AmeriHealth Caritas Louisiana

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Applied Behavior Analysis (ABA) Ages 0-20 **(Added verbiage from Updated LDH ABA Provider Manual (IB 25-9).** 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: **(Removed verbiage per IB 25-9 update)** • Any pediatrician, general practitioner, or NP who has, as part of their practice diagnosed and treated children with ASD and related disorders for at least five years or any pediatrician, or NP whose CDEs were approved to determine the medical necessity for ABA prior to 2023.	122 - 123
Member Grievance and Appeal Process **Grievance Procedures** **(Removed verbiage)** The enrollee's written approval to file a grievance may be obtained in advance as part of the enrollee intake process	220
Informal Reconsideration **(Removed verbiage)** The enrollee's written approval to file an informal reconsideration may be obtained in advance as part of the enrollee intake process.	221

Standard Appeals **(Changed verbiage from 90 to 60)** The enrollee, an authorized representative, or provider acting on behalf of the enrollee with the enrollee's written consent may file an expedited appeal either orally or in writing within 60 calendar days from the date on the determination letter. **(Removed verbiage underlined)** The enrollee's written approval may be obtained in advance. 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 and must contain the word "Appeal" at the top of the request or the appeal may be submitted online via the NaviNet portal: "Appeal" AmeriHealth Caritas Louisiana Attn: Appeals Department P.O. Box 7328 London, KY 40742	221-222

Expedited Appeals **(Added verbiage underlined)** 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. **(Removed the word *level* from the above sentence)** **(Removed verbiage due to not required per contract rules)** A signed provider certification 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 must be provided to AmeriHealth Caritas Louisiana per CFR 42 Sec. 438.410 (a). The provider certification is required regardless of whether the expedited appeal is filed verbally or in writing by the enrollee or the provider acting on behalf of the enrollee. No action is taken against the provider, acting on behalf of the enrollee with the enrollee's consent, who supports the enrollee's appeal. Upon receipt of a verbal or written request for expedited review, AmeriHealth Caritas Louisiana verbally informs the enrollee or enrollee representative of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so. **(Added verbiage)** 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. **(Removed verbiage)** A written report from a licensed physician or other appropriate provider in the same or similar specialty that typically manages or consults on the service/item in question is required **(Added verbiage)** 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. **(Removed verbiage underlined)** 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 two (2) business days of the decision within seventy-two (72) hours of the request.	223

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Table of Contents **(Added Third Party Liability and Medicare Advantage Plan Update Requests)**	8
Covered Services **(Added hyperlink)** Crisis Stabilization for Youth Behavioral Health Crisis Care Crisis Stabilization for Adults	41
Bariatric Surgery **(Changed verbiage)** 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:	46

Outpatient Hospital Services **(Changed verbiage)** The only exceptions to this criteria are as follows: • If either of the above exceptions are met, separate billing and payment for the outpatient hospital service is allowed.	82
Medical Transportation Services **(Changed verbiage)** 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. **(Added hyperlink)** Please reference our **Air Ambulance Transport clinical policy** for more details.	93 -94
Personal Care Services (0-20) **(Added bullet point)** • Assisting the enrollee with transferring and bed mobility. **(Added verbiage from our clinical policy CCP.1511-04)** 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.	93, 105-106

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. **(Removed verbiage)** The Louisiana Service Reporting Systems (LaSRS) is LDH's electronic visit verification (EVV) system for providers of EPSDT personal care services (PCS) and behavioral health personal care services. Utilization of an EVV system is a federal requirement that applies to all managed care PCS providers. In accordance with the 21st Century Cures Act, LDH collects the following identifiable information for Home and Community-Based Services (HCBS) waiver and Louisiana Medicaid State Plan services through LaSRS: • The type of service performed; • The enrollee receiving the service; • The date of the service; • The location of service delivery; • The individual providing the service; and • The time the service begins and ends. LaSRS does not "track" direct service workers—it only collects the location of service delivery at the time of clock in and clock out. LaSRS can be accessed by devices with internet connectivity (e.g., computer, smartphone, tablet). When a worker "clocks in" or "clocks out", the system collects the location of the device being used at that time, as well as the time, date, individual providing the service, and the individual receiving the service. The intent of this system is to ensure that enrollees receive services authorized in their plans of care, reduce inappropriate billing/payment, safeguard against fraud, replace paper timesheets, and improve program oversight. PCS providers are required to use LaSRS and if it is not used, reimbursement will be denied for services.	
Telehealth Requirements for Applied Behavior Analysis (ABA) **(Changed verbiage)** The use of telehealth is reimbursed, when appropriate, for rendering certain ABA services for the care of or to support the caregivers of enrollees.	124

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.	
Third Party Liability and Medicare Advantage Plan Update Requests **(Added verbiage from IB 16-15 revised 2.20.25)** General Private TPL and Medicare Advantage Plan Update Requests Providers may submit all private TPL and Medicare Advantage Plan updates to HMS, the Louisiana Department of Health (LDH) TPL vendor. All general private TPL and Medicare Advantage Plan update requests can be submitted to HMS via the TPL Portal, fax, email or phone. Fax: (877) 204-1325 Email: latpr@gainwelltechnologies.com Phone: (877) 204-1324 Providers can access the TPL Portal at the following URL: https://tplportal.hms.com/?ClientCd=LA. For any questions on logging into the TPL Portal, or requesting credentials, refer to the User Manual at https://www.lamedicaid.com/Provweb1/Forms/UserGuides/TPL_Portal_User_Manual_External.pdf. Private TPL and Medicare Advantage Plan Update Request Change Forms can be found here: https://www.lamedicaid.com/ProvWeb1/ProviderTraining/Packets/2008ProviderTrainingMater Questions concerning HMS updates should be addressed to HMS at (877) 204-1324. HMS hours of operation are Monday through Friday, 8 a.m. – 5 p.m. Louisiana state holiday are excluded. Urgent Private TPL and Urgent Medicare Advantage Plan Update Requests Providers should submit all urgent TPL 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. Escalations: For escalated requests, submit the TPL information to the LDH TPL Unit. Escalation requests are: • After five business days, when a provider has sent a request to add, term, or change policy to HMS and policy has not changed in the BTPL Portal • Pharmacy, Awaiting add/term/ or change request • Emergency updates due to awaiting immediate medical care to add, term or change a policy	149 - 150

• Traditional Medicare updates All TPL escalation requests can be submitted to LDH via email, fax or phone. Email: tpl.inquiries@la.gov Fax: (225) 389-2709 Phone: (225) 342-4510 Traditional Medicare update request forms can be found here: http://www.lamedicaid.com/ProvWeb1/ProviderTraining/TraditionalMedicare.pdf	
Member Grievance and Appeal Process **Grievance Procedures** **(Changed verbiage to 5 business days per our contract -removed 1 business day)** 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. **(Per the contract)** 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.	220
Standard Appeals **(Added verbiage)** 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. **(Per the contract)** AmeriHealth Caritas Louisiana sends the enrollee a letter acknowledging receipt of the request for an appeal review within five (5) business days.	221 - 222
Expedited Appeals **(Added verbiage)**	223

