Provider Manual

TRANSFORMING HEALTH TOGETHER

louisiana healthcare connections™

Inside

Last Revised: April 2024. The current version of the Louisiana Healthcare Connections Provider Manual can be found online at: *LaHealth.cc/provider-resources*.

Thank you.

As a health care provider, you are a leader in our shared purpose – **transforming Louisiana's health, one person at a time**.

You know all-too-well the litany of chronic challenges resulting in our state's near-worst-in-the-nation health outcomes, year after year. Moving beyond poverty, cultural forces, historic inequities, structural constraints, and under-funding requires that the entire health care system work collaboratively and in innovative ways to care for the people entrusting their health to us.

We believe that providing our members – your patients with physical, mental, and social wellbeing is more than providing insurance – it's the pursuit of health equity. And we seek your partnership in that pursuit.

Within this document, you will find the sort of administrative procedures about eligibility, claims and authorizations you would expect. Simplifying the administrative process of delivering health care is a high priority for us, and we welcome your input and partnership in continuously improving the way we do business together.

You will *also* find a wealth of resources for your practice and patients that you may not expect. Services like transportation, real-time interpretation, 24/7 nurse advice, above-and-beyond benefits, health incentives, in-person consultants, community health workers, care coordinators and more, all available at no cost to you or your patients. Please, take advantage of them for the health of your patients – our members.

Again, **thank you** for the care you provide to those with the greatest needs in our community. We're proud to be your ally in transforming the health of our state.

Supporting Your Practice

KEY CONTACTS

Provider Services Answers provider questions, including verification of eligibility, authorization, claim inquiries and appeals	1-866-595-8133 Fax: 1-866-768-9374
Demographic Updates Accurate provider information is critical to members' access to care. Submit demographic changes, including: address, phone number, Tax Identification Number (TIN), office hours, billing information, panel status, and other key information.	LHCC_PDM@CENTENE.COM
Provider Relations We're here to help! Our local representatives visit provider offices, conduct webinars and consult over the phone to provide quality and administrative support.	1-866-595-8133
Network Manager Manages the provider relations team. Resolves high-level concerns and network development.	Joe Tidwell, Vice President, Network Development & Engagement, Joetidwell@LouisianaHealthConnect.com
Clinical Services Team of clinicians who will assist with referrals, authorizations and provider guidance regarding treatment plans and Outpatient Treatment Review.	1-866-595-8133 Fax: 1-888-725-0101
Clinical Trainers In-depth provider education as it pertains to treatment plans and utilization management.	1-866-595-8133
Authorizations, Concurrent Review, Care Management	1-866-595-8133 Fax numbers: IP PH: 1-877-401-8175 IP BH: 1-866-698-6341 BH OP: 1-888-725-0101 Concurrent Review: 1-877-668-2080 Chisholm/PAL: 1-877-668-2076

When calling, please have the following information available:

- National Provider Identifier (NPI) number
- Tax ID Number (TIN) number
- Member's Medicaid ID number

State Departments

Department Name	Phone
Louisiana Department of Children and Family Services	1-888-524-3578
Louisiana Department of Health	1-225-342-9500
Louisiana Medicaid (Healthy Louisiana)	1-855-229-6848
Louisiana Medicaid Enrollment Broker	1-888-342-6207
Office of Behavioral Health	1-225-342-2540
Office of Juvenile Justice	1-225-287-7900
Office of Education	1-877-453-2721
Office of Citizens with Developmental Disabilities	1-225-342-0095

Claims and Appeals Addresses

Paper Claims Submission

Louisiana Healthcare Connections
Attn: Claims
P.O. Box 4040
Farmington, MO 63640-3826

Electronic Claims Submission

Louisiana Healthcare Connections
c/o Centene EDI
1-800-225-2573 Ext. 25525
EDIBA@centene.com

Claim Appeals

Louisiana Healthcare Connections
Attn: Claim Appeals
P.O. Box 4040
Farmington, MO 63640-3826

Medical Necessity Appeal

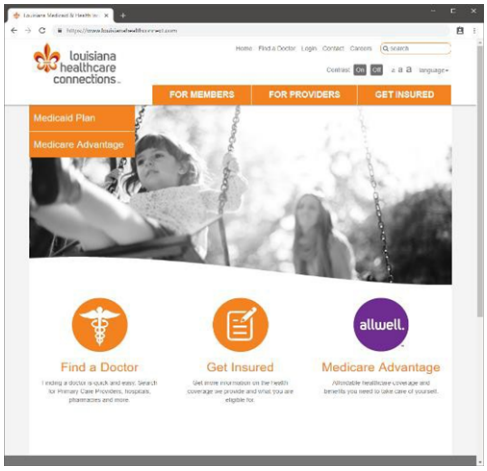
Louisiana Healthcare Connections
Attn: Medical Necessity
P.O. Box 84180
Baton Rouge, LA 70884

ONLINE RESOURCES

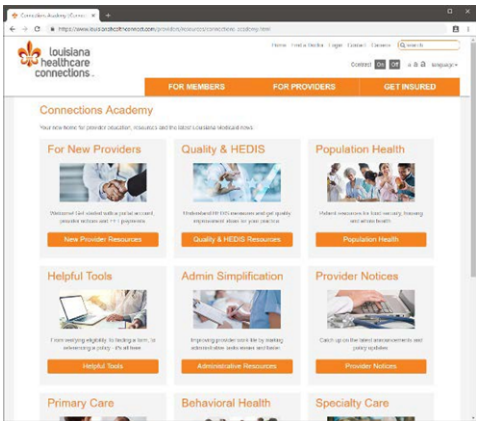
LouisianaHealthConnect.com

We understand that your practice moves quickly and when you need information or resources, you need them *now*. Our website, LouisianaHealthConnect.com, delivers an array of useful tools, references, and resources designed especially for Louisiana's Medicaid providers, including:

- Provider Notices and email sign-up
- Pre-auth Check Tool
- Find a Provider
- Clinical practice guidelines
- Connections Academy training and resources hub
- Quality in Practice blog
- The latest version of the Provider Manual and forms
- And much more.



As changes to Medicaid and health plan clinical and payment policies are developed, we will publish the information first on the Provider Notices section of our website. These Provider Notices are an extension of the Provider Manual, and we recommend that providers, practice managers, and other relevant staff subscribe to receive our weekly *Provider News Round Up* to stay up to date on the latest in Louisiana Medicaid.



Secure Provider Portal

Our secure provider portal is designed to reduce administrative burden so you can spend more time focused on member care. By offering tools to help your practice earn quality bonuses, streamline claims and authorizations, and simplify administrative tasks, we strive to be your partner in improving your patients' health.

QUALITY IMPROVEMENT

- Quality Incentive Reports
- Patient quality analytics dashboards
- Patients' health records
- EPSDT and care gap target lists
- Export reports to Excel for convenience

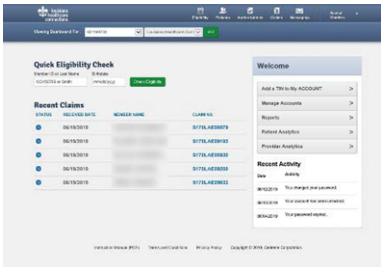
AUTHS & BILLING

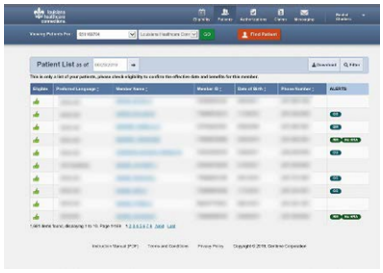
- Submit authorizations and check their status
- Submit claims and adjustments
- Verify claim status
- Review coding guidelines
- View payment history and Explanations of Payment

ADMINISTRATION

- Check patient eligibility
- View your PCP panel
- Manage your practice's portal user accounts
- Contact us securely

Registration is free and easy. You'll need your practice's tax ID number to create an account, so be sure to have that on hand. If you'd like help setting up your account, you can call us at 1-866-595-8133. And if you'd like in-person help to get the most out of our portal, your dedicated Provider Consultant will be happy to help!





IN-PERSON SUPPORT

We understand the complexity providers face in today's every-changing healthcare environment, whether it's adapting to Medicaid coverage changes, training new staff or maximizing your quality incentive earnings. And we're here to help!

Our Provider Consultants and Clinical Nurse Liaisons are located in communities all around Louisiana and are dedicated to helping your practice succeed. We often help with:

- Network performance profiling
- Individual physician performance profiling
- Physician and office staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider education, updates, and training
- Updating provider demographic information

Our goal is to provide you and your staff with the necessary tools to deliver the highest quality of healthcare to our members – your patients. To contact the Provider Consultant / Clinical Nurse Liaison for your area, call 1-866-595-8133.

Top Reasons to Contact a Provider Consultant / Clinical Nurse Liaison

1. To learn about electronic solutions for web authorizations, claims submissions and member eligibility
2. To review quality reports and strategize ways to increase incentive earnings
3. To schedule an in-service training for new staff or ongoing education for existing staff
4. To report any changes to your practice (locations, NPI, TIN numbers, open/close panel)
5. To check of network participation status
6. To get clarification of the contract, policies and procedures
7. To request fee schedule information
8. To obtaining Provider Profiles

"Louisiana Healthcare Connections works together with us to improve care while saving costs, giving us data on utilization, care gaps, health risks and high ED usage, at both panel and member levels, to help us focus on both population and individual patient needs."

- *Physician, Lafayette*

VERIFYING ELIGIBILITY

Eligibility for enrollment in the Louisiana Medicaid Program is available to individuals who are determined eligible for Louisiana Medicaid and the LaCHIP Programs and who belong to mandatory or voluntary Managed Care Organization (MCO) populations.

To verify patient eligibility, please use one of the following methods:

1. **Log on to our Secure Provider Portal** at LouisianaHealthConnect.com. Using our secure provider website, you can check patient eligibility. You can search by date of service and either of the following: patient name and date of birth, or patient Medicaid ID and dateof birth.
2. **Call our automated member eligibility IVR system.** Call 1-866-595-8133 from any touchtone phone and follow the appropriate menu options to reach our automated member eligibility verification system 24 hours a day. The automated system will prompt you to enter the patient Medicaid ID and the month of service to check eligibility.
3. **Call Louisiana Healthcare Connections Provider Services.** If you cannot confirm a patient's eligibility using the methods above, call our toll-free number at 1-866-595-8133. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the patient name or patient Medicaid ID to verify eligibility.

Reviewing Your Member Panel

Through our Secure Provider Portal, Primary Care Providers (PCPs) are able to access a list of eligible members in their panel. The Member List is reflective of all demographic changes made within the last 24 hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. To view this list, log on to www.LouisianaHealthConnect.com.

Eligibility changes can occur at any time and the Patient List does not guarantee coverage. Always verify member eligibility online or by phone on the date of service.

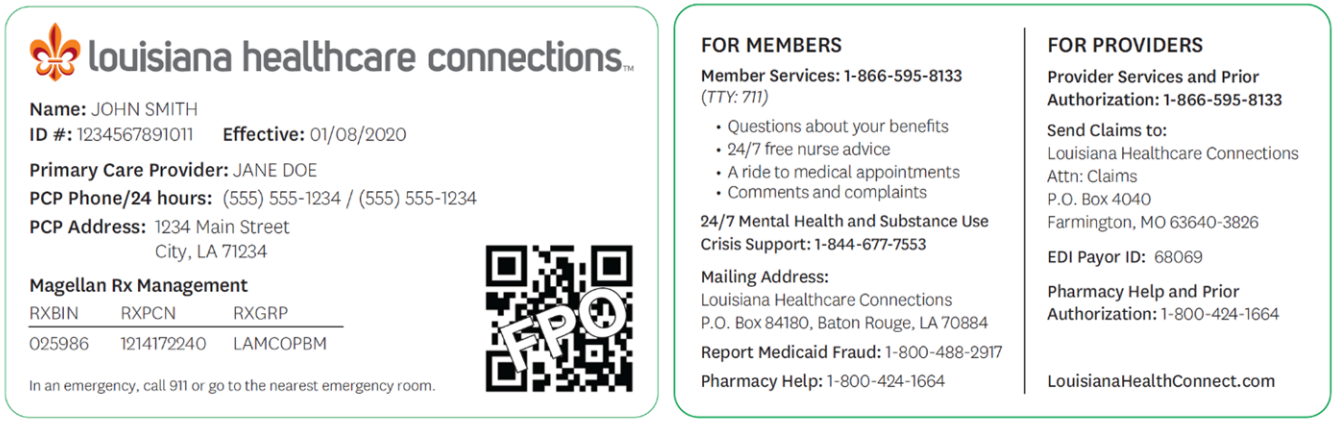
Member ID Cards

All new Louisiana Healthcare Connections members receive a Louisiana Healthcare Connections ID card. Members will keep their state-issued Medicaid ID card to receive services not covered by us. A new card is issued only when the information on the card changes or if a member requests a new card.

