CommunityCARE PROVIDER TRAINING

Medicaid Issues 2004
(Fall Issue)

LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVCIES FINANCING

UNISYS

ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the Fall 2004 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability. Such information is presented only in the Basic Medicaid Information Training packet. This packet may be obtained by attending the Basic Medicaid Information workshop; by requesting a copy from Unisys Provider Relations; or by downloading it from the Louisiana MEDICAID website, www.lamedicaid.com.

FOR YOUR INFORMATION! SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

I. MR/DD Waiver Waiting List

The MR/DD Waiver Program provides services in the home, instead of institutional care, to persons who are mentally retarded or have other developmental disabilities. Each person admitted to the Waiver Program occupies a "slot." Slots are filled on a first-come, first-served basis. Services provided under the MR/DD Waiver are different from those provided to Medicaid recipients who do not have a Waiver slot. Some of the services that are only available through the Waiver are: *Respite Services; Substitute Family Care Services; Supervised Independent Living and Habilitation/Supported Employment*. There is currently a Waiting List for waiver slots.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

II. Benefits for Children and Youth on the MR/DD Waiver Waiting List

Case Management

If you are a Medicaid recipient under the age of 21 and have been on the MR/DD Waiver Waiting list at any time since October 20, 1997, you may be eligible to receive case management *NOW*.

YOU NO LONGER NEED TO WAIT FOR THIS SERVICE. A case manager works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

Notice P-17
Revised November 1, 2000
***DISCLAIMER: This information is currently being updated and some content may be incorrect or incomplete. If you are unable to get assistance using the telephone numbers listed under the specific programs, you may contact Medicaid Program Operations at 225-342-5774.

III. Benefits Available to All Children and Youth Under the Age of 21

THE FOLLOWING SERVICES ARE AVAILABLE NOW. YOU DO NOT NEED TO WAIT FOR A WAIVER SLOT TO OBTAIN THEM.

EPSDT/KIDMED Exams And Checkups
Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history, physical exam, immunizations, vision and hearing checks, and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed.

TO OBTAIN AN EPSDT SCREEN OR DENTAL SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

EPSDT screens may help to find problems which need other health treatment or additional services. **Children under 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.** Some of these additional services are very similar to services provided under the MR/DD Waiver Program. There is no waiting list for these Medicaid services.

Personal Care Services
Personal care services are provided by attendants to persons who are unable to care for themselves. These services assist in bathing, dressing, feeding, and other non-medical activities of daily living. PCS services *do not* include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. Once ordered by a physician, the PCS service provider must request approval for the service from Medicaid.
FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A PCS SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

Extended Home Health Services
Children and youth may be eligible to receive *Skilled Nursing Services* and *Aide Visits* in the home. These can exceed the normal hours of service and types of service available for adults. These services are provided by a Home Health Agency and must be provided in the home. This service must also be ordered by a physician. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.
FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A HOME HEALTH SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services

If a child or youth wants *Rehabilitation Services* such as *Physical, Occupational, or Speech Therapy, or Audiology Services* outside of or in addition to those being provided in the school, these services can be provided by Medicaid at hospitals on an outpatient basis, or, in the home from Rehabilitation Centers or under the *Home Health* program. These services must also be ordered by a physician. Once ordered by a physician, the service provider must request approval for the service from Medicaid.

FOR ASSISTANCE IN APPLYING FOR THESE SERVICES AND LOCATING A SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

Services in Schools or Early Intervention Centers

Children and youth can also obtain *Physical, Occupational, and Speech Therapy, Audiology Services, and Psychological Evaluations and Treatment* through early intervention centers (for ages 0-2) or through their schools (For ages 3-21). Medicaid covers these services if the services are a part of the IFSP or IEP. These services may also be provided in the home.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR EARLY INTERVENTION CENTER OR SCHOOL OR CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

Medical Equipment and Supplies

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions. *Medical Equipment and Supplies* must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

FOR ASSISTANCE IN APPLYING FOR MEDICAL EQUIPMENT AND SUPPLIES AND LOCATING MEDICAL EQUIPMENT PROVIDERS CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

Mental Health Rehabilitation Services

Children or youth with mental illness may receive *Mental Health Rehabilitation Services*. These services include: clinical and medical management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. *MENTAL HEALTH REHABILITATION SERVICES MUST BE APPROVED BY THE LOCAL OFFICE OF MENTAL HEALTH*.

FOR ASSISTANCE IN APPLYING FOR MENTAL HEALTH REHABILITATION SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

Transportation

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment.

TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

Other Medicaid Covered Services

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

NOTICE TO ALL PROVIDERS

Pursuant to Chisholm v. Cerise DHH is required to inform both recipients and providers of certain services covered by Medicaid. The following two pages contain notices that are sent by DHH to some Medicaid recipients notifying them of the availability of services for EPSDT recipients (recipients under age 21). These notices are being included in this training packet so that providers will be informed and can help outreach and educate the Medicaid population. Please keep this information readily available so that you may provide it to recipients when necessary.

DHH reminds providers of the following services available for all recipients under age 21:

- Children under age 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. **This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.**

- Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

- Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment. **TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).**

- **Recipients may also CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544) for referral assistance with all services, not just transportation.**

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Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

*Doctor's Visits
*Hospital (inpatient and outpatient) Services
*Lab and X-ray Tests
*Family Planning
*Home Health Care
*Dental Care
*Rehabilitation Services
*Prescription Drugs
*Medical Equipment, Appliances and Supplies (DME)
*Case Management
*Speech and Language Evaluations and Therapies
*Occupational Therapy
*Physical Therapy
*Psychological Evaluations and Therapy
*Psychological and Behavior Services
*Podiatry Services
*Optometrist Services
*Hospice Services
*Extended Skilled Nurse Services
*Residential Institutional Care or Home and Community Based (Waiver) Services
*Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
*Immunizations
*Eyeglasses
*Hearing Aids
*Psychiatric Hospital Care
*Personal Care Services
*Audiological Services
*Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
*Appointment Scheduling Assistance
*Substance Abuse Clinic Services
*Chiropractic Services
*Prenatal Care
*Certified Nurse Midwives
*Certified Nurse Practitioners
*Mental Health Rehabilitation
*Mental Health Clinic Services