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.	
State Fair Hearing **(Added verbiage)** 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.	224

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(Added bullet points)

▪ Inpatient Hospitalization in a District Part Psychiatric Unit, Medication Assisted Treatment
▪ Freestanding Psychiatric Hospital</td><td>41</td></tr>
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(Added verbiage)

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:</td><td>80</td></tr>
</table>

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	

Covered Behavioral Health Benefits **(Removed verbiage as it was duplicative)** Behavioral Health Services include: • Basic Behavioral Health Services: Services provided through primary care, including but not limited to, screening for mental health and substance abuse issues, prevention, early intervention, medication management, and treatment and referral to specialty services. Specialized Behavioral Health Services: • Licensed Practitioner Outpatient Therapy (Evidence Based Services *Refer to **Claim Filing Instructions** manual for Tracking Codes) o Parent-Child Interaction Therapy (PCIT)Child Parent Psychotherapy (CPP)Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT) o Triple P Positive Parenting Program o Trauma-Focused Cognitive Behavioral Therapy o Eye Movement Desensitization and Reprocessing (EMDR) Therapy o Dialectical Behavior Therapy (DBT) • Mental Health Rehabilitation Services o Community Psychiatric Support and Treatment (CPST) • 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) o Psychosocial Rehabilitation (PSR) o Crisis Intervention o Crisis Stabilization (Ages 0-20) o Crisis Response Services: o Mobile Crisis Response (MCR) (age 21 and over) ▪ Ages 0-20, effective April 1, 2024 o Community Brief Crisis Support (CBCS) (age 21 and over) ▪ Age 0 – 20, effective April 1, 2024 o Behavioral Health Crisis Care (BHCC) (age 21 and over) o Crisis Stabilization for Adults (age 21 and over) • Therapeutic Group Homes (TGH) (Ages 0-20) • Psychiatric Residential Treatment Facilities (PRTF) (Ages 0-20) • Inpatient Hospitalization (Ages 0-21; 65 and older) • Outpatient, Inpatient, and Residential Substance Use Disorder Services • Opioid Treatment Programs (OTPs) • Behavioral Health Personal Care Services for DOJ Agreement Target Population • Individual Placement and Support (IPS) Services for DOJ Agreement Target Population	200

Behavioral health Access and Appointment Standards **(Added verbiage)** 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."	201
Behavioral Health Provider Monitoring Plan **Procedure** **(Added verbiage)** • 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.	209
Websites Resources **(Revised link)** Find a Pharmacy	232

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January 2025 Provider Manual Updates	Page
Table of Contents **(Added Dental Care)**	2
Dental Care **(Added verbiage for 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.**	55
Non-Covered Services **(Added verbiage for children to bullet point** **Routine dental services for children)**	126
Introduction to Credentialing **(Moved verbiage to the beginning of the Credentialing section)** **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.**	170

December 2024 Provider Manual Updates	Page
Important AmeriHealth Caritas Louisiana Telephone Numbers (Changed Dental Phone Numbers) 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) 1-855-702-6262 • DentaQuest (LDH Dental Benefit Manager) 1-800-685-0143 • AmeriHealth Caritas Louisiana Member Services 1-888-756-0004 (Removed Magellan) Pharmacy Benefits Manager – Prime Therapeutics	12
Provider Enrollment in the Louisiana Medicaid Provider Enrollment Portal **(Changed verbiage per IB 24-22 revised 10.28.24)**	18
Enrollee Reassignment Policy **Reassignment** (Added verbiage) • An enrollee will also be eligible for reassignment to another PCP if they have not visited any PCP within the previous 12 months. • 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.	26
Provider Enrollment in the Louisiana Medicaid Provider Enrollment Portal (Changed training title) • Culturally and Linguistically Appropriate Services (CLAS) in Nursing	34
Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies (Added verbiage from IB 24-41https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2024/IB24-41.pdf) 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.	58

• 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.	
Medical Transportation Services (Removed verbiage) TIP terminated 12.31.23 (Changed verbiage) "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.	88
Telemedicine/Telehealth (Made change to verbiage) 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.	113
Therapy Services (Made change to verbiage) Speech therapy, physical therapy, and occupational therapy services are covered to enrollees of any age	114
Tobacco Cessation Services (Made change to verbiage) Tobacco cessation counseling services are covered For dates of service on or after December 1, 2023	114
Vagus Nerve Stimulators (VNS) (Made change to verbiage) Implantation of the vagus nerve stimulator (VNS) is covered Coverage of the surgery to implant the VNS is restricted	116-117
Applied Behavior Analysis (ABA) Ages 0-20 (Made change to verbiage) 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. (Corrected link) Please reference our **Applied Behavior Analysis (ABA)** clinical policy.	120-121
Provider Preventive Conditions (Made change to verbiage) Any days that are attributable to the OPPC are not reimbursed.	125

Pharmacy Services (Removed Magellan, changed verbiage) Prime Therapeutics	128
Pharmacy Prior Authorization (Removed Magellan, changed verbiage) Prime Therapeutics	129
Claims Filing Guidelines (Made change to verbiage) Emailed claim forms are not accepted with no exception. Verification that all diagnosis and procedure codes 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 t • 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 last resort" on all claims submitted.	141
Completion of Encounter Data **(Changed verbiage)** Emailed claim forms are not accepted	141
Claims Mailing Instructions (Changed verbiage) All providers are encouraged to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or **Change Healthcare's Provider Support Line at 1-877-363-3666** to arrange transmission.	143
Claims Filing Deadlines (Changed verbiage) See **exception** below for retro enrollees and Medicare primary enrollees. 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. (Changed verbiage) Ninety percent (90%) of all clean claims of each claim type are processed, paid, or denied as appropriate within fifteen (15) calendar days receipt. One hundred percent (100%) of all clean claims of each claim type are processed, paid, or denied as appropriate within thirty (30) calen 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 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 ch or other form of payment.	143

Wait and See (Changed verbiage) 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.	145
Post-Payment Recoveries (TPL/COB/Encounters/Claim Audits) (Changed verbiage) a letter is sent 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 provide reconciling claims, a letter is sent to the provider detailing the claims impacted by TPL coverage. This letter indicates the 60-day timeline for provider to submit a check or dispute the TPL information. If a response is not received within 60 days, the recoupment process is then initiat We strive to identify and recover claim overpayments within 365 days from the claim's last date of service; however, this timeframe may extended in the following circumstances: • There is evidence of fraud, • There is an established pattern of inappropriate billing, • Enrollee retro-enrollment (Removed verbiage) • A system error is identified.	145
Exclusions to Post Payment Recoveries from Providers (Changed verbiage) payment is recovered	145
Third Party Liability (TPL) (Removed verbiage)	146
Weekly Check Cycles (Changed verbiage) Three (3) provider payment check cycles are run per week	150
Provider Demographic Information (Corrected title) AmeriHealth Caritas Louisiana Health Plan Provider Network Management Department	153

