AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana

Provider Manual

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INTRODUCTION

FORWARD

Welcome to AmeriHealth Caritas Louisiana. This Provider Manual was created as a guide to assist you and your office staff with providing services to our enrollees, your patients. As a condition of providing services to AmeriHealth Caritas Louisiana enrollees, providers agree to comply with the provisions in this manual.

No content found in this publication or in the AmeriHealth Caritas Louisiana's participating Network Provider Agreement is to be construed as encouraging providers to restrict medically necessary covered services or to limit clinical dialogue between providers and their patients. Regardless of benefit coverage limitations, providers should openly discuss all available treatment options.

The provisions of this Provider Manual may be changed or updated periodically. AmeriHealth Caritas Louisiana provides notice of the updates at: www.amerihealthcaritasla.com.

Providers are responsible for checking regularly for updates.

Your review and understanding of this manual is essential, and we encourage you to contact our Provider Network Management department with any questions, concerns and/or suggestions regarding the Provider Manual.

Thank you for your participation with the AmeriHealth Caritas Louisiana provider network.

ABOUT AMERIHEALTH CARITAS LOUISIANA

WHO WE ARE

AmeriHealth Caritas Louisiana is the Medicaid managed care program of AmeriHealth Caritas, Louisiana, Inc., and part of the AmeriHealth Caritas Family of Companies, one of the largest organizations of Medicaid managed care plans in the United States. AmeriHealth Caritas Louisiana, headquartered in Baton Rouge, Louisiana, is a mission-driven health care organization that helps people get care, stay well and build healthy communities.

OUR VALUES

Our service is built on:

Advocacy, Dignity, Diversity, Care for the Poor, Compassion, Hospitality and Stewardship.

OUR MISSION

We Help People:

Get Care
Stay Well
Build Healthy Communities

IMPORTANT AMERIHEALTH CARITAS LOUISIANA TELEPHONE NUMBERS		
Department	**Phone**	**Fax**
Behavioral Health Member Crisis Intervention Center Hotline (Available 24/7)	1-844-211-0971	
Behavioral Health and Substance Use Utilization Management	1-855-285-7466	1-855-301-5356
Bright Start (Maternity Management)	1-888-913-0327	1-888-877-5925
Credentialing	1-888-913-0349	1-215-863-6369
Dental Benefits through LDH (Louisiana Medicaid beneficiaries under 21 years of age and Adult Dental Services 21 years of age and older): • MCNA (LDH Dental Benefit Manager) • DentaQuest (LDH Dental Benefit Manager) • AmeriHealth Caritas Louisiana Member Services Dental Benefits provided by participating Federally Qualified Health Centers (Louisiana Medicaid beneficiaries age 21 and over)	 1-855-702-6262 1-800-685-0143 1-888-756-0004 1-888-756-0004	
EDI Technical Support Hotline	1-866-428-7419	
Change Healthcare: • EDI and ERA • EFT **NOTE**: Providers can **now** submit electronic attachments (**275 transactions**) using: • Payer name: AmeriHealth Caritas Louisiana • Payor ID: 27357 Refer to our Claims Filing Instructions manual for more details.	 1-877-363-3666 1-866-506-2830	
Medical Necessity Appeals (Pre-Service)	1-888-913-0362	1-888-987-5830
Member Services	1-888-756-0004	
NaviNet www.navinet.net (Provider portal) **NOTE:** Claim reconsiderations (1st level disputes), claim appeals (2nd level disputes), independent review reconsiderations, complaints and appeals on behalf of the member (medical necessity denials pre-claim) can **now** be submitted via NaviNet.	1-888-482-8057	
Non-Emergency Medical and Behavioral Health Transportation-Verida Provider Transportation Line	1-888-913-0364	
Nurse Call Line for enrollees (Available 24/7)	1-888-632-0009	

Pharmacy Benefits Provider Services- PerformRx℠ -**Termination date 10/27/23**	1-800-684-5502	1-855-452-9131
Pharmacy Benefits Member Services -PerformRx -**Termination date 10/27/23**	1-866-452-1040 1-855-294-7047 TTY	
Pharmacy Benefits Manager -Prime Therapeutics	1-800-424-1664	1-800-424-7402 (for prescription drug prior authorization requests)
Provider Network Management (Contracting)	1-877-588-2248	1-225-300-9126
Provider Services	1-888-922-0007	1-866-426-7393
Radiology Utilization Management for AmeriHealth Caritas Louisiana (National Imaging Associates -NIA)	1-800-424-4897	
Rapid Response (Care coordination, case management, EPSDT, member outreach, referrals, appointment scheduling and transportation assistance)	1-888-643-0005	
Utilization Management (Prior authorizations, concurrent review, discharge planning, delivery notification)	1-888-913-0350	1-866-397-4522
Vision Benefits	1-888-922-0007	

MEDICAID PROGRAM OVERVIEW

Medicaid provides medical coverage to eligible, low-income children, families, and adults, seniors, persons with disabilities and pregnant women. The state and federal governments share the costs of the Medicaid program. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare & Medicaid Services (CMS). Medicaid services in Louisiana are administered by the Louisiana Department of Health (LDH). For more information about Louisiana Medicaid covered services, visit LDH's website at: https://www.ldh.la.gov/page/medicaid-services.

AmeriHealth Caritas Family of Companies is one of the largest organizations of Medicaid managed care plans in the United States. We are proud to partner with the Louisiana Department of Health (LDH) under the Healthy Louisiana program to provide healthcare for Louisiana's most vulnerable residents. By offering Medicaid coordinated care in Louisiana, we are building and growing our vision and mission to lead in the provision of health care services to the underserved.

Our coordinated care approach, leading technology solutions, and innovative community outreach programs enable our enrollees to achieve healthier lives. Working with dedicated health care providers, our programs offer improved outcomes for our enrollees and help build healthy communities.

SECTION I: MEMBER ELIGIBILITY

Enrollment Process

Once LDH determines that an individual is an eligible Medicaid beneficiary, an Enrollment Specialist assists the beneficiary with the selection of a Plan. AmeriHealth Caritas Louisiana is informed daily of eligible beneficiaries who have selected AmeriHealth Caritas Louisiana as their plan. If the beneficiary does not select a plan, he/she is auto assigned to a plan. The enrollee is assigned an effective date by the state and this information is transmitted in the enrollment broker file.

During the enrollment process, enrollees work with the enrollment broker to choose an AmeriHealth Caritas Louisiana PCP. If the enrollee does not select a PCP at the time of enrollment or within 15 calendar days of enrollment, the following AmeriHealth Caritas Louisiana process is used to ensure the enrollee is assigned to a PCP:

- Identify the most recent PCP utilized by the enrollee and determine whether that PCP is in the AmeriHealth Caritas Louisiana Network;
- Identify a PCP in the network used by another AmeriHealth Caritas Louisiana enrollee in same family. If appropriate, AmeriHealth Caritas Louisiana assigns the enrollee to that PCP; or
- If neither of these options are appropriate, AmeriHealth Caritas Louisiana selects a PCP from or close to the enrollee's zip code.

Enrollees can choose a different PCP at any time by calling Member Services at 1-888-756-0004.

The above process activates the release of an AmeriHealth Caritas Louisiana ID card and a Welcome Package to the enrollee. Enrollees are encouraged to always keep the ID card with them.

The AmeriHealth Caritas Louisiana (ACLA) Identification (ID) Card includes the following information:

- **Top left:** ACLA logo
- **Top right:** ACLA PO Box address and ACLA website
- **Left side**:
    - Always carry your AmeriHealth Caritas Louisiana card. You'll need it to get your benefits.
    - Go to your AmeriHealth Caritas Louisiana primary care practitioner (PCP) for medical care.
    - Emergency room: Go to an emergency room near you when you believe your medical condition may be an emergency. If you get emergency care, please notify your PCP.
    - Out-of-area care: Report out-of-area care to AmeriHealth Caritas Louisiana and your PCP within 48 hours.
    - Nonemergency medical transport (NEMT):
    - For transportation services, call 1-888-913-0364.
- **Right side:**
    - Member Services and filing grievances or appeals
      1-888-756-0004 or TTY 1-866-428-7588
    - Provider Services and prior authorization
      1-888-922-0007
    - Report Medicaid fraud
      1-800-488-2917
    - To speak with a nurse anytime
      1-888-632-0009
    - 24-hour Mental Health and Substance Use Crisis Line
      1-844-211-0971
    - Pharmacy Member and Provider Services
      1-800-424-1664
    - AmeriHealth Caritas Louisiana Claims Processing

P.O. Box 7322
London, KY 40742

Verifying Eligibility

Each network provider is responsible for determining an enrollee's eligibility with AmeriHealth Caritas Louisiana before providing services.

Verification of eligibility consists of a few simple steps:

- As a first step, all Providers should ask to see the enrollee's AmeriHealth Caritas Louisiana Identification Card along with a picture ID. The picture ID is used to verify the person presenting the ID card is the same as the person named on the ID Card. Services may be refused if the provider suspects the presenting person is not the card owner and no other ID can be provided. Please report such occurrences to AmeriHealth Caritas Louisiana Fraud and Abuse Hotline at 1-866-833-9718.
- It is important to note that AmeriHealth Caritas Louisiana ID cards are not dated and do not need to be returned to AmeriHealth Caritas Louisiana should the enrollee lose eligibility. Therefore, a card itself does not indicate a person is currently enrolled with AmeriHealth Caritas Louisiana.

Since a card alone does not verify that a person is currently enrolled in AmeriHealth Caritas Louisiana, it is critical to verify eligibility through any of the following methods:

1. NaviNet - This free, easy to use web-based application provides real-time current and past eligibility status and eliminates the need for phone calls to AmeriHealth Caritas Louisiana. For more information or to sign up for access to NaviNet visit: https://navinet.navimedix.com/Main.asp.
2. Louisiana Department of Health https://www.lamedicaid.com/provweb1/default.htm.
3. Louisiana Medicaid REVS Telephone Line: 1-800-776-6323. The 7-digit Louisiana Medicaid provider number or the 10-digit NPI number must be entered to begin the eligibility verification process.
4. AmeriHealth Caritas Louisiana's Automated Eligibility Hotline 24 hours/7 days a week, 1-888-922-0007.
    - Provides immediate real-time eligibility status with no holding to speak to a representative.
    - Verify an enrollee's coverage with AmeriHealth Caritas Louisiana by their AmeriHealth Caritas Louisiana identification number, Social Security Number, name, birth date or Medicaid Identification Number.
    - Obtain the name and phone number of the enrollee's PCP.

Panel/Linkages List

AmeriHealth Caritas Louisiana does not print and mail the panel listings. The panel listing is available through our secure provider portal, NaviNet, at www.navinet.net. However, if your practice is not set up with NaviNet or you need help accessing the monthly panel report, please contact your Account Executive with questions or to schedule training.

SECTION II: PROVIDER OFFICE STANDARDS AND REQUIREMENTS

Provider Enrollment in the Louisiana Medicaid Provider Enrollment Portal

Louisiana Medicaid launched its Medicaid Provider Enrollment Rebaseline at the end of October 2024, with future rebaselines for new providers occurring every two months thereafter.

Rebaseline means new managed care organization (MCO) credentialed providers that have not enrolled with Louisiana Medicaid will receive an invitation letter to enroll through the web portal. The invitation letter will provide specific provider information along with detailed instructions needed for the enrollment process.

Providers that receive an enrollment invitation letter must enroll with Louisiana Medicaid to avoid impacts to claims processing. This includes admitting, ordering, referring and prescribing providers and out of state providers that have billed Louisiana Medicaid.

Providers with multiple provider types must complete an enrollment for each type.

Providers will have 120 days to complete an enrollment and must allow several weeks for application processing. Providers that have not completed enrollment within 120 days of receiving the enrollment invitation letter will result in denied claims and deactivation from the Louisiana Medicaid program.

Providers that are unsure of their enrollment status or that want to check the status their application may use the Provider Portal Enrollment Lookup Tool at https://www.lamedicaid.com/portalenrollmentstatus/search.

Results will show the provider's status as either enrollment complete, action required, application not submitted, or currently in process by Gainwell Technologies.

Providers that are not shown in the results are not required to enroll at this time.

Invitation letters for those providers will be sent at a later date.

Provider Resources

- For additional information, including frequently asked questions, recorded webinar presentations and manuals containing the individual and facility enrollment process, provider account registration and previous Louisiana Medicaid Enrollment notifications, visit www.ldh.la.gov/medicaidproviderenrollment.

- Providers needing assistance with enrollment should contact Gainwell Technologies by emailing louisianaprovenroll@gainwelltechnologies.com or contacting 1 (833) 641-2140.

Provider Responsibilities

This section provides information for maintaining network privileges and sets forth expectations and guidelines for PCPs, Specialists and Facility providers.

In general, the responsibilities, expectations and processes outlined in the Provider Manual pertain to all providers, including but not limited to behavioral health providers, unless otherwise indicated. For questions or for more information, please contact AmeriHealth Caritas Louisiana's Provider Services at **1-888-922-0007**.

All providers who participate in AmeriHealth Caritas Louisiana have responsibilities, including but not limited to the following:

- Managing and coordinating the medical and behavioral health care needs of enrollees to ensure that all medically necessary services are made available in a timely manner;
- Referring patients to specialists or subspecialists and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;
- Communicating with all other levels of medical care to coordinate, and follow up the care of individual patients;
- Providing the coordination necessary for the referral of patients to specialists or subspecialists;
- Maintaining a medical record of all services rendered by the PCP and a record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;
- Development of plans of care to address risks and medical needs and other responsibilities as defined in this section;
- Ensuring that in the process of coordinating care, each Enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 and all State statutes. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information;
- Providing after-hours availability to patients who need medical advice. At a minimum, the PCP office shall have a return call system staffed and monitored in order to ensure that the Enrollee is connected to a designated medical practitioner within thirty (30) minutes of the call;
- Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at a AmeriHealth Caritas Louisiana participating hospital;
- Working with AmeriHealth Caritas Louisiana case managers to develop plans of care for enrollees receiving case management services;
- Participating in the AmeriHealth Caritas Louisiana's case management team, as applicable and medically necessary; and
- Conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/ ACEs, and substance use, early detection, identification of developmental disorders/delays, social-emotional health, and SDOH to determine whether the enrollee needs behavioral health services.
- To coordinate and cooperate with other service providers who serve Medicaid enrollees such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships, Early Intervention programs, Aging and Disability Councils and Area Councils on Aging and school-based programs, as appropriate.

Providers may not deny to an enrollee any covered service or availability of a facility.

All instructional materials provided to our enrollees emphasize the role of the PCP and recommend they seek advice from their PCP before accessing non-emergency medical care from any other source.

Providers Who Qualify to Serve as PCPs

A PCP is an individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of an enrollee's health care. The primary care provider is the enrollee's point of access for preventive care or an illness and may treat the enrollee directly, refer the enrollee to a specialist (secondary/tertiary care), or admit the enrollee to a hospital.

Your Role as PCP

AmeriHealth Caritas Louisiana understands a good relationship with a PCP is necessary. As a result, AmeriHealth Caritas Louisiana does not lock enrollees into a PCP; they may change PCPs at any time. The PCP serves as the enrollee's initial and most important point of interaction with ACLA's provider network. A PCP shall be an individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of an enrollee's health care. The PCP is the enrollee's point of access for preventive care or an illness and may treat the enrollee directly, refer the enrollee to a specialist (secondary/tertiary care) or admit the enrollee to a hospital.

- PCPs should provide the level of care and range of services necessary to meet the medical needs of its enrollees, including those with special needs and chronic conditions.
- PCPs should monitor and follow-up on care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid FFS.
- PCPs should maintain a medical record of all services rendered by the PCP and other specialty providers.
- PCPs should coordinate case management services including, but not limited to, performing screening and assessment, developing a plan of care to address risks and medical needs and basic behavioral health services such as screening, prevention, early intervention, and medication management.
- PCPs should coordinate the services AmeriHealth Caritas Louisiana furnishes to the enrollee with the services the enrollee receives from any another plan during transition of care.
- PCPs should share the results of identification and assessment of any enrollee with Special Health Care Needs (SHCN), defined as individuals of any age with mental disabilities, physical disabilities, or other circumstances that place their health and ability to fully function in society at risk requiring individualized health care approaches, with another MCO to which an enrollee may be transitioning or has transitioned so that those activities need not be duplicated.
- PCPs should ensure that in the process of coordinating care, each enrollee's privacy is protected.
- PCPs are to contact all new panel enrollees for an initial appointment. AmeriHealth Caritas Louisiana has Special Needs and Care Management Programs that contact enrollees with the following conditions:
    - Pregnant enrollees
    - Enrollees with chronic conditions, including but not limited to:
        - Asthma
        - Diabetes
        - COPD
        - Heart Failure
        - Sickle Cell Disease.
- Providers that provide EPSDT well child preventative screenings must be enrolled in the VFC program and utilize VFC vaccines for enrollees aged birth through 18 years of age. Providers can obtain a VFC enrollment packet by calling the Office of Public Health's (OPH) Immunization Section at 1-504-568-2600.
- PCPs must inform AmeriHealth Caritas Louisiana if he/she learns that an enrollee is pregnant so they can be included in the AmeriHealth Caritas Louisiana maternity program. Please call 1-888-913-0327 to refer an enrollee to the AmeriHealth Caritas Louisiana Bright Start (Maternity) Program and/or for assistance in locating an OB/GYN practitioner.
- Office hours for availability must be 24 hours per week.

- Enrollee medical records must be maintained in an area that is not accessible to those not employed by the practice. Network providers must comply with all applicable laws and regulations pertaining to the confidentiality of enrollee, including, obtaining any required written enrollee consents to disclose confidential medical records.
- If an enrollee changes PCPs or MCO plans, the PCP forwards a copy of the enrollee's medical record and supporting documentation to the new PCP within ten (10) business days of the receiving PCPs request.
- PCPs are prohibited from making referrals to healthcare entities with which, they or an enrollee of their family has a financial relationship.
- PCPs must comply with all cultural competency standards. This includes offering language assistance to individuals who have limited English proficiency, hearing impairment, and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. AmeriHealth Caritas Louisiana offers Language Access Services for use by providers with enrollees in need of these services.
- PCP office hours must be clearly posted and reviewed with enrollees during the initial office visit.

Finding a Specialist

AmeriHealth Caritas Louisiana recognizes the importance of adequate access to healthcare providers and continues to place provider access monitoring and maintenance as one of its highest priorities. To assist providers in finding specialist to refer their member to, AmeriHealth Caritas Louisiana has developed a “Finding a Specialist” dedicated email account. Providers can email request at SpecialistsInquiries@amerihealthcaritas.com.

Providers are expected to make a reasonable attempt to locate the appropriate specialist. Our email account is staffed by knowledgeable provider network staff to assist providers when a specialist may not be easily located. Except for emergency cases, the normal turnaround will be within three business days.

Patient-Centered Medical Home

AmeriHealth Caritas Louisiana appreciates the tremendous commitment and progress the State of Louisiana has invested towards the establishment of Patient-Centered Medical Homes. AmeriHealth Caritas Louisiana shares the same goals and commitment and wants to work with our PCPs to help them receive Patient-Centered Medical Home certification through NCQA or JCAHO. Through this commitment, we support and encourage efforts to monitor, track and improve the quality of the care provided to patients.

The Medical Home Concept is:

- An approach to providing comprehensive primary care
- Taking personal responsibility and accountability for the on-going care of patients
- Physicians accessibility to their patients on short notice (expanded hours and open scheduling)
- Physicians able to conduct consultations through email and telephone
- Utilizing the latest health information technology and evidence-based medical approaches as well as maintaining updated electronic personal health records
- Conducting regular check-ups with patients to assist in identifying health crises, and initiating treatment/prevention measures before costly, last minute emergency procedures are required
- Advising patients on preventive care based on environmental and genetic risk factors they face
- Helping patients make healthy lifestyle decisions
- Referring enrollees to medically necessary specialty or sub-specialty care
- Coordinating care, when needed, such as helping enrollees get procedures that are relevant, necessary and performed efficiently.

Access and Communication

Programs to assist providers in this area:

- Transportation assistance and coordination,
- Provider Claims Service Contact Center for assistance with claims is available Monday-Friday from 7:00 am – 6:00 pm (CST),
- Provider Services Contact Center for any other calls not related to claims assistance is available 24/7,
- AmeriHealth Caritas Louisiana Provider Services can be reached at 1-888-922-0007,
- Multi-cultural health information available online,
- Handbooks and website in multiple languages, and
- Translation and interpreter assistance.

Access Standards for PCPs*

AmeriHealth Caritas Louisiana has established standards for accessibility of medical care services. The standards apply to PCPs and are requirements of the PCP contract.

Appointment Accessibility Standards

Medical Care	Access Standard
Emergency care	24 hours, 7 days/week within 1 hour of request
Urgent non-emergency care	24 hours, 7 days/week within 24 hours of request
Non-urgent sick primary care	72 hours
Non-urgent routine primary care	6 weeks
After hours, by phone	Answered by live person or call-back from a designated medical practitioner within 30 minutes
OB/GYN care for pregnancy women	1st Trimester 14 days; 2nd Trimester 7 days; 3rd Trimester 3 days; High risk pregnancy, any trimester 3 days
Family planning appointments	1 week
Specialist appointments	1 month
Scheduled appointments	Less than a 45-minute wait in office
Non-urgent routine behavioral health care	14 days
Urgent non-emergency behavioral care	48 hours
Psychiatric inpatient hospital (emergency involuntary)	4 hours
Psychiatric inpatient hospital (involuntary)	24 hours
Psychiatric inpatient hospital (voluntary)	24 hours
ASAM Level 3.3, 3.5 and 3.7	10 business days
Residential withdrawal management	24 hours when medically necessary
Psychiatric Residential Treatment Facility (PRTF)	20 calendar days

After Hours Accessibility Standards

Medical Care	Access Standard
After-Hours Care by a PCP or a Covering PCP must be available *	24 hours/7 days a week

*When the PCP uses an answering service or answering machine to intake calls after normal business hours, the call must be answered by ten (10) rings and must be returned by a clinical provider within 30 minutes. If the PCP's office telephone is answered after normal business hours by a recording directing the enrollee to call another number to reach the PCP or another provider designated by the PCP, someone must be available to answer the designated provider's telephone. Another recording is not acceptable.

- If the PCP's office telephone is transferred after office hours to another location where someone answers the telephone, they must be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

- It is not acceptable to have a message on an answering machine that instructs the enrollee to go to the emergency room for care without providing instructions on how to reach the PCP.

The following information must be included in the message:

1. Instructions for reaching the provider.
2. Instructions for obtaining emergency care.

Enrollee Reassignment Policy

The PCP shall serve as the enrollee's initial and most important point of interaction within the AmeriHealth Caritas Louisiana's provider network. A PCP in the Plan's network must be a provider who provides or arranges for the delivery of medical services, including case management, to assure that all medically necessary services are made available in a timely manner.

In an effort to promote accountability for the quality of care of our enrollees, the Plan assigns enrollees at the individual PCP level.

The Plan shall perform claims analysis on a quarterly basis and based on the previous 12 months (at minimum) of claims history, including wellness visits and sick visits.

Reassignment

An enrollee will be eligible for reassignment if they have been assigned to a current PCP for at least 90 days, as follows:

- If the enrollee has seen an unassigned PCP within the same tax ID number (TIN) as the assigned PCP, the enrollee will not be reassigned.
- If an enrollee has not seen the assigned PCP and has seen multiple unassigned PCPs, the enrollee will be assigned to the PCP with the most visits.

- If the enrollee has the same number of visits with multiple unassigned PCPs, the enrollee will be assigned to the most recently visited PCP.

- If the enrollee has an established relationship, defined by at least one claim within the previous 12 months, with an unassigned PCP, the Plan will reassign that enrollee appropriately, even if the unassigned PCP's panel shows that it is closed. The enrollee-PCP relationship takes priority over a closed panel.
- An enrollee will also be eligible for reassignment to another PCP under the following conditions:
  - ❖ If they have not visited any PCP within the previous 12 months. ϖ
  - ❖ If they are under 4 years of age and have not visited a PCP within the previous 6 months.
  - ❖ If they have not visited a PCP within 6 months of giving birth
- Once enrollee reassignment is completed, provider must make a good faith effort to outreach enrollee and establish PCP relationship. A good faith effort includes but is not limited to:
  - Three outreaches to enrollee with no response.
  - Documentation of three outreaches and request for disenrollment must be sent to PCP assignment PCPassignment@amerihealthcaritas.com.

- All reassignments shall be prospective. An enrollee who has been reassigned may be transferred to another PCP upon enrollee request.

Month 1 of each quarter

- 15th of the month – AmeriHealth Caritas Louisiana will begin claims analysis on the previous 12 months of PCP wellness visits and PCP sick visits claims history and identify Enrollees eligible for reassignment.

Month 2 of each quarter

- 15th of the month – AmeriHealth Caritas Louisiana will send panel analysis results to providers for review via portal. If the due date falls on a weekend or a State-recognized holiday, the results will be published on the next business day.
- A provider alert will be sent notifying providers the report has been posted to the portal to ensure they are informed of any potential reassignment changes. The alert will also include a link on our website to the Navinet User Training Guide.
- The results shall identify all enrollees eligible for reassignment from the PCP along with enrollees eligible for reassignment to the PCP. Enrollees identified as eligible for reassignment to the PCP shall be shared as informational only considering this data is subject to change via the dispute protocol below.
  - o The results of the analysis shall be published in a format that is able to be downloaded/exported into Excel.
- The PCP shall have 15 business days to review before any enrollees are reassigned.

Month 3 of each quarter

- 16th business day of the month – The Plan will review any received provider responses and begin the reassignment process.
- At the completion of the reassignment process, the Plan will send new PCP information to enrollees and updated panel rosters to providers.

Provider Notification of Enrollee Reassignment

The Plan will publish the results of the claims analysis to the provider portal on the 15th calendar day of the second month of each quarter. If the due date falls on a weekend or a State-recognized holiday, the results will be published on the next business day.

The results shall identify all enrollees eligible for reassignment from the PCP along with enrollees eligible for reassignment to the PCP. Enrollees identified as eligible for reassignment to the PCP shall be shared as informational only considering this data is subject to change via the dispute protocol below.

The results of the analysis shall be published in a format that is able to be downloaded/exported into Excel.

Providers who disagree with the Plan's data analysis must provide documentation (medical record, proof of billed claim) within 15 business days that they have seen the enrollee within the last rolling 12 months.

Disputes may be submitted to PCP assignment at.
If a provider does not respond, the Plan will begin reassignment process.

The Provider Network Management Department will notify both the enrollee via letter notification and relinquishing PCP via panel roster of enrollee reassignment.

On-Going Reporting

Following the assignment process, the panel roster report is generated and available within the Plan's provider portal, NAVINET, and refreshed on the 15th of each month.

PCP Panel Roster Report

The summary report provides the summary of enrollees assigned to the PCP's panel.

Enrollees re-assigned to a new primary care provider will be denoted by an electronic indicator in the panel roster under the "New Enrollee" column.

Enrollees auto-assigned to a primary care provider will be denoted by an electronic indicator in the panel roster under the "auto-assigned" column.

The summary report can be pulled via PDF or Excel or CSV, which can be filtered and/or sorted per the provider's preference.

Provider Requested Review of Panel for Reassignment

By written request, a primary care provider may request a review of their current plan enrollee linkages outside of the quarterly re-assignment process to ensure the most effective relationship with his or her linked enrollees.

A written request on your letterhead asking for the removal of the enrollee from your panel must be sent to the Plan's Provider Network Management team and must include the following:

- The group name, applicable practitioner and AmeriHealth Caritas Louisiana provider identification number, and practice location for which they are requesting review (if multi-site groups)
- The requesting PCP's signature

Provider will receive an automatic acknowledgment of plan receipt of request. A comprehensive review of Enrollee panel to include claims/data mining will be accomplished within 30 days of receipt of the written request, during which time the PCP must continue to render services to assigned panel.

Following review, the Provider Network Management Department shall contact the provider to discuss the findings and timeframes associated with addition of new enrollees to panel, if applicable. The Plan will notify the enrollee of the new PCP assignment and when the transfer is effective, as applicable.

Requests for panel review outside of quarterly algorithm should be directed to PCPAssignment@amerihealthcaritas.com.

Transfer of Non-Compliant/Compliant Enrollees (PCP or Enrollee Request)

AmeriHealth Caritas Louisiana's goal is to accomplish the uninterrupted transfer of care for an enrollee who cannot maintain an effective relationship with his/her PCP.

PCP transfers can be requested as follows:

- By PCP request, any enrollee whose behavior would preclude delivery of optimum medical care may be transferred from the PCP's panel, or
- By enrollee request.

A written request on your letterhead asking for the removal of the enrollee from your panel must be sent to:

AmeriHealth Caritas Louisiana
Provider Network Management Department
P.O. Box 83580
Baton Rouge, LA 70884

Or email to network@amerihealthcaritasla.com

The request must include the following:

- The enrollee's full name and AmeriHealth Caritas Louisiana enrollee identification number.
- The reason(s) for the requested PCP transfer: (To ensure that AmeriHealth Caritas Louisiana enrollees are not subject to discriminatory practices, such as separate waiting rooms or separate appointment days. Enrollees must be provided all covered services without regard to race, color, religion, sex, age, national origin, ancestry, nationality, creed, citizenship, alienage, marital or domestic partnership or civil union status, affectional or sexual orientation, physical, cognitive or mental disability, veteran status, whistleblower status, gender identity and/or expression, genetic information, health status, pre-existing condition, income status, source of payment, program memberships or physical or behavioral disability, except where medically indicated, or any other characteristic protected under federal, state, or local law.)
- The requesting PCP's signature and AmeriHealth Caritas Louisiana provider identification number.

Enrollee/Provider staff conflict issues are reviewed on a case-by-case manner. Providers may not deny an enrollee any covered service or availability of a facility.

Providers receive an automatic acknowledgment of plan receipt of request. The Plan reviews the request, determines action, and sends the provider a resolution letter. If approved for transfer, transfer will be accomplished within 30 days of receipt of the written request, during which time the PCP must continue to render any needed care.

The Provider Network Management Department assigns the enrollee to a new PCP and notifies in a letter both the enrollee and requesting PCP when the transfer is effective. Requests for transfer of non-compliant enrollees should be directed to PCPAssignment@amerihealthcaritas.com.

PCP Requesting a Freeze or Limitation of Your Enrollee Linkages

AmeriHealth Caritas Louisiana recognizes that a PCP occasionally needs to limit the volume of patients in his/her practice in the interest of delivering quality care. Each PCP office must accept at least 50 enrollees but may specify after 50, the number of enrollees/PCP linkages they will accept from AmeriHealth Caritas Louisiana. Our system automatically closes the PCP Panel once a PCP has reached the specified number of linkages. A PCP may also forward a request to limit or stop assignment of enrollees to his/her panel if his/her circumstances change.

Providers may contact the Provider Network Management Department to freeze or limit their enrollee linkages, by written request and must include the following:

- The Group name, applicable practitioner and AmeriHealth Caritas Louisiana provider identification number. Practice location for which they are requesting review (if multi-site groups)
- Limitation requested and the requesting PCP's signature
- The Group name, applicable practitioner and AmeriHealth Caritas Louisiana provider identification number. Practice location for which they are requesting review (if multi-site groups)
- The requesting PCP's signature

Provider requests to freeze or limit enrollee assignment should be directed to PCPAssignment@amerihealthcaritas.com.

Providers receive an automatic acknowledgment of plan receipt of request. The Plan reviews requests and sends the provider a resolution letter. Freeze/panel limitation is accomplished within 30 days of receipt of the written request, during which time the PCP must continue to render any needed care to assignment membership.

Provider Office Standards

Physical Environment

The following are examples of standards that must be met for AmeriHealth Caritas of Louisiana network participation:

1. Office must be wheelchair accessible/ADA compliant
2. Office must have visible signage
3. Office hours must be posted
4. Office must be clean and presentable
5. Office must have a waiting room with chairs

6. Office must have an adequate number of staff/personnel to handle patient load, with an assistant available for specialized procedures
7. Office must have at least two examination rooms that allow for patient privacy
8. Office must have the following equipment:
    - Examination table
    - Otoscope
    - Ophthalmoscope
    - Sphygmomanometer
    - Thermometers
    - Needle disposal system
    - Accessible sink/hand washing facilities
    - Bio-hazard disposal system

AmeriHealth Caritas of Louisiana Site Review Standards	
Category	**Description**
Physical Accessibility	Handicap parking is clearly designated Facility is wheelchair accessible/ADA compliant externally and internally All exits are clearly labeled and free of obstruction
Appearance and Cleanliness	Interior surroundings are clean; carpet and tile are secure Public areas are free from food, beverages and food containers Public areas are free from personnel belongings Office hours are clearly posted
Adequacy of Waiting Area	Waiting room is well lit Waiting room has adequate patient seating (i.e., seating accommodates 3-4 patients per practitioner per hour) Furniture is clean, secure and free of rips and tears Patient registration ensures confidentiality
Adequacy of Exam Rooms	Exam room is well lit and has adequate space for patient scheduling (i.e., at least two available exam rooms for each provider; each exam room can accommodate 3-4 patients per hour) Exam room ensures patient privacy and confidentiality Trash containers have appropriate liners (i.e., red for regulated waste) Sharp containers are present and not overfilled Exam room, table and equipment are clean, secure and free of rips and tears.

Americans with Disabilities Act (ADA)

Americans with Disabilities Act of 1990 (ADA) – 42 U.S.C. §12101-12213, as amended by the ADA Amendments of 2008, P.L. 110-325, prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. The ADA also establishes requirements for telecommunications relay services.

For more information, you can go to the Department of Justice's ADA Home Page: https://www.ada.gov/

Mainstreaming and Enrollee Access

AmeriHealth Caritas Louisiana requires all providers to accept enrollees for treatment and not intentionally segregate enrollees in any way from other persons receiving services. AmeriHealth Caritas Louisiana shall ensure that providers do not exclude treatment or placement of enrollees for authorized behavioral health services solely based on state agency (DCFS or OJJ, etc.) involvement or referral.

AmeriHealth Caritas Louisiana monitors compliance and accessibility standards so that enrollees are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to the following:

- Denying or not providing to an enrollee any covered service or availability of a facility.
- Providing to an enrollee any covered service which is different, or is provided in a different manner, or at a different time from that provided to other enrollees, other public or private patients, or the public at large.
- Discriminatory practices regarding Healthy Louisiana enrollees such as separate waiting rooms, separate appointment days, separate physical locations, or preference to private pay or Medicaid fee-for-service patients.

When AmeriHealth Caritas Louisiana becomes aware of a provider's failure to comply with mainstreaming, AmeriHealth Caritas Louisiana works with the provider to develop a written plan for coming into compliance within thirty (30) calendar days and notifies the Louisiana Department of Health in writing.

Provider Monitoring Access

AmeriHealth Caritas Louisiana monitors appointment waiting times using various mechanisms, including:

- Reviewing provider records during site reviews
- Monitoring administrative complaints and grievances
- Conducting an annual *Access to Care* survey to assess enrollee access to daytime appointments and after care
- Performing after-hour calls to verify coverage availability
- Performing "Mystery Shopper" surveys to verify compliance

AmeriHealth Caritas Louisiana monitors compliance with appointment standards in a variety of ways: During visits by your Provider Network Account Executive, monitoring enrollee complaints, telephone surveys, and mystery shopper calls. On an annual basis, AmeriHealth Caritas Louisiana monitors the compliance of all participating PCP Offices against the established Accessibility Standards. The data collected to monitor for compliance include Appointment Access to Data Only, After-Hours Access Data Only, and Appointment Access and After-Hours Access Data. All non-compliant providers are notified of all categories requiring improvement. The non-compliant providers are given a timeline for submitting a corrective action to meet the performance standards.

Reimbursement/Fee-for-Service Payment

AmeriHealth Caritas Louisiana reimburses all contracted providers the rates as described in the network provider's individual AmeriHealth Caritas Louisiana Provider Agreement.

Specialist/Sub-Specialist Services

Specialists and Sub-specialists shall provide Medically Necessary covered services to AmeriHealth Caritas Louisiana enrollees referred by the enrollee's PCP. These services include:

- Ambulatory care visits and office procedures
- Arrangement or provision of inpatient medical care at an AmeriHealth Caritas Louisiana participating hospital
- Consultative Specialty Care Services 24 hours a day, 7 days a week

Specialist Access and Appointment Standards

The office waiting time should be no more than 45 minutes (including time in the waiting room and examining room), or no more than one (1) hour when the network provider encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. If a provider is delayed, patients must be notified immediately. If the wait is over ninety (90) minutes, the patient must be offered a new appointment. Scheduling procedures should ensure:

- Emergency appointments immediately upon request
- Urgent Care appointments within twenty-four (24) hours of request
- Routine appointments within one month of the request
- Non urgent Lab and diagnostic (x-ray) within three weeks
- Urgent lab and diagnostic (x-ray) within forty-eight (48) hours
- Family Planning visits within one (1) week of request

If an enrollee presents to the Specialist in need of emergency behavioral health services the provider shall: (a) instruct the enrollee to seek help from the nearest emergency medical provider by calling 911, and (b) contact Member Services at 1-888-756-0004, 24 hours a day, 7 days a week.

Access Standards for OB/GYNs

AmeriHealth Caritas Louisiana has established standards to assure accessibility of medical care services. The standards apply to OB/GYNs.

Initial Examination for Enrollees	Appointment Scheduled with an OB/GYN Practitioner
Pregnant women in their 1st trimester	Within 14 business days of AmeriHealth Caritas Louisiana learning the enrollee is pregnant
Pregnant women in their 2nd trimester	Within 7 business days of AmeriHealth Caritas Louisiana learning the enrollee is pregnant
Pregnant women in their 3rd trimester	Within 3 business days of AmeriHealth Caritas Louisiana learning the enrollee is pregnant
High risk-pregnant women	Within 3 days of AmeriHealth Caritas Louisiana learning the enrollee is high risk or immediately if an Emergency Medical Condition exists.

PCP and Specialist Medical Record Requirements

Providers must follow the medical record standards outlined below, for each enrollee's medical record, as appropriate:

- Maintain accurate and legible records
- Safeguard against loss, destruction, or unauthorized use and maintain in an organized fashion, for all enrollees evaluated or treated, and records are accessible for review and audit
- Ensure records provide medical and other clinical data required for Quality and Utilization Management review
- Medical records should include, minimally, the following:
    - Enrollee identifying information including name, identification number, date of birth, sex and legal guardianship (if applicable)
    - Primary language spoken by the enrollee and any translation needs of the enrollee
    - Services provided through the Plan, date of service, service site, and name of provider
    - Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or
    - dispensed, beginning with, at a minimum, the first enrollee visit
    - Enrollees who are prescribed a controlled substance must have a patient specific query completed through the Prescription Monitoring Program (PMP). This should be completed upon writing the first prescription and annually. Additional queries can be performed at the prescriber's discretion. All PMP queries should be printed and filed in the enrollee's medical record
    - Referral information including follow-up and outcome of referral
    - Documentation of emergency and/or after-hours encounters and follow-up;
    - Signed and dated consent forms (as applicable)
    - Documentation of immunization status
    - Documentation of advance directives, as appropriate
- Documentation of each visit must include:
    - Date and begin and end times of service
    - Chief complaint or purpose of the visit
    - Diagnoses or medical impression
    - Objective findings
    - Patient assessment findings
    - Studies ordered an results of those studies (e.g., laboratory, x-ray, EKG)
    - Medications prescribed
    - Health education provided
    - Name and credentials of the provider rendering services (e.g., MD, DO, OD) and the signature or initials of the provider; and initials of providers must be identified with correlating signatures

Components of EPSDT preventive medical screenings include but are not limited to:

- Comprehensive health history and developmental history (including assessment of both physical and mental health and development)
- Comprehensive unclothed physical exam or assessment
- Appropriate immunizations according to age and health history (unless medically contraindicated or parents/guardians refuse at the time)
- Lab testing (including age-appropriate screenings for newborns, iron deficiency anemia, blood lead levels, dyslipidemia, and sexually transmitted infections); and
- Health education and anticipatory guidance

- Blood lead levels and iron deficiency anemia components of the preventive medical screening must be provided on-site on the same date of service as the screening visit.

Providers must maintain medical records for a period not less than 10 years from the close of the Network Provider Agreement and retained further if the records are under review or audit until the audit or review is complete.

PCP and Specialist Cultural and Linguistic Requirements

Section 601 of Title VI of the Civil Rights Act of 1964 states that:

No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance. Providers shall deliver services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the enrollee's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2).

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

As a provider of health care services who receives federal financial payment through the Medicaid program, you are responsible for making arrangements for language services for enrollees who are either Limited English Proficient (LEP) or Low Literacy Proficient (LLP) to facilitate the provision of health care services to such enrollees.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/health care provider relationship. The key to equal access to benefits and services for LEP, LLP and sensory-impaired enrollees is to make sure that our Network Providers can effectively communicate with these enrollees**.** Plan providers are obligated to offer translation services to LEP and LLP enrollees, and to make reasonable efforts to accommodate enrollees with other sensory impairments.

Providers are required to:

Provide written and oral language assistance at no cost to Plan enrollees with limited- English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request.

Upon request, provide enrollees verbal or written notice, in their preferred language or format, about their right to receive free language assistance services; Post and offer easy-to-read enrollee signage and materials in the languages of the common cultural groups in your service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats upon request.

Note: The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where an enrollee has been made aware of his/her right to receive free interpretation and continues to insist on using a friend, family enrollee, or bilingual staff for assistance in his/her preferred language.

Enrollees should be advised that translation services from AmeriHealth Caritas Louisiana are available. When an enrollee uses AmeriHealth Caritas Louisiana translation services, the provider must sign, date and complete documentation of the services provided in the medical record in a timely manner.

Health care providers who are unable to arrange for translation services for an LEP, LLP or sensory impaired enrollee should contact AmeriHealth Caritas Louisiana Member Services department at 1-888-756-0004 and a representative will help locate a professional interpreter that communicates in the enrollee's primary language. AmeriHealth Caritas Louisiana contracts with a competent telephonic interpreter service provider. These services are also available face-to-face at the physician's office at the time of the enrollee's visit. If you need more information on using the telephonic interpreter service or face-to-face services, please visit our website at www.amerihealthcaritasla.com or contact the Plan's Member Services department.

Additionally, under the Culturally Linguistically Appropriate Standards (CLAS) of the Office of Minority Health, Plan providers are strongly encouraged to:

- Provide effective, understandable, and respectful care to all enrollees in a manner compatible with the enrollee's cultural health beliefs and practices of preferred language/format;
- Implement strategies to recruit, retain and promote a diverse office staff and organizational leadership representative of the demographics in your service area;
- Educate and train staff at all levels, and across all disciplines, in the delivery of culturally and linguistically appropriate services;
- Establish written policies to provide interpretive services for AmeriHealth Caritas Louisiana enrollees upon request;
- Document preferred language or format, such as Braille, audio or large type in all enrollee medical records.

AmeriHealth Caritas Louisiana requires all providers to have yearly trainings on cultural competence, including tribal awareness. Providers may meet this requirement by attending an AmeriHealth Caritas Louisiana offered training, or one offered by any other Healthy Louisiana plan or a governmental agency with proof of attendance. Providers are required to obtain a minimum of three (3) hours per year of cultural competence training.

The U.S. Department of Health & Human Services webpage, Think Cultural Health, offers training that meets this requirement, including:

- A Physician's Practical Guide to Culturally Competent Care
- Culturally and Linguistically Appropriate Services (CLAS) in Nursing

Preventive Health Guidelines

AmeriHealth Caritas Louisiana's Preventive Health Guidelines represent current professional standards, supported by scientific evidence and research. They are not intended to interfere with or supersede a Health Care Provider's professional judgment. The Preventive Health Guidelines are now available in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com or you can call your Provider Network Account Executive to request hard copies.

Clinical Practice Guidelines

AmeriHealth Caritas Louisiana has adopted clinical practice guidelines for use in guiding the treatment of AmeriHealth Caritas Louisiana enrollees, with the goal of reducing unnecessary variations in care. AmeriHealth Caritas Louisiana clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual. AmeriHealth Caritas Louisiana's Clinical Practice Guidelines are available online in the Provider section of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com or you may call your Provider Network Account Executive to request a hard copy. In support of the above guidelines, AmeriHealth Caritas Louisiana's Integrated Care Management program is available to assist you in the education and management of your patient with special health needs, chronic diseases or complex conditions. For additional information or to refer an AmeriHealth Caritas Louisiana enrollee for Care Management Services, please call the Rapid Response team at 1-888-643-0005.

Advance Directives

All AmeriHealth Caritas Louisiana providers are required to comply with 42 C.F.R. 489.102 for individuals who are their patients, our enrollees, as defined in 42 C.F.R 489.100. An advance directive is a written instruction, such as a do not resuscitate (DNR) order, living will or declaration, or a durable power of attorney for health care (DPAHC), recognized under Louisiana law, relating to the provision of health care when an individual is incapacitated.

AmeriHealth Caritas Louisiana requires its network providers to maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advanced directives must be furnished by providers as required by Federal regulations:

- Hospital - At the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - At the time of the individual's admission as a resident.
- Home Health Agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient at the time of the first home visit, if the information is furnished before care is provided.
- Personal Care Services - In advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, if the information is furnished before care is provided.
- Hospice Program - At the time of initial receipt of hospice care by the individual from the program.

Providers and/or organizations are not required to:

- Provide care that conflicts with an advance directive.
- Implement an advance directive if, as a matter of conscience,
    a) the provider cannot implement an advance directive; and
    b) the law allows any health care provider or any agent of such provider to conscientiously object.

AmeriHealth Caritas Louisiana provides our enrollees with information about advanced directives via the Member Handbook. The member handbook can be found on our website at www.amerihealthcaritasla.com under Getting Started on the Members tab.

Provider and Subcontractor Requirements

At the time of entry into a contract with AmeriHealth Caritas Louisiana, providers and subcontractors must adhere to enrollees' rights to file grievances and appeals, and request State Fair Hearings as per Section XI of this handbook.

Providers and subcontractors must report loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of receipt of notification, if required to be accredited.

Providers and subcontractors must immediately report cancellation of any required insurance coverage, licensure, or certification to AmeriHealth Caritas Louisiana.

SECTION III: COVERED SERVICES

Covered Services

AmeriHealth Caritas Louisiana enrollees are entitled to all the covered services provided under the Louisiana Medicaid Program. There may be limits or co-payments associated with the services mentioned in this section of the *Provider Manual.*

- **Physical Health Services**
  - Advanced Practice Registered Nurses
  - After Hours Care on Evenings, Weekends, and Holidays
  - Allergy Testing and Allergen Immunotherapy
  - Ambulatory Surgical Services
    - Ambulatory Surgical Centers (ASC) - (Non-Hospital)
    - Ambulatory Surgery - (Outpatient Hospital)
  - Anesthesia
  - Assistant Surgeon/Assistant at Surgery
  - Audiology Services
  - Bariatric Surgery
  - Breast Surgery
  - Cardiovascular Services
  - Chiropractic Services (Ages 0-20)
  - Cochlear Implant (Ages 0-20)
  - Community Health Workers
  - Concurrent Care -Inpatient
  - Corneal Collagen Cross-Linking
  - Dental Services (Medically Necessary in Inpatient or ASC Setting)
  - Diabetes Self-Management Training
  - Diabetic Supplies
  - Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies
  - Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Ages 0-20)
  - Emergency Services
  - End Stage Renal Disease Services
  - Eye Care and Vision Services
  - Family Planning Services
  - Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Services
  - Genetic Counseling and Testing
  - Glasses, Contacts, and Eyewear
  - Gynecology
  - Home Health-Extended Services (Ages 0-20)
  - Home Health Services
  - Hospice Services
  - Hospital Services
    - Inpatient Hospital Services
    - Outpatient Hospital Services
  - Hyperbaric Oxygen Therapy
  - Immunizations/Vaccines
  - “Incident to” Services
  - Intrathecal Baclofen Therapy
  - Laboratory Services

- Limited Abortion Services
- Medical Transportation Services
- Newborn Care and Discharge
- Nursing Facility/Non-Hospital Facility
- Obstetrics
- Organ Transplants
- Pediatric Day Healthcare Services (Ages 0-20)
- Personal Care Services (Ages 0-20)
- Pharmacy Services
- Physician Administered Drugs
- Physician Assistants
- Physician/Professional Services
- Podiatry Services
- Portable Oxygen
- Portable Oxygen Concentrators
- Portable X-Ray Services
- Pregnancy-Related Services
- Preventive Services for Adults (Ages 21 and older)
- Radiology Services
- Routine Care Provided to Enrollees Participating in Clinical Trials
- Sinus Procedures
- Skin Substitutes for Chronic Diabetic Lower Extremity Ulcers
- Sterilization
- Substitute Physician Billing
- Telemedicine/Telehealth
- Therapy Services
- Tobacco Cessation Services
- Transcranial Magnetic Stimulation (TMS)
- Vagus Nerve Stimulators

- **Behavioral Health Services** include:
  - Basic Behavioral Health Services. Services provided through primary care, including, but not limited to, screening for mental health and substance use issues, prevention, early intervention, medication management, and treatment and referral to specialty services.
  - Specialized Behavioral Health Services
    - Licensed Practitioner Outpatient Therapy
      - Parent-Child Interaction Therapy (PCIT)
      - Child Parent Psychotherapy (CPP)
      - Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)
      - Triple P Positive Parenting Program
      - Trauma-Focused Cognitive Behavioral Therapy
      - Eye Movement Desensitization and Reprocessing (EMDR) Therapy
      - Dialectical Behavior Therapy (DBT)
    - Mental Health Rehabilitation Services
      - Community Psychiatric Support and Treatment (CPST)
      - Evidence-Based Programs (EBPs) specialized for high-risk populations, including:
        - Multi-Systemic Therapy (MST) (Ages 0-20)
        - Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare (Ages 0-20)

    - Homebuilders® (Ages 0-20)
    - Assertive Community Treatment (Ages 18 and older)
  - Psychosocial Rehabilitation (PSR)
  - Crisis Intervention
  - Crisis Stabilization for Youth (Ages 0-20)
  - Crisis Response Services:
    - Mobile Crisis Response (MCR) (Ages 21+)
      - Ages 0-20, effective April 1, 2024
    - Community Brief Crisis Support (CBCS) (Ages 21+)
      - Ages 0-20, effective April 1, 2024
    - Behavioral Health Crisis Care (BHCC) (Ages 21+)
    - Crisis Stabilization for Adults (Ages 21+)
- Peer Support Services (Ages 21+)
- Therapeutic Group Homes (TGH) (Ages 0-20)
- Psychiatric Residential Treatment Facilities (PRTF) (Ages 0-20)
- Inpatient Hospitalization (Ages 0-21; 65 and older)
- Inpatient Hospitalization in a District Part Psychiatric Unit, Medication Assisted Treatment
- Freestanding Psychiatric Hospital
- Outpatient, Residential and Inpatient Substance Use Disorder Services
- Opioid Treatment Program (OTPs)
- Behavioral Health Personal Care Services for DOJ Agreement Target Population
- Individual Placement and Support (IPS) Services for DOJ Agreement Target Population

Please refer to the **Section XII: Behavioral Health Addendum** in this manual for more details on covered behavioral health services.