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

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You may access other services by calling KIDMED at (toll-free) 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

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Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

If you live in a CommunityCARE parish, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

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CommunityCARE
Department of Health and Hospitals
Vision for Improving Health Care in Louisiana

I. OVERVIEW

- CommunityCARE is operated under the freedom of choice waiver approved by the Centers for Medicare/Medicaid Services (CMS).
- It is a system of comprehensive health care based on a primary care case management model (PCCM).
- CommunityCARE links Medicaid eligibles with a primary care provider (PCP) that serves as their medical home.
- In addition to the normal fee-for-service payment, the PCP is paid a monthly management fee to manage the enrollee's healthcare.
- The PCP acts as a "facilitator" and is responsible for preventative and acute care, health education, and referrals/authorizations to specialists, outpatient hospital services, and other ancillary health services.
- The PCP provides basic primary care and after hours coverage – 24 hours a day, 7 days a week, 365 days a year.

II. RECIPIENT ENROLLMENT

Participation in the CommunityCARE program is mandatory for most Medicaid recipients. Currently seventy-five to eighty percent of all Medicaid recipients are linked to a primary care provider. Recipients not linked to a CommunityCARE PCP may continue to receive services without a referral/authorization just as they did before CommunityCARE. Those recipient types that are **EXEMPT** from participation in CommunityCARE and will not be linked to a PCP are listed below. (This list is subject to change):

- Residents of long term care nursing facilities, psychiatric facilities, or intermediate care facilities for the mentally retarded (ICF/MR) such as state developmental centers and group homes
- Recipients who are 65 or older
- Recipients with Medicare benefits, including dual eligibles
- Foster children or children receiving adoption assistance
- Hospice recipients
- Office of Youth Development recipients (children in State custody)
- Recipients in the Medicaid physician/pharmacy 'Lock-In' program (recipients that are pharmacy-only 'Lock-In' are not exempt)
- Recipients who have other primary insurance with physician benefits, including HMOs
- Recipients who have an eligibility period of less than 3 months
- Recipients with retroactive only eligibility (CommunityCARE does not make retroactive linkages)
- BHSF case-by-case approved "Medically High Risk" exemptions

- Native American Indians residing in parish of reservation (currently Jefferson Davis, St. Mary, LaSalle and Avoyelles parishes).

A. How to Identify CommunityCARE Enrollees

- CommunityCARE recipients are identified through multiple eligibility verification systems; REVS (telephone recipient eligibility verification system), MEVS (swipe card Medicaid eligibility verification system) and online verification through the Unisys website – www.lamedicaid.com.

- When a Medicaid eligible requests services, it is the Medicaid provider's responsibility to verify recipient eligibility and CommunityCARE enrollment status, **before providing services,** by accessing the REVS, MEVS or www.lamedicaid.com

- When providers check recipient eligibility through REVS, MEVS or www.lamedicaid.com, the system will list the PCP's name and telephone number **if** the recipient is linked to a CommunityCARE PCP. If there is no CommunityCARE PCP information given, then the recipient is **NOT** linked to a PCP and may receive services without a referral/authorization.

  NOTE: If the provider requesting information from REVS or MEVS is the enrollees linked PCP the specific PCP information is not given.

B. How Recipients Are Notified and Linked

- During the first week of the month before linkage, potential enrollees receive a notice (the choice notice) advising them to choose a PCP. Included with the choice notice is a list of CommunityCARE providers in the enrollee's parish of residence. The letter gives them a toll free telephone number and informs them that if they do not call the toll-free number and make a choice by the date specified in the letter (usually between the 21st-23rd of any given month) the state will assign a PCP to them.

- By the first of the month that the linkage is effective, each enrollee receives a confirmation letter providing them with the name, address and telephone number of the PCP they chose or the one assigned to them by the State if they did not choose prior to the deadline. This letter restates the educational information in previously sent notices, and gives them the effective date they must start using their new PCP. It also informs them that if they are not satisfied with the PCP listed on the letter, they have 90 days to change to another PCP, and instructs them on how to make the change. A confirmation letter is also sent each month to enrollees who have changed PCP's.

  Example -A choice letter is mailed the first week of September. The enrollee makes a PCP selection by the September 23rd deadline. The PCP selection becomes effective on October 1. If the enrollee fails to make a PCP selection by the deadline, the enrollee is auto-assigned to a PCP effective October 1. Confirmation letters are mailed out by October 1.

- All PCP changes, whether initiated by the recipient or the PCP, are processed in the same time frame. Changes called in before the 23rd of any given month will be effective the first of the following month. If the 23rd fall on a Saturday or Sunday, the deadline is the previous Friday. Any changes received after the deadline will not be effective until the 1st of the second following month.

- Federal regulations require that an enrollee be able to change PCPs within 90 days of any linkage which means that, conceivably, the enrollee could call in a change before the 23rd of each month and be linked to a new PCP for the first of each month following. However, if the enrollee has changed multiple times and chooses a PCP with whom they have previously been linked, then the enrollee loses that 90 day option. Once the enrollee has been linked to a PCP for 90 days, they are linked to that PCP for 12 months. Enrollees may request a change at any time for cause. Requests for cause will be reviewed by the State on a case by case basis.

- Enrollees are also permitted to change PCPs without cause during a 60 day "open enrollment" period. All CommunityCARE enrollees are notified that they may change from October 23rd through December 23rd. If a change is not requested prior to December 23rd, the enrollee will remain linked to the same PCP for the next until the next open enrollment period unless cause is established in accordance with CommunityCARE policy.

