels of DAA agents and may result in failure to achieve SVR. Recent studies reported a possible relationship between HCV-infected patients taking both DAA Agents and PPIs and

Table of Contents

decreased chances of achieving SVR when compared to HCV-infected patients taking DAA agents without PPIs; however, results have been inconsistent. A systematic review and meta-analysis was performed in March of 2017 to evaluate the available evidence and clarify this association.

Nine cohort studies containing 32,684 participants met the criteria for eligibility and were included in the meta-analysis. The authors concluded that DAA therapies given in combination with PPIs result in a significant increase in the risk of failure to achieve SVR. The risk of failure to achieve SVR when PPIs are taken concomitantly with DAA agents is 1.4 times greater than the risk of failure to achieve SVR when DAA agents are taken without concomitant PPIs.

Healthcare providers should carefully evaluate the need for PPIs in these patients and discontinue PPI therapy in the absence of appropriate PPI indications.

Reference: Wijarnpreecha K, et al. Efficacy and Safety of Direct-Acting Antivirals in Hepatitis C Virus-Infected Patients Taking Proton Pump Inhibitors. *Journal of Clinical and Translational Hepatology*. 2017; 5(4): 327-334. doi**:** 10.14218/JCTH.2017.00017

FDA Drug Safety Communication: Risk of Serious and Potentially Fatal Blood Disorder Prompts FDA Action on Oral Benzocaine Products Used for Teething and Mouth Pain and Prescription Local Anesthetics

On May 23, 2018, the U.S. Food and Drug Administration (FDA) released a drug safety communication regarding oral over-the-counter benzocaine products used for teething and mouth pain and prescription local anesthetics.

The FDA warned that oral drug products containing benzocaine should not be used to treat infants and children younger than 2 years, and that benzocaine oral drug products should only be used in adults and children 2 years and older if they contain certain warnings on the drug label. These products carry serious risks and provide little to no benefits for treating oral pain, including sore gums in infants due to teething. Benzocaine, a local anesthetic, can cause a condition in which the amount of oxygen carried through the blood is greatly reduced. This condition, called methemoglobinemia, can be life-threatening and result in death.

Due to the significant safety risk of methemoglobinemia, the FDA urged manufacturers that they should stop marketing oral drug products for treating teething in infants and children younger than 2 years. If companies do not comply, the FDA will take action to remove these products from the market. The manufacturers of oral drug products containing benzocaine for adults and children 2 years and older were also urged to make the following changes to the labels of their products:

- Adding a warning about methemoglobinemia;
- Adding contraindications, FDA's strongest warnings, directing parents and caregivers not to use the product for teething and not to use in infants and children younger than 2 years; and
- Revising the directions to direct parents and caregivers not to use the product in infants and children younger than 2 years.

The FDA will continue to monitor the safety and effectiveness of benzocaine products and intends to take additional actions in the future as needed. In addition to recent actions regarding benzocaine products, the FDA is also requiring a standardized methemoglobinemia warning to be included in the prescribing information of all prescription local anesthetics.

Parents and caregivers should follow the American Academy of Pediatrics' recommendations for treating teething pain. These recommendations include gently rubbing or massaging the child's gums using a finger and using a firm rubber teething ring.

Topical pain relievers and medications that are rubbed on the gums are not useful because they wash out of a baby's mouth within minutes.

Alternative treatments for adults who experience mouth pain may include dilute salt water mouth rinse and pain relief medications.

Healthcare professionals should warn patients of the possibility of methemoglobinemia and advise them of the signs and symptoms when recommending or prescribing local anesthetic products. These signs and symptoms include pale, gray or blue-colored skin, lips, and nail beds; shortness of breath; fatigue; confusion; headache; lightheadedness; and fast heart rate. Signs and symptoms of methemoglobinemia may appear within minutes to one to two hours after using benzocaine. Symptoms may occur after using benzocaine for the first time, as well as after prior uses.

Some patients are at greater risk for complications related to methemoglobinemia. This includes those with breathing problems such as asthma, bronchitis, or emphysema; heart disease, and the elderly. Healthcare professionals using local anesthetics during medical procedures should take steps to minimize the risk for methemoglobinemia. These include monitoring patients for signs and symptoms suggestive of methemoglobinemia; using co-oximetry when possible; and having resuscitation equipment and medications readily available, including methylene blue.

