UNISYS

CommunityCARE PROVIDER TRAINING

Fall 2007

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

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 2007 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 recipient eligibility and ID cards, and third party liability. The 2006 Basic Training packet may be obtained by downloading it from the Louisiana Medicaid website, www.lamedicaid.com.

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES.
TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.
(See listing of numbers on attachment)

MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator 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. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.** Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828.

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED.
TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955
(or TTY 1-877-544-9544)

MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive Mental Health Rehabilitation Services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by mental health prior authorization unit.

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

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; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically 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 covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES
Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. Personal Care 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 must be ordered by a physician. The PCS provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES
Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT
If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. *EARLYSTEPS* CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

MEDICAL EQUIPMENT AND SUPPLIES
Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve 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.

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 in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544).
IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED, CALL 1-888-758-2220 FOR ASSISTANCE.

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.

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)
*Support Coordination
*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.

If you need a service that is not listed above call the referral assistance coordinator at KIDMED (toll free) 1-877-455-9955 (or TTY 1-877-544-9544). If they cannot refer you to a provider of the service you need call 225-342-5774.

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD Request for Services Registry, you may be eligible for support coordination services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office. If you are a Medicaid recipient under age 21, and it is medically necessary, you may be able to receive support coordination services immediately by calling SRI (toll free) at 1-800-364-7828.

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.

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.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CSRAs

METROPOLITAN HUMAN SERVICES DISTRICT
Janise Monetta, CSRA
1010 Common Street, 5th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

CAPITAL AREA HUMAN SERVICES DISTRICT
Pamela Sund, CSRA
4615 Government St. – Bin#16 – 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Fee: 1-800-768-8824

REGION III
John Hall, CSRA
690 E. First Street
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

REGION IV
Celeste Larroque, CSRA
214 Jefferson Street – Suite 301
Lafayette, LA 70501
Phone (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

REGION V
Connie Mead, CSRA
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Phone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

REGION VI
Nora H. Dorsey, CSRA
429 Murray Street – Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
Rebecca Thomas, CSRA
3018 Old Minden Road – Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

REGION VIII
Deanne W. Groves, CSRA
122 St. John St. – Rm. 343
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
Marie Gros, CSRA
21454 Koop Drive – Suite 2H
Mandeville, LA 70471
Phone: (985) 871-8300
FAX: (985) 871-8303
Toll Free: 1-800-866-0806

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
Stephanie Campo, CSRA
Donna Francis, Asst CSRA
3300 W. Esplanade Ave. –Suite 213
Metairie, LA 70002
Phone (504) 838-5357
FAX: (504) 838-5400

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STANDARDS OF PARTICIPATION

Provider participation in Medicaid of Louisiana is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. These standards are listed as follows:

- Provider agreement and enrollment with the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH);
- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;
- Agreement to accept as payment in full the amounts established by the BHSF and refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.
- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services;
- **NOTE: Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, or the state Attorney General's Medicaid Fraud Control Unit.**
- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1978*, and, where applicable, *Title VII of the 1964 Civil Rights Act*.

PICKING AND CHOOSING SERVICES

On March 20, 1991, Medicaid of Louisiana adopted the following rule:

> ***Practitioners who participate as providers of medical services shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by the provider as a Medicaid patient.***

This rule prohibits Medicaid providers from "picking and choosing" the services for which they agree to accept a client's Medicaid payment as payment in full for services rendered. Providers must bill Medicaid for **all** Medicaid covered services that they provide to their clients.

Providers continue to have the option of picking and choosing from which patients they will accept Medicaid. Providers are not required to accept every Medicaid patient requiring treatment.

STATUTORILY MANDATED REVISIONS TO ALL PROVIDER AGREEMENTS

The 1997 Regular Session of the Legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437.14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

- comply with all federal and state laws and regulations;
- provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- have all necessary and required licenses or certificates;
- maintain and retain all records for a period of five (5) years;
- allow for inspection of all records by governmental authorities;
- safeguard against disclosure of information in patient medical records;
- bill other insurers and third parties prior to billing Medicaid;
- report and refund any and all overpayments;
- accept payment in full for Medicaid recipients providing allowances for copayments authorized by Medicaid;
- agree to be subject to claims review;
- the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- notification prior to any change in ownership;
- inspection of facilities; and,
- posting of bond or letter of credit when required.

MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive. The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify Provider Enrollment immediately that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.

SURVEILLANCE UTILIZATION REVIEW

The Department of Health and Hospitals' Office of Program Integrity, in partnership with Unisys, perform the Surveillance Utilization Review function of the Louisiana Medicaid program. This function is intended to combat fraud and abuse within Louisiana Medicaid and is accomplished by a combination of computer runs, along with medical staff that review providers on a post payment basis. Providers are profiled according to billing activity and are selected for review using computer-generated reports. The Program Integrity Unit of DHH also reviews telephone and written complaints sent from various sources throughout the state, including the fraud hotline.

☞ Program Integrity and SURS would also like to remind all providers that they are bound by the conditions of their provider agreement which includes but is not limited to those things set out in Medical Assistance Program Integrity Law (MAPIL) R.S. 46:437.1 through 440.3, The Surveillance and Utilization Review Systems Regulation (SURS Rule) Louisiana Register Vol. 29, No. 4, April 20, 2003, and all other applicable federal and state laws and regulations, as well as Departmental and Medicaid policies. Failure to adhere to these could result in administrative, civil and/or criminal actions.

Providers should anticipate an audit during their association with the Louisiana Medicaid program. When audited, providers are to cooperate with the representatives of DHH, which includes Unisys, in accordance with their participation agreement signed upon enrollment. Failure to cooperate could result in administrative sanctions. The sanctions include, but are not limited to:

- Withholding of Medicaid payments
- Referral to the Attorney General's Office for investigation
- Termination of Provider Agreement

Program Integrity and the Unisys Surveillance Utilization Review area remind providers **that a service undocumented is considered a service not rendered**. Providers should ensure their documentation is accurate and complete. All undocumented services are subject to recoupment. Other services subject to recoupment are:

- Upcoding level of care
- Maximizing payments for services rendered
- Billing components of lab tests, rather than the appropriate lab panel
- Billing for medically unnecessary services
- Billing for services not rendered
- Consultations performed by the patient's primary care, treating, or attending physicians

FRAUD AND ABUSE HOTLINE

The state has a hotline for reporting possible fraud and abuse in the Medicaid Program. Providers are encouraged to give this phone number/web address to any individual or provider who wants to report possible cases of fraud or abuse.

Anyone can report concerns at (800) 488-2917 or by using the web address at http://www.dhh.state.la.us/offices/fraudform.asp?id=92

DEFICIT REDUCTION ACT OF 2005

Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC §1396(a)(68)), set forth in that subsection and as the Secretary of US Department of Health and Human Services may specify. As an enrolled provider, it is your obligation to inform all of your employees and affiliates of the provisions the provisions of False Claims Act. When monitored, you will be required to show evidence of compliance with this requirement.

- Effective July 1, 2007, the Louisiana Medicaid Program requires all new enrollment packets to have a signature on the PE-50 which will contain the above language.

- The above message was posted on LAMedicaid website, (https://www.lamedicaid.com/sprovweb1/default.htm), RA messages, and in the June/July 2007 Louisiana Provider Update

- Effective November 1, 2007, enrolled Medicaid providers will be monitored for compliance through already established monitoring processes.

- All providers who do $5 million or more in Medicaid payments annually, must comply with this provision of the DRA.

COMMUNITYCARE DEPARTMENT OF HEALTH AND HOSPITALS VISION FOR IMPROVING HEALTH CARE IN LOUISIANA

I. OVERVIEW

- CommunityCARE is operated as a State Plan option as published in the Louisiana Register volume 32: number 3 (March 2006).
- 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 fee-for-service payment, the PCP is paid a monthly management fee to coordinate 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 PCP. 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 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).
- Recipients in pregnant woman eligibility categories

- Recipients in the PACE program
- SSI recipients under the age of 19
- Recipients under the age of 19 in the NOW and Children's Choice waiver programs

A. How to Identify CommunityCARE Enrollees

- CommunityCARE enrollees may be identified through any of the eligibility verification systems:
  - eMEVS (the Unisys website – www.lamedicaid.com).
  - REVS (telephone recipient eligibility verification system),
  - MEVS (swipe card Medicaid eligibility verification system).

NOTE: 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 eMEVS.

- When providers check recipient eligibility through REVS, MEVS or eMEVS, 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, MEVS or eMEVS is the enrollee's linked PCP, the specific PCP information is not given.

B. How Recipients Are Notified and Linked

- During the first week of each month new Medicaid eligibles who meet the criteria to be enrolled in CommunityCARE receive a notice (the choice notice) advising them to choose a PCP in their parish of residence or a contiguous parish. 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. All assignments (choice or auto-assignment) will be effective the first day of the next month.

- 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 notifies the enrollee of the date they must start using their new PCP. It also informs them that if they are not satisfied with the PCP listed in 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 PCPs.

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. The confirmation letter is mailed to the enrollee 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 deadline (usually the 23rd of the month) will be effective the first of the following month. If the 23rd falls 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 PCPs 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 or until open enrollment. Enrollees may request a change at any time for cause. Requests for cause will be reviewed on a case by case basis.

- Enrollees are permitted to change PCPs without cause during an annual 60 day "open enrollment" period which runs from approximately October 23 to December 23. In early October, all CommunityCARE enrollees are notified that they may request to change their PCP during this time. If a change is not requested prior to December 23rd, the enrollee will remain linked to the same PCP for the next 12 months or until the next open enrollment period, unless cause is established in accordance with CommunityCARE policy.

- In accordance with Federal guidelines DHH must track PCP requests to unlink CommunityCARE enrollees from their practice. PCPs who want to unlink enrollees from their practice should first refer to the CommunityCARE handbook for acceptable reasons to request re-assignment of enrollees.

  NOTE: DHH has recently become aware that some providers are requesting to unlink CommunityCARE enrollees who miss appointments, using "recipient non-compliance" as the reason. It is DHH's position that missed appointments alone does not constitute non-compliance and is not an appropriate reason to request that an enrollee be unlinked.

- PCPs with a valid request to unlink a CommunityCARE enrollee must submit the request in writing to the State's CommunityCARE/KIDMED contractor. Such requests are handled on a case by case basis. **The PCP simply notifying the enrollee will not ensure the linkage will close.** If the enrollee does not call the 800 number to request a PCP change, they will remain linked to that PCP. However, once ACS receives a valid request from the PCP to unlink an enrollee, the enrollee will be notified by ACS to select a new

PCP. If the enrollee does not select a new PCP, he/she will be auto-assigned to a new PCP.

NOTE: Until the PCP notifies ACS, and the recipient no longer appears on the PCP's CP-0-92, the PCP is still responsible for treating and/or coordinating that recipient's care.

C. Enrollee Assistance

Medicaid provides several options for enrollees to obtain assistance with their CommunityCARE enrollment. Providers should make note of these numbers and share them with recipients.

- CommunityCARE Enrollee Hotline (800) 259-4444: Provides assistance with questions or complaints about CommunityCARE or their PCP. It is also the number recipients call to select or change their PCP.
- Specialty Care Resource Line (877) 455-9955: Provides assistance with locating a specialist in their area who accepts Medicaid.
- Nurse Helpline (866) 529-1681: Is a resource for recipients to speak with a nurse 24/7 to obtain assistance and information on a wide array of health-related topics.
- www.la-communitycare.com – DHH Website
- www.lamedicaid.com -- Unisys Website

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 (who meet specific additional criteria)
- Other specialties may be considered for enrollment if practicing primary care in accordance with CommunityCARE policies and procedures.

B. Standards for PCP 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**

  - PCPs 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. A live person may include an answering service that will immediately contact on-call medical personnel who will appropriately triage the call. (See page 3-3 in the CommunityCARE Handbook).
  - When the PCP is on vacation, they must have an appropriate message on the phone that provides the recipient with the name and phone number of whom to receive treatment from. The Emergency Department is not acceptable.

- **Back Up Coverage**

  - The PCP must have a backup arrangement with another provider to provide coverage and referrals/authorizations to other providers as appropriate, when the PCP 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 PCP must maintain admitting privileges sufficient to meet the needs of all enrollees linked to him/her, 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.