- Federal requirements state that the PCP may not request disenrollment of an enrollee because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity or uncooperative or disruptive behavior resulting from his/her special needs (except when his or her continued enrollment seriously impairs the PCP's ability to furnish services to either this particular enrollee or other enrollees). The State will monitor PCP requests for disenrollment.

III. PRIMARY CARE PROVIDER (PCP) ENROLLMENT

A. Who Can Participate as a PCP?

The following Medicaid enrolled providers may participate as PCPs:

- General Practitioners
- Family Practitioners
- Pediatricians
- Internists
- Obstetricians/Gynecologists
- Academic Health Center Teams (A team is comprised of a staff physician and four mid-level practitioners or residents)
- Federally Qualified Health Center's (FQHC)
- Rural Health Center's (RHC)
- Nurse Practitioners (Under specific guidelines determined by DHH.)
- Other specialties may be considered for enrollment if practicing primary care in accordance with CommunityCARE policies and procedures.

B. Standards for Participation

- **Must be a currently enrolled Medicaid provider**

  As a CommunityCARE provider, the PCP must adhere to all general Medicaid enrollment conditions, as well as Medicaid regulations, State Plan standards, and policies and procedures set forth in the CommunityCARE Handbook and KIDMED manual.

- **Appointment Scheduling/Waiting Times**

  Every effort should be made by the PCPs to meet the following office visit access standards:

  - In-office waiting time for scheduled appointments – 1 hour
  - In-office waiting time for walk-ins – 2 hours
  - Urgent but non-emergent medical or behavioral problems – within 24 hours
  - Non-urgent sick visits – within 48-72 hours, as clinically indicated
  - Routine, non-urgent or preventive care – within 20 days
  - Emergency Room follow-up visits – in accordance with attending ER physician instructions

- **Telephone Accessibility**

  - A PCP must have arrangements for 24-hour, 7 days a week access to care coverage, including weekends and holidays.
  - A single 24-hour access telephone number must be provided by the PCP to all enrollees.
  - The use of an answering machine or other automated telephone system is acceptable, however, the message must direct the caller to a live person (see page 3-3 in the CommunityCARE Handbook).

- **Back Up Coverage**

  - The PCP must have a backup arrangement with another provider to provide coverage when he/she is not available. The backup provider must be a Medicaid provider but DOES NOT have to be enrolled in CommunityCARE.
  - The designated backup provider will use the PCP's referral authorization number on his/her claim forms and referrals/authorizations when providing or ordering services. The backup provider must forward copies of all referrals/authorizations made on behalf of the PCP to the PCP within 24 hours.
  - The PCP must have a 'PCP Statement of Coverage' on file with Louisiana Medicaid. This statement must include who the backup provider is, what days/hours the agreement is in effect and a step by step account of how an enrollee linked to a PCP obtains care when the PCP is not available

- **Admitting Privileges**

  - A CommunityCARE physician must maintain admitting privileges or must have arrangements with a physician who has admitting privileges at a Medicaid-participating hospital. The distance to the hospital from the CommunityCARE practice must be such that the enrollee travel time does not exceed 60 minutes.

- **KIDMED Services**

  - PCP's must either be enrolled as a certified KIDMED provider, or must have a CommunityCARE/KIDMED subcontract with a certified KIDMED provider for all CommmunityCARE enrollees under the age of 21 who are linked to him/her.

  - If the enrolling PCP decides to sub-contract his/her KIDMED responsibilities a signed "CommunityCARE/KIDMED Services Agreement" must be included in the CommunityCARE enrollment packet at the time of enrollment as a PCP.

  - Reminder: The PCP and the subcontracted KIDMED provider need to have arrangements to share recipient information and reports.

  - CommunityCARE PCPs must comply with all KIDMED procedures contained in the *KIDMED Provider Manual*.

IV. PCP LINKAGE/CAPACITY INFORMATION

CommunityCARE enrollees are linked to an individual physician if the physician is enrolled in Medicaid/CommunityCARE as an individual. If the PCP is a physician group, the enrollee is linked to the group. The enrollee is not linked to a specific physician within a group. If an enrollee is linked to a PCP that has multiple sites, the enrollee will be linked to a specific site. When an enrollee is linked to a specific site, the REVS, MEVS, and WWW.lamedicaid.com eligibility verification systems will indicate the specific site and will provide the appropriate phone number for that site.

- PCPs have several enrollment options to choose from:

  - Open Panel: Providers who enroll without any restrictions may serve a maximum of 2,500 enrollees per full time physician.

    - In order to preserve existing medical homes, a CommunityCARE enrolled provider may exceed the 2,500 maximum if there is an established medical relationship with that recipient.
    - An enrolled PCP that employees a certified nurse practitioner (CNP), nurse midwife, physician assistant (PA) or clinical nurse specialist (CNS) may serve an additional 500 enrollees per full time mid-level provider. (NOTE: Per Medicaid policy, if an individual physician employs or contracts with a nurse practitioner, the physician must obtain a physician

group number and bill Medicaid using the group number with the nurse practitioner as the attending/servicing provider).

- PCPs who are accepting newborns into their practice will be able to continue to do so once they have reached their linkage capacity. However, when a provider sees a newborn in the hospital, and wants the baby linked to his/her practice, the PCP must educate the parents about calling the CommunityCARE enrollee hotline and selecting them as the baby's PCP when they receive their enrollment letter from CommunityCARE. PCP linkages made via auto-assignment are based on a history of paid claims. Frequently, for newborns, the claims are not in the system in time to be considered for auto-assignment. Therefore, most newborns are linked randomly, unless the parent has called and made a PCP selection.

- Restricted Panel: Physicians who want to participate on a limited basis may limit their participation in several ways. They may enroll for current practice only (defined as recipients with a paid claim for an office visit with that provider in the past year), for a specific number of enrollees (i.e. 3, 50, 200), or by age and gender (i.e. female, 16 years and older). Providers who want to participate on limited basis should discuss the details of the possible array of limits that may be available.