Whenever possible, members should present both their Louisiana Healthcare Connections member ID card and a photo ID each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification.

If you suspect fraud, please contact Provider Services at 1-866-595-8133 immediately.

Members must also keep their state-issued Medicaid ID card in order to receive benefits not covered by Louisiana Healthcare Connections.



Eligibility changes can occur at any time and possession of a member ID card is not a guarantee of current eligibility. Always verify member eligibility online or by phone on the date of service.

TRANSPORTATION TO COVERED SERVICES

Non-Emergent Medical Transportation

Patients in all coverage groups except the population residing in a nursing facility* are covered for non-emergency transportation to appointments for Medicaid-covered services.

To schedule transportation for a patient, call us at **1-855-369-3723** (Hearing loss: 1-866-288-3133) with this information:

- Member Name
- Medicaid ID number from their member ID card
- Date and time of the appointment
- Complete physical address for the location of the appointment

Transportation requests for medical appointments not called in at least 48 hours in advance may be denied. Urgent medical appointments and same-day referrals do not require 48 hours advanced notice. Please call as soon as the appointment is scheduled so we can make arrangements. Hospital discharges will be transported within three hours of notification by a medical facility.

The members should be ready to leave two hours before the scheduled appointment. The driver will pick them up during this time before the appointment.

Non-emergency transportation should comply with the geo-access guidelines indicated below. Requested trips over 30 miles (one-way) to a Provider or 60 miles to a Specialist requires health plan prior authorization.

DESTINATION	URBAN	RURAL
PCP	10 miles	30 miles
Acute Inpatient hospitals	10 miles	30 miles
Specialist	60 miles for at least 75% all members	60 miles for at least 75% all members
Lab/Radiology	20 miles	30 miles
Pharmacies	10 miles	30 miles
Hemodialysis	10 miles	30 miles
Specialized BH	15 for 90% of members	30 for 90% of members
Psychiatric inpatient	90 miles for 90% of members	
BH, ASAM Level 3.3	30 miles for 90% of members	
BH, ASAM Level 3.5	40 miles for 90% of members	
BH, ASAM Level 3.7	60 miles for 90% of members	
BH, ASAM Level 3.7 WM	60 miles for 90% of members	
PRTF Facility	200 miles for 100% of members	

Cancellations. If transportation has been scheduled and the medical appointment is cancelled, please call **1-855-369-3723** as soon as possible to cancel the ride.

***For members residing in nursing facilities:** non-emergency medical transportation is covered by their nursing facility. Please contact their nursing facility to schedule transportation to Medicaid-covered services for these members.

Non-Emergency Ambulance Transportation

For members who are unable to get out of bed or to sit up, non-emergency ambulance transportation to appointments may be appropriate. When medically necessary, non-emergency ambulance transportation is a covered benefit for all coverage groups.

For this service, LDH defines medical necessity as:

- Unable to get up from bed without assistance;
- Unable to walk; and
- Unable to sit in a chair or wheelchair.

The nursing facility or other provider should call our transportation broker, MTM, to request authorization and schedule the transportation at least 48 hours ahead of time. The Certification of Ambulance Transportation (CAT) Form is required prior to scheduling, and is available on our website under Provider Resources/Manuals, Forms and Resources.

Phone: 1-855-369-3723 (TTY:711) Fax: 480-757-6082

Louisiana Healthcare Connections will prohibit ambulance companies that are enrolled in Medicaid from soliciting Medicaid enrollees for membership fees for a subscription plan. Solicitation of such fees is a violation of Section 1916 of the Social Security Act and regulations at 42 C.F.R. §§ 447.15 and 447.56. If membership fees are collected, the members must be refunded in full, or the ambulance provider will be terminated from the program.

It is not a violation of the regulations when a Medicaid-enrolled ambulance company accepts membership fees if the Medicaid enrollee voluntarily subscribes to the plan.

If a Medicaid-enrolled ambulance company's subscription plan operates as an insurance policy, and the Medicaid enrollee pays the fee, the fee is treated as an insurance premium and is not in violation of Medicaid regulations.

TRANSLATION AND INTERPRETATION

As part of our efforts for greater network cultural competency, Louisiana Healthcare Connections provides access to free resources, including a telephonic interpretation line for members with Limited English Proficiency (LEP). Louisiana Healthcare Connections discourages the use of friends or family members as interpreters because they can interpret incorrectly or censor the information. If a Louisiana Healthcare Connections member with LEP does not call in advance to schedule an in-person interpreter, please use our telephonic interpretation line. All providers are required to provide medical services to LEP members in a language he or she understands.

To access our telephonic interpretation line, simply follow these steps:

- Be sure you have the member ID available. Using a phone in the exam room, call the Provider Services line at 1-866-595-8133 and tell them you need a telephonic interpreter.
- When our staff connects you to the interpreter in the desired language, use the speakerphone function to communicate with the member.

Federal law prohibits providers and staff from recommending or requiring the use of family or friends as interpreters or requesting them to provide an interpreter.

Bilingual staff training must meet quality standards provided in the definitions section of the Code of Federal Registrar (45 CFR 92).

Staff may also use the language line as a three-way call function to call members for scheduling appointments or giving test results.

24/7 NURSE ADVICE: 1-866-595-8133

All Louisiana Healthcare Connections members have access to our 24-hour nurse advice hotline. Through this service, they can call a Registered Nurse and receive basic health education, nurse triage and answers about urgent or emergency access.

Our staff often answers basic health questions but is also available to triage more complex health issues using nationally recognized protocols. Members with chronic problems, like asthma or diabetes, are connected to care management for ongoing support to improve their health.

Members may use the hotline to request information about providers and services available in the community after hours, when the Louisiana Healthcare Connections Member Services department is closed. The nurse advice staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and to offer our members access to a registered nurse at any time – day or night.

Participating in Our Network

CONNECTING PATIENTS TO CARE

Louisiana Healthcare Connections maintains a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with LDH's access and availability requirements.

Louisiana Healthcare Connections offers a network of PCPs to ensure every member has access to a Medical Home within the required travel distance standards (30 miles in the rural regions and 10 miles in the urban regions).

In addition, Louisiana Healthcare Connections will have available, at a minimum, the following specialists for both adult and pediatric members:

- Allergy/Immunology
- Anesthesiology
- Chiropractic
- Dermatology
- Electro-diagnostic Medicine
- Emergency Medicine
- Family Medicine (General)
- Internal Medicine (General)
    - Internal Medicine (Subspecialties)
    - Cardiovascular Disease *
    - Endocrinology and Metabolism*
    - Gastroenterology
    - Hematology
    - Infectious Disease
    - Medical Oncology
    - Nephrology*
    - Pediatrics
    - Pulmonary Disease
    - Rheumatology
    - Geriatric Medicine
    - Intensive Critical Care
- Medical Genetics
- Mental Health Services
- Nephrology
- Neurology
    - Neurological-Surgical
    - Nuclear Medicine
- Obstetrics and Gynecology
    - Maternal and Fetal Medicine
- Oncology
- Optometry
- Orthopedics
- Osteopathy
- Otolaryngology
- Pathology
- Pediatric (General)
- Pediatric (Subspecialties)
- Cardiology
- Hematology/Oncology
- Internal Medicine
- Nephrology
- Neonatal Medicine
- Endocrinology
- Pulmonology
- Gastroenterology
- Intensive Critical Care
    - Adolescent Medicine
    - Physical Medicine and Rehabilitation
    - Psychiatry
    - Radiology
    - Respiratory/Pulmonary
- Medical Services
- Substance Use Treatment
- Surgery (General)
- Surgery (Subspecialties)
    - Cardiac/Thoracic
    - Plastic (limited)
    - Pediatric
    - Vascular Surgery (General)
    - Surgery of the Hand
    - Surgical Critical Care

HOW TO JOIN OUR NETWORK

Louisiana Healthcare Connections partners with healthcare providers across our state to improve the wellbeing of our members, build a better healthcare system, and transform Louisiana's health. If you'd like to become a network provider and join us in this mission, we'd love to hear from you.

Visit www.LouisianaHealthConnect.com/Provider

Call 1-866-595-8133 and ask for Provider Contracting

Streamlined Contract Applications

We work directly with Council for Affordable Quality Healthcare (CAQH) to receive application and credentialing documentation. If you have not already signed up with CAQH, visit www.CAQH.org or call CAQH at 1-888-599-1771 for more information.

Once your CAQH application is complete, grant Louisiana Healthcare Connections access to it through the CAQH website and submit a contract request at www.LouisianaHealthConnect.com.

Make sure you have an active account with CAQH and update your information every 120 days.

Once we receive your information, your application will be reviewed for network participation. Providers will be notified within three business days of a decision. Upon approval, we will verify that applicable state and health plan requirements are met, an agreement will be sent to you. Please read fully, sign, and return to our attention. Keep in mind that two steps must be completed:

- Verifying the information you submitted
- Executing your agreement by signing and returning it

Once the agreement is executed, you will receive a welcome packet, which will include your credentialing and effective date. The provider agreement will include the effective date of your agreement.

You may be paid at a non-par rate until your agreement is fully executed and an authorization will be required.

We evaluate our network needs semi-annually; if a provider is denied, they may re-apply in six months.

"One company has reached out to provide support and training for me as a new provider. Louisiana Healthcare Connections has gone above and beyond to assure I am comfortable and knowledgeable... I was set up with a new provider orientation and my representative came to my office to educate me on their online system, expectations, and resources. My Louisiana Healthcare Connections clients and I will both greatly benefit from this. In a world where insurance has become impersonal and impossibly complicated, Louisiana Healthcare Connections has set a new standard."

- Behavioral Health Provider, Shreveport

CREDENTIALING AND RE-CREDENTIALING

Prior to contracting, Louisiana Healthcare Connections shall credential providers to ensure provider facilities, organizations, and staff meet all qualifications and requirements established by LDH policy including but not limited to the Medicaid Behavioral Health Provider Manual, State and Federal Laws, and rules and regulations for all specialized behavioral health providers. For reference, please see link below to the Medicaid Behavioral Health Provider Manual.

https://www.lamedicaid.com/provweb1/Providermanuals/manuals/BHS/BHS.pdf

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by the Louisiana Healthcare Connections as well as government regulations and standards of accrediting bodies.

Providers must submit at a minimum the following information when applying for participation with Louisiana Healthcare Connections:

- Complete signed and dated Louisiana Standardized Credentialing application or authorize Louisiana Healthcare Connections access to the Council for Affordable Quality Health Care (CAQH)
- Business and Individual Ownership and Disclosure Documents
- Signed attestation of the correctness and completeness of the application; history of loss of license and/or clinical privileges; disciplinary actions and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence; and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Louisiana regulations regarding malpractice coverage or alternate coverage
- Copy of current Louisiana Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of Louisiana
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 120 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable

Agencies not accredited at the time of credentialing shall supply proof that the agency applied for accreditation and paid the initial application fee. Agencies must present proof of full accreditation within eighteen (18) months of the initial accreditation application date.

Louisiana Healthcare Connections will verify the following information submitted for Credentialing and/or Re-credentialing:

- Louisiana license through appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Review five-year work history
- Review federal sanction activityincluding Medicare/Medicaid services (OIG-Office of Inspector General)

Behavioral health providers must submit at a minimum the following information when applying for participation with Louisiana Healthcare Connections:

- Current CAQH application
- Facility application
- W9
- Provider/Facility Specialty Profile (this is your opportunity to tell us your specialties)
- Disclosure of Ownership and Control Interest Statement
- Completed and signed contract, and other documents as required by state

Behavioral Health Providers must submit the additional information below when applying for participation:

- BH Professional Roster Template
- Facility Agency Application
- BH Provider Specialty-Profile

- LA Facility Specialty Provider
- Copy of current accreditation through one of the LDH approved national accrediting bodies which include:
    - The Council on Accreditation (COA)
    - The Commission on Accreditation of Rehabilitation Facilities (CARF); or
    - The Joint Commission (TJC)

Credentialing Decisions and Timeline

Once the application is completed, the Louisiana Healthcare Connections Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting.

Louisiana Healthcare Connections will completely process credentialing applications from all types of providers within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments. Providers must be credentialed prior to accepting or treating members without authorization. PCPs cannot accept member assignments until they are fully credentialed.

Credentialing Committee

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination. Committee meetings are held at least quarterly and more often as deemed necessary.

NOTE: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Site visits are performed at practitioner offices within 60 days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner's site visit score is less than 80 percent, the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

Re-Credentialing

To comply with accreditation standards, Louisiana Healthcare Connections conducts the re-credentialing process for providers at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the Louisiana Healthcare Connections network.