Provider Marketing Activities and Compliance (Removed or, changed verbiage) Added and	161
Member Fraud, Waste and Abuse (Changed phone number & mailing address for Beneficiary FWA Complaints) o Medicaid beneficiary FWA reporting call toll-free 1-833-920-1773 o By mail to: Louisiana Department of Health Program Integrity Unit – Beneficiary Complaints P. O. Box 91030 Baton Rouge, LA 70821	165
Objectives (Hyperlink website) www.amerihealthcaritasla.com	177
Benefits and Service Descriptions (Added statue) ACT 582 La R.S.40:2162	203
Behavioral Health Services Requiring Prior Authorization **(Removed hyperlink to Behavioral Health and Substance Use Disorder Utilization Management Guide)** (Added hyperlink) 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	204-205
	205
Adverse Incident Reporting (Added verbiage) 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:	207
State Fair Hearing (Corrected email address) Email: LDHProcessing@adminlaw.state.la.us	221
Additional Resources (hyperlinked website)	230

Medicaid Website – www.lamedicaid.com	
Appendix **(Changed link to Find a Provider and Find a Pharmacy)** https://www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx	230

Emergency Services (Removed verbiage) AmeriHealth Caritas Louisiana	65
Family Planning Services (Removed verbiage) AmeriHealth Caritas Louisiana addresses	69
Home Health Services (Removed verbiage) Beginning October 2, 2023	76
Immunizations/Vaccines (Added verbiage from IB 24-42) 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).	83

Transcranial Magnetic Stimulation (TMS) (Removed verbiage per IB 24-27 revised 10.28.24) Failure of a full course of evidence based psychotherapy, such as cognitive behavioral therapy for the current depressive episode (Added verbiage per IB 24-27 revised 10.28.24) **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.	116-117

Physical Health In Lieu of Services (ILOS) **Added links to the following:** **Care at Home** https://www.amerihealthcaritasla.com/pdf/provider/resources/care-at-home-in-lieu-of.pdf **Hospital-Based Care Coordination of Pregnant and Postpartum Individuals with Substance Use Disorder (SUD) and their Newborns** https://www.amerihealthcaritasla.com/pdf/provider/resources/provider-hospital-based-care-coordination.pdf **Outpatient Lactation Support** https://www.amerihealthcaritasla.com/pdf/provider/newsletters/2024/103024-provider-alert-outpatient-lactation-support.pdf	119
Applied Behavior Analysis (ABA) Ages 0-20 (Changing verbiage to mirror 2024-ABA-2 https://ldh.la.gov/page/medicaid-provider-manuals) A QHCP is defined as a: • 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: o 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; o 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 o 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. (Adding verbiage from 2024-ABA-2) • Any pediatrician, general practitioner, or NP who has, as part of their practice diagnosed and treated children with ASD and related disorders for at least five years or any pediatrician, or NP whose CDEs were approved to determine the medical necessity for ABA prior to 2023.	120-122
Guidance for Telehealth ABA	123

(Removed verbiage) The purpose of this service is to provide family adaptive behavior treatment guidance, which helps parents and/or caregivers properly use treatment procedures designed to teach new skills and reduce challenging behaviors. (Updated hyperlink) Please reference our **Applied Behavior Analysis (ABA)** clinical policy.	
Pay and Chase (Removed dash per CMS guidelines) CMS 1500	146

AmeriHealth Caritas Louisiana

November 2024 Provider Manual Updates	Page
Ambulatory Surgery – (Outpatient Hospital) (Removed verbiage) AmeriHealth Caritas Louisiana pays	43
Anesthesia Services (Removed verbiage) AmeriHealth Caritas Louisiana requires AmeriHealth Caritas Louisiana reimburses	44
Chiropractic Services for Enrollees (Ages 0-20) (Added verbiage) (s) to treatment	51
Diabetes Self-Management Training (Removed verbiage) AmeriHealth Caritas Louisiana requires (Removed verbiage by the PCP to duplicate the current MCO manual) 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. (Changed verbiage and removed as requested, to Louisiana Medicaid, its authorized representatives, or the state's Attorney General's Medicaid Fraud Control Unit) Enrollee records, facility accreditation, and proof of staff licensure, certification, and educational requirements must be kept readily available to be furnished when requested.	55-57
Diabetic Supplies (Removed verbiage) Starting October 28, 2023 and Effective with dates of service on or after October 28, 2023, the following diabetic supplies will be reimbursed as a pharmacy benefit as well as a durable medical equipment (DME) service. For dates of service on or after December 1, 2023	57

Donor Human Milk - Outpatient (Removed verbiage) AmeriHealth Caritas Louisiana considers (Added from IB 24-07) **NOTE**: Single, manual and hospital-grade breast pumps are still not covered.	59
Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies (Removed verbiage) Continued Medicaid eligibility and AmeriHealth Caritas Louisiana	59

Emergency Services (Removed verbiage) AmeriHealth Caritas Louisiana	65
Family Planning Services (Removed verbiage) AmeriHealth Caritas Louisiana addresses	69
Home Health Services (Removed verbiage) Beginning October 2, 2023	76
Immunizations/Vaccines (Added verbiage from IB 24-42) 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).	83

Transcranial Magnetic Stimulation (TMS) (Removed verbiage per IB 24-27 revised 10.28.24) Failure of a full course of evidence based psychotherapy, such as cognitive behavioral therapy for the current depressive episode (Added verbiage per IB 24-27 revised 10.28.24) **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.	116-117

Physical Health In Lieu of Services (ILOS) **Added links to the following:** **Care at Home** https://www.amerihealthcaritasla.com/pdf/provider/resources/care-at-home-in-lieu-of.pdf **Hospital-Based Care Coordination of Pregnant and Postpartum Individuals with Substance Use Disorder (SUD) and their Newborns** https://www.amerihealthcaritasla.com/pdf/provider/resources/provider-hospital-based-care-coordination.pdf **Outpatient Lactation Support** https://www.amerihealthcaritasla.com/pdf/provider/newsletters/2024/103024-provider-alert-outpatient-lactation-support.pdf	119
Applied Behavior Analysis (ABA) Ages 0-20 (Changing verbiage to mirror 2024-ABA-2 https://ldh.la.gov/page/medicaid-provider-manuals) A QHCP is defined as a: • 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: o 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; o 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 o 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. (Adding verbiage from 2024-ABA-2) • Any pediatrician, general practitioner, or NP who has, as part of their practice diagnosed and treated children with ASD and related disorders for at least five years or any pediatrician, or NP whose CDEs were approved to determine the medical necessity for ABA prior to 2023.	120-122
Guidance for Telehealth ABA	123

