PROVIDER BULLETIN

News and Updates on the Louisiana Medicaid Provider Portal

This Provider Bulletin was developed to answer questions and address concerns providers may have regarding Medicaid's new enrollment and eligibility system. Launched on November 13, 2018, the new system includes a new Provider Portal that replaces the former Facility Notification System (FNS) as ***the primary way providers manage documentation requirements****. The Self-Service Portal can be accessed at https://sspweb.lameds.ldh.la.gov/selfservice/.*

Claims resolution contacts for all providers

To expedite the resolution of provider claims, Medicaid offers two distinct paths for contacting provider relations representatives. Providers should use the point of contact that is most appropriate for their situation for the fastest response.

- Claims issues for all provider types can be routed to the DXC (formerly Molina) provider relations staff at 1-800-423-2783.
- Claims issues for long-term care providers can be routed to Medicaid's MMIS provider relations staff by email at MMISclaims@la.gov or 225-342-3855. When prompted to choose the reason for your call, long-term care providers should not select option 7 or they will be routed incorrectly. They should instead select option 8 for "all other calls" to reach the appropriate staff.

Long-term care issues dealing with application status or eligibility questions should continue to be handled through the long-term care email account – LTCContactUs@la.gov – and the Contact Us – Long Term Care web form. Medicaid advises providers should only submit their issue a single time to a single point of contact. Duplicative requests will result in slower response time.

Common denied claims issues and resolutions

Medicaid audits with providers have identified some root causes for areas where we are seeing a high volume of claims denials.

BILLING ISSUE 1: USING CASE ID NUMBERS INSTEAD OF MEMBER ID NUMBERS WHEN BILLING CLAIMS

One of the most frequent claims issues (represented by denial codes 215 and 216) occurs when there is no Medicaid eligibility in MMIS for the recipient. MMIS is Medicaid's claims processing system with the fiscal intermediary, DXC Technology. Our new eligibility system passes information to MMIS, which allows reimbursement to providers.

The most likely cause is the provider using the wrong identification number on the claim. Medicaid has recognized a pattern in these denials when the provider uses the recipient's CASE identification number instead of their MEMBER identification number. The case ID number appears on notice letters between Medicaid and the recipient and cannot be used for billing. **The member ID number must be used for billing. It can be found in the electronic verification system (eMEVS) at** www.lamedicaid.com. The member ID number previously appeared on the notice letters but was removed to comply with federal privacy requirements. Providers will no longer find the member ID number required for billing on notice letters and must now access this information through eMEVS. Both numbers are 13 digits, so please be sure your billers are made aware of this change and use the correct number for billing to avoid denied claims. **Before resubmitting any denied claims for payment, please have your billing department check that they are using the correct identification number on the claim.**

BILLING ISSUE 2: COMMON DENIAL CODES

In addition to the 215 and 216 code denials, the following denial codes are also widespread. Any providers seeing denials based on these codes should work to identify and make sure there is resolution to the issue noted in the claim description below.

- **Denial Code 159** – The provider will see this code when they have billed a claim that does not match the provider listed on file in the MMIS system. Typically, this means that status change forms or admit and discharge forms are not yet processed, or the eligibility coverage dates (i.e., eligibility segment or period) in Medicaid's eligibility and enrollment system has not been sent to the MMIS system yet. Providers do not need to resubmit claims to get paid. The weekly claims recycles will pick up these denied claims to pay once the forms are processed by LDH and the information sent to MMIS.
- **Denial Code 173** – The level of care on the claims does not match the level of care on the information in the MMIS system for payment. This denial code can be triggered for any day of the claim where the levels do not match, even a single day. Some denials are caused by Medicaid caseworker or systems errors and will be fixed internally by LDH and subsequently paid through the claims recycle process. However, for claims where providers are putting the wrong level of care or putting zero (0) for the level of care, the claim will continue to deny. In such cases, the provider should correct the form and resubmit.
- **Denial Code 568** – This "long-term care not eligible" code means the person is not eligible for nursing home coverage because the MMIS system does not have the eligibility information for the time period of that particular claim. In some cases, this is due to an internal Medicaid systems disconnect and will be fixed internally by Medicaid. Other times this code appears when providers are billing for a full month when there was a home leave or hospital leave for greater than 7 days during the month billed. In such cases, providers will need to change the dates submitted for payment to reflect the actual nursing facility stay, exclusive of the home or hospital leave, and resubmit the claim.