Between credentialing cycles, Louisiana Healthcare Connections conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate Louisiana state licensing agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry ensures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles.

Additionally, Louisiana Healthcare Connections reviews monthly reports released by the Office of the Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Louisiana Healthcare Connections Credentialing Committee that credentialing requirements are no longer being met.

Right to Review and Correct Information

All providers participating within the Louisiana Healthcare Connections network have the right to review information obtained by Louisiana Healthcare Connections to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Louisiana Healthcare Connections credentialing department. Upon receipt of this information, the provider

will have 14 days to provide a written explanation detailing the error or the difference in information. The Louisiana Healthcare Connections Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All providers who have submitted an application to join Louisiana Healthcare Connections have the right to be informed of the status of their application upon request. To obtain status, contact Provider Services at 1-866-595-8133.

Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within 14 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Louisiana Healthcare Connections network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation.

The applicant will be sent a written response to his/her request within two weeks of the final decision.

NON-DISCRIMINATION AND NON-RETALIATION

We do not limit the participation of any provider or facility in the network and/or otherwise discriminate against any provider or facility based on any characteristic protected under state or federal discrimination laws. Furthermore, we do not retaliate against or terminate a provider for:

- advocating on behalf of a member
- filing a complaint against us
- appealing a decision

PROVIDER DATA ACCURACY AND UPDATES

Reliable access to primary care and other healthcare providers is a crucial factor in our members' health. Unfortunately, reliable information about providers accepting Medicaid has, in some cases, become a barrier to care for the more than 30 percent of Louisiana's population – including 45 percent of our state's children -- who receive care through the Healthy Louisiana Medicaid program.

Submitting provider data updates is a contractual requirement for all providers in our network. In addition to audits by the LDH, Louisiana Healthcare Connections is increasing the frequency and volume of secret shopper audits to confirm provider directory data. This step is necessary to ensure our members have reliable access to the care they need.

The provider data audits focus on information that is relevant to our members' access to care:

- the locations at which a practitioner works
- acceptance of our health plan
- acceptance of new patients
- address
- phone numbers
- hours of operation
- provider type and specialties

If a provider is found to be out of compliance with this contractually required responsibility, Louisiana Healthcare Connections may issue remediation, assess penalties and/or terminate the provider's network participation agreement.

How To Verify and Update your Provider Data:

- Verify and update provider data online: https://provider.louisianahealthconnect.com.
- Email updates and staff roster changes to: LHCC.PDM@centene.com
- Email Mental Health Rehabilitation provider updates and staff roster changes (both licensed and non-licensed staff) to: LHC_BHProv_Roster@ LouisianaHealthConnect.com
- Have questions? Call us at 1-866-595-8133, Monday - Friday, 7 a.m. - 7 p.m.

LEAVING THE NETWORK

Providers must give Louisiana Healthcare Connections 180 days' notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to Louisiana Healthcare Connections or the member.

Louisiana Healthcare Connections assumes the responsibility for providing reasonable advance notice to a member of the impending termination of a provider who is currently treating the member in accordance with our contract with LDH.

Louisiana Healthcare Connections shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within 15 calendar days of the receipt of the termination notice from the provider.

Louisiana Healthcare Connections shall provide notice to a member, or the parent/legal guardian and the involved state agency as appropriate, who has been receiving prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven calendar days from the date we become aware of such, if it is prior to the change occurring.

Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to the provider's illness or the death of a provider; when the provider moves from the service area and fails to notify the plan; or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon Louisiana Healthcare Connections becoming aware of the circumstances.

The procedure outlined below shall be followed in notifying members of the termination of a provider:

- A case will be created by Provider Relations staff when a termination notice is received in accordance with the provider's contract.
- Upon receipt of a Provider's Notice of Termination, the Eligibility Specialist (ES) will run a report with names, ID numbers and addresses of all members impacted as a result of the provider being the member's PCP or having provided services on a regular basis.
- The state-approved "Provider Termination" letter will be used to notify members of the provider's termination.
- The ES will assign new providers to all members prior to the mailing of the termination notice. This reassignment of members will be conducted as follows:
    - If the member move is due to a Provider Termination, the plan will select the member's new PCP based upon the following criteria:
        - If the provider is a PCP within a group and leaves the network (Non-Par), members will be reassigned to a PCP within the group.
        - If the group remains open, but the provider leaves the practice, members will be reassigned to a PCP within the group.
        - If the provider group closes, but the PCP remains in the network (PAR), members will be reassigned to the same PCP and will follow that PCP to the new practice.

- The following PCP auto-assignment algorithm will be employed in certain situations:
    - First preference will be given to a Premier Provider Group if the member is age appropriate for that group.
    - Second preference will be given to Premier Lite Provider Group if the member is age appropriate for that group.
    - Third preference will be given to providers in order of decreasing HBR (lower HBR gets first priority).
    - This algorithm shall be used in the following situations
- The PCP auto-assignment algorithm shall be used in the following situations, based on the geographic location (zip code) of the terming practice:
    - The provider is a not currently a PCP within a group and leaves the network.
    - The provider group leaves the network (Non-Par).
    - The members have been incorrectly assigned to a specialist or practice which should not have a panel.
    - The provider group closes, but the PCP remains in Network but outside of the member's geographical range.

- If it is determined that a PCP could cause imminent harm to members, members will be removed immediately and notified by written letter of the change. Where appropriate, members will be reassigned a new PCP and notified of their right to change PCPs.
- Members will receive a replacement Member ID card including their new PCP name and phone number. The replacement Member ID card will be postmarked within five (5) business days of the change.
- The PCP Panel/Member List will be available to all PCPs via Louisiana Healthcare Connections' secure provider web portal 24 hours a day, seven (7) days a week, and be reflective of members assigned to that provider within the last business day.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 days, the anniversary date of the member's coverage, or until Louisiana Healthcare Connections can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Louisiana Healthcare Connections will reimburse the provider for the provision of covered services for up to 90 days from the termination date. In addition, Louisiana Healthcare Connections will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from Louisiana Healthcare Connections

Louisiana Healthcare Connections will also provide, within 30 days, written notice to a member who has been receiving a prior authorized course of treatment when the treating provider becomes unavailable.

Improving Member Health

COVERED BENEFITS

Louisiana Healthcare Connections members enjoy access to a comprehensive suite of health benefits and services, many of which are itemized on the following pages. For specific information not listed in the following pages, you can use our "Pre-Authorization Required?" tool at LouisianaHealthConnect.com or contact Provider Services at 1-866-595-8133 from 7 a.m. to 7 p.m., Monday through Friday.

Louisiana Healthcare Connections covers, at a minimum, those core benefits and services specified in our agreement with LDH and defined in the Louisiana Medicaid State Plan, administrative rules and department policies and procedure handbook. In addition, we offer a number of member and provider value-add benefits designed to extend coverage and improve member health.

Authorization Requirements

This list is not intended to be an all-inclusive list of covered services, but it substantially provides current prior authorization guidelines. All services are subject to benefit coverage, limitations and exclusions as described in applicable plan coverage guidelines.

Use the Pre-Auth Check tool at www.LouisianaHealthConnect.com to quickly determine if a specific service requires authorization.

All Out of Network (Non-Par) services require prior authorization, excluding family planning, ER and tabletop X-ray.

Service	Prior Auth Required?	Benefit Limitation	Notes
Abortion	Yes	Covered as allowed under Louisiana law and regulation	*Must submit Louisiana "*Certification for Informed Consent - Abortion" *with Claim*
Acute medical detoxification	See notes		Urgent/emergent admissions require notification within 2 business days. Elective/scheduled admissions are managed by EVOLENT
Allergy Testing	See notes		Presence of symptoms of allergic disease, such as respiratory symptoms, skin symptoms, or other symptoms that consistently follow a particular exposure, not including local reactions after an insect sting or bite.
Allergen Immunotherapy	No	A minimum of 180 doses every calendar year, per member, for supervision of preparation and provision of antigens other than stinging or biting insects; and A minimum of 52 doses every calendar year, per member, for supervision of preparation and provision of antigens related to stinging or biting insects	
Ambulance – Airplane	Yes		Prior authorization required for Fixed Wing (airplane) Ambulance Services for emergent and non-emergent use
Ambulance – Emergent	No		Includes emergency ground and emergency helicopter ambulance.
Ambulance-Non-Emergency	No		

Service	Prior Auth Required?	Benefit Limitation	Notes
Ambulatory Surgery Center Services	See notes		Prior authorization required for elective/scheduled admissions. Urgent/emergent admissions require notification within one business day
Antepartum Care	No		Must be billed as individual visit services are rendered, not global antepartum or global delivery codes.
Audiology	No		Code specific limits apply
BioPharmaceutical Drugs	See notes		Prior Authorization required for selected J codes when administered/dispensed in a provider's office, outpatient facility or in the home
Breast Pump	No		Electric Breast Pump Request Attestation is required for all DME providers, signed by the member and prescribing physician at the point of sale. Coverage extends only to personal-use, double electric breast pumps. 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. Billable code for the breast pump is E0603.
C-Section	Maybe		A length of stay due beyond 4 days requires prior authorization.
Chiropractic Services	Yes	For members less than 20 years old	Manipulative treatment for members under 20 years of age when medically necessary and upon referral from an EPSDT medical screening primary care provider. Members age 21 and older, up to 18 sessions per year are covered.
Circumcision	No	For newborns during the initial hospitalization of the child at birth, or in an office setting within the first 30 days of life.	
Clinic Services	No		Including non-IEP Medicaid covered services provided in schools, and when such services are not funded through certified public expenditures.
Cochlear Implants	Yes	For members under 21 years of age. Implants must be in accordance with Food and Drug Administration Guidelines.	All aspects of cochlear implant care (preoperative evaluation, implantation, implants, repairs, supplies, therapy) must be prior authorized. LDH IB 21-29
Communicable Disease Services	No		Includes testing and treatment
Dental – Emergency, Medical, Surgical	Yes		Prior authorization is required for services performed by an oral surgeon in the office.
Dental – Non-Emergency Medical, Surgical	No		Coverage includes members under age 21 years and pregnant members
Dental – General Anesthesia	No		
Dental – Routine and Preventive Adult	No	$500 per year for value-added benefit	As a value-added benefit, dental services performed by an Envolve Dental provider are covered for members age 21 and older.
Dental – Routine and Preventive Child	No		Dental care for children is covered by Louisiana Medicaid through a separate dental managed care organization. See Healthy.LA.Gov for more information.
Developmental and Autism Screening	No		Only reimburse the use of age-appropriate, caregiver-completed, and validated screening tools as recommended by the AAP. Provider must give appropriate developmental health recommendations, refer the member for additional evaluation, or both, as clinically appropriate. Providers must document the screening tool(s) used, the result of the screen, and any action taken, if needed, in the member's medical record.
Dialysis	No		Includes free standing and outpatient hospital setting; Prior Authorization required for any biopharmacy and Non-Par provider.

Service	Prior Auth Required?	Benefit Limitation	Notes
Durable Medical Equipment (DME)	See notes		Prior Authorization required for: apnea monitors; bi-paps; bone growth stimulators; C-paps; neuro stimulators; wound vacuums; wheelchairs (powered and standard); hospital beds; traction equipment; gait trainers; custom compression burn garments; infusion pumps; miscellaneous DME over $2000. Diabetic supplies including CGM will be covered un the pharmacy benefit effective 10/1/2023
Early Periodic Screening Diagnosis and Treatment	No	For members less than 21 years old	EPSDT/ well child services (previously KidMed)
Emergency Room Services	No		Services rendered in an ER place of service by non-participating providers will be reimbursed at 100 percent of the Medicaid rate for emergency services.
Endovascular Revascularization for Peripheral Artery Disease	No		LDH IB 21-30
Elective Invasive Coronary Angiography (ICA)	No		LDH IB 21-30
Elective Percutaneous Coronary Intervention (PCI)	No		LDH IB 21-30.
Peripheral Arterial Disease Rehabilitation for Symptomatic Peripheral Arterial Disease	No	Limited to 36 sessions annually. Providers shall adhere to CPT Guidance on the time per session, exercise activities permitted, and the qualifications of the supervising provider.	It is recommended, but not required, to have sessions 3 times per week over a 12 week period. Providers shall adhere to CPT Guidance on the time per session, exercise activities permitted, and the qualifications of the supervising provider. LDH IB 21-30
Enteral & Parenteral Nutrition for Home Use	Yes		
Family Planning	No		Well woman exams, screenings, pregnancy testing, birth control pills, Mirena and other IUDs
FQHC & RHC Services	No		Only clinical psychologist and LCSWs can provide BH services.
Fluoride Varnish	No	Covered when provided by PCP	No prior authorization required; however, only certain PCPs are certified to provide these services. Please contact Provider Services for a listing of eligible providers prior to obtaining services.
Genetic Testing	Yes		Prior authorization required: CPT codes such as: 83890-83898; 83900-83909; 83912-83914; 88230-88239; 88240-88249; 88261-88267 and select 'S' codes
Hearing Aids and Batteries	See notes		For members less than 21 years of age. Molds V5264 and batteries do not require authorization. As a value added benefit: > 21 years of age, one annual hearing exam and one set of hearing aids every two years
High Tech Imaging	Yes		Prior authorization required for CT, MRA, MRI. Service managed by National Imaging Associates. Cardio Nuclear imaging requires authorization from health plan.
Home Health Care Services (Adult Members- 21 years of age and over)	Yes		Prior authorization required. Services include but are not limited to: Skilled Nursing Services, Home Health Aide, Home infusion and Wound Therapy. Home Therapy (physical, occupational and/or speech) is managed by National Imaging Associates (EVOLENT).
Home Health Care Services (Pediatric Members- 20 years of age and under)	Maybe		Prior authorization required for Extended Home Health/Private Duty Nursing and Routine Skilled Nursing for 2 or more visits on the same day. Home Therapy (physical, occupational and/or speech) is managed by National Imaging Associates (NIA).