- **Applied Behavior Analysis (ABA) Therapy** (Ages 0-20):

  Details of ABA Therapy is after all covered services descriptions below.

Physical Health Services

Advanced Practice Registered Nurses

An advanced practice registered nurse (APRN) must hold a current, unencumbered, and valid license from the Louisiana Board of Nursing to participate in Louisiana Medicaid. A nurse licensed as an APRN includes:

- Clinical Nurse Specialist (CNS)
- Certified Nurse Practitioner (CNP)
- Certified Nurse Midwife (CNM)

Immunizations, physician-administered drugs, long-acting reversible contraceptives, and Early Periodic Screening, Diagnostic, and Treatment (EPSDT) medical, vision, and hearing screens are reimbursed at a minimum of 100% of the physician fee on file. All other payable procedures are reimbursed at a minimum of 80% of the physician fee file.

After Hours Care on Evenings, Weekends, and Holidays

This policy is intended to facilitate enrollee access to services during non-typical hours primarily to reduce the inappropriate use of the hospital emergency department. The reimbursement for the evening, weekend, and holiday codes is intended to assist with coverage of the additional administrative costs associated with staffing during these times.

The CPT evening, weekend, and holiday codes are reimbursed in addition to the reimbursement for most outpatient evaluation and management (E/M) services when the services are rendered in settings other than hospital emergency departments during the hours of:

- Monday through Friday between 5 p.m. and 8 a.m. (when outside of regular office hours),
- Weekends (12 a.m. Saturday through midnight on Sunday), or
- State/Governor proclaimed legal holidays (12 a.m. through midnight).

Only one of the evening, weekend, and holiday codes may be submitted by a billing provider per day per enrollee. Providers should select the evening, weekend, and holiday procedure code that most accurately reflects the situation on a particular date. These codes are never reported alone, but rather in addition to another code or codes describing the service related to that enrollee's visit or encounter. The following examples illustrate the appropriate use of evening, weekend, and holiday procedure codes based on the situation described.

- If the existing office hours are Monday through Friday from 8 a.m. to 5 p.m., and the physician treats the enrollee in the office at 7 p.m., then the provider may report the appropriate basic service (E/M visit code) and evening, weekend, and holiday code.
- If the existing office hours are Monday through Friday from 8:30 a.m. to 6:30 p.m., and the physician treats the enrollee in the office at 6 p.m., then the provider may not report the evening, weekend, and holiday code.
- If an enrollee is seen in the office on Saturday during existing office hours, then the provider may report the appropriate basic service (E/M visit code) and evening, weekend, and holiday code.

Documentation in the medical record relative to this reimbursement must include the time the services were rendered.

The reimbursement for evening, weekend and holiday services is based on the following current CPT codes or their successors.

- 99050 (Services…at times other than regularly scheduled office hours…) or
- 99051 (Services …at regularly scheduled evening, weekend, or holiday hours…).

When used, these procedure codes must be submitted with the code(s) for the associated evaluation and management services on that date.

Allergy Testing and Allergen Immunotherapy

Allergy testing and allergen immunotherapy relating to hypersensitivity disorders manifested by generalized systemic reactions as well as by localized reactions in any organ system of the body are covered. Covered allergy services shall include:

- In vitro specific IgE tests;
- Intracutaneous (intradermal) skin tests;

- Percutaneous skin tests;
- Ingestion challenge testing; and
- Allergen immunotherapy.

Allergen immunotherapy for enrollees who have symptoms of allergic disease, such as respiratory symptoms, skin symptoms, or other symptoms that consistently follow a particular exposure, not including local reactions after an insect sting or bite is covered.

Allergen immunotherapy is covered at:

- A minimum of 180 doses every calendar year, per enrollee, for supervision of preparation and provision of antigens other than stinging or biting insects; and
- A minimum of 52 doses every calendar year, per enrollee, for supervision of preparation and provision of antigens related to stinging or biting insects.

Allergen immunotherapy doses exceeding the above quantities are covered when medically necessary.

Ambulatory Surgical Services

Surgical services where patients do not require hospitalization and in which the expected duration of services would not exceed 24 hours are covered. Ambulatory surgical services can be provided in non-hospital ambulatory surgical centers and outpatient hospitals.

Ambulatory Surgical Centers (ASC) - (Non-Hospital)

Medically necessary, preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished to an outpatient by or under the direction of a physician or dentist in a free-standing facility which is not part of a hospital, but which is organized and operated to provide medical care to enrollees.

ASC services are items and services furnished by an outpatient ASC in connection with a covered surgical procedure. Covered services include, but are not limited to the following:

- Nursing, technician, and related services;
- Use of an ambulatory surgical center;
- Lab and radiology, drugs, biological, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
- Administrative, record keeping, and housekeeping items and services;
- Material for anesthesia;
- Intraocular lenses; and
- Supervision of the services of an anesthetist by the operating provider.

ASC services do not include:

- Professional services;
- Lab and radiology services not directly related to the surgical procedure;
- Diagnostic procedures (other than those directly related to performance of the surgical procedure);

- Prosthetic devices (except intraocular lens implants);
- Ambulance services
- Leg, arm, back and neck braces;
- Artificial limbs; and
- Durable medical equipment for use in the enrollee's home.

ASCs must have an agreement with the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 C.F.R. §416.30 and are licensed and certified by Louisiana's licensing and certification agency.

ASCs must have a system to transfer enrollees requiring emergency admittance or overnight care to a fully licensed and certified hospital following any surgical procedure performed at the facility.

ASCs are reimbursed a flat fee per service. The minimum reimbursement is in accordance with the four payment groups specified in the Louisiana Medicaid Ambulatory Surgical Center (Non-Hospital) Fee Schedule.

The flat fee reimbursement is for facility charges only, which covers all operative functions associated with the performance of a medically necessary surgery while the enrollee is in the center including the following:

- Admission;
- Patient history and physical;
- Laboratory tests;
- Operating room staffing;
- Recovery room charges; and
- All supplies related to the surgical care of the enrollee and discharge.

The flat fee excludes reimbursements for professional services (e.g., the provider performing the surgery, dentists, anesthesiologists, radiologists, or osteopaths).

For surgical procedures not included in the payment groupings, the minimum reimbursement is the flat fee for the service specified on the Louisiana Medicaid Ambulatory Surgical Centers (Non-Hospital) Fee Schedule.

Only one procedure code may be reimbursed per outpatient surgical session.

Ambulatory Surgery – (Outpatient Hospital)

Certain ambulatory surgical procedures are covered if they are performed in the outpatient hospital setting. Hospitals are reimbursed for the performance of these outpatient surgical procedures on a flat fee per service basis.

When more than one surgical procedure is performed on the same date of service, only the primary surgical procedure is reimbursed.

Please refer to the **Claim Filing instructions** manual for detailed billing instructions on Ambulatory Surgery- (Outpatient Hospital) claims.

Anesthesia Services

Surgical anesthesia services are covered when provided by an anesthesiologist or certified registered nurse anesthetist (CRNA).

Coverage for surgical anesthesia procedures must be based on formulas utilizing base units, time units (1 unit = 15 min) and a conversion factor as identified in the Anesthesia Fee Schedule.

Administration of anesthesia by the surgeon performing the surgical procedure for a non-obstetrical surgery is not covered.

Medical direction is defined as:

- Performing a pre-anesthetic examination and evaluation;
- Prescribing the anesthesia plan;
- Participating personally in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensuring that any procedures in the anesthesia plan that anesthesiologist or CRNA does not perform are rendered by a qualified individual;
- Monitoring the course of anesthesia administration at frequent intervals;
- Remaining physically present and available for immediate diagnosis and treatment of emergencies; and
- Providing the indicated post-anesthesia care.

Only anesthesiologists are reimbursed for medical direction.

Maternity-related anesthesia services are covered when provided by anesthesiologists, CRNAs, or the delivering physician.

A group practice frequently includes anesthesiologists and/or CRNA providers. One may provide the pre-anesthesia examination/evaluation, and another may fulfill other criteria. It is required that the medical record indicate the services provided and identify the provider who rendered the service.

Reimbursement for maternity-related procedures, other than general anesthesia for vaginal delivery, is a flat fee.

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

Moderate sedation coverage is restricted to enrollees from birth to age 13. Exceptions to the age restriction are made for children who have severe developmental disabilities; however, no claims are considered for enrollees 21 years of age or older.

Moderate sedation includes the following services (which are not to be reported/billed separately):

- Assessment of the enrollee (not included in intra-service time);
- Establishment of intravenous (IV) access and fluids to maintain patency, when performed;
- Administration of agents;
- Maintenance of sedation;
- Monitoring of oxygen saturation, heart rate and blood pressure; and
- Recovery (not included in intra-service time).

Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

A second physician is reimbursed other than the healthcare professional performing the diagnostic or therapeutic when the second physician provides moderate sedation in a facility setting (e.g., hospital, outpatient hospital, ambulatory

surgical center, skilled nursing facility). However, moderate sedation services performed by a second physician in a non-facility setting (e.g., physician office, freestanding imaging center) should not be reported.

Please refer to the **Claim Filing instructions** manual for detailed billing instructions for **all** anesthesia services.

Assistant Surgeon/Assistant at Surgery

Only one assistant is reimbursed at surgery. The assistant to the surgeon should be a qualified physician. However, in those situations when a physician does not serve as the assistant, a qualified, enrolled, physician assistant or advanced practice registered nurse may function in the role of an assistant at surgery and submit claims for their services under their Medicaid provider number.

Please refer to the **Claim Filing Instructions** manual for billing guidelines for assistant surgeon or assistant at surgery services.

Audiology Services

Audiology services are covered and are defined as diagnostic, preventive, or corrective services for individuals with speech, hearing, and/or language disorders provided by or under the direction of an audiologist. Generally, a referral must be made by a licensed physician for these services.

Payment for certain audiology codes is restricted to one code per recipient per 180 days.

Please refer to the **Claim Filing Instructions** manual for a list of the codes.

Bariatric Surgery

Bariatric surgery is clinically proven and, therefore, may be medically necessary for open or laparoscopic procedures that revise the gastrointestinal anatomy to restrict the size of the stomach, reduce absorption of nutrients, or both when the following criteria are met. An authorization must be obtained for bariatric surgery.

Bariatric surgery criteria:

- The enrollee has received a preoperative evaluation within the previous 12 months that is conducted by a multidisciplinary team including, at a minimum, a physician, nutritionist or dietician, and a licensed qualified mental health professional. For enrollees under the age of 18, the multidisciplinary team must have pediatric expertise. For all enrollees, the preoperative evaluation must document all the following:
  - A determination that previous attempt(s) at weight loss have been unsuccessful and that future attempts, other than bariatric surgery, are not likely to be successful; and
  - A determination that the enrollee can adhere to the post-surgery diet and follow-up care; and
  - For enrollees capable of becoming pregnant, counseling to avoid pregnancy preoperatively and for at least 12 months postoperatively and until weight has stabilized.

- Enrollees age 18 and older must have:
  - A body mass index equal to or greater than 40 kg/m², or more than 100 pounds overweight; or

- A body mass index of greater or equal to 35 kg/m² with one or more of the following comorbidities related to obesity:
  - Type 2 diabetes mellitus;
  - Cardiovascular disease (e.g., stroke, myocardial infarction, poorly controlled hypertension (systemic blood pressure greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite pharmacotherapy);
  - History of coronary artery disease with a surgical intervention such as coronary artery bypass or percutaneous transluminal coronary angioplasty;
  - History of cardiomyopathy;
  - Obstructive sleep apnea confirmed on polysomnography with an AHI or RDI of ≥ 30; or
  - Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss; or
- A body mass index of 30 to 34.9 kg/m² with type 2 diabetes mellitus if hyperglycemia is inadequately controlled despite optimal medical control by oral or injectable medications.

- Enrollees age 13 through 17 years old must have:
  - A body mass index equal to or greater than 40 kg/m²or 140% of the 95th percentile for age and sex, whichever is lower; or
  - A body mass index of 35 to 39.9 kg/m² or 120% of the 95th percentile for age and sex, whichever is lower, with one or more comorbidities related to obesity:
    - Obstructive sleep apnea confirmed on polysomnography with an AHI > 5;
    - Type 2 diabetes mellitus;
    - Idiopathic intracranial hypertension;
    - Nonalcoholic steatohepatitis;
    - Blount's disease;
    - Slipped capital femoral epiphysis;
    - Gastroesophageal reflux disease;
    - Hypertension; or
    - Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss.

- Requests for bariatric surgery for enrollees under the age of 13 are reviewed for medical necessity on a case-by-case basis.

Panniculectomy after bariatric surgery is covered when medically necessary, as determined by the following criteria:

- The enrollee had bariatric surgery at least 18 months prior and the enrollee's weight has been stable for at least 6 months; and
- The pannus is at or below the level of the pubic symphysis; and
- The pannus causes significant consequences, as indicated by at least one of the following:
  - Cellulitis, other infections, skin ulcerations, or persistent dermatitis that has failed to respond to at least 3 months of non-surgical treatment; or
  - Functional impairment such as interference with ambulation.

Breast Surgery

Mastectomy or breast conserving surgery is covered when medically necessary.

Risk-reducing mastectomy to prevent cancer is considered medically necessary for enrollees that meet all the following criteria:

- A high risk of breast cancer, as defined by one or more of the following:
    - Positive genetic mutation that is known or likely to confer a high risk of breast cancer (e.g., BRCA1 and BRCA2) where risk-reducing mastectomy is recommended by National Comprehensive Cancer Network guidelines; or
    - Significant family history, as defined by meeting the family history criteria listed under "Breast and Ovarian Cancer" within the "Genetic Testing" policy; or
    - Prior thoracic radiation therapy at an age less than 30 years old; and
- A life expectancy greater than or equal to 10 years.

Reconstructive breast surgery is covered after a therapeutic intervention (e.g., mastectomy) or trauma resulting in significant loss of breast tissue.

The following services are considered medically necessary:

- Reconstruction of the affected breast;
- Reconstruction of the contralateral breast to produce a symmetrical appearance;
- Prostheses (implanted, external, or both); and
- Treatment of complications of the reconstruction.

All prosthetic implants must be FDA approved and used in compliance with all FDA requirements at the time of the surgery.

Reduction mammaplasty and removal of breast implants for the purpose of breast reconstruction are covered under the above breast reconstruction policy.

Reduction mammaplasty for purposes other than reconstruction is considered medically necessary when all the following criteria are met:

- Pubertal breast development is complete;
- A diagnosis of macromastia with at least 2 of the following symptoms for at least a 12- week duration:
    - Chronic breast pain
    - Headache
    - Neck, shoulder, or back pain
    - Shoulder grooving from bra straps
    - Upper extremity paresthesia due to brachial plexus compression syndrome, secondary to the weight of the breasts being transferred to the shoulder strap area
    - Thoracic kyphosis
    - Persistent skin condition such as intertrigo in the inframammary fold that is unresponsive to medical management
    - Congenital breast deformity;

- There is a reasonable likelihood that the symptoms are primarily due to macromastia; and
- The amount of breast tissue to be removed is reasonably expected to alleviate the symptoms.

Removal of breast implants for purposes other than reconstruction is considered medically necessary for the following indications:

- Visible capsular contracture causing pain (Baker Grade IV)
- Diagnosed or suspected implant rupture
- Local or systemic infection
- Siliconoma or granuloma
- Implant extrusion
- Interference with the diagnosis or treatment of breast cancer
- Breast implant-associated anaplastic large cell lymphoma

If an indication for medically necessary removal of breast implants is present unilaterally, removal of the contralateral breast implant is also considered medically necessary when performed during the same operative session.

When the procedure is not reconstructive and is performed solely for the purpose of altering the appearance of the breast, reduction mammaplasty and removal of breast implants are considered cosmetic and not medically necessary.

Cardiovascular Services

Elective invasive coronary angiography (ICA) and percutaneous coronary intervention (PCI) are covered as treatment for cardiovascular conditions under specific circumstances. ICA for non-acute, stable coronary artery disease is not considered medically necessary, including for patients with stable angina who are not interested in revascularization or who are not candidates for PCI or coronary artery bypass graft surgery.

This policy only applies to enrollees age 18 and older and does not apply to the following enrollees:

- Enrollees under the age of 18;
- Pregnant enrollees;
- Cardiac transplant enrollees;
- Solid organ transplant candidates; and
- Survivors of sudden cardiac arrest.

Elective ICA is covered and is considered medically necessary for enrollees with one or more of the following:

- Congenital heart disease that cannot be characterized by non-invasive modalities such as cardiac ultrasound, CT, or MRI;
- Heart failure with reduced ejection fraction for the purposes of diagnosing ischemic cardiomyopathy;
- Hypertrophic cardiomyopathy prior to septal ablation or myomectomy;
- Severe valvular disease or valvular disease with plans for surgery or percutaneous valve replacement;
- Type 1 myocardial infarction within the past three months defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:
    - Symptoms of acute myocardial ischemia;
    - New ischemic electrocardiogram (ECG) changes;
    - Development of pathological Q waves;
    - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality in a

  - pattern consistent with an ischemic etiology; and
  - Identification of a coronary thrombus;
- History of ventricular tachycardia requiring therapy for termination or sustained ventricular tachycardia not due to a transient reversible cause, within the past year;
- History of ventricular fibrillation;
- Return of angina within nine months of prior PCI;
- Enrollees without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine); or
- High risk imaging findings, defined as one or more of the below:
  - Severe resting left ventricular dysfunction (LVEF ≤35%) not readily explained by noncoronary causes;
  - Resting perfusion abnormalities ≥10% of the myocardium in enrollees without prior history or evidence of myocardial infarction;
  - Stress electrocardiogram findings including ≥2 mm of ST-segment depression at low workload or persisting into recovery, exercise-induced ST-segment elevation, or exercise-induced ventricular tachycardia/ventricular fibrillation;
  - Severe stress-induced left ventricular dysfunction (peak exercise LVEF <45% or drop in LVEF with stress ≥10%);
  - Stress-induced perfusion abnormalities affecting ≥10% myocardium or stress segmental scores indicating multiple vascular territories with abnormalities;
  - Stress-induced left ventricular dilation;
  - Inducible wall motion abnormality (involving >2 segments or 2 coronary beds);
  - Wall motion abnormality developing at low dose of dobutamine (≥10 mg/kg/min) or at a low heart rate (<120 beats/min); or
  - Left main stenosis (≥50% stenosis) on coronary computed tomography angiography.

Elective PCI for angina with stable coronary artery disease is covered and is considered medically necessary for:

- Enrollees without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine).

  Elective PCI for other cardiac conditions is considered medically necessary in enrollees with one or more of the following:

  - Heart failure with reduced ejection fraction for the purposes of treating ischemic cardiomyopathy;
  - Left main stenosis ≥50% as determined on prior cardiac catheterization or coronary computed tomography angiography, if the enrollee has documentation indicating they were declined for a coronary artery bypass graft surgery; and
  - Type 1 myocardial infarction within the past three months as defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:
    - Symptoms of acute myocardial ischemia;
    - New ischemic electrocardiogram changes;
    - Development of pathological Q waves;
    - Imaging evidence of new loss of viable myocardium, or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and
    - Identification of a coronary thrombus.

Elective PCI for non-acute, stable coronary artery disease is not considered medically necessary in all other enrollee populations, including if the enrollee is unwilling to adhere with recommended medical therapy, or if the enrollee is unlikely to benefit from the proposed procedure (e.g., life expectancy less than six months due to a terminal illness).

Endovascular revascularization procedures (stents, angioplasty, and atherectomy) for the lower extremity are covered and are considered medically necessary for the following conditions:

- Acute limb ischemia;
- Chronic limb-threatening ischemia, defined as the presence of any of the following:
    - Ischemic pain at rest;
    - Gangrene; or
    - Lower limb ulceration greater than two weeks duration.

Endovascular revascularization procedures are also covered and are considered medically necessary for enrollees with peripheral artery disease who have symptoms of intermittent claudication and meet all the following criteria:

- Significant peripheral artery disease of the lower extremity as indicated by at least one of the following:
    - Moderate to severe ischemic peripheral artery disease with ankle-brachial index (ABI) ≤0.69; or
    - Stenosis in the aortoiliac artery, femoropopliteal artery, or both arteries, with a severity of stenosis ≥70% by imaging studies; and
- Claudication symptoms that impair the ability to work or perform activities of daily living; and
- No improvement of symptoms despite all the following treatments:
    - Documented participation in a medically supervised or directed exercise program for at least 12 weeks. Individuals fully unable to perform exercise therapy may qualify for revascularization only if the procedure is expected to provide long-term functional benefits despite the limitations that precluded exercise therapy; and
    - At least six months of optimal pharmacologic therapy including all the below agents, unless contraindicated or discontinued due to adverse effects:
        - Antiplatelet therapy with aspirin, clopidogrel, or both
        - Statin therapy
        - Cilostazol
        - Antihypertensives to a goal systolic blood pressure ≤140 mmHg and diastolic blood pressure ≤90 mmHg; and
    - At least one documented attempt at smoking cessation, if applicable, consisting of pharmacotherapy, unless contraindicated, and behavioral counseling, or referral to a smoking cessation program that offers both pharmacotherapy and counseling.

Endovascular revascularization procedures for the lower extremity are not considered and not medically necessary in the following circumstances:

- Claudication due to isolated infrapopliteal artery disease (anterior tibial, posterior tibial or peroneal) including enrollees with coronary artery disease, diabetes mellitus, or both;
- To prevent the progression of claudication to chronic limb-threatening ischemia in an enrollee who does not otherwise meet medical necessity criteria;
- Enrollee is asymptomatic; or
- Treatment of a nonviable limb.

Peripheral arterial disease rehabilitation, also known as supervised exercise therapy, involves the use of intermittent exercise training for the purpose of reducing intermittent claudication symptoms.
Up to 36 sessions of peripheral arterial disease rehabilitation are covered and considered medically necessary annually. Delivery of these sessions three times per week over a 12-week period is recommended, but not required. Providers

must adhere to CPT guidance on the time per session, exercise activities permitted, and the qualifications of the supervising provider.

Chiropractic Services for Enrollees (Ages 0-20)

Chiropractic manipulative treatments are covered for enrollees under 21 years of age when medically necessary and upon referral from an EPSDT medical screening PCP.

Cochlear Implant for Enrollees (Ages 0-20)

Unilateral or bilateral cochlear implants are covered when deemed medically necessary for the treatment of severe-to-profound, bilateral sensorineural hearing loss in enrollees under 21 years of age. Implants must be used in accordance with Food and Drug Administration (FDA) guidelines.

A multi-disciplinary implant team is required to collaborate on determining eligibility and providing care that includes, at minimum: a fellowship-trained pediatric otolaryngologist or fellowship-trained otologist, an audiologist, and a speech-language pathologist.

An audiological evaluation must find:

- Severe-to-profound hearing loss determined using an age-appropriate combination of behavioral and physiological measures; and
- Limited or no functional benefit achieved after a sufficient trial of hearing aid amplification.

A medical evaluation must include:

- Medical history;
- Physical examination verifying the candidate has intact tympanic membrane(s), is free of active ear disease, and has no contraindication for surgery under general anesthesia;
- Verification of receipt of all recommended immunizations;
- Verification of accessible cochlear anatomy that is suitable to implantation, as confirmed by imaging studies (computed tomography (CT) and/or magnetic resonance imagery (MRI)), when necessary; and
- Verification of auditory nerve integrity, as confirmed by electrical promontory stimulation, when necessary.

For bilateral cochlear implants, an audiologic and medical evaluation must determine that a unilateral cochlear implant plus hearing aid in the contralateral ear will not result in binaural benefit for the enrollee.

Non-audiological evaluations must include:

- Speech and language evaluation to determine enrollee's level of communicative ability; and
- Psychological and/or social work evaluation, as needed.

Pre-operative counseling shall be provided to the enrollee, if age appropriate, and the enrollee's caregiver and must provide:

- Information on implant components and function; risks, limitations, and potential benefits of implantation; the surgical procedure; and postoperative follow-up schedule;
- Appropriate post-implant expectations, including being prepared and willing to participate in pre- and post-implant assessment and rehabilitation programs; and
- Information about alternative communication methods to cochlear implants.

If prior authorized, preoperative evaluation services (i.e., evaluation of speech, language, voice, communication, auditory processing, and/or audiologic/aural rehabilitation) are reimbursed even when the enrollee may not subsequently receive an implant.

At the time of surgery, the hospital is reimbursed for both the implant and the per diem.

Other necessary equipment, repairs, and replacements are covered according to the Durable Medical Equipment fee schedule.

The cochlear implant surgery as well as postoperative aural rehabilitation by an audiologist and subsequent speech, language, and hearing therapy are also covered.

Cochlear implant post-operative programming and diagnostic analysis services are covered as well.

Community Health Workers

Services rendered to enrollees by qualified community health workers (CHW) meeting the criteria and policy outlined below are covered.

A qualified Community Health Worker is defined as someone who:

- Has completed state-recognized training curricula approved by the Louisiana Community Health Worker Workforce Coalition; or
- Has a minimum of 3,000 hours of documented work experience as a CHW.

Eligibility Criteria include:

- Diagnosis of one or more chronic health (including behavioral health) conditions;
- Suspected or documented unmet health-related social need; or
- Pregnancy.

Covered services include:

- Health promotion and coaching; includes assessment and screening for health-related social needs, setting goals and creating an action plan, on-site observation of enrollees' living situations, and providing information and/or coaching in an individual or group setting.
- Care planning with enrollees and their healthcare team; this should occur as a person-centered approach to improve health by meeting the enrollee's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention.
- Health system navigation and resource coordination services; this includes helping to engage, reengage, or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions.

Services must be ordered by a physician, advanced practice registered nurse (APRN), or physician assistant (PA) with an established clinical relationship with the enrollee. Services must be rendered under this supervising provider's general supervision, but the provider's presence is not required during the performance of the CHW services.

Places of service for enrollees are not restricted. Services are also available via telehealth/telemedicine.

The following services are not covered when provided by CHWs:

- Insurance enrollment and insurance navigator assistance;
- Case management;
- Direct provision of transportation for an enrollee to and from services; and
- Direct patient care outside the level of training an individual has attained.

A maximum of two hours per day, and ten hours per month per enrollee are reimbursed.

CHW services "incident to" the supervising physician, APRN, or PA are reimbursed.

Federally qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) receive the rate on file for community health worker services in addition to the all-inclusive encounter rate payment on the same date of service.

Please refer to the **Claim Filing Instructions** manual for all CHW billing instructions.

Concurrent Care – Inpatient

Inpatient concurrent care is covered when an enrollee's condition requires the care of more than one provider on the same day and the services rendered by each individual provider are medically necessary and not duplicative.

Providers from different specialties/subspecialties are reimbursed separately, whether from the same group or a different group. Each provider from a different specialty/subspecialty can be reimbursed for one initial hospital visit per admission plus a maximum of one subsequent hospital visit per day.

Within the same specialty/subspecialty, only one provider can be reimbursed for one initial hospital visit per admission and, subsequently, only one provider can be reimbursed for a maximum of one subsequent hospital visit per day. Only the provider responsible for discharging the enrollee for hospital discharge services on the discharge day is reimbursed.

Corneal Collagen Cross-Linking

Effective May 1, 2024, coverage of corneal collagen cross-linking (CXL) procedures are covered.

CXL is a procedure used to treat progressive keratoconus. Keratoconus is a progressive ocular disease that increases the curvature of the cornea, leading to decreased visual acuity. Ultraviolet (UV) light is combined with riboflavin eye drops to induce collagen crosslinks in the cornea, strengthening and stabilizing the cornea and delaying progressive deformation.

The CXL procedure, including the riboflavin drops and administration of UV light, is approved for patients between 14-20 years of age with progressive keratoconus.

Coverage guidelines for CXL are as follows:

- Epithelium-off photochemical CXL using riboflavin and ultraviolet A may be considered medically necessary for treatment of progressive keratoconus when conservative treatments (e.g., spectacles and contact lens) have been tried without success and the individual does not have either of the following contraindications: a corneal thickness of fewer than 400 microns or a prior herpetic ocular infection.
- Progressive keratoconus is defined as one or more of the following:
    - An increase of 1 diopter (D) in the steepest keratometry value; or
    - An increase of 1 D in regular astigmatism evaluated by subjective manifest refraction; or
    - A myopic shift (decrease in the spherical equivalent) of 0.50 D on subjective manifest refraction; or
    - A decrease > 0.1 mm in the back optical zone radius in rigid contact lens wearers where other information was not available.

Please refer to the **Claim Filing Instructions** manual for CXL billing guidelines.

Dental Care

Members younger than age 21 are eligible to receive dental care, including exams, cleanings, X-rays, teeth sealants, and fluoride treatments. The Louisiana Department of Health offers members the option to choose DentaQuest or Managed Care of North America (MCNA) as the child dental provider. For more information, call DentaQuest at **1-800-685-0143** or TTY **1-800-466-7566**, Monday to Friday, 7 a.m. to 7 p.m.; or MCNA at **1-855-702-6262** TTY **1-800-846-5277**, Monday to Friday, 7 a.m. to 7 p.m. You can also visit DentaQuest on the web at **www.DentaQuest.com** or MCNA at **www.mcnala.net**.

Members aged 21 and older are eligible for up to $500 a year for exams, cleanings, filings, extractions, and x-rays when services are performed by a participating Federally Qualified Health Center (FQHC). For a list of participating providers, please call Member Services at 1-888-756-0004.

Dental Services (Medically Necessary in Inpatient or ASC Setting)

Medically Necessary dental treatment services for enrollees are covered under AmeriHealth Caritas Louisiana's medical benefit when rendered in an inpatient or ASC setting, and when appropriately authorized by AmeriHealth Caritas Louisiana's Utilization Management Department.

Routine adult dental care is **not** covered.

AmeriHealth Caritas Louisiana PCPs conducts initial EPSDT dental screenings and AmeriHealth Caritas Louisiana assists in coordinating follow up care through the Louisiana Medicaid dental network managed by the following dental vendors:

DentaQuest
1-800-685-0143
TTY: 1-800-466-7566
www.DentaQuest.com

MCNA Dental
1-855-702-6262
TTY: 1-800-846-5277
www.mcnala.net

Diabetes Self-Management Training

Diabetes self-management training (DSMT): A collaborative process through which enrollees with diabetes gain knowledge and skills needed to modify behavior and successfully manage the disease and its related conditions.

Covered DSMT programs, at a minimum, must include the following:

- Instructions for blood glucose self-monitoring;
- Education regarding diet and exercise;
- Individualized insulin treatment plan (for insulin dependent enrollees); and
- Encouragement and support for use of self-management skills.

DSMT must be aimed at educating enrollees on the following topics to promote successful self-management:

- Diabetes overview, including current treatment options and disease process;
- Diet and nutritional needs;
- Increasing activity and exercise;

- Medication management, including instructions for self-administering injectable medications (as applicable);
- Management of hyperglycemia and hypoglycemia;
- Blood glucose monitoring and utilization of results;
- Prevention, detection, and treatment of acute and chronic complications associated with diabetes (including discussions on foot care, skin care, etc.);
- Reducing risk factors, incorporating new behaviors into daily life, and setting goals to promote successful outcomes;
- Importance of preconception care and management during pregnancy;
- Managing stress regarding adjustments being made in daily life; and
- Importance of family and social support.

All educational material must be pertinent and age appropriate for each enrollee. Parents or legal guardians can participate in DSMT rendered to their child, but all claims for these services must be submitted under the child's Medicaid coverage.

DSMT services are required to be provided and reimbursed under the direction of a physician, advanced practice registered nurse or physician assistant.

Providers of DSMT services are required to be accredited by one of the follow national accreditation organizations:

- American Diabetes Association (ADA),
- American Association of Diabetes Educators (AADE), and
- Indian Health Service (IHS).

Services provided by providers without proof of accreditation from one of the above listed organizations are not covered.

At a minimum, providers of DSMT services must include at least one registered dietician, registered nurse, or pharmacist. Each enrollee of the instructional team must be a Certified Diabetes Educator (CDE) or have recent didactic and experiential preparation in education and diabetes management, and at least one member of the instructional team must be a CDE who has been certified by the National Certification Board for Diabetes Educators (NCBDE). Providers are required to maintain and provide proof of certification of staff members.

All DSMT services must adhere to the National Standards for Diabetes Self-Management Education.

DSMT is covered for eligible enrollees who have been diagnosed with type 1, type 2, or gestational diabetes mellitus and who have an order from a provider involved in the management of their diabetes, such as a PCP or obstetrician.

The ordering provider is required to maintain a copy of all DSMT orders. Each order must be signed and must specify the total number of hours being ordered, not to exceed the following coverage limitations:

- A maximum of 10 hours of initial training (one hour of individual and nine hours of group sessions) are allowed during the first 12-month period beginning with the initial training date.

- A maximum of two hours of individual sessions are allowed for each subsequent year.

If special circumstances occur in which the ordering provider determines an enrollee would benefit from individual sessions rather than group sessions, the order must also include a statement specifying that individual sessions would be more appropriate, along with an explanation.

If a DSMT order must be modified, the updated order must be signed by the ordering provider and copies must be retained in the medical record.

The following enrollees are not eligible for DSMT:

- Enrollees residing in an inpatient hospital or other institutional setting such as a nursing care facility or a residential care facility; or
- Enrollees receiving hospice services.

The policy for initial DSMT includes the following:

- Initial DSMT may begin after receiving the initial order. DSMT is allowed for a continuous 12- month period following the initial training date. For services to be considered initial, the enrollee must not have previously received initial or follow up DSMT.
- The 10 hours of initial training may be provided in any combination of 30-minute increments over the 12-month period. Sessions lasting less than 30 minutes are not covered.
- Group sessions may be provided in any combination of 30-minute increments. Sessions less than 30 minutes are not covered. Each group session must contain between 2-20 enrollees.

After receiving 10 hours of initial training, an enrollee shall be eligible to receive a maximum of two hours of follow-up training each year, if ordered. Additional training for enrollees under age 21 is covered if determined to be medically necessary and documented in the record.

Follow-up training is based on a 12-month calendar year following completion of the initial training. If an enrollee completes 10 hours of initial training, the enrollee shall be eligible for two hours of follow-up training for the next calendar year. If all 10 hours of initial training are not used within the first calendar year, then the enrollee shall have 12 months to complete the initial training prior to follow up training.

Providers are expected to communicate with enrollees to determine if the enrollee has previously received DSMT services or has exhausted the maximum hours of DSMT services for the given year.

Only 10 hours of initial training are covered (for the first 12 months) and two hours of follow-up training (for each subsequent year) regardless of the providers of service.

Providers are required to ensure the following conditions are met to receive reimbursement.

The enrollee meets one of the following requirements:

- Is a newly diagnosed diabetic, gestational diabetic, pregnant with a history of diabetes, or has received no previous diabetes education,
- Demonstrates poor glycemic control (A1c>7),
- Has documentation of an acute episode of severe hypoglycemia or hyperglycemia occurring in the past 12 months, or
- Has received a diagnosis of a complication, a diagnosis of a co-morbidity, or prescription for new equipment such as an insulin pump.

The provider maintains the following documentation requirements:

- A copy of the order for DSMT from the enrollee's PCP;
- A comprehensive plan of care documented in the medical record;
- Start and stop time of services;
- Clinical notes, documenting enrollees progress;
- Original and ongoing pertinent lab work;
- Individual education plan;
- Assessment of the individual's education needs;
- Evaluation of achievement of self-management goals;
- Proof of correspondence with the ordering provider regarding the enrollee's progress; and
- All other pertinent documentation.

Enrollee records, facility accreditation, and proof of staff licensure, certification, and educational requirements must be kept readily available to be furnished when requested.

Please refer to the **Claim Filing Instructions** manual for DSMT billing guidelines.

Diabetic Supplies

In accordance with La. R.S. 46:450.8, continuous glucose monitors and other diabetic supplies are reimbursed as a pharmacy benefit.

The following diabetic supplies are reimbursed as a pharmacy benefit **only**. Durable medical equipment (DME) claims will deny.

- Diabetes glucose meters
- Diabetic test strips
- Continuous glucose meters
- Transmitters and sensors
- External insulin pumps (e.g., Cequr Simplicity, Omnipod and V-Go)
- Control solution
- Ketone test strips
- Lancets and devices
- Pen needles
- Re-usable insulin pens
- Syringes

The procedure codes for the above diabetic supplies are no longer located on the Louisiana Medicaid Durable Medical Equipment fee schedule.

NOTE: Insulin pumps requiring tubing and supplies are still covered as DME. All reservoirs and canisters are covered through DME as well.

Donor Human Milk and Human Milk Storage Bags

Donor Human Milk - Inpatient

Donor human milk provided in the inpatient hospital setting for certain medically vulnerable infants is covered. This coverage shall be provided without restrictions or the requirement for prior authorization. Donor human milk is considered medically necessary when all the following criteria are met:

- The hospitalized infant is less than 12 months of age with one or more of the following conditions:
  - Prematurity;
  - Malabsorption syndrome;
  - Feeding intolerance;
  - Immunologic deficiency;
  - Congenital heart disease or other congenital anomalies;
  - Other congenital or acquired condition that places the infant at high risk of developing necrotizing enterocolitis (NEC) and/or infection; and
  - The infant's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding; and
  - The infant's caregiver has received education on donor human milk, including the risks and benefits, and agrees to the provision of donor human milk to their infant; and
  - The donor human milk is obtained from a milk bank accredited by, and in good standing with, the Human Milk Banking Association of North America.

Donor Human Milk – Outpatient

Donor human milk is covered outpatient for use by medically vulnerable infants. Eligibility Criteria Donor human milk is considered medically necessary when the following criteria are met:

- The enrollee is less than 12 months of age with one or more of the following conditions:
  - Post-surgical nutrition;
  - Organ transplantation;
  - Renal disease;
  - Short gut syndrome;
  - Malabsorption syndrome;
  - Feeding or formula intolerance;
  - Failure to thrive;
  - Inborn errors of metabolism;
  - Immunologic disorders;
  - Congenital heart disease or other congenital anomalies; or
  - Neonatal abstinence syndrome.
- The enrollee's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding; or the enrollee is medically or physically unable to receive caregiver breast milk or participate in breastfeeding;
- The enrollee's caregiver has received education on donor human milk, including the risks and benefits; and
- A bank accredited by, and in good standing with, the Human Milk Banking Association of North America supplied the donor human milk.

Prescriptions for donor human milk must include the following:

- Number of prescribed calories per ounce;
- Total ounces prescribed per day;
- Total number of weeks donor human milk is required;

- Total allowable refills; and
- Reason for prescribing donor human milk, including enrollee's diagnoses.

Please refer to the **Claim Filing Instructions** manual for more details on reimbursement and claim filing.

Personal use, double and electric breast pumps are considered a covered item for nursing mothers. A new breast pump is covered for each viable pregnancy. The breast pump may be obtained at the gestational age of 32 weeks to expectant mothers who meet the criteria and intend to breastfeed their infant.

A prior authorization is not required for breast pump, but it is subject to post payment medical review. Replacement of a breast pump is allowed for a pump older than three years and after expiration of manufacturer's warranty. Electric breast pump supplies will be available to the nursing mother once every 180 days. DME providers must obtain a prior authorization for replacement supplies. The request must include the Fillable Electric Breast Pump Request Form.

NOTE: Single, manual and hospital-grade breast pumps are still not covered.

Please refer to the **Claim Filing Instructions** manual for more details on breast pump claim filing.

Human Milk Storage Bags

Human milk storage bags for lactating enrollees is covered when the following criteria is met:

- Prescription signed by prescribing physician;
- Documentation that enrollee is lactating (This can be included on the prescription or submitted separately);
- Storage bags are limited to 100 bags per month; and
- The Medicaid fee on file is for a one-month supply of storage bags.

Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies

Enrollees are eligible to receive medically necessary durable medical equipment (DME), prosthetics, orthotics, certain supplies, appliances, and assistive devices including but not limited to hearing aids for and disposable incontinence supplies for enrollees under the age of 21.

Effective with dates of service **on or after September 1, 2024,** elastomeric, disposable infusion pumps, and supplies as a benefit for short-term use (less than 30 days) for antibiotic infusion therapy is covered. Prior authorization is required and the request for approval must include the following:

- Information on the underlying diagnosis or condition
- A physician's order and documentation supporting medical necessity
- The name of the antibiotic, dosage, the duration of therapy, and the frequency of administration

DME policy related to access to oxygen equipment and supplies during an official state and/or federally declared emergency are outlined below:

- Medically necessary backup oxygen and equipment provided during an official state and/or federally declared emergency cannot be considered non-covered.
- Backup oxygen and equipment provided outside an official state and/or federally declared emergency is non-covered.

- Providers are responsible for ensuring that medical oxygen and oxygen-related equipment are available during official state and/or federally declared emergencies, if medically necessary.
- DME providers are not reimbursed for unused equipment and supplies picked up after an emergency.

Most DME requires prior authorization. Please refer to AmeriHealth Caritas Louisiana website's Prior Authorization Lookup Tool to determine if a prior authorization is necessary for respective DME item(s).

Because enrollees may lose eligibility or switch plans, DME providers are encouraged to access NaviNet for verification of the enrollee's continued enrollment with AmeriHealth Caritas Louisiana when equipment is authorized for more than a one-month period. Failure to do so could result in claim denials.

Occasionally, additional information is required, and the network provider is notified of the need for such information. If you have questions regarding any DME item or supply, please contact the Utilization Management at 1-888-913-0350 or the Provider Services Department at 1-888-922-0007.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Program (Ages 0-20)

The EPSDT program is a comprehensive and preventive child health program for individuals under the age of 21. The program consists of two mutually supportive, operational components: (1) ensuring the availability and accessibility of required healthcare services; and (2) helping Medicaid enrollees and their parents or guardians effectively use these resources. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

Enrollees under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical or mental conditions (Section 1905(r) of the Social Security Act). The EPSDT benefit is comprehensive in nature and includes coverage of all services described in federal Medicaid statutes and regulations including those that are not covered for adults, not explicitly described in the Contract, not included in the Medicaid FFS fee schedules, and not covered in the Louisiana Medicaid State Plan.

Enrollee screening includes medical (including developmental, perinatal depression, and behavioral health), vision, hearing, and dental screenings.

AmeriHealth Caritas Louisiana's policy includes the following EPSDT screening guidelines, as age appropriate.

Louisiana Medicaid has adopted the "Recommendations for Preventive Pediatric Health Care" periodicity schedule promulgated by the American Academy of Pediatrics (AAP)/Bright Futures with two exceptions:

- The Louisiana Medicaid EPSDT screening guidelines and policies are for individuals under 21 years of age; and
- Louisiana Medicaid has stricter requirements for lead assessment and blood lead screening in keeping with LAC 48:V.7005-7009. Based on surveillance data gathered by the State Childhood Lead Poisoning Prevention Program and review by the state health officer and representatives from medical schools in the state, all parishes in Louisiana are identified as high risk for lead poisoning.
    - AmeriHealth Caritas Louisiana ensures children ages six months to 72 months are screened in compliance with Louisiana Medicaid EPSDT requirements and in accordance with practices consistent with current Centers for Disease Control and Prevention guidelines, which include the following specifications:

- Administer a risk assessment at every well child visit;
- Use a blood test to screen all children at ages 12 months and 24 months or at any age older than 24 months and up to 72 months, if they have not been previously screened; and
- Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels ≥5 µg/dl (micrograms per deciliter).

- AmeriHealth Caritas Louisiana's policy requires providers to report a lead case to the Office of Public Health's Childhood Lead Poisoning Prevention Program [link] within 24 working hours. A lead case is indicated by a blood lead test result of ≥5 µg/dl.

The AAP Bright Futures "Recommendations for Preventive Pediatric Health Care" can be found on the American Academy of Pediatrics" website [link].

If an abnormality or problem is encountered and treatment is significant enough to require an additional evaluation and management (E&M) service on the same date, by the same provider, no additional E&M of a level higher than CPT code 99212 is reimbursable.

The physician, advanced practice registered nurse (APRN), or physician assistant (PA) listed as the rendering provider must be present and involved during a preventive visit. Any care provided by a registered nurse or other ancillary staff in a provider's office is subject to the policy in the *"incident to" Services section* of this Manual and must only be providing services within the scope of their license or certification.

If a child misses a regular periodic screening, that child may be screened off-schedule to bring the child up to date at the earliest possible time. However, all screenings performed on children who are under two years of age must be at least 30 days apart, and those performed on children age two through six years of age must be at least six months apart.

Interperiodic screenings may be performed if medically necessary. The parent/guardian or any medical provider or qualified health, developmental, or education professional that comes into contact with the child outside the formal healthcare system may request the interperiodic screening.

An interperiodic screening may only be provided if the enrollee has received an age-appropriate preventive medical screening. If the preventive screening has not been performed, then the provider must perform an age-appropriate preventive screening.

An interperiodic screening includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education and other age-appropriate procedures.

An interperiodic screening may be performed and billed for a required Head Start physical or school sports physical but must include all of the components required in the EPSDT preventive periodic screening.

Documentation must indicate that all components of the screening were completed. Medically necessary laboratory, radiology, or other procedures may also be performed and may be billed separately. A well diagnosis is not required.

Components of the EPSDT preventive medical screenings include the following:

- A comprehensive health and developmental history (including assessment of both physical and mental health and development);
- A comprehensive unclothed physical exam or assessment;
- Appropriate immunizations according to age and health history (unless medically contraindicated or parents/guardians refuse at the time);

- Laboratory tests* (including age-appropriate screenings for newborns, iron deficiency anemia, blood lead levels, dyslipidemia, and sexually transmitted infections); and
- Health education (including anticipatory guidance).

*The blood lead levels and iron deficiency anemia components of the preventive medical screening must be provided on-site on the same date of service as the screening visit.

The services shall be available both on a regular basics, and whenever additional health treatment or services are needed. EPSDT screenings may identify problems needing other health treatment or additional services.

Providers are responsible for obtaining the results of the initial neonatal screening by contacting the hospital of birth, the health unit in the parish of the mother's residence, or through the Office of Public Health (OPH) Genetics Diseases Program's web-based Secure Remote Viewer (SRV).

If screening results are not available, or if newborns are screened prior to 24 hours of age, newborns must have another newborn screen. The newborn infant must be rescreened at the first medical visit after birth, preferably between one and two weeks of age, but no later than the third week of life.

Initial or repeat neonatal screening results must be documented in the medical record for all children less than six months of age. Children over six months of age do not need to be screened unless it is medically indicated. When a positive result is identified from any of the conditions specified in LAC, Book Two of Two: Part V. Preventive Health Services Subpart 18. Disability Prevention Program Chapter 63. Newborn Heel Stick Screening §6303, and a private laboratory is used, the provider must immediately notify the Louisiana OPH Genetics Disease Program.

Please refer to the **Claim Filing Instructions** manual for neonatal/newborn screenings for genetic disorders billing guidelines.

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of any:

- Eye disorders of the child or the child's family;
- Systemic diseases of the child or the child's family which involve the eyes or affect vision;
- Behavior on the part of the child that may indicate the presence or risk of eye problems; and
- Medical treatment for any eye condition.

Objective vision screenings may be performed by trained office staff under the supervision of a licensed physician, physician assistant, registered nurse, advanced practice registered nurse, or optometrist. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, physician assistant, registered nurse, or advanced practice registered nurse.

Vision screening services are to be provided according to the AAP/Bright Futures recommendations.

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of:

- The child's response to voices and other auditory stimuli;
- Delayed speech development;
- Chronic or current otitis media; and
- Other health problems that place the child at risk for hearing loss or impairment.

The objective hearing screenings may be performed by trained office staff under the supervision of a licensed audiologist or speech pathologist, physician, physician assistant, registered nurse, or advanced practice registered nurse. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, physician assistant, registered nurse, or advanced practice registered nurse.

Hearing screening services are to be provided according to the AAP/Bright Futures recommendations.

An oral health risk assessment must be performed per the Bright Futures periodicity schedule.

Developmental and autism screenings administered during EPSDT preventive visits in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule are covered.

Developmental and autism screenings performed by PCPs when administered at intervals outside EPSDT preventive visits if they are medically indicated for an enrollee at-risk for, or with a suspected, developmental abnormality are covered.

Requirements for coverage:

- The use of age-appropriate, caregiver-completed, and validated screening tools as recommended by the AAP.
- If an enrollee screens positive on a developmental or autism screen, the provider must give appropriate developmental health recommendations, refer the enrollee for additional evaluation, or both, as clinically appropriate.
- Providers must document the screening tool(s) used, the result of the screen, and any action taken, if needed, in the enrollee's medical record.
- Developmental screening and autism screening are currently reimbursed using the same procedure code.
- Providers may only receive reimbursement for one developmental screen and one autism screen per day of service.
- To receive reimbursement for both services performed on the same day, providers may submit claims for 2 units of the relevant procedure code.

Perinatal depression screening administered to an enrollee's caregiver in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule is covered. The screening can be administered from birth to 1 year during an EPSDT preventive visit, interperiodic visit, or E&M office visit. This service is a recommended, but not required, component of well-child care.

Perinatal depression screening must employ one of the following validated screening tools:

- Edinburg Postnatal Depression Scale (EPDS)

- Patient Health Questionnaire 9 (PHQ-9)
- Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9

Documentation must include the tool used, the results, and any follow-up actions taken. If an enrollee's caregiver screens positive, the provider must refer the caregiver to available resources, such as their PCP, obstetrician, or mental health professionals, and document the referral. If screening indicates possible suicidality, concern for the safety of the caregiver or enrollee, or another psychiatric emergency, then referral to emergency mental health services is required.

Though the screening is administered to the caregiver, this service is reimbursed under the child's Medicaid coverage.

Please refer to the **Claim Filing Instructions** manual for perinatal depression claims filing guidelines.

Appropriate immunizations (unless medically contraindicated or the parents/guardians refuse) are a federally required medical screening component.

The current Childhood Immunization Schedule recommended by Advisory Committee on Immunizations Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP), which is updated annually, must be followed. Providers are responsible for obtaining current copies of the schedule.

Age-appropriate laboratory tests are required at selected age intervals. Documented laboratory procedures provided less than six months prior to the medical screening must not be repeated unless medically necessary. Iron deficiency anemia and blood lead testing when required are included in the medical screening fee and must not be billed separately.