Provider manuals for eMEVS and DXC web guidance

Medicaid's fiscal intermediary, DXC Technology, has created a number of helpful manuals for enrolling in and navigating the provider login web spaces at www.lamedicaid.com, including the electronic verification system, eMEVS.

User manuals are found here near the bottom of the web page with other forms, files and surveys. Entries are listed alphabetically, and the Medicaid Eligibility Verification System manual provides guidance on the application, including how to access and search.

Waiver applications and health plan selection

Medicaid has confirmed that selection of a health plan during Medicaid waiver application online does not automatically put the applicant into managed care for physical health.

All waiver applicants initially go into a behavioral health only category. Physical health services will be provided through fee-for-service Medicaid. Once certified, the recipient can choose to opt-in to managed care for physical health, but they must make a proactive choice.

Long-term care paper renewals

Some enrollees or providers have tried to complete renewals on a defunct 2-L paper renewal form for long-term care. This form was retired a few years ago and is not currently accepted by the program. Please ensure that you and your clients are not submitting this form, but are instead following the instructions on the renewal letters.

Medicaid Renewals

Standard renewal letters for Medicaid enrollees were mailed Monday, May 6, 2019, and should be received soon.

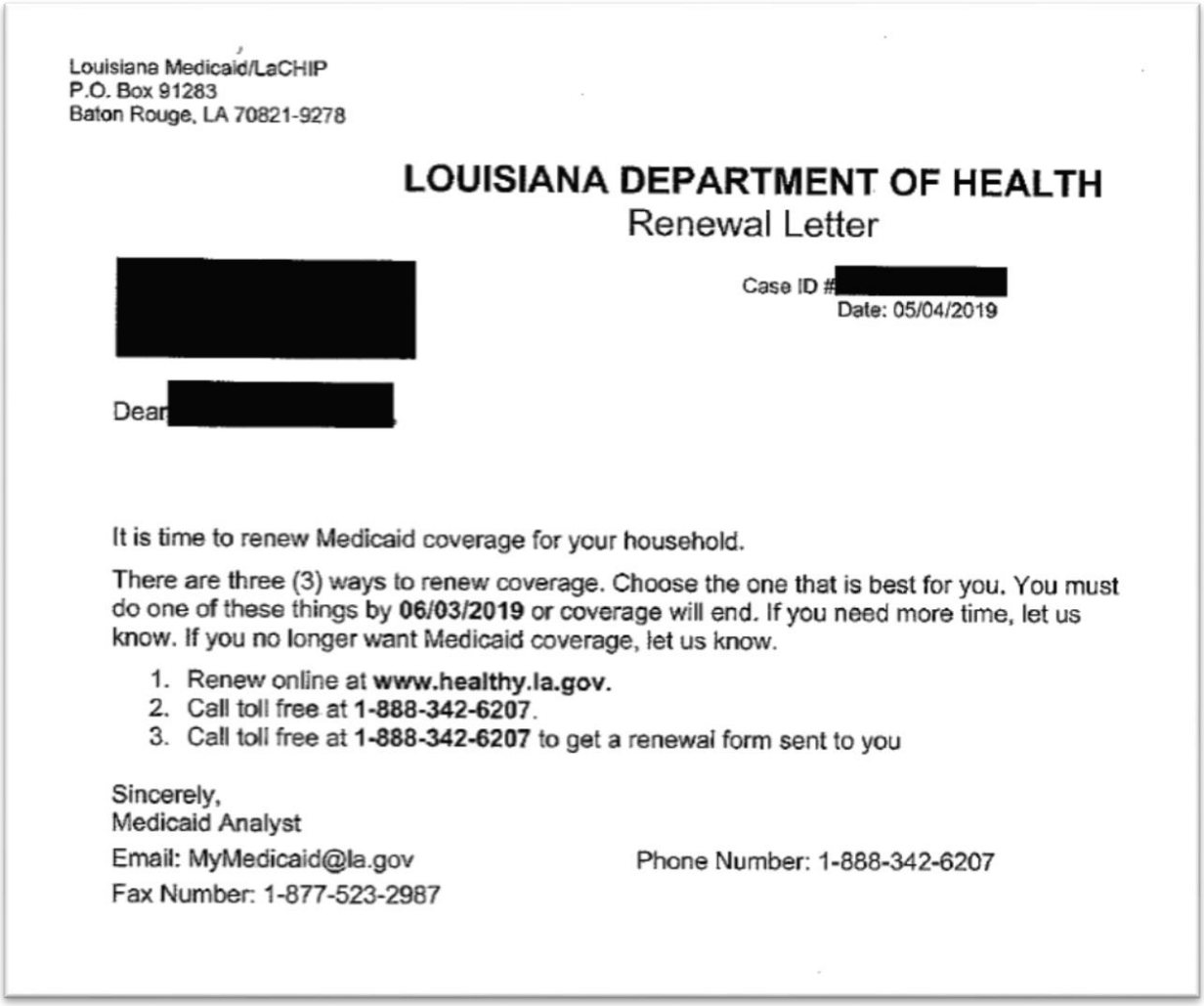
What to Expect

The process for renewals is as follows:

Step 1: Medicaid will check eligibility in our system for all enrollees who have a renewal date between June 1, 2018 and June 30, 2019.

Step 2: Anyone that remains eligible within program limits based on data sources already available in the Medicaid system will be sent a decision letter noting their continued coverage.