    NOTE: <u>If a PCP provides primary care to all ages, but only has admitting privileges for adults, or only has privileges at a hospital that does not accommodate pediatric patients, a detailed explanation of arrangements for pediatric patients must be provided. If a PCP provides primary care for all ages, but only has admitting privileges for patients under the age of 21, an explanation of arrangements for adult admissions is required.</u>

- **KIDMED Services**

  - PCPs must either be enrolled as a certified KIDMED provider, or must have a CommunityCARE/KIDMED subcontract with a certified KIDMED provider for all CommunityCARE 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 procedures in place to ensure the appropriate sharing of enrollee information between them.

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

- **Reporting Requirements**

  - PCPs must keep the CommunityCARE Program and their CommunityCARE patients informed of changes that may effect enrollment. Participation in the CommunityCARE Program and the choices made by enrollees to become linked to a particular PCP were based on the PCP's practice and qualifications at the time of certification.

- If there is to be a change in ownership or a change in the provider's Medicaid identification number (such as conversion to an RHC or FQHC), the CommunityCARE Program must be notified in writing at least 60 days prior to the change. It typically takes the State a minimum of 30-60 days to make the necessary changes for a smooth transition.

- More specific information regarding PCP Reporting Requirements may be found in the CommunityCARE Provider Handbook.

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 eMEVS eligibility verification systems will provide the appropriate phone number for that site.

- PCPs have several linkage/capacity options to choose from when enrolling in CommunityCARE:

  - Open Panel: Providers who enroll without any restrictions may serve a maximum of 2,500 enrollees per full time physician, except as noted below. Full time is defined as a minimum of 20 hours per week in-office direct care.

    - 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 employs 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 equivalent. (NOTE: Per Medicaid policy, if an individual physician employs or contracts with a nurse practitioner or physician assistant, the physician MUST obtain a physician group number and bill Medicaid using the group number with the nurse practitioner or physician assistant as the attending/servicing provider. This policy was first published for NP's in the summer 1996 Provider Update. This is new policy for PA's and was published in the March/April 2005 Provider Update).

    - PCPs who are accepting newborns into their practice will be able to continue to do so once they have reached their linkage capacity. However, in order for this to happen, 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 claims history. 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 and should discuss the details of the following options with an ACS Certification Specialist.

  - Current practice only (defined as recipients with a paid claim for an office visit with that provider in the past year)

  - Restricted to a specific number of enrollees (i.e. 3, 50, 200)

  - Restricted by age and gender (i.e. female, 16 years and older)

  - The designation of "closed panel" applies to CommunityCARE PCPs who wish to "close" their practice to any additional CommunityCARE linkages. It is not intended to be a mechanism to routinely accept additional linkages on a case-by-case basis (i.e. newborns only). In accordance with Federal guidelines and the CommunityCARE enrollment agreement, PCPs must accept individuals in the order in which they are assigned within their established restrictions, such as age, current practice, etc. Providers who enroll with "closed panel" and repeatedly request to add new enrollees will be required to change their restrictions to a more appropriate designation: i.e. – PCPs who provide care to ages 0-16, but do not want any new patients except for newborns who they saw at birth in the hospital, do not meet the criteria to be enrolled as a "closed panel" provider. The more appropriate designation would be "current patients only with no auto-assignments"

- RHCs/FQHCs staffed only by CNPs or PAs (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 or PA 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 (not in a RHC) who meet the criteria to enroll as a PCP may serve a maximum of 1,000 enrollees per full time Nurse Practitioner.

V. PCP MANAGEMENT FEE INFORMATION

The CP-0-92 report is a report which lists all enrollees who are linked to a PCP, and the projected management fee, for a given month. The purpose of the CommunityCARE management fee is to provide compensation for the additional administrative requirements placed on providers who choose to enroll as CommunityCARE PCPs. The management fee is a per recipient, per month fee which is paid regardless of whether or not an enrollee received services that particular month with that provider. The

CP-0-92 report is considered a payment record and must be maintained in the provider's office for a minimum period of 5 years.

- The CP-0-92 is available online at the www.lamedicaid.com website.

- Only the current and previous month's CP-0-92 reports are available online at any given time. Therefore, it is important that providers either print or download a copy of their CP-0-92 each month for audit purposes.

- DHH does not intend to mail hardcopy CP-0-92 reports to providers who have internet access. It is the intent of DHH to require Medicaid providers to utilize our electronic capabilities to the fullest extent possible.

- 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

- 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 PCP's care coordination responsibilities they are 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 shall not unreasonably withhold or deny valid requests for referrals/authorizations that are made in accordance with CommunityCARE policy.
- All valid requests for referral/authorizations must be responded to by the PCP within 10 days of receipt of the request. This time frame was designed to provide guidance for responding to requests for referrals/authorizations. PCPs should respond to requests sooner than 10 days if possible.
- Deliberately holding referrals/authorizations until the 10th day because of the 10 day guideline is inappropriate.
- If the PCP out of the office for an extended period of time (i.e. vacation, illness, etc), arrangements must be made for the timely response to requests for CommunityCARE referrals/authorizations in compliance with CommunityCARE program policy, even in the PCP's absence.
- PCPs are not required to respond to requests for referrals/authorizations not made in accordance with CommunityCARE policy (i.e. requests made after the service has been rendered or Emergency Department post-authorization requests not made next business day).
- DHH and Unisys will not assist providers with obtaining referrals/authorizations not requested in accordance with CommunityCARE policy.
- The PCP also shall not require that the requesting provider complete the referral authorization form.
- As published in the January/February 2005 Provider Update, U.S. Mail is not an acceptable method of requesting or responding to requests for CommunityCARE referrals/authorizations.
- The PCP referral/authorization requirement 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.

A. Referral/Authorization Form

The State encourages providers to use the standardized CommunityCARE Referral/Authorization Form. However, it is acceptable to use existing preprinted forms such as outpatient lab/x-ray orders, scripts and WIC-17s, etc. if the following required pertinent information is included as appropriate:

- Enrollee's name and Medicaid ID number.
- Purpose/reason for the referral.
- Name of facility or organization to which the person is being referred.
- PCP's referral/authorization number.

- Original signature, date of issue and/or a date range that the authorization is effective (signature stamps or computer-generated signatures are acceptable, but must be initialed by the PCP or authorized representative of the PCP.

B. Scope of Referral

Depending on the medical needs of the enrollee as determined by the PCP, referrals/authorizations for specialty care should 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. When the PCP refers a recipient to a specialist for treatment of a specific condition, it is appropriate for the specialist to share a copy of the PCP's written referral/authorization for additional services that may be required in the course of treating that condition.

Examples**:**

a. An oncologist has received a written referral/authorization from the PCP to provide treatment to his CommunityCARE patient. During the course of treatment, the oncologist sends a patient to the hospital for a blood transfusion. The oncologist should send the hospital a copy of the written referral/authorization that he received from the PCP. **The hospital SHOULD NOT require a separate referral/authorization from the PCP for the transfusion.**

   However, if the oncologist discovers a **new** condition not related to the condition for which the original referral/authorization was written, and that new condition requires the services of a different specialist, the PCP must be advised. The PCP would then determine whether or not the enrollee should be referred for the new condition.

b. The PCP refers his CommunityCARE patient to a surgeon for an outpatient procedure and sends the surgeon a written referral/authorization. The surgeon must provide a copy of that written referral/authorization to any other provider whose services may be needed during that episode of care (i.e. anesthesia, DME, Home Health).

C. Non-Emergent (Routine) Services

For non-urgent care such as routine office visits, specialty care etc. the PCP should be the initiator of the referral authorization (except for exempt services which do not require a referral/authorization). That is, the PCP should have referred the enrollee to the non-PCP provider, and provided a written referral/authorization to the non-PCP provider prior to services being rendered. When an enrollee presents for a non-exempt service/specialty care without having been referred by their PCP, the office personnel should advise/educate the enrollee of the following:

1. That they are linked to a PCP who is responsible for their care and they should make an appointment with that PCP to determine if they need to see a specialist.
2. That their Medicaid card will not cover specialty care unless the PCP has determined they need specialty care and referred them to the specialist. The provider may offer to see the enrollee as a private pay patient.

However, **IF THE ENROLLEE CHOOSES TO PAY FOR THE VISIT, NO PORTION OF THE VISIT CAN BE BILLED TO MEDICAID (including lab, radiology etc)**. Discussion of the enrollee's choice/obligation to pay the bill must be documented in the enrollee's medical records.

- When a CC enrollee presents for non-urgent services without a referral from their PCP; it is **not** acceptable to provide services under the condition that if the PCP approves the referral/authorization the services will be billed to Medicaid, but if the PCP does not approve the request for referral/authorization the enrollee will be responsible for the bill. **The recipient's responsibility for payment must be determined and documented prior to services being rendered.**

- Recipients may not be held responsible for claims denied due to provider errors or failure to follow Medicaid policies/procedures, such as failure to obtain a PCP referral/authorization, prior authorization or pre-cert, failure to timely file, incorrect TPL carrier code, etc.

- 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 an appropriately requested referral/authorization, an acceptable reason MUST be included as part of the denial.

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

D. Services Provided in the Emergency Department

- 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 follow-up and evaluation**.

- 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. **Enrollees shall be referred back to their PCP for any necessary follow-up. They shall <u>not</u> be referred directly to a specialist, or advised to return to the ER for follow up.**

- 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. Post-authorization requests not submitted to the PCP the next business day are not considered valid requests.

REMINDER: Presenting symptoms should demonstrate degree of fever, duration of symptoms, and brief history. Example of appropriate documentation of presenting symptoms:

Presenting Problem: fever and headache

Assessment:

Onset: 2 days
Symptom/description/location: headache-frontal/above eyes; no vision problems; temp decrease to 101R with OTC
Pain Scale: 6-headache
Temp: 102.5R
Treatment: Tylenol X 4 doses for 2 days

- 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. The request for additional information should be specific: "need more information" is not sufficient. "Was dizziness present?" or "How high was the fever?" are acceptable questions. Under no circumstances should the PCP deny the referral or just hold it because of insufficient information, or pending receipt of the ER medical record.

- All valid requests for ER post-authorizations must be responded to by the PCP within 10 days of receipt of the request. This time frame was designed to provide guidance for responding to requests for referrals/authorizations. PCPs should respond to requests sooner than 10 days if possible. Deliberately holding post-authorizations until the 10th day because of the 10 day guideline is inappropriate.

- Once the individual is screened and it is determined the individual has only presented to the ED for a non-emergency purpose, the hospital's EMTALA obligation ends for that individual at the completion of the MSE. Hospitals are not obligated under EMTALA to provide screening services beyond those needed to determine that there is no emergency medical condition.

- 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.**

- **"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 visit must be authorized. If the presenting symptoms do not meet the Prudent Layperson Standard, the request for the post-authorization should be denied, regardless of the time of day of the visit.

E. Non-Medical Authorizations

In some circumstances, it is appropriate for a CommunityCARE PCP to issue an authorization to another provider. Non-medical authorizations are intended to address a number of situations that must be authorized for payment but are not medical in nature.

- **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 request is received, 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" as the reason for the authorization.

  - Transitional Authorizations **are not medical referrals**, and do not imply that the PCP has suggested/endorsed any particular medical treatment or service administered by the other provider. It is simply an authorization for payment that allows the new PCP to be reimbursed for services until he/she is recognized as the recipient's PCP in the claims processing system.

    Note: <u>The PCP shall not require the enrollee to be seen in the PCP's office prior to issuing an Transitional Authorization. It is also not acceptable for the PCP to require an enrollee to travel to the PCP'S office to pick up a Transitional Authorization. It must, at a minimum, be faxed to the new PCP</u>

  - The State encourages PCPs to issue Transitional Authorizations as quickly as possible taking into consideration the urgency of the enrollee's medical needs not to exceed a period of 10 days. Although this time frame was designed to provide <u>guidance</u> for responding to requests for post-authorizations, deliberately holding Transitional Authorizations because of the 10 days guideline is inappropriate.

  - When a CommunityCARE enrollee changes PCPs and calls the new PCP to schedule an appointment, the new PCP's office should consider that it may take up to 10 days to obtain the Transitional Authorization and should schedule the appointment accordingly. In an effort to reduce the inappropriate use of the Transitional Authorization, the State does not encourage PCPs to routinely make Transitional Authorizations effective retroactively. The following scenario is **not** the intended purpose of the transitional authorization and is **not** an acceptable application of policy:

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. **The State will not assist providers with obtaining Transitional Authorizations under these circumstances. Transitional Authorizations should be requested and obtained prior to the enrollee's visit with the new PCP**.