Screening services are performed to ensure that health problems are found, diagnosed, and treated early before becoming more serious and additional treatment is necessary. Providers are responsible for identifying any general suspected conditions and reporting the presence, nature, and status of the suspected conditions.

Providers must follow the following diagnosis and treatment guidelines:

- When a screening indicates the need for further diagnosis or evaluation of a child's health, the child must receive a complete diagnostic evaluation within 60 days of the screening or sooner as medically necessary.
- Make any necessary referrals of the enrollee to a specialist.

AmeriHealth Caritas Louisiana maintains a referral system with an adequate provider Network to support the provider in making the referrals and to support the enrollee in accessing the services to ensure that the enrollee receives the diagnostic services required.

Medically necessary health care, initial treatment, or other measures needed to correct or ameliorate physical or mental illnesses or conditions discovered in a medical, vision, or hearing screening must be initiated within 60 days of the screening or sooner if medically necessary.

Providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the enrollee for care. Providers who perform the diagnostic and/or initial treatment services should do so at the screening appointment, when possible, but must ensure that enrollees receive the necessary services within 60 days of the screening or sooner if medically necessary.

Providers who refer the enrollee for care must make the necessary referrals at the time of screening. This information must be maintained in the enrollee's record.

It is the provider's responsibility to make any necessary referrals of the enrollees to a specialist.

Fluoride varnish applications are covered when provided in a physician office setting (including RHCs and FQHCs) once every six months for enrollees six months through five years of age. Providers eligible for reimbursement of this service include physicians, physician assistants, and nurse practitioners who have reviewed the Smiles for Life fluoride varnish training module [**link**] and successfully completed the post assessment. Physicians are responsible to provide and document training to their participating staff to ensure competency in fluoride varnish applications.

Fluoride varnish applications may only be applied by the following disciplines:

- Appropriate dental providers;
- Physicians;
- Physician assistants;
- Nurse practitioners;
- Registered nurses;
- Advanced practice registered nurses;
- Licensed practical nurses; or
- Certified Medical Assistants.

Emergency Services

Emergency services, including those for specialized behavioral health, may be rendered without the requirement of prior authorization of any kind. Emergency Services are covered and reimbursable regardless of whether the provider that furnishes the emergency services is part of AmeriHealth Caritas Louisiana's provider network.

Payment is not denied for treatment when an AmeriHealth Caritas Louisiana representative instructs the enrollee to seek emergency services and payment is not denied for treatment when an enrollee has an emergency medical condition as defined in 42 C.F.R. § 438.114(a).

The attending emergency physician, or the provider treating the enrollee shall determine when the enrollee is sufficiently stabilized for transfer or discharge and that determination is binding on coverage and payment of emergency and post-stabilization services.

An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

Emergency ancillary services which are provided in a hospital include, but are not limited to, radiology, laboratory, emergency medicine and anesthesiology.

The professional component of these services is reimbursed at a rate equal to or greater than the published Medicaid FFS rate in effect on the date of service to in-network providers (either inpatient or outpatient).

Emergency ancillary services rendered by non-network providers in a hospital setting are reimbursed at the published Medicaid fee schedule in effect on the date of service.

Post-Stabilization services (after emergency services) are covered as specified in 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(2)(i), (ii) and (iii), and are paid within or outside the AmeriHealth Caritas Louisiana network that are:

- Pre-approved by a network provider or other AmeriHealth Caritas Louisiana representative; or
- Not preapproved by a network provider or other AmeriHealth Caritas Louisiana representative, but are:
    - Administered to maintain the enrollee's stabilized condition within one hour of a request for pre-approval of further post-stabilization care services or
    - Administered to maintain, improve, or resolve the enrollee's stabilized condition if AmeriHealth Caritas Louisiana:
- Does not respond to a request for pre-approval within one hour;
- Cannot be contacted; or
- AmeriHealth Caritas Louisiana's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a network physician is not available for consultation. In this situation, the treating physician is given the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.

AmeriHealth Caritas Louisiana's financial responsibility for post-stabilization care services that it has not pre-approved ends when:

- A network physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A network physician assumes responsibility for the enrollee's care through transfer;
- A representative of AmeriHealth Caritas Louisiana and the treating physician reach an agreement concerning enrollee's care; or
- The enrollee is discharged.

End Stage Renal Disease Services

Dialysis treatment replaces the function of the kidneys, which normally serve as the body's natural filtration system. Using a blood filter and a chemical solution known as dialysate, the treatment removes waste products and excess fluids from the bloodstream, while maintaining the proper chemical balance of the blood. There are two (2) types of dialysis treatment:

1. Hemodialysis; and
2. Peritoneal dialysis.

Dialysis services are covered as an optional medical service for enrollees. Enrolled free-standing end stage renal disease (ESRD) facilities are reimbursed for the services outlined in this manual to include, but not limited to, the following:

1. Dialysis treatment including routine laboratory services;
2. Medically necessary non-routine lab services; and
3. Medically necessary injections.

Only outpatient end stage renal disease (ESRD) services are covered at enrolled freestanding ESRD centers. Renal dialysis services are covered for the first three months of dialysis, pending Medicare eligibility. Covered services include renal dialysis treatments (hemodialysis and peritoneal dialysis), routine laboratory services, non-routine laboratory services and medically necessary injections.

NOTE: Hospital inpatient ESRD services are not covered at free-standing ESRD centers.

Reimbursement is provided to free standing ESRD facilities for hemodialysis services.

Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) services may be provided to home dialysis patients. Providers approved for CAPD services may also provide CCPD services.

For both services, Louisiana Medicaid utilization of Medicare's composite rate reimbursement system, Method I only is followed. Under this reimbursement system, the dialysis facility must assume responsibility for providing all home dialysis equipment, supplies, and home support services. Some of the support services include the administering of medications, training the enrollee to perform the home dialysis treatment, and the delivery of supplies. Reimbursement for these support services is included in the composite rate.

Support services specifically applicable to the home CAPD and CCPD enrollee include:

- Changing the connection tube (also referred to as an administration set);
- Observing the enrollee perform CAPD and CCPD to:
    - Ensure the process is completed correctly;
    - Instruct the enrollee in the techniques he/she may have forgotten; or
    - Inform the enrollee of modifications in the apparatus or technique.
- Documenting whether the enrollee has or had peritonitis that requires physician intervention or hospitalization (Unless there is evidence of peritonitis, a culture for peritonitis is not necessary);
- Inspecting the catheter site;

- Drawing blood samples;
- Administering medications prescribed by the enrollee's physician to treat a renal related condition;
- Administering blood or blood products prescribed by the physician;
- Providing social services consultation and/or intervention;
- Performing delivery, installation, maintenance, repair and testing of the cycler; and
- Delivering all dialysis related supplies.

Eye Care and Vision Services

Benefits for routine eye care and visions services are as follows:

- Enrollees younger than 21 years of age are eligible for:
    - Routine eye examinations once every calendar year, or more often if medically necessary.
    - Three (3) pairs of prescription eyeglasses, per calendar year, or more often if medically necessary.
    - Prescription contact lenses if medically necessary when they are the only method for restoring vision.
- Enrollees 21 years of age and older are eligible for:
    - Routine eye examinations once per year.
    - $100 allowance toward the purchase of eyeglasses (frame and lenses) or contact lenses once per year.

Non-routine eye care services resulting from accidental injury or trauma to the eye(s), or treatment of eye disease is also covered. The PCP should initiate appropriate authorizations for all non-routine eye care services.

Replacements for lost, stolen or broken prescription eyeglasses are covered if approved. Also, if prescription contact lens are lost, stolen, or broken they may be replaced with prescription eyeglasses. Please contact Provider Services at 1-888-922-0007 to obtain an approval.

All routine eye care, vision services (including medical treatment of eye diseases) inquiries should also be directed to Provider Services at 1-888-922-0007.

Requirements for provision and authorization of services within the scope of licensure for optometrists is not more stringent than those requirements for participating ophthalmologists.

AmeriHealth Caritas Louisiana will not limit an enrollee's free choice of providers by restricting access to eyewear from a single optical lab. Enrollees will be given a choice of using a local provider for eyewear.

Family Planning Services

Enrollees are covered for family planning services without a referral and do not require prior authorization for either participating or non-participating providers.

Hysterectomies and abortions are NOT considered family planning.

Family planning services, include but not limited to:

- Comprehensive medical history and physical exam at least once per year. This visit includes anticipatory guidance and education related to enrollees' reproductive health/needs;

- Contraceptive counseling to assist enrollees in reaching an informed decision (including natural family planning, education follow-up visits, and referrals);

- Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health;

- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered;

- Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration;

- Male and female sterilization procedures provided in accordance with 42 C.F.R. Part 441, Subpart F;

- Treatment of major complications from certain family planning procedures such as: treatment of perforated uterus due to intrauterine device insertion; treatment of severe menstrual bleeding caused by a medroxyprogesterone acetate injection requiring dilation and curettage; and treatment of surgical or anesthesia-related complications during a sterilization procedure; and

- Transportation services to and from family planning appointments provided all other criteria for Non-Emergency Medical Transportation (NEMT) are met.

- Family planning services also include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection, or treatment of sexually transmitted infections (STIs), and age-appropriate vaccination for the prevention of HPV and cervical cancer. Prior authorization shall not be required for treatment of STIs.

High STI prevalence is addressed by incentivizing providers to conduct screening, prevention education and early detection, including targeted outreach to at risk populations.

Family planning providers are encouraged to communicate with the enrollee's PCP once any form of medical treatment is undertaken.

Assisted reproductive technology is not reimbursed for treatment of infertility.

Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Services

An FQHC/RHC agrees to provide those primary care services typically included as part of a physician's medical practice. Services and supplies that are furnished by FQHC/RHC staff and are incident to the FQHC/RHC professional service are considered part of the FQHC/RHC service. An FQHC/RHC can also provide services related to the diagnosis and treatment of mental illness, and, in certain instances, visiting nurse services.

The following FQHC/RHC reimbursable services are referred to as core services:

- Physician services;

- Services and supplies incident to physician's services;
- Physician assistant services;
- Nurse practitioners and certified nurse mid-wife services;
- Services and supplies incident to the services of nurse practitioners, physician assistants, and certified nurse mid-wives;
- Visiting nurse services to the homebound;
- Clinical psychologist services;
- Clinical social worker services; and
- Services and supplies incident to the services of clinical psychologists and clinical social workers.
- Basic lab services (specific to RHCs).

NOTE: DSMT and Fluoride Varnish applications are covered but these services alone do not constitute an encounter visit.

For reimbursement purposes, a service visit must be provided for a provider to be paid a Prospective Payment System (PPS) rate.

Payments specified as the PPS rates are all inclusive of professional, technical and facility charges, including evaluation and management, routine surgical and therapeutic procedures, and diagnostic testing (including laboratory/pathology and radiology) capable of being performed on site at the FQHC/RHC and must be billed by utilizing the facilities' provider identification number (ID) and Tax Identification Number (TIN).

- Laboratory/pathology, radiology and medications administered are not separately reimbursable. To the extent that the provider has the capabilities to provide these services and has historically provided these services, the FQHC/RHC shall continue to provide such services; and
- The bundling of therapeutic and diagnostic testing services in the PPS rate is not meant to imply that the FQHC/RHC shall vend or refer out such ancillary services to other providers merely for the purpose of maximizing reimbursement.

Services and supplies incidental to a service visit include those services commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications, and supplies used in a patient service visit. Services provided incidental to a service visit must be furnished by an employee and must be furnished under the direct supervision of an FQHC/RHC health care practitioner, meaning the health care practitioner must be immediately available, when necessary, even if by telephone.

NOTE: Professional services performed in the FQHC/RHC are subject to recoupment if billed under a physician/practitioner's individual Medicaid ID number.

Please refer to the **Claim Filing Instructions** manual for FQHC/RHC billing guidelines.

Genetic Counseling and Testing

Genetic testing for a particular disease should generally be performed once per lifetime; however, there are rare instances in which testing may be performed more than once in a lifetime (e.g., previous testing methodology is inaccurate, or a new discovery has added significant relevant mutations for a disease).

Genetic counseling is required before and after all genetic testing. Counseling must consist of at least all the following and be documented in the enrollee's medical record:

- Obtaining a structured family genetic history;
- Genetic risk assessment; and
- Counseling of the enrollee and family about diagnosis, prognosis, and treatment.

When performed by licensed genetic counselors, services using the procedure code specific to genetic counseling are reimbursed. Reimbursement for this service is "incident to" the services of a supervising physician and is limited to no more than 90 minutes on a single day of service.
When performed by providers other than licensed genetic counselors, counseling under an applicable evaluation and management code is reimbursed.

Genetic testing for BRCA1 and BRCA2 mutations is covered and considered in cancer-affected individuals and cancer-unaffected individuals to be medically necessary if the enrollee meets the criteria listed below:

- Individuals with any blood relative with a known *BRCA1*/*BRCA2* mutation;
- Individuals meeting the criteria below but with previous limited testing (e.g., single gene and/or absent deletion duplication analysis) interested in pursuing multi-gene testing;
- Individuals with a personal history of cancer, defined as one or more of the following:
    - Breast cancer and one or more of the following:
        - Diagnosed age ≤ 45 years; or
        - Diagnosed at age 45—50 years with:
            - Unknown or limited family history; or
            - A second breast cancer diagnosed at any age; or
              ≥ 1 close blood relative* with breast, ovarian, pancreatic, or high-grade (Gleason score ≥ 7) or intraductal prostate cancer at any age
        - Diagnosed at age ≤ 60 years with triple negative (ER–, PR–, HER2–) breast cancer;
        - Diagnosed at any age with:
            - Ashkenazi Jewish ancestry; or
            - ≥1 close blood relative* with breast cancer at age ≤ 50 years or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or
            - ≥3 total diagnoses of breast cancer in patient and/or close blood relatives*
        - Diagnosed at any age with male breast cancer; or
        - Epithelial ovarian cancer (including fallopian tube cancer or peritoneal cancer) at any age;
    - Exocrine pancreatic cancer at any age;
    - Metastatic or intraductal prostate cancer at any age;
    - High-grade (Gleason score ≥ 7) prostate cancer at any age with:
        - Ashkenazi Jewish ancestry; or
        - ≥1 close blood relative* with breast cancer at age ≤ 50 years or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or

        - ≥2 close blood relatives* with breast or prostate cancer (any grade) at any age
    - A mutation identified on tumor genomic testing that has clinical implications if also identified in the germline
    - To aid in systemic therapy decision-making, such as for HER2-negative metastatic breast cancer
- Individuals with a family history of cancer, including unaffected individuals, defined as one or more of the following:
    - An affected or unaffected individual with a 1st- or 2nd-degree blood relative meeting any of the criterion listed above (except individuals who meet criteria only for systemic therapy decision-making); or
    - An affected or unaffected individual who otherwise does not met criteria above but also has a probability > 5% of a *BRCA1/2* pathogenic variant based on prior probability models (e.g., Tyer-Cuzick, BRCAPro, Pennll)

*For familial assessment, close blood relatives include first-, second-, and third-degree relatives on the same side of the family (maternal or paternal):

- 1st-degree relatives are parents, siblings, and children;
- 2nd-degree relatives are grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings; or
- 3rd-degree relatives are great-grandparents, great-aunts, great-uncles, great grandchildren and first cousins.

FAP is caused by a hereditary genetic mutation in the APC tumor suppressor gene which leads to development of adenomatous colon polyps.

Genetic testing for adenomatous polyposis colic (APC) gene mutation to diagnose Familial Adenomatous Polyposis (FAP) is covered and considered to be medically necessary if the enrollee meets the following criteria:

- Personal history of > 20 cumulative adenoma; or
- Known deleterious APC mutation in first-degree family enrollee.

Genetic testing for Lynch Syndrome is covered and considered to be medically necessary when an enrollee meets the following criteria:

- Amsterdam II criteria; or
- Revised Bethesda Guidelines; or
- Estimated risk ≥ 5% based on predictive models (MMRpro, PREMM5, or MMRpredict).

For Amsterdam II criteria there must be at least three relatives with a Lynch Syndrome associated cancer (e.g., cancer of the colorectal, endometrium, small bowel, ureter, or renal pelvis) and all the following criteria should be present:

- One must be a first-degree relative to the other two;
- Two or more successive generations must be affected;
- One or more must be diagnosed before 50 years of age;
- Familial adenomatous polyposis should be excluded in the colorectal cancer; and
- Tumors must be verified by pathological examination.

For revised Bethesda guidelines one or more criterion must be met:

- Colorectal or uterine cancer diagnosed in a patient who is less than 50 years of age;

- Presence of synchronous (coexist at the same time), metachronous (previous or recurring) colorectal cancer, or other Lynch Syndrome associated tumors*;
- Colorectal cancer with the MSI-H** histology*** diagnosed in a patient who is less than 60 years of age;
- Colorectal cancer diagnosed in one or more first-degree relatives with a Lynch syndrome related tumor, with one of the cancers being diagnosed under 50 years of age; and/or
- Colorectal cancer diagnosed in two or more first- or second-degree relatives with Lynch Syndrome related tumors, regardless of age.

*Hereditary nonpolyposis colorectal cancer (HNPCC)-related tumors include colorectal, endometrial, stomach, ovarian, pancreas, ureter and renal pelvis, biliary tract, and brain (usually glioblastoma as seen in Turcot syndrome) tumors, sebaceous gland adenomas and keratoacanthomas in Muir-Torre syndrome, and carcinoma of the small bowel.

**MSI-H - microsatellite instability–high in tumors refers to changes in two or more of the five National Cancer Institute-recommended panels of microsatellite markers

***Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern.

Glasses, Contacts, and Eyewear

Refer to **Eye Care and Vision Services** section of this manual for coverage details.

Gynecology

Gynecologic services include:

- Hysterectomies;
- Long-acting reversible contraceptives;
- Mammograms;
- Pap smears;
- Pelvic examinations; and
- Saline Infusion sonohysterography or hysterosalpingography

Non-elective, medically necessary **hysterectomies** are covered if the following requirements are met:

- The person securing authorization to perform the hysterectomy has informed the individual and her representative (if any), both orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and

- The individual or their representative (if any) has signed a written acknowledgement of receipt of that information.

NOTE: These regulations apply to all hysterectomy procedures, regardless of the enrollee's age, fertility, or reason for surgery.

Hysterectomies are **not** covered if one of the following applies**:**

- If it is performed solely for the purpose of terminating reproductive capability; or
- If there is more than one purpose for performing the hysterectomy, but the procedure would not be performed except for the purpose of rendering the individual permanently incapable of reproducing.

The Acknowledgement of Receipt of Hysterectomy Information (hysterectomy consent form) (available online at www.amerihealthcaritasla.com) must be signed and dated by the enrollee on or before the date of the hysterectomy, and include signed acknowledgement the enrollee has been informed the hysterectomy will result in permanent loss of reproductive ability.

When submitting claims for services that require a hysterectomy consent form, the name on the Medicaid file for the date of service on which the form was signed, must be the same as the name signed at the time consent was obtained. If the enrollee's name is different, the provider must attach a letter from the physician's office from which the consent was obtained. The letter must be:

- Signed by the physician;
- State that the enrollee's name has changed;
- Include the enrollee's social security number and date of birth; and
- Be attached to all claims requiring consent upon submission for claims processing.

A witness signature is needed on the hysterectomy consent form when the enrollee meets one of the following criteria:

- Enrollee is unable to sign and must indicate "x" on the signature line; or
- There is a diagnosis on the claim that indicates mental incapacity.

If a witness signs the consent form, the signature date must match the date of the enrollee's signature. If the dates do not match, or the witness does not sign and date the form, claims related to the hysterectomy will deny.

Obtaining consent for a hysterectomy is unnecessary in the following circumstances:

- The individual was already sterile before the hysterectomy, and the physician who performed the hysterectomy certifies that the individual was sterile at the time of the hysterectomy and states the cause of sterility.
- The individual required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible, and the physician certifies in his own writing that the hysterectomy was performed under these conditions and includes in his narrative a description of the nature of the emergency.
- The individual was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy certifies in his own writing that the individual was informed before the operation that the hysterectomy would make the enrollee permanently incapable of reproducing.
- In addition, if the individual was certified retroactively for benefits, and the hysterectomy was performed under one of the two other conditions listed above, the physician must certify in writing that the hysterectomy was

performed under one of those conditions and that the enrollee was informed, in advance, of the reproductive consequences of having a hysterectomy.

Please refer to the **Claim Filing Instructions** manual for details on filing a hysterectomy claim.

Long-acting reversible contraceptive (LARC) devices, in addition to the hospital reimbursement, when provided in the postpartum period prior to discharge are covered. Minimum reimbursement for the LARC device is provided on the Louisiana Medicaid Durable Medical Equipment (DME) Fee Schedules.

Please refer to the **Claim Filing Instructions** manual for billing instruction on the LARC.

Effective June 1, 2024, one mammogram (either film or digital) is covered per calendar year for enrollees meeting one or more of the following criteria:

- Any woman age 30 or older with hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation.
- Provider recommendation for any woman 35 years of age or older with a predicted lifetime risk greater than 20 percent.
- Any woman who is 35 through 39 years of age. Please note: Only one baseline mammogram is allowable between this age range for beneficiaries not meeting other criteria.
- Any woman who is 40 years of age or older.

Under the following instances reimbursement is allowed for an annual magnetic resonance imaging (MRI):

- Women at least 25 years of age with hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation.
- Provider recommendation for any woman 35 years of age or older with a predicted lifetime risk greater than 20 percent.
- Any woman 40 or older, with increased breast density (C and D density), if recommended by their physician.
- Women with a prior history of breast cancer below 50 years of age or women with a prior history of breast cancer an any age and dense breast (C and D density).

NOTE: A breast ultrasound is the initial preferred modality, followed by MRI if found to be inconclusive, in this instance.

Pap smears (or cervical cancer screenings), including repeat screening, medically necessary for enrollees under 21 years of age are considered if they meet the following criteria:

- Were exposed to diethylstilbestrol before birth;
- Have human immunodeficiency virus;
- Have a weakened immune system;
- Have a history of cervical cancer or abnormal cervical cancer screening test; or
- Meet other criteria subsequently published by ACOG.

As a **value-added service**, pap smears (or cervical cancer screenings) are covered for **pregnant** enrollees under 21 **regardless of ACOG criteria**. The **claim must be submitted with** a pregnancy diagnosis **(O00.XX-O99.XX)** or it will deny.

Collection of Pap test specimens is included in the reimbursement of the evaluation and management service.

For those enrollees under the age of 21, it is the responsibility of the treating provider to submit the required documentation needed for billing to the laboratory provider.

Routine pelvic examinations are included in the reimbursement for the evaluation and management service. Therefore, routine pelvic examinations are not allowed to be billed as separate procedures.

Pelvic examinations under anesthesia may be medically necessary for certain populations. The provider is required to indicate the medical justification for the pelvic examination under anesthesia in the enrollee's medical record.

Saline infusion sonohysterography or hysterosalpingography are covered, limited to the assessment of fallopian tube occlusion or ligation following a sterilization procedure.

Home Health-Extended Services (Ages 0-20)

Extended Home Health, also known as extended skilled nursing services (a minimum of three or more hours of nursing services per day) may be provided to enrollees under the age of 21 by the home health agency (HHA) if determined to be medically necessary, ordered by an authorized healthcare provider (AHP) and prior authorized by Utilization Management. The enrollee must require skilled nursing care that exceeds the caregiver's ability to care for the enrollee without the extended home health services.

Home Health Services

The following home health services are covered:

- Skilled nursing (intermittent or part-time);
- Home health aide services, in accordance with the plan of care (POC) as recommended by the attending physician;
- Extended skilled nursing services (also referred to as extended home health), as part of EPSDT services, is extended nursing care by a registered nurse (RN) or a licensed practical nurse (LPN) and may be provided to enrollees under age 21 who are considered "medically fragile";
- Rehabilitation services are physical, occupational and speech therapies, including audiology services; and
- Medical supplies, equipment, and appliances, as recommended by the physician, required in the POC for the enrollee and suitable for use in the place of residence.

NOTE: For the initiation of home health services, a face-to-face encounter with the AHP and the enrollee must occur no more than 90 days prior to the start of home health services, or no later than 30 days after the start of home health services.

AmeriHealth Caritas Louisiana's Utilization Management Department coordinates medically necessary home health and home infusion needs with the PCP, attending specialist, hospital home care departments and other providers of home care services. Contact AmeriHealth Caritas Louisiana's Utilization Management Department through NaviNet or fax to 1-866-397-4522 or call 1-888-913-0350 to obtain an authorization.

Due to possible interruptions of the enrollee's State Medicaid coverage, it is strongly recommended that providers call for verification of the enrollee's continued eligibility the 1st of each month. If the need for service extends beyond the initial authorized period, the provider must re-verify eligibility through NaviNet or if not enrolled in NaviNet, through the Medicaid Eligibility Verification System (MEVS).

Section 12006(a) of the 21st Century Cures Act has mandated that states implement an electronic visit verification (EVV) program for home health. The program became effective January 1, 2024. EVV is a web-based system that electronically verifies service visit occurrences and documents the precise time services begin and end via smart devices.

Agencies should use the EVV system designed by the Louisiana Department of Health (LDH), the Louisiana Service Reporting System (LaSRS), to electronically report begin and end times (i.e., clock-in and clock-out) for home health services. Providers have access to this system at no cost and should schedule training for the EVV system by calling LDH's EVV contractor, Statistical Resources Incorporated (SRI) at 225-767-0501.

Agencies that currently utilize a third party EVV vendor may be able to use that vendor in lieu of LaSRS. The required forms are located here. Any questions regarding this should be directed to SRI at 225-767-0501.

Effective April 1, 2024, services are not payable if providers are not utilizing EVV system.

An FAQ has been created to assist providers with their implementation of EVV. It can be found here.

Hospice

Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional, and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

Hospice is covered if an enrollee is terminally ill. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

- Enrollees under 21 years of age who elect hospice shall be eligible for the concurrent care model of hospice.
    - Concurrent care allows the enrollee to elect to receive life-prolonging therapies. Life-prolonging therapies consist of any aspects of the enrollee's medical plan of care that are focused on treating, modifying, or curing a medical condition so that the enrollee may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis.
    - The hospice provider for an enrollee receiving concurrent care is responsible for facilitating communication and coordinating services with the enrollee, enrollee's caregiver (if applicable) and enrollee's non-hospice providers to ensure that the enrollee's overall care is met and that services are non-duplicative.

- When the enrollee turns 21 years of age, the concurrent care benefit is no longer available. Enrollees and families may change their election between standard and concurrent care anytime with the hospice during the hospice benefit period.

- The hospice provider is responsible for making a daily visit available and optional to all enrollees under 21 years of age and for coordinating care to ensure there is no duplication of services.

    - If a daily visit is declined by the enrollee, or their family, then the hospice provider must maintain documentation of the date and reason for not making a visit.
    - The daily visit is not required if the person is not in the home due to hospitalization or inpatient respite stays.

- All questionable services and/or treatments are sent for medical review. All treatments and therapies must be included in the POC. Documentation of therapies and treatment as well as progress notes are required upon each request for a continuation of hospice care and upon the initial request for hospice care if the enrollee is already receiving curative treatment(s).

- An enrollee with a serious illness may have multiple subspecialists, along with a pediatrician, and can continue to receive care from the subspecialist/pediatrician as necessitated by the enrollee's goals of care.

    - The subspecialist/pediatrician shall assist with care coordination for life-prolonging therapies. The hospice providers and subspecialist/pediatrician shall work together to ensure a collaborative approach when concurrent care model is being utilized.

- For the duration of an election of hospice care, an enrollee age 21 and over waives all rights to the following covered services:

    - Hospice care provided by a hospice agency other than the hospice agency designated by the enrollee or a person authorized by law to consent to medical treatment for the enrollee; and

    - If the enrollee is 21 years or older, any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or services that are equivalent to hospice care, except for services provided by:

        - The designated hospice provider;
        - Another hospice provider under arrangements made by the designated hospice provider; and
        - The enrollee's attending physician if that physician is not an employee of the designated hospice provider or receiving compensation from the hospice provider for those services.

- Services must be approved by the Utilization Department and to avoid denials please follow the guidelines when submitting for assistance.

Hospital Services-Inpatient and Outpatient

A hospital is defined as any institution, place, building, or agency, public or private, whether for profit or not, maintaining, and operating facilities, 24-hours a day, seven days a week, having 10 licensed beds or more.

The hospital must be properly staffed and equipped for the diagnosis, treatment and care of persons admitted for overnight stay or longer who are suffering from illness, injury, infirmity, or deformity or other physical or mental conditions for which medical, surgical and/or obstetrical services would be available and appropriate.

Such hospitals must meet the Louisiana Department of Health's (LDH's) licensing requirements.

Trade area is defined as the counties located in Mississippi, Arkansas, and Texas that border the state of Louisiana. Acute care out-of-state providers in the trade area are treated the same as in-state providers.

The following is a list of counties located in the trade area:

Louisiana Trade Area		
Arkansas Counties	Mississippi Counties	Texas Counties
Chicot County	Hancock County	Cass County
Ashley County	Pearl River County	Marion County
Union County	Marion County	Harrison County
Columbia County	Walthall County	Panola County
Lafayette County	Pike County	Shelby County
Miller County	Amite County	Sabine County
	Wilkerson County	Newton County
	Adams County	Orange County
	Jefferson County	Jefferson County
	Claiborne County	
	Washington County	
	Issaquena County	
	Warren County	

Inpatient Hospital Services

Inpatient hospital care is defined as care needed for the treatment of an illness or injury, which can only be provided safely and adequately in a hospital setting and includes those basic services that a hospital is expected to provide. Payment shall not be made for care that can be provided in the home or for which the primary purpose is of a convalescent or cosmetic nature.

- Inpatient hospital services must be ordered by the following:

  - Attending physician, or other licensed and qualified health care provider;
  - An emergency room physician; or
  - Dentist (if the patient has an existing condition which must be monitored during the performance of the authorized dental procedure).

- Each day of an inpatient stay must be medically necessary.
- Physicians responsible for an enrollee's care at the hospital are responsible for deciding whether the enrollee should be admitted as an inpatient. Place of treatment must be based on medical necessity.
- Prior authorization is required except for dual Medicare/Medicaid eligible enrollees and pregnant enrollees that meet the delivery day requirements. Please refer to Obstetrics section in this manual.

The number of days of care charged to an enrollee for inpatient hospital services is in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for Medicaid reporting purposes. A part of a day, including the day of admission, counts as a full day. However, the day of discharge or death is not counted as a day unless discharge or death occurs on the day of admission. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Rapid whole genome sequencing performed in the inpatient setting for infants with complex illnesses of unknown etiology is covered. Rapid whole genome sequencing includes individual sequencing; trio sequencing of the parents of the infant; and ultra-rapid sequencing.

Rapid whole genome sequencing is considered medically necessary for infants less than 12 months of age who are receiving inpatient hospital services in an intensive care or pediatric unit if they meet the following criteria:

- Are suspected of having a rare genetic condition that is not diagnosable by standard methods;
- Have symptoms that suggest a broad differential diagnosis that requires an evaluation by multiple genetic tests if advanced molecular techniques, including, but not limited to, traditional whole genome sequencing, rapid whole genome sequencing, and other genetic and genomic screening, are not performed;
- Timely identification of a molecular diagnosis is necessary to guide clinical decision making, and the advanced molecular techniques including, but not limited to, traditional whole genome sequencing, rapid whole genome sequencing, and other genetic and genomic screening results may guide the treatment or management of the infant's condition;
- Have an illness with at least one of the following features:
  - Multiple congenital anomalies;
  - Specific malformations highly suggestive of a genetic etiology;
  - Abnormal laboratory tests suggesting the presence of a genetic disease or complex metabolic phenotype like, but not limited to, an abnormal newborn screen, hyperammonemia, or lactic acidosis not due to poor perfusion;
  - Refractory or severe hypoglycemia;
  - Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems;
  - Severe hypotonia;
  - Refractory seizures;
  - A high-risk stratification on evaluation for a brief resolved unexplained event with any of the following:

    - A recurrent event without respiratory infection,
    - A recurrent witnessed seizure-like event, or
    - A recurrent cardiopulmonary resuscitation;
  - Abnormal chemistry levels including, but not limited to, electrolytes, bicarbonate, lactic acid, venous blood gas, and glucose suggestive of inborn error of metabolism;
  - Abnormal cardiac diagnostic testing results suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease; or
  - Family genetic history related to the infant's condition.

Rapid whole genome sequencing requires prior authorization and must be ordered by the infant's treating physician. The ordering physician must be a medical geneticist or other physician sub-specialist including, but not limited to, a neonatologist or pediatric intensivist with expertise in the conditions and/or genetic disorder for which testing is being considered.

Counseling is required before and after all genetic testing, and must be documented in the medical record, as per the *Genetic Counseling and Testing* section of this manual.

Please refer to the **Claim Filing Instructions** manual for reimbursement and billing details for rapid whole genome sequencing claims.

Outpatient Hospital Services

Outpatient hospital services are defined as diagnostic and therapeutic services rendered under the direction of a physician or dentist to an outpatient in an enrolled, licensed, and certified hospital. Medically necessary outpatient hospital services provided to enrollees are covered.

Inpatient services shall not be billed as outpatient, even if the stay is less than 24 hours. Federal regulations are specific regarding the definition of both inpatient and outpatient services.

Outpatient services (including diagnostic testing) that are related to an inpatient admission and are performed either during or within 24 hours of the inpatient admission, regardless of hospital ownership, will not be reimbursed separately as an outpatient service. The inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may reflect the outpatient charges on its claim.

The only exceptions to this criteria are as follows:

- Outpatient therapy services performed within 24 hours before an inpatient admission or 24 hours after the enrollee's discharge that are either related or unrelated to the inpatient stay; and
- Transfers from a hospital emergency department to a different hospital/provider for inpatient admission.
- If either of the above exceptions are met, separate billing and payment for the outpatient hospital service is allowed.

If an enrollee is treated in the emergency room and requires surgery, which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided the enrollee is not admitted as an inpatient.

Physicians responsible for an enrollee's care at the hospital are responsible for deciding whether the enrollee is to be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for enrollees who are expected to need hospital care for 24 hours or more and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment, which can be made only after the physician has considered several factors. Admissions of enrollees are not covered or non-covered solely based on the length of time the enrollee spends in the hospital.

Reimbursement is made up to 48 hours when medically necessary for an enrollee to be in an outpatient status. This time frame is for the physician to observe the enrollee and to determine the need for further treatment, admission to an inpatient status or for discharge. If the enrollee is admitted as an inpatient, the admit date goes back to the beginning of the outpatient services.

Hyperbaric Oxygen Therapy

Hyperbaric oxygen (HBO) therapy is covered when provided in an outpatient hospital setting.

HBO therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Reimbursement for hyperbaric oxygen therapy is limited to treatments administered in a hyperbaric oxygen therapy chamber. HBO therapy is covered for the following conditions, if deemed medically necessary:

- Aute carbon monoxide intoxication;
- Decompression illness;
- Gas embolism;
- Gas gangrene;
- Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
- Crush injuries and suturing of severed limbs. HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened;
- Progressive necrotizing infections (necrotizing fasciitis);
- Acute peripheral arterial insufficiency;
- Preparation and preservation of compromised skin grafts (not for primary management of wounds);
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management;
- Osteoradionecrosis as an adjunct to conventional treatment;
- Soft tissue radionecrosis as an adjunct to conventional treatment;
- Cyanide poisoning; and
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.
- Diabetic wounds of the lower extemities when:
    - The wound is classified as Wagner grade 3 or higher; and
    - An adequate course of standard wound therapy was not sufficient to lead to healing.

Immunizations/Vaccines

All Medicaid-enrolled providers that provide EPSDT well child preventive screenings are required to be enrolled in the Vaccines for Children (VFC) program and utilize VFC vaccines for enrollees aged birth through 18 years of age.

Providers can obtain a VFC enrollment packet by calling the Office of Public Health's (OPH) Immunization Section [**link**] at (504) 568-2600.

For enrollees age 18 and younger, only vaccine administration for immunizations recommended by the Advisory Committee on Immunization practices (ACIP) are covered. Vaccines for enrollees age 18 and younger are provided free of charge through the Louisiana Immunization Program/Vaccines for Children program, as described below.

For enrollees age 19 and older, all ACIP-recommended vaccines, and vaccine administration are covered, according to ACIP recommendations and without restrictions or prior authorization.

AmeriHealth Caritas Louisiana encourages combination vaccines to maximize the opportunity to immunize and to reduce the number of injections a child receives in one day. Providers are not reimbursed for a single-antigen vaccine and its administration if a combined-antigen vaccine is medically appropriate, and the combined vaccine is approved by the Secretary of the U.S. Department of Health and Human Services.

AmeriHealth Caritas Louisiana's policy includes the following provisions regarding flu vaccine shortages:

- If a Medicaid provider does not have the VFC pediatric influenza vaccine on hand to vaccinate a **high priority** Medicaid-enrolled child, the provider should not turn away, refer, or reschedule the enrollee for a later date if the vaccine is available from private stock. The provider should use pediatric influenza vaccine from private stock and replace the dose(s) used from private stock with dose(s) from VFC stock when the VFC vaccine becomes available.
- If a Medicaid provider does not have the VFC pediatric influenza vaccine on hand to vaccinate a **non-high priority or non-high risk** Medicaid-enrolled child, the enrollee can:
    - Wait for the VFC influenza vaccine to be obtained, or
    - If the enrollee chooses not to wait for the VFC influenza vaccine to be obtained, and the provider has private stock of the vaccine on hand, AmeriHealth Caritas reimburses only the administration of the private stock vaccine.
        - If the provider intends to charge the enrollee for the vaccine, then prior to the injection, the provider must inform the enrollee/guardian that the actual vaccine does not come from the VFC program and the enrollee is responsible for the cost of the vaccine. In these situations, the provider must obtain signed documentation that the enrollee is responsible for reimbursement of the vaccine only.

Louisiana Immunization Network (LINKS) is a computer-based system designed to track immunization records for providers and their patients by:

- Consolidating immunization information among all healthcare providers,
- Assuring adequate immunization coverage levels, and
- Avoiding duplicative immunizations.

AmeriHealth Caritas Louisiana accesses LINKS directly to obtain immunization reports. LINKS can be accessed through the OPH website [link].

Providers are required to report the required immunization data into LINKS.

Effective for dates of service **on and after August 1, 2024**, LDH has updated immunization fee schedules to include immunization coverage for some ages that were not previously included. A listing of the immunization CPT codes that have been added for certain ages is in our **Claims Filing instructions** manual (link below).

Please refer to the **Claim Filing Instructions** manual for reimbursement and billing details on Immunizations/Vaccines.

"Incident to" Services

"Incident to" services mean services or supplies that are furnished as an integral, although incidental, part of a supervising provider's professional services. For physicians, "incident to" services include those provided by auxiliary personnel (e.g., medical assistants, licensed practical nurses, registered nurses, etc.) but exclude those provided by an advanced practice registered nurse (APRN) and physician assistant (PA).

For APRNs and PAs, "incident to" services also include those provided by auxiliary personnel. For all "incident to" services, auxiliary personnel must only operate within the scope of practice of their license or certification.

Provider supervision must consist of either personal participation in the service or direct supervision coupled with review and approval of the service notes. Direct supervision is defined as the provider being present in the facility, although not necessarily present in the room where the service is being rendered, and immediately available to provide assistance and direction throughout the time the service is performed. For Office of Public Health clinics and services provided by community health workers (CHWs), providers must furnish general supervision, defined as under the supervising provider's overall direction and control, but the provider's presence is not required in the facility during the performance of the service.

When an APRN or PA provides all parts of the service without a supervising or collaborating physician's involvement, even if a physician signs off on the service or is present in the facility, the service does not meet the requirements of "incident to" services. Instead, claims for these services must be submitted using the APRN or PA as the rendering provider.

It is inappropriate for a physician to submit claims for services provided by an APRN or PA with the physician listed as the rendering provider when the physician is only supervising, reviewing, or "signing off" on the APRN's or PA's records. Services billed in this manner are subject to post-payment review, recoupment, and additional sanctions as deemed appropriate by Louisiana Medicaid.

Integrated Healthcare Screening

AmeriHealth Caritas Louisiana understands that coordination of care for members is imperative. Through collaboration and communication, we can identify not only biological needs of the patient, but the psychological and social needs as well. Therefore, to advance healthcare integration, we are asking our physical health and behavioral health providers to use screening tools to help identify issues and make appropriate referrals for services.

Physical health providers may complete any of the following screenings for behavioral health concerns:

- Patient Health Questionnaire-9A (PHQ-9A) (Ages 12-17)

- Patient Health Questionnaire-9 (PHQ-9) (Ages 18+)

- Patient Stress Questionnaire (Ages 18+)

Physical health providers will be reimbursed $15 for each screen completed on a member. The screening may be conducted/performed up to 4 times per calendar year.

Behavioral health providers may complete the following screening on any member for physical health concerns:

- Health and Wellness Questionnaire.

Behavioral health providers will be reimbursed $15 for each screen completed on a member. The screening may be conducted/performed up to 2 times per calendar year. A Licensed Mental Health Practitioner (LMHP) should be completing this form as part the full bio-psycho-social assessment.

Please refer to the **Claim Filing Instructions** manual for Integrated Healthcare Screening billing guidelines

Intrathecal Baclofen Therapy (ITB)

Surgical implantation of a programmable infusion pump for the delivery of intrathecal baclofen (ITB) therapy is covered for individuals four years of age and older who meet medical necessity for the treatment of severe spasticity of the spinal cord or of cerebral origin.

The following diagnoses are considered appropriate for ITB treatment and infusion pump implantation:

- Meningitis;
- Encephalitis;
- Dystonia;
- Multiple sclerosis;
- Spastic hemiplegia;
- Infantile cerebral palsy;
- Other specified paralytic syndromes;
- Acute, but ill-defined, cerebrovascular disease;
- Closed fracture of the base of skull;
- Open fracture of base of skull;
- Closed skull fracture;
- Fracture of vertebral column with spinal cord injury;
- Intracranial injury of other and unspecified nature; or
- Spinal cord injury without evidence of spinal bone injury.

Implantation of an ITB infusion pump is considered medically necessary, when the candidate is four years of age or older with a body mass sufficient to support the implanted system, and one or more of the following criteria is met:

- Inclusive Criteria for Candidates with Spasticity of Cerebral Origin
    - There is severe spasticity of cerebral origin with no more than mild athetosis;
    - The injury is older than one year;
    - There has been a drop in Ashworth scale of 1 or more;

  - Spasticity of cerebral origin is resistant to conservative management; or
  - The candidate has a positive response to test dose of ITB.

- Inclusive Criteria for Candidates with Spasticity of Spinal Cord Origin
  - Spasticity of spinal cord origin that is resistant to oral antispasmodics or side effects unacceptable in effective doses;
  - There has been a drop in Ashworth scale of 2 or more; or
  - The candidate has a positive response to test dose of intrathecal baclofen.

Caution should be exercised when considering ITB infusion pump implantation for candidates who:

- Have a history of autonomic dysreflexia;
- Suffer from psychotic disorders;
- Have other implanted devices; or
- Utilize spasticity to increase function such as posture, balance, and locomotion.

Consideration is not made if the candidate:

- Fails to meet any of the inclusion criteria;
- Is pregnant, or refuses or fails to use adequate methods of birth control;
- Has a severely impaired renal or hepatic function;
- Has a traumatic brain injury of less than one year pre-existent to the date of the screening dose;
- Has history of hypersensitivity to oral baclofen;
- Has a systematic or localized infection which could infect the implanted pump; or
- Does not respond positively to a 50, 75, or 100 mcg intrathecal bolus of baclofen during the screening trial procedure.

Outpatient bolus injections given to candidates for the ITB infusion treatment are covered if medically necessary even if the enrollee fails the screening trial procedure.

Please refer to the **Claim Filing Instructions** manual for ITB billing guidelines.

Laboratory Services

Inpatient and outpatient (hospital and non-hospital) laboratory services are covered when ordered by a physician or other licensed practitioner acting within their scope of practice. Laboratory services that may be required to treat an emergency or to provide surgical services for an excluded service, such as dental services are covered.

Providers are required to include a valid Clinical Laboratory Improvement Amendments (CLIA) number on all claims submitted for laboratory services, including CLIA waived tests.

Please refer to the **Claim Filing Instructions** manual for details on how to submit a CLIA number on the CMS 1500 claim form.

CLIA claim edits are applied to all claims for laboratory services that require CLIA certification and claims that do not meet the required criteria are denied.

Claims are edited to ensure reimbursement is not made to:

- Providers who do not have a CLIA certificate;
- Providers rendering services outside the effective dates of the CLIA certificate; and
- Providers submitting claims for services not covered by their CLIA certificate.

Providers with waiver or provider-performed microscopy (PPM) certificate types may be paid for only waiver and/or PPM codes approved for billing by CMS.

NOTE: The CLIA number is not required for UB-04 claims.

Laboratory services furnished in an office or similar facility other than a hospital outpatient department or clinic are covered. Physicians and other licensed practitioners are reimbursed for laboratory services that they personally perform or supervise, and these physicians and other licensed practitioners are required to comply with all state and federal requirements.

Laboratory services furnished in a hospital laboratory are covered.

For inpatient laboratory services, hospitals are allowed to contract with an independent laboratory. The hospital is required to pay the laboratory for the technical component. AmeriHealth Caritas Louisiana reimburses the independent laboratory for only the professional component of the service, when applicable.

For outpatient laboratory services, hospitals are allowed to contract with an independent laboratory. When a hospital contracts with an independent laboratory for the performance of the technical service only, the hospital is required to pay the laboratory. AmeriHealth Caritas Louisiana does not reimburse the independent laboratory for the technical component only.

When a hospital contracts with an independent laboratory for outpatient or inpatient services, the hospital is required to ensure that both the physician who performs the professional service and the laboratory that performs the technical service meets all applicable state and federal requirements.

Laboratory services provided in independent laboratories are covered. An independent laboratory performs diagnostic tests and is independent of the ordering provider, the hospital, or both.

AmeriHealth Caritas Louisiana only contracts with independent laboratories that meet all applicable state and federal requirements.

Providers are limited to billing the laboratory services that they are CLIA-certified to perform.

Specimen collection is not reimbursed separately, as that service is considered incidental to the evaluation and management service, the laboratory test, or both.

Presumptive and definitive urine drug testing is covered under the following parameters:

- Presumptive drug testing is limited to 24 total tests per enrollee per calendar year.
- Definitive drug testing is limited to 12 total tests per enrollee per calendar year. Definitive drug testing is limited to individuals with an unexpected positive or unexpected negative finding on presumptive drug testing or if there is a clinical reason to detect a specific substance or metabolite that would be inadequately detected through presumptive drug testing.

- Testing more than 14 definitive drug classes in one test is not reimbursable.
- No more than one presumptive test and one definitive test are reimbursed per day per enrollee, from the same or different provider.
- Universal drug testing (screening) in a primary care setting is not covered. Drug testing without signs or symptoms of substance use or without current controlled substance treatment is not covered.

Proprietary Laboratory Analyses (PLA) testing is covered when used for the particular "brand" respiratory panel kit as stated within the CPT codebook.

Coverage of the CPT Proprietary Laboratory Analyses codes **0202U**, **0223U**, **0224U**, **0225U**, **0226U**, **0240U** and **0241U** will be limited solely to services performed in a (UB-04) facility, observation and/or inpatient setting. These procedure codes are no longer covered in an outpatient setting as such they have been removed from the Louisiana Medicaid Laboratory and Radiology Fee Schedule.

Please refer to the **Claim Filing Instructions** manual for details on claim billing for PLA.

Effective **September 1, 2024**, respiratory viral panel codes **87631**, **87632** and **87633** are covered as follows:

CPT code **87631** is deemed medically necessary in the following instances:

- Infants receiving monthly RSV prophylaxis with palivizumab because of high-risk conditions such as prematurity, respiratory disease, or cardiac disease.

- Long-term care facility residents returning to a facility, or a person of any age returning to a congregate setting.

PLEASE NOTE: A primary care physician may perform this 3-5 panel test if medically necessary.

CPT codes **87632** and **87633** are deemed potentially medically necessary only for:

- Beneficiaries with serious or critical illness or at imminent risk of becoming seriously or critically ill, immunodeficiency, and/or severe underlying condition contributory to testing using an expanded syndromic panel.

Testing is approved for the following places of service (POS):

- Places of service (POS) **19** – off-campus outpatient hospital, **21** – inpatient hospital, **22** – on-campus outpatient hospital, **23** – emergency room.

PLEASE NOTE: Tests should be ordered as follows (for healthcare POS other than those listed in the above bullet):

Testing for these services should only occur in accordance with one or more of the following instances:

- For immune-competent beneficiaries, the test must be ordered by an infectious disease specialist or pulmonologist who is diagnosing and treating the beneficiary.

- For immune-compromised beneficiaries, the test must be ordered by a clinician specialist in one of the following: infectious diseases, oncology, transplant (for any panel), or pulmonologist who is diagnosing and treating the beneficiary.

PLEASE NOTE: Regarding the previous two bullets, an exception may be made within geographic locations where the specialist(s) cannot be reasonably reached by the beneficiary; AND the beneficiary is under the care of one of these providers: infectious diseases, oncology, transplant (for any panel), or pulmonologist; and the ordering provider is located closer to the beneficiary's place of residence than the nearest specialist.

This exception is intended for beneficiaries living in rural locations with limited clinical specialist access only.

Limited Abortion Services

This policy describes induced, threatened, incomplete, or missed abortions. Providers are not reimbursed for elective abortions and related services.

Coverage of induced abortions is restricted to that which meets the following criteria:

- A physician has found, and so certifies that based on his/her professional judgment, the life of the pregnant woman would be endangered if the fetus was carried to term.
- The certification statement, which must contain the name and address of the enrollee, must be attached to the claim form. The diagnosis or medical condition which makes the pregnancy life endangering must be specified on the claim.

OR

In the case terminating a pregnancy due to rape or incest, the following requirements must be met:

- The enrollee shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest.
- The report of the act of rape or incest to a law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest must be submitted along with the treating physician's claim for reimbursement for performing an abortion.
- The enrollee shall certify that the pregnancy is the result of rape or incest, and this certification shall be witnessed by the treating physician.
- The "Office of Public Health Certification of Informed Consent-Abortion" form shall be witnessed by the treating physician.

As a condition of reimbursement, claims for treatments related to a threatened, incomplete, or missed abortion must include the enrollee history and complete documentation of treatment.

Supportive documentation that substantiates reimbursement may include one or more of the following, but is not limited to:

- Sonogram report showing no fetal heart tones;
- History indicating passage of fetus at home, en route, or in the emergency room;
- Pathology report showing degenerating products of conception; or
- Pelvic exam report describing stage of cervical dilation.