(Removed verbiage) The purpose of this service is to provide family adaptive behavior treatment guidance, which helps parents and/or caregivers properly use treatment procedures designed to teach new skills and reduce challenging behaviors. (Updated hyperlink) Please reference our **Applied Behavior Analysis (ABA)** clinical policy.	
Pay and Chase (Removed dash per CMS guidelines) CMS 1500	146

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October 2024 Provider Manual Updates	Page
Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies (Added verbiage from IB 24-34) 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	59
Laboratory Services (Added verbiage from IB 24-31) 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.	87-88

• 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.**	
Pain Management **Chronic Intractable Pain** (Removed verbiage) AmeriHealth Caritas Louisiana's coverage policy includes the provisions within this section	98
Pharmacy Services (Removed verbiage) AmeriHealth Caritas Louisiana	104
Physician Administered Medication (Removed verbiage) AmeriHealth Caritas Louisiana	104
Physician/Professional Services (Removed verbiage) AmeriHealth Caritas Louisiana	105-106
Physical Health In Lieu of Services (ILOS) (Added link to policy) Care at Home	118

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September 2024 Provider Manual Updates	Page
Table of Contents (Added verbiage Transcranial Magnetic Stimulation (TMS)	4
Bariatric Surgery (Changed symbol to 2) 40 kg/m²	45-46
Cardiovascular Services (Changed verbiage) Endovascular revascularization procedures for the lower extremity are not considered and	50
Diabetic Supplies (Changed verbiage) In accordance with La. R.S. 46:450.8, continuous glucose monitors, and other diabetic supplies are reimbursed as a pharmacy benefit	57
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Program (Ages 0-20) **(Changed verbiage)** Though the screening is administered to the caregiver, this service is reimbursed under the child's Medicaid coverage.	63
Emergency Services (Changed verbiage) Emergency services, including those for specialized behavioral health, may be rendered Payment is not denied for treatment when a representative of AmeriHealth Caritas Louisiana instructs the enrollee to seek emergency services and payment is not denied for treatment	65
End Stage Renal Disease Services (Removed verbiage AmeriHealth Caritas provides)	67

Family Planning Services (Changed verbiage) Family planning providers are encouraged Assisted reproductive technology is not reimbursed	69
Genetic Counseling and Testing (Changed verbiage) services using the procedure code specific to genetic counseling are reimbursed counseling under an applicable evaluation and management code is reimbursed	70
Immunizations/Vaccines (Changed verbiage) only vaccine administration for immunizations recommended by the Advisory Committee on Immunization practices (ACIP) are covered	81
Laboratory Services (Changed verbiage) CLIA claim edits are applied Claims are edited Laboratory services furnished in an office or similar facility other than a hospital outpatient department or clinic are covered Specimen collection are not reimbursed separately Presumptive and definitive urine drug testing is covered	85-86
Limited Abortion Services (Changed verbiage) Providers are not reimbursed	87

Medical Transportation Services (Changed verbiage) 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 Oxygen and disposable supplies are reimbursed "Ambulance 911-Non-emergency" services are not covered Every effort is made to schedule urgent transportation requests and a request is not denied 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	88-90
Newborn Care and Discharge (Changed verbiage) Up to three normal newborn subsequent care days are covered **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. A baby **detained** after the mother's discharge is regarded as a new admission requiring separate authorization. The admission must be reported to our	92
Nursing Facility/Non-Hospital Facility (Changed verbiage) our Utilization Management (UM) Department. Necessary arrangements are coordinated by UM Placement in a Nursing Facility for rehabilitation, skilled nursing, or short-term needs for nursing facility services is covered.	93
Obstetrics **(Changed verbiage)** 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	94

Transcranial Magnetic Stimulation (TMS) (Adding from IB 24-27 revised 8.23.24,since the TMS procedure codes have been added to the LA Medicaid Professional Services and not only to the Specialized Behavioral Health Fee Schedule it's ok to add TMS to PH covered services) 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 of a full course of evidence-based psychotherapy, such as cognitive behavioral therapy for the current depressive episode • Failure or intolerance to psychopharmacologic agents, choose one of the following: o 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 o 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. Please refer to the **Claim Filing Instructions** manual for billing guidelines on TMS.	114-115
Prescription Co-Payments (Added co-payments) $0.00 $5.00 or less $0.50 $5.01 to $10.00	129

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August 2024 Provider Manual Updates	Page
Table of Contents (Added verbiage Cardiovascular Services)	2
Allergy Testing and Allergen Immunotherapy (Removed verbiage AmeriHealth Caritas Louisiana covers)	41
Cardiovascular Services (Added exclusions from page 132 in the current MCO manual) AmeriHealth Caritas Louisiana does not consider endovascular revascularization procedures for the lower extremity 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.	50
Gynecology (Added verbiage from the Louisiana Medicaid Professional Services manual) 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.	75
Home Health Services (Changing the verbiage for the PHB and adding the claims denied verbiage to the CFI) Effective April 1, 2024, services are not payable if providers are not utilizing EVV system.	77
Immunizations/Vaccines (Moved to the CFI and added reference to CFI at the bottom of this section)	82-83

AmeriHealth Caritas Louisiana requires providers to indicate the CPT code for the specific vaccine in addition to the appropriate administration CPT code(s) to receive reimbursement for the administration of appropriate immunizations. The listing of the vaccine on the claim form is required for federal reporting purposes. Vaccines from the Vaccines for Children Program are available at no cost to the provider and are required to be used for Medicaid enrollees through 18 years of age. Therefore, AmeriHealth Caritas Louisiana reimburses CPT codes for vaccines available from the VFC Program at zero ($0) for every enrollee from birth through 18 years of age.	
Second-Level Claim Disputes (Changed 30 days to 90 days)	156
Behavioral Health In Lieu of Services (ILOS) (Removed verbiage Therapeutic Day Center for Ages 5-20 due to center closing in April 2024) The Center for Resilience is a therapeutic day center which provides educational and intensive mental health supports in an innovative partnership with the Tulane University Medical School Department of Child and Adolescent Psychiatry to ensure the emotional well-being and academic readiness of children with behavioral health needs. Children receive instructional, medical, and therapeutic services at the day program site with the goal of building the skills necessary to successfully transition back to the traditional school setting. Center for Resilience provides a caring, non-punitive, therapeutic milieu with positive behavioral supports, trauma-informed approaches, evidence-based mental health practices, small-group classroom instruction, and therapeutic recreation activities. The leadership team is comprised of clinicians, educators, and medical doctors, and the therapeutic milieu is a result of this intentionally interdisciplinary collaboration. The goal of this ILOS is to reduce incidents of crisis hospitalization and residential psychiatric care.	192-193
Behavioral Health Personal Care Services (Removed verbiage since it is related to claims filing and moving it to the CFI. Inserting reference to CFI for BH Personal Care Services (PCS) billing instructions at the end of the section) Claims may deny for reimbursement if providers fail to use the system as directed (Changed the number sequencing and added verbiage Please refer to the **Claim Filing Instructions** manual for Behavioral Health PCS billing guidelines)	193-194
Behavioral Health Services Requiring Prior Authorization (Removed verbiage In Lieu of: Therapeutic Day Center (age 5-20))	203

