Louisiana Department of Health
Informational Bulletin 15-6
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2015 MCO CPT/HCPCS Update

In legacy Medicaid, until the claims system is updated, providers are asked to submit claims using new codes when appropriate. These claims will deny initially with a specific denial message, but the submission preserves timely filing of the claim. Once the new codes are on file, claims for that denial code are recycled with no action required by the provider.

The processes and timelines for the five Managed Care Plans for adding new Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes are as follows:

Aetna - Once we receive the new codes from Optum© our goal is to load them within 30 days. Providers should bill with new codes as appropriate and we will reprocess the claims; the provider does not need to resubmit. The goal is to load the fee schedules within 30 days of receipt. We will then reprocess any claims affected by the change.

Healthy Blue - Providers should bill as required per national coding guidelines. New 2015 codes that are not listed on the state's fee schedule will deny until the state's fee schedule is updated to reflect the new codes. Healthy Blue will recycle all impacted claims after our system has been updated to reflect the states 2015 code updates.

AmeriHealth Caritas (ACLA) - ACLA updates its claim system with new codes within 45 days of Molina posting the revised Louisiana Medicaid fee schedules. Until the Louisiana Medicaid fee schedules are updated, providers should call ACLA's Utilization Department to request authorization for new codes. Providers are notified of the need to request authorization for miscellaneous and unlisted codes during provider orientation and in the provider handbook. If the provider files the claim before the new code is added to the system, the claim will deny but timely filing is preserved. When the new codes are loaded into ACLA's system, authorized claims for the new codes are reprocessed with no additional action from the provider.

Louisiana Healthcare Connections - Once the Lousiana Department of Health (LDH) updates the fee schedules for the new 2015 codes, we require 45 – 60 days to review and implement configuration relating to covered/non-covered status. The provider's explanation of benefits (EOB) returns an explanation code of cL (DENY: NO ACTION NEEDED - WILL BE REPROCESSED AFTER STATE REVIEWS NEW CODE) if the code is billed before a coverage determination is made. When that determination is made, all claims, whether covered or non-covered, are reprocessed with no action required by the provider. Our fee schedules are updated within 30 days of an update posted by LDH.

United Healthcare Community Plan (UHC) - Providers should bill with the most appropriate code available for the service provided. Providers whose reimbursement is based on the state's fee schedules are paid a default rate for new codes until the state updates their fee schedules and those updates are applied in UHC's system. Once the state rates are loaded, impacted claims will be recycled with no action required by the provider.