- It is acceptable and advisable for the PCP to confirm that the recipient has requested a PCP change with ACS before issuing a Transitional Authorization.

- **Administrative Authorizations**

  Administrative Authorizations are intended to address a number of situations that must be authorized for payment but are not medical in nature. For example:

  - When an enrollee becomes linked to a CommunityCARE PCP in the midst of ongoing treatment (i.e. chemotherapy, occupational/physical therapy) already in progress for an existing condition. If the enrollee arrives for a prescheduled appointment without a referral from the CommunityCARE PCP, **before providing services to the enrollee**, the treating provider should advise the enrollee that they are linked to a PCP and that the visit must be authorized by their PCP. The treating provider should then contact the PCP's office to request an authorization. The treating provider should furnish the CommunityCARE PCP with appropriate medical information to support the medical necessity of the treatment for which the referral/authorization is being requested. It would be appropriate for the PCP to issue an Administrative Authorization for a specific period of time until the PCP can schedule an office visit to evaluate the enrollee's existing condition. The treating physician should advise the enrollee that the PCP is not obligated to issue additional authorizations without the enrollee making an appointment with their CommunityCARE PCP. The intent is to avoid an adverse impact on the enrollee's health status as a result of an interruption of an existing treatment plan.

  - When a patient is being discharged from an inpatient hospital stay, it is the responsibility of the discharging physician/discharge planner to coordinate with the patient's PCP to obtain the appropriate referral/authorization for any equipment or services that the patient may need after discharge (i.e. durable medical equipment, home health, etc.). The discharging physician/discharge planner should provide the PCP with appropriate documentation which verifies the need for the service. The PCP should then issue an Administrative Authorization as appropriate.

Note: <u>The PCP shall not require the enrollee to be seen in the PCP's office prior to issuing an Administrative Authorization. It is also not acceptable for the PCP to require an enrollee to travel to the PCP'S office to pick up an Administrative Authorization. It must, at a minimum, be faxed.</u>

F. e-RA

The Electronic Referral/Authorization (e-RA) application permits CommunityCARE PCPs and hospitals to more efficiently manage the post-authorization process for services provided to CommunityCARE enrollees in emergency room. The hospital enters a post-authorization request(including presenting symptoms documentation) in the e-RA system; a PCP Alert feature informs the PCP when there are outstanding requests pending; the PCP reviews the request and makes a determination to approve/deny/or return for additional information. The e-RA application may be used for pre or post authorization of emergency room services.

If a PCP is using e-RA, it should be used consistently with all other providers who are utilizing the e-RA process. For instance, a PCP using e-RA to receive referrals/authorizations from Hospital A should also use e-RA to receive referrals/authorizations from Hospital B. This means that a PCP should not require faxing of referrals/authorizations to and from Hospital B while making use of e-RA with Hospital A.

PCPs who are utilizing the electronic referral/authorization process shall not require hospitals to submit hardcopy medical records in addition to the medical documentation presented in the e-RA request. However, hospitals must include **all** pertinent presenting symptom information in the electronic request in order for the PCP to make an informed decision. If the information provided by the hospital in the e-RA request is insufficient, the PCP shall return the request electronically, requesting the specific additional information he/she is seeking.

DHH strongly encourages PCPs and hospitals who have internet access to use the e-RA application instead of the hardcopy process. Additional electronic applications are being made available to providers, and as DHH/Medicaid moves toward a paperless system it is becoming more and more important for providers to integrate these electronic applications into their office processes.

Note: The following section of the packet will instruct providers on the e-RA web applications and the usage, functions, and capabilities.

In addition, an **Admin Menu** button provides a link (for DHH users only) to view referral management reports.

Note: For all screens in the e-RA application, data is entered only in a white field:

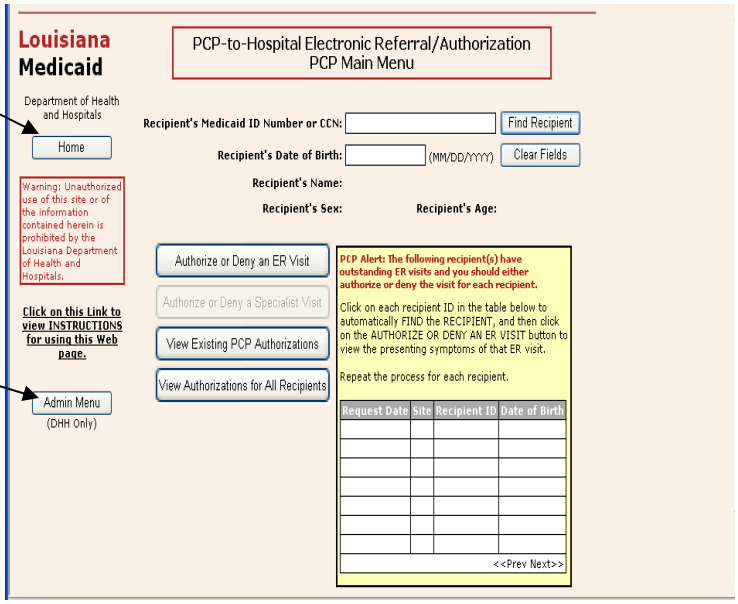
The yellow fields display specific information related to the transaction, but data cannot be entered into yellow fields:

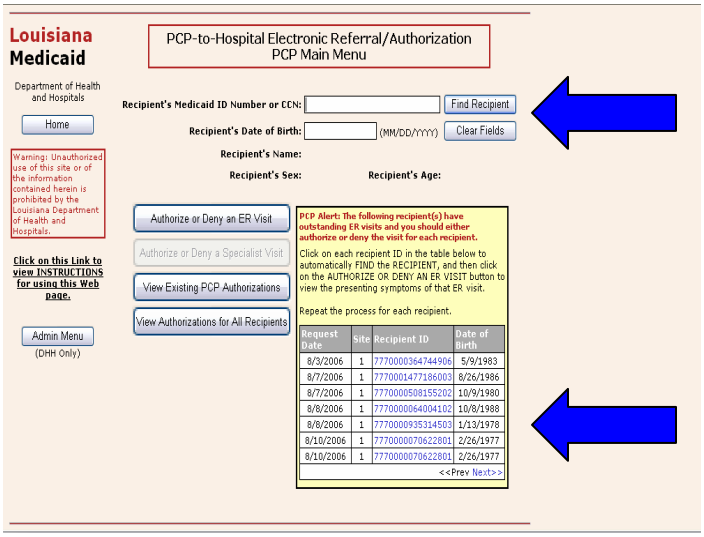
Note: In the examples provided throughout this section, protected health information (PHI) has been blotted out in order to comply with HIPAA provisions.

PCP Main Menu

The **Home** button returns you to the Provider Applications Area.

The **Admin Menu** button links to a series of administrative reports for DHH only.

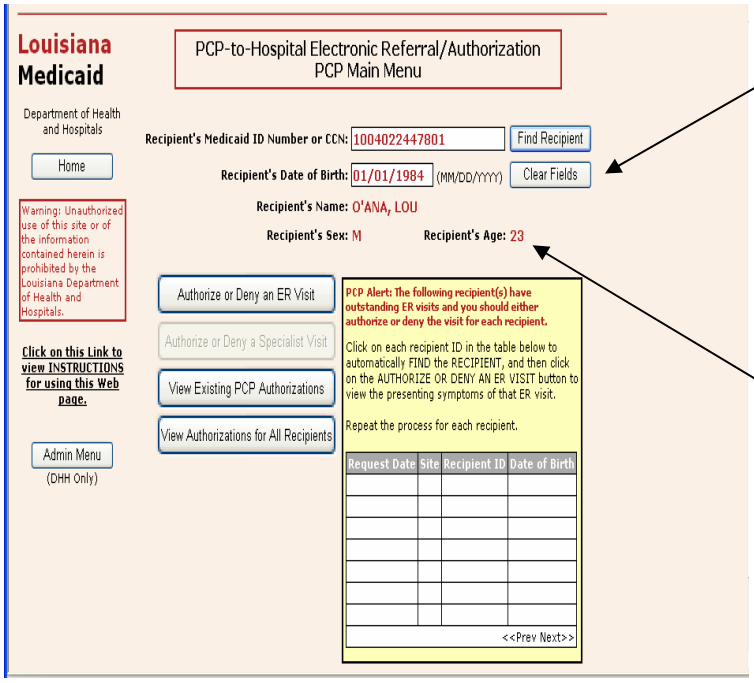




If there are no recipients with outstanding visits listed, then the first step is to enter a recipient's Medicaid ID Number or CCN and Date of Birth, then click on the **Find Recipient Button**.

If there are recipients associated with your Provider ID that have outstanding visits, they will be listed here. You can click the recipient ID link to automatically find the recipient.

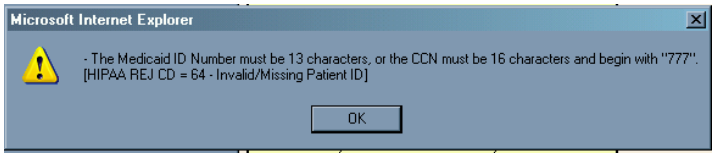
Screen example of no recipients listed with outstanding visits:



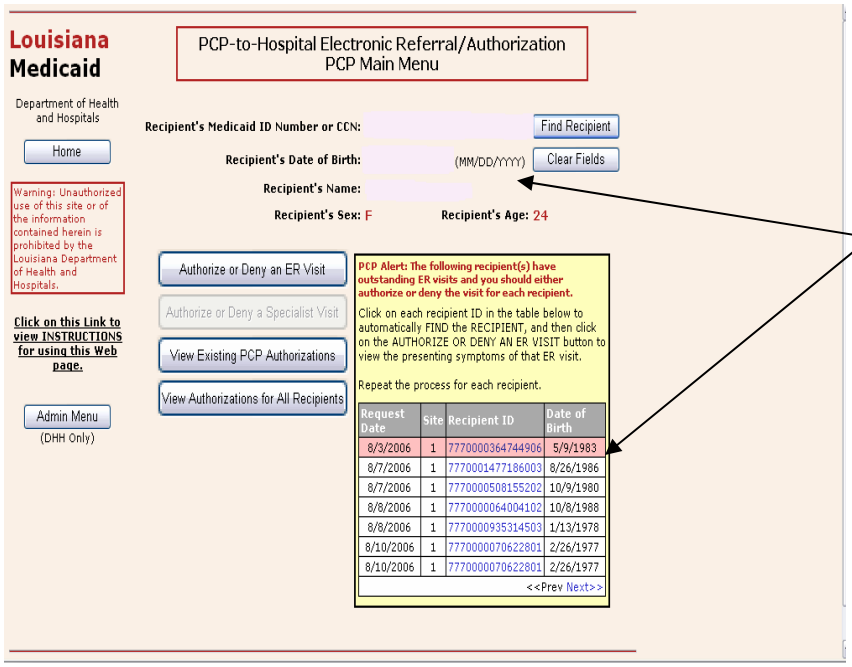
You may click on the **Clear Fields** button at any time to start over.

Once you have entered the recipient's Medicaid ID Number or CCN and Date of Birth and clicked on **Find Recipient**, the name, sex, and age of the recipient are displayed.

If you enter the CCN or other data incorrectly (wrong format, etc.), an error message similar to the one shown below will prompt you to try again:



Screen example of recipients listed with outstanding visits:

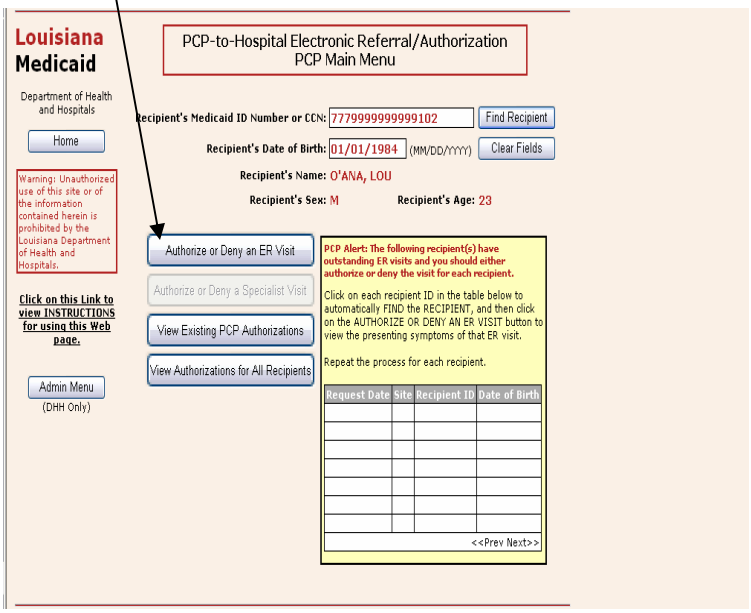


The list of recipients with outstanding visits are displayed. Select the recipient from which you are searching from the list – the recipient is highlighted and the recipient's Medicaid ID number, DOB, name, age, and sex appear at the top of the screen.