Standard Appeals (Changed verbiage to mirror the upcoming verbiage update to the MCO manual) https://ldh.la.gov/assets/medicaid/MCPP/MCO_Manual_3.0_Claim_Reconsideration_Appeal_and_Arbitration_06.27.24.pdf 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 expedited appeal either orally or in writing within 90 calendar days from the date on the determination letter, from the original request for claim reconsideration .	217

July 2024 Provider Manual Updates	Page
Cardiovascular Services (Added verbiage LDH MCO manual draft for upcoming update to manual from link below): https://ldh.la.gov/assets/medicaid/MCPP/6.6.24/2024-LDH-11_ICA_Policy_Correction.pdf 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.	48
Preferred Drug List (Corrected the link for the complete list of preferred products)	126
Standard Appeals (Removed 60 calendar days and changed it to 90 calendar days)	217

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June 2024 Provider Manual Updates	Page
Table of Contents (Added Concurrent Care-Inpatient and Corneal Collagen Cross-Linking)	2
Covered Services (Added Corneal Collagen Cross-Linking to Physical Health Services)	38
Behavioral Health Services (Removed verbiage refer to the Behavioral Health Services Manual chapter of the Medicaid Services Manual and its appendices for a specialized behavioral health services). (Removed Individual Evidenced Based Practices) (Added Dialectical Behavior Therapy) (Added Evidence-Based Programs specialized for high-risk populations, including from 6.5.24 update to MCO manual) (Removed Group Evidenced Based Practices as CPST per 6.5.24 MCO Manual) (Added verbiage for youth by Crisis Stabilization per 6.5.24 MCO Manual)	39
Crisis Responses Services (Added verbiage to mirror 6.5.24 MCO Manual) o Mobile Crisis Response (Ages 21+) ➢ Ages 0-20, effective April 1, 2024 o Community Brief Crisis Support (Ages 21+) ➢ Ages 0-20, effective April 1, 2024 o Behavioral Health Crisis Care (Ages 21+) o Crisis Stabilization for Adults (Ages 21+) o Peer Support Services (Ages 21+) (Added Inpatient to Substance Use Disorder Services per 6.5.24 MCO Manual) (Added OTPs to Opioid Treatment Program Services per 6.5.24 MCO Manual) (Added Behavioral Health Personal Care Services for DOJ Agreement Target Population and Individual Placement and Support (IPS Services for DOJ Agreement Target Population per 6.5.24 MCO Manual) (Removed bullet points from under Individual Placement and Support Services for DOJ Agreement Target Population: Personal Care Services, Mobile Crisis Response, Community Brief Crisis Support, Behavioral Health Crisis Care, Crisis Stabilization per 6.5.24 MCO Manual)	40
Concurrent Care-Inpatient (Added verbiage) 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	53

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 (Added all verbiage under title per IB 24-17).	53
Gynecology (Removed verbiage because this is claim filing instructions) The primary surgeon's claim requires hard copy submission with a valid consent form and the primary surgeon is expected to share copies of the completed consent forms to facilitate ancillary provider billing for hysterectomy services. Ancillary providers include the assistant surgeon, anesthesiologist, hospital, and/or ambulatory surgical center. If an ancillary provider submits a claim for hysterectomy services without the appropriate consent form, the claim is paid only if the primary surgeon's claim has been approved. The ancillary provider's claim may be held for up to 30 days pending review of the primary surgeon's claim. If the primary surgeon's claim has not been approved during this timeframe, the claim will deny. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim hard-copy with the appropriate consent form. (Added verbiage) Please refer to the **Claim Filing Instructions** manual for detailed instructions on filing for a hysterectomy claim). (Added verbiage 5/21/24 update to the LA Medicaid Prof Services manual page 3 of 9 under Gynecology section that was approved through Act 319 public posting and from IB 24-18) Effective June 1, 2024, AmeriHealth Caritas Louisiana covers one mammogram (either film or digital) 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.	73-74

• 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.	
Laboratory Services (Added verbiage from IB 24-16) Effective May 1, 2024, 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.	86

Sterlization (Removed verbiage and adding to the CFI) For services requiring a sterilization consent form, the enrollee's name on the Medicaid file for the date of service must be the same as the name signed at the time of consent. If the enrollee's name is different, the provider must attach a letter from the provider's office from which the consent was obtained. The letter must be signed by the physician and must state the enrollee's name has changed and must include the enrollee's social security number and date of birth. The informed consent must be obtained and documented prior to the performance of the sterilization. Errors in the following sections can be corrected, but only by the person over whose signature they appear: • "Consent to Sterilization," • "Interpreter's Statement," • "Statement of Person Obtaining Consent," and • "Physician's Statement". If either the enrollee, the interpreter, or the person obtaining consent returns to the office to make a correction to his/her portion of the consent form, the medical record must reflect his/her presence in the office on the day of the correction. To make an allowable correction to the form, the individual making the correction must line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction. Erasures, "write-overs," or use of correction fluid in making corrections are unacceptable. Only the enrollee can correct the date to the right of their signature. The same applies to the interpreter, to the person obtaining consent, and to the doctor. The corrections of the enrollee, the interpreter, and the person obtaining consent must be made before the claim is submitted. The date of the sterilization may be corrected either before or after submission by the doctor over whose signature it appears. However, the operative report must support the corrected date. The sterilization consent form or a physician's written certification must be obtained before providers may be reimbursed. Ancillary providers and hospitals may submit claims without the hard copy consent. However, providers may only be reimbursed if the surgeon submitted a valid sterilization consent and was reimbursed for the procedure. (Added Please refer to the **Claim Filing Instructions** manual for more details on filing a claim for a sterilization).	111-112

Therapy Services (Added verbiage LA Medicaid Hospital Services manual). Therapy evaluations do not require an authorization but are limited to one evaluation per 180 days. (Added verbiage) **Please refer to the Claim Filing Instructions manual for specific CPT/HCPCS codes limited to 180 days.**	114
Covered Behavioral Health Benefits (Added Dialectical Behavior Therapy (DBT)) (Added verbiage) o Crisis Response Services: o Mobile Crisis Response (MCR) (age 21 and over) ▪ Ages 0-20, effective April 1, 2024 o Community Brief Crisis Support (CBCS) (age 21 and over) ▪ Age 0 – 20, effective April 1, 2024 o Behavioral Health Crisis Care (BHCC) (age 21 and over) (Added Inpatient to bullet point Outpatient, Inpatient, and Residential Substance Use Disorder Services) (Removed Medication Assisted Treatment) (Added Opioid Treatment Programs (OTPs); Behavioral Health Personal Care Services for DOJ Agreement Target Population and Individual Placement and Support (IPS) Services for DOJ Agreement Target Population)	197