Service	Prior Auth Required?	Benefit Limitation	Notes
Home Health Care Services	Yes		Prior authorization required. Limited to 50 visits per year for members age 21 and older. Services include but are not limited to: Skilled Nursing Services, Home Health Aide, Home infusion and Wound Therapy. Home Therapy (physical, occupational and/or speech) is managed by EVOLENT.
Hospice Care	Yes		
Hyperbaric Oxygen Therapy	Yes		
Hysterectomy	Yes		Prior Authorization required. Must submit copy of Louisiana "Acknowledgment of Receipt of Hysterectomy Information Form" with claim
Immunizations	No		Includes children and adults; Providers must participate in Vaccines for Children (VFC) for child immunizations
Inpatient Hospital Services	See notes		Prior authorization required for those services and procedures noted elsewhere on this list (hysterectomy, potentially cosmetic, etc). Urgent/Emergent admissions require notification within 2 business day. 5-day restriction for inpatient care during the hospice election period was removed .
Laboratory Services	No	Must use Network Provider	See Prior Authorization List
Locum Tenum	Maybe		Prior authorization must be obtained for Locum Tenum services if practitioner is not credentialed with the facility through Louisiana Healthcare Connections.
Maternity Care Services	No	Prenatal through Postpartum	Submit Notice of Pregnancy (NOP) form at first visit.
Neuro-Psychological Services	Yes		Prior authorization required for codes: 96119, 96120, 96132 and 96133.
Nurse Midwife Services	No		
OB Home Health Services	Yes		17P administration, Hypertension, Preeclampsia, N&V (Zofran/Reglan pumps), DM, NST, Preterm labor management.
OB Ultrasound	No	76811 and 76812 may be billed by Perinatologist and Maternal Fetal Specialist only	
Observation	Yes		Prior authorization required for hospital observation admissions and services which exceed 48 hours; *however,* the service or procedure may require authorization as noted elsewhere on this list.
Oral Surgeon Services	Yes		Prior authorization required for procedures conducted by oral surgeon.
Orthotics	See notes		Certain codes are age-specific; please refer to Prior Authorization list and fee schedule.
Out-of-Network Physician & Facility	Yes		Prior authorization required for all out-of-network provider/facility. Excludes ER services, family planning services, and tabletop X-rays.
Pain Management Services	Yes	Limited to Age 0-20	Prior authorization required for services, including pain/nerve blocks, epidural injections and neuro-stimulators, anesthesia (both in office and outpatient), except for acute post-operative pain.
Perinatal Depression Screening	No	Birth to 1 year during EPSDT preventative visit, interperiodic visit or E&M office visit.	Requirements: Perinatal depression screening must use one of the following validated screening tools: Edinburg Postnatal Depression Scale (EPDS) Patient Health Questionnaire 9 (PHQ-9) Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9 Documentation must include the tool used, the results, and any follow-up actions taken.
Personal Care Services	Yes		
Physician, PA, NP, Office Visits	No		See out-of-network

Service	Prior Auth Required?	Benefit Limitation	Notes
Plastic Surgeon	Yes		Prior authorization required for all treatments & procedures in office or outpatient setting. Services for cosmetic purposes are not a covered benefit.
Podiatrist Services	No		
Prescription Drugs	Louisiana Healthcare Connections follows the Louisiana Department of Health Medicaid single PDL. Refer to the Preferred Drug List for details on specific drugs at www.LouisianaHealthConnect.com/PDL. **Specialty Drug Benefit and Office-Administered Drugs** Prior authorization required for specialty medications in order for reimbursement to be issued to the provider. We will reimburse a drug given in the office setting if it is listed on the LDH Professional Fee Schedule. The Outpatient Prior Authorization Form can be used for Physical Health Authorizations. Providers should utilize the Prior Authorization Prescreen Tool to determine if an authorization is necessary for a particular drug.		
Procedures, Surgery	See notes		Prior authorization required for the following: Bariatric surgery, Blephroplasty, Breast reconstruction, Breast reduction, Mammoplasty, Otoplasty, Rhinoplasty, Varicose Vein treatments. (All other potentially cosmetic services)
Prosthetics	See notes		Prior authorization may be required for selected codes.
Radiology and X-rays	See notes		Prior authorization required for high-tech radiology including CT, MRI, MRA. Services managed by National Imaging Associates (EVOLENT). No PA required for routine X-rays. See OB Ultrasound.
School-Based Clinic	No		Except as otherwise noted on list.
Sinus Procedures	No		See section, Sinus Procedures, for details
Skin Substitutes for Diabetic Ulcers	Yes	Limit of 10 applications per wound per 12 week period.	Prior authorization, and medical documentation will be required to be submitted demonstrating that the member meets all of the requirements. If there is no measurable decrease in surface area, or depth, after five applications, then further applications will not be covered, even when prior authorized. LA.CP.MP 185c
Sleep Study	Yes		Prior authorization is required for study in outpatient or home setting.
Specialty Injection and/ or Infusion Services	See notes		Prior authorization is required for selected codes.
Stereotactic Radiosurgery	Yes		Prior authorization is required.
Sterilization Procedures	No		Must submit “Consent for Sterilization Form” with claim.
Therapy (OT, PT, ST) Services (Outpatient)	Yes		Prior authorization required *after Initial evaluation*. Submit treatment plan & goals for continued services. Must bill with appropriate G modifiers. Services managed by National Imaging Associates (NIA). Excludes specified early steps services.
Transplant Service	Yes		Prior authorization required for all transplant services including transplant evaluation, pre and post services.
Transportation (Gas reimbursement and non-emergency medical transportation)	See notes		For members who lack transportation to/from Medicaid covered services. Services managed by LogistiCare.
Urgent Care Center	No		Place of Service/Location = 20
Urine Drug Testing	No	Presumptive/screening drug testing is limited to 24 total tests per calendar year Definitive/confirmatory drug testing is limited to 12 total tests per calendar year	Screening drug testing in a primary care setting without signs or symptoms of substance use or without current controlled substance treatment Please see Clinical Policy LA.CP.MP.50c for additional criteria
Vaginal Delivery	See notes		Prior authorization required for any length of stay beyond 2 days.

Service	Prior Auth Required?	Benefit Limitation	Notes
Vision Services and Eyewear			< 21 years – includes routine screening, corrective and medical services. Max of three pairs of glasses per calendar year or contacts w/PA. 21 and older – Annual routine exam and refraction, one pair of frames and lenses per calendar year. Services managed by Envolve Vision.

In some cases, the table above lists a policy reference in the notes (e.g., ”LA.CP.MP.xxx”); these policies can be reviewed in full on the Clinical and Payment Policies section of our website. Any references to LDH IBs can be reviewed on the LDH Informational Bulletins page.

Behavioral Health Benefits Overview

Louisiana Healthcare Connections covers a broad range of specialized behavioral health services, including:

- Psychiatry (for patients of all ages)
- Licensed Mental Health Professional (LMHP) treatment
- Mental Health Rehabilitation Services
- Community Psychiatric Support and Treatment (CPST)
- CPST specialized for high-risk populations. This includes:
    - Multi-Systemic Therapy (MST) 12-17 years of age
    - Functional Family Therapy (FFT) 10-18 years of age
    - Functional Family Therapy-Child Welfare (ages 0-18)
    - Homebuilders birth to 18 years
    - Assertive Community Treatment (ACT) (limited to 18 years and older)
- Psychosocial Rehabilitation (PSR)
- Crisis Intervention
- Crisis stabilization (under age 21)
- Therapeutic Group Homes (TGH) (under age 21): Therapeutic Group Homes have a non-Medicaid funded room and board component that must be addressed prior to placement.
- Psychiatric Residential Treatment Facilities (PRTF) (under age 21)
- Inpatient hospitalization (age 21 and under; 65 and older) for Behavioral Health Services. Adult inpatient 21-65 is covered as an in lieu of by Louisiana Healthcare Connections. Recipients of any age can get 15 days of treatment, and authorized longer term stays can also be covered with state funding.
- Outpatient and Residential Substance Use Services in accordance with the American Society of Addiction Medicine (ASAM) levels of care
- Intensive Outpatient Services (IOP) for mental health (limited to 18 years and older)
- Outpatient therapy using specialized evidence-based practices, including:
    - Child Parent Psychotherapy
    - Parent Child Interaction Therapy
    - Preschool and Youth PTSD Treatment
    - Opioid Treatment Programs (OTP)

VALUE-ADDED BENEFITS AND SERVICES

Louisiana Healthcare Connections offers extra benefits to improve the health and wellbeing of our members, above and beyond Medicaid covered benefits. This section describes value-added benefits that any member can self-refer to. There are additional value-added benefits available specifically for members in care management to address specific health conditions and challenges; those are described in the section of this Manual on Care Management.

Healthy Rewards for Members

Louisiana Healthcare Connections offers rewards to members who practice certain healthy behaviors with the goal of increasing their appropriate utilization of preventive services. The program will strengthen the relationship with the medical home as members regularly access preventive services and will promote personal responsibility for and ownership of the member's own health care.

Healthy Rewards also benefits members because it provides them with financial resources to purchase nutritious foods and healthcare items, such as over-the-counter medications that they might otherwise not be able to afford. Services that qualify for rewards include completion of certain disease-specific screenings and prenatal and postpartum care.

How does it work? Members will receive a rewards card when they earn their first reward. Credit will be added to the account balance as claims are processed for qualifying screenings or preventive care services that the member receives. Members may use their card to help pay certain household bills or purchase groceries and everyday items at select stores. For more details, visit LouisianaHealthConnect.com/rewards.

Adult Vision Coverage

Vision services for adults ages 21 and over are covered as a value-add benefit. These benefits include one preventive exam and one pair of eyeglasses or twelve sets of contacts per calendar year. Providers should submit vision service claims to Envolve Vision.

Newborn Circumcisions

Louisiana Healthcare Connections covers circumcisions for newborns during the initial hospitalization of the child at birth. Circumcisions are also covered in an office setting within the first 30 days of life.

Home Health Coverage

Louisiana Healthcare Connections offers members an increased number of skilled nursing visits per day for children and adult members. There is no annual limit to the number of days, as long as applicable criteria and medical necessity are met. Prior authorization is required for most home health services – see the preceding benefit grid for details.

Louisiana Medicaid has published a Home Health Services Fee Schedule that includes modifiers with enhanced rates for situations in which two beneficiaries are cared for simultaneously, for children in Extended Home Health (EHH) with high medical needs, for overnight shifts, for weekend or holiday shifts, and for EHH services in rural areas. These rate modifiers may be used in applicable circumstances to provide an enhanced reimbursement rate to home health providers in order to facilitate fully staffing prior approved EHH services for class members.

A home health agency may also submit claims using the TU modifier to identify hours for an EHH member that were paid as overtime to the nurse delivering the care. This modifier shall not require prior authorization but must be for hours already authorized for the member. When billing, this modifier may be used in addition to any other authorized modifiers (e.g., TG) for procedure codes S9123 and S9124, but will be paid at a minimum of 1.5 times the base rate of the procedure code. The use of this modifier is subject to post-payment review. Louisiana Healthcare Connections will require the home health agency to maintain all necessary documentation to support the use of this modifier. Non-compliance with written policy may result in recoupment and additional sanctions, as deemed appropriate by Louisiana Medicaid.

MyStrength Mobile Mental Health Coach

myStrength® is an innovative online and mobile portal, offering evidence-based resources to strengthen the whole person, mind, body, and spirit. Its simple tools, trusted resources, daily motivational tips, and personalized eLearning programs will help your clients build and sustain mental wellness.