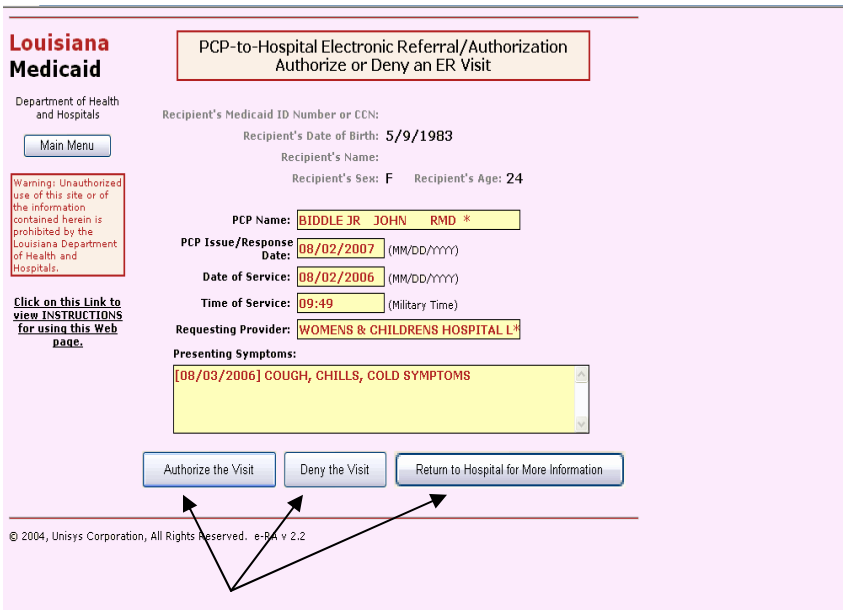
Authorize or Deny an ER Visit

The steps to authorize or deny an ER visit are as follows:

1. Select **Authorize or Deny an ER Visit** of the specified recipient.



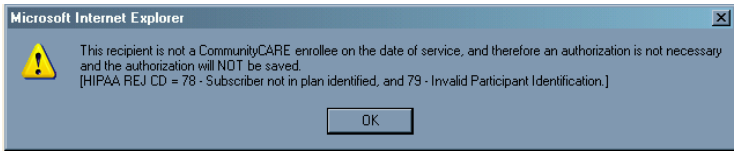
2. The recipient's CCN, (or Medicaid ID number), DOB, name, sex, and age are displayed along with the requesting provider and PCP name. Select **Authorize the Visit, Deny the Visit, or Return to Hospital for More Information**.



Authorize the Visit

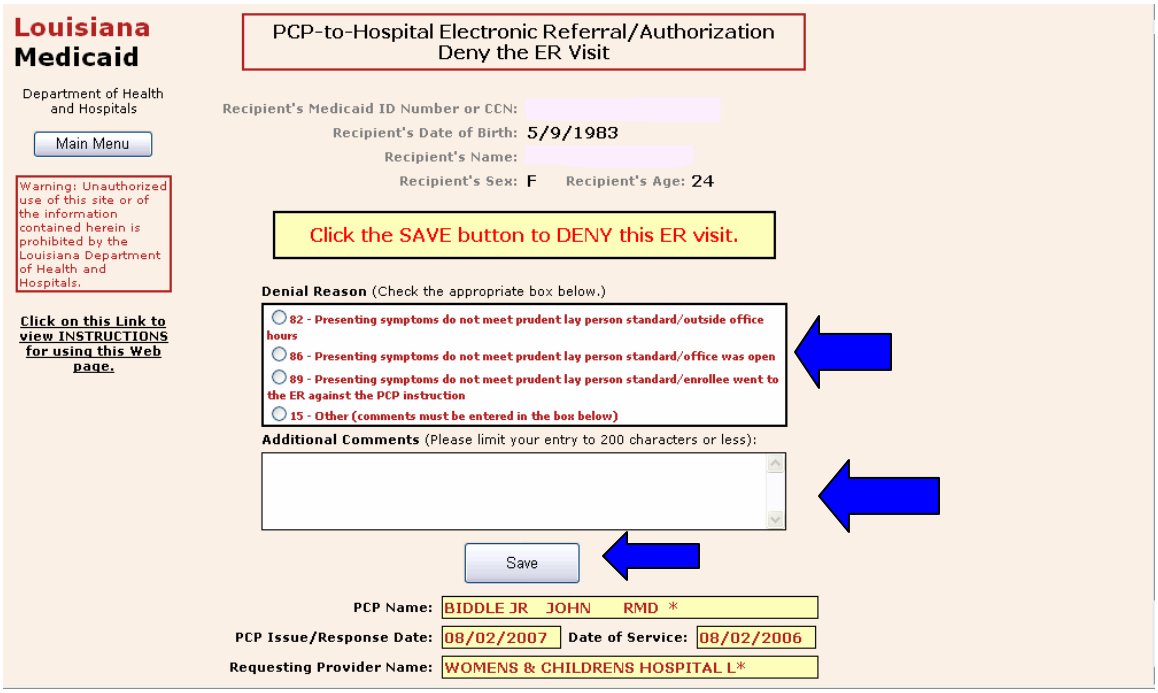
The system responds with the following confirmation. Press the **Cancel** button to return to the PCP Main Menu. Press the **OK** button to make and save the referral.

If the recipient is not a CommunityCARE enrollee, the system responds with the following explanation. Press the **OK** button to continue and return to the PCP Main Menu.



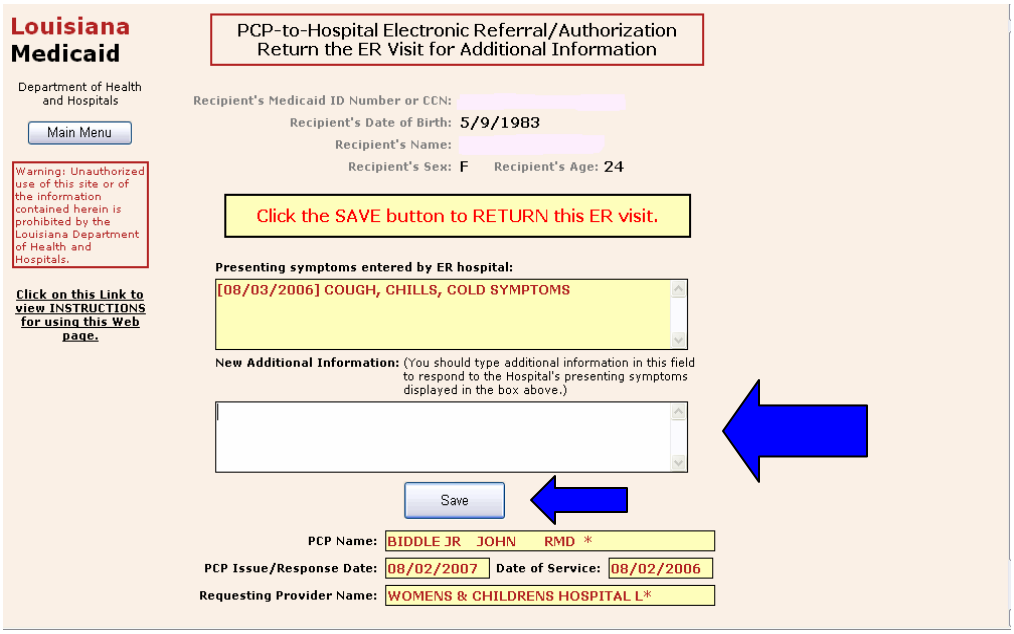
Deny the Visit

The system responds with the following confirmation. Select the denial reason, add any additional comments, and click **SAVE** to deny the ER visit.



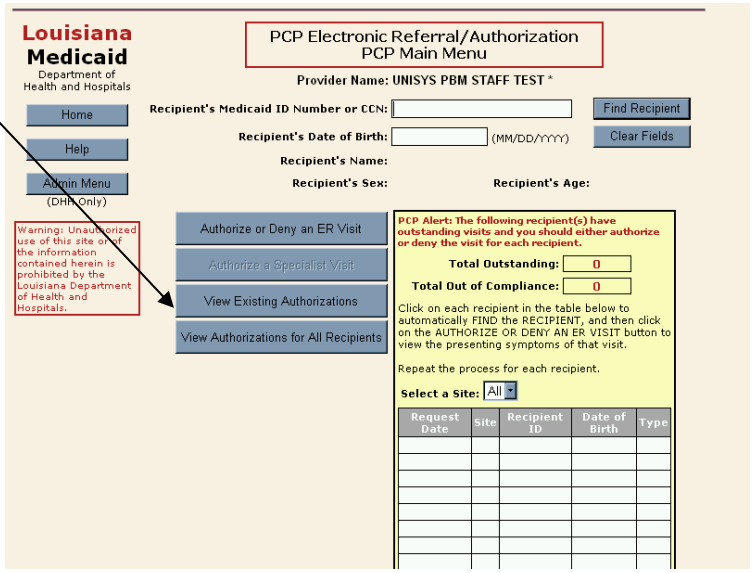
Return to Hospital for More Information

The system responds with the following confirmation. Type additional information in the additional comments field (to respond to the Hospital's presenting symptoms displayed in the box above), and click **SAVE** to return to hospital for more information.

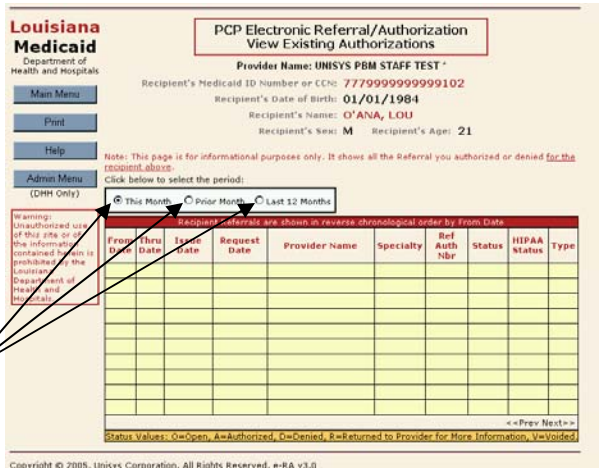


View Existing Authorizations

If you click on the **View Existing Authorizations** button without first having entered a recipient's Medicaid ID Number or CCN and DOB, the system responds with this reminder:

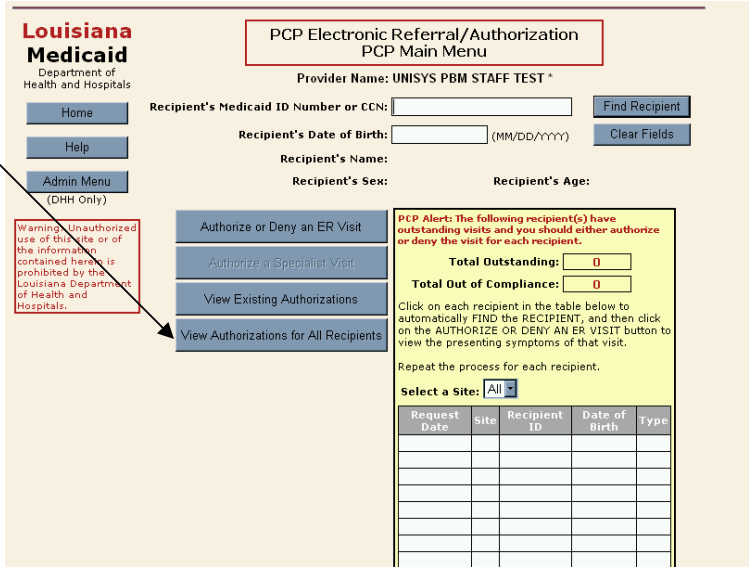


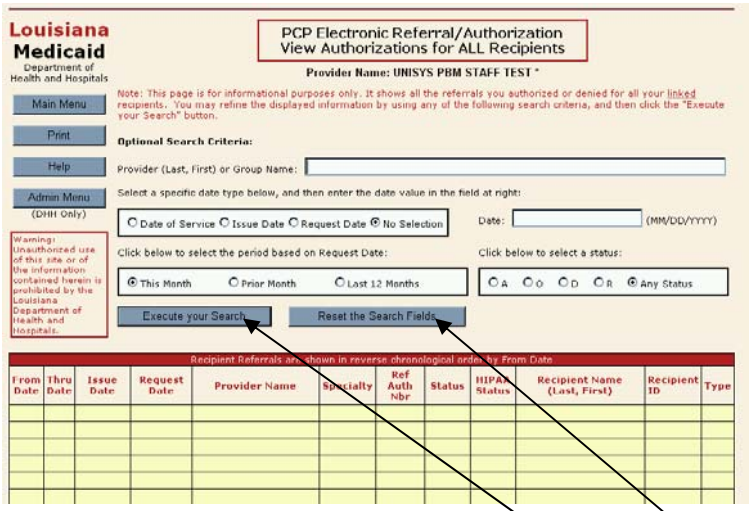
Once you have entered a recipient's Medicaid ID number or CCN and DOB, and then pressed the **View Existing Authorizations** button, the system responds with a report similar to the one shown on the right. The page displays all the referrals the provider authorized for the specified recipient. You can view referrals for **This Month** (the default), the **Prior Month**, or the **Last 12 Months** by clicking on the appropriate radio button.