Please refer to the **Claim Filing Instructions** manual for billing guidelines on abortions.

Medical Transportation Services

AmeriHealth Caritas Louisiana provides emergency and non-emergency medical transportation for its enrollees.

Non-emergency medical transportation (NEMT) is transportation provided to enrollees to and/or from a covered service, including carved-out services, or value-added benefit (VAB) when no other means of transportation is available. NEMT does not include transportation provided on an emergency basis, such as trips to emergency departments in life threatening situations.

Services shall be provided in accordance with the Louisiana Administrative Code (LAC), Title 50, Part XXVII, Chapter 5. NEMT shall not include any non-emergency ambulance transportation or other type of transportation by ambulance . See (La. R.S. 40:1257.1).

NEMT is covered for the least costly means of transportation available that accommodates the level of service required by the enrollee to and/or from a covered service. NEMT must be within the member's transportation service area.

Eligible expenses include the following when necessary to ensure the delivery of medically necessary services:

- Transportation for the enrollee and one attendant; and
- Meals, lodging, and other related travel expenses for the enrollee and one attendant when long distance travel is required. Long distance is defined as when the total travel time, including the duration of the appointment plus the travel to and from the appointment, exceeds 12 hours.

NEMT may be approved on commercial airlines for out-of-state trips when no comparable healthcare services can be provided in Louisiana, and the risk to the enrollee's health is grave if transported by other means. All out-of-state non-emergency medical care must be prior authorized. Transportation may be included in the prior authorization for medical services.

Air travel is reimbursed for the enrollee plus a maximum of one attendant, if medically necessary or if the enrollee is a child, at the lowest, refundable, coach/economy class fare. Upgrades (e.g., fare class or seat) and additional costs (e.g., in-flight refreshments) are not reimbursed.

Transportation providers are informed if an enrollee intends to bring accompanying children or if an attendant is required. Please note, providers may refuse to transport accompanying children. If a child is to be transported, either as the enrollee or an additional passenger, the parent or guardian of the child is responsible for providing an appropriate child passenger restraint system as outlined by **La. R.S. 32:295**. If the enrollee is under the age of 17, an attendant is required.

Emergency ambulance transportation is provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the enrollee (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

An enrollee may also require emergency ambulance transportation if he or she is psychiatrically unmanageable or needs restraint. An ambulance trip that does not meet at least one of these criteria would be considered a non-emergency service and must be coded and billed as such.

Prior review or prior authorization is not required for emergency ambulance transportation; however, can be subject to a post-payment review after service delivery.

Oxygen and disposable supplies are reimbursed separately when medically necessary.

"Ambulance 911-Non-emergency" services are not covered. If the enrollee's medical condition does not present itself as an emergency in accordance with the criteria in this Manual, the service may be considered a non-covered service.

Please refer to the **Claim Filing Instructions** manual for billing guidelines on ambulance non-emergency services.

Non-emergency ambulance transportation (NEAT) is transportation provided by ground or air ambulance to an enrollee to and/or from a covered service, including carved-out services, or value-added benefits (VAB) when no other means of transportation is available, and the enrollee's condition is such that use of any other method of transportation is contraindicated or would make the enrollee susceptible to injury. The nature of the trip is not an emergency, but the enrollee requires the use of an ambulance.

The enrollee's treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition which necessitates ambulance services.

The certifying authority shall complete the date range on the CAT, which shall be no more than 180 days. A single CAT is utilized for all the enrollee's transports within the specified date range. A new CAT from the certifying authority for the same enrollee during this date range is not required.

NEAT must be scheduled by the enrollee or a medical facility through AmeriHealth Caritas Louisiana or the ambulance provider.

- If transportation is scheduled through AmeriHealth Caritas Louisiana, we verify, prior to scheduling, enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed CAT form for the date of service is obtained, reviewed, and accepted by us or our transportation broker. Once the trip has been dispatched to an ambulance provider and completed, the ambulance provider is reimbursed upon submission of the clean claim for the transport.

- If transportation is scheduled through the ambulance provider, the ambulance provider is required to verify the following prior to reimbursement: enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed CAT form for the date of service is obtained, reviewed, and accepted by the ambulance provider. The ambulance provider is reimbursed only if a completed CAT form is submitted with the clean claim or is on file with us or our transportation broker prior to reimbursement.

Mileage must be reimbursed in accordance with the type of services indicated by the licensed medical professional on the CAT form. The **CAT form** is located on the Louisiana Department of Health website.

Enrollees may seek medically necessary services in another state when it is the nearest option available. All out-of-state NEAT transportation to facilities that are not the nearest available option, must be prior approved by AmeriHealth Caritas Louisiana. Transportation to out-of-state medical care may be approved only if the enrollee has been granted approval to receive medical treatment out of state.

Every effort is made to schedule urgent transportation requests and a request is not denied based solely on the appointment being scheduled less than 48 hours in advance. Urgent transportation refers to a request for transportation made by a healthcare provider for a medical service which does not warrant emergency transport but cannot be postponed.

Urgent transportation shall include chemotherapy, radiation, dialysis, OTP, or other necessary medical care that cannot be rescheduled to a later time. An urgent transportation request may occur concurrently with a standing order.

Ambulance providers are prohibited from charging the enrollee or anyone else for the transportation of additional passengers and any claims submitted for transporting additional passengers is not reimbursed.

An attendant is required when the enrollee is under the age of 17. This attendant must:

- Be a parent, legal guardian, or responsible person designated by the parent/legal guardian; and
- Be able to authorize medical treatment and care for the enrollee.

Attendants may not:

- Be under the age of 17; or
- Be a provider or employee of a provider that is providing services to the enrollee being transported, except for employees of a mental health facility in the event an enrollee has been identified as being a danger to themselves or others or at risk for elopement.

Exceptions: All females, regardless of their age, seeking prenatal and/or postpartum care are not required to have an attendant.

Nursing facilities are required to provide medically necessary transportation services for enrollees residing in their facilities. Any nursing facility enrollee needing non-emergency, non-ambulance transportation services are the financial responsibility of the nursing facility. NEAT services provided to a nursing facility enrollee must include the CAT, in accordance with the Coverage Requirements section, to be reimbursed; otherwise, the nursing facility shall be responsible for reimbursement for such services.

Air ambulances may be used for emergency and non-emergency ambulance transportation when medically necessary. Licensure by the LDH Bureau of Emergency Medical Services (EMS) is also required. Licensure for air ambulance services is governed by La. R.S. 40:1135.8. Rotor winged (helicopters) and fixed winged emergency aircraft must be certified by Bureau of Health Services Financing (BHSF) to receive reimbursement.

All air ambulance services must comply with state laws and regulations governing the personnel certifications of the emergency medical technicians, registered nurses, respiratory care technicians, physicians, and pilots as administered by the appropriate agency of competent jurisdiction.

Air ambulance services are covered only if:

- Speedy admission of the enrollee is essential and the point of pick-up of the enrollee is inaccessible by a land vehicle; or
- Great distances or other obstacles are involved in getting the enrollee to the nearest hospital with appropriate services.

If both ground and air ambulance transport are necessary during the same trip, each type of provider is reimbursed separately according to regulations for that type of provider.

Please reference our **Air Ambulance Transport clinical policy** for more details.

When an enrollee is transported to a hospital by ambulance on an emergency basis and is not admitted, the hospital shall request an NEMT return trip with AmeriHealth Caritas Louisiana unless the enrollee meets the medical necessity requirements for NEAT.

An ambulance transfer is the transport of an enrollee by ambulance from one hospital to another. Ambulance transfers are only covered when it is medically necessary for the enrollee to be transported by ambulance. The enrollee must be transported to the most appropriate hospital that can meet their needs.

If the physician makes the decision that the level of care required by the enrollee cannot be provided by the hospital, and the enrollee must be transported by the provider to another hospital, the transportation provider for both transfers are reimbursed once clean claims are submitted for the transfers.

Please refer to the **Claim Filing Instructions** manual for ambulance claim filing instructions.

Newborn Care and Discharge

AmeriHealth Caritas Louisiana assumes financial responsibility for services (in-network or out-of-network) provided to newborns of mothers who are active enrollees within the first month of life. However, these newborns are not automatically enrolled in AmeriHealth Caritas Louisiana at birth.
AmeriHealth Caritas Louisiana contacts enrollees who are expectant mothers 60 calendar days prior to the expected date of delivery to encourage the mother to choose a PCP for her newborn.

Hospitals must report the births of newborns within 24 hours of birth for enrolled enrollees via the LDH Self-Service Provider Portal and they must continue to report births to LDH via the Newborn Request Form via the web-based facility notification system. . If the enrollee makes a PCP selection during the hospital stay and one was not already identified, this information must be reported to AmeriHealth Caritas Louisiana. If no selection is made, AmeriHealth Caritas Louisiana provides the enrollee with a minimum of 14 calendar days after birth to select a PCP prior to assigning one.

Hospitals must also register all births within (15) calendar days through LEERS (Louisiana Electronic Event Registration System) administered by LDH/Vital Records Registry.

The appropriate CPT codes for the initial care of the normal newborn may be paid when the service provided meets the criteria as defined by CPT. This service is limited to once per lifetime of the enrollee.

The CPT code for subsequent care of the normal newborn may be paid for each day care is rendered after the date of birth, other than the discharge date. Up to three normal newborn subsequent care days are covered.

Babies that are not medically appropriate for discharge and remain hospitalized in the regular nursery after the mother's discharge are referred to as "boarder babies". In these cases, the nursery per diem identified on the Louisiana Medicaid Inpatient Hospital Per Diem Fee Schedule shall be the minimum rate paid to hospitals billing the appropriate and covered nursery revenue codes.

Circumcisions are covered as a value-added benefit in the hospital or physician's office setting without an authorization.

Newborn screening includes testing for certain specified conditions recommended by the American College of Medical Genetics. AmeriHealth Caritas Louisiana's policy includes that La. R.S. 40:1081.1 and 40:1081.2 require hospitals with delivery units to screen all newborns before discharge regardless of the newborn's length of stay at the hospital. The Louisiana Administrative Code Title 48, Part V, Subpart 18, Chapter 63 provides the requirements related to newborn screenings.

NOTE: Refer to the *EPSDT Services Program (Ages 0-20)* section in this manual for additional information on obtaining the results of newborn screenings for genetic disorders.

AmeriHealth Caritas Louisiana has its claims processing systems configured, regarding the billing of initial/subsequent neonatal and pediatric critical care and initial and continuing intensive care services, as follows:

- The claims billed with these codes are configured to pay based on provider specialty.
- The provider specialties listed below are configured to pay with these codes:
    - Neonatologist
    - Pediatric Intensivist
- Claims will deny for any other provider specialty that bills this set of codes.

A baby **detained** after the mother's discharge is regarded as a new admission requiring separate authorization. The admission must be reported to our Utilization Management department and a new case reference number will be issued for the detained baby. Reimbursement for the higher level of care for the baby will revert to the day the baby is admitted to the higher level of care, based on meeting criteria.

Facilities are required to notify us of all admissions to an **intensive care** or **transitional nursery** facility within 24 hours of the admission (even if the admission does not result in the baby being detained).

Facilities are also required to notify of all newborn admissions where the payment under their contract will be other than the newborn rate (even if the baby is not detained or admitted to an intensive care or transitional nursery facility).

Facilities should report through NaviNet, or Fax to 866-397-4522 or call the Utilization Management department at **1-888-913-0350** and follow prompts. When reporting a detained baby or other newborn admission notifications, please be prepared to leave the following information:

- Mother's first and last name
- Mother's AmeriHealth Caritas ID #
- Baby's first and last name
- Baby's date of birth (DOB)

- Baby's sex
- Admission date to intensive care/transitional nursery
- Baby's diagnosis
- First and last name of baby's attending practitioner
- Facility name and AmeriHealth Caritas Louisiana ID #
- Caller's name and complete phone number

Upon review, a Utilization Management Representative contacts the facility and provides the authorization number assigned for the baby's extended stay or other admission. **All facility and associated practitioner charges should be billed referencing this authorization number.**

Detained newborn or other newborn admission charges are paid according to established hospital-contracted rates for the bed-type assigned (e.g., NICU) commencing with the day the mother is discharged from the hospital. A new admission with a new case reference number is assigned for the detained newborn or newborn admitted for other reasons.

Please refer to the **Claim Filing Instructions** manual for details on billing for Newborn Care and Discharge.

Nursing Facility/Non-Hospital Facility

If an enrollee needs to be referred to a Nursing Facility, the PCP should contact our Utilization Management (UM) Department. Necessary arrangements are coordinated by UM between the PCP, the referring facility, and the Nursing Facility to provide the needed care.

Reimbursement for long term care placement in a Nursing Facility is not covered.

Placement in a Nursing Facility for rehabilitation, skilled nursing, or short-term needs for nursing facility services is covered.

If an enrollee is entering a Nursing Facility for long-term care needs, they are transitioned out of the Healthy Louisiana program by LDH, and AmeriHealth Caritas Louisiana is not responsible for those charges.

If an enrollee requires extended care in a non-hospital facility for rehabilitation purposes, our Utilization Management Department assists by coordinating the appropriate placement, thus ensuring receipt of medically necessary care.

Prior Authorization is required prior to the enrollee's transfer. Concurrent Review follows the initial authorization. The Utilization Management Department can be reached at 1-888-913-0350.

Obstetrics

Two initial prenatal visits are covered per pregnancy (270 days). These two visits may not be performed by the same attending provider.

The enrollee is considered a 'new patient' for each pregnancy whether the enrollee is a new or established patient to the provider/practice.

Reimbursement for the initial prenatal visit shall include, but is not limited to, the following:

- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy below.);
- Identification of patient at risk for complications including those with prior preterm birth;
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

Notification is required by the provider of obstetrical care at the time of the first visit of the pregnancy.

The reimbursement for this service shall include, but is not limited to:

- The obstetrical (OB) examination;
- Routine fetal monitoring (excluding fetal non-stress testing);
- Diagnosis and treatment of conditions both related and unrelated to the pregnancy; and
- Routine dipstick urinalysis.

Reimbursement is allowed for one postpartum visit per 270 days.

The reimbursement for the postpartum care visit includes, but is not limited to:

- Physical examination;
- Body mass index (BMI) assessment and blood pressure check;
- Routine dipstick urinalysis;
- Follow up plan for women with gestational diabetes;
- Family planning counseling;
- Breast feeding support including referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), if needed;
- Screening for postpartum depression and intimate partner violence; and
- Other counseling and or services associated with releasing a patient from obstetrical care.

The obstetric panel test as defined by CPT is covered only once per pregnancy. A complete urinalysis is covered only one per pregnancy (270 days) per billing provider, or more when medically necessary, for example, to diagnose a disease or infection of the genitourinary tract.

Non-Invasive Prenatal Testing (NIPT) is a genetic test which uses maternal blood that contains cell-free fetal DNA from the placenta. NIPT is completed during the pre-natal period of pregnancy to screen for the presence of some common fetal

chromosomal abnormalities. Common types of chromosomal abnormalities (aneuploidies and microdeletions) in fetuses include:

- Trisomy 21 (Down syndrome);
- Trisomy 18 (Edwards syndrome); and
- Trisomy 13 (Patau syndrome).

NIPT is covered when medically necessary and without the requirement of prior authorization.

NIPT is considered medically necessary once per pregnancy for pregnant women over the age of 35, and for women of all ages who meet one or more of the following high-risk criteria:

- Abnormal first trimester screen, quad screen, or integrated screen;
- Abnormal fetal ultrasound scan indicating increased risk of aneuploidy;
- Prior family history of aneuploidy in first (1st) degree relative11 for either parent;
- Previous history of pregnancy with aneuploidy; and
- Known Robertsonian translocation in either parent involving chromosomes 13 or 21.

NIPT for women with multiple gestations is not covered.

A minimum of three obstetric ultrasounds shall be reimbursed per pregnancy (270 days) without the requirement of prior authorization or medical review when performed by providers other than maternal fetal medicine specialists:

- When an obstetric ultrasound is performed for an individual with multiple gestations, leading to more than one procedure code being submitted, this shall only be counted as one obstetric ultrasound; and
- Obstetric ultrasounds performed in inpatient hospital, emergency department, and labor and delivery triage settings are excluded from this count.

For maternal fetal medicine specialists, there shall be no prior authorization or medical review required for reimbursement of obstetric ultrasounds. In all cases, obstetric ultrasounds must be medically necessary to be eligible for reimbursement.

Fetal non-stress tests are covered when medically necessary as determined by meeting one of the following criteria:

- The pregnancy is post-date/post-maturity (after 41 weeks gestation);
- The treating provider suspects potential fetal problems in an otherwise normal pregnancy; or
- The pregnancy is high risk, including but not limited to diabetes mellitus, pre-eclampsia, eclampsia, multiple gestations, and previous intrauterine fetal death.

Fetal biophysical profiles are covered when medically necessary, as determined by meeting at least two of the following criteria:

- Gestation period is at least 28 weeks
- Pregnancy must be high-risk, and if so, the diagnosis should reflect high risk
- Uteroplacental insufficiency must be suspected in a normal pregnancy

Tobacco cessation counseling for pregnant enrollees is covered when provided by the enrollee's PCP or OB provider. Tobacco cessation counseling may be provided by other appropriate healthcare professionals upon referral from the enrollee's PCP or OB provider, but all care must be coordinated.

During the prenatal period through 60 days postpartum, up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year are covered. These limits may be exceeded if deemed medically necessary.

Minimum reimbursement for tobacco cessation counseling shall be based on the applicable CPT code on the Professional Services Fee Schedule and must be supported by appropriate documentation.

Remote patient monitoring for the management of hypertension and diabetes for pregnant enrollees is covered.

Please refer to the **Claim Filing Instructions** manual for detailed instructions on how to bill all claims related to obstetrics/maternity services.

Organ Transplants

Medically necessary organ transplants are covered when performed in a hospital that is a Medicare approved transplant center for that procedure. Bone marrow transplant, stem cell transplant, and certain autologous immunotherapies (such as CAR T-cell therapy) services shall only be allowable for payment to hospitals that are accredited by the Foundation for the Accreditation of Cellular Therapy (FACT).

Our Medical Director may grant an exception to a transplant center for a specific procedure if the transplant surgeon can demonstrate experience with that specific procedure and a history of positive outcomes in another hospital. The other hospital must be a Medicare approved transplant center for that specific procedure.

Pain Management

Epidurals that are administered for the prevention or control of acute pain are covered, such as that which occurs during delivery or surgery, as professional services for this purpose only.

Pain Management – Chronic Intractable Pain

Coverage for chronic intractable pain is dependent on the clinical etiology and the type of service or treatment.

If an enrollee requests treatment for chronic intractable pain, depending on the underlying cause or anatomical defect, the provider may determine treatment or management to include physical therapy, occupational therapy, medication therapy management (MTM), epidural steroid injection (ESI) therapy, acupuncture, chiropractic, behavioral health, and addiction medicine services in coordination with case management. These include some alternative treatments, and the inclusion of coverage on the Professional Services Fee Schedule to define covered treatments.

Certain Medicaid procedures or services may require prior authorization. CPT codes for the treatment of chronic intractable pain requiring PA can be identified on the **PA Lookup Tool** on the AmeriHealth Caritas Louisiana website.

Note: Medical necessity for ESI is determined by the history of illness, physical examination, and concordant diagnostic imaging supporting radiculopathy, radicular pain, or neurogenic claudication due to herniation, stenosis, and/or degenerative disease protracted and severe enough to greatly impact quality of life or function.

Pediatric Day Healthcare Services (Ages 0-20)

The Pediatric Day Health Care (PDHC) program is designed to provide an array of services to meet the medical, social and developmental needs of children from birth up to 21 years of age who have a complex medical condition which requires skilled nursing care and therapeutic intervention on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life.

PDHC is intended for individuals needing a higher level of care that cannot be provided in a more integrated community-based setting and serves as a community-based alternative to long-term care and extended in-home nursing care. PDHC does not provide respite care, and it is not intended to be an auxiliary (back-up) for respite care.

All PDHC services must be prior authorized. Services may be provided seven days per week and up to 12 hours per day, for qualified enrollees as documented in the Plan of care.

The PDHC facility Medicaid per diem rate includes the following services/equipment:

1. Nursing care;
2. Respiratory care;
3. Physical therapy;
4. Speech-language therapy;
5. Occupational therapy;
6. Social services;
7. Personal care services (activities of daily living); and
8. Transportation to and from the PDHC facility;
9. Transportation shall be paid in a separate per diem.

PDHC providers are not allowed to send enrollees to outside sources to receive the above services.

PDHC services require prior authorization. To receive prior authorization, the following documentation must be sent for each request:

1. An explanation of why the services provided at the PDHC facility cannot be provided elsewhere, including the school system;

2. Physician's most recent note documenting medical necessity for the PDHC;

3. Physician's order and plan of care (POC) for PDHC; and

4. PA checklist indicating the enrollee's skilled nursing care requirements.

NOTE: PDHC services must be approved prior to the delivery of services.

Services shall be ordered by the enrollee's prescribing physician. A face-to-face evaluation must take place every 90 days between the enrollee and prescribing physician. In exceptional circumstances, at the discretion of the physician prior authorizing PDHC services, the face-to-face evaluation requirement may be extended to 180 days. The physician's order for services is required to individually meet the needs of the enrollee and shall not exceed the enrollee's needs.

The order shall contain:

1. Enrollee's name;

2. Date of birth;

3. Sex;

4. Medicaid ID number;

5. Description of current medical conditions, including the specific diagnosis codes;

6. Parent/guardian's name and phone number; and

7. Provider's name and phone number. The physician shall acknowledge if the enrollee is a candidate for outpatient medical services in a home or community-based setting. The physician shall sign, date, and provide their NPI number.

The facility shall maintain an attendance record for each trip.

The record shall include:

1. Method used to transport the enrollee to and from the facility;

2. Name of the person transporting the enrollee;

3. Date and time of the trip release; and

4. Signatures of the driver or parent/guardian and the PDHC facility representative.

The PDHC per diem rate does not include the following services:

1. Education and training services;
2. Before and after school care;
3. Respite services;
4. Childcare due to work or other parental time constraints;
5. Medical equipment, supplies, and appliances;
6. Parenteral or enteral nutrition; and
7. Infant food or formula.

Personal Care Services (Ages 0-20)

Personal care services **covered** for enrollees ages 0-20 are defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements.

EPSDT Personal Care Services (PCS) include the following tasks:

- Basic personal care, including toileting, grooming, bathing, and assistance with dressing;
- Assistance with bladder and/or bowel requirements or problems, including helping the enrollee to and from the bathroom or assisting the enrollee with bedpan routines, but excluding catheterization;
- Assistance with eating and food, nutrition, and diet activities, including preparation of meals for the enrollee only;
- Performance of incidental household services, only for the enrollee, not the entire household, which are essential to the enrollee's health and comfort in his/her home. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the enrollee. Examples of such activities are:
    - Changing and washing the enrollee's soiled bed linens;
    - Rearranging furniture to enable the enrollee to move about more easily in his/her own home; and
    - Cleaning the enrollee's eating area after completion of the meal and/or cleaning items used in preparing the meal, for the enrollee only.
- Remind/prompt an EPSDT eligible enrollee who is over 18 years of age about self-administered medication;

- Accompanying, not transporting, the enrollee to and from his/her physician and/or medical appointments for necessary medical services; and
- Assisting the enrollee with locomotion in their place of service, while in bed or from one surface to another.
- Assisting the enrollee with transferring and bed mobility.

Intent of Services include the following:

- EPSDT PCS shall not be provided to meet childcare needs nor as a substitute for the parent or guardian in the absence of the parent or guardian;
- EPSDT PCS shall not be used to provide respite care for the primary caregiver; and
- EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services that are provided by or shall be provided by the Department of Education.

The following **excluded** services are not appropriate for personal care and are **not** reimbursable as EPSDT PCS:

- Insertion and sterile irrigation of catheters (although changing of a catheter bag is allowed);
- Irrigation of any body cavities which require sterile procedures;
- Application of dressing, involving prescription medication and aseptic techniques; including care of mild, moderate, or severe skin problems;
- Administration of intradermal , subcutaneous, intramuscular, or intravenous injections;
- Administration of medicine;
- Cleaning of the home in an area not occupied by the enrollee;
- Laundry, other than that incidental to the care of the enrollee;

Example: Laundering of clothing and bedding for the entire household as opposed to simple laundering of the enrollee's clothing or bedding.

- Skilled nursing services as defined in the state Nurse Practices Act, including medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;
- Teaching a family member or friend how to care for an enrollee who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the patient is possible;
- Specialized nursing procedures such as:
    - Insertion of nasogastric feeding tube;

  - In-dwelling catheter;
  - Tracheotomy care;
  - Colostomy care;
  - Ileostomy care;
  - Venipuncture; and
  - Injections.

- Rehabilitative services such as those administered by a physical therapist;
- Teaching a family member or friend techniques for providing specific care;
- Palliative skin care with medicated creams and ointments and/or required routine changes of surgical dressings and/or dressing changes due to chronic conditions;
- Teaching of signs and symptoms of disease process, diet, and medications of any new or exacerbated disease process;
- Specialized aide procedures such as:
  - Rehabilitation of the enrollee (exercise or performance of simple procedures as an extension of physical therapy services);
  - Measuring/recording the enrollee's vital signs (temperature, pulse, respiration and/or blood pressure, etc.), or intake/output of fluids;
  - Specimen collection; and
  - Special procedures such as non-sterile dressings, special skin care (nonmedicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight measurement, enemas.
- Home IV therapy;
- Custodial care or provision of only instrumental activities of daily living tasks or provision of only one activity of daily living task;
- Occupational therapy;
- Speech pathology services;
- Audiology services;
- Respiratory therapy;

- Personal comfort items;
- Durable medical equipment;
- Oxygen;
- Orthotic appliances or prosthetic devices;
- Drugs provided through the Louisiana Medicaid pharmacy program;
- Laboratory services; and
- Social work visits.

The agency must use an electronic visit verification (EVV) system for time and attendance tracking and billing for EPSDT – PCS. EPSDT – PCS providers identified by the Plan must use the following:

- The (EVV) system designated by the Department; or
- An alternate system that has successfully passed the data integration process to connect to the designated EVV system and is approved by the Department.

Reimbursement for services may be withheld or denied if an EPSDT – PCS provider fails to use the EVV system or uses the system not in compliance with Medicaid's policies and procedures for EVV.

Please reference our **EPSDT-PCS clinical policy** for more details.

Pharmacy Services

Distribution of specialty drugs are not limited. Any qualified pharmacy that can procure specialty drugs from distributors, has any one of the nationally recognized accreditations and is willing to accept the terms of AmeriHealth Caritas Louisiana's contract are allowed to participate in the network (any willing provider). Any one of the nationally recognized accreditation programs to meet its specialty pharmacy network requirement are accepted.

For additional information regarding pharmacy services, refer to **Section V: Pharmacy Services** of this manual.

Physician Administered Drugs

Only medically necessary rebate eligible physician-administered drugs are covered. All drugs on the Louisiana Medicaid FFS fee schedules are covered as a medical benefit but also may be elected to be covered in the pharmacy benefit. Rebate eligible drugs that are not on the Louisiana Medicaid FFS fee schedules, may be covered in either the medical benefit, the pharmacy benefit, or both.

Physician administered drugs that are included on the PDL have the same preferred status and prior authorization criteria as the PDL, even when billed and paid as a medical benefit (except Antiemetic/Antivertigo Agents therapeutic class). According to 42 CFR 438.3(s)(6), a prior authorization response for a drug shall be provided by telephone or other telecommunication devise within 24 hours of a request for prior authorization.

Edits are applied for physician-administered drugs, updated quarterly, based on the CMS NDC-HCPCS Crosswalk file.

Please refer to the **Claim Filing Instructions** manual for billing guidelines for physician administered drugs.

Physician Assistants

Unless otherwise excluded by Louisiana Medicaid, the services rendered by physician assistants are determined by individual licensure, scope of practice, and supervising physician delegation. The supervising physician must be an enrolled Medicaid provider. Clinical practice guidelines and protocols are available for review upon request by authorized representatives of AmeriHealth Caritas Louisiana.

Immunizations, physician-administered drugs, long-acting reversible contraceptives, and EPSDT medical, vision, and hearing screens are reimbursed at a minimum of 100% of the physician fee on file. All other reimbursable procedures are reimbursed at a minimum of 80% of the physician fee on file.

Physician assistants must obtain an individual Medicaid provider number and, when the rendering provider, must bill under this provider number for services rendered.

Physician/Professional Services

Professional services are provided by, but are not limited to, physicians, advanced practice registered nurses, certified registered nurse anesthetists, physician assistants, audiologists, optometrists, and other health care professionals. These services are provided within the licensed individual's scope of practice, as defined by Louisiana law, and are provided by, or under the personal direction and supervision of, a State Board licensed individual as authorized under Louisiana law.

Physicians and all other professionals must abide by the scope of practice set forth by their licensing or certifying agencies in addition to complying with Louisiana Medicaid regulations and policies.

The following includes a non-exhaustive excluded or limited list of services:

- **Services that are not medically necessary**

  Services that are not medically necessary including services that are not approved by the Food and Drug Administration, experimental or investigational services, and cosmetic services are not reimbursed.

- **Aborted surgical procedures**

Professional, operating room, or anesthesia charges for an aborted surgical procedure, regardless of the reason are not payable.

- **Services not provided or not documented**

  Providers should not bill AmeriHealth Caritas Louisiana or the enrollee for a missed appointment or any other services not actually provided.

  NOTE: Services that have not been documented are considered services not rendered and are subject to recoupment.

- **Never events**

  "Never events" or medical procedures performed in error that are preventable and have a serious, adverse impact to the health of the enrollee are not payable.

  Reimbursement is not provided when the following "never events" occur:

  - The wrong surgical procedure is performed on an enrollee;
  - The surgical or invasive procedures are performed on the wrong body part; or
  - The surgical or invasive procedures are performed on the wrong enrollee.

- **Services related to non-covered services**

  Services related to a non-covered service are not reimbursable. Any payment received for non-covered and related services is subject to post-payment review and recovery.

- **Infertility services**

  Services relating to the diagnosis or correction of infertility, including sterilization reversal procedures are not payable. This policy extends to any surgical, laboratory, or radiological service when the primary purpose is to diagnose infertility or to enhance reproductive capacity.

- **"New patient" evaluation and management visits with an established provider**

  Consistent with CPT guidelines, AmeriHealth Caritas Louisiana defines a new patient as one who has not received and professional services from the physician/provider or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

  Exception: The initial pre-natal visit of each new pregnancy. (See Obstetrics section in this manual)

AmeriHealth Caritas Louisiana reimburses professional service providers for psychiatric services delivered in the office, or other outpatient facility settings. Providers are to select the most appropriate CPT codes for psychiatric services rendered as outline in the CPT manual.

Podiatry Services

All medically necessary podiatry services are covered, including x-rays, from a podiatrist in the network. It is recommended that the PCP use discretion in referring enrollees for routine care such as nail clippings and callus removal, taking into consideration the enrollee's current medical condition and the medical necessity of the podiatry services.

Network podiatrists may dispense any medically necessary orthotic device compensable under the Plan upon receiving prior authorization from our Utilization Management Department at 1-888-913-0350. Questions regarding an item should be directed to the Provider Services Department at 1-888-922-0007.

Portable Oxygen

Portable oxygen equipment will be reimbursed for enrollees who need continuous oxygen and require portable units while in route to a doctor's office, hospital, or medically necessary appointment.

Documentation of medical necessity as well as the anticipated number of visits per month needed must be submitted by the enrollee's treating physician with the prior authorization request. Portable systems will not be approved to be used on a standby basis only. Units will be authorized per month based on review of submitted medical justification. An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

For enrollees under 21 years of age only, portable oxygen may be approved when needed for travel to and from school.

Enrollees may require multiple units of portable oxygen per month for medical appointments, treatment, and/or travel to and from school (for beneficiaries under 21 years of age).

Please refer to the **Claim Filing Instructions** manual for portable oxygen billing requirements.

Portable Oxygen Concentrators

Portable oxygen concentrators may be approved for enrollees who meet the above criteria for portable oxygen; however, additional documentation is required. Documentation includes one or more of the below:

- Enrollee is:
    - under the age of 21 and less costly portable oxygen options for medical appointments, medical treatment, and travel to/from school will not suffice;

      or
    - over the age 21 and requires oxygen for out of state travel for medical appointments
- Portable oxygen needs exceed what can be provided via less costly portable oxygen equipment

The enrollee's treating physician must submit documentation of medical necessity, as well as the anticipated number of medical visits per month with the prior authorization request.

If the enrollee is under the age of 21, documentation of the mileage the enrollee travels to/from school must be provided including the home and school address.

Portable oxygen concentrators will not be approved to be used on a standby basis only.

Reimbursement may be based on equipment's rental or purchase price.

Portable X-Ray Services

Portable x-rays are covered for enrollees who are unable to travel to a physician's office or outpatient hospital's radiology facility.

Specific diagnostic radiology services are covered for an eligible enrollee to be provided in the enrollee's place of residence by an enrolled portable x-ray provider.

Covered radiographs shall be limited to:

- Skeletal films of an enrollee's limbs, pelvis, vertebral column or skull;
- Chest films which do not involve the use of contrast media; and
- Abdominal films which do not involve the use of contrast media.

Transportation of portable x-ray equipment is covered only when the equipment used is transported to the location where x-ray services are provided.

Only a single transportation payment per trip to a facility or location for a single date of service is reimbursed.

The physician's order is required to clearly state the following:

- Suspected diagnosis or the reason the x-ray is required;
- Area of the body to be exposed;
- Number of radiographs ordered; and
- Precise views needed.

Enrollees must be home bound. Enrollees are considered to be homebound when a medical condition causes them to be unable to leave their place of residence without the use of special transportation or the assistance of another person. The place of residence may be the enrollee's own home, a nursing home, or an intermediate care facility for a person with a developmental disability.

Providers are required to comply with the following regarding portable x-rays:

- Comply with all Medicare guidelines for portable x-ray providers;
- Maintain certification to practice radiology in the state of Louisiana;

- Enroll with Louisiana Medicaid as a portable x-ray provider; and
- Exist independently of any hospital, clinic, or physician's office.

Portable x-ray services must be provided under the general supervision of a licensed physician who is qualified by advanced training and experienced in the use of diagnostic x-rays. The supervising physician is responsible for the ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of non-physician personnel that use the equipment.

Any non-physician personnel utilized by the portable x-ray provider to perform tests must demonstrate the basic qualifications and possess appropriate training and proficiency as evidence by licensure or certification.

Please refer to the **Claim Filing Instructions** manual for portable x-ray billing guidelines.

Preventive Services for Adults (Ages 21 and older)

All United States Preventive Services Task Force Grade A and B preventive services for adults age 21 years and older are covered without restrictions or prior authorization. In addition, one preventive medicine E&M service for adults age 21 years and older per calendar year is covered.

The policy for preventive medicine E&M services includes the following:

- Providers are to use the appropriate Preventive Medicine Services "New Patient" or "Established Patient" CPT code based on the age of the enrollee when submitting claims for the services.
- The information gathered during the preventive medicine visit is to be forwarded to any requesting provider to communicate findings and prevent duplicative services.
- Preventive medicine E&M services are comprehensive in nature and should reflect age and gender specific services.
- The medical record documentation must include, but is not limited to:
    - Physical examination;
    - Medical and social history review;
    - Counseling/anticipatory guidance/risk factor reduction intervention; and
    - Screening test(s) and results.

In addition, one preventive gynecological examination per calendar year is covered for enrollees age 21 and over when performed by a PCP or gynecologist. This is to allow enrollees to receive both the necessary primary care and gynecological components of their annual preventive screening visits. The visit must include:

- Examination;
- Sexually Transmitted Infection (STI) screening and counseling;
- Breast and pelvic examination;
- Pap smear, if appropriate; and
- Contraceptive methods and counseling, as age appropriate.

A referral is not required for access to a women's health specialist for routine and preventive women's health care services.

Please refer to the **Claim Filing Instructions** for how to bill if an abnormality or pre-existing problem is encountered and treatment is significant enough to require additional work to perform the key components of a problem-oriented E&M service on the same date of service by the provider performing the preventive medicine service visit.

Radiology Services

Inpatient and outpatient radiology services are covered.

Radiological services that may be required to treat an emergency or to provide surgical services for an excluded service are covered.

Positron emission tomography, with or without computed tomography, is covered when medically necessary. For oncologic conditions, coverage is in accordance with National Comprehensive Cancer Network guidelines.

Providers are not reimbursed for full services of radiology services that are not performed in the providers own offices, including tests which are sent to other facilities for processing.

Refer to the **Portable X-Ray Services** section of the manual for additional information.

Routine Care Provided to Enrollees Participating in Clinical Trials

Any item or service provided to an enrollee participating in a qualifying clinical trial to the extent that the item or service would otherwise be covered for the enrollee when not participating in the qualifying clinical trial is covered. This includes any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation.

A qualifying clinical trial is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition that meets any of the following criteria:

- The study or investigation is approved, conducted, or supported (which may include funding) by one or more of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Healthcare Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - A cooperative group or center of any of the entities described in subclauses (I) through (IV) or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-government research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - The study of investigation is approved or funded by one of the following and has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigation used by the National Institutes of Health which assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:

    - The Department of Veterans Affairs.
    - The Department of Defense.
    - The Department of Energy.
- The clinical trial is conducted pursuant to an investigational review new drug exemption under section 335(i) of Title 21 or an exemption for a biological product undergoing investigation under section 262(a)(3) of this title.
- The clinical trial is a drug trial that is exempt from having such an investigational new drug application.

Coverage determinations are:

- Expedited and completed within 72 hours;

- Made without limitation on the geographic location or network affiliation of the health care provider treating such individual or the principal investigator of the qualifying clinical trial;

- Based on attestation regarding the appropriateness of the qualifying clinical trial by the health care provider and principal investigator using the following form and kept on file by the provider: https://www.medicaid.gov/resources-for-states/downloads/medicaid-attest-form.docx; and

- Completed without any requirement of submission of the protocols of the qualifying clinical trial, or any other documentation that may be proprietary or determined by the HHS Secretary to be burdensome to provide.

The following services are not covered:

- The investigational item or service that is the subject of the qualifying clinical trial;
- Any service provided to the individual solely to satisfy data collection and analysis needs for the qualifying clinical trial and is not used in the direct clinical management of the individual; and
- Services not otherwise covered by AmeriHealth Caritas Louisiana.

Sinus Procedures

Balloon ostial dilation and functional endoscopic sinus surgery is covered when considered medically necessary for the treatment of chronic rhinosinusitis when all the following criteria are met:

- Uncomplicated chronic rhinosinusitis limited to the paranasal sinuses without the involvement of adjacent neurological, soft tissue, or bony structures that has persisted for at least 12 weeks with at least two of the following sinonasal symptoms:
    - Facial pain/pressure;
    - Hyposmia/anosmia;
    - Nasal obstruction;
    - Mucopurulent nasal discharge; and

- Sinonasal symptoms that are persistent after maximal medical therapy has been attempted, as defined by all the following, either sequentially or overlapping:
    - Saline nasal irrigation for at least six weeks;
    - Nasal corticosteroids for at least six weeks;

  - Approved biologics, if applicable, for at least six weeks;
  - A complete course of antibiotic therapy when an acute bacterial infection is suspected;
  - Treatment of concomitant allergic rhinitis if present; and

- Objective evidence of sinonasal inflammation as determined by one of the following:
  - Nasal endoscopy; or
  - Computed tomography.

Balloon ostial dilation and functional endoscopic sinus surgery are not covered and not considered medically necessary in the following situations:

- Presence of sinonasal symptoms but no objective evidence of sinonasal disease by nasal endoscopy or computed tomography;
- For the treatment of obstructive sleep apnea and/or snoring when the above criteria are not met;
- For the treatment of headaches when the above criteria are not met; and
- For balloon ostial dilation only, when sinonasal polyps are present.

Skin Substitutes for Chronic Diabetic Lower Extremity Ulcers

Skin substitutes are covered and considered medically necessary for the treatment of partial-and full-thickness diabetic lower extremity ulcers when the enrollee meets the criteria listed below:

The enrollee must meet all the following criteria to be considered eligible:

- Presence of a lower extremity ulcer that:
  - Is at least 1.0 square centimeter (cm) in size;
  - Has persisted for at least four weeks;
  - Has not demonstrated measurable signs of healing, defined as a decrease in surface area and depth or a decreased amount of exudate and necrotic tissue, with comprehensive therapy including all of the following:
    - Application of dressings to maintain a moist wound environment;
    - Debridement of necrotic tissue if present; and
    - Offloading of weight.
- A diagnosis of type 1 or type 2 diabetes mellitus;
- A glycated hemoglobin (HbA1c) level of ≤9% within the last 90 days or a documented plan to improve HbA1c to 9% or below as soon as possible;
- Evidence of adequate circulation to the affected extremity, as indicated by one or more of the following:
  - Ankle-brachial index (ABI) of at least 0.7;
  - Toe-brachial index (TBI) of at least 0.5;
  - Dorsum transcutaneous oxygen test (TcPO2) >=30 mm Hg; and/or
  - Triphasic or biphasic Doppler arterial waveforms at the ankle of the affected leg.
- No evidence of untreated wound infection or underlying bone infection; and
- Ulcer does not extend to tendon, muscle, joint capsule, or bone or exhibit exposed sinus tracts unless the product indication for use allows application to such ulcers.

The enrollee must not have any of the following:

- Active Charcot deformity or major structural abnormalities of the foot, when the ulcer is on the foot;

- Active and untreated autoimmune connective tissue disease;
- Known or suspected malignancy of the ulcer;
- Enrollee is receiving radiation therapy or chemotherapy; and
- Re-treatment of the same ulcer within one year.

The following coverage limitations apply:

- Coverage is limited to a maximum of 10 treatments within a 12-week period;
- If there is no measurable decrease in surface area or depth after five applications, then further applications are not covered;
- For all ulcers, a comprehensive treatment plan must be documented, including at least all the following:
    - Offloading of weight;
    - Smoking cessation counseling and/or medications, if applicable;
    - Edema control;
    - Improvement in diabetes control and nutritional status; and
    - Identification and treatment of other comorbidities that may affect wound healing such as ongoing monitoring for infection.
- While providers may change products used for the diabetic lower extremity ulcers, simultaneous use of more than one product for the diabetic lower extremity ulcers is not covered; and
- Hyperbaric oxygen therapy is not covered when used at the same time as skin substitute treatment.

Prior Authorization is required, and medical documentation submitted must demonstrate that the enrollee meets all the aforementioned requirements. If there is no measurable decrease in surface area, or depth, after five applications, then further applications are not covered even when prior authorized.

Sterilization

In accordance with federal regulations, sterilization is covered if the following requirements are met:

- The individual is at least 21 years of age at the time the consent is obtained;
- The individual is not a mentally incompetent individual;
- The individual has voluntarily given informed consent in accordance with all federal requirements; and
- At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since an enrollee gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Hysterectomies performed solely for the purpose of terminating reproductive capability (sterilization) are not covered.

The current sterilization consent forms HHS-667 English and HHS-687-1 Spanish are available from the U.S. Department of Health and Human Services website [link].

The consent form must be signed and dated by:

- The individual to be sterilized,
- The interpreter, if one was provided,
- The person who obtained the consent, and
- The physician performing the sterilization procedure.

NOTE: If the physician who performed the sterilization procedure is the one who obtained the consent, the physician must sign both statements.

The physician who obtains the consent must share the consent form with all providers involved in that enrollee's care (e.g., attending physician, hospital, anesthesiologist, and assistant surgeon).

Enrollees who undergo a covered hysterectomy must complete a hysterectomy consent form but are not required to complete a sterilization consent form.

Please refer to the **Claim Filing Instructions** manual for more details on filing a claim for a sterilization.

Substitute Physician Billing

Both the reciprocal billing arrangement and the locum tenens arrangement are allowed when providers utilize substitute physician services.

A **reciprocal billing arrangement** occurs when a regular physician or group has a substitute physician provide covered services to a Medicaid enrollee on an occasional reciprocal basis. A physician can have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

NOTE: A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid enrollees of the regular physician and ends with the last day on which the substitute physician provides these services to the enrollees before the regular physician returns to work. This period continues without interruption on days on which no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work.

The regular physician must keep on file a record of each service provided by the substitute physician and make the record available to Louisiana Medicaid or its representatives upon request.

This situation **does not apply** to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who performed the service must be identified.

A **locum tenens arrangement** occurs when a substitute physician is retained to take over a regular physician's professional practice for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician generally has no practice of his/her own. The regular physician usually pays the substitute physician a fixed amount per diem, with the substitute physician being an independent contractor rather than an employee.

NOTE: A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid enrollees of the regular physician and ends with the last day on which the substitute physician

provides these services to the enrollees before the regular physician returns to work. This period continues without interruption on days on which no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work. If the regular physician does not come back after the 60 days, a new 60-day period can begin with a different locum tenens doctor.

The regular physician must keep on file a record of each service provided by the substitute physician and make the record available to AmeriHealth Caritas Louisiana or its representatives upon request.

Please refer to the **Claim Filing Instructions** manual for billing instructions on substitute physician and locum tenens arrangement billing.

Telemedicine/Telehealth

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician or other licensed practitioner and an enrollee are not in the same location.

The telecommunications system shall include, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the enrollee at the originating site and the physician or other licensed practitioner at the distant site. The telecommunications system must be secure, ensure patient confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act.

Originating site means the location of the enrollee at the time the services are provided. There is no restriction on the originating site, and it can include, but is not limited to, a healthcare facility, school, or the enrollee's home.

Distant site means the site at which the physician or other licensed practitioner is located at the time the services are provided. The distant site may include a provider or facility that is not physically located in this state in temporary or emergency situations (e.g., pandemics, natural disasters).

When otherwise covered, services located in the Telemedicine appendix of the CPT manual, or its successor, when provided by telemedicine/telehealth are covered. In addition, other services provided by telemedicine/telehealth are covered when indicated as covered via telemedicine/telehealth in Medicaid program policy. Physicians and other licensed practitioners must continue to adhere to all existing clinical policy for all services rendered. Providing services through telemedicine/telehealth does not remove or add any medical necessity requirements.

The distant site provider is reimbursed for services provided via telemedicine/telehealth. Reimbursement for services provided by telemedicine/telehealth is at the same level as services provided in person.

The provider is required to include in the enrollee's clinical record documentation that the service was provided through using telemedicine/telehealth.

The distant site provider must be enrolled as a Louisiana Medicaid provider to receive reimbursement for covered services rendered to enrollees.

Please refer to the **Claim Filing Instructions** manual for billing instructions for telemedicine/telehealth services.

Therapy Services

Speech therapy, physical therapy, and occupational therapy services are covered to enrollees of any age without restrictions to place of service.

Therapy services require an authorization. Therapy evaluations do not require an authorization but are limited to one evaluation per 180 days.

Please refer to the **Claim Filing Instructions** manual for specific CPT/HCPCS codes limited to 180 days.

Tobacco Cessation Services

Tobacco cessation counseling services are covered for enrollees who use tobacco products or who are being treated for tobacco use when provided by, or under the supervision of, the enrollee's primary care provider or other appropriate healthcare professionals.

Up to four tobacco cessation counseling sessions per quit attempt are covered, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

The entity rendering tobacco cessation counseling services must be an enrolled Medicaid provider.

Health care professionals who may provide tobacco cessation counseling include physicians, advanced practice register nurses, and physicians' assistants, as well mental health providers who are licensed to practice independently. Other professional or paraprofessional healthcare practitioners must have completed training in the provision of tobacco cessation counseling and must provide services under the supervision of a licensed practitioner.

Transcranial Magnetic Stimulation (TMS)

Effective August 2, 2024, Transcranial Magnetic Stimulation (TMS) is covered for major depression only.

TMS is considered medically necessary when all the following criteria are met:

- Member is 18 years of age or older
- Diagnosis of major depressive disorder (DSM 5 diagnostic terminology)
- Failure or intolerance to psychopharmacologic agents, choose one of the following:
    - Failure of psychopharmacologic agents, both of the following:
        - Lack of clinically significant response in the current depressive episode to four trials of agents from at least two different agent classes
        - At least two of the treatment trials were administered as an adequate course of mono- or poly-drug therapy with antidepressants, involving standard therapeutic doses of at least six weeks duration

- The member is unable to take anti-depressants due to one of the following:
    - Drug interactions with medically necessary medications
    - Inability to tolerate psychopharmacologic agents, as evidenced by trials of four such agents with distinct side effects in the current episode

- No contraindications to TMS are present (see section on contraindications)
- Electroconvulsive therapy has previously been attempted, is medically contraindicated, or has been offered and declined by the member.

NOTE: Maintenance therapy is considered not medically necessary, as there is insufficient evidence to support this treatment at the present time.

Retreatment is considered medically necessary when all of the following criteria have been met:

- Current major depressive symptoms have worsened by 50 percent from the prior best response of the PHQ-9 score
- Prior response demonstrated a 50 percent or greater reduction from baseline depression scores
- No contraindications to TMS are present (see section on contraindications)

Contraindications:

- Individuals who are actively suicidal
- Individuals with a history of or risk factors for seizures during TMS therapy
- Individuals with vagus nerve stimulators or implants controlled by physiologic signals, including pacemakers, and implantable cardioverter defibrillators
- Individuals who have conductive, ferromagnetic, or other magnetic-sensitive metals implanted in their head within 30 cm of the treatment coil (e.g. metal plates, aneurysm coils, cochlear implants, ocular implants, deep brain stimulation devices, and stents)
- Individuals who have active or inactive implants (including device leads), including deep brain stimulators, cochlear implants, and vagus nerve stimulators
- History of seizure disorder except seizures induced by ECT
- Metal implants or devices present in the head or neck
- Substance use at the time of treatment
- Diagnosis of severe dementia
- Diagnosis of severe cardiovascular disease

A referral from a psychiatrist is required and must be submitted prior to treatment.

Please refer to the **Claim Filing Instructions** manual for billing guidelines on TMS.

Vagus Nerve Stimulators (VNS)

Implantation of the vagus nerve stimulator (VNS) is covered when the treatment is considered medically necessary, the enrollee meets the published criteria, and the enrollee has a diagnosis of medically intractable epilepsy.

