Louisiana Medicaid | Provider UPDATE

Volume 30, Issue 2 | March/April 2012

New Claims Cycle and Payment Dates Implemented

All Providers

A new review process and payment calendar for Medicaid claims processed by Molina is being implemented. On February 26, 2012, Medicaid payments moved from a typical payment cycle of seven to eight days to a cycle of approximately fourteen days. Beginning the week of June 3, 2012, the second phase of this new process will move the payment cycle to an approximate 21-day review period.

This change has been implemented to provide for increased monitoring and a closer examination of claims prior to payments being made to prevent fraud and abuse. Providers will continue to receive payment for claims based on the published Medicaid rate that is in effect on the day the service was performed.

Providers can expect to see new codes on their remittance advices related to this new process. "Error Code 241 – Claim in process (short); claim held for pre-payment review (long)" will appear for every claim submitted indicating the claim is being held for pre-payment screening. "Error Code 551 – Pre-pay review 0 pay (short); zero paid due to pre-payment review" or "Error Code 501 – Cannot adjust pre-pay (short message); cannot adjust zero-paid claim from pre-pay review process (long)" will appear if a claim is zero paid based on fraud, abuse or waste detected in the pre-pay process.

The payment schedule change does not apply to payments made to providers enrolled in one of the three prepaid BAYOU HEALTH Plans: Amerigroup Real Solutions, LaCare, or Louisiana Healthcare Connections. Providers should check with these health plans to receive their payment schedules.

Additional information about this change can be found at www.lamedicaid.com. Providers should contact Molina Provider Relations at 1-800-473-2783 or (225) 924-5040 for related questions.

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Payment Error Rate Measurement (PERM)

All Providers

The Improper Payments Information Act of 2002 directs Federal agency heads to report improper payment estimates to Congress on programs that are susceptible to payment errors. The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant payment errors. In response to this requirement, the Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) Program to measure the accuracy of these programs.

CMS uses contractors to measure improper payments in Medicaid and CHIP by reviewing a sample of claims along with supporting medical records based on a three year state rotation. Louisiana is currently participating in PERM for federal fiscal year 2011.

Providers in the sample will be contacted by the PERM contractor, A+ Government Solutions, Inc., who will explain the purpose of the call and CMS's right to collect medical records for audit purposes, and to request identification of the appropriate point of contact for each provider. After confirming that the correct provider has been reached and the necessary medical records have been identified, a written request is sent to the provider specifying the type of documents needed and the instructions on how to submit records to them.

Providers have 75 calendar days to submit the information after receipt of the written request. A+ Government Solutions, Inc. may request additional documentation if the documentation submitted is insufficient to support the claim.

Claims with no documentation or insufficient documentation will count against the state as an error. It is important that all sampled providers cooperate with A+ Government Solutions, Inc. and submit all requested documentation in a timely manner to avoid possible sanctioning by Louisiana Medicaid.

For more information on PERM and your role as a provider, please visit the Provider link on the CMS PERM website at https://www.cms.gov/PERM/07_Providers.asp or contact your state PERM representative, Deanie Vincent, at (225) 219-4279.

Affordable Care Act to Bring About Provider Screening and Enrollment Changes

All Providers

The Louisiana Medicaid Program will be adopting the Affordable Care Act (ACA) mandated provider enrollment and screening requirements. Although an effective date has not yet been determined, the following is intended to provide an overview of these anticipated changes.

Provider types categorized by risk level – high, moderate, or limited
The Centers for Medicare and Medicaid Services (CMS) has established this categorization based on an assessment of potential for fraud, waste, and abuse for each provider type. Louisiana Medicaid will determine the risk level for providers who do not have a provider type recognized by CMS.

Providers screened according to assigned risk level
The following table shows the assigned risk levels for most of Louisiana Medicaid provider types and outlines the general screening activities associated with each risk category.

