INQUIRIES AND COMPLAINTS

Q

Q-100 AGENCY RESPONSIBILITY

The agency is responsible for:

- responding to inquiries and resolving complaints regarding:
  - recipient eligibility file problems,

    **
  - Third Party Resource File problems, other than Medicare, and
  - which providers accept Medicaid. Inform the recipient that there is no ***complete*** listing of providers who accept Medicaid and that it is the recipient's responsibility to locate a provider. ***However, two websites provide program and provider information: www.la-kidmed.com and www.la-communitycare.com.***
- accepting LTC complaints and forwarding them to BHSF State Office using special procedures in Q-130, Long Term Care, and
- referring all other complaints, depending on the nature of the complaint, to either:
  - BHSF State Office with a copy to the Medical Program Specialist;
  - the Fiscal Intermediary; or
  - the Medical Program Specialist.

Q-100 Continued

Inquiries, complaints, and the policies for handling them are divided into the following areas:

- Billing
- Third Party Resource File Other Than Medicare, and
- Long Term Care.

Q-110 BILLING

Applicant/recipient identifying information is confidential. Information may be given to a provider only under the following circumstances:

- if the provider has the correct recipient name (first and last), correct SSN, and correct date of birth and is requesting a Medicaid ID number for that recipient, give him the recipient ID number.

- if the provider has the recipient ID number and name and is inquiring about eligibility for a particular date of service, check ***MEDS*** and respond "yes" or "no".

  Do not give spans of coverage. Reply specifically to dates of service requested.

  Note:

  Under no circumstances shall an agency representative discuss or release information concerning Medicare coverage.

- if a claim has been filed and denied, the provider should have a remittance advice document which will contain an explanation for each denial. Ask the provider for the denial reason for each claim line in question.

Q-110 Continued

- If the denial reason is "name/ number mismatch between ***MEDS*** and MMIS" and the recipient is eligible on the date of service, it is the agency's responsibility to correct the erroneous information and inform the provider.

- If the denial reason is "recipient not on file" or "recipient not eligible on date of service", it is the agency's responsibility to assure that the ***recipient*** ID number ***and identifying information matches the MEDS person number and information****.* If the information on ***MEDS*** and MMIS matches and appears to be correct, refer the problem by memorandum to ***BHSF Claims Resolution***.

  Refer the provider to the Fiscal Intermediary, Provider Relations Section, for all other billing problems and inquiries.

- When the recipient contacts the local office because the provider has not been paid and refuses to assist the recipient with the problem:

  – verify that the recipient was eligible on the date(s) of service and that the ***recipient*** ID number ***and identifying information matches the MEDS person number and information*** **, and

  – if the recipient was eligible on the date of service and the ***recipient*** ID is correct, refer the problem by memorandum to ***BHSF Claims Resolution***.

  If recipient or provider fraud or abuse is reported, advise ***Program Integrity*** in writing of the complaint. ***Refer to Q-210***.

  If the complainant wishes to report the suspected fraud or abuse personally, refer him to ***the Fraud Hotline Number 1-800-488-2917.***

Q-120 THIRD PARTY RESOURCE FILE OTHER THAN MEDICARE

Complaints regarding third party codes ***on the recipient eligibility file*** shall be resolved by **:

- verifying current third party coverage with the recipient, and/or
- correcting information on ***MEDS***, dependent TPL section, and/or on the MMIS Third Party Resource File by use of the Health Insurance Resource Form, and/or
- correcting the case ID, carrier code and policy number by memo to BHSF/TPL Unit, and/or
- deleting the health insurance coverage by memo to the BHSF/TPL Unit, and/or
- correcting the scope of coverage by memo to the BHSF/TPL Unit.

Note:

Correction of the ***MEDS*** file only does not correct TPL coding on the ***recipient eligibility file***. Refer to J-250, Medical Insurance Codes.

Q-130 LONG TERM CARE

When an LTC complaint is received orally or in writing, it shall be forwarded in writing within one day of receipt to BHSF Health Standards Section, Attention: Nursing Home Complaint Desk.

When a complainant indicates that a patient's health and safety are endangered, immediately telephone the information to the Special Consultant for Long Term Care at ***1-888-810-1819***. Confirm the information by memo with a copy to the Nursing Home Complaint Desk.

Memos addressing both written and oral complaints shall include all of the following information that is available:

- name and Medicaid ID number of the recipient involved, if applicable,
- the name of the facility,
- the date the complaint was received,
- the name, address, and telephone number of the person who made the complaint,

  Note:

  If a complainant requests anonymity, state this fact in the memo. Do not include his name, address, and telephone number in the memo.

- the original written complaint or a detailed report of an oral complaint, and
- the name of the agency employee who received the complaint.

Do not contact the complainant to obtain additional information. BHSF Health Standards Section will investigate.

Q-200 REFERRALS

Referrals ** shall include:

- recipient name,
- recipient ID (13 digits),
- recipient mailing address,
- provider's name,
- description of the problem,
- recipient's telephone number, if available,
- provider telephone number, if available, and
- copies of provider remittance advice, if appropriate and if available.

Q-210 REFERRALS TO BHSF

Refer complaints to t***he appropriate section in*** BHSF. Complaints regarding:

- ***Medicare Savings Program and Medicaid Buy-In refer to Eligibility Program Operations,***
- ***Medicaid Recovery refer to the Third Party Unit,***
- ***the Fiscal Intermediary refer to MMIS,***
- ***Medicaid Transportation scheduling refer to the appropriate Regional Dispatch Office,***
- ***Other Medicaid Transportation complaints refer to Program Operations at (225) 342-1417.***

Note:

Do not refer eligibility problems ** to BHSF Program Operations.

Q-210 Continued

- ***Suspected fraud and abuse refer to* Program Integrity**
  - ***Toll free at 1-800-488-2917***
  - ***To the web site at www.dhh.louisiana.gov, or***
  - ***By mail at:***
    Program Integrity
    ATTENTION: Chief Investigator
    Louisiana Department of Health and Hospitals
    543 Spanish Town Road
    Baton Rouge, Louisiana 70802

Q-220 REFERRALS TO FISCAL INERMEDIARY

Refer providers to the Fiscal Intermediary, Provider Relations Section, for billing problems not related to recipient eligibility.

Note:

Do not refer recipients with billing problems to the Fiscal Intermediary under any circumstances.

Refer applicants for approval of services requiring prior authorization to the Fiscal Intermediary, Prior Authorization Unit. These services include extraordinary medical care, durable medical equipment and supplies, outpatient rehabilitative services, certain inpatient surgical procedures, out-of-state medical care and transportation, and extensions of inpatient hospital days or physician office visits.

Refer providers to the Fiscal Intermediary, Prior Authorization Unit, for problems related to services needing prior authorization.