The following criteria shall be used to determine medical necessity of the VNS:

- Partial epilepsy confirmed and classified according to the International League Against Epilepsy (ILAE) classification. The enrollee may also have associated generalized seizures, such as tonic, tonic-clonic, or atonic. The VNS may have efficacy in primary generalized epilepsy as well;
- Age 12 years or older, although case by case consideration may be given to younger children who meet all other criteria and have sufficient body mass to support the implanted system;
- Seizures refractory to medical anti-epilepsy treatment, with adequately documented trials of appropriate standard and newer anti-epilepsy drugs or documentation of enrollee's inability to tolerate these medications;
- Enrollee has undergone surgical evaluation and is considered not to be an optimal candidate for epilepsy surgery;
- Enrollee is experiencing at least four to six identifiable partial onset seizures each month. Enrollee must have had a diagnosis of intractable epilepsy for at least two years. The two-year period may be waived if waiting would be seriously harmful to the enrollee to six identifiable partial onset seizures each month. Enrollee must have had a diagnosis of intractable epilepsy for at least two years. The two-year period may be waived if waiting would be seriously harmful to the enrollee;
- Enrollee must have undergone quality of life (QOL) measurements. The choice of instruments used for the QOL measurements must assess quantifiable measures of daily life in addition to the occurrence of seizures; and
- In the expert opinion of the treating physician, there must be reason to believe that QOL will improve as a result of implantation of the VNS. This improvement should occur in addition to the benefit of seizure frequency reduction. The treating physician must document this opinion clearly.

Regardless of the criteria for enrollee selection, VNS implantation is not covered if the enrollee has one or more of the following criteria:

- Psychogenic seizures or other non-epileptic seizures;
- Insufficient body mass to support the implanted system;
- Systemic or localized infections that could infect the implanted system; or
- A progressive disorder contraindicated to VNS implantation (e.g., malignant brain neoplasm, Rasmussen's encephalitis, Landau-Kleffner syndrome and progressive metabolic and degenerative disorders).

Coverage of the surgery to implant the VNS is restricted to an outpatient hospital, unless medically contraindicated.

Coverage for vagus nerve stimulation shall include, but is not limited to, the following:

- Vagus Nerve Stimulator;
- Implantation of VNS;
- Programming of the VNS; and
- Battery replacement.

Hospitals are advised to confirm that the provider performing the implantation has received an authorization for the procedure prior to submitting their claim to prevent denials.

Please refer to the **Claim Filing Instructions** manual for billing guidelines on vagus nerve stimulators.

Physical Health In Lieu of Services (ILOS)

"In lieu of" services (ILOS) are alternative services or settings covered by AmeriHealth Caritas Louisiana as a substitute or alternative to services or settings covered under the Louisiana Medicaid State Plan.

The following authorized physical health ILOS are offered:

- Care at Home
- Chiropractic Services for Adults Age 21 and Older
- Doula Services
- Hospital-Based Care Coordination of Pregnant and Postpartum Individuals with Substance Use Disorder (SUD) and their Newborns
- Outpatient Lactation Support
- Remote Patient Monitoring

Behavioral Health Services

Basic behavioral health services are mental health and substance use services which are provided to enrollees with emotional, psychological, substance use, psychiatric symptoms and/or disorders that are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities.

Specialized behavioral health services are mental health services and substance use/addiction disorder services, specifically defined in the Louisiana Medicaid State Plan and/or applicable waivers. These services are administered under LDH authority in collaboration with AmeriHealth Caritas Louisiana, as well as through the Coordinated System of Care (CSoC) program contractor, for CSoC enrollees.

AmeriHealth Caritas Louisiana screens enrollees to determine level of need for the purpose of service authorization based on medical necessity. Based on this medical necessity determination, specialized behavioral health services are authorized as appropriate. Services are managed to promote utilization of best, evidence-based and informed practices and to improve access and deliver efficient, high-quality services.

For individuals screened and considered to need substance use services, the ASAM 6 Dimension risk evaluation shall be used to determine appropriate placement in substance use withdrawal management or treatment levels of care.

Screening for services, including the CSoC, shall take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care. AmeriHealth Caritas Louisiana ensures (either using care management protocols or by ensuring appropriate, proactive discharge planning by contracted providers) the screening takes place while a youth resides in an out-of-home level of care (such as inpatient, PRTF, SUD residential treatment or TGH) and is prepared for discharge to a home and community-based setting.

For settings such as PRTF and TGH with lengths of stay allowing sufficient time for comprehensive and deliberate discharge and aftercare planning, AmeriHealth Caritas Louisiana ensures that screening for CSoC takes place at least 30 days and up to 90 days prior to the anticipated discharge date. If CSoC screening shows appropriateness, referral to CSoC up to 90 days prior to discharge from a residential setting shall occur, as it is expected to assist in comprehensive discharge and treatment planning, prevent disruption, and improve stabilization upon reentry to a home and community environment.

This section provides guidance relative to implementation of Act 390 of the 2015 Regular Legislative Session relative to reimbursement for inpatient/residential behavioral health services for persons admitted to treatment under an emergency certificate. Emergency certificates are inclusive of Physician's Emergency Certificates, Coroner's Emergency Certificates, and Judicial Certificates.

Claims are paid for behavioral health services provided to enrollees committed under an emergency certificate to an inpatient or residential facility regardless of medical necessity. This payment requirement is for a maximum period of 24 hours from the time of admission to the inpatient or residential facility, if the following conditions are met:

- The admitting physician and the evaluating psychiatrist or medical psychologist shall offer the subject of the emergency certificate the opportunity for voluntary admission; and
- Any person committed under an emergency certificate shall be evaluated by a psychiatrist or medical psychologist in the admitting facility within 24 hours of arrival at the admitting facility.

After the psychiatric evaluation has been completed, payment of claims is determined by medical necessity. If the subject of the emergency certificate does not receive a psychiatric evaluation within the required timeframe, behavioral health claims are only paid within the first 24 hours of admission. Payment for any subsequent claim shall be determined by medical necessity. Reimbursement under this Act is limited to behavioral health claims and usual and customary laboratory services necessary to monitor patient progress.

AmeriHealth Caritas Louisiana is not responsible for payment of non-behavioral health service claims which fail to meet medical necessity criteria.

Please refer to the **Section XII: Behavioral Health Addendum** in this manual for more details on covered behavioral health services.

Applied Behavior Analysis (ABA) Ages 0-20

Covered applied behavior analysis (ABA)-based therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapy services teach skills using behavioral observation and reinforcement, or prompting, to teach each step of targeted behavior. ABA-based therapy services are based on reliable evidence and are not experimental.

Covered ABA-based therapy must be:

- Medically necessary;
- Prior authorized by AmeriHealth Caritas Louisiana; and
- Delivered in accordance with the enrollee's behavior treatment plan.

Services must be provided by, or under the supervision of, a behavior analyst who is currently licensed by the Louisiana Behavior Analyst Board, or a licensed psychologist or licensed medical psychologist, hereafter referred to as the licensed professional. Payment for services must be billed by the licensed professional.

Prior to requesting ABA services, the enrollee must have documentation indicating medical necessity for the services through a completed **comprehensive diagnostic evaluation** (**CDE**) that has been performed by a **qualified health care professional** (**QHCP**).

NOTE: Medical necessity for ABA-based therapy services must be determined according to the provisions of the Louisiana Administrative Code (LAC), Title 50, Part I, Chapter 11.

A QHCP is defined as a:

Pediatricians using the MCHAT-R/F, and clinical judgment may diagnosis and complete a CDE. For children who receive a high-risk score of ≥ 8 on the MCHAT-R/F, pediatricians can independently make a diagnosis of autism (if their clinical judgment concurs with this score). For children who receive a moderate risk score of 3 to 7 on the MCHAT-R/F, pediatricians can complete the MCHAT-R/F follow-up interview, and based on their confidence in their clinical judgment, either independently make a diagnosis of autism or refer to a subspecialist listed below for a diagnostic evaluation:

- Pediatric neurologist;
- Developmental pediatrician;
- Psychologist (including a medical psychologist);
- Psychiatrist (particularly pediatric and child psychiatrist)
- Pediatrician under a joint working agreement with an interdisciplinary team of providers who are qualified to diagnose developmental disabilities;
- Nurse practitioner (NP) practicing under the supervision of a pediatric neurologist developmental pediatrician, psychologist, or psychiatrist; or
- Licensed individual, including speech and language pathologist, licensed clinical social worker (LCSW), or licensed professional counselor (LPC), who meets the requirements of a QHCP when:
    - Individual's scope of practice includes a differential diagnosis of autism spectrum disorder and comorbid disorders for the age and/or cognitive level of the enrollee;

- Individual has at least two years of experience providing such diagnostic assessments and treatments or is being supervised by someone who is listed as a QHCP under bullets 1-5 above; and
- If the licensed individual is working under the supervision of a QHCP, the QHCP must sign off on the CDE as having reviewed the document and agrees with the diagnosis and recommendation.

The CDE must include at a minimum:

- Thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history;
- Direct observation of the enrollee, to include but not be limited to, assessment of current functioning in the areas of social and communicative behaviors and play or peer interactive behaviors;
- Review of available records;
- Valid Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) or current edition, diagnosis;
- Justification/rationale for referral/non-referral for an ABA functional assessment and possible ABA services; and
- Recommendations for any additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or any additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.

When the results of the screening are borderline, or if there is any lack of clarity about the primary diagnosis, comorbid conditions or the medical necessity of services requested, the following categories of assessment shall be included as components of the CDE and must be specific to the enrollee's age and cognitive abilities:

- Autism specific assessments;
- Assessments of general psychopathology;
- Cognitive/developmental assessment; and
- Assessment of adaptive behavior.

The licensed supervising professional shall provide case oversight and management of the treatment team by supervising and consulting with the enrollee's team. The licensed supervising professional must also conduct regular meetings with family members to plan, review the enrollee's progress and make any necessary adjustments to the behavior treatment plan. Part of the supervision must be done in the presence of the enrollee receiving treatment and state-certified assistant behavior analyst (CaBA) or the registered line technician (RLT).

Supervision shall be approved on a 2:10 basis that is two hours of supervision for every ten hours of therapy. Supervision will not be approved if the licensed supervising professional is delivering the direct therapy.

One-on-one supervision may by be conducted and billed simultaneously and concurrently with one-on-one therapeutic behavioral services. Supervision can only occur when a non-licensed professional is providing the therapeutic behavioral services.

The licensed supervising professional should supervise no more than 24 technicians a day. More technicians may be supervised if a CaBA is part of the professional support team or depending on the mix of needs in the supervisor's caseload. The licensed professional can supervise no more than ten CaBAs.

Telehealth Requirements for Applied Behavior Analysis (ABA)

The use of telehealth is reimbursed, when appropriate, for rendering certain ABA services for the care of or to support the caregivers of enrollees.

Telehealth requires prior authorization for services. Subsequent assessments and behavior treatment plans can be performed remotely via telehealth only if the same standard of care can be met.

Previously approved prior authorizations can be amended to increase units of care and/or to reflect re-assessment goals.

The codes listed below can be performed via telehealth.

Relevant CPT codes include:

97151	97155
97152	97156
97153	97157
97154	97158

Guidance for Telehealth ABA

Telehealth services must be based on ABA methodology and rendered or directed by an RLT, LBA, or CaBA. The caregivers/patients and RLT/LBA/CaBA must be linked through an interactive audio/visual telecommunications system.

Please reference our **Applied Behavior Analysis (ABA)** clinical policy.

Please refer to the **Claim Filing Instructions** manual for billing guidelines on ABA therapy.

SECTION IV: NON-COVERED AND PROHIBITED SERVICES

Non-Covered Services

Some services are not covered, including but not limited to the following:

- Routine dental services for children;
- ICF/IIDs Services;
- Nursing Facility Services, except for post-acute rehabilitative care in place of continued inpatient care as an approved in Lieu of Service;
- Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by OPH certified school-based health clinics);
- All Home and Community-Based Waiver Services;
- Personal Care Services for enrollees ages 21 and older;
- Targeted Case Management Services;
- Services provided through LDH's Early-Steps Program;
- The following excluded drugs:
    - Select agents when used for symptomatic relief of cough and colds, not including prescription antihistamine and antihistamine/decongestant combination products;
    - Select agents when used for anorexia, weight loss, or weight gain, not including orlistat;
    - Select agents when used to promote fertility;
    - Drug Efficacy Study Implementation (DESI) drugs; and
    - Select nonprescription drugs, not including OTC antihistamines, antihistamine/decongestant combinations, or polyethylene glycol;
    - Drugs and biologicals discarded and not administered to any patient appended with JW modifier(refer to the **Claim Filing Instructions** manual for instructions on how to bill the administered portion and the discarded portion).
- Proton Beam Radiation Therapy (PBRT) for enrollees 21 years of age and older.
- Outpatient psychiatric or substance abuse treatment in an outpatient hospital setting.

Prohibited Services

The following prohibited services are not covered and shall not be provided to enrollees:

- Elective abortions and related services;
- Any service (drug, device, procedure, or equipment) that is not medically necessary;
- Experimental/investigational drugs, devices, procedures, or equipment, unless approved by the Secretary of LDH in writing;
- Elective cosmetic surgery (including cosmetic drugs, devices, or equipment);
- Assistive reproductive technology for treatment of infertility;
- Surgical procedures discontinued before completion;
- Harvesting of organs when a Louisiana Medicaid enrollee is the donor of an organ to a non-Medicaid enrollee;
- Provider preventable conditions, described below.

Provider Preventable Conditions

AmeriHealth Caritas Louisiana is mandated to meet the requirements of 42 C.F.R. §447.26 with respect to non-payment for provider preventable conditions (PPCs).

PPCs are defined into two separate categories:

- Health care-acquired condition (HCAC), meaning a condition occurring in any inpatient hospital setting, identified as a hospital acquired condition (HAC) in accordance with 42 C.F.R. §447.26; and
- Other provider preventable condition (OPPC), meaning a condition occurring in any health care setting in accordance with 42 C.F.R. §447.26.

A reduction in reimbursement is not imposed for a PPC when the condition defined as a PPC for a particular enrollee existed prior to the initiation of treatment for the enrollee by that provider.

Reductions in provider reimbursement may be limited to the following:

- The identified PPCs would otherwise result in an increase in reimbursement.
- It is practical to isolate for non-payment the portion of the reimbursement directly related to treatment for, and related to, the PPC.

Non-payment of PPCs shall not prevent access to services for enrollees.

Services related to HCAC or HAC are not reimbursable. Refer to the **CMS website** for the current listing of HACs and associated diagnoses.

NOTE: HACs are considered as identified by Medicare, other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

The **Present-on-Admission** (**POA**) indicators are required as listed below with all reported diagnosis codes. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

POA Reporting Options:

Code	Definition
Y	Present at the time of inpatient admission
N	Not present at the time of inpatient admission
U	Documentation is insufficient to determine if condition is present on admission
W	Provider is unable to clinically determine whether condition was present on admission or not

Refer to the **CMS website** for the current listing of diagnoses that are exempt from POA reporting requirements

Providers are not reimbursed for the following other provider preventable conditions (OPPCs) in any setting:

- Wrong surgical or other invasive procedure performed on a patient;
- Surgical or other invasive procedure performed on the wrong body part; or
- Surgical or other invasive procedure performed on the wrong patient.

Any days that are attributable to the OPPC are not reimbursed. The diagnosis codes that are utilized for the three OPPCs listed above are included below:

- Y65.51 — Performance of wrong operation (procedure) on correct patient (existing code);
- Y65.52 — Performance of operation (procedure) on patient not scheduled for surgery;
- Y65.53 — Performance of correct operation (procedure) on wrong side/body part.

In the event an outpatient surgery is performed erroneously, as described below, the appropriate modifiers to all lines related to the erroneous surgery/procedure are:

- PC: Wrong Surgery on Patient;
- PB: Surgery Wrong Patient; or
- PA: Surgery Wrong Body Part.

It is the responsibility of the provider to identify and report (through the UB-04) any PPC and not seek reimbursement for any additional expenses incurred because of the PPC. The PPC services will be disallowed, or reimbursement will be reduced on a post-payment review of the medical records.

When uncertain about whether AmeriHealth Caritas Louisiana will pay for health care services, please contact the Provider Services Department at 1-888-922-0007.

Providers are required to inform enrollees in writing about the costs associated with services that are not covered, prior to rendering such services. If the patient and provider agree the services will be rendered as a private pay arrangement, the provider must obtain a signed document from the enrollee to validate the private payment arrangement. The document must provide:

- the nature of the service(s) to be rendered;
- that AmeriHealth Caritas Louisiana does not cover the services; and
- that the enrollee is financially responsible for the services if the enrollee elects to receive the services.

Furthermore, providers shall hold harmless AmeriHealth Caritas Louisiana and the enrollee for any claim or expense arising from such services when the enrollee has not been notified of the non-covered services as set forth herein.

SECTION V: PHARMACY SERVICES

Pharmacy Services

Our Pharmacy Benefit Manager, PerformRx manages AmeriHealth Caritas Louisiana's prescription pharmacy services. Through valid prescriptions, AmeriHealth Caritas Louisiana covers all medically necessary prescription medicines on the Louisiana Medicaid Single Preferred Drug List. AmeriHealth Caritas Louisiana also covers certain diabetic supplies. A list of those supplies can be found on link below: https://www.amerihealthcaritasla.com/pdf/pharmacy/preferred-diabetic-supplies.pdf.

Direct questions related to retail pharmacy (prescription) pharmacy services, including those about claims and prior authorizations, to PerformRx Pharmacy Services at 1-800-684-5502 or fax to 1-855-452-9131.

For provider-administered injectable drugs, providers are reimbursed using specific HCPCS CODES, units, amounts and NDC codes. (Note: NDC Codes are required on all claims, in addition to specific HCPCS Codes). These drugs are reimbursed at the Louisiana Medicaid fee schedule amounts. For those provider-administered medications that are not listed on the fee schedule, providers can verify if the drug requires prior auth by utilizing the Prior Authorization Lookup Tool.

If the provider-administered drug is not on the Louisiana Medicaid fee schedule, but is covered by AmeriHealth Caritas Louisiana, then reimbursement is set at the current Louisiana Medicaid reimbursement. More information on pharmacy services and formulary can be found at www.amerihealthcaritasla.com/pharmacy/index.aspx. Direct prior authorization questions related to physician-administered pharmacy services to PerformRx Provider Services at 1-800-684-5502 or fax to 1-855-452-9131.

Preferred Drug List

AmeriHealth Caritas Louisiana maintains a Preferred Drug List (PDL) established by the Louisiana Department of Health (LDH). The PDL indicates the preferred and non-preferred status of covered drugs. All non-preferred medications require a prior authorization. AmeriHealth Caritas Louisiana utilizes LDH's prior authorization criteria. Please visit the website for a complete list of preferred products at https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf.

Physician administered medication that are included on the PDL have the same preferred status and prior authorization criteria as the PDL, even when billed and paid as a medical benefit. Direct requests for prior authorization for physician-administered (medical injectable) medications to AmeriHealth Caritas Louisiana /PerformRx Pharmacy Services at 1-800-684-5502 or fax to 1-855-452-9131. Retail pharmacy (prescription) prior authorizations requests should be directed to Prime Therapeutics Medicaid Administration at 1-800-424-1664 or fax to 1-800-424-7402.
OTE: Experimental drugs, procedures or equipment not approved by Medicaid are excluded.

Coverage of Brand Name Products

There shall be a mandatory generic substitution for all drugs when there are "A"-rated, therapeutically equivalent, less costly generics available. Unless the brand is justified with applicable DAW codes or the brand is preferred, prior authorization is required for brand name products. Prescribers who wish to prescribe brand name products must furnish documentation of generic treatment failure prior to dispensing. The treatment failure must be directly attributed to the patient's use of a generic form of the brand name product.

Please refer to the formulary posted on AmeriHealth Caritas Louisiana website at https://www.ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf.

Claims for multi-source "Brand Name Products" that are not included in the PDL/NPDL process (i.e., drugs not listed on the Preferred Drug List on the static link), do not require prior authorization. AmeriHealth Caritas Louisiana allows dispense as written (DAW) codes "1", "5" "8", and "9" for brand name processing. The following codes must accommodate the filling of a brand name product without use of prior authorization:

- DAW "1": Brand name medically necessary from prescriber
- DAW "5": Substitution allowed-brand drug dispensed as a generic (should be allowed when the brand drug is less expensive for 340B providers)
- DAW "8": Substitution allowed, generic drug not available in marketplace
- DAW "9": Preferred brand over generic drugs

Denials of brand drugs (unless the brand is a preferred drug) should deny with an error code stating "generic substitution required".

Pharmacy Prior Authorization

In a continuing effort to improve patient care and pharmaceutical utilization, AmeriHealth Caritas Louisiana, in conjunction with PerformRx (prior to 10/28/23) Prime Therapeutics (10/28/23 and after), has implemented a prior authorization (PA) program for certain medications. AmeriHealth Caritas Louisiana utilizes the LDH prior authorization criteria for determining the medical necessity of a medication. PA requests for retail pharmacy (prescription) medications should be directed to Prime Therapeutics Medicaid Administration at 1-800-424-1664 or faxed to 1-800-424-7402. PA requests for medical injectable (physician-administered) should be directed to PerformRx at 1-800-684-5502 or faxed to 1-855-452-9131. Providers may also submit Prior Authorization requests using the Online PA request form located here: https://www.amerihealthcaritasla.com/pharmacy/priorauth.aspx

In most cases where the prescribing health care professional/provider has not obtained prior authorization, enrollees receive a three-day supply of the medication.

In the instances when an enrollee is receiving a prescription medication that is removed from the PDL and now requires a prior authorization, both the provider and enrollee are notified. The enrollee is allowed to continue that prescription medication for at least 60 days in which time a prior authorization must be submitted for the enrollee to continue beyond that timeframe. Also, if an enrollee is discharged from a psychiatric facility or residential substance use facility, and AmeriHealth Caritas Louisiana is notified of the behavioral health discharge medications, then prior authorization restrictions are overridden for a ninety (90) day period. This includes, but is not limited to, naloxone, Suboxone, and long-acting injectable anti-psychotics.

To obtain the statewide universal prior authorization request form, go to AmeriHealth Caritas Louisiana pharmacy website at https://www.amerihealthcaritasla.com/pharmacy/priorauth.aspx. Prescribers may request copies of the criteria used to make the Prior Authorization determination by contacting PerformRx at 1-800-684-5502.

Appeal of Prior Authorization Denials for Pharmacy

The prescriber or the PCP, with the enrollee's written consent, may ask for reevaluation on any denied prior authorization request or suggested alternative by contacting AmeriHealth Caritas Louisiana's Appeals verbally or in writing at:

AmeriHealth Caritas Louisiana
Attn: Member Appeals
P.O. Box 7328
London, KY 40742

Continuity of Care (Transition Supply)

AmeriHealth Caritas Louisiana provides coverage of prescriptions taken on a regular basis for chronic conditions (maintenance medicines) that are not on the PDL for at least 60 days after the enrollee's transition from the fee-for-service pharmacy program or another Managed Care Organization. AmeriHealth Caritas Louisiana provides supplies of antidepressant and antipsychotic medicines for at least 90 days after the transition.

Prescription Co-payments

Some adult enrollees (21 years of age or older) are subject to a sliding copay per prescription. The following table shows the co-payment amounts:

$0.00	$5.00 or less
$0.50	$5.01 to $10.00
$1.00	$10.01 to $25.00
$2.00	$25.01 to $50.00
$3.00	$50.01 or more

Copayments do not apply to the following enrollees:

- Less than 21 years of age
- Pregnant
- Receiving emergency services
- Residing in long-term care facilities or other institutions
- Federally recognized as Native Americans or Alaskan Eskimos
- Enrollees of a Home and Community Based Waiver
- Women whose basis of Medicaid Eligibility is Breast or Cervical Cancer
- Enrollees receiving hospice services

AmeriHealth Caritas Louisiana also ensures that copays of Medicaid family members do not exceed five percent (5%) of the family income. Copay amounts stop once the monthly threshold is met.

Enrollees must pick up medications at a pharmacy that is within AmeriHealth Caritas Louisiana network. A list of participating pharmacies may be found online at https://www.amerihealthcaritasla.com/pharmacy/index.aspx.

SECTION VI: AUTHORIZATION REQUIREMENTS

Authorization and Eligibility

Due to possible interruptions of an enrollee's State Medicaid coverage, it is strongly recommended that Providers call for verification of an enrollee's continued eligibility on the 1st of each month when a Prior Authorization extends beyond the calendar month in which it was issued. If the need for service extends beyond the initial authorized period, the Provider must call AmeriHealth Caritas Louisiana's Utilization Management Department to obtain Prior Authorization for continuation of service.

Referrals

Referrals are not required for specialty services. However, we encourage PCPs and specialists to coordinate enrollee care.

Out-of-Network Services

Occasionally, an enrollee's needs cannot be provided through the AmeriHealth Caritas Louisiana Network and out-of-network services may be required. Out-of-network providers are those that do not have an agreement to work with AmeriHealth Caritas Louisiana or have not completed the Louisiana Department of Health Provider Enrollment Process. When the need for "out-of-network" services arises, the provider should contact the Utilization Management Department for a prior authorization. Every effort is made to locate a specialist within easy access to the enrollee.

If a service from a non-participating provider is prior authorized, that provider must obtain a Non-Participating Provider number to be reimbursed for services provided. For some services, a Single Case Agreement (SCA) or negotiated rate may be required for reimbursement.

Prior Authorization Requirements

The most up to date list of services requiring prior authorization can be found using our Prior Authorization Lookup Tool. The results of this tool are not a guarantee of coverage or authorization. If you have questions about this tool or a service or to request a prior authorization, call **1-888-913-0350.**

Authorization requests may be submitted electronically via the Provider Portal in NaviNet. If you are not registered for NaviNet access, please visit www.navinet.net or contact your account executive for registration details.

Prior authorization requests submitted by fax transmissions must be sent for one enrollee at a time. AmeriHealth Caritas Louisiana's Utilization Management (UM) team is unable to accept more than one enrollee per faxed transmission.

The fax number is (866) 397-4522 for physical health authorization requests. The fax number is (855) 301-5356 for behavioral health authorization requests.

Prior Authorization Determinations

Only licensed clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease and training in the use of any required assessments shall determine Service Authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

Hospital Transfer Policy

When an enrollee presents to the ER of a hospital not participating with AmeriHealth Caritas Louisiana and the enrollee requires admission to a hospital, AmeriHealth Caritas Louisiana may require that the enrollee be stabilized

and transferred to an AmeriHealth Caritas Louisiana participating hospital for admission. When the medical condition of the enrollee requires admission for stabilization, the enrollee may be admitted, stabilized, and then transferred within twenty-four (24) hours of stabilization to the closest AmeriHealth Caritas Louisiana participating facility.

Elective inter-facility transfers must be prior authorized by AmeriHealth Caritas Louisiana's Utilization Management Department at 1-888-913-0350.

These steps must be followed by the health care provider:

- Complete the authorization process
- Approve the transfer
- Determine prospective length of stay
- Provide clinical information about the patient

Either the sending or receiving facility may initiate the prior authorization, however, the original admitting facility will be able to provide the most accurate clinical information. Although not mandated, if a transfer request is made by an AmeriHealth Caritas Louisiana participating facility, the receiving facility may request the transferring facility obtain the prior authorization before the case is accepted. When the original admitting facility has obtained the prior authorization, the receiving facility should contact AmeriHealth Caritas Louisiana to confirm the authorization, obtain the case reference number and provide the name of the attending health care provider.

In emergency cases, notification of the transfer admission is required within forty-eight (48) hours or by the next business day (whichever is later) by the receiving hospital. Lack of timely notification may result in a denial of service. Within 24 hours of notification of inpatient stay, the hospital must provide a comprehensive clinical review, initial assessment and plans for discharge.

Notification Requested

Maternity obstetrical services (after the first visit) and outpatient care (includes 48-Hour Observations)

Services Requiring Prior Authorization:

A list of services requiring prior authorization review for medical necessity and place of service can be found on our website at www.amerihealthcaritasla.com/provider/resources/priorauth/index.aspx.

Services that do not Require Prior Authorization

A list of services that do not require prior authorization review for medical necessity and place of service can be found on our website at www.amerihealthcaritasla.com/provider/resources/priorauth/index.aspx.

Medically Necessary Services

Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. To be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and

- Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the enrollee. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and are deemed not medically necessary. The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his or her discretion on a case-by-case basis.

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis must be documented in writing.

The determination is based on medical information provided by the enrollee, the enrollee's family/caretaker and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the enrollee. All such determinations must be made by qualified and trained practitioners. Any decision to deny or reduce in amount, duration or scope a request for covered services are made by clinical professionals who possess an active, unrestricted license and have the appropriate education, training, or professional experience in medical or clinical practice.

Letters of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, health care providers are required to supply supporting documentation to substantiate medical necessity when services require prior authorization.

Supporting medical documentation should be directed to the Utilization Management staff that is managing the case of the patient in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The enrollee's name and AmeriHealth Caritas Louisiana ID number

- The diagnosis for which the treatment or testing procedure is being sought

- The goals of the treatment or testing for which progress can be measured for the enrollee

- Other treatment or testing methods which have been tried but have not been successful, along with the duration of the treatment

- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure, which is being requested.

Providers are advised that failure to provide medical documentation or respond to requests for medical documentation to establish medical necessity result in the denial of prior authorization. Claims submitted without required authorization

are denied. AmeriHealth Caritas Louisiana considers it a Quality of Care issue if an enrollee is in need of medically necessary services and the service is not provided because of lack of prior authorization when that lack of prior authorization is a direct result of the provider's failure to supply medical documentation. Quality of Care issues are referred to the Quality Management Department.

Medical Necessity Decision Making

Requests for benefit coverage or medical necessity determinations are made through staff supervised by a Registered Nurse. Decisions to approve coverage for care may be made by utilization management staff when falling within AmeriHealth Caritas Louisiana 's written guidelines. Any request that is not addressed by, or does not meet, Medical Necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure or extension of stay, based on Medical Necessity, or to approve a service in an amount, duration or scope that is less than requested is made by a Medical Director or other designated practitioner under the clinical direction of the Regional Medical Director.

Medical Necessity decisions made by a Medical Director are based on the Louisiana Department of Health's definition of Medical Necessity [as defined in LAC 50:1.101 (Louisiana Register, Volume 37, Number 1)], in conjunction with the enrollee's benefits, medical expertise, AmeriHealth Caritas Louisiana Medical Necessity guidelines, and/or published peer-review literature. AmeriHealth Caritas Louisiana will not retroactively deny reimbursement for a covered service provided to an eligible enrollee by a provider who relied on written or oral authorization from AmeriHealth Caritas Louisiana or an agent of AmeriHealth Caritas Louisiana, unless there was material misrepresentation or fraud in obtaining the authorization.

Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. To be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and
- Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the enrollee.
- Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the enrollee requires at that specific point in time.
- Although a service may be deemed medically necessary, it doesn't mean the service is covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and are deemed "not medically necessary."

AmeriHealth Caritas Louisiana shall not deny continuation of higher-level services (e.g., inpatient hospital) for failure to meet medical necessity unless ACLA can provide the service through an in-network or out-of-network provider for a lower level of care.

AmeriHealth Caritas Louisiana provides its Utilization Management (UM) criteria to network providers upon request. To obtain a copy of AmeriHealth Caritas Louisiana UM criteria:

- Call the UM Department at 1-888-913-0350
- Identify the specific criteria you are requesting
- Provide a fax number or mailing address

A faxed copy of the requested criteria is sent to the provider within 24 hours or written copy by mail within five business days of the request.

Providers may also request prior authorization requirements used to make a medical necessity determination by sending an email to: HB424Request@amerihealthcaritas.com. Prior authorization requirements are furnished to the requesting provider within 24 hours of request.

Please remember that AmeriHealth Caritas Louisiana has Medical Directors and Physician Advisors who are available to address UM issues or answer your questions regarding decisions relating to Prior Authorization, DME, Home Health Care and Concurrent Review. To contact these resources call the Peer-to-Peer Hotline at: 1-866-935-0251.

Additionally, AmeriHealth Caritas Louisiana would like to remind health care providers of our affirmation statement regarding incentives:

- Utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage;
- Providers, associates or other individuals conducting utilization review are not rewarded by AmeriHealth Caritas Louisiana for issuing denials of coverage or service; and
- Financial incentives for UM decision makers do not encourage decisions that result in under- utilization.

Hours of Operation

AmeriHealth Caritas Louisiana provides and maintains a toll-free number for health care providers and enrollees to contact AmeriHealth Caritas Louisiana's UM staff for prior authorizations 24 hours per day, 7 days per week. The toll-free number is 1-888-913-0350. AmeriHealth Caritas Louisiana's UM Department is available to answer calls from health care providers during normal business hours, 8:00 a.m. to 5:00 pm (CST). Translation services are available as needed.

After business hours and on weekends and holidays, health care providers, practitioners and enrollees are instructed to contact the on-call clinician through the same toll-free number 1-888-913-0350. Callers are automatically routed to the Member Services' department. An enrollee services representative assists in connecting the provider to the appropriate on-call clinician.

Timeliness of UM Decisions

Several external standards guide AmeriHealth Caritas Louisiana's timelines for UM decisions and notifications. These include NCQA, local requirements and accompanying regulations, and other applicable state and federal laws and regulations. When standards conflict, AmeriHealth Caritas Louisiana adopts the more rigorous of the standards. The table below identifies AmeriHealth Caritas Louisiana's timeliness standards.

Table: Timeliness of UM Decisions

Case Type	Decision	Initial Notification	Written Confirmation
Urgent Prior Authorization	As expeditiously as the enrollee's health requires, no later than 72 hours from receipt of the request	As expeditiously as the enrollee's health requires, no later than 72 hours from receipt of the request	Within the earlier of 2 business days from the decision or 72 hours of the request

Non-Urgent Prior Authorization	Within 2 business days of receiving the necessary information or 14 calendar days from receipt of the request	As expeditiously as the enrollee's health requires, no later than 1 business day of making the decision	Within the earlier of 2 business days from the decision or 14 calendar days of the request
Concurrent Review	Within 1 calendar day of obtaining the appropriate medical information day from receipt of the request	Within 1 business day from receipt of the request	Within 1 business day from receipt of the request
Retrospective Review	30 calendar days from receipt of medical information, but in no instance later than 180 days from the date of service	Not Applicable	Within 30 calendar days from receipt of the request
Expedited Prior Authorization (Pre-Service)	As expeditiously as the member's health requires, no later than 72 hours from receipt of the request; or no later than 14 calendar days for requested extensions	As expeditiously as the member's health requires, no later than 72 hours from receipt of the request. Or no later than 14 calendar days for requested extensions.	Within the earlier of 2 business days from the decision or 72 hours of the request. Or no later than 14 calendar days for requested extensions
Non-Urgent Prior Authorization (Pre-Service)	80% of requests: Within 2 business days of receiving the necessary documentation; all inpatient hospital authorizations within 2 calendar days of obtaining appropriate medical documentation; or 14 calendar days (CD) from receipt of the request. Or no later than 28 CD for requested extensions information	As expeditiously as the member's health requires, no later than 1 business day of making the decision	Within the earlier of 2 business days from the decision or 14 calendar days of the request. Or no later than 28 CD for requested extensions
Community Psychiatric Supportive Treatment and Psychosocial Rehabilitation	All within 5 calendar days of receiving appropriate documentation or 14 calendar days from receipt of the request	As expeditiously as the member's health requires, no later than 1 business day of making the decision	Within the earlier of 5 calendar days from the decision or 14 calendar days of the request

Behavioral Health Crisis Services	Determinations for any behavioral health crisis services that require prior authorization are to be made as expeditiously as the Enrollee's condition requires, but no later than one (1) calendar day after obtaining appropriate clinical documentation	As expeditiously as the member's health requires, no later than 1 business day of making the decision	All within 1 calendar day of obtaining the appropriate documentation
Urgent Concurrent Review	All within 1 calendar day of obtaining the appropriate medical information	All within 1 calendar day of making the decision	All within 2 business days of making the decision
Retrospective Review	30 calendar days from receipt of the request but in no instance later than 180 days from the date of receipt of request for Service Authorization; retro-enrolled into the plan – no later than 365 days from date of service	Within 30 calendar days from receipt of the request but in no instance later than 180 days from the date of receipt of request for Service Authorization.	Within 30 calendar days from receipt of the request but in no instance later than 180 days from the date of receipt of request for Service Authorization
PRTF Admission (Psychiatric Residential Treatment Facility)	Within 48 hours of completion of the screen	48 hours	48 hours from receipt of request to provider and member

The timeframes for decisions and notification may be extended if additional information is needed to process the request. In these instances, the enrollee and requesting health care provider are notified of the required information in writing.

Physician Reviewer Availability to Discuss Decision

If a practitioner wishes to discuss a medical necessity decision, AmeriHealth Caritas Louisiana's physician reviewers are available to discuss the decision with the practitioner. Calls to discuss the determination are accepted:

- Within five (5) business days of denial or reduction of a previously authorized service. AmeriHealth Caritas Louisiana attempts to contact the requestor within 1 business day of request.
- Up to 48 hours or the end of the second (2nd) business day after the enrollee 's discharge date, whichever is later.
- Up to 48 hours or until the end of the second (2nd) business day after a determination of a retrospective review has been rendered, whichever is later.

A dedicated Peer-to - Peer reconsideration line is available for practitioners to call at 1-866-935-0251. A physician reviewer is available at any time during the business day to interface with practitioners. If a practitioner is not satisfied with the outcome of the discussion with the physician reviewer, then the practitioner may file a formal provider dispute of a Medical Necessity Decision.

Denial Reasons

All denial letters include specific reasons for the denial, the rationale for the denial, and a summary of the UM criteria. If an authorization is denied based upon an interpretation of a law, regulation, policy, procedure, or medical criteria guideline, then the denial letter must contain instructions for accessing the criteria or include a copy. In addition, if a different level of care is approved, the clinical rationale is also provided. These letters incorporate a combination of NCQA standards and Louisiana Department of Health requirements. Denial letters are available in six languages for enrollees with Limited English Proficiency. Letters are translated into other languages upon request. This service is available through the cooperation of Member Services and Utilization Management.

Appeal Process

All denial letters include an explanation of the enrollee's rights to appeal and the processes for filing appeals through the AmeriHealth Caritas Louisiana Medical Necessity Appeal Process and the Fair Hearing Process. Enrollees contact the Member Service Unit to file Grievances or Appeals; an enrollee advocate is available to assist enrollees as needed.

Evaluation of New Technology

When AmeriHealth Caritas Louisiana receives a request for new or emerging technology, it compiles clinical information related to the request and reviews available evidence-based research and/or technology assessment group guidelines. AmeriHealth Caritas Louisiana Medical Directors make the final determination on coverage.

SECTION VII: CLAIMS FILING GUIDELINES

Claims Filing Guidelines

This section provides a general overview of AmeriHealth Caritas Louisiana's claims filing process. More details and guidelines for claim filing are outlined in the **Claim Filing Instructions** which is an appendix to this handbook and available on the website at www.amerihealthcaritasla.com.

Encounter

An Encounter is defined as "an interaction between an individual and the health care system." An Encounter is any health care service provided to an enrollee. Encounters must result in the creation and submission of an Encounter record (CMS 1500 or UB-04 form or electronic submission). The information provided on these records represents the Encounter data that is provided to the Louisiana Medicaid Program by AmeriHealth Caritas Louisiana.

Completion of Encounter Data

Providers must submit electronically an 837P format for professional or 837I format for institutional claims. Providers who bill hardcopy should complete and submit a CMS 1500 claim form or UB-04 claim form each time an enrollee receives covered services. Emailed claim forms are not accepted with no exception. Completion of the CMS 1500 or UB-04 form or electronic claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services
- It allows AmeriHealth Caritas Louisiana to gather statistical information regarding the medical services provided to enrollees

Claim submissions are accepted via paper or electronically via Electronic Data Interchange (EDI). For more information on electronic claim submission and how to become an electronic biller, please refer to the **Claim Filing Instructions** available in the Provider area of AmeriHealth Caritas Louisiana website at the following address: www.amerihealthcaritasla.com.

Encounter data submissions are monitored for accuracy, timeliness, and completeness through claims processing edits and through network provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely, or incomplete information. Network providers are notified of the rejection or denial and are expected to resubmit corrected information to:

AmeriHealth Caritas Louisiana
Claims Processing Department
P.O. Box 7322
London, KY 40742

AmeriHealth Caritas Louisiana Network providers may be subject to sanctions for improper billing or any type of non-compliance by providers. Nothing contained herein shall prohibit LDH from imposing sanctions, including civil monetary penalties, license revocation and Medicaid termination, upon a health care provider for its violations of federal or state law, rule, or regulations.

AmeriHealth Caritas Louisiana is required by state and federal regulations to capture specific data regarding services rendered to its enrollees. All billing requirements must be adhered to by the provider for timely processing of claims.

When required data elements are missing or are invalid, claims are **rejected** for correction and re-submission. Rejected claims are not identified in our claims adjudication system.

Claims for billable services provided to enrollees must be submitted by the provider who performed the services.

Claims filed are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of enrollee eligibility for services under AmeriHealth Caritas Louisiana during the time in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible enrollee.
- Verification that the provider is eligible to participate with the Medicaid Program at the time of service.
- Verification that an authorization has been given for services that require prior authorization.
- Verification of whether there are any other third-party resources and, if so, verification that AmeriHealth Caritas Louisiana is the "payer of last resort" on all claims submitted.

IMPORTANT:

Rejected claims are defined as claims with invalid or required missing data elements, such as the provider tax identification number or enrollee ID number, that are returned to the provider or EDI* source without registration in the claim processing system.

Rejected claims are **not** registered in the claim processing system and can be resubmitted as a new claim.

Denied claims are registered in the claim processing system but do **not** meet requirements for payment under AmeriHealth Caritas Louisiana guidelines.

Please refer to the **Claim Filing Instructions** manual for electronic billing information.

Note: These apply to claims submitted on paper or electronically.

Claims Editing Policy

AmeriHealth Caritas Louisiana's claim payment policies, and the resulting edits, are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC) as outlined below:

- These edits are maintained and updated annually unless otherwise appropriate and apply to practitioners, outpatient hospitals, and DME services.
- Edits are based on current industry benchmarks and best practices including, but not limited to, specialty society criteria, American Medical Association CPT coding guidelines, and CMS mandated edits for Medicaid, which include the quarterly National Correct Coding Initiative (NCCI) edits or its successors.

- Clinical edits include, but are not limited to, units of service, unbundling, mutually exclusive and incidental procedures, pre/post-op surgical periods, modifier usage, multiple surgery reduction, add-on codes, cosmetic, and assistant surgeon.
- Editing includes the ability to apply edits to the current claim as well as paid history claims when applicable.
- NCCI edits are updated quarterly as directed by CMS and adhere to CMS/Louisiana Department of Health (LDH) timelines.
- Edits are applied for physician-administered drugs, updated quarterly, based on the CMS NDC-HCPCS Crosswalk file.

Claim Mailing Instructions

Submit claims to the following address:

AmeriHealth Caritas Louisiana Claims Processing Department
P.O. Box 7322
London, KY 40742

For providers to have their claims processed timely, providers **must submit** claims only to the **address above** and not to the Baton Rouge office. Claims are **not** processed in Baton Rouge. Claims are **only** processed in London, Kentucky.

All providers are encouraged to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or one of the following clearinghouses:

- Optum/Change Healthcare's Provider Support Line, available via online chat or by calling 1-800-527-8133, option 2, Monday - Friday, 7am to 5:30pm CT.
- Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday from 7 AM to 7 PM CT.

Any additional questions may be directed to the AmeriHealth Caritas Louisiana **EDI Technical Support** at **1-866-428-7419**.

Claims Filing Deadlines

All claims (including claims with explanation of benefits (EOBs) from the primary carrier) must be submitted within 365 calendar days from the date services were rendered or compensable items were provided.
See **exception** below for retro enrollees and Medicare primary enrollees.

Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 180 calendar days from the date of the denial.

An enrollee may be retroactively enrolled up to 12 months prior to the enrollee's linkage add date. Providers have up to 365 calendar days from the date of service or 180 calendar days from the enrollee's linkage add date, whichever is later, to submit claims for dates of service during the retrospective enrollment period.

When Medicare is primary, claims must be submitted within 180 calendar days from the Medicare's EOB of payment or denial.

Claims that do not need additional investigation are generally processed more quickly. A large percentage of EDI claims submitted are processed within 10 to 15 days of their receipt. Ninety percent (90%) of all clean claims of each claim type are processed, paid, or denied as appropriate within fifteen (15) calendar days of receipt. One hundred percent (100%)

of all clean claims of each claim type are processed, paid, or denied as appropriate within thirty (30) calendar days of receipt. One hundred percent (100%) of pended claims within sixty (60) calendar days of the date of receipt. The date of receipt is the date AmeriHealth Caritas Louisiana receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

Please refer to the **Claim Filing Instructions** manual for additional electronic billing information at: www.amerihealthcaritasla.com, click Providers; Claims and billing; Claim filing instructions.

Cost Avoidance

As a Healthy Louisiana Plan under the Louisiana Medicaid program, AmeriHealth Caritas Louisiana is intended to be the payer of last resort pursuant to state and federal law. This means all available Third-Party Liability (TPL) resources must meet their claim payment obligations before AmeriHealth Caritas Louisiana makes payment on a claim. Cost Avoidance refers to a method of paying claims in which the provider is not reimbursed until the provider has demonstrated that all available TPL resources have been exhausted.

AmeriHealth Caritas Louisiana implemented cost avoidance process for prenatal services, labor and delivery, and postpartum care, in which we no longer pay these claims first and then seek reimbursement from responsible third parties.

If primary coverage is available for these services, they must be processed by the TPL agency prior to sending to AmeriHealth Caritas Louisiana for reimbursement of remaining balances.

If the primary coverage is Major Medical Health Insurance benefit scope of coverage (SOC) 27 or HMO Major Medical Health Insurance benefit (also SOC 27) which both exclude maternity benefits, then the cost avoidance process is not applicable.

Providers must report primary payments and denials for enrollees with TPL to avoid rejected claims. A provider who has been paid by AmeriHealth Caritas Louisiana and subsequently receives reimbursement from a third party must repay AmeriHealth Caritas Louisiana the difference between the primary carrier's contractual obligation and the patient liability.

If a balance remains after the provider bills the liable third party or the claim is denied payment for a substantive reason, the provider may submit a claim to AmeriHealth Caritas Louisiana for payment up to the Medicaid allowable amount.

Pay and Chase

The "Pay and Chase" method is followed for certain services and occurs when payment is made by AmeriHealth Caritas Louisiana for claims despite the known existence of liable third parties, and attempts are made to recover these payments from the liable third parties.

Services for Preventive Pediatric Care (PPC) including Early and Preventive Screening, Diagnostic and Treatment (EPSDT), EPSDT referral and when well-baby procedure codes 99460, 99462, and 99238 are billed with diagnosis codes Z38 through Z38.8 are processed via the Pay and Chase method.

Pay and chase method of payment is done for preventive pediatric services for individuals under the age of 21 with other health insurance when the pediatric preventive diagnosis codes is reported in the primary position of the claim. Hospitals are not included and must continue to file claims with the health insurance carriers. Primary preventive diagnoses are confined to those listed on www.lamedicaid.com. EPSDT referral is indicated as "Y" in field 24H of the CMS 1500 claim form or "A1" as a condition code on the UB-04 (fields 18-28).

Please review EPSDT fee schedules for services available under the Pay and Chase policy.

Wait and See

The "Wait and See" policy is followed on claims for enrollees on whose behalf child support enforcement is being carried out by the state. "Wait and See" is defined as payment of a claim after documentation is submitted demonstrating 100 days have passed since the provider initially billed the third party and payment has not been received. AmeriHealth Caritas Louisiana reviews for third party liability using TPL files transmitted by LDH's fiscal intermediary.

The provider can only bill for the unpaid balance from the liable third party and payment can only be made up to the allowable amount for services covered under the Plan.

Providers must complete the attestation forms and submit them along with hard copy claim submissions. The claims must reflect the primary carrier's information. The hard copy claims, and attestation forms must be mailed to the following address:

AmeriHealth Caritas Louisiana
Claims Processing Department
P.O. Box 7322
London, KY 40742

Post-Payment Recoveries (TPL/COB/Encounters/Claim Audits)

AmeriHealth Caritas Louisiana reviews TPL information and audits claim payments on a routine basis.

Providers receive notification of our intent to recover overpayments identified during these reviews and audits. To assist the provider in reconciling claims, a letter is sent to the provider detailing the claims impacted by TPL coverage. This letter indicates the 60-day timeline for the provider to submit a check or dispute the TPL information. If a response is not received within 60 days, the recoupment process is then initiated.

We strive to identify and recover claim overpayments within 365 days from the claim's last date of service; however, this timeframe may be extended in the following circumstances:

- There is evidence of fraud,
- There is an established pattern of inappropriate billing,
- Enrollee retro-enrollment

Exclusions to Post Payment Recoveries from Providers

- Pay and chase claims are always referred directly to the liable third parties.
- Claims billed with an EOB denial from other health insurance.
- If the liable third party is traditional Medicare, Tricare, or Champus VA, and more than 10 months have passed since the date of service, payment is recovered from the provider.
- Point of Sale (POS) is always referred directly to liable third parties.

Third Party Liability (TPL)

AmeriHealth Caritas Louisiana seeks recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party.

AmeriHealth Caritas Louisiana seeks recovery from the provider where dates of services (DOS) are 10 months or less from the date stamp on the provider recovery letter.

AmeriHealth Caritas Louisiana does not seek recovery from the provider where DOS is older than 10 months but seeks recovery directly from liable third parties. AmeriHealth Caritas Louisiana may utilize Act 517 of the 2008 Regular Legislative Session to seek recovery of reimbursement from liable third parties for up to 36 months from the date of service reported on the claim.

Providers have 60 days from the date stamp of the recovery letter to refute the recovery, otherwise recoupment from future remittance advices (RAs) shall occur.

Providers are given an additional 30-day extension at their request when the provider billed the liable third party and hasn't received an EOB.

If after 60 days of the recovery letter, or 90 days if a 30-day extension was requested, a response hasn't been received from the provider, the recovery is then initiated.

If a provider disagrees with the recovery and would like to dispute the findings, we must be notified in writing with the following information enclosed:

- A copy of the recovery letter including the Project Number
- The reason for your dispute
- Documentation supporting your position

Send your correspondence to:

AmeriHealth Caritas of Louisiana
Cost Containment and TPL Department
P.O. Box 7320
London, KY 40742

If a provider agrees with the findings, a check may be submitted for the amount of the overpayment. The check must be accompanied by a copy of the recovery letter including the Project Number and should be submitted to:

AmeriHealth Caritas of Louisiana
Cost Containment and TPL Department
P.O. Box 7322
London, KY 40742

Note: **Checks received without a copy of recovery letter including the Project Number are returned and the overpayment is recovered from future payments.**

Third Party Liability and Medicare Advantage Plan Update Requests

General Private TPL and Medicare Advantage Plan Update Requests

All general private TPL and Medicare Advantage Plan update requests must be submitted to AmeriHealth Caritas Louisiana via fax, email or phone.