Risk Level	Screening Activities	Provider Types
High	• Fingerprinting and criminal background check for all disclosed individuals • Unannounced site visits before and after enrollment • Verification of provider-specific requirements, including: ► License verification ► National Provider Identifier (NPI) check ► Office of the Inspector General (OIG) exclusion check ► Ownership/controlling interest information verification	• Prospective (newly enrolling) home health agencies • Prospective (newly enrolling) suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
Moderate	• Unannounced site visits before and after enrollment • Verification of provider-specific requirements, including: ► License verification ► NPI check ► OIG exclusion check ► Ownership/controlling interest information	• Community mental health centers • Comprehensive outpatient rehabilitation facilities • Hospices • Independent diagnostic testing facilities • Independent clinical laboratories • Non-public, non-government owned or affiliated ambulance service suppliers • Currently enrolled (revalidating) home health agencies • Currently enrolled (revalidating) suppliers of DMEPOS
Limited	Verification of provider-specific requirements, including: • License verification • NPI check • OIG exclusion check • Ownership/controlling interest information verification	• Ambulatory surgical centers • End-stage renal disease facilities • Federally qualified health centers • Histocompatibility laboratories, • Hospitals, including critical access hospitals • Indian Health Service facilities • Mammography screening centers • Organ procurement organizations • Mass immunization roster billers • Portable x-ray suppliers • Religious nonmedical health care institutions • Rural health clinics • Radiation therapy centers • Public or government owned or affiliated ambulance services suppliers • Skilled nursing facilities

Affordable Care Act to Bring About Provider Screening and Enrollment Changes

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Certain providers subject to a non-refundable application fee of $523

The application fee amount is set by CMS and may be adjusted annually. The fee, which is assessed at the point of initial enrollment and at enrollment revalidation, is to be charged individually and in full for each service location. If a provider pays an application fee to Medicare or to another state Medicaid agency for a service location, the provider will not be required to pay an additional application fee for that location to Louisiana Medicaid. The application fee applies to "institutional" providers, as defined by CMS, including, but not limited to, the following provider types:

- Clinical laboratories
- Community mental health centers
- Federally Qualified Health Centers
- Hospice providers
- Hospitals
- Nursing facilities
- Outpatient physical therapy
- Occupational therapy groups
- Durable medical equipment (DME) providers
- Pharmacies
- Speech/hearing therapy groups

Generally, application fees do not apply to individual professionals, such as physicians.

Enrollment forms to collect additional information

Updated Louisiana Medicaid enrollment forms will require additional information for all disclosed individuals.

Revalidation of all enrolled providers at least every five years

Under current policy, providers have not been required to re-enroll on a regular basis. Providers will be required to revalidate their enrollments with the Louisiana Medicaid Program at five-year intervals. A more frequent three-year revalidation requirement will apply to DME providers and pharmacy providers with DME or home medical equipment (HME) specialty enrollments. All providers will be required to revalidate their enrollment under ACA criteria. Louisiana Medicaid plans to revalidate existing providers in phases, with completion scheduled for March 23, 2015.

Information about additional ACA provider screening and enrollment criteria can be found in the Federal Register, Volume 76, No. 22, Page 5862, published Wednesday, February 2, 2011. Additional guidance will be provided in future provider communications as Louisiana Medicaid prepares to implement an ACA-compliant enrollment and screening process.

Home and Community-Based Services Final Licensing Rule Published

All Providers

Final licensing standards for home and community-based services (HCBS) providers were published in the *Louisiana Register, Vol. 38, No. 1 on January 20, 2012*. These standards apply to providers licensed for the following services:

- Adult day care (ADC),
- Family support,
- Personal care attendant (PCA),
- Respite,
- Substitute family care (SFC),
- Supervised independent living (SIL), including shared living conversion services in a waiver home, and
- Supported employment.

State surveyors will apply the regulations in this rule to all compliance surveys conducted after January 20, 2012. A copy of the final rule can be viewed on the Health Standards HCBS web site at http://new.dhh.louisiana.gov/index.cfm/directory/detail/719.