View Authorizations for All Recipients

You may click on the **View Authorizations for All Recipients** button with or without having first entered a recipient's Medicaid ID Number or CCN and DOB.



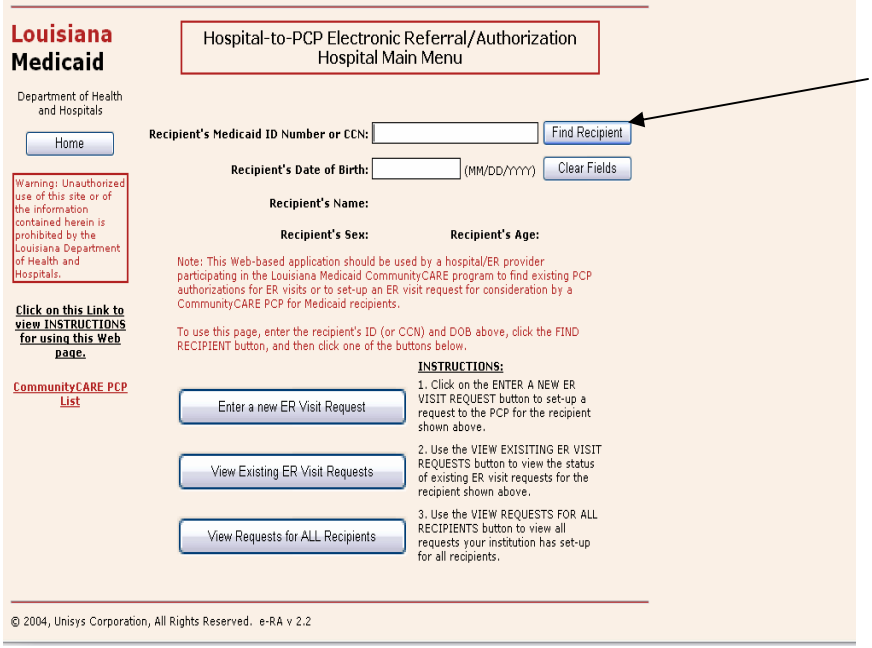


The system responds with a report of all referrals for all CommunityCARE recipients linked to your Provider ID. However, you may refine the report by specifying a **Provider** or **Group**, or a date type (**Date of Service**, **Issue Date**, **Request Date**, or **No Selection**—the default). If you choose to search by a date type, you must also enter a **Date** in the Date text box. Alternatively, you may click on the radio button for **This Month** (the default), **Prior Month**, or **Last 12 Months.** You may also search with a status indicator by clicking on the radio button for a status indicator of **A**, **O**, **D**, **R**, or **Any Status** (the default).

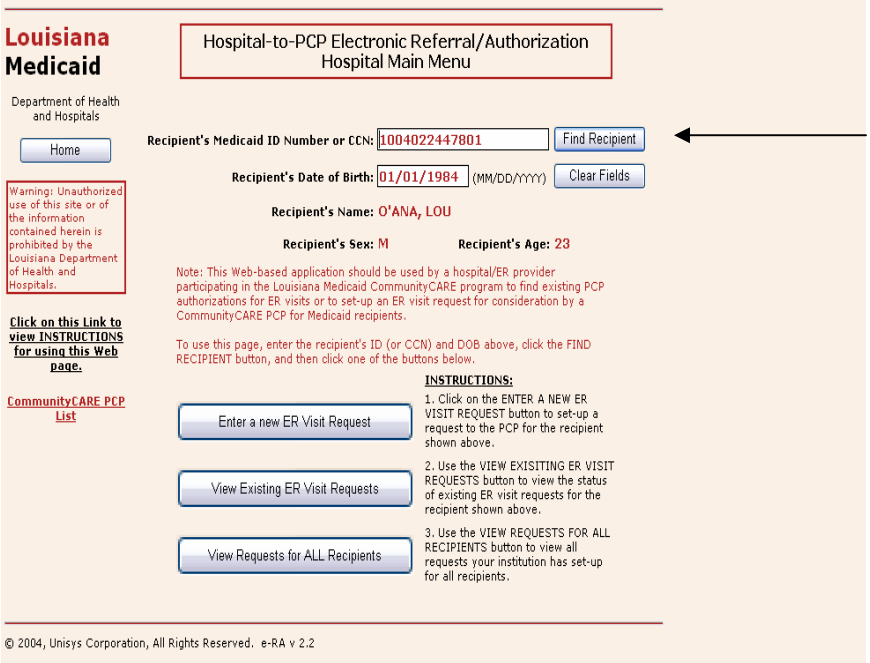
Click on the **Reset the Search Fields** button to start over. Click on the **Execute Your Search** button once you have entered your selected search parameters.

Hospital Main Menu

This application should be used by a hospital/ER provider participating in the LA Medicaid CommunityCARE program to find existing PCP authorizations for ER visits or to set-up an ER visit request for consideration by a CommunityCARE PCP for Medicaid recipients.

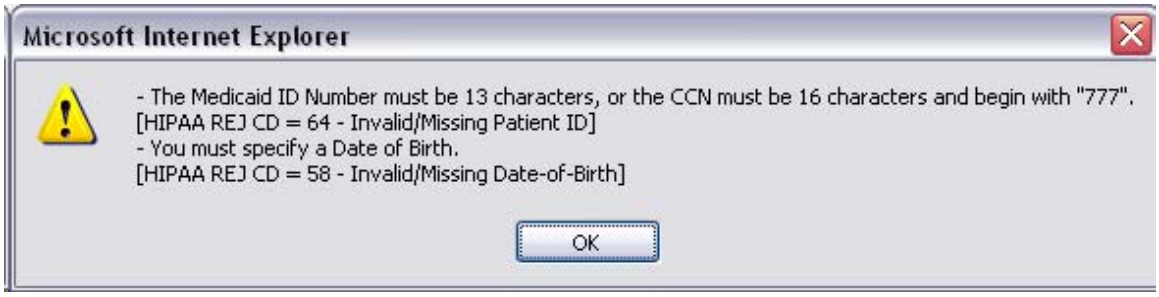


Enter the recipient's ID (or CCN0 and DOB, then Click the **Find Recipient** button.



Once you have entered the recipient's Medicaid ID (or CCN) and DOB and clicked on **Find Recipient**, the name, sex, and age of the recipient is displayed.

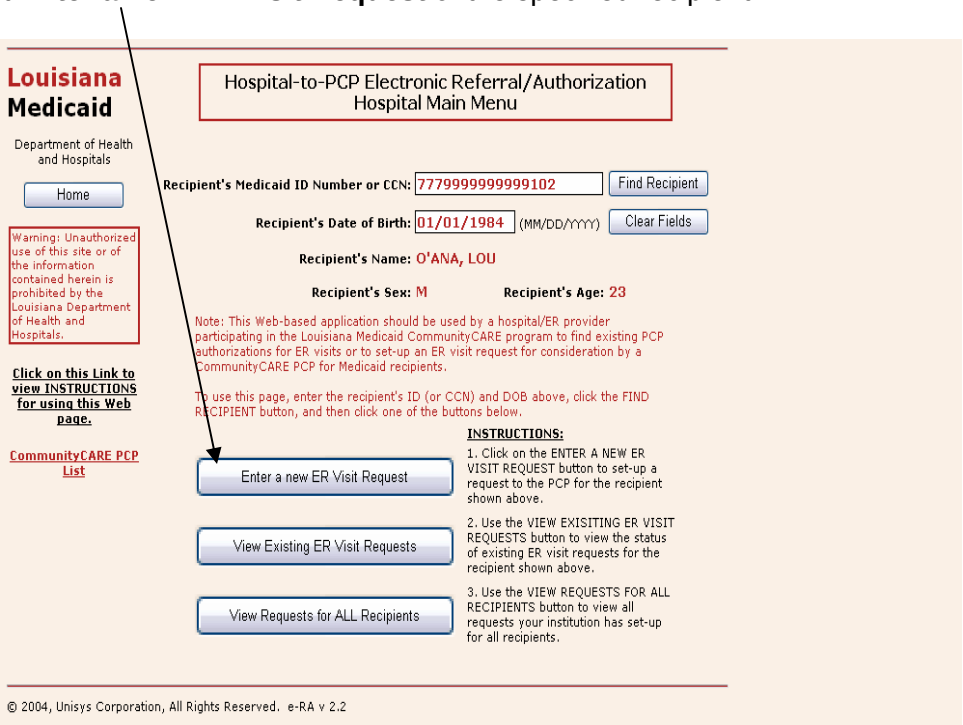
If you enter the recipient ID (or CCN) and other data incorrectly (wrong format, etc.), an error message similar to the one shown below will display and prompt you to try again:



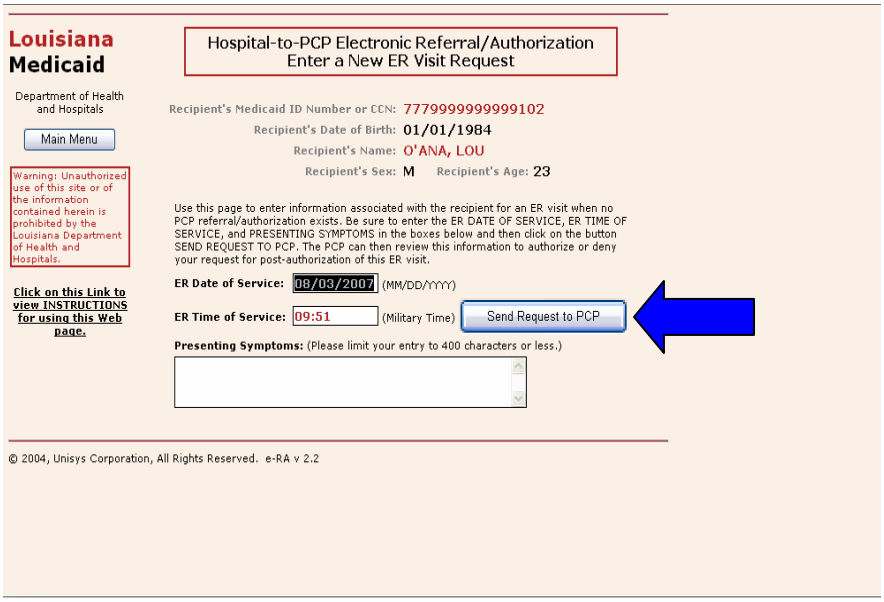
Enter a new ER Visit Request

The steps to setup a new ER visit request to the PCP are as follows:

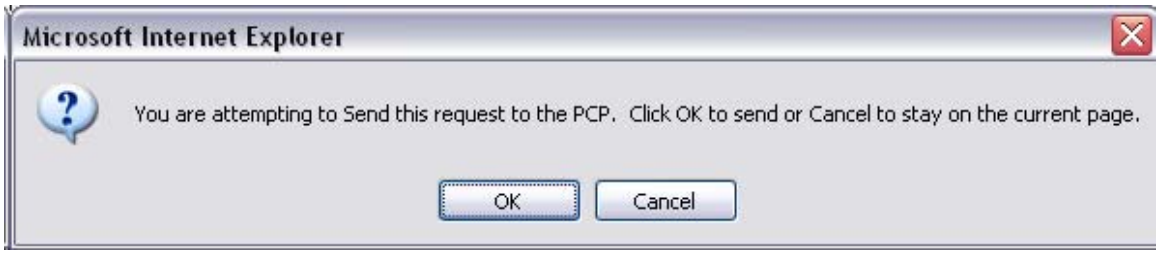
1. Select **Enter a new ER Visit Request** of the specified recipient.