Fax: (215) 863-5423

Email: tpl@amerihealthcaritas.com

Phone: (888) 922-0007

Urgent Private TPL and Urgent Medicare Advantage Plan Update Requests

Providers should submit all urgent TPL and urgent Medicare Advantage Plan update requests for members who are enrolled with AmeriHealth Louisiana Caritas using the contact information above.

Urgent TPL requests are defined as the inability of a member to either have a prescription filled or access immediate care because of incorrect third-party insurance coverage. All other requests are considered "general" TPL update requests.

Traditional Medicare and Escalations:

All TPL update requests for traditional Medicare should be submitted to the **Louisiana Department of Health (LDH) TPL Unit** via email, fax or phone.

Escalations requests may also be sent to this unit in the following situations:

- More than **5 business days** have passed since the initial request, and the change is not reflected in the Medicaid Eligibility Verification System (MEVS).
- Urgent pharmacy requests that have not been resolved in 4 business hours.
- Emergency updates needed to ensure immediate medical care access.

LDH TPL Unit Contact Information

Email: tpl.inquiries@la.gov

Fax: (225) 389-2709

Phone: (225) 342-4510

Hours: Monday through Friday, 8 a.m. – 4:30 p.m. (excluding Louisiana state holidays)

Private TPL and Medicare Advantage Plan Update Request Change Forms can be found here: Recipient_Insurance_Update.pdf.

The Traditional Medicare Update Form can be found here: TraditionalMedicare.pdf.

Please sent any questions regarding TPL to tpl.inquiries@la.gov.

Third Party Liability and Global Maternity Procedure Codes

Global Maternity Procedure codes are accepted for claims ONLY when billed as secondary payer. Claims billed for Global Maternity Codes as primary payer are denied.

Add on codes for maternity related anesthesia do not apply to claims billed with global maternity codes, therefore, add-on rates are bypassed when modifiers 47 and 52 are reported on the claim.

Global maternity care includes pregnancy-related antepartum care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care. Other antepartum services are not considered part of global maternity services. They are reimbursed separately. An initial visit, confirming the pregnancy, is not part of the global maternity care services.

The provider should bill prenatal, delivery and/or postpartum services separately if the enrollee's Medicaid eligibility terminates prior to delivery.

Calculation of Payment for LaHIPP Secondary Claims

Claims processed as secondary payer for LaHIPP (Louisiana's Health Insurance Premium Payment Program) enrollees' claims are processed and paid at the full patient responsibility (co-pay, co-insurance, and/or deductible) regardless of Medicaid's allowed amount, billed charges or TPL payment amount if the participant uses a provider that accepts the enrollee's insurance as primary payer and Medicaid as secondary payer. If the provider does not accept this payment arrangement, the enrollee is responsible for the patient responsibility. AmeriHealth Caritas Louisiana is always payer of last resort, except when we are responsible for payment as primary payer for Medicaid covered services not covered by commercial insurance as primary payer (e.g., mental health, and transportation services).

LaHIPP Enrollee Claim Example:

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Plan payment
99213	70.00	40.00	36.13	10.00	10.00

TPL Payment and TPL Payment Calculation

If a TPL insurer requires the enrollee to pay any co-payment, coinsurance, or deductible, the Plan is responsible for making these payments under the method described below, even if the services are provided outside of the Plan network.

Scenario 1 Professional Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Plan Payment
99212	55.00	0.00	24.10	36.00 (Ded)	24.10
83655-QW	30.00	0.00	11.37	28.20 (Ded)	11.37
Totals	85.00	0.00	35.47	64.20 (Ded)	35.47

The Medicaid allowed amount minus the TPL paid amount is LESS than the patient responsibility; therefore, the Medicaid allowed amount is the payment.

Scenario 2 Outpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Plan Payment
HR270	99.25	74.44	22.04	0.00	0.00
HR450	316.25	137.19	70.24	100.00	0.00
Total	415.50	211.63	92.28	100.00	0.00

Medicaid "zero pays" the claim. When cost-compared, the private insurance paid more than Medicaid allowed amount for the procedure. When compared, the lesser of the Medicaid allowed amount minus the TPL payment AND the patient responsibility is the former; thus, no further payment is made by the Plan. The claim is paid in full.

Scenario 3 Inpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Plan Payment
Multiple HR	12, 253.00	2,450.00	5, 052.00	300.00	300.00

The Medicaid allowed amount minus the TPL payment is greater than the patient responsibility; thus, the patient responsibility is paid on this covered service.

Scenario 4 FQHC/RHC/American Indian Clinic

Provider's PPS Rate (Medicaid allowable)	Procedure Code	Billed Charge	TPL Paid Amount	Patient Responsibility Amount	Plan Payment
150.00	T1015	150.00	50.00	40.00 (Ded)	100.00

Provider's PPS rate is $150.00. The third party paid $50.00. Medicaid pays the difference from the PPS rate and third-party payment making the provider whole. The Plan must pay the difference between the third-party payment and the PPS for the service.

Scenario 5 Outpatient Pharmacy Claim

Amount Billed	TPL Paid Amount	Medicaid Maximum Allowable	Patient Responsibility Amount from Primary	Plan Pharmacy Co-Pay	Plan Payment
38.55	28.55	31.36	10.00 (Copay)	0.50	2.31

613.00	60.00	40.73	553.00 (Ded)	0.00	0.00
177.97	5.22	14.39	172.75 (Ded)	0.50	8.67

If third party liability (TPL) is involved, the Plan as the secondary payer may not deny the claim for a high dollar amount billed for claims less than $1,500. If the TPL pays $0.00 or denies the claim, then the pharmacy claims should be treated as a straight Medicaid pharmacy claim. Taxes on the primary claim should be subtracted before calculating the Medicaid Maximum Allowable. Maximum Medicaid allowable is defined as professional dispensing fee plus ingredient cost (quantity * price per unit) or usual and customary, whichever is less.

The pricing calculation is ingredient cost (quantity * price per unit) + Dispensing Fee – TPL amount paid – copayment = Medicaid payment. If U&C is less than the Medicaid allowable, then the calculation is U&C – TPL amount paid – copayment = Medicaid payment. If there is other third-party liability (TPL) payment greater than $0.00, the Plan electronically bypasses prior authorization requirements and Point of Sale edits that would not be necessary as the secondary payer. Safety edits still apply. TPL claims process with the same PCN and BIN number as primary claims.

Scenario 6 LaHIPP Enrollee Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Plan Payment
99213	70.00	40.00	36.13	10.00	10.00

As previously mentioned in the **Calculation of Payment for LaHIPP Secondary Claims** section because this is a LaHIPP enrollee, the Plan pays the co-pay regardless of Medicaid's allowed amount even though the private insurance payment is more than the Medicaid allowable. The Plan pays the patient responsibility on covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.

Refunds for Claims Overpayments or Errors

Providers are encouraged to conduct routine self-audits to ensure receipt of accurate payment(s) from the health plan. Funds disbursed by AmeriHealth Caritas Louisiana must be promptly returned to the Plan when identified as improperly paid or overpaid.

All reviews and/or audits of a provider claim are completed no later than one (1) year after the date of payment, regardless of whether the provider participates in the network. This includes an "automated" review, which is one for which an analysis of the paid claim is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.

If a provider identifies improper payment or overpayment of claims, the improperly paid or overpaid funds must be returned within 60 days from the date of discovery of the overpayment and the provider must notify the Plan in writing of the reason for the overpayment.

Providers may return improper or overpaid funds to the health plan by submitting the refund check with enrollee's name and ID, date of service and claim ID by mail to:

Claims Processing Department
AmeriHealth Caritas Louisiana
PO Box 7322
London, KY 40742

If a provider prefers the improper payment or overpayment be recouped from future claim payments, the overpayment must be reported by calling Provider Services at 1-888-922-0007 or send the request to the following address:

Claims Processing Department
AmeriHealth Caritas Louisiana
P. O. Box 7322
London, KY 40742

If the improper payment or overpayment is related to a subrogation issue—slip and fall, worker's compensation or motor vehicle accident (MVA)—send the completed subrogation overpayment worksheet or any related documentation to subrogation@amerihealthcaritas.com.

Clean Claim Interest Payment and Claims Reprocessed Due to Payment Errors

Providers are paid interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) day claims processing deadline. Interest owed is paid the same date that the claim is adjudicated.

If AmeriHealth Caritas Louisiana, LDH or subcontractors or providers discover errors made by the Plan when a claim was adjudicated, corrections are made and reprocessed within fifteen (15) calendar days of discovery or notification, or if circumstances exist that prevent from meeting this time frame, by a specified date subject to LDH written approval. Providers are paid interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond either the fifteen (15) calendar day claims reprocessing deadline or the specified deadline approved by LDH in writing, whichever is later.

Weekly Check Cycles

Three (3) provider payment check cycles are run per week, (Monday, Wednesday and Friday). On occasion, there may be two check runs for the week due to an AmeriHealth Caritas Louisiana recognized holiday.

Claim System Updates

Our Claims Adjudication system is updated within 30 days of receiving new fee schedules from the Louisiana Department of Health and claims are recycled within 15 days after the system updates.

SECTION VIII: PROVIDER NETWORK MANAGEMENT

Provider Network Management

Provider Network Management is responsible for building and maintaining a robust Provider Network for enrollees. Contracting staff is responsible for negotiating contracts with hospitals, physicians, ancillary, DME and other providers to assure our Network can provide the full range of Medicaid covered benefits in an accessible manner for our enrollees. The primary contact for network providers with AmeriHealth Caritas Louisiana is the Provider Network Management Account Executives (AE). The AEs function as a provider relations team to advise and educate AmeriHealth Caritas Louisiana providers, and can help providers become familiar with policies, processes and AmeriHealth Caritas Louisiana initiatives. Providers are contacted by AmeriHealth Caritas Louisiana representatives to conduct meetings that address topics including, but not limited to:

- Contract Terms
- Credentialing or AmeriHealth Caritas Louisiana's Re-credentialing Site Visits
- Health Management Programs
- Marketing Compliance
- The Plan's Model of Care Orientation, Education and Training Program Updates and Changes
- Provider Complaints
- Provider Responsibilities
- Quality enhancements
- Self-Service tools

Provider Network Management, in collaboration with the Utilization Management Department, negotiates rates for Non-Participating Providers and facilities when services have been determined to be Medically Necessary and are Prior Authorized by AmeriHealth Caritas Louisiana.

Call **Provider Services at 1-888-922-0007:**

- Arrange for orientation or in-service meetings for network providers or staff
- Respond to any questions or concerns regarding your participation with AmeriHealth Caritas Louisiana
- Report any changes in your status, e.g.:
    - Phone number
    - Address
    - Tax ID Number
    - Additions/deletions of physicians affiliated with your practice

NaviNet (AmeriHealth Caritas Louisiana's secure provider portal)

NaviNet offers your practice full-circle services from visit to claim payment and beyond at no charge! Using NaviNet reduces the time spent on paperwork and allows you to focus on more important tasks such as patient care. NaviNet is a one- stop service that supports your office's clinical, financial and administrative needs.

NaviNet provides the following services:

- Eligibility and Benefits Inquiry
- Care Gaps and Care Gaps Reports
- Enrollee Clinical Summary
- Provider Data Information Form
- Authorization Requests
- Claims Management Functions, including the Claims Inquiry Tool
- Dispute/Appeal on Behalf of Member/Complaint Submission Form

Log on to www.navinet.net or contact NaviNet Customer Service at 1-888-482-8057 to help you get started.

Provider Demographic Information

Network Providers are required to notify AmeriHealth Caritas Louisiana **at least sixty (60) days, and in no event not less than five (5) days**, **prior to** any change to its name, address, telephone number, medical specialty, hospital affiliations, and other similar information relevant to inclusion in the provider directory. Providers should contact their Provider Network Account Executive or Provider Services with changes to their demographic information or submit changes via the Provider Data Information Form (PDIF) in our secure provider portal, NaviNet. Network providers may verify their demographic data at any time using the real-time Provider Network directory at www.amerihealthcaritasla.com. If any corrections are necessary, we ask that these corrections are reported immediately.

Accurate provider information is imperative to successful participation in our network. Accuracy of provider demographics associated with service location addresses, telephone numbers, languages spoken, current staff rosters and status of accepting new AmeriHealth Caritas Louisiana referrals are necessary for our enrollees to make appointments and find your office location. Correct NPIs, Tax IDs and remit addresses are necessary for you to be properly reimbursed for your services.

Requests for changes to address, phone number, Tax I.D., or additions and/or deletions to group practices can be made by completing the Provider Change Form. This form is available online at www.amerihealthcaritasla.com; complete it and return by mail to the Provider Network Management Department at:

AmeriHealth Caritas Louisiana Health Plan
Provider Network Management Department
PO Box 83580
Baton Rouge, LA 70884

AmeriHealth Caritas Louisiana providers also can attest to the accuracy of practice data and submit demographic changes directly via the **PDIF** feature.

Note: This feature is only available to professional provider groups.

Provider Validation and Attestation of Demographic Information

The Provider Data Information Form feature in our secure provider portal, NaviNet, allows you to review your demographic and practice information on file, attest to the accuracy of the information, and make any necessary changes.

Demographic changes are reflected within the online provider directory within 14 business days. If the change is not reflected in 14 days, please contact your Provider Network Management account executive.

Upon request, providers are asked to review current demographic information as it is listed in the directory and submit updates or corrections. **Please note: Providers will be given 30 days to attest to the accuracy of the information or submit any changes. Failure to respond in the specified time frame may result in claim denials.**

If your practice is not registered with NaviNet, we highly recommend registering. To register, please visit our website at **www.amerihealthcaritasla.com/provider/resources/navinet/index.aspx** and sign up or contact your provider account executive. For additional guidance on this feature, please refer to the Provider Data Information Form User Guide also available on our website.

Email

AmeriHealth Caritas Louisiana can email providers' contracts, documents and amendments for review and signature. It is important that we have the correct email for the practice's office management and that the information is routed to the person responsible for handling contracts, documents and amendments.

Provider Services Department

AmeriHealth Caritas Louisiana's Provider Services Department operates in conjunction with the Provider Network Management Department, answering network provider concerns and offering assistance. Both departments make every attempt to ensure all network providers receive the highest level of service available.

The Provider Claims Services Department can be reached between 7:00 am – 6:00 pm (CST) Monday -Friday for claims assistance at the number listed below. Provider Services for any other calls not related to claims assistance can be reached 24/7. Calls received after business hours, on weekends and holidays are answered by our off-hours team. The Off-Hours team will contact the on-call UM nurse for any urgent issues. A Medical Director is also on-call to address any medical necessity determination requests.

Call the Provider Services Department at 1-888-922-0007 to:

- Ask policy and procedure questions
- Report enrollee non-compliance
- Obtain the name of your Provider Network Account Executive
- Request access/information about centralized services such as:
    - Outpatient laboratory services
    - Vision
    - Dental (limited coverage)

New Provider Orientation

Upon completion of AmeriHealth Caritas Louisiana's contracting and credentialing processes, the provider is sent a welcome letter, which includes the effective date and the provider services contact information. The welcome letter refers all AmeriHealth Caritas Louisiana providers to online resources and this Provider Manual. The Provider Manual serves as a source of information regarding AmeriHealth Caritas Louisiana's covered services, policies and procedures, selected statutes and regulations, telephone access and special requirements intended to assist the provider to comply with all provider contract requirements.

Provider Education and Ongoing Training

AmeriHealth Caritas Louisiana's training and development are fundamental components of continuous quality and superior service. AmeriHealth Caritas Louisiana offers ongoing educational opportunities for providers and their staff. AmeriHealth Caritas Louisiana has a commitment to provide appropriate training and education to help providers achieve compliance with AmeriHealth Caritas Louisiana's standards, as well as federal and state regulations. This training may occur in the form of an on- site visit or in an electronic format, such as online training sessions or interactive training sessions. Detailed training information is available in the "Provider" section of our website at www.amerihealthcaritasla.com. Plan providers also have access to the Provider Services Department at 1-888-922-0007 and your Account Executive for questions.

AmeriHealth Caritas Louisiana conducts initial training within thirty calendar days of placing a newly contracted provider or provider group on active status. AmeriHealth Caritas Louisiana also conducts ongoing provider education and training. Orientation and training topics includes:

- Billing and claims filing, and encounter data reporting
- Electronic funds transfers/remittance advice
- Covered services, benefit limitations and value-added services
- Credentialing
- Cultural competency
- Fraud, Waste and Abuse
- Policies and procedures
- Provider responsibilities
- Plan's Model of Care
- Medicaid compliance
- Provider inquiry and complaint process
- Quality enhancement programs / Community resource capability
- Utilization Management, Quality Assurance Performance Improvement (QAPI) and
- Integrated Care Management Programs

Claims Issues

The Provider Services Department also assists providers with claims questions and adjustments. Some of the claims-related services include:

- Review of claim status (Note: claim status inquiries can also be done online via NaviNet)
- Dispute/Appeal on Behalf of Member/Complaint Submission Form online via NaviNet or Hardcopy Submission
- Research on authorization, eligibility and coordination of benefits (COB) issues related to denied claims
- Clarification of payment discrepancies

- On-line adjustments to incorrectly processed claims
- Assistance in reading remark, denial and adjustment codes from the remittance advice

Additional administrative services include:

- Explanation of Plan policies in relation to Claim processing procedures
- Explanation of authorization issues related to Claim payment
- Information on billing and Claim coding requirements
- Assistance in obtaining individual network provider numbers for network providers new to an existing AmeriHealth Caritas Louisiana group practice

Call the Provider Claim Services Unit at 1-888-922-0007 or look online in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

Provider Complaints and Claim Disputes

DEFINITIONS and EXAMPLES:

Provider Complaint – Any verbal or written expression by a provider indicating dissatisfaction with an AmeriHealth Caritas Louisiana policy, procedure, claims processing and/or payment or any other communication or action by AmeriHealth Caritas Louisiana, (excluding requests for reconsideration or appeal for specific individual claims) filed by phone, in writing or in person with AmeriHealth Caritas Louisiana.

Examples of provider complaints include:

- Claims processing issues, such as lack of timely payment
- Insufficient reimbursement rates
- Prior authorization issues, including dissatisfaction AmeriHealth Caritas Louisiana's prior authorization process or turnaround times
- PCP linkage concerns, including PCP auto-assignment methodology and patient linkage policies, procedures, or results
- Provider enrollment and/or credentialing issues, such as lack of timely processing or allegation of a discriminatory. practice or policy
- Lack of access to providers or services, such as difficulty in locating specialty providers that will agree to treat enrollees
- Provider directory or database issues, including incorrect information or lack of information in AmeriHealth Caritas Louisiana s system and/or directory
- Lack of information or response, including failure by AmeriHealth Caritas Louisiana to return a provider's calls, infrequency of site visits by AmeriHealth Caritas Louisiana Network Management Account Executives, or lack of provider network orientation / education by AmeriHealth Caritas Louisiana

How To File a Complaint

By phone:
Call Provider Services at **1-888-922-0007** (available 24/7)

Online:
Complaint Submission Form online via NaviNet

In writing by mail:

Attn: Provider Complaints
AmeriHealth Caritas Louisiana
P.O. Box 7323
London, KY 40742

You may also request an on-site meeting to discuss your complaint. You may file a complaint with your Provider Network Management Account Executive.

Claim Disputes – A claim dispute is a request for post-service review of claims that have been previously denied, underpaid, or otherwise limited by AmeriHealth Caritas Louisiana.

Examples of claim disputes include:

- Inaccurate payment
- Claims denied for missing information, such as invalid coding or failure to include tax ID number
- Claims denied administratively for untimely filing or failure to include prior authorization information
- Payment limitations, including iHealth or NCCI edits and TPL misinformation

How To File a Claim Dispute

You may file a claim dispute by submitting a completed Provider Claim Dispute Form which can be found in the provider forms section or via NaviNet online submission.

You may choose to mail your completed form to:

AmeriHealth Caritas Louisiana
Attn: Provider Disputes
P.O. Box 7323
London, KY 40742

Claim disputes should be marked “first-level" or "second-level" claim dispute on the outer envelope and in the correspondence.

- **First-level claim dispute**: an initial written request for post-service review of claims.
- **Second-level claim dispute**: a secondary written request for review of first-level claim dispute resolution.

Multiple claims with different denial reasons should not be submitted on the same form.

If several claims are impacted by the same issue, you may submit the claim dispute via the multiple claims project spreadsheet (Opens in a new window) (PDF).

Claim Dispute Time Frames

Claim disputes are acknowledged by AmeriHealth Caritas Louisiana within three business days.

First-level claim disputes

First-level claim dispute requests must be received within 180 calendar days of the remittance advice or denial. A determination is made within 30 calendar days of receipt of the claim dispute by AmeriHealth Caritas Louisiana.

Second-level claim disputes

If you are dissatisfied with the first-level claim dispute resolution, you may file a second-level claim dispute within 90 calendar days of the date on the first-level claim dispute determination letter.

Second-level claim disputes are reviewed and decided upon by a second-level claim dispute reviewer of AmeriHealth Caritas Louisiana leadership or their designees.

A determination is made within 30 calendar days of receipt of the claim dispute by AmeriHealth Caritas Louisiana.

Independent Review Process

Step 1: Request for independent review reconsideration

Independent review reconsideration allows providers dissatisfied with an adverse claim determination to request additional review.

Must be submitted in writing on the LDH-required form within 180 calendar days of one of the following:

- the transmittal date of an electronic remittance advice (RA) or the postmark date of a paper RA
- 60 days from the claim submission date if no RA is received
- the date of claim recoupment

An IRR may be emailed to aclaindependentreviewrequest@amerihealthcaritas.com or mailed to the physical address AmeriHealth Caritas Louisiana at:

AmeriHealth Caritas Louisiana
Attn: Provider Disputes
PO Box 7323
London, KY 40742

OR

- Providers may submit online via NaviNet portal
- Providers may initiate a reconsideration using the Independent Review Provider Reconsideration Form, which can be found in the provider forms section

The IRR is acknowledged within 5 days of receipt and it is resolved within 45 days of receipt.

Step 2: Request for Independent Review

If a provider is still not satisfied with the determination after the independent review reconsideration request process, a request for independent review may be submitted to the Louisiana Department of Health (Opens in a new window). Independent review allows providers dissatisfied with an AmeriHealth Caritas Louisiana's reconsideration decision to uphold an adverse claim determination to request independent review.

Note: Mental health rehabilitation service providers have rights to request independent reviews due to adverse determinations made by AmeriHealth Caritas Louisiana, which resulted in claim payments being recouped based on findings of waste or abuse.

Must be submitted in writing on the Louisiana Department of Health-required form within 60 days of one of the following:

- the date of AmeriHealth Caritas Louisiana's reconsideration decision
- the last day of AmeriHealth Caritas Louisiana's 45-day period to enter a reconsideration decision, if no decision is received

Must be mailed to LDH at:

LDH/Health Plan Management
PO Box 91030, Bin 24
Baton Rouge, LA 70821-9283
Attn: Independent Review

It is resolved by the independent reviewer within 60 days (or longer if a medical necessity determination is required) of receipt of all documentation.

It costs $750 and is paid for by AmeriHealth Caritas Louisiana; however, the provider must reimburse AmeriHealth Caritas Louisiana if the adverse determination is upheld by the independent reviewer.

The required Request for Independent Review form is available at https://www.amerihealthcaritasla.com/pdf/provider/resources/forms/independent-review-provider-reconsideration-form.pdf.

Arbitration

If you are not satisfied with AmeriHealth Caritas Louisiana's internal claim dispute resolution, you have the option to request binding arbitration by a private, independent arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. Arbitration requests must be submitted in writing to AmeriHealth Caritas Louisiana within 30 days of the Second Level Dispute determination letter to:

AmeriHealth Caritas Louisiana
Market President
Attn: Arbitration
10000 Perkins Rowe
Block G, 4th Floor
Baton Rouge, LA 70810

Arbitration regarding a claim dispute is binding on all parties. The arbitrator conducts a hearing and issue a final ruling within 90 calendar days of being selected, unless you and AmeriHealth Caritas Louisiana mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, are shared equally by the parties. You must exhaust

AmeriHealth Caritas Louisiana's internal claim dispute process before proceeding to arbitration. You do not have the right to a state fair hearing for claim issues.

Disputes about Non-AmeriHealth Caritas Louisiana Covered Services

Louisiana's Healthy Louisiana plans provide Medicaid-covered services for enrollees in the Healthy Louisiana program; however, not all Medicaid services are included in the Plan's core benefits. The previous section outlines the provider complaint system involving AmeriHealth Caritas Louisiana-covered services; however, there may be times when a provider has a dispute regarding non-AmeriHealth Caritas Louisiana services. Our Provider Services department can assist a provider in identifying whether the issue in dispute is a plan or LDH responsibility.

Provider Contract Terminations

AmeriHealth Caritas Louisiana Provider Agreements specify termination provisions that comply with CMS requirements. Provider terminations are categorized as follows:

- Provider Initiated
- Plan Initiated "For Cause"
- Plan Initiated "Without Cause"

Aside from those requirements identified in the Provider Agreement, AmeriHealth Caritas Louisiana complies with the following guidelines, based on category of termination.

Provider Initiated

The provider must provide written notice to AmeriHealth Caritas Louisiana if intending to terminate from the AmeriHealth Caritas Louisiana Network. Written notice must be provided at least 90 days before the termination date in accordance with the method(s) specified in your Network Provider Agreement, and the termination letter must reflect the signature of an individual authorized to make the decision to terminate the agreement.

AmeriHealth Caritas Louisiana Initiated "For Cause"

AmeriHealth Caritas Louisiana may initiate termination of a Provider Agreement if the provider breaches the AmeriHealth Caritas Louisiana Network Provider Agreement. A "for cause" termination may also be implemented when there is an immediate need to terminate a provider's contract. If terminating a Provider Agreement for cause, AmeriHealth Caritas Louisiana:

- Sends applicable termination letters in accordance with the notification provisions of the Network Provider Agreement;
- Notifies provider(s), CMS and the enrollee immediately in cases where an AmeriHealth Caritas Louisiana enrollee's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action of the State Board of Medicine or other governmental agency;
- Offer appeal rights for physicians as applicable.

AmeriHealth Caritas Louisiana Initiated "Without Cause"

AmeriHealth Caritas Louisiana may terminate a Provider Agreement "without cause" for various reasons. If this occurs, AmeriHealth Caritas Louisiana:

- Sends applicable termination letters in accordance with the notification provisions of the Network Provider Agreement;
- Notifies the AmeriHealth Caritas Louisiana Network provider;
- and enrollees who received care from the terminated provider within the last eighteen (18) months;
- Offers Coordination of Care to transition enrollees to new providers.

Mutual Terminations

A Mutual Termination is a termination of a Provider Agreement(s) in which the effective date is agreed upon by both parties. The termination date may be other than the required days' notice specific to the AmeriHealth Caritas Louisiana Network's Provider Agreement language.

- All mutual termination letters require signatures by both parties.
- Regarding mutual terminations of any AmeriHealth Caritas Louisiana Network Provider Agreement, the termination date should provide a minimum number of required days to provide notice to enrollees and effectuate continuity of care. A mutual agreement termination date should not be a retroactive date.
- AmeriHealth Caritas Louisiana notifies all enrollees who received care within the last eighteen (18) months at least 30 calendar days before the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice.
- Coordination of Care must be offered to transition enrollees to new providers.

Adverse Action Reporting

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986 with governing regulations codified at 45 CFR Parts 60 and 61, AmeriHealth Caritas Louisiana sends information on reportable events as outlined in the NPDB and HIPDB reporting manual instructions to the respective entity and to the Louisiana State Board of Medical or Dental Examiners, as appropriate.

All review outcomes, including actionable information, are incorporated in the practitioner/provider credentialing file and database.

Provider Marketing Activities and Compliance

All health care providers delivering services to Louisiana Medicaid and LaCHIP beneficiaries enrolled in Healthy Louisiana plans are welcome to inform their patients of the Healthy Louisiana plans they have chosen to participate with, but Healthy Louisiana has strict prohibitions against patient steering, which all providers must observe.

- Providers may inform their patients of all Health Plans in which they participate, and can inform patients of the benefits, services and specialty care services offered through the Health Plans in which they participate.
- Providers are not allowed to disclose only some of the Health Plans in which they participate. Disclosure of Health Plan participation must be all or nothing.
- Providers can display signage, provided by the Health Plan, at their location indicating which Health Plans are accepted there, but must include all Health Plans in which they participate in this signage.
- If a provider participates in only one Healthy Louisiana Plan, the provider can display signage for only one Health Plan and can tell a patient that is the only Health Plan accepted by that provider.
- Providers MAY NOT RECOMMEND one Health Plan over another Health Plan, MAY NOT OFFER patients incentives for selecting one Health Plan over another, and MAY NOT ASSIST IN ANY WAY (faxing, using the office phone, computer in the office, etc.) the patient in deciding to select a specific Health Plan.

- Patients who need assistance with their Health Plan services should call the Member Services Hotline for the Plan in which they are enrolled, and those who wish to learn more about the different Health Plans should contact the Healthy Louisiana Enrollment Broker at 1-855-229-6848 to receive assistance in making a Health Plan decision.
- Under NO CIRCUMSTANCES is a provider allowed to change an enrollee's Health Plan for him/her or request a Health Plan reassignment on an enrollee's behalf. Enrollees who wish to change Health Plans for cause must make this request to Medicaid themselves through the Healthy Louisiana Enrollment Broker.
- If a provider or Health Plan is found to have engaged in patient steering, they may be subject to sanctions such as, but not limited to monetary penalties, loss of linked patients and/or excluded from enrollment in Medicaid/Healthy Louisiana Plan network opportunities.

Site Visits Resulting from Receipt of a Complaint and/or Ongoing Monitoring

Provider Network Management or the Credentialing department may identify the need for a site visit due to receipt of an enrollee's dissatisfaction regarding the provider's office environment. At the discretion of the Provider Network Management representative a site visit to address the specific issue(s) raised by an enrollee may occur. Follow-up site visits are conducted as necessary.

Communication of Results

The Provider Network Management Representative reviews the results of the Site Visit Evaluation Form (indicating all deficiencies) with the office contact person.

- If the site meets and/or exceeds the passing score, the Site Visit Evaluation Form is signed and dated by both AmeriHealth Caritas Louisiana and the office contact person.
- If the site does not receive a passing score AmeriHealth Caritas Louisiana follows the procedures outlined below to follow-up on identified deficiencies.

Follow-Up Procedure for Identified Deficiencies

1. The Provider Network Management Representative requests a corrective action plan from the provider within one week of the visit.
2. The Provider Network Management Representative schedules a re-evaluation visit with the provider office, to occur within 30 days of the initial site visit to review the site and verify that the deficiencies were corrected.
3. The Provider Network Management Representative reviews the corrective action plan with the office contact person.
4. The Provider Network Management Representative reviews the results of the follow-up Site Visit Evaluation Form (including a re-review of previous deficiencies) with the office contact person:
    a. If the site meets and/or exceeds the passing score, the Provider Network Management Representative, the Site Visit Evaluation Form is signed and dated by both AmeriHealth Caritas Louisiana's Representative and the office contact person.
    b. If the site does not receive a passing score, the Provider Network Management Representative follows the procedures outlined below for follow-up for secondary deficiencies.

Follow-Up Procedure for Secondary Deficiencies

1. The Provider Network Management Representative re-evaluates the site monthly, up to three times (from the first Site Visit date).
2. If after four (4) months, there is evidence the deficiency is not being corrected or completed, then the office receives a failing score unless there are extenuating circumstances.
3. Further decisions as to whether to pursue the Credentialing process or take action to terminate participation of a provider who continues to receive a failing Site Visit Evaluation score are handled on a case-by-case basis by the AmeriHealth Caritas Louisiana Medical Director and Credentialing Committee.

Fraud and Abuse

AmeriHealth Caritas Louisiana receives state and federal funding for payment of services provided to our enrollees. In accepting claims payment from AmeriHealth Caritas Louisiana, health care providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or abuse against the Medicaid program. As a provider you are responsible to know and abide by all applicable State and Federal Regulations.

AmeriHealth Caritas Louisiana is dedicated to eradicating fraud and abuse from its programs and cooperates in fraud and abuse investigations conducted by state and/or federal agencies, including CMS, the Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, HHS, Office of Inspector General (OIG), State Auditor's Office, General Accounting Office (GAO), Comptroller General, as well as local authorities.

Examples of fraudulent/abusive activities:

- Billing for services not rendered or not medically necessary
- Submitting false information to obtain authorization to furnish services or items to enrollees
- Prescribing items or referring services which are not medically necessary
- Misrepresenting the services rendered
- Submitting a claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing enrollees for covered services
- Failure to perform services required under a capitated contractual arrangement

False Claims and Self Auditing

AmeriHealth Caritas Louisiana takes the identification and reporting of fraud, waste and abuse seriously and holds enrollees and providers accountable for reporting all concerns of fraud, waste and abuse. Providers are responsible for self-auditing and reporting any findings that may result in an over or underpayment.

The False Claims Act is an important tool U.S. taxpayers must recover money stolen through fraud. Under the False Claims Act, those who knowingly submit or cause another entity to submit false claims for payment of government funds are liable for government damages plus civil penalties. If you suspect fraud or wish to report suspicious activities, please call the AmeriHealth Caritas Louisiana Fraud and Abuse Hotline 1-866-833-9718 or email at fraudtip@amerihealthcaritas.com.

Contact Information

To report or refer suspected cases of fraud and please contact AmeriHealth Caritas Louisiana's Fraud and Abuse Hotline by calling 1-866-833-9718 or sending an email to fraudtip@amerihealthcaritasla.com or by sending correspondence to:

Program Integrity
AmeriHealth Caritas Louisiana
200 Stevens Drive
Philadelphia, PA 19113

Program Integrity

AmeriHealth Caritas Louisiana is obligated to ensure the effective use and management of public resources in the delivery of services to its Enrollees. AmeriHealth Caritas Louisiana does this in part through its Program Integrity department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of AmeriHealth Caritas Louisiana, regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

- **Prospective (Pre-claims payment)**
    - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services (“CMS”), the American Medical Association (“AMA”), state regulatory agencies or AmeriHealth Caritas Louisiana medical/claim payment policy are applied to prepaid claims.
    - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
        - *Please note: Claims requiring itemized bills or medical records are denied if the supporting documentation is not received within the requested timeframe*.
    - Coordination of Benefits (“COB”) - Process to verify third party liability to ensure that AmeriHealth Caritas Louisiana is only paying claims for enrollees where AmeriHealth Caritas Louisiana is responsible, i.e., where there is no other health insurance coverage.
    - Within the clearinghouse environment, a review of claim submission patterns are performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.
- **Retrospective (Post-claims payment**)

- Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation – As a Medicaid plan, AmeriHealth Caritas Louisiana is the payer of last resort. The effect of this rule is if AmeriHealth Caritas Louisiana determines an enrollee has other health insurance coverage, payments made by AmeriHealth Caritas Louisiana may be recovered.
- Please also see Section VII: Claims Filing Guidelines for further description of TPL/COB/Subrogation.
- Data Mining – Using paid claims data, AmeriHealth Caritas Louisiana identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
- Medical Records Review/Itemized Bill review – a Medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill, validation of procedures or diagnosis billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.
- Please note if medical records are not received within the requested timeframe, AmeriHealth Caritas Louisiana recoups funds from the provider. Your failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.

Member Fraud, Waste and Abuse

Unfortunately, there may be times when you see enrollees involved in fraud, waste or abuse. If you have knowledge of enrollee FWA, please report the circumstances to AmeriHealth Caritas Louisiana or the Louisiana Department of Health (LDH) as outlined below. You do not have to give your name and, if you do, you will not be identified to the enrollee you are reporting.

Some examples of FWA by an enrollee are:

- Enrollees selling or lending their ID cards to other people.
- Enrollees abusing their benefits by seeking drugs or services that are not medically necessary.

You can report FWA by calling the AmeriHealth Caritas Louisiana Hotline number at **1-866-833-9718** or **fraudtip@amerihealthcaritas.com.**

You can also report FWA to the Louisiana Department of Health through any of the following:

- For provider or enrollee FWA, report to the LDH via their website www.ldh.la.gov/page/reporting-fraud

- You may also report FWA to LDH via the following:
  - Medicaid beneficiary FWA reporting call toll-free 1-833-920-1773
  - By mail to:
    Louisiana Department of Health
    Program Integrity Unit – Beneficiary Complaints
    P. O. Box 91030
    Baton Rouge, LA 70821

Provider's Bill of Rights

Each provider who contracts with AmeriHealth Caritas Louisiana to furnish services to the enrollees shall be assured of the following rights.

A Health Care Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of an enrollee who is his/her patient, for the following:

- The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the enrollee needs to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The enrollee's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and State Fair Hearing procedures.
- To have access to AmeriHealth Caritas Louisiana policies and procedures covering the authorization of services.
- To be notified of any decision by AmeriHealth Caritas Louisiana to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge, at the request of the Medicaid/CHIP enrollee on their behalf, the denial of coverage of, or payment for, medical assistance.
- AmeriHealth Caritas Louisiana provider selection policies and procedures must not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely based on that license or certification.

Note: The provider shall not be prohibited or otherwise restricted from advising an AmeriHealth Caritas Louisiana enrollee about the health status, medical care or treatment of enrollee's condition or disease, regardless of whether benefits for such care or treatment are provided under AmeriHealth Caritas Louisiana's contract, if provider is acting within the lawful scope of practice.

SECTION IX: PROVIDER CREDENTIALING

Introduction to Credentialing

Health care providers are selected to participate in the AmeriHealth Caritas Louisiana network based on an assessment and determination of network need.

AmeriHealth Caritas Louisiana is responsible for the credentialing and re-credentialing of its provider network including practitioners, behavioral health providers, facilities, and organizational providers. AmeriHealth Caritas Louisiana's credentialing/re-credentialing criteria and standards are consistent with Louisiana requirements, Federal regulations, and the National Committee for Quality Assurance (NCQA). Practitioners, behavioral health providers, facilities, and organizational providers are re-credentialed at least once every three years.

The criteria, verification methodology and processes used by AmeriHealth Caritas Louisiana are designed to credential and re-credential practitioners and providers in a non-discriminatory manner, with no attention to race, ethnic/national identity, gender, age, sexual orientation, specialty or procedures performed.

Effective 8/1/2022 ACLA – Act 143 HB 286: All of the following providers shall be considered to have satisfied, and shall otherwise be exempt from having to satisfy, any credentialing requirements of a managed care organization:

(1) Any provider who maintains hospital privileges or is a member of a hospital medical staff with a hospital licensed in accordance with the Hospital Licensing Law, R.S. 40:2100 et seq.

(2) Any provider who is a member of the medical staff of a rural health clinic licensed in accordance with R.S. 40:2197 et seq.

(3) Any provider who is a member of the medical staff of a federally qualified health center as defined in R.S. 40:1185.3.

Any provider having the said privileges must submit a Medicaid Credential Exemption Notification to the Plan to be exempt from the credentialing requirements.

Note : If a provider qualifies to credential or re-credential in accordance with Act 143, verification of meeting one of the above three conditions can be submitted to the following email address including "ACT 143" in the subject line: Credentialing@amerihealthcaritasla.com

Practitioner Requirements

The following types of professional providers (practitioners) require initial credentialing and re-credentialing (every 3 years):

- Audiologists
- Speech and Language Therapists
- Physicians (DOs and MDs)
- Physician Assistants
- Certified Nurse Midwife

- Occupational Therapists
- Podiatrists
- Chiropractors
- Oral Surgeons
- Nurse Practitioners
- Physical Therapists
- Dentists
- Optometrists (who provide medical care)
- Allied Health Practitioners
- School-Based Practitioners
- Applied Behavior Analysts
- Registered Dieticians
- Psychiatrists
- Licensed Mental Health Professionals (LMPH)
    - Medical Psychologists
    - Licensed Psychologists
    - Licensed Clinical Social Workers (LCSW)
    - Licensed Professional Counselors (LPC)
    - Licensed Marriage and Family therapists (LMFT)
    - Licensed Addiction Counselors (LAC)
    - Advanced Practice Registered Nurses (must be a Nurse Practitioner Specialist in Adult Psychiatric and Behavioral Health, Family Psychiatric and Behavioral health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, Child Adolescent Mental Health)

Please note, hospital-based practitioners are not required to be independently credentialed if those practitioners serve AmeriHealth Caritas Louisiana's enrollees only through the hospital. Hospital based practitioners include but are not limited to:

- Pathologists
- Anesthesiologists
- Radiologists
- Emergency Medicine
- Neonatologists
- Hospitalists

The following criteria must be met, as applicable, to be credentialed as a qualified network practitioner:

- All practitioners must submit a correct, complete, and legible, signed/dated application and attestation/release form. Applications are accepted through the Council for Affordable Quality Healthcare (CAQH) or via an AmeriHealth Caritas Louisiana or State of Louisiana paper application. The signature and date on the attestation must not be older than 305 calendar days at the time of the credentialing decision.
- Valid and current Medicaid, Medicare, and/or Individual National Provider ID numbers, as applicable.
- A current, active license. AmeriHealth Caritas Louisiana considers a practitioner if the license is in "probationary" status. Pursuant to Section 1.R.S.46:460.63, AmeriHealth Caritas Louisiana never enforces any

conditions in its credentialing program that are more restrictive than those conditions established by the State of Louisiana's Medicaid program or by State or Federal guidelines.

- A valid and current DEA and CDS/CSC license, if applicable.
- Proof of education and training that supports the requested specialty or service, as well as the degree credential of the practitioner. For example, proof of practitioner's medical school graduation, completion of residency, and/or other postgraduate training. Foreign trained practitioners must submit an Education Commission for Foreign Medical Graduates (ECFMG) certificate or number with the application.
    - Board certification is not required for practitioners; however, if a practitioner reports to be board certified, then current certification is verified. Practitioners must be able to demonstrate competency or training in the specialty that he or she is requesting.
- Work history containing current employment, as well as explanation of any gaps greater than six (6) months within the last five (5) years.
- History of professional liability claims including an explanation of all cases in the past five (5) years.
- A detailed explanation to any questions on the application answered affirmatively, including but not limited to, inability to perform the essential functions of the position, illegal drug use, loss of licensure, felony convictions, loss of limitation or privileges, or disciplinary actions. Practitioners are expected to provide dates of each incident, as well as a detailed description of events.
- A current copy of the professional liability insurance face sheet (evidencing coverage); a minimum of $1M per occurrence and $3M aggregate OR additional PCF is required.
- Practitioners, including PCPs, CRNPs, and CNMs, must have hospital affiliation with an institution that participates with AmeriHealth Caritas Louisiana. As an alternative, those practitioners who do not have hospital privileges, but require them, may enter into an admitting agreement with a practitioner who is able to admit.
- A current CLIA (Clinical Laboratory Improvement Act) certificate or waiver of a certificate of registration along with a CLIA identification number, if applicable.
- All Nurse Practitioners (NPs) and Physician Assistants (PAs) must have their national certification to participate with AmeriHealth Caritas. NPs and PAs must also have a collaborative or supervision agreement with a physician preceptor who is participating with the Plan.
- Completed and signed Ownership Disclosure, if applicable.

As part of the practitioner credentialing process, AmeriHealth Caritas Louisiana:

- Processes completely within 60 calendar days of receipt of a completed application including all necessary documentation and attachments, and a signed provider contract.
- Requests information on practitioner sanctions prior to making a credentialing or re- credentialing decision. Information from the National Practitioner Data Bank (NPDB), Health Integrity Provider Data Bank (HIPDB), System for Award Management (SAM), EPLS (Excluded Parties Links System), and HHS Office of Inspector General (OIG) (Medicare exclusions), Federation of Chiropractic Licensing Boards (CIN-BAD), and State Disciplinary Action report is reviewed as applicable.
- Performance review of complaints, quality of care issues and utilization issues is included in provider re-credentialing.

- Maintain confidentiality of the information received for the purpose of credentialing and re-credentialing. Safeguard all credentialing and re-credentialing documents, by storing them in a secure location, only accessed by authorized plan employees.

Facility and Organizational Provider Requirements

Facility and organizational providers include those such as hospitals or ancillary providers where the facility or organization undergoes credentialing instead of the individual practitioner. The following types of facilities and organizational providers require initial credentialing and re-credentialing (every 3 years):

- Hospitals (Acute Care and Acute Rehabilitation)
- Home Health Agencies/Home Health Hospice
- Skilled Nursing Facilities (SNFs)
- Skilled Nursing Facilities Providing Sub-Acute Services
- Clinical Laboratories (CMS-issued CLIA certification or hospital-based exemption from CLIA)
- Nursing Homes
- Ambulatory Surgery Centers (ASCs)
- Sleep Center/Sleep Lab – Free Standing
- Free Standing Radiology Centers
- Durable Medical Equipment Suppliers (DME)
- Home Infusion
- EPSDT Clinics
- Louisiana Office of Public Health (OPH)
- Certified School Based Health Clinics (SBHCs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Personal Care Services Agency
- Hospice Agency
- Pharmacies
- Providers of End-Stage Renal Disease Services
- Providers of Outpatient Diabetes Self-Management Training
- Portable X-Ray Suppliers/Imaging Centers
- Psychiatric Residential Treatment Facilities (PRTF)
- Free-Standing Psychiatric Hospitals and Distinct Part Psychiatric (DPP) Units (age 21 and under; 65 and older)
- Substance Use Service Providers
- Home and Community Based Services Providers
- Opioid Treatment Clinics
- Hospital/Inpatient Facilities
- Certified Outpatient Clinics

The following criteria must be met, as applicable, to be credentialed as a qualified network facility or organizational provider:

- All facility and organizational providers must submit a correct, complete, and legible, signed/dated application and supporting documents. For providers with multiple locations, one application documenting every address,

with supporting licensure and accreditation information for each location, is acceptable. In addition to the application, facilities and organizational providers must submit:

- An attestation of the correctness and completeness of the information supplied.
- An unrestricted and current State license, if applicable.
- A copy of accreditation certificate from a recognized accrediting body. If the provider is not accredited, a CMS State Survey or letter stating the provider has been certified by CMS may be accepted for credentialing. If the provider is not accredited and cannot provide a CMS State Survey or letter, or if the most recent survey is older than three (3) years, AmeriHealth Caritas Louisiana will conduct a site visit.
- Evidence of eligibility with State and Federal regulatory bodies, including Medicare and Medicaid, as applicable.
- A copy of the current malpractice insurance face sheet and history of liability; minimum limit requirement of $1M per occurrence/$3M aggregate.
- Documentation of any history of disciplinary actions, loss or limitation of license, Medicare/Medicaid sanctions, or loss limitation, or cancellation of liability insurance.
- An active Medicaid ID number and/or enrollment and/or certification, as applicable.
- An active Medicare ID number, as applicable.
- A completed Disclosure of Ownership form, which must include the name, DOB, SSN, and email address of each owner.

As part of the facility and organization provider credentialing process, AmeriHealth Caritas Louisiana:

- Confirms that the facility is in good standing with all state and regulatory agencies, including the Louisiana Department of Health, and has been reviewed by an accredited body, as applicable.
- Conducts a site visit only if no governmental agency, such as CMS, has conducted an onsite visit in the past 3 years. Satisfactory survey results from the last licensure survey may be accepted in place of a site visit by AmeriHealth Caritas Louisiana.
- Requests information on facility sanctions prior to rendering a credentialing or re-credentialing decision, by obtaining information from the National Practitioner Data Bank (NPDB), Health Integrity and Protection Data Bank (HIPDB), EPLS (Excluded Parties Lists System), System for Award Management (SAM) to identify those excluded from receiving Federal contracts and financial benefits, and HHS Office of Inspector General (OIG) (Medicare exclusions).
- Performance reviews may include a site visit from AmeriHealth Caritas Louisiana, review of complaints and quality of care issues as a requirement of re-credentialing.
- Maintain confidentiality of the information received for the purpose of credentialing and re-credentialing.
- Safeguard all credentialing and re-credentialing documents, by storing them in a secure location, only accessed by authorized plan employees.

Using CAQH to Submit Electronic Credentialing Applications

Through CAQH, credentialing information is provided to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH.

There is no charge to providers to participate in CAQH or to submit applications. AmeriHealth Caritas Louisiana encourages all providers to utilize this service.

Submit your application to participate with AmeriHealth Caritas Louisiana via CAQH (www.caqh.org):

- Register for CAQH.

- Grant authorization for AmeriHealth Caritas Louisiana to view your information in the CAQH database.
- Contact your Provider Network Management Account Executive to provide your CAQH ID number to continue the credentialing process.

Credentialing Rights

After the submission of the application, health care providers have the following rights:

- Have the right to review the information submitted to support their credentialing application, except for recommendations, references, and peer protected information obtained by ACLA.
- Have the right to correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information the provider provided, the Credentialing Department notifies the Health Care Provider to correct the discrepancy. The provider has 10 calendar days from the date of the notification to correct the erroneous information. All requests for the above information must be made in writing by the practitioner.
- Have the right, upon request, to be informed of the status of their credentialing or re-credentialing application. The Credentialing department shares all information with the provider except for references, recommendations or peer-review protected information(i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing Department responds to all requests within 24 business hours of receipt. Responses are via email or a phone call to the provider.
- Have the right to be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision.
- Have the right to appeal any credentialing/re-credentialing denial within 30 calendar days of receiving written notification of the decision.

To request or provide information for any of the above, the provider should contact the AmeriHealth Caritas Corporate Credentialing department at the following address:

AmeriHealth Caritas
Attn: Credentialing Department
200 Stevens Drive
Philadelphia, PA 19113

Re-Credentialing for Practitioners

AmeriHealth Caritas Louisiana re-credentials network practitioners at least once every 36 months. All practitioners receive their first notice of re-credentialing requirement no more than six (6) months prior to the expiration of the practitioner's current credentialing. The notice includes the effective date of termination if the practitioner fails to meet the requirements and deadlines of AmeriHealth Caritas Louisiana's re-credentialing process. A total of four (4) notices are sent prior to the expiration of the current credentialing cycle. The 2nd notice is sent four (4) months prior to the expiration of the file, the 3rd notice is sent 60 days prior to the expiration of the file, and the 4th and final notice is sent to the provider at least 15 days prior to the expiration date of the file. The Plan also attempts to retrieve an application from CAQH if the practitioner has granted access for same. All notices are sent to the last known credentialing contact address provided by the practitioner as well as via email. Practitioners failing to respond to these notices may be terminated from the Plan for non-compliance with re-credentialing requirement. Termination notice is sent via certified mail to the provider's last known mailing address.

As with initial credentialing, all applications and attestation/release forms must be signed and dated no more than 305 days prior to the Credentialing Committee or Medical Director's decision date. Additionally, all supporting documents must be current at the time of the decision date.