The FDA urges patients, consumers, and healthcare professionals to report side effects involving benzocaine, prescription local anesthetics, or other medicines to the FDA MedWatch program, which can be accessed at https://www.fda.gov/Safety/MedWatch/default.htm.

Reference: https://www.fda.gov/Drugs/DrugSafety/ucm608265.htm

Pharmacy Facts
Program Updates from Louisiana Medicaid

Pharmacy facts, which includes program updates from Louisiana Medicaid, can be found online at: http://ldh.la.gov/index.cfm/page/3036.

Implementation of New Medicaid Eligibility System Delayed

The implementation of LaMEDS, the state's new Medicaid eligibility and enrollment system, is being delayed with a tentative target date of November. LaMEDS includes a Provider Portal, which replaces the current Facility Notification System (FNS) and allows provider representatives, hospital representatives, and Support Coordination Agency (SCA) reps to submit forms for Medicaid to process. All current representatives authorized to submit forms in FNS will be required to reregister in the new system. Announcements will be posted on the current FNS site in advance of Go Live. Please send all questions to MSMcomm@la.gov

Healthy Louisiana Open Enrollment

The Healthy Louisiana open enrollment period will begin June 15, 2018 and close July 31, 2018 with enrollment changes becoming effective September 1, 2018. Letters containing information on this process will be mailed to enrollees in May. Enrollees can make changes to their health plan through the Healthy Louisiana mobile app, online at www.myplan.healthy.la.gov or by calling 1-855-229-6848. If enrollees want to keep their current managed care organization (MCO) they don't need to do anything. The member will stay with their MCO for another year, as long as they are still eligible for Medicaid. A flyer containing the open enrollment information for posting in your office may be accessed here.

As a reminder, all health care providers delivering services to Louisiana Medicaid and LaCHIP recipients enrolled in MCOs are welcome to inform their patients of the plans with which they have chosen to participate, but Louisiana Medicaid has strict prohibitions against patient steering, which all providers must observe. Refer to Informational Bulletin 12-31 for more information about the requirements.

Healthy Louisiana

Stay Informed Through Social Media

Be sure to "like" the Louisiana Department of Health (LDH) on Facebook and follow LDH on Twitter for up to date news about the department, public health issues, Medicaid and more. The LDH website is also a great resource for information and the department's blog covers timely topics written by LDH staff.

LOUISIANA DEPARTMENT OF HEALTH

Common Hospital Observation Policy

Effective July 1, 2018, all 5 MCOs will adopt a Common Hospital Observation Policy which is detailed below.

Purpose:

This policy outlines how Healthy Louisiana Managed Care Organizations (MCOs) will utilize a common hospital observation policy. This policy has been developed collectively by MCO personnel with approval of the Louisiana

Department of Health (LDH). The common hospital observation policy shall be reviewed annually by LDH and the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation of any new or revised language. The purpose of the outpatient hospital services program is to provide outpatient services to eligible Medicaid members and performed on an outpatient basis in a hospital setting. Hospital providers are to ensure that the services provided to Medicaid members are medically necessary, appropriate and within the scope of current evidence based medical practice and Medicaid guidelines.

Definitions:

Business Day- Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m., unless the context clearly indicates otherwise.
Observation Time- This begins at the time the order is written to place in observation status or the time a member presents to the hospital with an order for observation, and ends with discharge or an order for inpatient admission.
Observation Care- Is a well-defined set of specific, clinically appropriate services furnished while determining whether a member will require formal inpatient admission or be discharged from the hospital. Observation is for a minimum of 1 hour and up to 48 hours**.**

- The member must be in the care of a physician during the period of observation, as documented in the medical record by an observation order, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

Observation Procedure:

Healthy Louisiana MCOs will reimburse up to 48 hours of medically necessary care for a member to be in an observational status. This time frame is for the physician to observe the member and to determine the need for further treatment, admission to an inpatient status, or for discharge. Observation and ancillary services do not require notification, precertification or authorization and will be covered up to 48 hours.

Hospitals should bill the entire outpatient encounter, including ED, Observation, and any associated services, on the same claim with the appropriate revenue codes, and all covered services are to be processed and paid separately.

Any observation service over 48 hours requires MCO authorization. For observation services beyond 48 hours that are not authorized, MCOs shall only deny the non-covered hours.

If a member is anticipated to be in observation status beyond 48 hours, the hospital must notify the MCO as soon as reasonably possible for potential authorization of an extension of hours. The MCO and provider shall work together to coordinate the provision of additional medical services prior to discharge of the member as needed.