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May 2024 Provider Manual Updates	Page
Table of Contents (Added Vaccines to Immunizations)	3
Covered Services (Added Vaccines to Immunizations)	38
After Hours Care on Evenings, Weekends, and Holidays (Removed definition of CPT). AmeriHealth Caritas Editorial Style Standards on page 15 includes CPT as abbreviations that do not need to be defined.	41
Diabetic Supplies (Added verbiage from IB 23-11) External insulin pumps (e.g., Cequr Simplicity, Omnipod and V-Go)	56
Newborn Care and Discharge (Removed verbiage because this is in CFI and is a billing instruction). These services must be billed under the newborn's Medicaid ID. AmeriHealth Caritas Louisiana 's policy for discharge services shall include the following: When the date of discharge is after the admission date, the provider shall submit claims for newborn hospital discharge services using the appropriate CPT code for hospital day management code. When newborns are admitted and discharged on the same date, the provider shall use the appropriate code for these services. All detained baby or other newborn admission charges must be billed on a separate invoice. (Added link to CFI) Please refer to the **Claim Filing Instructions** manual for details on billing for Newborn Care and Discharge.	91-93
Obstetrics (Removed verbiage) The appropriate level E&M CPT procedure code is required to be billed for the initial prenatal visit with the TH modifier. A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis. If the pregnancy is not verified, or if the pregnancy test is negative, the service may only be submitted with the appropriate level E&M without the TH modifier.	93 -95

AmeriHealth Caritas Louisiana requires the provider to submit the appropriate level E&M CPT code from the range of procedure codes used for an established patient for the subsequent prenatal visit(s). The E&M CPT code for each of these visits must be modified with the TH modifier. The postpartum care CPT code (which is not modified with –TH) shall be reimbursed for the postpartum care visit when performed. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. (Added verbiage) Please refer to the **Claim Filing Instructions** manual for detailed instructions on how to bill all claims related to obstetrics/maternity services.	
Substitute Physician Billing (Removed verbiage) The enrollee's regular physician may submit the claim and receive payment for covered services which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if: • The regular physician is unavailable to provide the services. • The substitute physician does not provide the services to Medicaid enrollees over a continuous period of longer than 60 days. If the regular physician does not come back after the 60 days, the substitute physician must bill for the services under his/her own Medicaid provider number. • The regular physician identifies the services as substitute physician services by entering the HCPCS modifier - Q5 after the procedure code on the claim. By entering the -Q5 modifier, the regular physician (or billing group) is certifying that the services billed are covered services furnished by the substitute physician for which the regular physician is entitled to submit Medicaid claims. (Added verbiage) Please refer to the **Claim Filing Instructions** manual for billing instructions on substitute physician and locum tenens arrangement billing.	112-113

Applied Behavior Analysis (ABA) Ages 0-20 (Updated verbiage according to the 4/22/24 revision of the LA Medicaid Applied Behavior Analysis manual (from Act 319 public posting) and IB 24-13). • Psychiatrist (particularly Pediatric and Child Psychiatrist) • A pediatrician under a joint working agreement with an interdisciplinary team of providers who are qualified to diagnose developmental disabilities; A valid Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) or current edition, diagnosis; The licensed supervising professional shall provide case oversight and management of the treatment team by supervising and consulting with the beneficiary's team. The licensed supervising professional must also conduct regular meetings with family members to plan, review the beneficiary's progress and make any necessary adjustments to the behavior treatment plan. Part of the supervision must be done in the presence of the beneficiary receiving treatment and state-certified assistant behavior analyst or the registered line technician. 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 nor more than 24 technicians a day. More technicians may be supervised if a Certified Assistant Behavior Analysis (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 10 CaBAs.	117 -119
Telehealth Requirements for Applied Behavior Analysis (ABA) (Updated verbiage according to the 4/22/24 revision of the LA Medicaid Applied Behavior Analysis manual (from Act 319 public posting). Louisiana Medicaid reimburses the use of telehealth, when appropriate, for rendering certain ABA services for the care of or to support the caregivers of enrollees. (Removed verbiage) An established patient is defined as one who already has an approved and a prior authorized treatment plan. An existing prior authorization does not need an addendum to be eligible for telehealth delivery. However, new patients still (Added verbiage) 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.	119

Guidance for Telehealth ABA (Added verbiage) Please refer to the **Claim Filing Instructions** manual for billing guidelines on ABA therapy.	120
Tobacco Cessation for Pregnant Women (Removed verbiage) Claims for services exceeding the limits must be submitted via hardcopy with supporting documentation. The documentation must detail the enrollee's failed attempts to stop using tobacco products, and that the enrollee still desires to quit. Documentation must demonstrate at a minimum that the enrollee was: Asked about tobacco use; Informed of the impact of smoking and advised to quit; Assessed for the willingness to attempt to quit; Assisted with setting a quit date; Assisted with the attempt to quit by providing methods and skills for quitting; and Arranged for follow-up counseling. AmeriHealth Caritas Louisiana requires the -TH modifier to be included on claims for tobacco cessation counseling within the prenatal period. The -TH modifier is not to be used for services in the postpartum period. If tobacco cessation counseling is provided as a significant and separately identifiable service on the same day as an E&M visit, and is supported by clinical documentation, a modifier to indicate a separate service may be used, when applicable. (Added verbiage) Please refer to the **Claim Filing Instructions** manual for billing guidelines on tobacco cessation for pregnancy women.	188

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Anesthesia Services (Removed verbiage since it is included in the Claim Filing Instructions) Minutes must be reported on anesthesia claims; Reimbursement for these services is a flat fee, except for general anesthesia for vaginal delivery. Moderate sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care.	44
Diabetic Supplies (Added from 3/18/24 update in the LA Medicaid DME Provider Manual) NOTE: Insulin pumps requiring tubing and supplies are still covered as DME. All reservoirs and canisters are covered through DME as well.	57
Donor Human Milk – Outpatient (Added new verbiage from the LA Medicaid DME Provider Manual 3/18/24 update) AmeriHealth Caritas Louisiana considers personal use, double and electric breast pumps 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. 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. Please refer to the **Claim Filing Instructions** manual for more details on breast pump claim filing.	58
Laboratory Services (Added verbiage from the update to the LA Medicaid Professional Services manual) Proprietary Laboratory Analyses (PLA) testing is covered when used for the particular "brand" respiratory panel kit as stated within the Current Procedural Terminology (CPT) codebook. PLA codes must be used with the specific device or kit. "Services should not be reported with any other CPT code and other CPT codes should not be used to report services that may be reported with that specific PLA code."	86