The following information is required to complete the practitioner re-credentialing process:

- A current CAQH or paper application. Signature and date on the application must not be older than 305 calendar days at the time of the re-credentialing decision.
- A current, active, unrestricted license. AmeriHealth Caritas Louisiana considers a practitioner if the license is in "probationary" status. Pursuant to Section 1.R.S.46:460.63, AmeriHealth Caritas Louisiana never enforces any conditions in its credentialing program that are more restrictive than those conditions established by the State of Louisiana's Medicaid program or by State or Federal guidelines.
- A valid and current DEA and CDS/CSC license, if applicable.
- A current copy of the professional liability insurance face sheet (evidencing coverage); a minimum of $1M per occurrence and $3M aggregate OR additional PCF is required.
- History of professional liability claims including an explanation of all cases in the past five (5) years.
- Practitioners, including PCPs, CRNPs, and CNMs, must have hospital affiliation with an institution that participates with AmeriHealth Caritas Louisiana. As an alternative, those practitioners who do not have hospital privileges, but require them, may enter into an admitting agreement with a practitioner who is able to admit.
    - Board certification is not required for practitioners who apply as a specialist; however, if a practitioner reports to be board certified, then current certification is verified. Practitioners must be able to demonstrate competency or training in the specialty that he or she is requesting.
- A detailed explanation to any questions on the application answered affirmatively, such as but not limited to, reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license, history of felony convictions, history of loss of limitation of privileges, or disciplinary actions. Practitioners are expected to provide dates of each incident, as well as a detailed description of events.
- A current CLIA (Clinical Laboratory Improvement Act) certificate or waiver of a certificate of registration along with a CLIA identification number, if applicable.
- A valid and current Medicaid, Medicare, and/or Individual National Provider ID numbers, as applicable.
- A completed and signed Disclosure of Ownership form, if applicable.

Re-credentialing for Facilities and Organizational Providers

Facilities are notified six (6) months prior to the re-credentialing due date and are required to submit the following:

- Current copy of licensure.
- Proof of current malpractice insurance.
- Proof of up-to-date accreditation or CMS State Survey.

AmeriHealth Caritas Louisiana performs the same verifications as noted under Facility and Organizational Provider Requirements. The Medical Director reviews and makes determination on all routine files. The Credentialing Committee meets monthly and reviews and makes determination on all non-routine files.

SECTION X: QUALITY AND UTILIZATION MANAGEMENT

Quality Management

AmeriHealth Caritas Louisiana employs a comprehensive Quality Assessment and Performance Improvement (QAPI) Program that integrates knowledge, structure and processes throughout the health care delivery system to assess risk and to improve quality and safety of clinical care and services provided to AmeriHealth Caritas Louisiana enrollees. The AmeriHealth Caritas Louisiana QAPI Program provides a framework for the evaluation and delivery of health care and services provided to enrollees.

Purpose and Scope

The purpose of the QAPI Program is to provide the infrastructure to systematically monitor, objectively evaluate and ultimately improve the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to AmeriHealth Caritas Louisiana enrollees in accordance with the following organizational mission statement:

We help people: Get care, Stay well, Build healthy communities. We have a special concern for those who are poor.

The Quality Assessment and Performance Improvement Program is also the mechanism for:

- Determining practice guidelines and standards on which the program's success are measured
- Complying with all applicable laws and regulatory requirements such as those from LDH and other applicable state and federal agencies, and accreditation body standards
- Providing oversight of all delegated services
- Conducting enrollee and practitioner satisfaction surveys to identify opportunities for improvement
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to enrollees through the credentialing/re-credentialing process

Reducing health care disparities by measuring, analyzing and redesigning of services and programs to meet the health care needs of AmeriHealth Caritas Louisiana's diverse membership.

Objectives

The objectives of the QAPI Program are to:

- Maximize utilization of collected information about the quality of clinical care (physical and behavioral), health outcomes and service and identify clinical and service improvement initiatives for targeted interventions
- Evaluate access to care, availability of services, continuity of care health care outcomes, and services provided and arranged by AmeriHealth Caritas Louisiana
- Assess the quality and appropriateness of care furnished to enrollees with special needs
- Strengthen provider capabilities and performance related to the provision of evidence-based clinical care
- Coordinate services between various levels of care, network practitioners, behavioral health providers and community resources to assure continuity of care and promote optimal physical, psychosocial, and functional wellness

- Utilize results of participant and practitioner/provider satisfaction measures when identifying and prioritizing quality activities
- Incorporate the results of external quality evaluations (e.g., EQR results, NCQA accreditation feedback, LDH findings) and internally generated evaluations such as HEDIS, satisfaction monitoring and internal audits and monitoring into quality program activities
- Implement and evaluate condition management programs to effectively address chronic illnesses affecting the population
- Design and implement provider outreach and education activities
- Maintain compliance with evolving NCQA accreditation standards
- Communicate results of clinical and service measures to practitioners, providers, and enrollees.
- Identify and implement activities that promote participant safety
- Document and report the results of monitoring activities and quality improvement initiatives to appropriate stakeholders
- Facilitate the delivery of culturally competent health care to reduce health care disparities

An annual QAPI work plan is derived from the QAPI Program goals and objectives. The work plan provides a roadmap for achievement of program goals and objectives and is also used by the Quality Department as well as the various quality committees as a method of tracking progress toward achievement of goals and objectives.

QI Program effectiveness is evaluated on an annual basis. This assessment allows AmeriHealth Caritas Louisiana to determine how well it has deployed its resources in the recent past to improve the quality of care and service provided to AmeriHealth Caritas Louisiana membership. When the program has not met its goals, barriers to improvement are identified and appropriate changes are incorporated into the subsequent annual QAPI work plan. Feedback and recommendations from various councils and committees are incorporated into the evaluation. Please go to www.amerihealthcaritasla.com for more information about our Quality Program and our annual goals.

QM Program Authority and Structure

The Board of Directors of AmeriHealth Caritas Louisiana provides strategic direction for the Quality Assessment Performance Improvement (QAPI) Program and retains ultimate responsibility for ensuring that the QAPI Program is incorporated into AmeriHealth Caritas Louisiana's operations. Operational responsibility for the development, implementation, monitoring, and evaluation of the QAPI Program are delegated by the AmeriHealth Caritas, Louisiana, Inc. Board of Directors to the AmeriHealth Caritas Louisiana Market President and Quality Assessment Performance Improvement Committee (QAPIC).

Quality Assessment Performance Improvement Committee

The Quality Assessment Performance Improvement Committee (QAPIC) oversees AmeriHealth Caritas Louisiana's efforts to measure, manage and improve quality of care and services delivered to AmeriHealth Caritas Louisiana enrollees, and evaluate the effectiveness of the QAPI Program. The QAPIC directs and reviews AmeriHealth Caritas Louisiana's Quality Improvement and Utilization Management activities.

Compliance Committee

The AmeriHealth Caritas Louisiana Compliance Committee assists the Compliance Director with the implementation and oversight of the AmeriHealth Caritas Louisiana Compliance Program. The committee serves in an oversight role to ensure that AmeriHealth Caritas Louisiana is in compliance with all applicable laws, rules, regulations and contractual requirements.

The AmeriHealth Caritas Louisiana Compliance Committee reports to the AmeriHealth Caritas, Louisiana, Inc. Board of Directors and Market President.

AmeriHealth Caritas Louisiana Provider Council

The AmeriHealth Caritas Louisiana Provider Council solicits input from provider and community stakeholders regarding the structure and implementation of new and existing clinical policies, initiatives and strategies. The Council provides input to the Provider Outreach Strategy and QAPIC, as appropriate.

AmeriHealth Caritas Louisiana Member Advisory Council

The AmeriHealth Caritas Louisiana Member Advisory Council provides a forum for enrollee participation and input to AmeriHealth Caritas Louisiana programs and policies to promote collaboration; maintain an enrollee-focus and enhance the delivery of services to AmeriHealth Caritas Louisiana communities.

Quality of Service Committee

The Quality of Service Committee (QSC) reports to the QAPIC. The purpose of the QSC is to assure that performance and quality improvement activities related to AmeriHealth Caritas Louisiana services are reviewed, coordinated and effective. The QSC reviews, approves and monitors action plans created in response to any identified variance.

Credentialing Committee

The Credentialing Committee is responsible for reviewing practitioner and provider applications, credentials and profiling data (as available) to determine appropriateness for participation in the AmeriHealth Caritas Louisiana network.

Confidentiality

Documents related to the investigation and resolution of specific occurrences involving complaints or quality of care issues are maintained in a confidential and secure manner. Specifically, enrollees' and health care providers' right to confidentiality are maintained in accordance with applicable laws. Records of quality improvement and associated committee meetings are maintained in a confidential and secure manner.

Provider Sanctioning Policy

It is the goal of AmeriHealth Caritas Louisiana to assure enrollees receive quality health care services. If health care services rendered to an enrollee by a network provider represent a serious deviation from, or repeated non- compliance with, AmeriHealth Caritas Louisiana's quality standards, and/or recognized treatment patterns of the organized medical community, the network provider may be subject to AmeriHealth Caritas Louisiana's formal sanctioning process. All sanctioning activity is strictly confidential.

Informal Resolution of Quality of Care Concerns

When an AmeriHealth Caritas Louisiana Quality Review Committee (Quality Improvement Committee, Medical Management Committee or Credentialing Committee) determines that follow-up action is necessary in response to the care and/or services begin delivered by a network provider, the Committee may first attempt to address and resolve the concern informally, depending on the nature and seriousness of the concern.

The Chairperson of the reviewing Committee sends a letter of notification to the network provider. The letter describes the quality concerns of the Committee, and what actions are recommended for correction of the problem. The network provider is afforded a specified, reasonable period of time appropriate to the nature of the problem. The letter recommends an appropriate period of time within which the network provider must correct the problem.

The letter is to be clearly marked: **Confidential: Product of Peer Review**

Repeated non-conforming behavior subjects the network provider to a second warning letter. In addition, the network provider's enrollee panel (if applicable) and admissions are frozen while the issue is investigated and monitored. Failure to conform thereafter is considered grounds for initiation of the formal sanctioning process.

Formal Sanctioning Process

In the event of a serious deviation from, or repeated non-compliance with, AmeriHealth Caritas Louisiana's quality standards, and/or recognized treatment patterns of the organized medical community, the AmeriHealth Caritas Louisiana Quality Improvement Committee, or the Chief Medical Officer (CMO) may immediately initiate the formal sanctioning process.

- The network provider receives a certified letter (return receipt requested) informing him/her of the decision to initiate the formal sanctioning process. The letter includes the following:
    - network provider's right to a hearing before a hearing panel
    - reason(s) for proposed action

  - network provider has 30 days within which to submit a written request for a hearing, otherwise the right to a hearing is forfeited
  - network provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action they wish to contest
  - a summary of rights in the hearing
  - network provider may waive their right to a hearing
- The network provider's current enrollee panel (if applicable) and admissions are frozen immediately during the sanctioning process.

Notice of Hearing

If the network provider requests a hearing in a timely manner, the network provider is given a notice stating:

- The place, date, and time of the hearing, which date shall not be less than thirty (30) days after the date of the notice
- That the network provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the CMO of AmeriHealth Caritas Louisiana and/or upon the advice of AmeriHealth Caritas Louisiana's Legal Department
- A list of witnesses (if any) expected to testify at the hearing on behalf of AmeriHealth Caritas Louisiana

Conduct of the Hearing and Notice

- The hearing is held before a panel of individuals appointed by AmeriHealth Caritas Louisiana.
- Individuals on the panel are not in direct economic competition with the network provider involved, nor have they participated in the initial decision to propose Sanctions.
- The panel is composed of physician enrollees of the AmeriHealth Caritas Louisiana's Quality Committee, the CMO of AmeriHealth Caritas Louisiana, and other physicians and administrative persons affiliated with AmeriHealth Caritas Louisiana as deemed appropriate by the CMO of AmeriHealth Caritas Louisiana.
- The AmeriHealth Caritas Louisiana CMO or his/her designee serves as the hearing officer.
- The right to the hearing is forfeited if the network provider fails, without good cause, to appear.

Provider's Rights at the Hearing

The network provider has the right:

- To representation by an attorney or other person of the network provider's choice
- To have a record made of the proceedings (copies of which may be obtained by the network provider upon payment of reasonable charges)
- To call, examine, and cross-examine witnesses
- To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law
- To submit a written statement at the close of the hearing
- To receive the written recommendation(s) of the hearing panel within 15 business days of completion of the hearing, including statement of the basis for the recommendation(s)

- To receive AmeriHealth Caritas Louisiana's written decision within 60 days of the hearing, including the basis for the hearing panel's recommendation

Appeal of the Decision of the AmeriHealth Caritas Louisiana Peer Review Committee

The network provider may request an appeal after the final decision of the Panel.

- The AmeriHealth Caritas Louisiana Quality Improvement Committee must receive the appeal by certified mail within 30 days of the network provider's receipt of the Committee's decision; otherwise the right to appeal is forfeited.
- Written appeal is reviewed and a decision rendered by the AmeriHealth Caritas Louisiana Quality

External Reporting

The CMO directs the Credentialing Department to prepare an adverse action report for submission to the National Provider Data Bank (NPDB), the Health care Integrity and Protection Data Bank (HIPDB), and State Board of Medical or Dental Examiners if formal Sanctions are imposed for quality of care deviations and if the Sanction is to last more than 30 days, and as otherwise required by law. (NOTE: NPDB reporting is applicable only if the Sanction is for quality of care concerns.)

If Sanctions against a network provider materially affects AmeriHealth Caritas Louisiana's ability to make available all capitated services in a timely manner, AmeriHealth Caritas Louisiana notifies all necessary parties of this issue for reporting/follow-up purposes.

Utilization Management Program

The Utilization Management (UM) program description summarizes the structure, processes and resources used to implement AmeriHealth Caritas Louisiana's programs, which were created in consideration of the unique needs of its Enrollees and the local delivery system. All departmental policies and procedures, guidelines and UM criteria are written consistent with National Committee for Quality Assurance (NCQA) accreditation standards and other applicable State and federal laws and regulations. Where standards conflict, AmeriHealth Caritas Louisiana adopts the most rigorous of the standards.

Annual Review

Annually, AmeriHealth Caritas Louisiana reviews and updates its UM policies and procedures, as applicable. These modifications, which are approved by the AmeriHealth Caritas Louisiana Quality Assessment Performance Improvement Committee, are based on, among other things, changes in laws, regulations, requirements, accreditation requirements, industry standards and feedback from health care providers, enrollees and others.

Scope

The AmeriHealth Caritas Louisiana Utilization Management Program establishes a process for implementing and maintaining an effective, efficient utilization management system. Utilization management activities are designed to assist the practitioner with the organization and delivery of appropriate health care services to enrollees within the

structure of their benefit plan. The AmeriHealth Caritas Louisiana UM Program promotes the continuing education of, and understanding amongst, enrollees, participating physicians and other health care professionals.

- Specialty Healthcare Referrals: The PCP may refer enrollees for most outpatient specialty health care services from practitioners and providers participating in the AmeriHealth Caritas Louisiana Network.
- Services for Women from an OB/GYN practitioner, plain x-ray films, electrocardiograms, EPSDT screening services and services to treat an Emergency Medical Condition do not require authorization from AmeriHealth Caritas Louisiana. (Authorization from AmeriHealth Caritas Louisiana is required for a referral for covered services from a practitioner or provider who does not participate with AmeriHealth Caritas Louisiana.)
- Authorization: AmeriHealth Caritas Louisiana utilizes an authorization process to approve coverage for select covered services for AmeriHealth Caritas Louisiana enrollees. AmeriHealth Caritas Louisiana performs non-urgent and urgent prior (pre- service) authorization review and review of ongoing services (concurrent review) of select health care services to determine Medical Necessity and eligibility for coverage under the enrollee‘s benefit package. At certain times, when information is not available to make a prior or concurrent determination and services have already been provided, enrollee records are reviewed retrospectively to determine benefit coverage and/or medical necessity. Utilization staff may approve services based on application of AmeriHealth Caritas Louisiana‘s criteria. AmeriHealth Caritas Louisiana does not arbitrarily deny or reduce the amount, duration or scope of a required service because of the diagnosis, type of illness or condition of the enrollee.
- Discharge Planning: AmeriHealth Caritas Louisiana nurses/social workers work collaboratively with staff from the Integrated Care Management programs to provide appropriate access to non-hospital based health care. Utilization Management staff work with the facility discharge planners to review and update the discharge plan, and take proactive actions to plan for discharge.

Evaluation of Member and Provider Satisfaction and Program Effectiveness

Annually, the UM department completes an analysis of enrollee and network provider satisfaction with the UM Program. At a minimum, the sources of data used in the evaluation include the annual enrollee satisfaction survey results, enrollee complaint and grievance data, provider satisfaction survey results, and provider complaint and appeal data.

To support its objective to create partnerships with physicians, AmeriHealth Caritas Louisiana actively seeks information about network provider satisfaction with its programs on an ongoing basis. In addition to monitoring health care provider complaints, AmeriHealth Caritas Louisiana holds meetings with network providers to understand ways to improve the program. Monthly, the department reports telephone answering response, abandonment rates and decision time frames.

SECTION XI: SPECIAL NEEDS AND CASE MANAGEMENT

Integrated Care Management (Health Education and Management)

AmeriHealth Caritas Louisiana's Integrated Care Management (ICM) program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This means that Complex Case Management and Disease Management is a fully integrated model that allows enrollees to move seamlessly from one component to another, depending on their unique needs.

Several services overlap all five components. Each component includes targeted interventions for special needs populations, EPSDT-eligible populations and enrollees with chronic conditions. There are five core components to our Integrated Care Management (ICM) program: Pediatric Preventive Health Care, Episodic Care Management, Bright Start (Maternity Management), Complex Care Management (CCM), and Rapid Response. Each of these is summarized below.

Pediatric Preventive Health Care

The Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of enrollees under age 21 by increasing adherence to EPSDT program guidelines. We accomplish this by identifying and coordinating preventive services for these enrollees.

The AmeriHealth Caritas Louisiana EPSDT Coordinator assists the parents or guardians of all enrollees younger than twenty-one (21) years of age in receiving EPSDT screens, treatment, and follow-ups, and makes referrals to the Early Intervention Program when appropriate. The EPSDT Coordinator also facilitates and ensures EPSDT compliance, provides follow-up concerning service issues, educates non-compliant enrollees on AmeriHealth Caritas Louisiana's rules and regulations, and assists enrollees in accessing care.

Episodic Care Management

The Episodic Care Management (ECM) program coordinates services for enrollees with short- term and/or intermittent needs who have single problem issues and/or co-morbidities. The Care Manager supports enrollees in the resolution of pharmacy, DME and/or dental access issues, transportation needs, identification of and access to specialists, and coordination with behavioral health providers or other community resources. Care Managers perform comprehensive assessments, address short-term and long-term goals, and develop a plan of care with input from the enrollee and the physician(s). The ECM team has both RN and MSW Care Managers.

Bright Start (Maternity Management)

The Bright Start (Maternity) Program is managed by a dedicated team of Care Managers and Care Connectors. The Bright Start team outreaches to pregnant enrollees and engages them in the program based on internal and external assessments that stratify them into high- and low-risk categories. Care Managers coordinate care and address various issues throughout the enrollee's pregnancy and post-partum period, including dental screenings and depression screenings. Enrollees assessed as low risk receive information via mailings with access to a Care Manager as necessary. Enrollees identified as high-risk are managed by the Plan with a team of both Care Managers and Care Connectors.

For more information about this program, please refer to the detailed program description later in this section of the *Provider Manual*

Complex Care Management

Enrollees identified for Complex Care Management (CCM) receive comprehensive and disease- specific assessments, and reassessments, along with the development of short-term and long- term goals and an individual plan of care, created with input from the enrollee/caregiver and the physician(s). These programs include Diabetes, COPD, Asthma, Sickle Cell, Obesity, HIV/AIDS, Hepatitis C and Cardiovascular Disease. The CCM process includes performing an initial assessment, reassessing and adjusting the care plan and its goals as needed. Care Connectors in Rapid Response are assigned tasks to assist the enrollee with various interventions under the direct supervision of the Care Manager. Care Managers coordinate care and address various issues including but not limited to pharmacy, DME and/or dental access, assistance with transportation, identification of and access to specialists and coordination with behavioral health providers or other community resources. The Complex Care Management team contains both nurse and social worker Care Managers. Using Motivational Interviewing Skills, the Care Managers develop a rapport with engaging them in care management programs for a timeframe based on their individual needs.

Rapid Response Team

An important component of the ICM model, the Rapid Response (RR) team was developed to address the urgent needs of our enrollees and to support our providers and their staff. The RR team consists of registered nurses, social workers, and non-clinical Care Connectors.

There are three key service functions performed in the Rapid Response unit:

- Inbound Call Service – Enrollees and providers may request RR support via a direct, toll- free Rapid Response line. Providers can call the Rapid Response team for assistance coordinating care for enrollees in their office; to request assistance for enrollees who need community resources or to refer an enrollee for any care management service.
- Outreach Service – Outreach activities include telephonic survey or assessment completion and support of special projects or quality initiatives. RR employees also initiate follow-up calls to enrollees recently discharged from the hospital and enrollees who contacted the 24- hour Nurse Line the previous day.
- Care Management Support – Care Connectors support Care Managers by completing tasks and reminder calls in support of the individualized plan of care. These include appointment scheduling and reminders, transportation support, enrollee educational mailings, and other administrative tasks assigned by Care Managers.

Several services overlap all five core components. Each component includes targeted interventions for special needs populations, EPSDT-eligible populations and enrollees with chronic conditions.

Let Us Know is a program designed to partner AmeriHealth Caritas Louisiana with the provider community by collaborating in the engagement and management of our chronically ill enrollees. We have support teams and tools available to assist in the identification, outreach, and education of these enrollees, as well as clinical resources for providers in their care management. There are three ways to let us know about chronically ill enrollees:

1. Contact our Rapid Response and Outreach Team:

The Rapid Response and Outreach Team (RROT) address the urgent needs of our enrollees and supports providers and their staff. The RROT consists of Registered Nurses, Social Workers, and Care Connectors who are trained to assist enrollees in investigating and overcoming the barriers to achieving their health care goals. They are here to support you, call them at 1-888-643-0005 from 8:00 a.m. until 5:30 p.m. CST.

OR

2. **FAX** a Member Intervention Request form to **1-866-426-7309** or complete and submit online**. This form can be found at www.amerihealthcaritasla.com/pdf/provider/resources/forms/member-intervention-request-form.pdf**

OR

3. **Refer a patient to the Complex Case Management Program:**

   Complex Case Management is a voluntary program focused on prevention, education, lifestyle choices and adherence to treatment plan and is designed to support your plan of care for patients with chronic diseases, such as asthma, diabetes, or coronary artery disease. Enrollees receive educational materials and, if identified as high risk, are assigned to a Care Manager for one-on-one education and follow up. For more information, or to refer a patient to the Complex Case Management program, call **1-888-643-0005**.

Somatus Program

AmeriHealth Caritas Louisiana is working with Somatus to offer an integrated care delivery program to support eligible members with or at risk of developing Chronic Kidney disease (CKD) or End Stage Renal Kidney disease (ESKD). This program is designed to help improve our members' clinical outcomes and quality measures.

The Somatus program provides our members with a personal support team of health professionals (e.g., doctors, nurses, clinical pharmacists,) to help manage their kidney disease and actively follow your treatment plan. The program is part of all eligible members' coverage and is available at no extra cost.

The Somatus team supports patients through:

- One-on-one care to help manage their kidney disease and comorbidities and address social determinants of health.
- Personal health coaching that is based on their condition, treatment options, and diet.
- Assistance to transition safely from hospital to home.
- Guidance exploring transplant options, if appropriate.
- A 24/7 Somatus Care Hotline: **1-855-851-8354, ext. 9**

A Somatus representative will contact providers to schedule an onsite visit to review the program. The representative can also share the patient list during the onsite visit.
For questions, please contact Somatus directly at **1-855-851-8354**, Monday through Friday, from 7 a.m. to 7 p.m., or email provider@somatus.com.

Special Needs

AmeriHealth Caritas Louisiana uses several methods to identify enrollees with special health needs, including data analysis and new enrollee surveys and triggers. Our processes focus on identification of conditions that require ongoing management, such as chronic illness, and specific services, including home health care, therapy, and equipment or oxygen rental, that may indicate an ongoing course of treatment or complex needs.

The health plan looks for diagnostic and procedure code indicators of chronic conditions, as well as services and bills from select provider types. In addition, the Plan uses the data to produce a predictive model of the population, identifying enrollees who are at risk for future avoidable episodes of care.

Table 1: Special Health Needs Population

Enrollees <u>with Special Health Care Needs (SHCN)</u> – Individuals of any age with a behavioral health disability, physical disability, developmental disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized care approaches. Enrollees with SHCN shall include any enrollees who:
• have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments;
• are at high risk for admission/readmission to a hospital within the next six (6) months;
• are at high risk of institutionalization;
• have been diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a Substance Use Disorder, or otherwise have significant behavioral health needs, including those enrollees presenting to the hospital or emergency department with a suicide attempt or non-fatal opioid, stimulants, and sedative/hypnotic drug overdose reason;
• are homeless as defined in Section 330(h)(5)(A) of the Public Health Services Act and codified by the US Department of Health and Human Services in 42 U.S.C. 254(b);
• are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors) or who have had an adverse pregnancy outcome during the pregnancy, including preterm birth of less than 37 weeks;
• have been recently incarcerated and are transitioning out of custody;
• are at high risk of inpatient admission or emergency department visits, including certain enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting;
• are members of the DOJ Agreement Target Population;
• are enrolled under the Act 421 Children's Medicaid Option; or
• receive care from other state agency programs, including, but not limited to, programs through OJJ, DCFS, or OPH.

Providers are encouraged to refer enrollees with SHCN to the Rapid Response team for triaging into one of our care management programs. The Rapid Response Team can be reached by calling 1-888-643-0005.

Bright Start Program for Pregnant Enrollees

AmeriHealth Caritas Louisiana has developed a comprehensive prenatal risk reduction program to decrease the poor obstetrical outcomes of our pregnant population, which were evidenced by the following:

- High percentage of low birth-weight infants
- High NICU length of stay
- Infant readmission rates
- Rising preterm births
- Increased incidents of maternal complication requiring extended hospitalizations

The goals of the Bright Start Program are:

- Early identification of pregnant enrollees
- Early and continued intervention throughout pregnancy
- Education and follow-up to promote recommended infant care
- Introduction and Education on Inter-pregnancy Care

AmeriHealth Caritas Louisiana utilizes several means to identify enrollees as early in their pregnancy as possible. These include but are not limited to claim data analysis, information from the initial health assessment, referrals from internal AmeriHealth Caritas Louisiana Department, the use of enrollee newsletters and referral networks, and physician referrals. Enrollees who agree to participate in the Bright Start Program are paired with an AmeriHealth Caritas Louisiana Bright Start Care Manager. The Bright Start Care Manager works closely with the enrollee, assuring that she has the means necessary to receive prenatal care and instruction and respond to various social and medical needs. Bright Start Care Managers offer the following types of special services to our Bright Start enrollees:

- Motivational Interviewing
- Health Coaching
- Counseling
- Health Education
- Connection to social support services

Enrollees may refer themselves to the participating OB/GYN specialist of choice for maternity care services, including the initial visit.

- Bright Start separates pregnant enrollees into low and high intensity risk categories:
    - Low Risk Pregnancy Management - Enrollees receive Care Coordination from Care Connectors, pregnancy-related educational materials encouraging good prenatal care and regular outreach calls
    - High Risk Pregnancy Management - Pregnant enrollees identified at risk for preterm labor and/or other pregnancy complications are assigned a Nurse Care Manager to provide ongoing supervision and education concerning pregnancy. A letter is sent to the enrollee's physician to notify him/her of the enrollee's enrollment in the program with a summary of the initial assessment

All pregnant enrollees have access to a 24-hour toll free registered nurse call line at 1-888-632-0009. All pregnant enrollees are encouraged to select a pediatrician prior to delivery. For more information or to refer enrollees to the Bright Start Program call 1-888-913-0327.

Outreach and Health Education Programs

The goal of AmeriHealth Caritas Louisiana's Health Education Programs is to increase enrollees' knowledge of self-management skills for selected disease conditions. These health education programs focus on prevention to help enrollees improve their quality of life. The AmeriHealth Caritas Louisiana Community Education Department works in collaboration with Outreach and Rapid Response units to achieve desired outcomes.

Tobacco Cessation

The tobacco cessation program offers enrollees a series of educational classes easily accessible within their communities. The program offers targeted outreach to enrollees who are pregnant or who have chronic conditions such as asthma, diabetes, cardiovascular disease or other serious medical conditions, encouraging these enrollees to enroll in tobacco cessation classes. For more information go to the Louisiana Tobacco Control Program website: www.latobaccocontrol.com or you can call 1-800-QUIT-NOW.

Tobacco Cessation for Pregnant Women

AmeriHealth Caritas Louisiana covers tobacco cessation counseling and pharmacotherapy as extended services for pregnant women. The counseling sessions shall be face-to-face with the enrollee's PCP or the enrollee's obstetrical (OB) provider. Tobacco cessation counseling may be provided by other appropriate healthcare professionals upon referral from the enrollee's PCP or OB provider but all care must be coordinated.

During the prenatal period through 60 days postpartum, enrollees may receive up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

Minimum reimbursement for tobacco cessation counseling shall be based on the applicable CPT code on the Professional Services Fee Schedule and must be supported by appropriate documentation.

Please refer to the **Claim Filing Instructions** manual for billing guidelines on tobacco cessation for pregnant women.

Transitional Case Management

AmeriHealth Caritas Louisiana covers Transitional Case Management. Transitional Case Management requires coordination with facilities to develop a plan of care for each enrollee, including enrollees identified as homeless at the time of transition, prior to being discharged.

The plan of care must be provided to each enrollee in writing and must include post-discharge care appointments, medication details, patient education, self-management strategies and prior authorization guidance for services requiring authorizations.

Discharging facilities are to provide AmeriHealth Caritas Louisiana access to medical records, either in paper or electronic form, upon request; providing discharge summaries from electronic health records is sufficient. The discharging facility should share information with the enrollee's PCP and behavioral health providers regarding treatment received and contact information.

Discharging facilities must notify AmeriHealth Caritas Louisiana of enrollees identified as homeless at the time of transition to help ensure the enrollee's plan of care includes a housing specialist to connect the enrollee to appropriate housing resources.

Gambling Addiction

If an enrollee has a gambling problem or concern, call or text the Louisiana Problem Gamblers Helpline **1-877-770-STOP (7867)** or visit https://www.ldh.la.gov/page/gambling-providers.

Gift of Life

The Gift of Life is an outreach program developed to increase enrollees' awareness of the importance of a mammography screening and to encourage female enrollees age 50 and older to have regularly scheduled mammograms. AmeriHealth Caritas Louisiana establishes partnerships with community organizations. Designated outreach staff contacts enrollees by phone or mail, to schedule mammography screenings, remind AmeriHealth Caritas Louisiana enrollees of appointments, and reschedule appointments if necessary. All results are sent to the PCP for follow-up.

Domestic Violence Intervention

There has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals and families. Health care providers can play an important role in identifying domestic violence. Routine screening for domestic violence increases the opportunity for effective intervention and enables health care providers to assist their patients, and family enrollees who are victims.

Louisiana has many resources for domestic violence victims and their family enrollees.

Domestic Violence Resource	Contact Information
Louisiana Coalition Against Domestic Violence	State-wide Domestic Violence Hotline: 1-888-411-1333 www.lcadv.org
National Domestic Violence Hotline	1-800-799-SAFE (7233) www.thehotline.org
Louisiana Foundation Against Sexual Assault Domestic Violence Advocates and Support Contacts (An Abuse, Rape and Domestic Violence Resource Collection)	www.lafasa.org Louisiana specific information: www.aardvarc.org/dv/sttes/ladv.shtml

For more information, including the National Coalition Against Domestic Violence Fact Sheet, visit the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

Early Steps (Early Intervention System)

Louisiana's Early Intervention is a collection of services and supports that help families to enhance their skills in raising a child with disabilities; these services and support are covered through Louisiana's Early Steps Program. AmeriHealth Caritas Louisiana helps coordinate services and access to early intervention programs.

Early Steps provides services to families with infants and toddlers aged birth to three years (36 months) who have a medical condition likely to result in a developmental delay, or who have developmental delays. Children with delays in cognitive, motor, vision, hearing, communication, social-emotional or adaptive development may be eligible for services. Early Steps services are designed to improve the family's capacity to enhance their child's development. These services are provided in the child's natural environment, such as the child's home, child care or any other community setting typical for children aged birth to 3 years (36 months).

When a child turns three years of age, the responsibility for funding Early Intervention services is an education expense. Children may remain eligible for Early Intervention services through the minimum age at which a child can attend first grade in his/her own school district.

An infant or toddler (birth to three years of age) is eligible for Early Intervention Services if he/she:

- Shows a significant delay in one or more areas of child development
- Has a physical disability, a hearing or vision loss
- Receives a specialist's determination that a delay exists even though it is not evident on evaluations (called informed clinical opinion)
- Has a known physical or mental condition with a high probability for developmental delay (Down Syndrome is one example)

If an infant or toddler is found not to be eligible for Early Intervention, he/she may still be eligible for follow-up tracking in the event the needs of the child and family change.

Children eligible for tracking are:

- Born weighing less than 3 ½ pounds
- Cared for in a neonatal intensive care unit
- Born to mothers who are chemically addicted
- Found to have blood lead levels at 15 micrograms per deciliter and above

The services provided to eligible children and their families are individualized in accordance with the developmental needs of each child. Early Intervention supports may include a range of informal and formal opportunities, experiences and resources found in each family's community.

Families with concerns about their child's development should consult their family network provider. If parents have continuing concerns, or want additional information, please go to the Early Steps website: https://ldh.la.gov/page/early-steps.

Early Intervention is directed to the System Point of Entry Office in the region of Louisiana where the family resides.

Initial contact with the referred family occurs locally at a time and place convenient to the family. A screening at no-cost to the family is offered to determine if the child shows any areas of delay. Further evaluations may determine eligibility for Early Intervention services or follow-up tracking.

SECTION XII: BEHAVIORAL HEALTH ADDENDUM

Mobile Crisis Response

AmeriHealth Caritas Louisiana covers Mobile Crisis Response (MCR). MCR is an initial or emergent crisis response intended to provide relief, resolution, and intervention through crisis supports and services during the first phase of a crisis in the community. Services are provided to an enrollee who is experiencing a psychiatric crisis until the enrollee experiences sufficient relief. After that time, the enrollee can remain in the community and return to existing services, or be linked to alternative behavioral health services, which may include higher levels of treatment like inpatient psychiatric hospitalization.

Community Brief Crisis Support

AmeriHealth Caritas Louisiana covers Community Brief Crisis Support (CBCS). CBCS services are an ongoing crisis response rendered for up to 15 days, and are designed to provide relief, resolution and intervention through maintaining the enrollee at home and in their community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers. CBCS is a face-to-face, time-limited service provided to an enrollee who is experiencing a psychiatric crisis until the crisis is resolved and the enrollee can return to existing services or be linked to alternative behavioral health services.

Behavioral Health Crisis Care

AmeriHealth Caritas Louisiana covers Behavioral Health Crisis Care (BHCC). BHCC services are an initial or emergent psychiatric crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis for adults. Services are designed to offer recovery oriented and time limited services up to 23 hours per intervention, generally addressing a single episode that enables an enrollee to return home with community-based services for support or be transitioned to a higher level of care if the crisis is unable to be resolved.

Crisis Stabilization

Crisis Stabilization (CS) for adults is a short-term bed-based crisis treatment and support service for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement. CS is utilized when additional crisis supports are necessary to stabilize the crisis and ensure community tenure in instances in which more intensive inpatient psychiatric care is not warranted or when the member's needs are better met at this level.
This service is designed to ameliorate a psychiatric crisis and/or reduce acute symptoms of mental illness and to provide crisis relief, resolution, and intensive supportive resources for adults who need temporary twenty-four (24) hours a day, seven (7) days a week support and is not intended to be a housing placement.

Behavioral Health In Lieu of Services (ILOS)

AmeriHealth Caritas Louisiana covers:

- 23-Hour Observation Bed Services for Adults Ages 21 and Older
- Freestanding Psychiatric Hospitals for Adults Ages 21-64
- Injection Services Provided by Licensed Nurses to Adults Ages 21 and Older
- Mental Health Intensive Outpatient Programs
- Population Health Management Programs
- Visions of Hope

23-Hour Observation Bed Services for Adults Age 21 and Older

This ILOS is an inpatient hospital-based intervention designed to allow for the opportunity to hold and assess an enrollee without admitting them.

Freestanding Psychiatric Hospitals for Adults Ages 21-64

The purpose of this ILOS is to assist adult enrollees with significant behavioral health challenges. Beds in this setting are limited; therefore, individuals often remain in emergency departments while waiting for available beds. Use of freestanding psychiatric units reduces emergency department consumption, increases psychiatric bed capacity, and provides an alternative to general hospital beds.

Injection Services Provided by Licensed Nurses to Adults Age 21 and Older

Many enrollees are unable or unwilling to take oral psychotropics, or their mental status indicates a need for injectable medication to ensure compliance and stability. Allowing licensed nurses instead of physicians to perform this service helps to ensure compliance. The goals are reducing subsequent office visits and reducing hospitalizations due to lack of compliance.

Mental Health Intensive Outpatient Programs

The purpose of this ILOS is to provide enrollees treatment and allow an alternative to inpatient hospitalization or Assertive Community Treatment, and providing a step-down option from inpatient hospitalization for enrollees at high risk for readmission.

Population Health Management Programs

Mindoula Clinical Services' Population Health Management Program (PHMP) is a solution that targets, engages, and serves enrollees with SMI, SUD, and/or Sickle Cell Disease (SCD) and other comorbid medical conditions through team-based, tech-enabled, care extension services. This focused approach includes:

- Identification of enrollees for the PHMP using algorithms and enrollee archetype data,
- Outreach and enrollment of enrollees using an intake process specific to SMI, SUD, and SCD populations, and
- Provision of tech-enabled programmatic interventions that include content and methods tailored to reducing total costs of care by addressing behavioral, medical, and social needs specific to SMI, SUD, and SCD populations.

These interventions are designed to enhance participants' skills, strategies, and supports, which in turn help to prevent and reduce unnecessary and avoidable medical costs associated with SMI, SUD, SCD, and other comorbid medical conditions, during the program and even after its completion.

Behavioral Health Personal Care Services

Electronic Visit Verification for Behavioral Health Personal Care Services

The Louisiana Service Reporting Systems (LaSRS) is the electronic visit verification (EVV) system for providers of behavioral health personal care services (PCS). Utilization of the EVV system is a federal requirement that applies to all managed care PCS providers. .

Personal Care Services

Personal care services (PCS) include assistance and/or supervision necessary for enrollees with mental illnesses to help enable them to accomplish routine tasks and live independently.

Components

Personal care services include the following:

1. Minimal assistance with, supervision of, or prompting the enrollee to perform activities of daily living (ADLs) including eating, bathing, grooming/personal hygiene, dressing, transferring, ambulation, and toileting;
2. Assistance with, or supervision of, instrumental activities of daily living (IADLs) to meet the direct needs of the enrollee, which includes:
    a. Light housekeeping, including ensuring pathways are free from obstructions;
    b. Laundry of the enrollee's bedding and clothing, including ironing;
    c. Food preparation and storage;
    d. Assistance with scheduling medical appointments;
    e. Assistance with arranging transportation depending on the needs and preferences of the enrollee;
    f. Accompanying the enrollee to medical and behavioral health appointments and providing assistance throughout the appointment;
    g. Accompanying the enrollee to community activities and providing assistance throughout the activity;
    h. Brief occasional trips outside the home by the direct service worker on behalf of the enrollee to include shopping to meet the health care or nutritional needs of the enrollee or payment of bills if no other arrangements are possible and/or the enrollee's condition significantly limits participation in these activities; and
    i. Medication reminders with self-administered prescription and non-prescription medication that is limited to:
        1. Verbal reminders;
        2. Assistance with opening the bottle or bubble pack when requested by the enrollee;
        3. Reading the directions from the label;
        4. Checking the dosage according to the label directions; or
        5. Assistance with ordering medication from the drug store.

NOTE: PCS workers are NOT permitted to give medication to enrollees. This includes taking medication out of the bottle to set up pill organizers.

3. Assistance with performing basic therapeutic physical health interventions to increase functional abilities for maximum independence in performing activities of daily living, such as range of motion exercise, as instructed by licensed physical or occupational therapists, or by a registered nurse.
4. Transportation is not a required component of PCS although providers may choose to furnish transportation for enrollees during providing PCS. If transportation is furnished, the provider must accept all liability for their employee/direct service worker transporting an enrollee. It is the responsibility of the provider to ensure the employee/direct service worker has a current, valid driver's license, automobile liability insurance, and pass a motor vehicle screen prior to transporting enrollees.

Please refer to the **Claim Filing Instructions** manual for Behavioral Health PCS billing guidelines.

Individual Placement and Support

AmeriHealth Caritas Louisiana covers Individual Placement and Support (IPS). IPS refers to the evidence-based practice of supported employment for enrollees with mental illness. IPS helps enrollees living with mental health conditions work at regular jobs of their choosing that exist in the open labor market and pay the same as others in a similar position, including part-time and full-time jobs. IPS helps people explore the world of work at a pace that is right for the enrollee. Based on enrollee's interests, IPS builds relationships with employers to learn about the employers' needs in order to identify qualified job candidates.

Behavioral Health Access and Appointment Standards

AmeriHealth Caritas Louisiana has established standards for accessibility of medical care services, in alignment with Louisiana Department of Health requirements. The standards listed below are requirements of the provider contract:

Appointment Availability and Access to Care Measures		Standards
	Psychiatric Inpatient Hospital	Admit to hospital not to exceed 4 hours (emergency involuntary), 24 hours (involuntary) or 24 hours (voluntary)
	ASAM Level 3.3, 3.5, and 3.7	Within 10 business days
	Withdrawal Management	Within 24 hours when medically necessary
	Psychiatric Residential Treatment (PRTF)	Within 20 calendar days
	Behavioral Health Urgent Non-Emergency Care	An appointment shall be arranged within 48 hours of request
	Behavioral Health Initial Visit Routine Non-Urgent Care	Within 14 days
	Behavioral Health Follow-Up Visit Routine Care	30 days
	Behavioral Health Follow-Up Post Discharge Care	Within 30 days of discharge
	According to hospital discharge instructions	According to hospital discharge instructions
	Wait time in office for scheduled appointments	Not to exceed 45 minutes

Appointment Availability and Access to Care Measures		Standards
	Delayed appointments	Notify Patient immediately if provider is delayed and if anticipated to be more than a 90 Minute Wait Time the enrollee shall be offered a new appointment
	Walk-in patients	Seen ASAP/Follow written provider procedures

AmeriHealth Caritas Louisiana monitors after-hours standards on a routine basis. The standards are outlined below.

- Provider shall either utilize an after-hours answering service or have a recorded message that includes instruction to dial 911, go to an emergency room, or to stay on the line if there is an emergency situation.
- Recorded messages shall have an option to reach a live party.
- Afterhours offers an option to speak with a medical provider within 30 minutes.

AmeriHealth Caritas Louisiana monitors compliance with appointment standards in a variety of ways: During visits by your Provider Network Account Executive, monitoring enrollee complaints, telephone surveys, and mystery shopper calls. Non-compliant providers are notified of all categories requiring improvement and required to submit a corrective action plan to meet the performance standards within a specific time period.

Dialectical Behavioral Therapy (DBT)

Dialectical Behavioral Therapy (DBT) helps adults, children, and teenagers deal with many different mental disorders. In DBT, people learn about themselves and learn skills so they can make changes in their feelings, actions, and thoughts. People may hurt themselves or try to end their lives when their emotions are too strong and they feel out of control. DBT skills help people get through tough moments and gain control.

Effective **March 1, 2025**, "If DBT is recommended by your providers, AmeriHealth Caritas Louisiana will pay for it."

For more information, please see the Claim Filing Instructions.

Peer Support Services

AmeriHealth Caritas Louisiana offers Peer support services (PSS), which is an evidence-based behavioral health service. PSS is provided by qualified peer support specialists who assist enrollees with their recoveries from mental illness and/or substance use. The PSS are provided by Office of Behavioral Health Recognized Peer Support Specialists (RPSS) who are individuals that have experienced recovery from behavioral health illnesses and are successfully receiving treatment from the behavioral health services system. The goal is to provide behavioral health rehabilitative services, which may reduce the impacts of illnesses and disabilities and may restore enrollees to functional capacities in their environments, to include where the enrollees live, work, attend school and socialize.

Screening for Basic Medical Health Services

AmeriHealth Caritas Louisiana requires all Behavioral Health providers to screen for basic medical issues. Behavioral Health provider may utilize the AmeriHealth Caritas Louisiana Medical Screening form.

Therapeutic Group Homes

Therapeutic Group Homes (TGHs) provide a community-based residential service in a home-like setting of no greater than ten beds, for enrollees under the age of 21, who are under the supervision and program oversight of a psychiatrist or psychologist. TGHs are located in residential communities to facilitate community integration through public education, recreation and maintenance of family connections. TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting.

The treatment should be targeted to support the restoration of adaptive and functional behaviors that enables the child or adolescent to return to and remain successfully in his/her home and community, and to regularly attend and participate in work, school or training, at the child's best possible functional level. Integration with community resources is an overarching goal of the TGH level of care, which is in part achieved through rules governing the location of the TGH facility, the physical space of the TGH facility, and the location of schooling for the resident youth.

The intention of the TGH level of care is to provide a 24-hour intensive treatment option for youths who need it, and to provide it in a location with more opportunities for community integration than can be found in other more restrictive residential placements (e.g., inpatient hospital or psychiatric residential treatment facility (PRTF)). To enhance community integration, TGH facilities must be located within a neighborhood in a community, must resemble a family home as much as possible, and the resident youths must attend community schools integrated in the community (as opposed to being educated at a school located on the campus of an institution).

This array of services, including psychiatric supports, therapeutic services (individual counseling, family therapy, and group therapy), and skill-building, prepares the youth to return back to their community. The setting shall be geographically situated to allow ongoing participation of the child's family. In this setting, the child or adolescent remains involved in community-based activities and attends a community educational, vocational program or other treatment setting.

Treatment

Treatment provided in the TGH or in the community should incorporate research-based approaches appropriate to the child's needs, whenever possible. The family/guardian should be involved in all aspects of treatment and face to face meetings as much as possible. Family enrollees should be provided assistance with transportation and video conferencing options to support their engagement with the treatment process.

The individualized, strengths-based services and supports must meet the following criteria:

1. Be identified in partnership with the child or adolescent and the family and support system, to the extent possible;
2. Be implemented with oversight from a licensed mental health professional (LMHP);
3. Be based on both clinical and functional assessments;
4. Assist with the development of skills for daily living, and support success in community settings, including home and school;
5. Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation;

6. Decrease problem behavior and increase developmentally appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement. As much as possible, this work should be done with the engagement of, and in the context of the family with whom the youth will live next, such that the skills learned to increase pro-social behavior are practiced within family relationships and so can be expected to generalize to the youth's next living situation;
7. Transition the child or adolescent from TGH to home- or community-based living, with outpatient treatment (e.g., individual and family therapy);
8. Care coordination is provided to plan and arrange access to a range of educational and therapeutic services; and
9. Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability when appropriate and relevant.

Reimbursement

The unit of service for reimbursement for the TGH is based on a daily rate for the services provided by unlicensed practitioners only.

TGH services are inclusive of, but not limited to, the allowable cost of clinical and related services, psychiatric supports, integration with community resources and the skill-building provided by unlicensed practitioners.

In addition to the per diem rate for treatment services, there is also a separate per diem room and board component to the rate that cannot be paid with AmeriHealth Caritas Louisiana funds. This room and board rate is typically paid by the youth's custodian (in some cases a child-serving state agency) or another designated payment source.

LMHPs bill for their services separately under the approved State Plan for "Other Licensed Practitioners". Therapy (individual, group, and family, whenever possible) and ongoing psychiatric assessment and intervention, as needed, (by a psychiatrist) are required of TGH, but provided and billed separately by licensed practitioners for direct time spent.

Glossary of Acronyms

APRN = Advanced Practice RN
CSOC = Coordinated System of Care
NOTE: When an enrollee is deemed presumptively eligible for CSOC on the 1st of the calendar month, Magellan is responsible for all specialized BH services as of the 1st of that calendar month
When an enrollee is deemed presumptively eligible for CSOC on the 2nd – 31st of a calendar month, AmeriHealth Caritas Louisiana is responsible for all specialized BH services until the 1st of the next calendar month. Magellan is responsible for all specialized BH services as of the 1st of the next calendar month
LAC = Licensed Addiction Counselor
LCSW = Licensed Clinical Social Worker
LMFT = Licensed Marriage and Family Therapist
LMHP = Licensed Mental Health Professional (Includes medical psychologists, licensed psychologists, LCSW, LPC, LMFT, LAC, APRN)
LPC = Licensed Professional Counselor
MHRS = Mental Health Rehab Services
NEMT= Non-Emergency Medical Transportation
NOTE: The NEMT benefit refers to non-emergency transportation not provided in an ambulance. This benefit is not covered for all enrollees. Non-emergency transportation in an ambulance is covered for all enrollees.
PRTF = Psychiatric Residential Treatment Facilities

SED = Serious Emotional Disturbance (for youth only)
SMI = Serious Mental Illness (for adults only)
SUD = Substance Use Disorders

Integrating Behavioral and Physical Health Care

Enrollees with behavioral health disorders may also experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions. AmeriHealth Caritas Louisiana understands that coordination of care for these enrollees is imperative. AmeriHealth Caritas Louisiana's integrated health care management platform, does, to the extent permissible under law, deliver across the physical and behavioral health and social service areas.

AmeriHealth Caritas Louisiana staff works with the appropriate PCP and behavioral health providers to develop an integrated Treatment Plan for enrollees in need of physical and behavioral health care coordination. Care Managers also assure that communication between the two disciplines, providers and organizations, occurs and, with appropriate consent, for all enrollees with physical and behavioral health issues. Care Managers also work to coordinate with alcohol and drug abuse providers and community resources, as permitted under the law. Care Managers proactively and regularly follow-up on required physical and behavioral health services, joint treatment planning and provider-to-provider communication to ensure that enrollee needs are continuously reviewed assessed and documented in the Treatment Plan.

For care coordination assistance, behavioral health providers may contact: **Rapid Response 1-888-643-0005.**

Benefit and Service Descriptions:

Mental Health Outpatient Services: These services are planned, regularly scheduled visits to a doctor, counselor, or therapist to talk about your mental health issues. These can include: individual, family, and group therapy, psychological and/or neuropsychological testing.

