INTRODUCTION

Manual Purpose and Organization

The service provider manual has been developed to present useful information and guidance to providers participating in the Louisiana Medicaid Program. The manual is divided into two major components, a general information and administration chapter and individual program chapters. The "general information and administrative" chapter contains information to which **all** enrolled providers must adhere. It encompasses the universal terms and conditions for a provider to deliver medical services and supplies to recipients of the Louisiana Medicaid Program. This chapter also outlines the information and procedures necessary to file claims for reimbursement in accordance with Medicaid policy.

The other component is divided into the individual program chapters. Each chapter is dedicated to a specific program and outlines the policies, procedures, qualifications and limitations specific to that program. Providers are provided a copy of the chapter(s) for the program(s) in which they are enrolled.

Providers are encouraged to use this manual as a reference guide and training tool to assist in understanding what procedures and services are covered by the Louisiana Medicaid Program. It is the provider's responsibility to assure that their employees have knowledge and understanding of and have access to the pertinent information in the manual which is necessary to perform their duties.

Medicaid program policies and procedures are revised based on developing health care initiatives and state and federal directives. Providers are notified of these changes through publication of administrative rules, manual chapter revisions, ***Provider Update*** newsletters, remittance advice messages, correspondence, and/or training materials. These changes may also be posted to the Louisiana Medicaid website. All of these forms of communication shall constitute formal notice to providers.

Manual Maintenance

To ensure that providers have current and accurate program information, changes or updates are made through quarterly manual revisions. A form titled the **Revision Index (Appendix C)** will be issued with each manual chapter revision, as a means of documenting/cataloging each revision. It is the responsibility of the provider to become familiar with each revision upon issuance. Revisions can be obtained through the internet or as paper manual chapter revisions.

Those providers who find it necessary to maintain a hardcopy of a provider manual chapter may find it helpful to use a three ring binder to house the chapter and all revisions and clarifications issued. When replacing a page in the manual, providers should retain the old page in the back of the manual for use with claims that originated under the old policy.

The Medicaid Program

The **Medicaid** Program was created in 1965 with the passage of Title XIX of the Social Security Act "for the purpose of enabling each State…to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose income and resources are insufficient to meet the cost of necessary medical services".

Medicaid is governed by the regulations contained in Title 42 of the Code of Federal Regulations, Chapter IV, Subchapter C. These regulations describe the groups of people and the services a state must cover to qualify for federal matching payments. States must design their programs to meet these federal requirements, and to provide coverage and benefits to the groups specified under federal law. States must also establish the reimbursement rates paid to providers for delivering care to eligible recipients.

Administration

Louisiana implemented its Medicaid Program in 1966. The **Department of Health and Hospitals (DHH)** administers the Medicaid Program through the **Bureau of Health Services Financing** (BHSF). The BHSF is responsible for Medicaid eligibility determinations, licensure and certification of health care providers, payment to Medicaid providers, fraud and abuse investigations, and other administrative functions.

The **Centers for Medicare and Medicaid Services** (CMS) is the federal regulatory agency that administrates the Medicaid Program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state's Medicaid State Plan. It also enforces the general provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Eligibility

Individuals are determined eligible for Medicaid by the BHSF field staff located in regional offices. Supplemental Security Income (SSI) recipients are determined Medicaid eligible by the Social Security offices.

Funding

Funding for the Medicaid Program is shared between the federal government and the state. The federal government matches Louisiana's share of program funding at an authorized rate between 50 and 90 percent, depending on the program. The contribution for the federal government is adjusted annually based on the per capita income of the state comparative to the nation as a whole.

Service Coverage

The federal government requires that each state provides coverage of mandatory services in its Medicaid Program in order to receive federal funding. In addition, states have the option to provide coverage of **optional services** that are recognized under federal regulations and approved by CMS.

States may also request approval from CMS to provide coverage for waiver and demonstration services that target a specific population. Waivers permit states more flexibility in providing services and coverage to individuals who otherwise would not be eligible for Medicaid.

Provider Participation

Providers supply health care services and/or medical equipment to Medicaid eligible recipients. In order to receive reimbursement for these services and equipment, the provider must be enrolled to participate in Louisiana Medicaid, meet all licensing and/or certification requirements inherent to his/her profession and comply with all other requirements in accordance with the federal and state laws and BHSF policies.

The Fiscal Intermediary

The **fiscal intermediary (FI)** enters into a contract with DHH and BHSF to maintain the Medicaid Management Information System (MMIS), a computerized system with an extensive network of edits and audits for the effective processing and payment of all valid provider claims submitted to the Medicaid Program. This system meets the requirements of the state and federal governments. Other functions of the FI include provider enrollment, technical assistance to providers on claim submission and processing, prior authorization of designated services, distribution of information, provider training, and on-site visits to providers. The FI's Provider Relations staff is also available to offer assistance and answer questions for providers when needed.

The Provider Update

The Bureau of Health Services Financing, Policy Development and Implementation Section produces a bi-monthly Medicaid newsletter which is distributed by the fiscal intermediary. This newsletter is produced for enrolled providers as a forum to disseminate pertinent Medicaid and health care information as well as to clarify current program policy and procedures.

It is the provider's responsibility to read this newsletter carefully. Providers may view the ***Provider Update*** newsletter via the Internet or receive a paper copy. Notification of programmatic changes through a Rule, manual chapter revision, provider notice, as well as the newsletter is considered formal notification and the provider can be held accountable for information contained therein.