- RHCs/FQHCs staffed only by CNPs (a staff physician is not present at least 20 hours a week) may serve a maximum of 1,000 recipients for each full time CNP in the clinic.

- Academic Health Center Teams (defined as a staff physician and four residents or mid-level practitioners) may serve up to 2,500 enrollees per team.

- Nurse Practitioners enrolling as PCPs may serve a maximum of 1,000 enrollees per full time Nurse Practitioner.

NOTE: Full time is defined as a minimum of 20 hours per week in-office direct care.

V. PCP MANAGEMENT FEE INFORMATION

The purpose of the CommunityCARE management fee is to provide compensation for the additional case management/administrative requirements placed on providers who choose to enroll as CommunityCARE PCPs. The CP-0-92 report is a report which lists all recipients linked to a provider for the current month and is available on line via Web access by going to the **www**.**lamedicaid.com** web site and obtaining a password.

NOTE: <u>It is the intent of DHH for all providers that have internet access to print their CP092's each month.</u>

- The CP-0-92 Report **will not** be considered as proof of eligibility. Even though an enrollee is listed on the PCP's CP-O-92, **the PCP should still verify recipient eligibility before seeing the enrollee or making a referrals/authorizations for the enrollee.** In order to get the CP-0-92 Report to PCPs by the first of the month, they must be run prior to the eligibility deadline, therefore, it is possible that an enrollee may have lost eligibility after the CP-0-92 was run.

- To ensure prompt and accurate payment of management fees each month, the CP-0-92 should be reviewed for accuracy and any discrepancies should be reported to the CommunityCARE program staff at the State as soon as possible.

- The signature page must be signed and dated with an **original** signature, then returned to the Unisys Electronic Data Interchange (EDI Department at the following address. Mailing the signature page to any other address will result in delayed payment of management fees. Providers should make a copy of the signature page **before** signing it.

  Unisys EDI Department
  P.O. Box 91025
  Baton Rouge, LA 70821

  NOTE: **The CP-0-92 is considered a payment record and must be maintained in the provider's office for a minimum period of 5 years**. As only the current and previous month reports are available online at www.lamedicaid.com., it is important that providers either print, or download, a copy of their CP-0-92 each month to keep with their records.

- The signature page should not be returned before the last working day of the report month. Every effort should be made to return it within the first 10 days of the following month. Returning the signature page early could result in a delay in payment.

- The provider should check the Remittance Advice (RA) within 2 -3 weeks of mailing the signature page to Unisys to ensure the management fee is paid. The management fee appears on the regular weekly RA as procedure code CC001, along with all other claims information.

- If the PCP does not receive the management fee payment by the third RA after mailing the signed signature page to Unisys, then it is the PCP's responsibility to resubmit the signature page with an **original** signature. **A facsimile or copied signature cannot be accepted.**

NOTE: Payment of the management fees are subject to the one year timely filing limit.

VI. PCP REFERRAL/AUTHORIZATION RESPONSIBILITIES

As part of the case management responsibility, the PCP is obligated to ensure that referrals/authorizations for medically necessary healthcare services which they can not/do not provide are furnished promptly and without compromise to quality of care. The PCP cannot unreasonably withhold them **OR** require that the requesting provider complete them.

Any referral/authorization requests must be responded to, either approved or denied, within 10 business days. The need for a PCP referral/authorization does not replace other Medicaid policies that are in existence. For example, if the service requires prior authorization, the provider must still obtain prior authorization **in addition to** obtaining the referrals/authorizations from the PCP.

> **NOTE:** It has come to the State's attention that some CommunityCARE PCP's are requiring enrollees to travel to the PCP's office to personally pick up authorization forms. This practice is contrary to the national goal to increase access to care for enrollees. Medicaid recipients, as a population, traditionally have issues with transportation. CommunityCARE considers this practice unreasonably withholding a referral authorization. **PCP's shall not require recipient's to travel to the PCP's office to obtain a document which can be mailed or faxed.**

A. Non-Emergent (Routine) Services

- Providers who are not an enrollee's PCP shall obtain referrals/authorizations for non-emergent care from the PCP **prior** to providing services to a CommunityCARE enrollee.

  > **NOTE:** DHH will **NOT** intervene or assist with any routine authorization requests that providers attempt to get after seeing the patient for a non-emergent visit.

- In the event an enrollee gets linked to a PCP in the midst of treatment already in progress for an existing condition, and the enrollee shows up for a prescheduled visit without a referral/authorization from their PCP, the treating provider should **(before providing services to the enrollee)** advise the enrollee of the situation, contact the linked PCP, advise the PCP of the situation, and provide the PCP with appropriate medical information to support the request for a referral/authorization.

- Depending on the medical needs of the enrollee as determined by the PCP, referrals/authorizations for specialty care may be written to cover a specific condition and/or a specific number of visits and/or a specific period of time not to exceed six months. There are exceptions to the six month limit for specific situations, as set forth in the CommunityCARE Handbook

- Referral/authorizations must be written or may be electronic within a secure hospital medical records system.

- A verbal authorization is **NOT** an acceptable referral/authorization format. Providers that accept a verbal authorization pending receipt of a written or electronic referral/authorization place themselves at risk of non-reimbursement. Services should **not** be billed to Medicaid before the written referral/authorization is obtained. Documentation of verbal authorization without the supporting written or electronic referral/authorization is not acceptable in the event of an audit.

- When a PCP denies a referral/authorization, an acceptable reason MUST be included as part of the denial.

NOTE : "Having never seen the patient" is an acceptable denial when services are **NON-EMERGENT** and the PCP is able to provide services within an appropriate time frame as is medically indicated.

- When a patient is being discharged from the hospital, it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the patient's PCP to obtain the appropriate referral/authorization for any follow-up services the patient may need after discharge (i.e. durable medical equipment (DME), home health, etc.).