Behavioral Health Inpatient Hospitalization: These are the most intensive services available. Hospitalization usually occurs when enrollees are at risk of harming themselves or others, experiencing a behavioral health crisis, when medications need close and continual checking, or when other services tried in the community have not helped to solve the problems that brought the enrollee in for service.

Psychiatric Rehabilitation Treatment Facility (PRTF): This service involves providing long term behavioral health care in a 24- hour group living facility for enrollees under the age of 21.

Therapeutic Group Home: These are community based 24-hour live-in services where the youth lives in a home-like setting with other youth to receive behavioral health services. This service is only available for youth enrollees under 21 years old.

Community Based Services: Clearly focused services provided in the community.

1. **Community Psychiatric Support and Treatment (CPST)**: Counseling services that are provided in the home, at work, or at school.
2. **Psychosocial Rehabilitation (PSR):** This service is for enrollees that live within the community and is designed to help enrollees achieve their goals and be able to continue to work and live in the community with family and friends. Enrollees receive assistance in day-to-day life skills and related goals.
3. **Multi-systemic Therapy (MST)**: This family-based service is for enrollees 12-17 years of age. It provides home and community behavioral health services designed to help keep the youth in the home. These services focus on providing a more safe, secure, and enhanced quality of life for the family.

4. **Family Functional Therapy (FFT)/FFT-Child Welfare (FFT-CW):** FFT services are for enrollees 10 to 18 years of age and their family to help focus on behavioral issues like "acting out." FFT-Child Welfare covers ages 10 and under. This service is provided in the home or community setting. It is designed to help enrollees change their behaviors.
5. **Homebuilders (HB):** This in-home service is for families with children age birth to 18 that provides clearly focused therapy such as family counseling and parent training. These services focus on a more safe, secure, and better quality home life for the enrollee and family.
6. **Assertive Community (ACT):** This service is provided for adults with serious mental illness. A team of providers works with the enrollee where they live. Services can include counseling, substance use disorder therapy, housing assistance, and medication management.
7. **Child Parent Psychotherapy (CPP):** is an intervention for children age 0-6 years and their parents who have experienced at least one form of trauma including but not limited to maltreatment, sudden traumatic death of someone close, a serious accident, sexual abuse, or exposure to domestic violence.
8. **Parent-child interaction therapy (PCIT):** is an evidence-based behavior parent training treatment developed by Sheila Eyberg, PhD for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent child interaction patterns.
9. **Preschool PTSD Treatment (PPT)** and **Youth PTSD Treatment (YPT):** are cognitive behavioral therapy interventions for posttraumatic stress disorder (PTSD) and trauma-related symptoms. PPT and YPT are adapted for different age groups: Preschool PTSD Treatment (PPT) is used for children ages 3-6; and Youth PTSD Treatment (YPT) is used for children and youth ages 7-18 years.
10. **Triple P Positive Parenting Program:** is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential.
11. **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):** is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events.
12. **Eye Movement Desensitization and Reprocessing (EMDR):** is an evidence-based psychotherapy that treats trauma-related symptoms, designed to resolve unprocessed traumatic memories in the brain.

Crisis Intervention: Crisis intervention is provided by a mental health rehabilitation (MHR) provider usually in a home setting.

Crisis Stabilization: These services occur in a secure setting with mental health professionals and includes assessments and intervention services to reduce crisis. This occurs in a secure setting with professionals.

Addiction Services: These services help enrollees deal with challenges of drug and alcohol use. These services can be inpatient, residential or outpatient and are designed to help the enrollee stop using alcohol and/or drugs.

NOTE: PSR and CPST Providers

To be eligible to receive Medicaid reimbursement, all behavioral health services providers rendering PSR or CPST services must meet the requirements set forth in ACT 582 La R.S.40:2162:

1. Be licensed as a BHSP agency
2. Be accredited by a department-approved accrediting organization
3. Have an NPI number
4. Implement an enrollee choice form
5. Be credentialed and in AmeriHealth Caritas Louisiana's provider network
6. Employ at least one (1) full-time physician or LMHP to supervise
7. Provide supervision for unlicensed individuals

8. Meet other requirements set forth in ACT 582
9. This legislation summary is not an all-inclusive list of requirements for providing PSR or CPST services, nor for receiving Medicaid reimbursement. The requirements noted in this legislation summary establish minimum standards for a limited number of requirements. The Louisiana Department of Health may establish additional requirements and may strengthen standards of requirements noted in this legislation summary
10. Providers must meet all requirements in statute, in rule, and in the Medicaid Behavioral Health Services Provider Manual. Providers should refer to the **Medicaid Behavioral Health Services Provider Manual** to find more information about standards, qualifications and requirements established to provide PSR or CPST services to Medicaid beneficiaries

Behavioral Health Services Requiring Prior Authorization

A list of behavioral health services requiring prior authorization review for medical necessity and place of service can be found in the Behavioral Health and Substance Use Disorder Utilization Management Guide. The Prior Authorization Lookup tool is also available to find out if a code requires authorization.

The AmeriHealth Caritas Louisiana Behavioral Health Utilization Management (Behavioral Health UM) department is available 24 hours per day, 7 days per week to assist with authorization requests. Normal hours of operation are 8 am – 5 pm, CST Monday through Friday. The Behavioral Health Utilization Management department telephone number is 1-855-285-7466. The Behavioral Health Utilization Management department fax number is 1-855-301-5356.

- All out of network services (except ER)
- Electroconvulsive Therapy (ECT)
- Psychiatric Health Facility (PRTF)
- Psychiatric In-patient services
- Psychoanalysis
- Psychological and Neuropsychological Testing
- Respite Care (Adult Crisis Stabilization)
- Community Psychiatric Supportive Treatment (CPST) including:
    - Homebuilders (HB)
    - Functional Family Therapy (FFT)
    - Assertive Community Treatment (ACT)
    - Multisystemic Therapy (MST)
- Crisis Intervention Follow Up Services
- Crisis Intervention- requires notification post service
- Psychosocial Rehabilitation (PSR)
- Short Term Residential Care in a Therapeutic Group Home
- Intensive Outpatient Program (ASAM Level 2.1)
- Clinically managed low-intensity residential treatment (ASAM Level 3.1)
- Clinically managed population specific high intensity residential treatment (Adult only ASAM Level 3.3)
- Clinically managed medium intensity residential treatment (ASAM Level 3.5)
- Medically monitored high intensity inpatient treatment-adult (ASAM Level 3.7)

- In Lieu of Services:
    - In Lieu Of: Residential SUD in freestanding facility (IMD) for adults 21-64 years old

        - ASAM Level 3.1: Halfway House (with option of Room & Board)
        - ASAM Level 3.2-WM: Sub-acute Detox (with option of Room & Board)
        - ASAM Level 3.3: Clinically managed population specific high intensity residential treatment – adult (with option of Room & Board)
        - ASAM Level 3.5: Clinically managed medium intensity residential treatment (with option of Room & Board)
        - ASAM Level 3.7: Medically monitored high intensity residential treatment-adult (with option of Room & Board)
        - ASAM Level 3.7-WM: Medically monitored inpatient withdrawal management-adult (with option of Room & Board)
    - In Lieu of: Freestanding Psych Hospital / IMD for adults
    - In Lieu of: Intensive Outpatient Program
    - In Lieu of: Mental Health Intensive Outpatient Program

For the initial prior authorization of psychiatric inpatient stays, residential levels of care, and electroconvulsive therapy, please submit requests by telephone to the Behavioral Health UM department. Requests are also accepted by fax if they contain all the appropriate information to support a medical necessity review and/or level of care evaluation. AmeriHealth Caritas Louisiana authorizes levels of care depending on medical necessity. Requests to extend authorization on these services may also be submitted by telephone to the Behavioral Health UM department.

For the initial prior authorization of outpatient services (including but not limited to: psychoanalysis, psychological/neuropsychological testing, CPST, Crisis Intervention Follow Up, Psychosocial Rehabilitation, and SUD Intensive Outpatient Program) please submit requests by completing and faxing the appropriate Outpatient Treatment Request Form to the Behavioral Health UM department. AmeriHealth Caritas Louisiana authorizes levels of care based on medical necessity. Requests to extend authorization on outpatient services may also be submitted by completing and faxing the appropriate Outpatient Treatment Request Form to the Behavioral Health UM department.

For additional information on how to submit a request for prior authorization, please refer to the provider area of our website https://www.amerihealthcaritasla.com/provider/resources/priorauth/index.aspx.
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Behavioral Health Services that Require Notification

The following is a list of services that do not require a clinical review by the health plan to determine medical necessity, but do require a notification to the Behavioral Health UM department as specified below:

- Substance Use Disorder Acute Detoxification (notification within 24 hours of discharge)
- Substance Use Disorder Sub-Acute Detoxification (notification within 24 hours of discharge)
- Crisis Intervention Behavioral Health Services (**Initial crisis intervention episode requires** post service notification within 2 business days)

Behavioral Health Services that Do Not Require Prior Authorization

- 48-Hour Observations
- Behavioral Health (BH) and Substance Use Disorder (SUD) Evaluations and Assessments

- Behavioral Health (BH) and Substance Use Disorder (SUD) Medical Team Conference
- Behavioral Health (BH) and Substance Use Disorder (SUD) Medication Evaluation, Management & Consultation
- Behavioral Health (BH))and Substance Use Disorder (SUD) Outpatient Therapy (Individual, Family, Group Therapy Sessions including SUD ASAM Level 1)
- Behavioral Health (BH) and Substance Use Disorder (SUD) Therapeutic Injections
- In Lieu of Services:

    - In Lieu of: 23-Hour Observation Bed Services for all Medicaid Eligible Adults (Age 21 and Above)
    - In Lieu of: Licensed Mental Health Professional Services for Adults (Age 21 and Above)
    - In Lieu of: Injection Services Provided by Licensed Nurses to All Medicaid Eligible Adults (Age 21 and Above)

Behavioral Health Provider Monitoring Plan

In concert with LDH, AmeriHealth Caritas Louisiana measures compliance with Behavioral Health Provider Monitoring Standards. The Behavioral Health Provider Monitoring Process of AmeriHealth Caritas Louisiana endeavors to facilitate appropriate utilization of health care resources for our enrollees through review and analysis of medical evaluation, treatment, and maintenance provided by Behavioral Health Service Providers included in the care of the enrollee. Results of the Behavioral Health Provider Monitoring are reviewed and reported by the Quality of Clinical Care Committee (QCCC), a subcommittee of AmeriHealth Caritas Louisiana's Quality Assessment and Performance Improvement Committee (QAPIC).

AmeriHealth Caritas Louisiana establishes policies and procedures, performance measures, and goals to evaluate treatment record keeping practices and addresses confidentiality, maintenance, and availability of quality treatment records through Provider contracts accessible to appropriate staff.

Procedure

- The Provider Monitoring process is continuous throughout the year.
- Records are audited utilizing the Behavioral Health Provider Audit Tool Elements. The tool is available for provider review in the following locations:
    - LDH's website: https://www.ldh.la.gov/assets/docs/BayouHealth/MCO_Templates/358_bh_provider_audit_elements.xlsx
    - AmeriHealth Caritas Louisiana 's Behavioral Health Provider Resources webpage
- Behavioral Health Provider Audit results are calculated for the following:
    - Overall Compliance Rate
    - Core Section Compliance Rate
    - Clinical Practice Guidelines (CPGs) Compliance Rate
    - Agency Requirements Compliance Rate

- The required performance benchmark for Behavioral Health Provider Audit if the calculated score for any element is below 80%.
    - If a score is calculated for less than 80% in any element (Core, Agency, or Clinical Practice Guides) of the Behavioral Health Provider Audit, the results are reviewed with the Behavioral Health Audit team. The provider may receive further recommendations including, but not limited to: submission of a Corrective Action; request for 15 Day Remediation; or the provider may be reviewed for termination as an

AmeriHealth Caritas Louisiana provider. Behavioral Health Providers are notified of their Provider Audit performance scores.

- Practice sites that fall below the required performance benchmark of 80% are notified of the deficiencies via email. Sites scoring below 80% on the audit are placed on a corrective action plan and receive a re-review within six (6) months from date of notification to determine if deficiencies have been remediated. After re-review, if a provider continues to fall below the required benchmark, the Behavioral Health department and PNM department work together to determine what further action is to be taken. This can include another CAP, referral to SIU and up to termination of the provider's contract.
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- Audit results are aggregated to identify trends and network opportunities. The PNM department, in collaboration with the Behavioral Health department, design network-level education and initiatives to improve documentation compliance.
- A quarterly summary of AmeriHealth Caritas Louisiana Behavioral Health Provider Monitoring is presented to the Quality of Clinical Care Committee (QCCC) for review and recommendations. The QCCC may take action for plan-wide follow-up on any standard not meeting AmeriHealth Caritas Louisiana performance goals.
- The Behavioral Health Provider Monitoring Summary Report results are reported quarterly to LDH.

Adverse Incident Reporting

AmeriHealth Caritas Louisiana assesses, investigates, reports, and follows up on all adverse incidents involving the specialized behavioral health population, including:

- Assuring the enrollee is protected from further harm and that medical or other services are provided, as needed;
- Following up to determine case and details of the critical incident if a provider agency or staff is involved;
- Identifying possible measures to prevent or mitigate the reoccurrence of similar critical incidents; and
- Monitoring the effectiveness of remedial actions when a provider agency or staff is involved.

If appropriate, AmeriHealth Caritas Louisiana and providers must report allegations of abuse, neglect, critical incidents, exploitation, or extortion, death, eviction, major medication incident, use of restraints, seclusion or restrictive intervention, self-neglect, human trafficking, involvement with law enforcement/member is victim of a crime, loss or destruction of home and major behavioral disturbance directly and immediately to the appropriate protective services agency or licensing agency. The following agencies are responsible for investigating such allegations:

- Department of Children and Family Services (DCFS);
- Adult Protective Services (APS) for vulnerable individuals ages 18 to 59;
- Governor's Office of Elderly Affairs Elderly Protective Services (EPS) for vulnerable individuals ages 60 and over or adults with disabilities; and
- LDH Health Standards Section (HSS) for people who reside in a public or private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), ICF/Nursing Facilities, and DCFS or APS cases in which the alleged perpetrator is an employee of an agency licensed by HSS.

Community providers are prohibited from using restrictive interventions/restraints. Any instances of restraint that threaten enrollees' health and welfare should be reported and referred to the appropriate protective service agency and the Health Standards Section.

- The following are types of adverse incidents:

    - Abuse (child/youth) - any one of the following acts that seriously endanger the physical, mental, or emotional health and safety of the child.
    - The infliction, attempted infliction, or, because of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person.
    - The exploitation or overwork of a child by a parent or any other person. The involvement of a child in any sexual act with a parent or any other person.
    - The aiding or toleration by the parent of the caretaker of the child's sexual involvement with any other person or of the child's involvement in pornographic displays or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Louisiana Children's Code Article 603(2))
- Abuse (adult) - the infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value. (La. R.S. 15:1503.2)
- Death - regardless of cause or the location where the death occurred. Documentation must address dates of all events and correspondence; cause of death; if the enrollee was receiving hospice or home health services; the who, what, when, where and why facts concerning the death; and relevant medical history and critical incidents associated with the death.
- Exploitation (adult) - the illegal or improper use or management of the funds, assets, or property of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage. (La. R.S. 15:1503.7)
- Extortion (adult) - the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or Abuse of legal or official authority. (La. R.S. 15:503.8)
- Neglect (child/youth) - the refusal or unreasonable failure of a parent of caretaker to supply the child with the necessary food, clothing, shelter, care, treatment, of counseling for any illness, injury, or condition of the child, as a result of which the child's physical, mental or emotional health and safety are substantially threatened or impaired. This includes prenatal illegal drug exposure caused by the parent, resulting in the Newborn being affected by the drug exposure and withdrawal symptoms. (La. Ch. Code art. 603(18))
- Neglect (adult) - the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 15:1503.10)

Completed incident reports should be forwarded by providers to AmeriHealth Caritas Louisiana within **one (1) business day** from discovery of the incident. Due to the sensitive nature of the information and identification of the enrollee, providers must submit the forms to AmeriHealth Caritas Louisiana via fax:

Fax to: 1-844-341-7641

Behavioral Medical Records Requirements

Providers must have a separate written record for each member served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, service providers must have adequate documentation of services offered and provided to members they serve. This documentation is an on-going chronology of activities undertaken on behalf of the member.

Providers shall maintain case records that include, at a minimum:

Member Rights:

- Psychiatric Advanced directive and Medical Advanced directive must be reviewed, signed by, and given to the member and/or responsible party, if applicable;
- Consent for treatment/Informed consent must be reviewed, signed by, and given to the member and/or responsible party, if applicable;
- Informed consent to deliver telemedicine/telehealth services must be reviewed, signed by, and given to the member and/or responsible party, if applicable. The consent form must include the following:
    - The rationale for using telemedicine/telehealth in place of in person services;
    - The risks and benefits of the telemedicine/telehealth, including privacy-related risks;
    - Possible treatment alternatives and those risks and benefits; and
    - The risks and benefits of no treatment.
- Rights to confidentiality must be reviewed, signed by, and given to the member and/or responsible party, if applicable.
- Name and date of birth of the individual;
- Each page of the record shall have a member identifier such as member name, member initials, member's client ID number, etc.
    - Social security number of the individual;
    - Address of the individual;
    - Dates and time of service;

Assessments

Copy of the treatment plans, based on and consistent with the assessment, which include at a minimum:

- Indication if treatment plan is an initial or an updated treatment plan;
- Goals and objectives, which are specific, measurable, action oriented, realistic and time-limited;
- Specific interventions;
- Service locations for each intervention;
- Staff providing the intervention;
- Estimated frequency and duration of service; and
- Signatures of the LMHP, member, and guardian responsible party, i.e., guardian/caregiver, (if applicable).
- Updated when there are significant life changes, achieved goals, or new problems identified; and
- Progression made towards all goals.
- Updated when there are significant life changes, achieved goals, or new problems identified; and
- Progression made towards all goals.
- Progress notes;
- Units of services provided;

Crisis Plan

- Crisis plan must be directed by the member and/or the responsible party, i.e., guardian/caregiver, if applicable; and

- Crisis plan must include signatures of the member and/or the responsible party, i.e., guardian/caregiver, if applicable.

Continuity and Coordination of Care:

- The record includes PCP name, address, phone number, and documentation of continuity and coordination of care between PCP and the member's treating provider;
- The record includes any other treating behavioral health clinician's name, address, phone number, and documentation of continuity and coordination of care between any other treating behavioral health clinician's and the member's treating provider;
- The record includes documentation of any referrals made on behalf of the member, if applicable; and
- The record must include a signed Release of Information by the member and/or responsible party, i.e., guardian/caregiver, if applicable, for communication and coordination of care to occur; if member and/or responsible party refuses, then this refusal must be noted within the record.

Medication Management, if applicable:

The record must indicate the following:

- Medication name;
- Medication type;
- Medication frequency of administration;
- Medication dosage;
- Person who administered each medication;
- Medication route;
- Ordered lab work that has been reviewed by the clinician ordering the lab work as evidenced by date and signature of clinician;
- Evidence of member education on prescribed medication including benefits, risks, side effects, and alternatives of each medication;
- The record must include a signed consent for psychotropic medications by the member and/or responsible party, i.e.,guardian/caregiver, if applicable; if member and/or responsible party refuses, then this refusal must be noted within the record;
- AIMS (Abnormal Involuntary Movement Scale) preformed when appropriate (e.g., member is being treated with antipsychotic medication);
- Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs, and chronic conditions to document ongoing monitoring; and
- Documentation of monitoring medication adherence, efficacy, and adverse effects.

Discharge plan

- Appointment date and/or time period of follow up with transitioning behavioral health provider and/or PCP, if medical comorbidity is present, must be documented on the discharge plan. Provider must document any barriers if unable to schedule an appointment when member is discharged or transitioned to a different level of care;
- Provider must ensure collaborative transition of care occurred with the receiving clinician/program as evidenced by documented communication. Provider must document any barriers if unable to communicate with the receiving clinician/program when member is discharged or transitioned to a different level of care; and

- Medication profile, if applicable, provided to outpatient provider and to member during transition of care. Provider must document any barriers while reviewing the transition of care with member or while providing the medication profile to the outpatient provider.

A member can sign the assessment and treatment plans electronically. A member's electronic signature will be deemed valid under federal law if it is authorized by state law. Under the Louisiana Uniform Electronic Transactions Act, La. R.S. 9:2601 et seq. ("LUETA") an electronic signature is valid if:

1. The signer intentionally, voluntary agrees to electronically sign the document;

2. The electronic signature is attributable to signer (i.e. be sure to have patient's printed name under signature); and

3. There are appropriate security measures in place which can authenticate the signature and prevent alteration of the signature (i.e. date and signature cannot be modified in the electronic health record).

Organization of Records, Record Entries and Corrections

Organization of individual member records and the location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record. All entries and forms completed by staff in member records must be legible, written in ink (not black) and include the following:

1. The name of the person making the entry;

2. The signature of the person making the entry;

3. The functional title, applicable educational degree and/or professional license of the person making the entry;

4. The full date of documentation; and

5. Reviewed by the supervisor, if required.

Any error made by the staff in a member's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid must never be used in a member's records.

Service/Progress Notes

Service/progress notes document the service/progress billed. Service/progress notes must reflect the service delivered and are the "paper trail" for services delivered.

The following information is required to be entered in the service/progress notes to provide a clear audit trail and to document claims:

1. Name of member;

2. Name of provider and employee providing the service(s);

3. Service provider contact telephone number;

4. Date of service contact;

5. Start and stop time of service contact; and

6. Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement.

A sample of the service/progress notes for each member seen by a non-LMHP must be reviewed by an LMHP supervisor at least monthly or more if needed. The signature of the LMHP attests to the date and time that the review occurred.

The service/progress note must clearly document that the services provided are related to the member's goals, objectives and interventions in the treatment plan, and are medically necessary and clinically appropriate. Each service/progress note must document the specific interventions delivered including a description of what materials were used when teaching a skill. Service/progress notes should include each member's response to the intervention, noting if progress is or is not being made. Effective documentation includes observed behaviors if applicable and a plan for the next scheduled contact with the member. Each service/progress note must include sufficient detail to support the length of the contact. The content must be specific enough so a third party will understand the purpose of the contact and supports the service and claims data.

The only staff who may complete a service/progress note is the staff who delivered the service. It is not permissible for one staff to deliver the service and another staff to document and/or sign the service notes.

Progress Summaries

A progress summary is a synthesis of all activities and services for a specified period (at least every 90 days or more often required by AmeriHealth Caritas Louisiana) which addresses each member's assessed needs, progress toward the member's desired personal outcomes, and changes in the member's progress and service needs. This summary must be of sufficient detail and analysis to allow for evaluation of the appropriateness of the member's treatment plan, sufficient information for use by supervisors, and evaluation of activities by program monitors.

Progress summaries must:

1. Document the time period summarized;
2. Indicate who was contacted, where contact occurred and what activity occurred;
3. Record activities and actions taken, by whom, and progress made;
4. Indicate how the member is progressing toward the personal outcomes in the treatment plan, as applicable;
5. Document delivery of each service identified on the treatment plan, as applicable;
6. Document any deviation from the treatment plan;
7. Record any changes in the member's medical condition, behavior or home situation that may indicate a need for a reassessment and treatment plan change, as applicable;
8. Be legible (including signature) and include the functional title of the person making the entry and date;
9. Be complete and updated in the record in the time specified;

10. Be complete and updated by the supervisor (if applicable) in the record as progress summary at the time specified;
11. Be recorded more frequently when there is frequent activity or when significant changes occur in the member's service needs and progress;
12. Be signed by the person providing the services; and
13. Be entered in the member's record when a case is transferred or closed.

Progress summaries must be documented in a narrative format that reflects delivery of each service and elaborates on the activity of the contact. Progress summaries must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note.

NOTE: General terms and phrases such as “called the member”, “supported member”, or “assisted member” are not sufficient and do not reflect adequate content. Checklists alone are not adequate documentation.

Discharge Summary for Transfers and Closures

A discharge summary details the member’s progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a member’s discharge.

SECTION XIII: MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities

AmeriHealth Caritas Louisiana is committed to treating our enrollees with respect. AmeriHealth Caritas Louisiana, its network providers, and other providers of service, may not discriminate against enrollees based on race, color, religion, sex, age, national origin, ancestry, nationality, creed, citizenship, alienage, marital or domestic partnership or civil union status, affectional or sexual orientation, physical, cognitive or mental disability, veteran status, whistleblower status, gender identity and/or expression, genetic information, health status, pre-existing condition, income status, source of payment, program memberships or physical or behavioral disability, except where medically indicated, or any other characteristic protected under federal, state, or local law.

Member Rights

AmeriHealth Caritas Louisiana enrollee's and potential enrollee's Bill of Rights ensure each enrollee is guaranteed the following:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected. Requests for information shall be compiled in the form and the language requested.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information — e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives — in a manner and format that may be easily understood as defined in the Contract between LDH and AmeriHealth Caritas Louisiana.
- To receive assistance from both LDH and the enrollment broker in understanding the requirements and benefits of AmeriHealth Caritas Louisiana.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- To receive aids and services to assist people with disabilities to communicate effectively with us, such as qualified sign language interpreters.
- To receive information on the AmeriHealth Caritas Louisiana's services, to include, but not limited to:
    - Benefits covered
    - Procedures for obtaining benefits, including any authorization requirements
    - Any cost sharing requirements
    - Service area
    - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, PCPs, specialists, and hospitals
    - Any restrictions on enrollee 's freedom of choice among network providers
    - Providers not accepting new patients
    - Benefits not offered by the AmeriHealth Caritas Louisiana but available to enrollees and how to obtain those benefits, including how transportation is provided

- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in core benefits and services at least 30 days before the intended effective date of the change.
- To receive information on grievance, appeal, and State Fair Hearing procedures.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
    - What constitutes an emergency medical condition, emergency services, and post- stabilization services
    - That emergency services do not require prior authorization
    - The process and procedures for obtaining emergency services
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract
    - Enrollee‘s right to use any hospital or other setting for emergency care
    - Post-stabilization care services rules as detailed in 42 CFR §422.113(c)
- To receive the AmeriHealth Caritas Louisiana’s policy on referrals for specialty care and other benefits not provided by the enrollee ‘s PCP.
- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way AmeriHealth Caritas Louisiana, its providers or LDH treat the enrollee.

Member Responsibilities

Enrollees have the responsibility to inform AmeriHealth Caritas Louisiana and its network providers of any changes in eligibility, or any other information that may affect their membership, health care needs or access to benefits. Examples include, but are not limited to the following:

- Pregnancy
- Birth of a baby
- Change in address or phone number
- An enrollee or an enrollee's child is covered by another health plan
- Special medical concerns
- Change in family size
- Loss or theft of AmeriHealth Caritas Louisiana ID Card

Enrollees have the responsibility to cooperate with AmeriHealth Caritas Louisiana and its network providers.

This includes:

- Following network provider instructions regarding care
- Making appointments with their PCP
- Canceling appointments when they cannot attend
- Calling AmeriHealth Caritas Louisiana when they have questions
- Keeping their benefits up to date with the case worker. Finding out when their benefits will end and making sure that all demographic information is up to date to keep their benefits.
- Understanding their health problems and working with their provider to set goals for their treatment, to the degree they are able to do so

Enrollees have the responsibility to treat their network provider and the network provider‘s staff with respect and dignity.

SECTION XIV: DISPUTES, MEMBER APPEALS AND GRIEVANCES

Member Grievance and Appeal Process

Grievance Procedures

A grievance is an expression of enrollee dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues. There is no timeframe to file a grievance. A grievance may be filed at any time.

To file a grievance on behalf of an enrollee with the enrollee's consent, call Member Services at 1-888-756-0004. Should the enrollee, or provider filing on behalf of an enrollee, need assistance, AmeriHealth Caritas Louisiana staff is trained to assist the enrollee. The provider may also, with the enrollee's consent, either write to us at the address below or submit online via the NaviNet portal:

AmeriHealth Caritas Louisiana
Member Grievance
P.O. Box 83580
Baton Rouge, LA 70884

An acknowledgement letter to the enrollee (with a copy to the provider filing on behalf of the enrollee) is mailed within 5 business days of AmeriHealth Caritas Louisiana's receipt of the grievance.

- AmeriHealth Caritas Louisiana sends a decision letter within (90) days of receiving the request. In, some cases, AmeriHealth Caritas Louisiana or the enrollee may need more information. If the enrollee needs more time to get the information, he/she may request up to 14 days more. AmeriHealth Caritas Louisiana can also have an additional 14 days if we document that additional time is needed and the delay is in the enrollee's best interest. If AmeriHealth Caritas Louisiana needs more time, the enrollee is informed orally of the reason for the extension by the end of the day of the decision and in writing within 2 calendar days from the decision date.

Appeal Procedures

Providers may follow the appeals processes below by filing on behalf of the enrollee and with the enrollee's written consent. AmeriHealth Caritas Louisiana recommends that the written consent contain the following elements:

- The name and address of the enrollee, the enrollee's date of birth, and the enrollee's Medicaid identification number. If the enrollee is a minor, or is legally incompetent, the name, address, and relationship to the enrollee of the person who signs the consent for the enrollee.
- The name, address, and AmeriHealth Caritas Louisiana identification number of the health care provider to whom the enrollee is providing the consent.
- An explanation of the specific service for which coverage was provided or denied to the enrollee to which the consent applies.
- The dates of service for which coverage was provided or denied.

- The consent document must also have the dated signature of the enrollee, or the enrollee's legal representative if the enrollee is a minor or is legally incompetent. A sample enrollee consent form can be found in the appendix.

Informal Reconsideration

As part of the appeal procedures, enrollees may request an Informal Reconsideration, which allows the enrollee, providers acting with the consent of the enrollee, or designated representative speaking on the enrollee's behalf, a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

To file an informal reconsideration on behalf of an enrollee with the enrollee's consent, call Member Services at 1-888-756-0004. Should the enrollee, or provider filing on behalf of an enrollee, need assistance, AmeriHealth Caritas Louisiana staff is trained to assist the enrollee.

The provider may also, with the enrollee's consent, either write to us at the address below or submit online via the NaviNet portal:

AmeriHealth Caritas Louisiana
Attention: Appeals Department
P.O. Box 7328
London, KY 40742

Also, if an enrollee would like to call AmeriHealth Caritas Louisiana to set up a meeting to present evidence in person, they can call Member Services 24 hours a day, 7 days a week at 1-888-756-0004.

Standard Appeals

An appeal is a request for a review of an Action pursuant to 42 CFR §438.400(b) which is: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner and the failure of the health plan to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR §438.400(b); and in a rural area with only one health plan, the denial of an enrollee's right to obtain services outside the provider network, as described in §438.52(b)(2)(ii).

Enrollees may file appeals either orally or in writing. The enrollee, an authorized representative, or provider acting on behalf of the enrollee with the enrollee's written consent may file an appeal either orally or in writing within 60 calendar days from the date on the determination letter. The request must be accompanied by all relevant documentation the enrollee, or provider acting on behalf of the enrollee, would like AmeriHealth Caritas Louisiana to consider during the appeal review. AmeriHealth Caritas Louisiana provides the enrollee and his or her Authorized Representative, at no cost, with records, reports, and documents relevant to the subject of the appeal within seven (7) calendar days of receipt of the request.

Requests for an enrollee appeal review, to include providers appealing on behalf of the enrollee, should be mailed to the appropriate post office box below or the appeal may be submitted online via the NaviNet portal:

AmeriHealth Caritas Louisiana
Attn: Appeals Department

P.O. Box 7328
London, KY 40742

AmeriHealth Caritas Louisiana sends the enrollee a letter acknowledging receipt of the request for an appeal review within five (5) business days.

If an appeal is filed to dispute a decision to discontinue, reduce or change a service/item that the enrollee has been receiving, the enrollee continues to receive the disputed service/item at the previously authorized level pending resolution of the appeal, if the appeal is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision. AmeriHealth Caritas Louisiana also honors a verbal filing of an appeal within ten (10) days of receipt of the written denial decision to continue services.

The appeal review is conducted by a medical director or physician designee who was not involved in the decision making for the original denial or prior reconsideration of the case. The medical director or physician designee issues a determination to uphold, modify or overturn the denial based on:

- Clinical judgment
- Established standards of medical practice
- Review of available information including but not limited to:
    - AmeriHealth Caritas Louisiana medical and administrative policies
    - Information submitted by the enrollee, the enrollee's health care provider acting on their behalf, or obtained by AmeriHealth Caritas Louisiana through investigation
    - The network provider's contract with AmeriHealth Caritas Louisiana
    - AmeriHealth Caritas Louisiana's contract with the State of Louisiana's Medicaid Program and relevant Medicaid laws, regulations and rules

The medical director or physician designee completes its review of the appeal as expeditiously as the enrollee's health condition requires, but no more than thirty (30) days from receipt of the appeal. AmeriHealth Caritas Louisiana sends a written notice of the appeal decision to the enrollee and other appropriate parties within five (5) business days of the decision, but not later than thirty (30) days from receipt of the appeal by AmeriHealth Caritas Louisiana. The written notice of the resolution includes the following:

- The results of the resolution process and the date it was completed.
- For appeals not resolved wholly in favor of the enrollee:
    - The right to request a State Fair Hearing, and how to do so;
    - The right to request to receive benefits while the hearing is pending, and how to make the request; and
    - That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds AmeriHealth Caritas Louisiana's action.

Expedited Appeals

An expedited appeal may be requested if the enrollee or enrollee representative believes that the enrollee's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the standard appeal process. An expedited appeal review may be requested either verbally or in writing.

AmeriHealth Caritas Louisiana provides the enrollee and his or her Authorized Representative, at no cost, with records, reports, and documents relevant to the subject of the expedited appeal within seven (7) calendar days of receipt of the request.

AmeriHealth Caritas Louisiana must conduct an expedited review of an appeal upon request from enrollee or provider at any point prior to the appeal decision.

If an expedited appeal is filed to dispute a decision to discontinue, reduce or change a service/item that the enrollee has been receiving, then the enrollee continues to receive the disputed service/item at the previously authorized level pending resolution of the expedited appeal, if the expedited appeal is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision.

If AmeriHealth Caritas Louisiana does not agree with the need to expedite an appeal, AmeriHealth Caritas Louisiana may deny the request to expedite. AmeriHealth Caritas Louisiana will notify the enrollee and other appropriate parties within two (2) calendar days that the appeal will not be reviewed as an expedited appeal. AmeriHealth Caritas Louisiana will then conduct the review under the standard appeal process and make a decision within thirty (30) calendar days.

The expedited appeal review is performed by a licensed physician, who was not involved in any previous level of review or decision making about the appeal. For appeals involving specialty care, input to the appeal determination may be obtained from a clinician in the same or similar specialty as the care being requested.

The expedited appeal review process is bound by the same rules and procedures as the standard appeal review process except for timeframes, which are modified as specified in this section of this Provider Manual.

AmeriHealth Caritas Louisiana issues the decision resulting from the expedited review in person or by phone to the enrollee and other appropriate parties within seventy–two (72) hours of receiving the enrollee‘s request for an expedited review. In addition, AmeriHealth Caritas Louisiana gives oral notification within seventy-two (72) hours of the request and mails the written notice of the decision to the enrollee and other appropriate parties within seventy-two (72) hours of the request.

The enrollee or enrollee representative may file a request for a Fair Hearing within 120 days from the date of the notice of resolution.

State Fair Hearing

Enrollees or enrollee representatives may request a State Fair Hearing within 120 days from the mail date on the written notice or appeal decision.

Enrollees, or providers filing on behalf of an enrollee, must exhaust AmeriHealth Caritas Louisiana‘s standard appeal processes before filing a State Fair Hearing Request.

The enrollee may file a State Fair Hearing directly with the Division of Administrative Law. The request for a State Fair Hearing should include a copy of the written notice of decision that is the subject of the request. A request form is located on DAL’s website. Requests may be sent to DAL via mail, fax, or email at:

Division of Administrative Law
Louisiana Department of Health Section
Post Office Box 4189
Baton Rouge, LA. 70821

Fax: 1-225-219-9823

Email: LDHProcessing@adminlaw.state.la.us

An enrollee who files a request for a Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the enrollee has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

Upon receipt of the request for a Fair Hearing, the Division of Administrative Law (DAL) designee schedules a hearing. The enrollee and AmeriHealth Caritas Louisiana receive notification of the hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the enrollee. The letter outlines the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

AmeriHealth Caritas Louisiana is a party to the hearing and must be present. AmeriHealth Caritas Louisiana, which may be represented by an attorney, must submit the Summary of Evidence (SOE) and be prepared to explain and defend the issue of the appeal. AmeriHealth Caritas Louisiana must submit the SOE packet to the Division of Administrative Law within seven (7) calendar days of receipt of the request for State Fair Hearing if the request is made directly to AmeriHealth Caritas Louisiana.

AmeriHealth Caritas Louisiana provides the enrollee and his or her Authorized Representative, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing with seven (7) calendar days of receipt of the request. The Fair Hearing Decision is issued within ninety (90) days the filing and is binding on AmeriHealth Caritas Louisiana If the Division of Administrative Law rules in favor of the claimant/appellant, AmeriHealth Caritas Louisiana receives a Directive from the Division of Administrative Law. The Directive shall be executed within ten days and reported to the LDH within 14 days of the date of the Directive or by the state level appeal's 90th day deadline, whichever is earliest.

Continuation of Benefits during Appeal during Appeal and State Fair Hearing Processes

An enrollee may continue to receive services while waiting for AmeriHealth Caritas Louisiana's decision if all the following apply:

- The appeal is filed within ten (10) business days after the notice of the adverse action is mailed;
- The appeal is filed within ten (10) business days after the intended effective date of the action;
- The appeal is related to reduction, suspension or termination of previously authorized services;
- The services were ordered by an authorized provider;
- The authorization has not ended, and
- The enrollee requested the services to continue.

The enrollee's services may continue until one (1) of the following happens:

- The enrollee decides not to continue the appeal.
- 10 business days have passed from the date of the notice of resolution unless the enrollee has requested a State Fair Hearing with continuation of services.
- The time covered by the authorization is ended or the limitations on the services are met.
- The State Fair Hearing office issues a hearing decision adverse to the enrollee.

The enrollee may have to pay for the continued services if the final decision from the State Fair Hearing is against them.

If the Administrative Law Judge agrees with the enrollee, AmeriHealth Caritas Louisiana pays for the services received while waiting for the decision.

If the State Fair Hearing decision agrees with the enrollee and he/she did not continue to get the services while waiting for the decision, AmeriHealth Caritas Louisiana issues an authorization for the services to restart as soon as possible and AmeriHealth Caritas Louisiana pays for the services.

Provision of and Payment for Services/Items Following Decision

If AmeriHealth Caritas Louisiana or the DAL reverses a decision to deny, limit, or delay services/items that were not furnished during the Grievance, Appeal or Fair Hearing process, AmeriHealth Caritas Louisiana authorizes or provide the disputed services/items promptly and as expeditiously as the enrollee's health condition requires.

If AmeriHealth Caritas Louisiana or the DAL reverses a decision to deny authorization of services/items, and the enrollee received the disputed services/items during the Complaint, Appeal or Fair Hearing process, the Plan promptly pays for those services.

SECTION XV: REGULATORY PROVISIONS

AmeriHealth Caritas Louisiana's Corporate Confidentiality Policy

The policy states that during business operations, Confidential Information and/or Proprietary Information, including enrollee Protected Health Information (PHI), may become available to AmeriHealth Caritas Louisiana Associates, Consultants and Contractors. AmeriHealth Caritas Louisiana's use and disclosure of enrollee PHI is regulated pursuant to HIPAA and its implementing regulations. AmeriHealth Caritas Louisiana's use and disclosure of PHI is also impacted by applicable state laws and regulations governing the confidentiality and disclosure of health information.

AmeriHealth Caritas Louisiana is committed to safeguarding Confidential Information and Proprietary Information, including ensuring the privacy and security of enrollee PHI, in compliance with all applicable laws and regulations. It is the obligation of all AmeriHealth Caritas Louisiana Associates, Consultants and Contractors to safeguard and maintain the confidentiality of Confidential and Proprietary Information, including PHI, in accordance with the requirements of all applicable federal and state statutes and regulations as well as the provisions of AmeriHealth Caritas Louisiana's Confidentiality Policy and other AmeriHealth Caritas Louisiana policies and procedures addressing Confidential and Proprietary Information, including PHI.

All Confidential Information and Proprietary Information, including PHI, is handled on a need-to-know basis. The AmeriHealth Caritas Louisiana Confidentiality Policy and other AmeriHealth Caritas Louisiana policies and procedures are adopted to protect the confidentiality of such information consistent with the need to effectively conduct business operations without using or disclosing more information than is necessary, for example, conducting research or measuring quality using aggregated data wherever possible. No Associate, Consultant or Contractor is permitted to disclose Confidential Information or Proprietary Information pertaining to AmeriHealth Caritas Louisiana or an enrollee to any other Associate, Consultant or Contractor unless such a disclosure is consistent with the AmeriHealth Caritas Louisiana Confidentiality Policy.

Both during and after an Associate's association with the AmeriHealth Caritas Louisiana, it shall be a violation of the AmeriHealth Caritas Louisiana Confidentiality Policy to discuss, release, or otherwise disclose any Confidential Information or Proprietary Information, except as required by the Associate's employment relationship with AmeriHealth Caritas Louisiana or as otherwise required by law. It is also a violation of AmeriHealth Caritas Louisiana's Confidentiality Policy for any Associate to use Confidential Information or Proprietary Information for his/her own personal benefit or in any way inconsistent with applicable law or the interests of AmeriHealth Caritas Louisiana. To the extent that a violation of the AmeriHealth Caritas Louisiana Confidentiality Policy occurs, AmeriHealth Caritas Louisiana reserves the right to pursue any recourse or remedy to which it is entitled under law. Furthermore, any violation of the AmeriHealth Caritas Louisiana Confidentiality Policy is subject the Associate(s) in question to disciplinary action, up to and including termination of employment.

The following information is provided to outline the rules regarding the handling of confidential information and proprietary information within AmeriHealth Caritas Louisiana.

Confidential information and proprietary information include, but is not limited to the following:

- Protected Health Information
- Certain sensitive demographic data
- Medical or personal information pertaining to Associates of AmeriHealth Caritas Louisiana (the Company) and/or its customers
- Accounting, billing or payroll information, and data reports and statistics regarding the Company, its Associates, enrollees, and/or Customers
- Information that AmeriHealth Caritas Louisiana is required by law, regulation, agreement or policy to maintain as confidential

- Financial information regarding the Company, its enrollees, network providers and Customers, including but not limited to contract rates and fees
- Associate personnel and payroll records
- Information, ideas, or data developed or obtained by AmeriHealth Caritas Louisiana, such as marketing and sales information, marketplace assessments, data on customers or prospects, proposed rates, rating formulas, reimbursement formulas, Health Care Provider payment rates, business of AmeriHealth Caritas Louisiana and/or its customers
- Information not generally known to the public upon which the goodwill, welfare and competitive ability of AmeriHealth Caritas Louisiana and/or its Customers depend, information regarding product plans and design, marketing sales and plans, computer hardware, software, computer systems and programs, processing techniques, and general outputs
- Information concerning AmeriHealth Caritas Louisiana's business plans
- Information that could help others commit Fraud or sabotage or misuse AmeriHealth Caritas Louisiana's products or services

Compliance with the HIPAA Privacy Regulations

In addition to maintaining the Corporate Confidentiality Policy, AmeriHealth Caritas Louisiana complies with the Privacy Regulations as specified under HIPAA.

To ensure compliance with these regulations, AmeriHealth Caritas Louisiana takes several measures including, but not limited to, the following:

- Employs a Privacy Officer who is responsible for the directing of on-going activities related to the AmeriHealth Caritas Louisiana's programs and practices addressing the privacy of enrollee's protected health information (PHI)
- Has a centralized Privacy Office, which is responsible for the day-to-day oversight and support of privacy related initiatives conducted at AmeriHealth Caritas Louisiana
- Issues copies of AmeriHealth Caritas Louisiana's Notice of Privacy Practices to recently enrolled and existing membership of the health plan, which describes how medical information is used and disclosed, as well as how it can be accessed
- Established and/or enhanced processes for our enrollees to exercise their rights under these regulations, such as requesting access to their PHI, or complaining about AmeriHealth Caritas Louisiana’s privacy practices

Allowed Activities under the HIPAA Privacy Regulations

The HIPAA Privacy Regulations allow covered entities, including health care providers and health plans (such as AmeriHealth Caritas Louisiana), the ability to use or disclose PHI about its enrollees for the purposes of Treatment, Payment and/or Health plan Operations (TPO) without an enrollee's consent or authorization. This includes access to an enrollee's medical records when necessary and appropriate.

“TPO” allows a Health Care Provider and/or AmeriHealth Caritas Louisiana to share enrollees’ PHI without consent or authorization.

“Treatment” includes the provision, coordination, management, and consultation of an enrollee between and among health care providers.

Activities that fall within the “Payment” category include, but are not limited to:

- Determination of enrollee eligibility
- Reviewing health care services for medical necessity and utilization review
- Review of various activities of health care providers for payment or reimbursement to fulfill AmeriHealth Caritas Louisiana's coverage responsibilities and provide appropriate benefits
- To obtain or provide reimbursement for health care services delivered to enrollees

"Operations" includes:

- Certain quality improvement activities such as Case Management and care coordination
- Quality of care reviews in response to enrollee or state/federal queries
- Response to enrollee Complaints/Grievances
- Administrative and financial operations such as conducting Health Plan Employer Data and Information Set (HEDIS) reviews
- Enrollee services activities
- Legal activities such as audit programs, including Fraud and abuse detection to assess conformance with compliance programs

While there are other purposes under the Privacy Regulations for which AmeriHealth Caritas Louisiana and/or a Health Care Provider might need to use or disclose an enrollee's PHI, TPO covers a broad range of information sharing.

For more information on HIPAA and/or the Privacy Regulation, please visit the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com and click on HIPAA or contact the Provider Services Department at 1-888-922-0007.

Prohibition on Payment to Excluded/Sanctioned Persons

Pursuant to Section 1128A of the Social Security Act and 42 CFR 1001.1901, AmeriHealth Caritas Louisiana may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other Federal health care programs.

A Sanctioned Person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Upon request of AmeriHealth Caritas Louisiana, a provider is required to furnish a written certification to AmeriHealth Caritas Louisiana that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a Sanctioned Person.

A provider is required to notify AmeriHealth Caritas Louisiana within one (1) business day upon knowledge that any of its contractors, employees, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. If a provider cannot provide reasonably satisfactory assurance to AmeriHealth Caritas Louisiana that a Sanctioned Person will not receive payment from AmeriHealth Caritas Louisiana under the Provider Agreement, AmeriHealth Caritas Louisiana may immediately terminate the Provider Agreement. AmeriHealth Caritas Louisiana reserves the right to recover all amounts paid by AmeriHealth Caritas Louisiana for items or services furnished by a Sanctioned Person.

Provider Protections

AmeriHealth Caritas Louisiana shall not exclude, discriminate against or penalize any Health Care Provider for its refusal to allow, perform, participate in or refer for health care services, when the refusal of the Health Care Provider is based on moral or religious grounds. The Health Care Provider must make information available to enrollees, prospective enrollees and AmeriHealth Caritas Louisiana about any such restrictions or limitations to the types of services they will/will not make referrals for or directly provide to AmeriHealth Caritas Louisiana enrollees, due to religious or moral grounds.

Health care providers are further protected in that no public institution, public official or public agency may take disciplinary action against, deny licensure or certification or penalize any person, association or corporation attempting to establish a plan, or operating, expanding or improving an existing plan, because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other health plans, when the refusal is based on moral or religious grounds. AmeriHealth Caritas Louisiana does not engage in or condone any such discriminatory practices.

AmeriHealth Caritas Louisiana shall not discriminate against or exclude from AmeriHealth Caritas Louisiana's Provider Network any Health Care Provider because the Health Care Provider advocated on behalf of an enrollee in a Utilization Management appeal or another dispute with AmeriHealth Caritas Louisiana over appropriate medical care, or because the Health Care Provider filed an appeal on behalf of an AmeriHealth Caritas Louisiana enrollee.

AmeriHealth Caritas Louisiana does not have policies that restrict or prohibit open discussion between health care providers and AmeriHealth Caritas Louisiana enrollees regarding treatment options and alternatives. AmeriHealth Caritas Louisiana encourages open communication between health care providers and our enrollees regarding all treatment options available to them, including alternative medications, regardless of benefit coverage limitations.

AmeriHealth Caritas Louisiana provides public notice prior to the implementation of a policy or procedure, per the requirements of House Bill 434 of the 2019 Louisiana Regular Session.

Additional Resources

Network providers should always have the most current regulatory requirements. Please call 1-888-922-0007 or call your Network Account Executive for additional information. You should consult an official publication or reporting service if you want to be assured you have the most up-to-date version of these regulations.

Below are some helpful links to federal and state regulations and state bulletins and other relevant general information. Announcement and new bulletins are also posted on www.amerihealthcaritasla.com.
CMS - www.cms.gov
Code of Federal Regulations www.govinfo.gov/app/collection/cfr/2021/

Louisiana Laws can be researched through the Louisiana State Legislature website https://legis.la.gov/legis/home.aspx.

Click on Louisiana Laws on the top banner – then click table of contents on the left-hand side. Once at the Table of Contents click on *Revised Statutes*. It brings you to a listing of all Louisiana Statutes.

Louisiana Office of State Register:

The Louisiana Register is a monthly publication which provides an access to the certified regulations and legal notices issued by the executive branch of the state government. All of these go through the formal rulemaking process. Proposed

and final rules published in the Louisiana Register are codified for easy Louisiana Administrative Code research capabilities.

www.doa.la.gov/doa/osr/

Medicaid Website – www.lamedicaid.com

Louisiana Department of Health https://ldh.la.gov/

Louisiana Helpful Resources for Your Patients-

Click on link below to find a listing of additional services available in the community to your enrollees. This includes contact information for WIC, advocacy, legal services, other human services, emergency, Department of Education and more and was compiled by LDH's Louisiana Children's Special Health Services (CSHS) and is localized to specific regions.

https://ldh.la.gov/page/documents

APPENDIX

Website Resources

The following resources are available on the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com under the Providers tab.

- Provider Handbook
- Newsletters and updates
- Self-service tools
    - NaviNet
    - Find a provider
    - Find a pharmacy
    - Louisiana Medicaid Single PDL (PDF)
    - Sign up for emails
- Prior authorization
- Billing and claims
- Forms
- Training
- Resources
- Behavioral health
- Pharmacy
- Non-contracted providers