2. The recipient's ID (or CCN), DOB, name, age, and sex are displayed along with the requirement to enter information associated with the referral request. Use this page to enter information associated with the recipient for an ER visit when no PCP referral/authorization exists. Be sure to enter the **ER DATE OF SERVICE**, **ER TIME OF SERVICE**, and **PRESENTING SYMPTOMS** in the boxes below and then click on the button **SEND REQUEST TO PCP**. The PCP can then review this information to authorize or deny your request for post-authorization of this ER visit.



The system responds with the following confirmation. Press the **Cancel** button to return to the Hospital Main Menu. Press the **OK** button to send and save the referral request to the PCP.

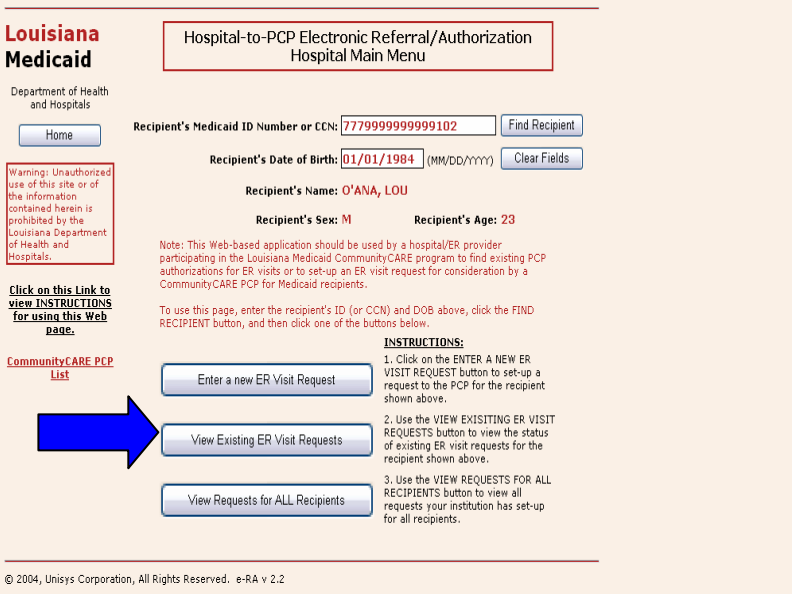


If the recipient is not a CommunityCARE enrollee, the system responds with the following explanation. Press the **OK** button to continue and return to the Hospital Main Menu.

View Existing ER Visit Requests

The steps to view existing ER visit requests are as follows:

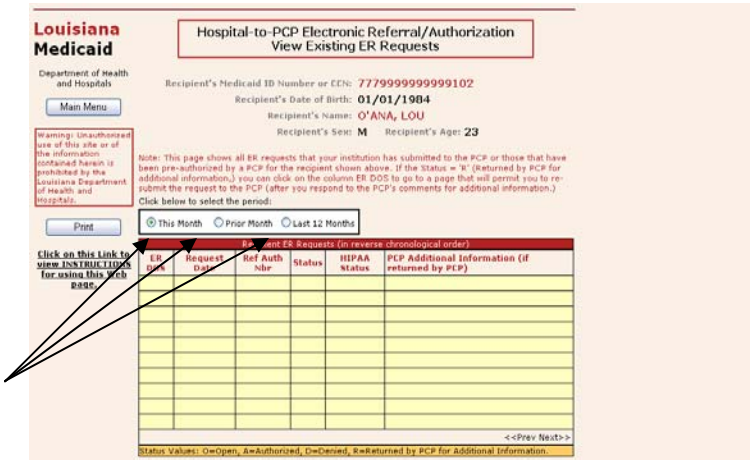
1. Select **View Existing ER Visit Requests** of the specified recipient.



Note: If you click the View Existing ER Visit Requests button without first having entered a recipient's Medicaid ID number (or CCN0 and DOB, the system will respond with this following reminder:

2. The following page is displayed showing all ER requests that your institution has submitted to the PCP or those that have been pre-authorized by a PCP for the recipient shown. If the Status = 'R' (Returned by PCP for additional information,) you can click on the column ER DOS to go to a page that will permit you to re-submit the request to the PCP (after you respond to the PCP's comments for additional information.)

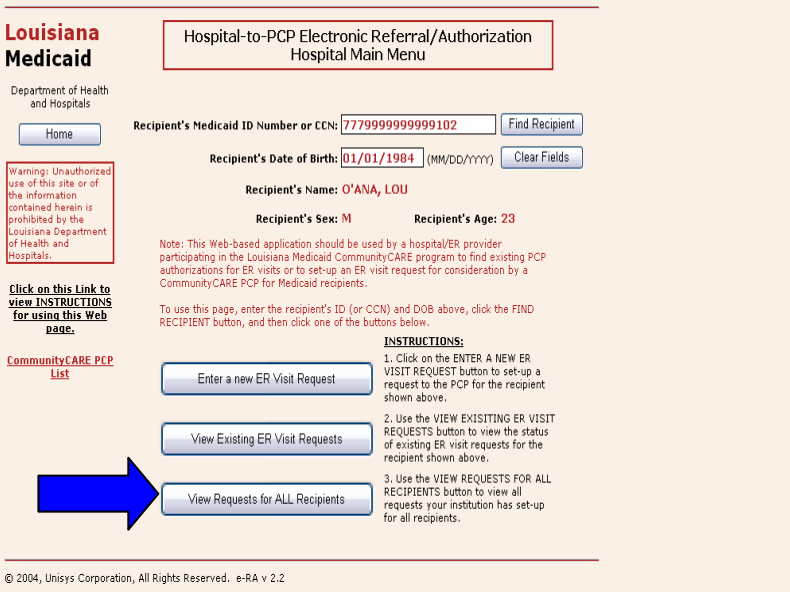
You can view all ER requests for **This Month** (the default), the **Prior Month**, or the **Last 12 Months** by clicking on the appropriate radio button.



View Requests for ALL Recipients

The steps to view requests for ALL recipients are as follows:

1. Select **View Requests for ALL Recipients** of the specified recipient.

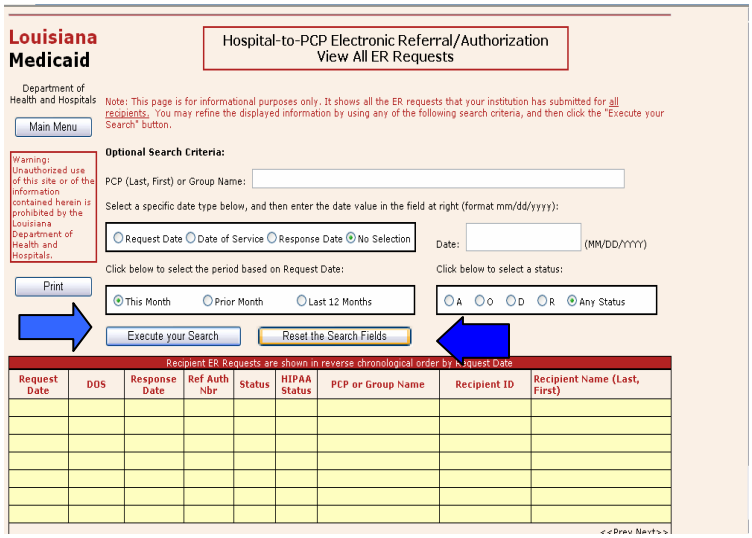


You may click on the **View Recipients for ALL Recipients** button with or without having first entered a recipient's Medicaid ID (or CCN) and DOB.

2. The following page is displayed showing all of the ER requests that your institution has submitted for <u>all recipients.</u>

   You may refine the displayed information by specifying a **Provider** or **Group**, or a date type (**Date of Service**, **Issue Date, Request Date**, or **No Selection** – the default). If you choose to search by a date type, you must also enter a **Date** in the Date text box. Alternatively, you may click on the radio button for **This Month** (the default), **Prior Month**, or **Last 12 Months**. You may also search by status indicator of **A, O, D, R**, or **Any Status** (the default).

Click on the **Reset the Search Fields** button to start over *or* Click on the **Execute Your Search** button once you have selected your search



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 without pre-certification for inpatient stays): hospital, physician, and ancillary services billed with inpatient place of service.
- 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.
- 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 (age 0-21)
- Pharmacy
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists services
- Transportation services
- Hemodialysis
- Hospice services
- Specific outpatient laboratory/radiology services
- Immunization for children under age 21 (Office of Public Health and their affiliated providers)
- WIC services (Office of Public Health WIC Clinics)
- Services provided by School Based Health Centers to recipients age 10 and over
- Tuberculosis clinic services (Office of Public Health)
- STD clinic services (Office of Public Health)
- Children's Special Health Services (CSHS) provided by OPH

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.

VIII. QUALITY OVERSIGHT ACTIVITIES

The CommunityCARE quality unit, a staff of registered nurses, will conduct quality improvement projects that rely on ongoing data analysis and planned interventions to achieve demonstrable and sustained improvements in significant clinical and non-clinical aspects of the services furnished to enrollees. Improvements are expected to have positive effects on enrollee health status and satisfaction with the program. Projects may Involve interventions at the program level, provider level, or patient level.

CommunityCARE Quality Improvement Projects have several shared features:

- Identification of patients
- Use of evidence-based practice guidelines
- Enhance patient self-management and adherence to his or her treatment plan
- Routine reporting/feedback loop
- Collaboration among providers
- Collection and analysis of process and outcome measures

PERFORMANCE MEASURES

A comprehensive set of performance measures is used to monitor, evaluate, and improve the quality of care provided to CommunityCARE enrollees. These measures enable the Program Managers to determine whether CommunityCARE: (1) complies with standards for preventive care and chronic or other specific health conditions, (2) assures adequate access to medically necessary services, and (3) enrollees and providers are satisfied with the program.

The performance measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS), the national data collection and reporting instrument that CMS recommends for Medicaid managed care. The selected HEDIS measures may be supplemented by several other widely utilized quality measures receive and patient outcomes. The measures are stratified by enrollee, provider, parish and region. PCPs may be asked to participate in program performance evaluations and supply needed data for focus studies and quality improvement projects.

Over the last few years DHH has been working towards reducing the paper work and improving the efficiency and quality of health care delivery through the development of several web based applications for Medicaid providers. DHH is currently in the process of developing two new web based applications for CommuityCARE PCPs: a Utilization Report and a Quality Profiles. We expect the reports to be available in the next 2-3 months. They will be accessible to CommunityCARE providers through the LA Medicaid website using your existing logon and password.

UTILIZATION REPORT

The purpose of the Utilization report is to provide PCPs with a tool to use in managing the care of their CommunityCARE patients. This report will include detailed information related to the utilization of specific services such as office visits, emergency department services, inpatient hospital stays .etc.. This report will provide PCPs with the ability to track those services for the enrollees that are linked to that PCP. The data will be updated quarterly using claims data for the previous quarter and will be based on paid claims per 100 CommunityCARE enrollees

linked to the PCP for at least two months during the quarter. The Utilization Report will not reflect any data for PCPs who have fewer than 100 CommunityCARE enrollees linked to their practice.

QUALITY PROFILES

CMS encourages states to improve performance measurement and ultimately the quality of care through the use of evidence-based measure sets that have wide acceptability in the healthcare industry. One of the goals of the CommunityCARE quality team is to assist in improving medical home management by providing education, office management tools, and utilization data to providers.