The expectation is that the procedure codes are billed in accordance with CPT guidelines.	
Pediatric Day Healthcare Services (Ages 0-20) (Added verbiage from IB 24-5) PDHC providers are not allowed to send enrollees to outside sources to receive the above services.	98
Radiology Services (Added verbiage from the LA Medicaid Professional Services manual) 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.	108
Telehealth Requirements for Applied Behavior Analysis (ABA) (Added topic and description back)	120

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Covered Services (Added Portable Oxygen Concentrators)	38
Anesthesia Services (Changed verbiage to the LDH 10/16/23 revision of the Professional Services Provider Manual through Act 319 public posting).	44
Diabetic Supplies (Added this from the 10/30/23 update to LA Medicaid DME Provider Manual through Act 319 public posting. Condensed verbiage.	57
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) (Added Basic lab services (specific to RHCs)…. because it's only listed in the LA Medicaid RHC Provider Manual and not the FQHC Provider Manual.	69
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) (Added verbiage from: FQHC manual, Section 22.1, page 8 of 12 and 10 of 12. RHC manual, Section 40.1, page 9 of 13 and 10 of 13 Note: DSMT and Fluoride Varnish applications are covered but these services alone do not constitute…..	69
Home Health-Extended Services (Ages 0-20) (Updated section according to LDH 12/12/23 revision in Home Health Provider Manual through Act 319 public posting). Changed PAU to Utilization Management because we do not use Prior Authorization Unit (PAU) language for UM.	75
Home Health-Extended Services (Ages 0-20) (Changed verbiage to what is currently in the LA Medicaid Home Health Provider Manual). Medical supplies bullet point	75
Home Health-Extended Services (Ages 0-20) (Changed verbiage to what is currently in the LA Medicaid Home Health Provider Manual). Note: For the initiation of home health services….	75
Home Health-Extended Services (Ages 0-20) (Added verbiage: if not enrolled in NaviNet, through the Medicaid Eligibility Verification System (MEVS)).	76

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Medical Transportation Services (Added from LDH 9/25/23 update to Medical Transportation Provider Manual from Act 319 public posting). Services shall be provided in accordance with Louisiana Administrative Code (LAC), Title 50, Part XXVII, Chapter 5.	87
Portable Oxygen (Removing verbiage from IB 23-3 and 23-17 and changing to updated verbiage in LA Medicaid DME manual as well as separating both out as it is in the manual).	105
Portable Oxygen Concentrators (Removing verbiage from IB 23-3 and 23-17 and changing to updated verbiage in LA Medicaid DME manual as well as separating both out as it is in the manual).	106
AmeriHealth Caritas Louisiana's Corporate Confidentiality Policy (Added bullet point: Certain sensitive demographic data)	224

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Home Health Services (Added verbiage from Informational Bulletin 23-14 revised January 19, 2024)	76
Tobacco Cessation Services (Added verbiage from current MCO Manual dated December 13, 2023)	113-114
Somatus Program (Added verbiage about the Program)	183

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Table of Contents (Added Enrollment to Section II)	17
Provider Enrollment in the Louisiana Medicaid Provider Enrollment Portal (Added verbiage from Informational Bulletin 22-38)	18-19

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Enrollee Reassignment Policy (Updated verbiage to reflect recently distributed provider notification ACLA Enrollee PCP Reassignment Dispute Process from 11/15/2023)	23
Early Steps (Corrected link to Early Steps)	186
Integrated Healthcare Screening (Added under Section III Covered Services)	196
Additional Resources (Corrected link to http://ldh.la.gov/page/documents)	223
Website Resources (Corrected link to Find a Provider)	224

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Enrollment Process (Updated Pharmacy Member & Provider Services phone numbers to Magellan	15
Verifying Eligibility (Corrected link to LDH website)	16
Providers Who Quality to Serve as PCPs (Changed definition of PCP to match what is in the contract)	19
Access and Communications (Corrected Phone Numbers for ACLA Provider Services)	21
Enrollee Reassignment Policy (Added verbiage medical records, proof of billed claims, etc. for at least one date of service)	23
Enrollee Reassignment Policy (Added verbiage under How does ACLA determine enrollee reassignments and Where can you find reports to review your roster?)	24
Americans with Disabilities Act (ADA) (Corrected link to Department of Justice's ADA Home Page)	27
Covered Services (Added Pregnancy-Related Services)	36
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Routine Care provided to Enrollees Participating in Clinical Trials (Corrected link to Medicaid.gov)	104
Provider Preventable Conditions (Corrected links to 42 C.F.R 447.26)	118
Pharmacy Services (Corrected link to Diabetic Supplies)	121
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Pharmacy Prior Authorization (Corrected link to Prior Authorization Requests and corrected link to Pharmacy website)	122

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Prescription Co-payments (Corrected link to Participating Pharmacies)	123
Prior Authorization Determinations (Added verbiage starting with Only licensed clinical professionals	125
Medically Necessary Services (Removed verbiage and added LDH's definition for bullet point starting with these for which)	127
Letters of Medical Necessity (Removed Department of Health & Hospitals and changed it to Louisiana Department of Health)	128
Medical Necessity Decision Making (Removed verbiage not at Medical Director's discretion)	128
Table Timeliness of UM Decision (Added verbiage for CPST/PSR and BH Crisis response)	129-130
Claims Filing Deadlines (Corrected to 15 calendar days; removed business days) (Added verbiage starting with One hundred percent of pended claims…)	137
Cost Avoidance (Removed Pay and Chase verbiage from this section) (Added verbiage up to Medicaid allowable amount)	137
Pay and Chase (Added verbiage starting with liable third parties…) (Removed responsible parties) (Added verbiage starting with EPSDT referral…. And added link to EPSDT fee)	137-138
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Provider's Rights at the Hearing (Removed bullet point Improvement Committee within 45 days of receipt of the notice of the appeal)	174
Gambling Addiction (Corrected link to Gambling Problem)	183
Early Steps (Corrected link to Early Steps website)	184
Behavioral Health Access and Appointment Standards (Removed BH Life Threating Emergent Care and Behavioral Health Non-Life-Threatening Emergent Care and the Standards)	190
Covered Behavioral Health Benefits (Spelled out the acronym EMDR Therapy)	191
Glossary of Acronyms (Put in alphabetical order)	194
PSR and CPST Providers (Added link to Medicaid Behavioral Health Services Provider Manual)	197
Behavioral Health Services Requiring Prior Authorization (Added link to Prior Authorization Lookup Tool)	197
Behavioral Health Services that do not require prior authorization (Removed verbiage under In Lieu of Services for Crisis Intervention Services for all Medicaid eligible Adults 21 and above)	199
Behavioral Health Provider Monitoring Plan (Corrected link to LDH's website)	199
Adverse Incident Reporting (Corrected Department of Children and Family Services) (Removed ages 59 and changed to 60 & over or adults with disabilities)	200
State Fair Hearing (Corrected link to Division of Administrative Law) (Added link to form on Dal's website) (Corrected address for Division of Administrative Law)	214
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Medicaid Program Overview (removed https:// and added www. to ldh.la.gov/page/319)	13
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PCP and Specialist Cultural and Linguistic Requirements (added hyperlink to training Culturally Competent Nursing Care: A Cornerstone of Caring)	30
Diabetic Supplies (added October 28, 2023, removed October 1, 2023) (added content starting with effective)	54
Eye Care and Vision Services (added bullet points)	64
Inpatient Hospital Services (added content starting with rapid whole genome)	75
Medical Transportation Services (added content starting with including carved-out services) (correcting AmeriHealth Caritas Louisiana must inform transportation providers if an enrollee intends to bring accompanying children or if an attendant is required.	83
Medical Transportation Services (added content starting with however, can be subject to a post-payment review after service delivery) (added content starting with including carved-out services)	84
Medical Transportation Services (added bolded content: If transportation is scheduled through the ambulance provider, AmeriHealth Caritas Louisiana requires the ambulance provider to verify the **following prior to reimbursement**)	85
Medical Transportation Services (added content starting with Exceptions)	86
Routine Care Provided to Enrollees Participating in Clinical Trials (removed https:// and added www. to medicaid.gov/resources-for-states/downloads/medicaid-attest-form.docx)	103
Physical Health In Lieu of Services (added content starting with Hospital-Based Care Coordination)	111