Remittance Advice Corner

All Providers

The following is a compilation of messages that were recently transmitted to providers through Remittance Advices (RA):

Update to "ClaimCheck" Product Editing

McKesson's "ClaimCheck" product is routinely updated by McKesson Corporation based on changes made to the resources used, such as Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding guidelines, the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule database, and/or provider specialty society updates. The "ClaimCheck" product's procedure code edits are guided by these widely accepted industry standards. These edit changes will affect claims processed beginning with the remittance advice of March 6, 2012 forward. Providers may notice some differences in claims editing that includes Pre/Post-op Days, Incidental, Mutually Exclusive, Rebundling and Multiple Surgery Reductions. Providers should expect that most claims will continue to be edited in the same manner, but when applicable, claims may now pay or deny for a different reason. Providers will continue to be notified when these routine updates are made in the future. For questions related to this information, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

Verifying Health Plan and Eligibility

Information for BAYOU HEALTH Members
Beginning 2/1/12, REVS, MEVS, and E-MEVS applications will show the name of the BAYOU HEALTH Plan and their phone number for Medicaid recipients enrolled in BAYOU HEALTH. Enrollment in a BAYOU HEALTH Plan is for the entire calendar month. This information will be located where current CommunityCARE PCP information is, and will no longer contain the PCP name. You may obtain PCP information from the BAYOU HEALTH Plan. DHH is making revisions that will allow future month Health Plan and eligibility information to be shown in these applications. Further information will be forthcoming.

Attention CommunityCARE Providers

Current CommunityCARE Primary Care Providers (PCPs) that intend to continue rendering care to Louisiana Medicaid recipients as PCPs in the BAYOU HEALTH program must ensure that each Health Plan is provided with the 7-digit Medicaid legacy provider ID and corresponding NPI enrolled in CommunityCARE. PCPs with CommunityCARE linkages at more than one location must also include the appropriate 3-digit site number for each enrolled location. This information is available on the CommunityCARE CP-0-92 reports submitted for payment of the monthly management fees.

NOTE: Physician group practices, FQHCs and RHCs must also provide the Medicaid IDs and NPIs for the individual practitioners at each CommunityCARE-enrolled location.

For assistance verifying the enrolled Medicaid legacy provider ID, PCPs may also contact the CommunityCARE contractor at 1-800-259-444, option #3.

Attention all Providers 2012 HCPCS Update

The Louisiana Medicaid files have been updated to reflect the new and deleted HCPCS codes for 2012. Providers will begin seeing these changes on the RA of March 6, 2012. Professional Services Fee Schedule on the LA Medicaid Website, www.lamedicaid.com will be updated in the very near future to reflect this update. Claims denied due to use of the new 2012 codes prior to their addition to our system will be systematically adjusted in the near future. Providers should monitor their RA messages for additional information.

Providers will see denials of codes with 2012 date of service that were deleted effective December 31, 2011. Those claims should be resubmitted with the correct 2012 code.

Additionally, the "Assistant Surgeon/Assistant at Surgery Covered Procedures List" under the 'ClaimCheck' icon on the website homepage will be updated to reflect the addition of applicable 2012 procedure codes. As a reminder, 'ClaimCheck' uses the American College of Surgeons (ACS) as its primary source for determining assistant surgeon designations.

Online Medicaid Provider Manual Chapters

All Providers

The following Medicaid Provider Manual Chapters are available on the Louisiana Medicaid website at www.lamedicaid.com under the "Provider Manual" link. This list will be updated periodically as other Medicaid program chapters become available online.