B. Services Provided in the Emergency Room

- Louisiana Medicaid is not obligated to pay for non-emergency (routine) care, provided in the emergency room, unless the person has presenting symptoms of sufficient severity (including severe pain) such that a *prudent layperson*, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:
    - placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
    - serious impairment of bodily function
    - serious dysfunction of any organ or body part
- Hospitals are required by EMTALA (Emergency Medical Treatment and Labor Act) to perform a medical screening exam (MSE) on all persons who present to the emergency room for services. If the MSE does not reveal the existence of an emergency medical condition, the enrollee should be advised that Medicaid does not cover routine/non-emergent care provided in the emergency room when the presenting symptoms do not meet the prudent layperson standard of an emergency condition, and that he/she may receive a bill if they are treated in the emergency room. The enrollee should then be referred back to his/her CommunityCARE PCP for care.
- If the MSE does reveal the existence of an emergency medical condition, the ER physician will provide such further examination and treatment as is needed to stabilize the medical condition. If the emergency visit is equivalent to CPT 99283, 99284, or 99285, no referral/authorization is required from the PCP. However, if the condition requires follow-up by the PCP, appropriate information shall be forwarded to the PCP for inclusion in the enrollee's medical record.
- Post-authorization from the PCP is required for the two lowest levels of emergency room services (CPT codes of 99281 and 99282) **and** associated services. A request for post authorization, along with appropriate documentation of presenting symptoms, should be submitted to the PCP the **next** business day. If the web-based electronic referral/authorization system (e-RA) is used, the appropriate information should be keyed in and available for the PCP to view the next business day. The PCP shall approve or deny the request based on whether or not the presenting symptoms were of sufficient severity to meet the prudent layperson standard

- The documentation should contain sufficient information so that the PCP is able to make an informed decision as to whether or not the enrollee's "presenting symptoms" met the prudent layperson standard. The decision to approve or deny a post authorization request for services provided in the emergency room should always be based on the Prudent Layperson standard. If there is not enough information on the post authorization request to make an accurate determination that the presenting symptoms met the prudent layperson standard, the PCP shall request additional documentation from the hospital to support the request for authorization.

  Reminder: The PCP must respond to requests for referrals/authorizations (whether approved, denied or need more information) in writing within 10 working days of the request. If the request is denied the PCP must provide a reason for denial.

- When the MSE indicates that an emergency medical condition does **not** exist, the assessment is considered a non-covered service by Medicaid. Non-covered services may be billable to the recipient. If the recipient was notified before the service was rendered that he/she would be responsible for the non-covered services then the hospital can bill the recipient.

- **"Having never seen the patient" or "my office was open" is not an acceptable denial reason for services provided in the emergency room.** Even if the PCP's office is open at the time of the visit, if the presenting symptoms met the prudent layperson standard for an emergency condition, the referral/authorization should not be denied. If the presenting symptoms do not meet the prudent layperson standard, the referrals/authorizations should be denied, regardless of the time of day of the visit.

C. Transitional Authorizations

In accordance with Federal policy, the state must have a process in place to ensure access to care for enrollees during the time period between when a PCP change is keyed in and the actual date that it is effective and visible in the eligibility verification systems. Therefore, it is CommunityCARE policy that existing/current PCPs shall write/issue "**transitional authorizations**" in order for enrollees to obtain care from the new PCP.

- Transitional Authorizations should be written for a period not to exceed two months, and should clearly state "Change of PCP" or "Administrative Error" as the reason for the authorization.

- Transitional Authorizations are not medical referrals/authorizations, and do not imply that the PCP has suggested/endorsed any particular medical treatment or service. Therefore, it is not necessary for the PCP to see the enrollee in his/her office prior to issuing a transitional authorization.

Reminder: It is not acceptable for a PCP to require an enrollee to travel to the PCP's office to pick up a referral/authorization. The authorization can be mailed or faxed to the new PCP.

- The transitional authorization must be requested from the current PCP **prior** to the enrollee making an appointment, or presenting for treatment, with the new PCP.

  Example: An enrollee makes an appointment, or presents for treatment at the office of a provider who is not the enrollee's PCP, and is advised that he/she must call the enrollee hotline and change to the new PCP prior to being seen. The enrollee calls the hotline from the provider's office and requests a PCP change to that provider. The provider then sees the patient, and requests a transitional authorization from the current PCP for that day. **This scenario is not the intent of the transitional authorization and is not acceptable application of policy. The State will not assist providers with obtaining transitional authorizations under these circumstances.**

D. Referral/Authorization Form Completion (Hard Copy Instructions)

- PCPs may use the standardized State suggested referral/authorization form (attached) or any other format as long as it contains all required information as follows:
- The enrollee's name and 13-digit Medicaid number.
- The name of the provider to whom the enrollee is being referred.
- The purpose/reason for the referral/authorization.
- The ICD-9 diagnosis code or written description of the suspected condition (if appropriate).
- The PCP's seven-digit Medicaid provider ID number on the referral/authorization as the *referral authorization number.*
- The scope of the authorization – (*Limited by Condition:* treatment, specific condition, or rule-out diagnosis. *Limited by Time/Visit Frequency:* referrals/authorizations may be issued for a single visit or for multiple visits over a period not to exceed six months (or one year for "medically high risk" enrollees as listed on page 5-3 in the CommunityCARE Handbook). See pages 9-3 and 9-4 in the CommunityCARE Handbook for further information.
- Original signature and date on form – signature stamps or computer-generated signatures are acceptable, but must be initialed by the PCP or an authorized representative of the PCP.
- Outpatient lab/x-ray order forms, scripts and WIC-17's may be used as referrals/authorizations if **all of the above information is complete** on the form.