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Pharmacy Services (removed https:// and added www. to amerihealthcaritasla.com/pdf/pharmacy/preferred-diabetic-supplies.pdf) (added the word Tool to Prior Authorization Lookup Tool)	120
Preferred Drug List and Coverage of Brand Name Products (removed https:// and added www. to ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf)	120
Pharmacy Prior Authorization (removed https:// and added www. to amerihealthcaritasla.com/pharmacy/priorauth.aspx)	121
Independent Review Process (added content starting with An IRR may be mailed to)	149
Request for Independent Review (removed https:// and added www. to amerihealthcaritasla.com/pdf/provider/resources/forms/independent-review-provider-reconsideration-form.pdf)	150
Follow-Up Procedure for Identified Deficiencies (added bolded content .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.	153
Let Us Know (removed https:// and added www. to amerihealthcaritasla.com/pdf/provider/resources/forms/member-intervention-request-form.pdf)	178
Bright Start Program for Pregnant Enrollees (removed Makena and 17-P)	180
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Important AmeriHealth Caritas Louisiana Telephone Numbers (added provider portal and note under Navinet about claim reconsiderations)	12
Important AmeriHealth Caritas Louisiana Telephone Numbers (Added PerformRx's term date and Magellan's effective date 10/28/2023)	12
Table of Contents (removed Glucose Monitoring Devices in TOC and added Diabetic Supplies)	1, 54 (content)
Portable Oxygen (added verbiage from IB 23-17 dated 9-15-23)	99
Non-Covered Services (added verbiage about drugs and biologicals discarded are not administered to any patient appended with JW modifier refer to CFI manual for instructions on how to bill the administered portion and the discarded portion)	115
Pharmacy Services (added live link for Prior Authorization Lookup and the term date for PerformRx and effective date/contact information for Magellan Medicaid Administration)	119
Pharmacy Prior Authorization (added the term date for PerformRx and effective date/contact information for Magellan Medicaid Administration)	120
TPL Payment & TPL Payment Calculation (Adding TPL Payment & TPL Payment Calculation)	137
Weekly Check Runs (removed the number two and corrected it to three for provider payment cycles per week)	140

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Facility and Organizational Provider Requirements (added verbiage from IB 23-18 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	162
Table 1: Special Health Needs Population (added acronym Enrollees with Special Health Care Needs (SHCN)	177
Benefit & Service Descriptions: (added Child Parent Psychotherapy, Parent Child Interaction Therapy, Preschool PTSD Treatment and Youth PTSD Treatment, Triple P Positive Parenting Program, Trauma focused Cognitive Behavioral Therapy, and Eye Movement Desensitization and Reprocessing)	193
Behavioral Health Services Requiring Prior Authorization (added In Lieu of: Therapeutic Day Center (age 5-20) In Lieu of: Intensive Outpatient Program In Lieu of: Mental Health Intensive Outpatient Program)	195
Behavioral Medical Records Requirements (added verbiage on member rights, assessments, crisis plan, continuity and coordination of care, medication management, discharge plan, organization of records/record entries and corrections, service/progress notes, progress summaries, discharge summary for transfers and closures)	198

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End Stage Renal Disease Services (removed beneficiary's and added enrollee's)	63
Gynecology (removed beneficiary's and added enrollee's)	70
Circumcisions (removed age restriction)	86
Pain Management	91
Personal Care Services (Ages 0-20) (removed beneficiary's and added enrollee's under specialized aide procedures)	95
Physician Administered Medication (added except Antiemetic/Antivertigo Agents therapeutic class). At a minimum, administration of the medication may be billed using the lowest office visit 9CPT procedure code 99211) if a higher-level evaluation and management visit has not been submitted for that date by the rendering provider. Any alternative reimbursement for medication administration must be equivalent to or greater than the reimbursement for CPT code 99211..	97
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Specialized Behavioral Health Services Individual Evidenced Based Practices (added)	33
Group Evidenced Based Practices as CPST Multi Systemic Therapy (age 0-20); Functional Family Therapy and Functional Family therapy Child Welfare (age 0-20) (added)	33-34
Peer Support Services; Individual Placement Services; Personal Care Services; Mobile Crisis Response; Community Brief Crisis Support, Behavioral Health Crisis Care; Crisis Stabilization (added)	34
Mental Health Rehabilitation Services Multi Systemic Therapy (age 0-20); Functional Family Therapy and Functional Family therapy Child Welfare (age 0-20) (Removed)	35
Policies and procedures physical health ILOS: Chiropractic Services for Adults Age 21 and Older (added hyperlink) Doula Services (added hyperlink) Remote Patient Monitoring (added hyperlink)	108
QHCP definition (updated)	110-111
Licensed individual that has been approved by the AmeriHealth caritas Louisiana's medical director as meeting the requirements of a QHCP when: The 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; and The individual has at least two years of experience providing such diagnostic assessments and treatments. (removed)	121
Behavioral Health In Lieu of Services (ILOS) Behavioral Health Crisis Care and Crisis Stabilization Units for Adults Ages 21 and Older (removed)	183-184

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