- Administrative Claiming
- Adult Day Health Care Waiver
- Ambulatory Surgical Centers
- American Indian 638 Clinics
- Children's Choice Waiver
- Dental
- Durable Medical Equipment
- Elderly and Disabled Adult Waiver
- End Stage Renal Disease
- Family Planning Clinics
- Family Planning Waiver (Take Charge)
- Federally Qualified Health Centers
- General Information and Administration
- Greater New Orleans Community Health Connection (GNOCHC)
- Home Health
- Hospitals
- ICF/DD
- Medical Transportation
- Mental Health Clinics
- Mental Health Rehabilitation
- Multi-Systemic Therapy
- New Opportunities Waiver (NOW)
- Pediatric Day Health Care
- Personal Care Services
- Pharmacy
- Professional Services
- Psychological Behavioral Services
- Residential Options Waiver
- Rural Health Clinics
- Supports Waiver
- Vision (Eye Wear)

Recent revisions have been made to the following Medicaid Provider Manual Chapters. Providers should review these revisions in their entirety at www.lamedicaid.com under the "Provider Manual" link:

Manual Chapter	Section	Date of Revision
Professional Services	Appendix G – Podiatry Codes	02/20/12
Professional Services	Section 5.1 – Covered Services – Abortion	02/24/12

Pharmacologic Prevention and Treatment of Sickle Cell Pain Crisis in Adults

Louisiana Drug Utilization Review (LADUR) Education

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Introduction

Sickle cell disease, which affects 70,000-100,000 Americans, is an autosomal recessive genetic disorder characterized by red blood cells forming a rigid, sickle shape when exposed to a low oxygen environment.[1,2] This abnormality is caused by a mutation in the beta-globin chain of hemoglobin where glutamic acid is substituted for a valine.[2] Interacting with normal blood cells and endothelial cells, the sickled hemoglobin (HbS) can cause occlusions in the vasculature which leads to tissue ischemia.[3] This cascade is considered the main pathophysiological cause of sickle cell pain along with splenic sequestration, leg ulceration, and avascular necrosis.[4]

Frequency and presentation of sickle cell pain crises, defined as pain lasting for at least 2 hours in the head, chest, trunk, back, or extremities, vary among patients. A prospective cohort study including 3,578 children and adults analyzed 12,290 reported pain crises. The number of hospitalizations per year for pain crises ranged from 0 (38.5% of participants) to > 6 (1% of participants). Overall, 32.9% of pain crises occurred in 5.2% of participants. Characteristics associated with an increased number of pain crises included a low percentage of fetal hemoglobin (HbF), a high hematocrit level, and patients who were homozygous for the HbS allele or heterozygous for HbS and ßº-thalassemia.[5] In another prospective cohort, the mean length of stay for sickle cell crisis was 7.6 days with 50% of patients being readmitted within 1 month.[6] Due to comorbidities and individual variation, sickle cell pain crises can be a challenge to treat.[7] This article will review the literature and clinical trials addressing the treatment of acute sickle cell pain.

Analgesics

The choice of analgesic varies based upon the individual patient, which includes but is not limited to the characteristics of the pain (location, severity, etc.), current medication use, organ function, comorbidities, vital signs, and previous successful treatment. The American Society of Pain recommends that acute pain management for patients with sickle cell disease should be based upon the severity of pain and patient response to current analgesic treatment, similar to the WHO Analgesic Ladder for cancer pain (Table 1). A complete physical exam, pain evaluation, aggressive treatment, and frequent re-evaluations are essential to successful treatment.[8]

Acute, severe pain uncontrolled by oral medications may require hospitalization for intensive treatment. Hydration is recommended and administration of intravenous opioids should begin immediately.[7] Dosing and choice of opioids vary based upon patient characteristics and institutional preferences. For severe, acute pain in opioid-naïve adults who are not adequately controlled by oral medication, the guideline for sickle cell pain management prepared by the Sickle Cell Working Party on behalf of the British Committee for Standards in Haematology recommends a starting dose of morphine 0.1 mg/kg IV/SC every 20 minutes until pain is controlled then 0.05 – 0.1 mg/kg IV/SC/PO every 2-4 hours or consider use of patient-controlled analgesia (PCA). The recommended PCA dosing for morphine is 2-10 mg on demand over 1 minute and a lock out of 20-30 minutes for patients who weigh > 50 kg. A continuous infusion up to 10 mg/hour may also be considered depending upon severity of pain and the patient's opioid naivety.[9] If another agent is preferred, refer to Table 2 for opioid equivalency.[10,11]