The Quality Profiles will provide CommunityCARE PCP's with data that will assist in identifying areas needing performance and efficiency improvement. This information is intended for use as an educational tool and supports the chronic care model concept of providing decision support tools to improve patient management. The data provided will consist of regional and statewide CommunityCARE PCP peer comparisons on specific HEDIS (Healthcare Effectiveness Data Information Set) measures and will include detailed enrollee information based on administrative claims data. In an effort to provide ongoing technical support, CommunityCARE quality staff may contact providers to review profile data and assist in developing quality improvement goals.

IX. COMMUNITYCARE IMMUNIZATION PAY-FOR PERFORMANCE (P4P) INITIATIVE

Louisiana Medicaid implemented an immunization pay-for-performance initiative which includes supplemental payments to providers. This initiative was implemented to promote up-to-date immunizations of Louisiana Medicaid eligible children and to increase the number of providers utilizing the Louisiana Immunization Network for Kids Statewide (LINKS) immunization registry.

Requirements to participate in this pay-for-performance initiative and receive supplemental payments include:

- The provider must be enrolled in Louisiana Medicaid as a CommunityCARE PCP;
- The provider must be enrolled in and utilizing the Vaccines for Children (VFC) Program (If KIDMED services including immunizations for recipients aged 19-35 months are contracted out, then the subcontractor must to be enrolled in and utilizing VFC);
- The provider must be enrolled in and **utilizing** LINKS. Utilizing LINKS is defined as input of recipient immunization data into LINKS in the past 30 days. (If KIDMED services including immunizations for recipients aged 19-35 months are contracted out, then the subcontractor must to be enrolled in and utilizing LINKS);

- Providers must enter the social security number of Medicaid eligible children linked to them for CommunityCARE into the LINKS record to ensure the child is correctly identified and included in the data for payment calculations.

CommunityCARE PCPs interested in participating in the immunization pay-for-performance initiative and receiving the supplemental payments will be required to register on a secure web page at www.lamedicaid.com.

Information required to complete this registration includes:

- CommunityCARE PCP Medicaid Billing Provider ID Number
- National Provider Identifier (NPI) if the provider has one
- VFC PIN Number
- LINKS Provider ID (IRMS Number)
- LINKS Facility Name

All of the above information will also be required for any subcontractor of KIDMED services that provide immunizations (including the subcontractors Medicaid Billing Provider ID number). The PCP will be responsible for obtaining this information from the subcontractor and completing the information required on the secure web page mentioned earlier. This information is to be completed at the time the PCP registers to participate in the pay-for-performance supplemental payments.

Note: The enrollment and utilization status of VFC and LINKS will be validated monthly with the Office of Public Health Immunization Program for all CommunityCARE PCPs registered to participate in the immunization pay-for-performance initiative.

Supplemental payments will be dependent on:

- The CommunityCARE PCP (or subcontractor of KIDMED services) being enrolled in and utilizing VFC and LINKS;

- The percentage of 24 month old Medicaid enrolled children linked to the PCP practice that are up-to-date with all childhood immunizations in the 4:3:1:3:3:1* vaccine series and these immunizations must be entered into LINKS; and

- The number of CommunityCARE linkages to the PCP for recipients under 21 years of age.

Payment calculations will be done on a monthly basis and payments of these monthly calculations will be made on a quarterly basis to the registered CommunityCARE PCPs. **Only** data that is in the LINKS immunization registry at the time of the monthly calculation for payments will be used.

The supplemental payment tiers or levels for payment are as follows:

- $0.25 per Medicaid recipient under the age of 21 linked to the CommunityCARE PCP **if** the PCP or subcontractor of KIDMED services is enrolled in and utilizing VFC and

LINKS **AND** < 75% † of the recipients aged 24 months old with CommunityCARE linkages to the PCP are up-to-date with the vaccine series 4:3:1:3:3:1* **or**;

- $0.50 per Medicaid recipient under the age of 21 linked to the CommunityCARE PCP **if** the PCP or subcontractor of KIDMED services is enrolled in and utilizing VFC and LINKS **AND** 75%† to 89%† of the recipients aged 24 months old with CommunityCARE linkages to the PCP are-up to-date with vaccine series 4:3:1:3:3:1, **or**:

- $1.00 per Medicaid recipient under the age of 21 linked to the CommunityCARE PCP **if** the PCP or subcontractor of KIDMED services is enrolled in and utilizing VFC and LINKS **AND** 90% † or more of the recipients aged 24 months old with CommunityCARE linkages to the PCP are up-to-date with vaccine series 4:3:1:3:3:1

  NOTE: Providers participating in this initiative will only qualify for a single level of payment (e.g. Providers with an immunization rate of 82% will only qualify for the second level or tier payment - not both the first and second tier).

For more information regarding the VFC Program or LINKS, contact the Office of Public Health Immunization Program at (504)838-5300.

For more information on the Immunization Pay-for-Performance Initiative, contact Unisys Provider Relations at (800)473-2783.

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* 4 doses of DTaP; 3 doses of poliovirus vaccine; 1 dose of MMR vaccine; 3 doses of *Haemophilus influenza* type b vaccine; 3 doses of hepatitis B vaccine; and 1 dose of varicella vaccine.

† Percentages of up-to-date 24 month old recipients are determined solely by data from the LINKS immunization registry and the use of CoCASA software.

COMMUNITYCARE REFERRAL/AUTHORIZATION FORM

(1) Patient Name:	(2) Medicaid ID Number:
(3) Address:	(4) Date of Birth:
	(5) Telephone Number:

(6) REFERRED TO:

Purpose For Referral/Authorization (select and complete section 7, 8 OR 9)

☐ **(7) Medical Referral**

(7a) Diagnosis/Suspected Condition: _____

_____

(7b) Scope of Referral/Comments: _____

_____

(7c) Effective Date: From: _____ Through: _____

(not to exceed 6 months except as specified on page 5-3 of the CommunityCARE Handbook)

(7d) ☐ **Approved**: Referral/Authorization Number: _____

(7e) ☐ **Denied:** Reason _____

_____

_____

☐ **(8) Post ER Authorization**

(8a) Presenting Symptoms: _____

_____

_____

_____

(8b) ☐ **Approved**: Referral/Authorization Number: _____

Effective Date/Date of Service: _____

(8c) ☐ **Denied** (Presenting symptoms do not meet prudent layperson standard)

(8d) ☐ **Need More Information** (specify what additional information is needed): _____

_____

☐ **(9) Non-Medical Authorization**

(9a) ☐ Administrative (9b) ☐ Transitional **(PCP Change-not to exceed 2 months)**

Effective Date: From: _____ Through: _____

(9c) Referral/Authorization Number: _____

(10) CommunityCARE PCP Name: _____ _____

(11) Address: _____ (12) Telephone Number: _____

NOTE: If enrolled in CommunityCARE as a group, indicate group name; if enrolled as an individual provider, indicate individual physician name.

(13) PCP Signature: _____ (14) Issue Date: _____

Unauthorized use of a CommunityCARE PCP's provider 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 a fine and/or imprisonment.

INSTRUCTIONS FOR COMPLETING THE COMMUNITYCARE REFERRAL/AUTHORIZATION FORM

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	**MEDICAL REFERRAL**	Check this box if The PCP is referring the recipient to another provider for care.
	(7a) Diagnosis/Suspected Condition	Enter the patient's diagnosis or suspected condition
	(7b) Scope of Referral/Comments	Enter any restrictions or conditions of the referral. i.e. limited by a specific number of visits, specific condition, etc
	(7c) Effective Date	Enter the "from" and "through" date for the referral. Not to exceed 6 months, except as specified on page 5-3 of the CommunityCARE Handbook.
	(7d) Approved	If the request is approved, check this box and enter the appropriate referral/Authorization number.
	(7e) Denied	If the request is denied, check this box and give a reason for the denial
FIELD NO.8	**POST ER AUTHORIZATION**	Check this box if the hospital is requesting post-authorization of an ER visit, by the PCP.
	(8a) Presenting Symptoms	Enter a detailed explanation of the patient's presenting symptoms, including severity, duration, etc. Simply listing symptoms such as "fever" or "rash" is not sufficient. DO NOT ENTER DIAGNOSIS
	(8b) Approved	If the PCP approves the visit, (s)he should check this box and enter the appropriate referral/authorization number and the effective date
	(8c) Denied	If the PCP denies the visit, (s)he should check this box.
	(8d) Need More Information	The PCP should check this box if information on presenting symptoms is not sufficient to determine whether the Prudent Layperson Standard was met.
FIELD NO. 9	**NON-MEDICAL AUTHORIZATION**	Check either 10a or 10b, then enter the appropriate authorization number
	(9a) Administrative Authorization	See the Administrative Authorization section of the CommunityCARE Provider Training packet for appropriate use.
	(9b) Transitional Authorization	To be issued when the recipient has requested a change of PCP that is not yet reflected in the Medicaid Eligibility Verification systems. **Transitional Authorizations should not be written for more than 60 days.**
	(9c) Referral/Authorization Number	Enter the appropriate referral/authorization number.
FIELD NO. 10	**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. 11	**ADDRESS**	Enter the referring CommunityCARE provider's physical address.
FIELD NO. 12	**PHONE NUMBER**	Enter the referring CommunityCARE provider's phone number.
FIELD NO. 13	**PCP SIGNATURE**	Enter the signature of the primary care provider authorizing the referral.
FIELD NO. 14	**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 UNISYS PROVIDER RELATIONS (800) 473-2783.

IF THE PCP AUTHORIZATION NUMBER IS NOT IN THE DESIGNATED FIELD OM THE CLAIM FORM THE CLAIM WILL BE DENIED -- EVEN IF A COPY OF THE REFERRAL IS ATTACHED TO THE CLAIM.

- Block 83A for inpatient and outpatient claims filed on the UB-92
- Block 17A for physician and durable medical equipment claims filed on the CMS1500
- Block 12 for claim type 05 (rehabilitation claims)
- Block 10 for claim type 06 (home health claims)

REVISED JUNE 2006

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 www.lamedicaid.com web site; 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
- Prior Authorization (e-PA) for requesting prior authorizations electronically.

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

e-MEVS:

Providers can 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 one-year 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.

e-PA

The Electronic Prior Authorization (e-PA) Web Application has been developed for requesting prior authorizations electronically. E-PA is a web application found on the www.lamedicaid.com website and provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. This application is currently restricted to the following prior authorization types:

01 – Inpatient
05 – Rehabilitation
06 – Home Health
09 – DME
14 – EPSDT PCS
99 - Other

Providers who do not have access to a computer and/or fax machine will not be able to utilize the web application. However, prior authorization requests will continue to be accepted and processed using the current PA hard-copy submission methods.

NOTE: Dental electronic Prior authorization (e-PA) Web Application will be implemented at a later date. In order to utilize the Dental e-PA Web Application, the dental provider will be required to obtain the services of a vendor to submit the electronic attachment information to Medicaid. Complete Dental e-PA instructions will be provided upon implementation of Dental e-PA.

Reminders:

PA Type 01: Outpatient Ambulatory Surgery performed Inpatient on the first or second day of the stay. This is only for State Operated hospitals and Out-of-State hospitals that have a DHH approval letter for the out of state stay. Use ICD-9-CM procedure codes.

PA Type 99: Outpatient Ambulatory Surgery (CPT procedures) performed Inpatient on the first or second day of the stay. The surgery was performed at a State Operated hospital and Out-of-State hospital that has a DHH approval letter for the out of state stay. This is also used for specialized CPT procedures. This is for professional services only.

PA Type 05: Providers must always submit the PA02 Form with each request. Do not request authorization for the evaluation procedures, these do not require prior approval. Submit only units on the e-PA transaction, Do Not submit dollar amounts.

Home Health Providers submitting Rehab Services should use PA Type 05 and PA Type 09 when submitting DME Services.

PA Type 09: When submitting a request with a miscellaneous procedure code, the provider must submit a PA01 Form with the description of the item they are requesting.

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

RECONSIDERATION REQUESTS (RECONS) CAN BE SUBMITTED USING e-PA AS LONG AS THE ORIGINAL REQUEST WAS SUBMITTED THROUGH e-PA.