VII. EXEMPT SERVICES

The Medicaid covered services that do not require referrals/authorizations from the CommunityCARE PCP are "exempt." The current list of exempt services is as follows:

- Chiropractic service upon KIDMED referrals/authorizations, ages 0-21

- Dental services for children, ages 0-21 (billed on the ADA claim form)
- Dental Services for Pregnant Women (ages 21-59), billed on the ADA claim form
- Dentures for adults
- The three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but **do require POST authorization**. Refer to "Emergency Services" in the CommunityCARE Handbook.
- Inpatient Care that has been pre-certed (this also applies to public hospitals even though they aren't required to obtain precertification for inpatient stays): hospital, physician, and ancillary services.
- EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program.
  Note: A referral/authorization from the PCP IS REQUIRED for "Children's Special Health Services" clinics (Handicapped Children's Services) operated by The Office of Public Health.
- Family planning services
- Prenatal/Obstetrical services
- Services provided through the Home and Community-Based Waiver programs
- Targeted case management
- Mental Health Rehabilitation(privately owned clinics)
- Mental Health Clinics(State facilities)
- Neonatology services while in the hospital
- Ophthalmologist and Optometrist services
- Pharmacy
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists services
- Transportation services
- Hemodialysis
- Hospice services
- Specific outpatient laboratory/radiology services

NOTE: Claims for services other than those listed in "Exempt Services" will be denied for Medicaid payment if they are not either *provided by* or *authorized by* the PCP.

COMMUNITYCARE REFERRAL/AUTHORIZATION FORM

(1) Patient Name:	(2) Medicaid I.D. Number:
(3) Address:	(4) Date of Birth:
	(5) Telephone Number:
(6) Referred To:	
(7) Provider's Address:	
(8) Diagnosis/Suspected Condition:	
(9) Reason for Referral:	
(10) **Scope of Referral:** (not to exceed 6 months except as specified on page 5-3 of the CommunityCARE Handbook). Enter any restrictions or conditions of the referral, i.e., limited by specific number of visits, specific conditions, and/or length of time. **From:** **Through:**	
Medical records must be forwarded to the referring CommunityCARE primary care physician when treatment is completed or as specified:	
(11) ☐ Need additional information: (12) ☐ Approved *Referral/Authorization Number:_____ (13) ☐ Denied (reason required) ☐ Office closed - does not meet prudent layperson ☐ Office open - does not meet prudent lay person ☐ Went to ER against PCP instruction-does not meet prudent layperson ☐ Other (14) CommunityCARE PCP Name: _____ (15) Address: _____ (16) Phone Number: _____ (NOTE: If enrolled as a group indicate group name; if enrolled as an individual provider indicate individual physician name.)	
(17) PCP Signature: _____ (18) Issue Date: _____	

*This number must be on the claim form in the field as designated below:

- Block 83A for inpatient, outpatient and home health claims filed on UB-92 claim form.
- Block 17A for physician and durable medical equipment claims filed on th CMS 1500.
- Block 12 for claim type 05 (rehabilitation claims).

If the authorization number is not in the designated field on the claim form, the claim will be denied— EVEN IF A COPY OF THE REFERRAL IS ATTACHED TO THE CLAIM.

Unauthorized use of a CommunityCARE provider's number for billing purposes shall result in recovery by the Medicaid Program of all unauthorized reimbursements from the unauthorized billing physician/ agency. Submission of a fraudulent claim is punishable by fine and/or imprisonment.

INSTRUCTIONS FOR COMPLETING THE COMMUNITYCARE REFERRAL/AUTHORIZATION FORM

NOTE: ONLY FIELDS 1-10 ARE TO BE COMPLETED BY THE AUTHORIZED REFERRING PHYSICIAN.

FIELD NO. 1	**PATIENT NAME**	Enter the patient name exactly as it appears on the claim form.
FIELD NO. 2	**MEDICAID I.D. NUMBER**	Enter the patient's 13-digit Medicaid number.
FIELD NO. 3	**ADDRESS**	Enter the patient's address.
FIELD NO. 4	**DATE OF BIRTH**	Enter the patient's date of birth in MMDDYYYY format.
FIELD NO. 5	**TELEPHONE NUMBER**	Enter the patient's telephone number.
FIELD NO. 6	**REFERRED TO (PROVIDER'S NAME)**	Enter the full name of the provider the patient is being referred to.
FIELD NO. 7	**PROVIDER'S ADDRESS**	Enter the referred to provider's address.
FIELD NO. 8	**DIAGNOSIS/SUSPECTED CONDITION**	Enter the diagnosis and/or suspected condition.
FIELD NO. 9	**REASON FOR REFERRAL**	Enter the reason for the referral. (Transitional, PCP change, etc.)
FIELD NO. 10	**SCOPE OF REFERRAL (FROM/THROUGH)**	Enter the 'from' date and the 'through' date of the referral. (Not to exceed 6 months except as specified on page 5-3 of the Community Care Handbook). Enter any restrictions or conditions of the referral, i.e., limited by specific number of visits, specific conditions, and/or length of time.
FIELD NO. 11	**NEED ADDITIONAL INFORMATION:**	Check this box if additional information is required and state the information needed.
FIELD NO. 12	**APPROVED *REFERRAL/AUTHORIZATION NUMBER**	Enter the appropriate referral/authorization number in this field. (This number must be on the claim form in the field as designated below:) • **Block 83A** for inpatient, outpatient, and home health claims filed on the UB92 claim form. • **Block 17A** for physician and durable medical equipment claims filed on the HCFA 1500 claim form. • **Block 12** for claim type 05 (rehabilitation claims). If enrolled as a group, indicate group number; if enrolled as an individual provider, indicate individual physician number. If the referral authorization number is not in the designated field on the claim form, the claim will be denied, even if a copy of the referral is attached to the claim. Unauthorized use of a CommunityCARE provider's authorization number for billing purposes shall result in recovery by the Medicaid Program of all unauthorized reimbursements from the unauthorized billing physician/agency.
FIELD NO. 13	**DENIED (REASON REQUIRED)**	If the referral is denied, select one of the four reasons provided for the denial.
FIELD NO. 14	**COMMUNITYCARE PCP NAME**	Enter the referring CommunityCARE provider's name. (If enrolled as a group, indicate group name; if enrolled as an individual provider, indicate individual physician name).
FIELD NO. 15	**ADDRESS**	Enter the referring CommunityCARE provider's physical address.
FIELD NO. 16	**PHONE NUMBER**	Enter the referring CommunityCARE provider's phone number.
FIELD NO. 17	**PCP SIGNATURE**	Enter the signature of the primary care provider authorizing the referral.
FIELD NO. 18	**ISSUE DATE:**	Enter the date of issue for the referral.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PROCESS TO COMPLETE THE COMMUNITYCARE REFERRAL FORM, PLEASE CONTACT THE UNISYS PROVIDER INQUIRY UNIT AT 1-800-473-2783.

