

Referral to LDH PAL for Medicaid Managed Care Member

EPSDT - Targeted Population

ONLY FOR USE AFTER SUBMITTING A

REFERRAL TO MEDICAID MANAGED CARE CASE MANAGEMENT (MMC APPENDIX J)

Date:

TO: LDH Prior Authorization Liaison (PAL) · P.O. Box 91030 · Baton Rouge, LA · 70821-9030

Attn: Danielle Boykin

Fax 225-389-2749

FROM:	Support Coordinator's Name:	Support Coordinator's Phone#:
Provider #:		Fax#:
Managed Care Organization:	Medicaid Managed Care Case Manager:	Phone #:
RE: Managed Care Provider:	Provider #:	Phone #:
Address:	City:	State/Zip:
Service Type (if DME be specific):	Service Name: () Initial () Renewal	Amount/# of Hours of Service:
Beneficiary Name:	MID#:	Phone#:
Responsible Party:		
Address:	City:	State/Zip:

This is to inform you that this individual is receiving EPSDT Support Coordination Services and we are having the following problem with the Managed Care Provider identified above that we have been unable to resolve with the MCO (only for services that require PA):

1. We have not received a decision within 60 calendar days of the Choice of Provider date (Untimely PA Notice).

This is to inform you that we submitted a Referral to Medicaid Managed Care Case Management on __/__/__ and the MCO has been unable to resolve the below issue within 10 days of the Referral:

2. We have not received a notice of approval from the MCO for the renewal and the previous PA expired on __/__/__.
3. The MCO has been unable to locate a willing provider to submit a request for prior authorization.
4. The provider is not providing services at the times the beneficiary requested.
5. The provider is not providing the amount of services as prior authorized.
6. Other:

___ I certify that I have completed the attached Managed Care Organization Contact Form and attached all tracking logs, service logs, referral forms and e-mails related to resolving this issue with the MCO.

___ I certify that all attempts to resolve the issue with the MCO PAL have been exhausted without success prior to submitting a referral to the LDH PAL.

Support Coordinator's Signature

Date

Managed Care Organization (MCO) Contact Form

Referral to Medicaid Managed Care Case Management (Medicaid Managed Care Appendix Q)

The Referral to Medicaid Managed Care Case Management (MMCCM) must be sent **prior** to a referral being sent to the LDH PAL. Fax *Medicaid Managed Care Appendix Q* to the fax number listed on *Medicaid Managed Care Appendix A*.

Date Referral to MMCCM Sent: _____

(Attach copy of Referral to MMCCM)

Reason for contact:

Initial MCO Contact

After sending the Referral to MMCCM (MMC Appendix Q), the SC must make an initial contact to the appropriate MCO PAL or Medicaid Managed Care Case Manager to attempt to resolve the issue. Contact info is located in *Medicaid Managed Care Appendix A*.

Date: _____ **Reason for contact:** _____

Type of contact:

- E-mail *(attach copy)*
- Phone *(attach service log)* #: _____ Contact Name: _____
- Other *(attach copy)* Specify: _____

Results of contact:

Results of contact: describe in detail exactly what happened, including who contact was with, what was discussed, any barriers, strategies to remove barriers, etc.

Second MCO Contact

The SC must make a second contact to the appropriate MCO PAL to attempt to resolve the issue. Contact info is located in *Medicaid Managed Care Appendix A*.

Date: _____ **Reason for contact:** _____

Type of contact:

- E-mail *(attach copy)*
- Phone *(attach service log)* #: _____ Contact Name: _____
- Other *(attach copy)* Specify: _____

Results of contact:

Third MCO Contact

The SC must make a third contact to the appropriate MCO PAL to attempt to resolve the issue. Contact info is located in *Medicaid Managed Care Appendix A*.

Date: _____ **Reason for contact:** _____

Type of contact:

- E-mail *(attach copy)*
- Phone *(attach service log)* #: _____ Contact Name: _____
- Other *(attach copy)* Specify: _____

Results of contact:

LDH will forward the referral to the MCO requesting notification upon resolution.