April 12, 2012 Contractor #3 Webinars
Questions

	Questions	Responses
1	Will David McCants' information be provided?	All attachments referenced in the webinar will be posted on the website by COB 4/12/12 @ http://new.dhh.louisiana.gov/index.cfm/faq/category/87
2	What is the timeframe of Medicaid approval…so that we can continue to check on clients that might retro approved?	There are nearly 40 programs in Medicaid. The average time-frame for processing various populations of Medicaid applications varies from 5 days to 3 months for adult applicants claiming disability (because of the need for obtaining medical records). Children average 14 days. Programs for adults other than Long Term Care (average 35 days), Pregnant Woman (5 days), Medically Needy (very low income – about 3 weeks), Low Income Families and Children (about 3-4 weeks), and Disability Medicaid (about 2-3 months). We also have some Medicare Savings Programs that average about 2-4 weeks.
3	Are we to still put our residential clients into LADDS until this is resolved?	Yes.
4	If we have clients that are 18 in our residential program at this moment, will we be reimbursed for them?	Yes.

5	If the initial point of entry agency failed to ask the client to fill out a Medicaid application and they are currently residing in our residential program, how will we be paid? We are not licensed to handle the application process on our end.	Your agency does not need to be an official Medicaid Application Center to "inform, encourage and assist" consumers to complete a Medicaid application per the Medicaid application policy. Since the consumer is in your facility, you will need to assist in completing the application. You will need to bill OBH utilizing the DHH Liability Limitation Schedule. If the client becomes eligible for Medicaid, you will need to reconcile the payments paid by OBH with the payments paid by Magellan for those services delivered during the time period in which Medicaid retroactively approved the client.
6	If we signed a contract with Magellan for 28-day treatment and per diem/room and board was completely covered within those parameters, are we still supposed to be entering our billable hours into Clinical Advisor as if each service was individually billed?	The treatment services of both licensed and unlicensed staff are covered in the per diem treatment rate for the Addictive Disorders Residential Rehabilitation facilities. The services are not billed individually.
7	What is the process required to transition OBH contracts to a FFS type contract under LCS? Is this something that can be done this Fiscal Year?	Pending approval from the Regional Manager/OBH Fiscal and the provider agency, requests for transfer of appropriate contracts can be made to LCS from OBH. Transfer could occur within the end of the FY if all parties are in agreement about moving forward in a timely fashion to ensure implementation prior to the end of the FY.

8	Where do residential halfway house ASAM Level III.1 fit? When we call for authorizations they put us under Non-Medical Group Homes. Is this correct? We are only getting 14 to 28 day authorizations and spending way too much time doing this. We need a solution	No. A residential facility at the ASAM III.1 level is a Residential Rehabilitation facility and NOT a non-Medical Group Home. A non-Medical Group Home does not provide any treatment services. Authorizations are a separate issue from the level of care provided at the facility. Authorizations for ASAM level 3.1 are being approved initially for 28 days
9	We have CITs (unlicensed staff) we've been told by Magellan that these CITs can author group notes, but can't sign them; they must be signed by a licensed clinician. We need clarification on this.	Unlicensed individuals must sign their own notes to authorize payment for claims. If they are providing authorized services per the SDM, they can sign their notes. Supervision is a separate process from the process of submitting notes.
10	Just to clarify: at this time, Functional Family Therapy (FFT) Services are to continue to be billed directly to OBH through the cost reimbursement contract.	Function Family Therapy is a Community Psychiatric Support and Treatment service that is covered by Medicaid. For Medicaid eligible, FFT is an EBT under CPST and should be billed at the FFT rate to Magellan.
11	I am getting ready to place ads in local papers for the staffing requirements I received from Dr. Dunham to include more nurses, psychologist, etc. for an adolescent residential s.a.tx.facility. I am going to hold off on actual hiring as we wait for the final decision to be regarding the staffing requirements. Is that the proper procedure for now?	We cannot advise on any organizational or clinician business practices. However, there are some recommended changes in the staffing requirements that may impact what staff is needed to meet staffing levels for the various ASAM levels. These changes are in the final stages of review and should be released shortly.
12	Is Magellan authorization required for services delivered only through cost reimbursement contracts?	Authorizations are required based on the type of benefit an individual is eligible to receive under Medicaid and on the type of service provided, not on how the contract is paid.
13	To confirm for substance residential facilities, all non-Medicaid clients or clients in the Medicaid application process will be billed on the provided OBH vendor invoice fee for service form and NOT through CA Magellan, correct?	Yes. Use the OBH vendor form for now. This will be done on an interim basis until Clinical Advisor is functioning for contractors.