LOUISIANA MEDICAID
WEBSITE APPLICATIONS

The newest way to obtain general and specific Medicaid information is on our Louisiana Medicaid Provider Website:

www.lamedicaid.com

This website has several applications that should be used by Louisiana Medicaid providers. These applications require that providers establish an online account for the site.

Provider Login And Password

To ensure appropriate security of recipient's patient health information (PHI) and provider's personal information, the secure area of the web site is available to providers only. It is the responsibility of each provider to become "Web Enrolled" by obtaining a login and password for this area of the site to be used with his/her provider number. Once the login and password are obtained by the provider who "owns" the provider number, that provider may permit multiple users to login using the provider number. This system allows multiple individuals to login using the same login and password OR a provider may have up to 500 individual logins and passwords established for a single provider number. The administrative account rights are established when a provider initially obtains a login and password, and should remain with the provider or designated office staff employed by the provider.

A login and password may be obtained by using the link, Provider Web Account Registration Instructions. Should you need assistance with obtaining a login and password or have questions about the technical use of the application, please contact the Unisys Technical Support Desk at 877-598-8753.

☞ Unisys has received inquiries from billing agents/vendors attempting to access this web application. DHH and CMS Security Policy restrictions will not permit Unisys to allow access of this secure application to anyone except the owner of the provider number being used for accessing the site. In cases where an outside billing agent/vendor is contracted to submit claims on behalf of a provider, any existing business partner agreement is between the provider and the billing agent/vendor. Unisys may not permit anyone except the provider to receive or ask for information related to a login and password to access secured information.

WEB APPLICATIONS

There are a number of web applications available on the Medicaid website, however, the following applications are the most commonly used:

- Medicaid Eligibility Verification System (e-MEVS) for recipient eligibility inquiries;
- Claims Status Inquiry (e-CSI) for inquiring on claims status; and
- Clinical Data Inquiry (e-CDI) for inquiring on recipient pharmacy prescriptions as well as other medical claims data

These applications are available to providers 24 hours a day, 7 days a week at no cost.

e-MEVS:

Providers can now verify eligibility, primary insurance information, and service limits for a Medicaid recipient using this web application accessed through www.lamedicaid.com. This application provides eligibility verification capability in addition to MEVS swipe card transactions and REVS. An eligibility request can be entered via the web for a single recipient and the data for that individual will be returned on a printable web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Since its release, the application has undergone some cosmetic and informational changes to make it more user-friendly and allow presentation of more complete, understandable information.

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to remittance advices for this purpose. A LA Medicaid/HIPAA Error Code Crosswalk is available on this website by accessing the link, Forms/Files.

Once enrolled in the website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

e-CDI:

The e-CDI application provides a Medicaid recipient's essential clinical history information at the authorized practitioner's finger tips at any practice location.

The nine (9) clinical services information components are:

1. Clinical Drug Inquiry
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a six-month period. These updates are based on Medicaid claims history. A print-friendly version of the information on each of the web pages will be accessible and suitable for the recipient's clinical chart.

The major benefits of the use of e-CDI by the practitioner will include:

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by all providers that have provided services to each individual recipient.
2. Provides the practitioner rapid access to current clinical data to help him/her evaluate the need for "modifications" of an individual Medicaid recipient's health care treatment.
3. Promotes the deliberate evaluation by a practitioner to help prevent duplicate drug therapy and decreases the ordering of duplicate laboratory tests, x-ray procedures, and other services.
4. Supplies a list of all practitioner types providing health care services to each Medicaid recipient.
5. Assists the practitioner in improving therapeutic outcomes and decreasing health care costs.

ADDITIONAL DHH AVAILABLE WEBSITES

www.lamedicaid.com/HIPAA: Louisiana Medicaid HIPAA Information Center

www.la-communitycare.com: DHH website – CommunityCARE (program information, provider listings, Frequently Asked Questions (FAQ)

www.la-kidmed.com: DHH website - KIDMED – (program information, provider listings, FAQ)

www.dhh.la.gov/BCSS DHH website - Bureau of Community Supports and Services

www.oph.dhh.state.la.us DHH website - EarlySteps Program

www.dhh.state.la.us/RAR DHH Rate and Audit Review (nursing home updates and cost report information, contacts, FAQ)

www.oph.dhh.state.la.us - DHH website - LINKS

PROVIDER ASSISTANCE

Many of the most commonly requested items from providers including, but not limited to, the Field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, and program training packets are available online at www.lamedicaid.com.

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure/ information/clarification, ordering printed material, requesting a Field Analyst visit, etc., and may be reached by calling:

(800) 473-2783 or (225) 924-5040*
FAX: (225) 237-3334**

* Please listen to the menu options and press the appropriate key for assistance.