Rooted in Cognitive Behavioral Therapy, the myStrength® program is a private resource where your clients and their families and caretakers can learn and practice new ways of managing stress, depression, or anxiety. myStrength® is best used in combination with traditional care; it will reinforce core skills for building mental health and provide support when you can't be there.

"As a pediatrician, ensuring an efficient, smooth experience for my patients is critically important... The incentive and reward programs and the way Louisiana Healthcare Connections conducts business enables providers to be successful while accepting Medicaid patients."

NON-COVERED SERVICES

These services are not covered by Louisiana Healthcare Connections as part of Medicaid managed care. They may be covered by other entities as noted.

Non-Covered Services	Comments
Acupuncture	Not Covered
Cosmetic Surgery	Not Covered
Dental Care Services For Children	Routine and preventive dental care services for children are covered by these state's dental MCO.
Elective Abortions and Related Services	Not Covered
Experimental/ Investigational Services	Not Covered. Including drugs, procedures and equipment. Phase I & II Clinical Trials are considered experimental.
Infertility Treatment Services	Not Covered
Institutional Long-Term Care Facilities / Nursing Homes / ICF/DD (Intermediate Care Facility for Persons with Developmental Disabilities) Services	Covered by LDH
Institutional Long-Term Care Facilities / Nursing Homes / ICF/DD Services	Covered by LDH
School Based IEP Services	Covered by LDH

CARE MANAGEMENT

Louisiana Healthcare Connections' care management program helps our members achieve better outcomes, satisfaction, and quality of life.

The program includes a systematic approach for early identification of member health risks; engagement of populations with special healthcare needs; health, wellness, and social needs assessments; and implementation of an individualized care plan. We establish care teams around each member, comprised of a multi-disciplinary care management team, providers caring for the member, caregivers, and relevant community-based organizations, while respecting member privacy rights. Care plans include member/family education, provider engagement and referrals, community support services, as well as outcome monitoring and reporting back to the care team.

Our Care Management functions include:

- Early identification of members who have special health care needs
- Assessment of member's risk factors and needs
- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members understand treatment recommendations
- Active coordination of care linking members to behavioral health practitioners and as needed medical services; including linkage with a physical health Care manager for members with coexisting behavioral and physical health conditions; and residential, social and other support services where needed
- Development of a care management plan of care
- Referrals and assistance to community resources and/or behavioral health practitioners

We will coordinate access to services not included in core benefit package and social services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

We are available to help all providers manage their Louisiana Healthcare Connections members. PCP's are encouraged to contact Care Management for updates on patients.

The following pages describe specialized care management services that are available to help support your patients' care, recovery, and health.

To refer a patient to Care Management, call: 1-866-595-8133, extension 69016.

On the following pages we describe some of the key areas of our care management program:

- Integrated Physical and Behavioral Care
- Chronic Care / Disease Management
- Coordination of Care
- Complex Care Management
- Community Health Workers
- Pregnancy Support

Member Integrated Physical and Behavioral Care

Our approach to integrated care focuses on the comprehensive care management of youth and adult behavioral and/or physical health concerns. The integrated care approach utilizes a holistic approach, focusing on *the whole person*, and includes integrating covered, carved out, and community-based services in its approach to care.

We use a multi-disciplinary Integrated Care Team to offer and coordinate care. Our staff coordinates care with all necessary members of the designated care team, including the member's primary and specialty providers, internal team members from other professional disciplines, and those identified as having a significant role in the member's life as appropriate.

We work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences. We work to increase the percentage of members with positive screens to identify possible referrals for more specialized treatment(s).

Our overarching goal is to help each, and every Louisiana Medicaid member achieve the highest possible levels of wellness, functioning and quality of life while demonstrating positive clinical results. Integrated care is an integral part of the range of services that we provide to all members. Through this program, we continually strive to achieve optimal health status through member engagement and behavior change motivation. Integrated care does this through a comprehensive approach that includes:

- Strong support for the integration of both physical and behavioral health services
- Assisting members in achieving optimum health, functional capability, and quality of life
- Empowering members through assistance with referrals and access to available benefits and resources
- Working collaboratively with members, family and significant others, providers and community organizations to assist members using a holistic approach to care
- Maximizing benefits and resources through oversight and cost-effective utilization management
- Rapid and thorough identification and assessment of program participants
- A team approach that includes staff with expertise and skills that span departments and services
- Information technologies that support care coordination within plan staff and among a member's providers and caregivers
- Multifaceted approaches to engage members in self-care and improve outcomes
- Multiple, continuous quality improvement processes that assess the effectiveness of integrated care and identify areas for enhancement to fully meet member priorities

The model emphasizes direct member contact, such as telephonic and face-to-face education and resource coordination, because it more effectively engages members and allows staff to provide information that can address member questions in real time and better meet member needs. Participating members also receive written materials, preventive care and screening reminders, invitations to community event, and can call anytime regarding healthcare and psychosocial questions or needs.

Recognizing that each member's clinical condition and psychosocial situation is unique, integrated care interventions and information meet each member's unique circumstance, and will vary from one member to another, including those with the same diagnosis.

Chronic Care / Disease Management

Chronic Care Management/Disease Management strives to integrate care, educate, and engage individuals in their health, and improve the effectiveness of treatment, to improve quality of life and reduce long-term health care costs.

To improve overall health, our chronic care management program (CCMP):

- Supports provider/member relationships and plan of care
- Emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and member empowerment strategies,
- Evaluates clinical, humanistic and economic outcomes on an ongoing basis

Our chronic care programs include but are not limited to: anxiety, asthma, ADHD, depression, diabetes and congestive heart failure. Our programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions.

Our chronic care / disease management program includes:

- Disease specific assessments to monitor symptom acuity
- Assessment of member's risk factors and needs
- Assessment and interventions to attempt to prevent escalation to Intensive Care Management status
- Active coordination of care linking members to behavioral health practitioners and as needed medical services; including linkage with a physical health Care Manager for members with coexisting behavioral and physical health conditions; and residential, social and other support services where needed
- Development of a care management plan of care
- Referrals and assistance to community resources and/or behavioral health practitioners

Not all members having targeted diagnoses will be enrolled in the CCMP. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions will be referred for care management evaluation.

Coordination of Care

Our coordination of care process is designed to ensure the coordination and continuity of care during the movement between providers and settings. During transitions, patients with complex medical needs are at risk for poorer outcomes due to medication errors and other errors of communication among the involved providers and between providers and patients/caregivers.

Continuity of healthcare means different things to different types of caregivers. It can include:

- Continuity of information, which ensures that information on prior events is used to give care that is appropriate to the patients current circumstances.
- Continuity of personal relationships, recognizing that an ongoing relationship between patients and providers is the foundation that connects care over time and bridges discontinuous events.
- Continuity of clinical management.

Our Care Coordination functions include:

- Coordinate with Louisiana Healthcare Connections, member advocates or providers for members who may need behavioral health services;
- Assist members with locating a provider; and
- Coordinate requests for out-of-network providers by determining need/access issues involved.

When members are newly enrolled and have been previously receiving behavioral health services, we will continue to authorize care as needed to minimize disruption and promote continuity of care. We will work with non-participating practitioners/providers (i.e., those that are not contracted and credentialed in our provider network) to continue treatment or create a transition plan to facilitate transfer to a participating provider.

In addition, if we determine that a member is in need of services that are not covered benefits, the member will be referred to an appropriate provider and we will continue to coordinate care including discharge planning.

Complex Care Management

Specialized complex care management teams will support members whose needs are primarily functional as well as those with such complex conditions as HIV, diabetes, CHF, organ transplants and renal dialysis. Foster care members and children with special healthcare needs are at special risk and are also eligible for enrollment in care management.

These teams will be led by licensed registered nurses with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers, and obstacles they face, and socioeconomic impacts on their ability to access services.

A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the Louisiana Healthcare Connections care management department for assessment and care management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

"One of the components that distinguishes Louisiana Healthcare Connections, from other insurers, is the hands-on approach toward providers and patients in helping to meet and exceed our health goals."

- Physician, Monroe

Community Health Workers

Our Community Health Workers are a liaison between the Louisiana Healthcare Connections and members in their own communities.

Home Visits are generally conducted with new members, new moms, and members identified by Care Management and providers as needing outreach in their home environment. During the home visit with the Community Health Worker, topics discussed with the member will be tailored to meet individual needs. These may include:

- Overview of covered benefits
- Visits to the Primary Care Physician
- Importance of, and how to obtain, preventive health services
- Appropriate use of preventive, urgent, and emergency care
- Medically necessary transportation
- Community Resources

Community Health Workers work with Program Specialists, Program Coordinators, and Care Managers to assist members with medical or social service appointments, access to food banks, and financial assistance provided by local community organizations. This assistance is provided telephonically or through home visits, hospital visits, and personal one on one health coaching.

For hospitalized members with complex, frequent or heightened needs, our Community Health Workers provide in room support to the members to ensure that they are receiving the best care and to assist in the transition once discharged. The Community Health Worker will also conduct a post-discharge outreach assessment to ensure individual needs are met, which can include a referral to care management or enrollment in health coaching.

In addition to home and hospital visits, Community Health Workers host new member orientations, community educational baby showers, and attend local health fairs. They often provide education on preventive health, accessing care, prenatal and postpartum care, general health and wellness, the Louisiana Medicaid program and benefits, and local social service support resources.

ConnectionsPlus® is designed for pregnant and high-risk members who have special healthcare needs. When a member qualifies, the Community Health Service leadership team request a free cell phone from Safe Link and is mailed to eligible members. Care Managers identify members who are considered to be at high risk for complications and who do not have access to a safe and reliable phone. These members may be identified by the treating physicians, claim history, hospital staff, or through the initial risk assessment conducted by the OB Care Management team. Members must be willing to engage into the Care Management program to be eligible for the cell phone.

Cell phones are pre-programmed with Louisiana Healthcare Connections member services number, our 24/7 free nurse advice hotline, 911, poison control, and transportation services. Care Managers will contact the member at least twice monthly to remind about appointments, preventive care, special concerns like 17P administration, and other member-specific needs. Members are able to contact Care Managers as often as needed during the normal business hours.

Effective for dates on or after January 1, 2022, Louisiana Healthcare Connections will cover services rendered to members by qualified community health workers (CHW) meeting the criteria and policy outlined below.

Community Health Worker Qualifications

A qualified Community Health Worker is defined as someone who:

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

Louisiana Healthcare Connections will require providers who employ CHWs to verify and maintain and provide documentation, as requested by LDH, those qualification criteria are met.

Eligibility Criteria

Louisiana Healthcare Connections will cover CHW services if a member has one or more of the following:

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

Covered Services

Covered services include:

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

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

Louisiana Healthcare Connections will not restrict the site of service which may include but is not limited to, a health care facility, clinic setting, community setting, or the member's home. The MCO shall permit delivery of the service through a synchronous audio/video telehealth modality.

Louisiana Healthcare Connections will reimburse only the CPT procedure codes in the 'Education and Training for Patient Self-Management' section that are provided by CHWs. CHWs will need to follow CPT guidance.

Coverage Limitations

Louisiana Healthcare Connections will not cover the following services when provided by CHWs:

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

Louisiana Healthcare Connections will reimburse a maximum of two hours per day and ten hours per month per member.

Reimbursement

Louisiana Healthcare Connections will reimburse CHW services “incident to” the supervising physician, APRN, or PA.

Louisiana Healthcare Connections will require a CHW who provides services to more than one member to document in the clinical record and bill appropriately using the approved codes associated with the number of people receiving the service simultaneously. This is limited to eight unique members per session.

“Incident to” Services “

Incident to” services means services or supplies that are furnished as an integral, although incidental, part of a supervising provider’s professional services. For physicians, “incident to” services include those provided by auxiliary personnel (e.g., medical assistants, licensed practical nurses, registered nurses, etc.), but exclude those provided by an advanced practice registered nurse (APRN) and physician assistant (PA). For APRNs and PAs, “incident to” services also include those provided by auxiliary personnel. For all “incident to” services, auxiliary personnel must only operate within the scope of practice of their license or certification.

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

When an APRN or PA provides all parts of the service independent of a supervising or collaborating physician’s involvement, even if a physician signs off on the service or is present in the facility, the service does not meet the requirements of “incident to” services. Instead, claims for such services must be submitted using the APRN or PA as the rendering provider.

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

Pregnancy and Newborn Health

Start Smart for Baby Pregnancy Support Program

The OB CM Team will implement our *Start Smart for Your Baby*® Program (Start Smart), which incorporates care management, care coordination and disease management with the goal of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that supports women for up to one year after delivery and includes neonates and qualified children up to one year of age.