Small randomized trials have been completed to identify the best delivery of intravenous opioids. One such trial, Gonzalez et al., randomized 35 patients to receive morphine by intermittent injection or by a PCA pump with two different dosing schemas. Trial results indicated that the patients in the PCA group received more doses of morphine compared to the intermittent IV group, but the total milligrams of morphine used during treatment did not differ between groups. Adverse effects and patient satisfaction with pain control were also similar with both regimens.[12] In a similar trial, Van Beers et al. randomized 19 patients to receive either a continuous infusion or PCA administration of intravenous morphine. The patients in the PCA group used less morphine overall (median of 33 mg) during their pain crises compared to patients who received the continuous infusion (median of 260 mg) both with adequate pain control. Also, severity of constipation and nausea were less severe in the PCA group compared to the continuous infusion group.[13]

Hydroxyurea

Hydroxyurea, a medication originally approved for the treatment of malignancies, has been shown to increase the percentage of HbF and decrease episodes of pain crises.[14] Charache, et al. conducted a randomized, double-blind, placebo-controlled clinical trial including 299 adults with sickle cell anemia. To be included, patients had to have three or more pain crises within the last year. Patients in the treatment group received hydroxyurea (HU) at a starting dose of 15 mg/kg orally daily with a maximum of 35 mg/kg/day. The participants in the HU group had significantly less pain crises compared to the placebo group, median of 2.5 and 4.5 crises yearly respectively. Also, the treatment group had lower rates of hospitalization, a higher percentage of HbF, and a longer time to vaso-occlusive episode.[15]

Due to myelotoxic and possible leukogenic effects of HU, long-term use has been a concern. In a single center follow-up study of 330 sickle cell anemia patients, those who received HU had a 10-year overall survival (OS) of 86% and patients who did not had a 10-year OS of 65% (p=0.001). Of note, patients who received HU were considered to have a more severe disease including significantly more pain crises and hospital admissions. Only 34 patients with sickle cell anemia were included in this study, and the rest had a form of sickle cell anemia and thalassemia. The most common adverse effects with HU were myelosuppression, specifically neutropenia and thrombocytopenia. There were no reported issues with fertility or HU-induced cancers.[16]

Conclusion

Even though there are many expert opinions published in the medical literature, most of the recommendations for the treatment of sickle cell pain in adults are based upon pain treatment in other patient populations, such as those with cancer. When a patient with sickle cell disease has acute pain, prompt medical attention including appropriate medication use is extremely important. Analgesic treatment should be tailored based upon each individual patient with PCA administration being considered in patients with severe pain requiring intravenous opioids. Hydroxyurea is an effective and safe option to decrease the quantity of pain crises and potentially decrease hospitalizations in those who have three or more pain crises per year.

Pharmacologic Prevention and Treatment of Sickle Cell Pain Crisis in Adults

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Table 1. WHO Analgesic Ladder8

Moderate to Severe Pain: Opioid ± non-opioid ± adjuvant
Mild to Moderate Pain: Opioid ± non-opioid ± adjuvant
Mild Pain: Non-opioid (acetaminophen or NSAID) ± adjuvant

Choose treatment based upon severity of pain and escalate to box above if no relief provided.
Adjuvant: medications used to enhance efficacy and/or treat toxicity or other symptoms of pain (ex. muscle relaxants)

Table 2. Opioid Conversion Chart*

Agent	Parenteral Dose	Oral Dose
Morphine	10 mg	30 mg
Codeine		200 mg
Fentanyl	100 mcg	
Hydrocodone		30 mg
Hydromorphone	1.5 mg	7.5 mg
Methadone	10 mg**	3-5 mg
Oxycodone		20-30 mg
Oxymorphonew	1 mg	10 mg

*When rotating opiates, consider giving 50-80% of total dose due to incomplete cross-tolerance.
Ex: morphine ER (MS Contin®) 60 mg orally twice daily
30 mg oral morphine = 20 mg oral oxycodone
120 mg oral morphine daily = x mg oral oxycodone daily
30 mg oral morphine 20 mg oral oxycodone
x=80 mg oral oxycodone daily
80 mg oral oxycodone x .75 (for cross-tolerance) = 60 mg oral oxycodone
60 mg oxycodone divided into twice daily = oxycodone ER (Oxycontin®) 30 mg orally twice daily

**For specific information regarding methadone dosing, refer to: Indelicato RA, Portenoy RK. Opioid Rotation in the Management of Refractory Cancer Pain. J Clin Oncol. 2002; 20: 348-52.