NOTE: Providers should access eligibility information via the Medicaid Eligibility Verification System (MEVS) or the automated Recipient Eligibility Verification System (REVS) at (800) 776-6323 or (225) 216-7387. Providers may also check eligibility by accessing the web-based application, e-MEVS, now available on the Louisiana Medicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

NOTE: UNISYS cannot assist recipients. If recipients have problems, please direct them to the Parish Office or the number on their card:

RECIPIENT HELPLINE (800) 834-3333

** Provider Relations will accept faxed information regarding provider inquiries on an **approved case by case basis**. However, faxed claims are not acceptable for processing.

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims.

All requests to the Correspondence Unit should be submitted to the following address:

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

NOTE: All correspondence sent to Provider Relations, including recipient file updates, must include a separate cover letter explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). A copy of the claim form along with applicable corrections and/or attachments must accompany all resubmissions.

Provider Relations staff does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

Requests to update Third Party Liability (TPL) should be directed to:

DHH-Third Party Liability
Medicaid Recovery Unit
P.O. Box 91030
Baton Rouge, LA 70821

"Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box. A complete list is available in this training packet under "Unisys Claims Filing Addresses".

NOTE: CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

Upon request, Provider Relations Field Analysts are available to visit and train new providers and their office staff on site. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. However, since Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.

FIELD ANALYST	PARISHES SERVED		
Martha Craft (225) 237-3306	Jefferson Orleans	St. Charles Plaquemines St. Bernard	
Open	Bienville Bossier Caddo Claiborne East Carroll Lincoln Madison Morehouse	Ouachita Richland Union Webster West Carroll Marshall, TX Vicksburg, MS	
Mona Doucet (225) 237-3249	Acadia Evangeline Iberia Lafayette	St. Landry St. Martin St. Mary Vermillion	
Open	Allen Beauregard Calcasieu Cameron	Jeff Davis Lafourche Terrebonne Vernon	Jasper, TX Beaumont, TX
Sharon Harless (225) 237-3267	Avoyelles Iberville West Baton Rouge	East Feliciana West Feliciana Woodville/Centerville (MS) Pointe Coupee	
Erin McAlister (225) 237-3201	Ascension Assumption Livingston St. Helena St. James	St. John the Baptist St. Tammany Tangipahoa Washington McComb (MS)	
Courtney Patterson (225) 237-3269	East Baton Rouge		
Kathy Robertson (225) 237-3260	Caldwell Catahoula Concordia DeSoto Franklin Grant Jackson LaSalle	Natchitoches Rapides Red River Caldwell Sabine Tensas Winn Natchez (MS)	

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

Department	Toll Free Phone	Phone	Fax
REVS - Automated Eligibility Verification	(800) 776-6323	(225) 216-7387	
Provider Relations	(800) 473-2783	(225) 924-5040	(225) 237-3334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 237-3381	(225) 237-3334
Electronic Data Interchange (EDI) - Unisys		(225) 237-3200 option 2	(225)237-3331
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 237-3342 or (225) 929-6803
Home Health P.A. - Unisys EPSDT PCS P.A. - Unisys	(800) 807-1320		(225) 237-3342 or (225) 929-6803
Dental P.A. - LSU School of Dentistry		(504) 619-8589	(504) 619-8560
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 237-3370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline-Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – DHH	(800) 834-3333 (225) 925-7948	Providers may request verification of eligibility for presumptively eligible recipients; recipients should contact to request a new card or to discuss eligibility issues.
Eligibility Operations –BHSF	(888) 342-6207	Recipients may address eligibility and questions and concerns
LaCHIP Program	(877) 252-2447	Providers and recipients may obtain information regarding the LaCHIP program, which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - Vaccines for Children	(504) 483-1900	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll
Referral Assistance - ACS	(877) 455-9955	Providers and recipients may obtain referral assistance
KIDMED Provider Hotline – ACS	(800) 259-8000	Providers may obtain information on KIDMED linkage, referrals, monitoring, certification, and names of agencies that provide PCS services.
KIDMED Recipient Hotline – ACS	(800) 259-4444	Recipients request enrollment in KIDMED program and obtain information on KIDMED linkage.
CommunityCARE Provider Hotline – ACS	(800) 609-3888	Providers inquire about PCP assignment for CommunityCARE recipients and about monitoring//certification.
CommunityCARE Recipient Hotline – ACS	(800) 359-2122	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, and express complaints concerning the CommunityCARE program.
Bureau of Community Support and Services – BCSS	(800) 660-0488 (225) 219-0200	Providers and recipients may request assistance regarding waiver services provided to waiver recipients (does not include claim or billing problems or questions)
EarlySteps Program - OPH	(866) 327-5978	Providers and recipients may obtain information on the EarlySteps Program and services offered
LINKS	(504)483-1900	Providers may obtain immunization information on recipients

DHH PROGRAM MANAGER REQUESTS

Questions regarding the rationale for Medicaid policy, procedure coverage and reimbursement, medical justification, written clarification of policy that is not documented, etc. should be directed in writing to the manager of your specific program:

Program Manager - (i.e. DME, Hospital, etc.)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

HOW DID WE DO

In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a Unisys representative or leave it on your table. Your opinion is important to us.

Seminar Date:_____ Location of Seminar (City):_____

Provider Subspecialty (if applicable):_____

FACILITY	**Poor**				**Excellent**
The seminar location was satisfactory	1	2	3	4	5
Facility provided a comfortable learning environment	1	2	3	4	5
SEMINAR CONTENT	**Poor**				**Excellent**
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS REPRESENTATIVES	**Poor**				**Excellent**
The speakers were thorough and knowledgeable	1	2	3	4	5
Topics were well organized and presented	1	2	3	4	5
Reps provided effective response to questions	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION: CommunityCARE					

What topic was most beneficial to you?_____

Please provide constructive comments and suggestions:_____

To order written materials provided by Unisys, please call Unisys Provider Relations Telephone Inquiry Unit at **(800) 473-2783 or (225) 924-5040.**

Electronic Referral Authorization (e-RA)