Observation-to-Inpatient Procedure:

Length of stay alone should not be the determining factor in plan denial of inpatient stay/ downgrading to observation stay.

Medicaid members should not be automatically converted to inpatient status at the end of the 48 hours. Admission of a member cannot be denied solely on the basis of the length of time the member actually spends in the hospital.

All hospital facility charges on hospital day one are included in the inpatient stay and billed accordingly inclusive of Emergency Department/observation facility charges. (NOTE: Professional charges continue to be billed separately).

All observation status conversions to an inpatient hospital admission require notification to the MCO within one business day of the order to admit a member. Acceptable notifications include the use of MCOs provider portals, ADT notifications, and other medium through which plans accept clinical communications.

MCOs are prohibited from including any observation hours in the inpatient admission notification period.

The MCO will notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but within no more than one (1) business day of making the initial determination. The MCO will subsequently provide written notification (i.e., via fax) to the provider within two (2) business days of making the decision to approve or deny an authorization request.

If you have any questions, please contact msmcomm@la.gov.

Application Fee for Entities

The Affordable Care Act requires that some entities/businesses enrolling or reenrolling in Louisiana Medicaid pay a fee to cover the cost of screening. Entities/businesses that are currently enrolled in Medicare or another state's Medicaid are exempt. If your application is received and you are required to pay a fee, you will receive a letter detailing the fee requirement and how to pay. The fee must be received before your application can be approved. The implementation date for the application fee is June 1, 2018. For questions, please contact Kate Stewart at 225-219-4146.

ATTENTION PROVIDERS: PAYMENT ERROR RATE MEASUREMENT (PERM) FFY17 Currently Underway

Louisiana Medicaid is mandated to participate in the Centers for Medicare and Medicaid (CMS) **Payment Error Rate Measurement (PERM)** program which will assess our payment accuracy rate for the Medicaid and CHIP programs. If chosen in a random sample, your organization will soon receive a *Medical Records Request* from the CMS review contractor, CNI Advantage.

Please be advised that sampled providers who fail to cooperate with the CMS contractor by established deadlines may be subject to sanctioning by Louisiana Medicaid Program Integrity through the imposition of a payment recovery by means of a withholding of payment until the overpayment is satisfied, and/or a fine.

Please be reminded that providers who are no longer doing business with Louisiana Medicaid are obligated to retain recipient records for 5 years, under the terms of the Provider Enrollment Agreement.

For more information about PERM and your role as a provider, please visit the Provider link on the CMS PERM website: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Providers.html

If you have any questions, please call Catherine Altazan at 225-342-2612.

Online Medicaid Provider Manual Chapter Revisions as of May, 2018

Manual Chapter	Section(s)	Date of Revision(s)
Behavior Health Services	2.3 Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults Appendix E-1 – Evidence Based Practices (ACT) Appendix E-2 – Evidence Based Practices (FFTFFTCW) Appendix E-3 – Evidence Based Practices (HOMEBUILDERS) Appendix E-4 – EBP (MST)	05/03/18 05/30/18 05/30/18 05/30/18 05/30/18 05/30/18 (All 05/30/18 Behavioral Health Services Revisions will show effective 06/01/18)
Pharmacy Benefits Management Services	37.5 Covered Services, Limitations and Exclusions	05/07/18

Archived Online Medicaid Provider Manual Chapter Revisions as of April, 2018

Manual Chapter	Section(s)	Date of Omission(s)
Behavior Health Services	2.3 Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults Appendix E-1 – Evidence Based Practices (ACT) Appendix E-2 – Evidence Based Practices (FFTFFTCW) Appendix E-3 – Evidence Based Practices (HOMEBUILDERS) Appendix E-4 – EBP (MST)	05/03/18 05/30/18 05/30/18 05/30/18 05/30/18 05/30/18 (All 05/30/18 Behavioral Health Services Revisions will show effective 06/01/18)
Pharmacy Benefits Management Services	37.5 Covered Services, Limitations and Exclusions	05/07/18

Remittance Advice Corner

Attention Providers Of Pediatric/EPSDT Services

The Louisiana Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Periodicity Schedule has been released with an effective date of 5/1/2018. The 2018 EPSDT Periodicity Schedule provides guidelines for the health supervision of infants, children and adolescents under the age of 21 years related to medical screenings, developmental and behavioral assessments, applicable procedures, and sensory screenings guidelines. Louisiana Medicaid has adopted the Bright Futures EPSDT Periodicity Schedule promulgated by the American Academy of Pediatrics with two exceptions:

1) The Louisiana Medicaid EPSDT guidelines are for ages zero through 20 years and 364 days (The AAP Bright Futures EPSDT Periodicity Schedule provides guidance for patients through age 21); and
2) The Louisiana Medicaid schedule has stricter requirements for lead assessment and blood lead screening in keeping with the Louisiana public health rule LAC 48:V.7005-7009 and the Medicaid Professional Services Manual, "Public Health Surveillance Mandates" section.