Step 3: Anyone for whom the system produces data indicating a discrepancy or that the person is over program limits will receive a renewal letter***. A sample of the letter is below.*** Please work with your patients to ensure they are responding to this letter by the deadline.



Louisiana Medicaid/LaCHIP
P.O. Box 91283
Baton Rouge, LA 70821-9278

LOUISIANA DEPARTMENT OF HEALTH
Renewal Letter

[redacted]

Case ID #[redacted]
Date: 05/04/2019

Dear [redacted]

It is time to renew Medicaid coverage for your household.

There are three (3) ways to renew coverage. Choose the one that is best for you. You must do one of these things by **06/03/2019** or coverage will end. If you need more time, let us know. If you no longer want Medicaid coverage, let us know.

1. Renew online at **www.healthy.la.gov.**
2. Call toll free at **1-888-342-6207**.
3. Call toll free at **1-888-342-6207** to get a renewal form sent to you

Sincerely,
Medicaid Analyst
Email: MyMedicaid@la.gov
Phone Number: 1-888-342-6207
Fax Number: 1-877-523-2987

Web Resources

Important notices, including all past and future Provider Bulletins, can be found at our website dedicated to provider issues related to the Medicaid system changes here. Additional links and contacts are found below.

IMPORTANT LINKS

Self-Service Portal – https://sspweb.lameds.ldh.la.gov/selfservice/
Medicaid Eligibility and Enrollment Web – http://ldh.la.gov/index.cfm/page/3497
Medicaid Customer Service – **1-888-342-6207** | medweb@la.gov
Provider Forms and User Manuals –
https://www.lamedicaid.com/provweb1/Forms/forms.htm
and http://ldh.la.gov/index.cfm/page/1278

USEFUL CONTACTS

Self-Service Provider Portal Assistance – MedicaidEligibilitySystemsHelp@la.gov
Long-Term Care Issues – www.ldh.la.gov/contactltc or LTCContactUs@la.gov.
Medicaid Customer Service – **1-888-342-6207** | MyMedicaid@la.gov