The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing care management to high and moderate risk members through the postpartum period. A nurse care manager with obstetrical experience will serve as lead care manager for members at high-risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the Neonatal Intensive Care Unit (NICU) and will follow them through the first year of life as needed based on their specific condition or diagnosis.

The OB/Neonate team has physician oversight advising the team on overcoming obstacles, helping identify high-risk members and recommending interventions. These physicians will provide input to Louisiana Healthcare Connections Medical Director on obstetrical care standards and use of newer preventive treatments.

Submit a Notification of Pregnancy within five days of the first prenatal visit so we can engage and support our pregnant members.

To refer a patient to Start Smart for Your Baby, call: 1-866-595-8133.

Neonatal / Newborn Screening for Genetic Disorders

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

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

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

For newborn screening for severe combined immunodeficiency (SCID), testing is covered under CPT code 81479. This code is only to be used for this purpose and until such a time as a permanent procedure code is in place.

Genetic Counseling and Testing Genetic Counseling

Counseling is required before and after all genetic testing. Counseling, at a minimum, must consist of the following and be documented in the beneficiary's medical record:

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

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

When performed by providers other than licensed genetic counselors, an applicable evaluation and management code must be used.

Louisiana Healthcare Connections will obtain the results of the initial neonatal screening by contacting the hospital of birth, the health unit in the parish of the mother’s residence, or through the Office of Public Health (OPH) Genetics Diseases Program’s web-based Secure Remote Viewer (SRV). If screening results are not available, or if newborns are screened prior to 24 hours of age, newborns will be required to have another newborn screen. The newborn infant is to be rescreened at the first medical visit after birth, preferably between one and two weeks of age, but no later than the third week of life. Initial or repeat neonatal screening results must be documented in the medical record for all children less than six months of age. Children over six months of age do not need to be screened unless it is medically indicated. When a positive result is identified from any of the conditions specified in LAC, Book Two of Two: Part V. Preventive Health Services Subpart 18. Disability Prevention Program Chapter 65. Newborn Heel Stick Screening 6303, and a private combined immunodeficiency (SCID), covered testing with CPT code 81479, limited to use for this purpose and until a permanent procedure code is in place.

Coordinated System of Care (CSOC)

The Coordinated System of Care (CSoC) is a program for children/youth with serious behavioral health challenges, who are in out-of-home placement or are at risk of being placed in an out-of-home setting, because of their problem behaviors. Members who are eligible for CSoC services may receive physical health, primary behavioral health, and pharmacy coverage from Louisiana Healthcare Connections. Their specialized behavioral health services will be covered by EVOLENT. They will also receive specialized CSoC services, including:

- Parent support and training
- Youth support and training
- Independent living/skills building
- Short term respite care

The Coordinated System of Care (CSoC) is a program for children/youth with serious behavioral health challenges, who are in out-of-home placement or are at risk of being placed in an out-of-home setting, because of their problem behaviors. CSoC works with the child and family to develop a plan to help keep the child/youth in their home and community. CSoC is supported by the state of Louisiana’s child serving state agencies.

Each child/youth in CSoC and their family receive wraparound to help coordinate their care. The wraparound facilitator in the wraparound agency will work with the family to develop one plan to help provide for the child.

Family Support Organization

Every child/youth and family in the CSoC program also has access to additional special services,

including those offered by the Family Support Organization. The Family Support Organization offers children/youth and their families support and training provided by parents with experience raising a child/youth with behavioral and/or emotional challenges, as well as youth with personal experience living with behavioral and/or emotional. The role of the parent and youth support is to assist the child and parent, in the home and community.

How do I know if CSoC may be right for my patient?

- Child has had to be placed in an out-of-home setting because of behavior problems
- Child has talked about or actually tried to hurt him/herself or acted in a way that might be dangerous such as reckless behaviors like riding on top of cars, running away from home, or promiscuity.
- Child has been a danger to others, such as threatening to kill or seriously injure another person, fighting to the point of serious injury, been accused of being sexually aggressive, or engaging in fire setting.
- Child has deliberately or purposefully behaved in a way that has gotten him/her in trouble with the authorities such as breaking rules at school or laws in your community.

If you think CSoC might be right for one of your patients, or you want more information, you can call Louisiana Healthcare Connections at 1-866-595-8133 and one of our behavioral health team members can assist in completing a screening and application for CSoC. You can also reach out to CSoC directly at their office toll free at 1-800-424-4399.

Additional Health Support for Care Management

The following are extra, value-add benefits available for our members in care management. If you identify a patient whose condition may benefit from these services, talk with their care manager.

Alternatives to Opioids for Chronic Pain Management

Members with a chronic pain diagnosis or those at-risk for developing chronic pain, regardless of age, can work with their care manager to receive alternatives to opioids for pain management. There are alternative treatments available if medically appropriate to alleviate pain and restore activity levels.

Home-Based Asthma Interventions

Many times, asthma can be made worse by things around the home, like mold. Members with asthma who are in Care Management can get extra help with these issues at home. This includes home-based services or products known to improve asthma, like mold clean up, and pest control. It also includes home asthma management education, like the Louisiana Department of Health's BREATHE program.

Help with Health-Harming Home Issues

Members active in care management and who agree to a home assessment may be eligible to receive a healthy home support for specific services such as mold removal, pest control, and utility connections to help with health-harming issues in their home.

Home Visiting Programs

Members who are pregnant and enrolled in care management can be connected to home visiting programs where they will get help and guidance during pregnancy and newborn care. These programs are proven to improve prenatal and maternal health and birth outcomes as well as child health and

development. Programs include:

- Louisiana Nurse-Family Partnership (NFP): provides guidance during pregnancy and newborn care
- Parents as Teachers (PAT): helps navigate services and keep babies on track for a healthy life

Post-acute Care Home Delivery of Nutritious Meals to Improve Recovery

Members with a diagnosis of heart failure, diabetes, or who are high-risk postpartum may receive two meals a day for seven days after discharge from a hospital, up to 28 meals a year. Meals are adjusted to meet specific nutritional needs of members to help stay healthy.

Transportation for Health and Wellness Needs

This extra transportation benefit includes rides to non-healthcare locations that improve member health and well-being. This can include places such as food pantries, pharmacies, WIC appointments, our Community Wellness Centers and more. These transportation services are for members participating in care management, subject to availability, and all members under the age of 17 must be with an adult.

Cell Phones: Federal SafeLink Program and ConnectionsPlus®

The federal SafeLink program provides free prepaid cell phones to people with limited or no phone access. This allows people to keep in contact with health care providers, care managers, telehealth services, and 911. For members participating in care management that do not qualify for SafeLink, we provide free cell phones and data plans through ConnectionsPlus®.

BEHAVIORAL HEALTH CRISIS STABILIZATION

Crisis Stabilization (CS) provides short-term and intensive supportive resources for the youth 0-20 years old and his/her family. The intent of this service is to provide an out-of-home crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the youth by responding to potential crisis situations. The goal will be to support the youth and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the crisis stabilization is supporting the youth, there is regular contact with the family to prepare for the youth's return and his/her ongoing needs as part of the family.

It is expected that the youth, family, and crisis stabilization provider are integral members of the youth's individual treatment team.

This service is provided as part of a comprehensive specialized mental health program available to all Medicaid eligible children with significant functional impairments resulting from an identified mental health. The medical necessity for this service must be determined, and service recommended, by a LMHP or physician, or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level.

For additional information about service components, exclusions, provider types, and other service details, please refer to Louisiana Medicaid Behavioral Health Services Manual at LaMedicaid.com.

COMMUNICATION BETWEEN BEHAVIORAL HEALTH AND PRIMARY CARE

Louisiana Healthcare Connections requires PCPs and behavioral health providers to consult each other. In many cases, the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged, with member consent when required.

Providers can identify the name and number for a member's PCP on the front of the Member ID Card. Practitioners/providers should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment. Whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered by the PCP, providers should communicate not only with the member's PCP, but also with other behavioral health clinicians we may be providing service to the member. Examples of some of the items to be communicated include:

- Prescription medication, especially when the medication has potential side effects, such as weight gain, that could complicate medical conditions, such as diabetes;
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment;
- The member has lab work indicating need for PCP review and consult;
- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (panic symptoms can be confused with heart attack symptoms); and
- The member's progress toward meeting the goals established in their treatment plan.

All communication attempts and coordination activities must be clearly documented in the member's medical record.

If you are unable to locate or contact other providers serving your member, please contact us for additional information.

We require that providers report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the provider's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner. Such consent shall meet the requirements set forth in 42 CFR 2.00 et seq., when applicable. If the member requests this information not be given to the PCP, the provider must document this refusal in the member's treatment record, and if possible, the reason why.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment
- Written notification of member's noncompliance with treatment plan (if applicable)
- Member's completion of treatment
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s)
- The results of functional assessments

Caution must be exercised in conveying information regarding substance use disorders, which is protected under separate federal law. We monitor communication with the PCP and other caregivers through audits. Failure to adhere to these requirements can be cause for termination from the network.

COVERED POPULATIONS

Coverage Groups

In Louisiana Medicaid, there are four coverage groups, depending upon which population a member falls into and whether (if permitted), they decide to voluntarily opt-in for full coverage. These are:

All Covered Services

This is the largest coverage group, both in terms of covered services and the number of members in the coverage group. These members receive coverage for physical and behavioral health as well as non-emergent medical transportation to any Medicaid-covered benefit, and other benefits. All behavioral health services (primary and specialized) are covered by Louisiana Healthcare Connections.

Specialized Behavioral Health Services and Non-Emergency Ambulance Transportation

Members of this coverage group are individuals residing in nursing facilities and individuals under the age of 21 residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD). These members receive coverage for specialized behavioral health and non-emergency ambulance transportation. Their physical health and primary behavioral health coverage, along with pharmacy and non-emergency transportation (NEMT) are all covered under their nursing facility benefit.

Specialized Behavioral Health and Non-Emergency Medical Transportation, including Non-Emergency Ambulance Transportation

Members of this coverage group are Home and Community Based Services (HCBS) recipients (though not all HCBS members are in this coverage group), Medicare Dual Eligible and Intermediated Care Facility residents. These members receive coverage for specialized behavioral health and non-emergent medical transportation to any Medicaid-covered benefit, as well as n on-emergency ambulance transportation. Coverage for physical health, primary behavioral health and pharmacy are not provided by Louisiana Healthcare Connections.

All Covered Services Except Specialized Behavioral Health and Coordinated System of Care (CSoC) Services, aka 1915(b)(3) and 1915(c)

The Coordinated System of Care (CSoC) is a program for children/youth with serious behavioral health challenges, who are in out-of-home placement or are at risk of being placed in an out-of-home setting, because of their problem behaviors.

Serious Mental Illness Population

The target population of the Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana) are defined as follows: (a) Medicaid-eligible individuals over age 18 with serious mental illness (SMI) currently residing in nursing facilities; (b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement during the course of this Agreement, or have been referred within two years prior to the effective date of this Agreement; and (c) excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis. Louisiana Healthcare Connections will comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the DOJ Agreement Compliance Guide.

Eligibility Categories

The Louisiana Medicaid population is comprised of individuals listed in a category of eligibility below:

Mandatory Populations

Individuals in a “mandatory population” are required to choose a Louisiana Medicaid Plan. Individuals considered mandatory are as follows:

1. Children under 19 years of age, including those eligible under Section 1931 poverty-level related groups and optional groups of older children in one of the following:
    a. TANF (Individuals and families receiving cash assistance through the Families in Temporary Need of Assistance (FITAP)) Program
    b. Child Health and Maternity Program (CHAMP) - Child Program
    c. Deemed Eligible Child Program
    d. Youth Aging Out of Foster Care (Chafee Option)
    e. Former Foster Care Children
    f. Regular Medically Needy Program
    g. Louisiana Children’s Health Insurance Program (LaCHIP)
2. Parents and caretaker relatives eligible under Section 1931 of the Social Security Act, including:
    a. Parents and Caretaker Relatives Program
    b. TANF (FITAP)
    c. Regular Medically Needy Program
3. Pregnant Women
    a. LaMOMS (CHAMP-Pregnant Women)
    b. LaCHIP Phase IV Program
4. Breast and Cervical Cancer (BCC) Program
5. Aged, Blind & Disabled (ABD):
    a. Supplemental Security Income (SSI) Program
    b. Extended Medicaid Programs
        i. Disabled adult children
        ii. Early widows/widowers
        iii. Pickle (ABD Persons Who Become Ineligible for SSI or Mandatory State Supplement (MSS) (* Group One, * Group Two)
        iv. Disabled widows/widowers and disabled surviving divorced spouses unable to perform any substantial gainful activity
        v. Blood Product Litigation Program
        vi. Medicaid Purchase Plan Program
        vii. Provisional Medicaid Program
        viii. Aged and related populations
6. Continued Medicaid Program
7. TB Individual Program
8. Not otherwise categorically eligible with income at or below 133% FPL

Voluntary Opt-In Populations

Individuals in a voluntary opt-in population are not automatically enrolled in Louisiana Medicaid, but may choose to enroll in a Louisiana Medicaid Plan. Voluntary opt-in members may initially enroll in Louisiana Medicaid at any time. They may also disenroll from Louisiana Medicaid at any time, effective the earliest possible month the action can be administratively taken. If a person has previously disenrolled from Louisiana Medicaid, they may only re-enroll during the annual open enrollment period. The MCO shall accept enrollment of the following Medicaid populations and provide for all Specialized Behavioral Health, NEMT services and NEAT Services. Members considered voluntary opt-in include:

1. Non-dually eligible Individuals receiving services through the following 1915(c) Home and Community Based Waiver and any HCBS waiver(s) that replaces these current waivers:
    a. Adult Day Health Care (ADHC)
    b. New Opportunities Waiver (NOW)
    c. Children's Choice (CC)
    d. Residential Options Waiver (ROW)
    e. Supports Waiver
    f. Community Choices Waiver (CCW)
2. Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities (OCDD) Request for Services Registry who are Chisholm Class Members
3. Voluntary opt-in populations may elect to receive all other state plan services through Medicaid Managed Care at any time.
4. Voluntary opt-in populations may return to Legacy Medicaid for all state plan services other than Specialized Behavioral Health and NEMT at any time effective the earliest possible month that the action can be administratively taken.
5. Voluntary opt-in populations who have previously returned to Legacy Medicaid for all state plan services other than Specialized Behavioral Health and NEMT may exercise this option to return to Medicaid Managed Care for other state plan services only during the annual open enrollment period.