A copy of the 2018 Louisiana Medicaid EPSDT Periodicity Schedule can be found at the following link: http://www.lamedicaid.com/provweb1/ProviderTraining/packets/2018ProviderTraining/2018_EPSDT_Periodicity_Schedule.pdf

More information about Bright Futures may be found on the American Academy of Pediatrics' website: https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx.

More information about lead poisoning prevention in children can be found at the following link: http://www.lead.dhh.louisiana.gov/.

Attention Louisiana Medicaid Providers

Effective June 1, 2018, pharmacy claims submitted to Fee for Service (FFS) Medicaid and Managed Care Organizations (MCOs) will have a diagnosis code requirement at Point of Sale (POS) for tadalafil (Cialis®) when used in the treatment of benign prostatic hyperplasia (BPH). Also, pharmacy claims for tadalafil 20mg (Adcirca®) and sildenafil 20mg (Revatio®) will have a diagnosis code requirement at POS for pulmonary arterial hypertension (PAH). Please refer to www.lamedicaid.com for more information.

Attention Providers Of Hospice Services

The Louisiana Medicaid Hospice Program fee schedule for federal fiscal year 17, effective date October 1, 2016, has been updated to reflect the federal change from Metropolitan Statistical Area (MSA) codes to Core Based Statistical Area (CBSA) codes. Effective immediately, please utilize the appropriate CBSA codes on the October 1, 2017 fee schedule when filing hospice claims with Molina Medicaid Solutions and Healthy Louisiana managed care organizations (MCOs).

The federal fiscal year 2018 rates are in place and the hospice fee schedule has been posted to www.lamedicaid.com with an effective date of October 1, 2017. All fee-for-service hospice claims from October 1, 2017 to May 22, 2018 will be recycled by Molina.

For questions regarding fee for service claims, please contact Molina Provider Relations at (800) 473-2783 or (225) 924-5040.

The MCOs have been directed to update their fee schedules and recycle any impacted claims within 30 days of the publishing of the updated fee schedule.

Attention LTC and ICF-DD Providers

Louisiana Medicaid UB-04 Billing Instructions Manual for Nursing Facility and ICF-DD, has long contained policy requiring Long Term Care and ICF-DD Providers to include a Principal Diagnosis when billing transactions. Previously, there wasn't an edit in place to validate a valid ICD-10 code was reported- but that will now change.
Effective for Dates of Service August 28, 2018 and forward, Medicaid will implement an edit requiring a valid ICD-10 diagnosis code is reported in the principal diagnosis field. Claims submitted without a valid principal diagnosis code will be denied for correction.

Louisiana Medicaid UB-04 Billing Instructions Manual for Nursing Facility and ICF-DD identifies Other Diagnosis Field as a situational field. While reporting Other Diagnosis is not required, effective with dates of service August 28, 2018 and forward, Medicaid will implement an edit to deny the claim for correction when an invalid ICD-10 code is reported in the Other Diagnosis Field.

Attention Providers of CLIA Waived Tests

CMS mandated Clinical Laboratory Improvement Amendments (CLIA) claim edits are applied to all laboratory services billed on fee for service claims. Claims submitted that do not meet the required CLIA criteria will deny.
Providers with waived or provider-performed microscopy (PPM) certificate types may be paid only for those waived and/or PPM codes approved for their certification types. Providers with these certification types are to add the 'QW' modifier to the procedure code for all applicable CLIA waived or PPM tests they submit for reimbursement.
The fee for service claims processing system has been updated to assure correct processing of claims for laboratory services. Effective for claims processed on or after April 17, 2018 the following Current Procedural Terminology (CPT) codes will require a "QW" modifier effective for the date of service provided below when submitted by providers with the certificate types described above:

Code	CLIA Waived Eff Date
80305	01/01/2017
87633	10/07/2016
87801	03/06/2017

Denied claims submitted with the codes above on or after the effective date listed that were submitted correctly with modif –QW will be systematically recycled on the remittance of April 24, 2017 without any action required by the provider.