ADDITIONAL DHH AVAILABLE WEBSITES

www.lamedicaid.com: Louisiana Medicaid Information Center which includes Field Analyst listing, RA messages, Provider Updates, Preferred Drug Listings, General Medicaid Information, Fee Schedules, and Program Training Packets

www.dhh.louisiana.gov: DHH website – LINKS (includes a link entitled "Find a doctor or dentist in Medicaid")

www.dhh.state.la.us: Louisiana Department of Health and Hospitals (DHH)

www.la-kidmed.com: KIDMED – Program Information, Frequently Asked Questions, Outreach Material ordering

www.la-communitycare.com: CommunityCARE – Program Information, PCP Listings, Frequently Asked Questions, Outreach Material ordering

https://linksweb.oph.dhh.louisiana.gov: Louisiana Immunization Network for Kids Statewide (LINKS)

www.ltss.dhh.louisiana.gov/offices/?ID=152: Division of Long Term Community Supports and Services (DLTSS)

www.dhh.louisiana.gov/offices/?ID=77: Office of Citizens with Developmental Disabilities (OCDD)

www.dhh.louisiana.gov/offices/?ID=334: EarlySteps Program

www.dhh.louisiana.gov/rar: DHH Rate and Audit Review (Information on Nursing Home, Adult Day Healthcare, Hospice, Administrative Claiming, Sub-Acute Care, PACE, and Assisted Living; Cost Reporting Information, Contacts and FAQ's.)

www.doa.louisiana.gov/osp/aboutus/holidays.htm: State of Louisiana Division of Administration site for Official State Holidays

PROVIDER ASSISTANCE

The Louisiana Department of Health and Hospitals and Unisys maintain a website to make information more accessible to LA Medicaid providers. At this online location, www.lamedicaid.com, providers can access information ranging from how to enroll as a Medicaid provider to directions for filling out a claim form.

Below are some of the most common topics found on the website:

New Medicaid Information
National Provider Identifier (NPI)
Disaster
Provider Training Materials
Provider Web Account Registration Instructions
Provider Support
Billing Information
Fee Schedules
Provider Update / Remittance Advice Index
Pharmacy
Prescribing Providers
Provider Enrollment
Current Newsletter and RA
Helpful Numbers
Useful Links
Forms/Files/User Guidelines

- ☞ The website also contains a section for Frequently Asked Questions (FAQ) that provide answers to commonly asked questions received by Provider Relations.

Along with the website, the Unisys Provider Relations Department is available to assist providers. This department consists of three units, (1) Telephone Inquiry Unit, (2) Correspondence Unit, and (3) Field Analyst. The following information addresses each unit and their responsibilities.

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure information/clarification; ordering printed materials; billing denials/problems; requests for Field Analyst visits; etc.

(800) 473-2783 or (225) 924-5040
FAX: (225) 216-6334*

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

The following menu options are available through the Unisys Provider Relations telephone inquiry phone numbers. Callers should have the 7-digit LA Medicaid provider number available to enter the system. Please listen to the menu options and press the appropriate key for assistance.

Press #2 - To order printed materials only**
Examples: Orders for provider manuals, Unisys claim forms, and provider newsletter reprints. To choose this option, press "2" on the telephone keypad. This option will allow providers to leave a message to request printed materials **only**. Please be sure to leave (1) the provider name, (2) provider number, (3) contact person, (4) complete mailing address, (5) phone number and (6) specific material requested.

- ☞ Only messages left in reference to printed materials will be processed when choosing this option. Please review the other options outlined in this section for assistance with other provider issues.

- ☞ Fee schedules, TPL carrier code lists, provider newsletters, provider workshop packets and enrollment packets may be found on the LA Medicaid website. Orders for these materials should be placed through this option **ONLY** if you do not have web access.

- ☞ Provider Relations staff mail each new provider a current copy of the provider manual and training packet for his program type upon enrollment as a Medicaid provider. An enrolled provider may also request a copy of the provider manual and training packet for the Medicaid program in which he is enrolled. A fee is charged for provider manuals and training packets ordered for non-providers (attorneys, billing agents, etc.) or by providers wanting a manual for a program for which they are not enrolled. All orders for provider manuals and training packets should be made by contacting the Provider Relations Telephone Inquiry Unit. Those requiring payment will be forwarded to the provider once payment is received.

Provider Relations cannot assist recipients. The telephone listing in the "Recipient Assistance" section found on page 80 should be used to direct Medicaid recipient inquiries appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

Press #3 - To verify recipient or provider eligibility; Medicare or other insurance information; Primary Care Physician information; or service limits.

- Recipient eligibility
- Third Party (Insurance) Resources
- CommunityCARE
- Lock-In

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

Press #4 - To resolve a claims problem

Provider Relations staff are available to assist with resolving claim denials, clarifying denial codes, or resolving billing issues.

NOTE: Providers must use e-CSI to check the status of claims and e-CSI in conjunction with remittance advices to reconcile accounts.

Press #5 – To obtain policy clarification, procedure code reimbursement verification, request a field analyst visit, or for other information.

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

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

Providers who wish to submit problem claims for research and want to receive a written response, **must submit a 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.

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**: Many providers submit claims that do not require special handling to the Provider Relations Department hoping to expedite processing of these claims. However, this actually delays claim processing, as the claims must pass through additional hands before reaching the appropriate processing area. In addition, it diverts productivity that would otherwise be devoted to researching and responding to provider requests for assistance with legitimate claim problems. Providers are asked to send claims that do not require special handling directly to the appropriate post office box for that claim type.

Eligiblity File Updates: Provider Relations staff also handles requests to update recipient files with correct eligibility. Staff in this unit 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.

TPL File Updates: 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: "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". **CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.**

Claims Over Two Years Old: Providers are expected to resolve claims issues within two years from the date of service on the claims. The process through which claims over two years old will be considered for re-processing is discussed in this training packet under the section, Timely Filing Guidelines. In instances where the claim meets the DHH established criteria, a detailed letter of explanation, the hard copy claim, and required supporting documentation must be submitted **in writing** to the Provider Relations Correspondence Unit at the address above. **These claims may not be submitted to DHH personnel and will not be researched from a telephone call to DHH or the Provider Inquiry Unit.**

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

Provider Relations Field Analysts are available to visit and train new providers and their office staff on site, upon request. 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 the Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for material, or other policy documentation. These calls should not be directed to the Field Analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

FIELD ANALYST	PARISHES SERVED	
Kellie Conforto (225) 216-6269	Jefferson Orleans Plaquemines	St. Bernard St. Tammany **(Slidell Only)**
Stacey Fairchild (225) 216-6267	Ascension Assumption Calcasieu Cameron Jeff Davis Lafourche St. Charles	St. James St. John St. Martin **(below Iberia)** St. Mary Terrebonne Vermillion Beaumont (TX)
Tracey Guidroz (225) 216-6201	West Baton Rouge Iberville Tangipahoa St. Tammany **(except Slidell**)	Washington Centerville (MS) McComb (MS) Woodville (MS)
Ursula Mercer (225) 216-6273	Bienville Bossier Caddo Caldwell Claiborne Catahoula Concordia East Carroll Franklin Jackson	LaSalle Lincoln Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Vicksburg (MS) Marshall (TX)
Kelli Nolan (225) 216-6260	East Baton Rouge East Feliciana Livingston	Pointe Coupee St. Helena West Feliciana
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin **(above Iberia)**
Sherry Wilkerson (225) 216-6306	Avoyelles Beauregard DeSoto Grant Natchitoches Rapides	Red River Sabine Vernon Winn Jasper (TX) Natchez (MS)

PROVIDER RELATIONS REMINDERS

The Unisys Provider Relations inquiry staff strives to respond to provider inquiries quickly and efficiently. There are a number of ways in which the provider community can assist the staff in responding to inquiries in an even more timely and efficient manner:

- Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:
    - The correct 7-digit LA Medicaid provider number
    - The 13-digit Recipient's Medicaid ID number
    - The date of service
    - Any other information, such as procedure code and billed charge, that will help identify the claim in question
    - The Remittance Advice showing disposition of the specific claim in question
- Obtain the name of the phone representative you are speaking to in case further communication is necessary.
- Because of the large volume of incoming provider calls, Telephone Inquiry staff are not allowed to be put on hold after answering a call.
- PLEASE review and reconcile the remittance advice before calling Provider Relations concerning claims issues. Some providers call Provider Relations frequently, asking questions that could be answered if the RA was reviewed thoroughly. However, providers are encouraged to call Provider Relations with questions concerning printed policy, procedures, and billing problems.
- **Provider Relations WILL NOT reconcile provider accounts or work old accounts for providers. Calls to check claim status tie up phone lines and reduce the number of legitimate questions and inquiries that can be answered. It is each provider's responsibility to establish and maintain a system of tracking claim billing, payment, and denial. This includes thoroughly reviewing the weekly remittance advice, correcting claim errors as indicated by denial error codes, and resubmitting claims which do not appear on the remittance advice within 30 - 40 days for hard copy claims and three weeks for EDI claims**.
- **Providers can check claim status through the e-CSI (Claim Status Inquiry) web application found in the secure area of the Louisiana Medicaid website at www.lamedicaid.com. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on e-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 e-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 e-CSI or hard copy remittance advices for this purpose. This includes provider's direct staff and billing agents or vendors. A LA Medicaid/HIPAA Error Code Crosswalk is available on the website by accessing the link, Forms/Files.**

- If a provider has a large number of claims to reconcile, it may be to the provider's advantage to order a provider history. Please see the Ordering Information section for instructions on ordering a provider history.

- **Provider Relations cannot assist recipients.** The telephone listing in the "Recipient Assistance" section found in this packet should be used to direct Medicaid recipient inquires appropriately. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

- Providers who wish to submit problem claims for a written response **must submit a cover letter** explaining the problem or question.

- Calls regarding eligibility, claim issues, requests for Unisys claim forms, manuals, or other policy documentation should not be directed to the Field Analysts but rather to the Unisys Provider Relations Telephone Inquiry Unit.

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 - CommunityCARE
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

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) 216-6334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 216-6381	(225) 216-6334
Electronic Media Claims (EMC) - Unisys		(225) 216-6000 option 2	(225) 216-6335
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 216-6342
Dental P.A. - LSU School of Dentistry		(225) 216-6470	(225) 216-6476
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 216-6370	
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) 925-6606	Providers may request verification of eligibility for presumptively eligible recipients; recipients may request a new card or discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information about the LaCHIP Program that expands Medicaid eligibility for children from birth to 19.
Office of Public Health - Vaccines for Children Program	(504) 838-5300	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Specialty Care Resource Line - ACS	(877) 455-9955	Providers and recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED. Providers may inquire about PCP assignment for CommunityCARE recipients and CommunityCARE monitoring/certification, and obtain information on KIDMED linkage, referrals, monitoring, and certification.
Louisiana Medicaid Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - OCDD	(866) 327-5978	Providers and recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4149	Providers may request termination as a recipient's lock-in provider.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (866) 758-5035	Providers and recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 342-0095 (866) 783-5553	Providers and recipients may request assistance regarding waiver services to waiver recipients.
Family Planning Waiver	(225) 219-4153	Providers may request assistance about the family planning waiver.
DHH Rate and Audit	(225) 342-6116	For LTC, Hospice, PACE, and ADHC providers to address rate setting and claims or audit issues.

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

Provider Relations cannot assist recipients. The telephone listing below should be used to direct recipient inquiries appropriately.

Department	Phone	Purpose
Fraud and Abuse Hotline	(800) 488-2917	Recipients may anonymously report any suspected fraud and/or abuse.
Regional Office – DHH	(800) 834-3333 (225) 925-6606	Recipients may request a new card or discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Specialty Care Resource Line - ACS	(877) 455-9955	Recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED.
Louisiana Medicaid Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program – OCDD	(866) 327-5978	Recipients may obtain information on the EarlySteps Program and services offered.
LINKS	(504) 838-5300	Recipients may obtain immunization information.
Office of Aging and Adult Services (OAAS)	(225) 219-0223 (800) 660-0488	Recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 342-0095 (866) 783-5553	Recipients may request assistance regarding waiver services.
Family Planning Waiver	(225) 219-4153	Recipients may request assistance regarding family planning waiver services.

NOTE: Providers should not give their provider numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.

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					
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS REPRESENTATIVES					
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 question	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION:					

Do you have internet access in the workplace?_____

Do you use www.lamedicaid.com?_____

What topic was most beneficial to you?_____

Please provide us with your business email address:_____

Please specify your Provider Number so we can cross reference it with your email address:_____

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**