Mandatory MCO Populations – Specialized BH and NEAT

Mandatorily enrolled individuals in Medicaid Managed Care for Specialized Behavioral Health Services and Non-Emergency Ambulance Transportation (NEAT) only:

1. Nursing Facilities (NF)
2. Individuals under the age of 21 residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD).

Mandatory MCO Populations- Specialized BH and NEMT

Specialized Behavioral Health and Non-Emergency Medical Transportation (NEMT) Services

1. Individuals who receive both Medicaid and Medicare (Medicaid dual eligible) are mandatorily enrolled in Medicaid Managed Care for Specialized Behavioral Health Services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified under Section 3.6.
2. LaHIPP members are mandatorily enrolled in Medicaid Managed Care for Specialized Behavioral Health Services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified under Section 3.6.

Mandatory MCO Populations – Except Specialized BH and CSoC

All Covered Services except Specialized Behavioral Health and CSoC services

The MCO shall accept Enrollment of the following Medicaid populations for all services specified in Section 6, except Specialized Behavioral Health Services and Coordinated System of Care (CSoC) services. For this population, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), and Substance Use Disorder (SUD) Residential services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21) remain the responsibility of the MCO:

1. Children who are functionally eligible and participate in the CSoC program.

Excluded Populations

Individuals in an “excluded population” may not enroll in a Louisiana Medicaid Plan. Excluded populations are:

1. Adults (age 21 and older) residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)
2. Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE) a community-based alternative to placement in a nursing facility that includes a complete “managed care” type of benefit combining medical, social and long-term care services
3. Refugee Cash Assistance
4. Refugee Medical Assistance
5. Take Charge Plus
6. SLMB only
7. QI 1
8. LTC Co-Insurance
9. QDWI
10. QMB only and
11. Individuals with a limited eligibility period including:
    a. Spend-down Medically Needy Program
    b. Emergency Services Only
    c. Continued Medicaid Program

The Louisiana Department of Health may add, delete, or otherwise change mandatory, voluntary opt-out, voluntary opt-in, and excluded population groups. If changed, they will provide sixty (60) days advance notice whenever possible, and we will work closely with them to inform our network providers and members of any changes.

Rights and Responsibilities

RIGHTS FOR ALL PROVIDERS

Louisiana Healthcare Connections providers have the **right** to:

- Be treated by our members and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital or other offices running smoothly
- Expect other network providers to act as partners in members' treatment plans
- Make a complaint or file an appeal against Louisiana Healthcare Connections and/or a member
- File a grievance with Louisiana Healthcare Connections on behalf of a member, with the member's consent
- Have access to information about Louisiana Healthcare Connections quality improvement programs, including program goals, processes and outcomes that relate to member care and services
- Contact Louisiana Healthcare Connections Provider Services with any questions, comments, or problems
- Collaborate with other healthcare professionals who are involved in the care of members

PROVIDER STANDARDS OF PRACTICE

- Comply with our Utilization Management (UM) Programs
- Cooperate with our Quality Improvement (QI) Program (e.g., allow review of or submit requested charts, receive feedback)
- Support member access to care by meeting or exceeding our access standards
- Use the concept of Medical Necessity and evidence-based best practices when formulating a treatment plan and requesting ongoing care
- Coordinate care with other clinicians as appropriate, including consistent communication with the PCP and assist members in identifying and utilizing community support groups and resources
- Maintain confidentiality of records and treatment and obtain appropriate written consents from members when communicating with others regarding member treatment;
- Notify us of any adverse incidents within one business day
- Notify us of any changes in licensure, any malpractice allegations, and any actions by your licensing board (including, but not limited to, probation, reprimand, suspension, or revocation of license)
- Report any suspected fraud, waste and/or abuse
- Notify us of any changes in malpractice insurance coverage
- Complete credentialing and re-credentialing materials as requested by us
- Maintain an office that meets all standards of professional practice
- Inform Louisiana Healthcare Connections when a member missed appointments – at your practice or another provider's – so we can educate them about the importance of keeping their appointments.

- Assume full responsibility for all tax obligations, worker's compensation insurance, and all other applicable insurance coverage obligations required, for provider and its employees. LDH and Louisiana Healthcare Connections will have no responsibility or liability for any taxes or insurance coverage.
- Timely implementation of LDH and Louisiana Healthcare Connection’s decisions related to grievances, member appeals, claims dispute or adverse incident mitigation recommendations.
- Assist members in understanding their right to file grievances and appeals.

PRIMARY CARE PROVIDERS

The Primary Care Provider (PCP) is the cornerstone of the Louisiana Healthcare Connections service delivery model. The PCP serves as the “medical home” for the member. The Medical Home concept assists in establishing a member-provider relationship, supports continuity of care and member safety, and leads to elimination of redundant services and ultimately more cost-effective care and better health outcomes.

PCP Responsibilities:

- Manage and coordinate the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring member safety at all times including members with special needs and chronic conditions.
- Communicate with other providers to coordinate and follow up on the care of individual patients.
- Provide the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid.
- Maintain a medical record of all services rendered by the PCP, of referrals to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care.
- Develop of plan of care to address risks, medical needs, and continuity of care for individuals with special health care needs.
- Ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes
- Provide after-hours availability to patients who need medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.
- Maintain hospital admitting privileges or arrangements with a physician who has admitting privileges at a participating hospital.
- Working with Louisiana Healthcare Connections care managers to develop plans of care for members engaged in care management.
- Participate in Louisiana Healthcare Connections’ care management team, as applicable and medically necessary.
- Conduct screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs) and substance use to determine needs for behavioral health services, and make appropriate referrals.
- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Maintain continuity of each member’s health care by serving as the member’s medical home.
- Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available.
- Adhere to the EPSDT periodicity schedule for members under age 21.
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list except for emergency services up to the

point of stabilization as well as coordinating services the member is receiving from another health plan during transition of care.

- Share results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned so services are not duplicated.
- Actively participate in and cooperate with all Louisiana Healthcare Connections quality initiatives and programs.
- Provide notice to Louisiana Healthcare Connections about any updated contact and demographic data about yourself and your practice to ensure our members have reliable access to the care they need.
- Adopt certified electronic health record technology (CEHRT) and comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC)
- Offer the same services to members as those offered to individuals not receiving services through the Louisiana Medicaid Program, provided that they are covered services.
- Treat members equally in terms of scope, quality, duration, and method of delivery of services, unless specifically limited by regulation.
- Not required to accept every member requesting services
- Personal care services (PCS) and home health care services to use the State-contracted electronic visit verification (EVV) system as directed by LDH.

"Incident to" Service

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

Provider Types That May Serve as PCPs

Specialty types who may serve as PCPs include Internists, Pediatricians, Obstetrician / Gynecologists, Family and General Practitioners and Nurse Practitioners. The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or outpatient clinic. Louisiana Healthcare Connections may allow some specialists to serve as a PCP for members with multiple disabilities or with acute or chronic conditions as long as the specialist is willing to perform the responsibilities of a PCP as stipulated on page 14 of this handbook.

Louisiana Healthcare Connections will provide members with access to PCPs who offer extended office hours during the week and on weekends. As part of its reporting responsibilities, Louisiana Healthcare Connections will notify the state's enrollment broker of any PCP who will not accept new patients or who has reached member enrollment capacity.

Assignment of PCPs / Medical Home

For those members who have not selected a PCP during enrollment, Louisiana Healthcare Connections will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the criteria and in the sequence presented below:

1. **Member history with a PCP:** The algorithm will first look to see if the member is a returning member and attempt to match them to previous PCP. If the member is new to Louisiana

Healthcare Connections, claims history provided by the state will be used where possible to match a member to a PCP with whom the member had a previous relationship.

2. **Family history with a PCP:** If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member's family, such as a sibling, is or has been assigned to.
3. **Geographic proximity of PCP to member residence:** The auto-assignment logic will ensure members travel no more than 30 miles in the rural regions and 10 miles in the urban regions.
4. **Appropriate PCP type:** The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.

Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester of gestation.

In the event that the pregnant member does not select a pediatrician or other appropriate PCP, Louisiana

Healthcare Connections will assign one for her newborn. If Louisiana Healthcare Connections was not aware the member was pregnant until she presented for delivery, Louisiana Healthcare Connections will assign a pediatrician or PCP to the newborn baby within one business day after birth.

Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Louisiana Healthcare Connections does not guarantee any provider will receive a certain number of members. The PCP to member ratio shall not exceed the following:

- Physicians 1: up to 2,500
- Nurse Practitioner 1: up to 1,000
- Physician with physician extenders (Nurse Practitioner/Physician Assistant and Certified Nurse Midwife for OB/GYNs only) may increase basic physician ratio of 1: up to 2,500 by 1,000 per extender.

If a PCP declares a specific capacity for his/her practice and wants to change that capacity, the PCP must contact Louisiana Healthcare Connections Provider Services at 1-866-595-8133. A PCP shall not refuse to treat members as long as the physician has not reached the requested panel size.

Providers shall notify Louisiana Healthcare Connections in writing at least 45 days in advance of his or her inability to accept additional Medicaid covered persons under Louisiana Healthcare Connections agreements. In no event shall any established member who becomes a Covered Person be considered a new patient. Louisiana Healthcare Connections prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

PCP Right to Dismiss Member from Panel

A PCP may request a member's disenrollment from his/her panel and the reassignment of that member to a new PCP. Louisiana Healthcare Connections facilitates these requests in a manner that continues to provide members with required healthcare in an environment acceptable to both the member and their provider.

The following are unacceptable reasons to request dismissal of a member from a PCP's panel:

- A change in the member's health status or need for treatment

- A member's diminished mental capacity or disruptive behavior that results from the member's special healthcare needs unless the behavior impairs the ability of the PCP to furnish services to the member or others
- Transfer requests shall not be based on race, color, national origin, disability, sexual identity, ethnicity, primary language, age, or gender.

Any request for dismissal of a member from a PCP's panel must be made in writing. Louisiana Healthcare Connections has the authority to approve all transfers.

The procedure outlined below shall be followed in making requests for dismissals and transfers:

- Providers are encouraged to contact Louisiana Healthcare Connections with concerns about at-risk members.
- The PCP must submit written notice of his/her intent to dismiss a member from his/her panel to both the member and to Louisiana Healthcare Connections.
- The member's new PCP will be selected based upon the following criteria:
    - If the member was previously a plan member, assignment shall be made to the previous PCP.
    - If a family member has a historical provider relationship with a PCP, assignment shall be made to the same PCP, provided that the PCP is appropriate based upon the age and gender of the member.
    - If the previous criteria is not met, the steps below will be followed based on the member's age, gender, and geographic (zip code) proximity (within 10 miles if the member resides in an urban region or within 30 miles if the member resides in a rural region):
        - If the member does not have a claims history and cannot be reached after the plan attempts to call three (3) times, the member will automatically be placed in a FQHC for placement.
        - For members with claims history on file:
            - First preference will be given to a Premier Provider Group if the member is age appropriate for that group.
            - Second preference will be given to Premier Lite Provider Group if the member is age appropriate for that group.
            - Third preference will be given to providers in order of decreasing HBR (lower HBR gets first priority).
    - As members are assigned to a PCP, the provider's panel status is updated to reflect current member count. Once the maximum panel limit is reached, members can no longer be assigned to that PCP through the automated process.
- Members will receive a Member ID card including their new PCP name by certified mail. The replacement Member ID card will be postmarked within five (5) business days of the requested change.
- Member will retain the right to seek urgent care from the original PCP for 30 days following their receipt of the notice of dismissal.
- If the member wishes to contest the dismissal, Member Services will assist the member with their request.