Please visit www.cms.gov for a complete listing of effective dates for recently added codes. For more information regardin CLIA, see Appendix A in the Professional Services Provider Manual.
For questions related to this information as it pertains to fee for service Medicaid claims processing, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

Questions related to Healthy Louisiana managed care organizations' updates should be directed to the specific health plan.

Attention Fee for Service (FFS) Louisiana Medicaid Providers

Effective May 1, 2018, Fee for Service (FFS) pharmacy claims for long-acting opioid prescription products will have revised quantity limits. Also, FFS pharmacy claims for concurrent use of opioid and benzodiazepine prescriptions will have edits at Point of Sale (POS). Please refer to www.lamedicaid.com for more information.

Attention Louisiana Medicaid Providers

Effective May 9, 2018, Fee for Service (FFS) Medicaid and Managed Care Organizations (MCOs) will have revisions to the Hepatitis C Direct-Acting Antiviral (DAA) Agents clinical prior authorization and pre-authorization criteria. Please refer to www.lamedicaid.com for more information.

Attention All DME Providers
Portable Oxygen Coverage and Reimbursement

Effective with dates of service July 1, 2018, reimbursement will be allowed for portable oxygen equipment for members who need continuous oxygen and require portable units while en route to the doctor's office, hospital, medically necessary appointments, or travel to or from school for individuals under the age of 21.

All requests for portable oxygen going forward must be submitted using the following procedure codes:

E0430-09 - Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing
E0431-07 - Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0443-09 – Portable oxygen contents, gaseous, 1 month's supply = 1 unit
Note: E0430-07 using modifier RR for rental will no longer be a billable code for portable oxygen.
It is the expectation of the Louisiana Department of Health that managed care organizations (MCOs) will update their systems to accommodate these corrections in allowable HCPCS codes for portable oxygen in accordance with the requirements set forth above.

Questions regarding this message and fee for service claims should be directed to Molina Provider Relations at (800) 473-2783 or (225) 924-5040.

Updates to Healthy Louisiana related policy, systems and claims processing changes are plan specific and are the responsibility of each health plan. For questions regarding Healthy Louisiana updates and prior authorization requirements, please contact the appropriate health plan.

Attention Louisiana Medicaid Providers

As of April 1, 2018, Fee for Service (FFS) Medicaid and Managed Care Organizations (MCOs) initiated new diagnosis code requirements at Point of Sale (POS) for attention deficit hyperactivity disorder (ADHD) agents, stimulants, and substance use disorder (SUD) agents. Please refer to www.lamedicaid.com for more information.

Attention Outpatient Hospital Providers
LARCs Inserted in the Outpatient Hospital Setting

For long-acting reversible contraceptives (LARCs) inserted in the outpatient hospital setting, hospitals receive an additional payment for the LARC device when it is inserted during an outpatient hospital visit. Payment for the LARC device in the outpatient hospital setting is in addition to the reimbursement for the outpatient hospital claim. Previously, providers had been instructed to bill the outpatient claim for the outpatient visit on the UB-04 and the claim for the LARC device on the CMS 1500 claim form.

Effective July 1, 2018 and forward, providers inserting LARCs in the outpatient hospital setting may bill the DME revenue code of 290 with the appropriate accompanying HCPCS code for the LARC device on the UB-04. Providers should consult the DME fee schedule for covered LARCs and their reimbursement.

Please contact the appropriate managed care organization with any questions concerning their billing instructions for LARCs inserted in the hospital setting. For questions related to this information as it pertains to fee-for-service Medicaid claims processing, please contact Molina Medicaid Solutions Provider Relations at 1(800) 473-2783 or (225) 924-5040.

For Information or Assistance, Call Us!

Provider Enrollment	(225)216-6370
Prior Authorization:	
Home Health/EPSDT – PCS	1-800-807-1320
Dental	1-866-263-6534 1-504-941-8206
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
MMIS Claims Processing Resolution Unit	(225) 342-3855
MMIS/Recipient Retroactive Reimbursement	(225) 342-1739 1-866-640-3905
Medicare Savings Program and Medicaid Purchase Hotline	1-888-544-7996
For Hearing Impaired	1-877-544-9544
Pharmacy Hotline	1-800-437-9101
Medicaid Fraud Hotline	1-800-488-2917