References

1. Hassell K. Sickle Cell Disease Population Estimation: Application of Available Contemporary Data to Traditional Methods. In: 35th Anniversary Convention of the National Sickle Cell Disease Program; 2007: Washington, DC.
2. Bunn HF. Pathogenesis and Treatment of Sickle Cell Disease. N Engl J Med. 1997; 337: 762-9.
3. Hebbel RP, Osarogiagbon, R, Kaul D. The Endothelial Biology of Sickle Cell Disease: Inflammation and a Chronic Vasculopathy. Microcirculation. 2004; 11: 129-51.
4. Niscola P, Sorrentino F, Scaramucci L, et al. Pain Syndromes in Sickle Cell Disease: An Update. Pain Medicine. 2009; 10: 470-80.
5. Platt OS, Thorington BD, Brambilla DJ, et al. Pain in Sickle Cell Disease: Rates and Risk Factors. N Engl J Med. 1991; 325: 11-6.
6. Ballas SK, Lusardi M. Hospital Readmission for Adult Acute Sickle Cell Painful Episodes: Frequency, Etiology, and Prognostic Significance. Am J Hematol. 2005; 79: 17-25.
7. Field JJ, Knight-Perry JE, DeBaun MR. Acute Pain in Children and Adults with Sickle Cell Disease: Management in the Absence of Evidence-Based Guidelines. Current Opinion in Hematology. 2009; 16: 173-6.
8. Benjamin LJ, Campier CD, Jacox AK, et al. Guidelines for the Management of Acute and Chronic Pain in Sickle-Cell Disease. APS Clinical practice Guidelines Series, No. 1. Glenview, IL: American Pain Society; 1999.
9. Rees DC, Olujohungbe AD, Parker NE, et al. Guidelines for the Management of the Acute Painful Crisis in Sickle Cell Disease. British Journal of Hematology. 2003; 120: 744-52.
10. Gammaitoni AR, Fine P, Alvarez N, McPherson ML, Bergman S. Clinical Application of Opioid Equianalgesic Data. The Clinical Journal of Pain. 2003; 19: 286-97.
11. Opana® [package insert]. Chadds Ford, PA; Endo Pharmaceuticals, Inc.; 2011.
12. Gonzalez ER, Bahal N, Hansen L. Intermittent Injection vs Patient-Controlled Analgesia for Sickle Cell Crisis Pain, Comparison in Patients in the Emergency Department. Arch Intern Med. 1991; 151: 1373-8.
13. Van Beers EJ, Van Tuijn CFJ, Nieuwkerk PT, et al. Patient-controlled Analgesia Versus Continuous Infusion of Morphine during Vaso-occulsive Crisis in Sickle Cell Disease, a Randomized Controlled Trial. Am J Hematol. 2007; 82: 955-60.
14. Charache S, Dover GJ, Moore RD, et al. Hydroxyurea: Effects on Hemoglobin F Production in Patients with Sickle Cell Anemia. Blood. 1992; 79: 2555-65.
15. Charache S, Terrin ML, Moore RD, et al. Effect of Hydroxyurea on the Frequency of Painful Crises in Sickle Cell Anemia. N Engl J Med. 1995; 332: 1317-32.
16. Voskaridou E, Christoulas D, Bilalis A, et al. The Effect of Prolonged Administration of Hydroxyurea on Morbidity and Mortality in Adult Patients with Sickle Cell Syndromes: Results of a 17-year, Single-Center Trial (LaSHS). Blood. 2010; 115: 2354-63.

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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

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