In the event Louisiana Healthcare Connections makes a manual assignment, the member retains the right to make PCP change selection within the plan at any time.

Member PCP Reassignment Process

Accurate PCP assignment is important to establish a medical home for each member. We regularly evaluate PCP assignment to reflect real world patterns of care, to strengthen and support relationships between PCPs and their patients. Member reassignment policies shall apply to all in-network PCPs, all members who have been assigned to the current PCP for at least 90 days, and members who have not seen the assigned PCP within the prior 12 months.

Louisiana Healthcare Connections will perform a claims analysis on a quarterly basis and shall be based on the previous 12 months (at minimum) of claims history, including wellness visits and sick visits.

A member will only be eligible for reassignment if they have visited an unassigned PCP at least once within the previous 12 months.

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

Members who have not seen the assigned PCP or any other PCP will not be reassigned.

If the member has an established relationship, defined by at least one claim within the previous 12 months, with an unassigned PCP, Louisiana Healthcare Connections will reassign that member appropriately, even if the unassigned PCP's panel shows that it is closed. The member-PCP relationship takes priority over a closed panel.

All reassignments shall be prospective.

Provider notification will include formal notification (via email/portal) to the PCP regarding results of the analysis and the notification shall be a set date each month. The PCP is allowed 15 business days to review before any member are reassigned.

Louisiana Healthcare Connections will include a protocol for provider disputes with the results from the claim analysis. The provider must provide documentation [e.g., medical record, proof of billed claim, etc. for at least one date of service (DOS)] that they have seen the member(s) during the previous 12 months.

A flag for providers will be incorporate to identify new members on their rosters/panels easily and a flag to indicate if the member was auto-assigned or not. This flag is for all members, not just reassigned.

Member (s) will be mailed a new Member ID card via certified mail which will include the name of their new PCP. The replacement Member ID card will be post marked within five (5) business days of the requested change completion date. Member (s) will also receive a letter advising them about the move.

24-Hour Access

Louisiana Healthcare Connections PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed 24 hours per day, 365 days per year as follows:

- A provider's office phone must be answered during normal business hours
- During after-hours, a provider must have arrangements for:
    - Access to a covering physician, an answering service, or a triage service; **or**

- A voice message that provides a second phone number that is answered. Any recorded message must be provided in English and Spanish if the provider's practice includes a high population of Spanish-speaking members.

Examples of unacceptable after-hours coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours;
- The provider's office telephone is answered after-hours by a recording that tells patients to leave a message;
- The provider's office telephone is answered after-hours by a recording that directs patients to go to an emergency room for any services needed; and/or
- A clinician returning after-hours calls outside 30 minutes.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision.

Whenever possible, the PCP, specialty physician or covering medical professional must return the call within 30 minutes of the initial contact.

After-hours coverage must be accessible using the medical office's daytime telephone number.

Louisiana Healthcare Connections will monitor providers' offices after-hours coverage through surveys and through mystery shopper calls conducted by Louisiana Healthcare Connections Provider Network staff.

Covering Providers

PCPs and specialty physicians must arrange for coverage with another provider during scheduled or unscheduled time off and preferably with another Louisiana Healthcare Connections network provider.

In the event of unscheduled time off, please notify the Provider Consulting department of coverage arrangements as soon as possible.

The covering physician is compensated in accordance with the fee schedule in their agreement, and, if not a Louisiana Healthcare Connections network provider, he/she should be paid as a non-participating provider.

Referrals

It is Louisiana Healthcare Connections' preference that the PCP coordinates healthcare services; however, PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of what the PCP can provide. Obtaining referrals from the PCP are not required as a condition of payment for services by Louisiana Healthcare Connections.

All out-of-network services require prior authorization except for family planning, emergency room and tabletop X-ray services. A provider is also required to promptly notify Louisiana Healthcare Connections when prenatal care is rendered, so we can engage and support pregnant members.

The PCP shall provide basic behavioral health and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

Louisiana Healthcare Connections encourages specialists to communicate to the PCP the need for a referral to another specialist. This allows the PCP to better coordinate their members' care and become aware of the additional service request.

In accordance with state law, providers are prohibited from making referrals to healthcare entities with which the provider or a member of the providers' family has a financial relationship.

Advanced Directives

Louisiana Healthcare Connections is committed to ensuring that its members are aware of and are able to execute advance directives. Louisiana Healthcare Connections is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to Louisiana Healthcare Connections members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

Louisiana Healthcare Connections recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an advance directive and the member's response should be documentedin the medical record.
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP's office and document this request in the member's medical record.
- An advance directive should be a part of the member's medical record and include mentalhealth directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

Providers are also encouraged to discuss the Louisiana Physician Orders for Scope of Treatment (LaPOST) document with patients who have serious, advanced illnesses. The LaPOST document and model of care were created to effectively communicate the wishes of patients with serious, advanced illnesses to have or to limit medical treatment as they move from one healthcare setting to another. The voluntary, non-biased document is a physician's order that outlines patients' end-of-life care wishes and treatment goals. The LaPOST document should only be completed after a thorough discussion with the patient, or the patient's healthcare representative, about the patient's illness, treatment preferences, values, and goals of care. Because it establishes medical orders, it must be signed by a physician and the patient, or the patient's healthcare representative, to be valid. The document may be revoked or modified at any time based on changes in, or new information about, the patient's condition or personal preferences. The LaPOST document is complementary to advance directives; it may be used in the absence of an advance directive or to translate an advance directive into a physician's order.

SPECIALISTS

Understanding the importance of specialist play in our members care, Louisiana Healthcare Connections encourages communication between specialist and PCPs.

Fostering this communication allows the PCP to better coordinate the members' care and ensure the referred specialty physician is a participating provider within the Louisiana Healthcare Connections network and that the PCP is aware of the additional service request.

The specialist provider must:

- Obtain authorization from Louisiana Healthcare Connections Medical Management Department if needed before providing services. Refer to the Prior Authorization section of the manual for additional details.
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for, or provide on-call coverage through another source, 24 hours per day for management of member care
- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all Louisiana Healthcare Connections quality initiatives and programs
- Adopt health information technology (HIT) and its meaningful use with specific emphasis on connection to the Louisiana Health Information Exchange (LaHIE) and development of a secure, web-accessible health record for members such as personal health records (PHRs)

Finding a Specialist

Louisiana Healthcare Connections is committed to working with providers to ensure our members – your patients – have access to the specialty care they need. For assistance locating an in-network specialist for your patients, providers may:

Search for a Specialist Online

The provider search tool at www.LouisianaHealthConnect.com is the fastest, easiest way to find the providers you need. You can search by location, provider name, specialty, and much more. And you can even get personalized directions to their office.

Email for Personalized Service:

Send us an email at FindASpecialist@LouisianaHealthConnect.com and let us know what type of specialist and location. Our provider services team will get to work finding the specialist you need.

HOSPITALS

Louisiana Healthcare Connections utilizes a network of hospitals to provide services to Louisiana Healthcare Connections members. Hospital service providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth by LDH.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's ER visit.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify Louisiana Healthcare Connections Medical Management department by sending an electronic file of the ER admission by the next business day. The electronic file should include the member's name, Medicaid ID, presenting symptoms/diagnosis, date of service and member's phone number.
- Notify Louisiana Healthcare Connections Medical Management department of all admissions within one business day.
- Notify Louisiana Healthcare Connections Medical Management department of all newborn deliveries within two business days of the delivery.
- Adopt health information technology (HIT) and its meaningful use with specific emphasis on connection to the Louisiana Health Information Exchange (LaHIE) and development of a secure, web-accessible health record for members such as personal health records (PHRs).
- Louisiana Healthcare Connections will require all emergency departments (EDs) in its network to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and chronic disease management. The visit registry would consist of three basic attributes: 1) the ability to capture and match patients based on demographics information, 2) the ability to identify the facility at which care is being sought, and 3) at minimum, the chief complaint of the visit. These three pieces of information are commonly available through the HL7 ADT message standard and in use by most ED admission systems in use today across the country.
- This data will be available in real-time in order to assist providers and systems with up-to-date information for treating patients appropriately.
- Report the births of newborns within 24 hours of birth for enrolled members using LDH's web-based Facility Notification System (FNS) Newborn Manual.
- Register all births through the Louisiana Electronic Event Registration System (LEERS) administered by LDH/Vital Records Registry.
- Louisiana Healthcare Connections will require all network hospitals to comply with the data submission requirements of La. R.S. 40: 1300.111-114. Including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:II.105). Louisiana Healthcare Connections will encourage the use of HIEs where direct connections to public health reporting information systems are not feasible or are cost prohibitive.

Emergency admissions will require notification to Louisiana Healthcare Connections' Medical

Management Department within two business days of admission to conduct medical necessity review. All non-emergency inpatient admissions require prior authorization from Louisiana Healthcare Connections.

Louisiana Healthcare Connections may withhold payment on hospital ER claims if Member ER Data is not submitted to the health plan within 10 calendar days after the member was present. Louisiana Healthcare Connections hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

BEHAVIORAL HEALTH PROVIDERS

Louisiana Healthcare Connections understands the value of behavioral health providers for our member's complete care. Behavioral health providers are required to:

- Only provide health care applicable to your provider license and the qualifications and requirements as stated in the LA Medicaid Behavioral Health Services provider manual.
- Refer Members with known or suspected physical health concerns or disorders to the PCP for examination and treatment.
- When your patients are involved in inpatient treatment, ensure appropriate discharge planning and outpatient follow-up treatment occurs within seven days from the date of discharge.
- Contact Members who have missed appointment within 24 hours to reschedule appointments.
- Meet Quality Mental Health Professional for Community Services (QMHP-CS) requirement minimums. The requirement minimums for a QMHP-CS are as follows:
    - Demonstrated competency in the work to be performed; and
    - Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or be a Registered Nurse (RN).
- Comply with all requirements stated in the Behavioral Health Services Provider Manual chapter in effect at the time of service, the state's Model Contract, and CMS approved waivers and SPA
- Notify Louisiana Healthcare Connections when you are not accepting new clients, or if you do not accept a new client and the associated cause.
- Utilize the electronic Medicaid Clinical Data Inquiry (e-CDI) system (accessible via www.lamedicaid.com) to perform medication searches within the member's medical history to ensure that appropriate medication management is conducted, prior to prescribing medication for members.
- Submit to LDH and/or Louisiana Healthcare Connections as determined by LDH of the National Outcome Measures, including access to services, engagement in services, independent and stable housing, employment, and employment training rates.
- Provide continuity of care for members reaching the age of majority without service disruptions or mandatory changes in providers.
- Louisiana Healthcare Connections will not offset LDH recouped payments on the behavioral health provider after LDH has verified that Louisiana Healthcare Connections was at fault for the error in payment, unless approved in writing by LDH.

TELEPHONE ARRANGEMENTS

PCPs and specialists must:

- Answer the member's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
    - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes
    - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibilityof professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record. When providing after-hours availability to patients who need medical advice, at minimum, the PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.

NOTE: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.

APPOINTMENT AVAILABILITY

The following appointment availability standards have been established as minimum requirements to ensure that members' needs are sufficiently met. Louisiana Healthcare Connections will ensure that appointments with qualified providers are conducted on a timely basis as follows:

TYPE OF VISIT/ADMISSION/APPOINTMENT	ACCESS/TIMELINESS STANDARD
Primary Care Appointment Access Standards	
Urgent non-emergency care	24 hours, 7 days per week within 24 hours of request.
Non-urgent sick	72 hours
Non-urgent routine primary care	6 weeks
After hours, by phone	Answer by live person or call-back from a designated medical practitioner within 30 minutes
Specialty Care Appointment Standards	
Specialist appointments	1 month
OB 1st Trimester	14 days
OB 2nd Trimester	7 days
OB 3rd Trimester	3 days
OB High-risk pregnancy, any trimester	3 days
OB Family planning appointments	1 week
Behavioral Health Appointment/Admission Access Standards	
Follow-up routine care prescribers	Within 30 days
Follow-up routine care non-prescribers	Within 20 days
Non-urgent initial routine behavioral health care prescribers/non-prescribers	Within 10 business days
Urgent non-emergency behavioral health care Prescribers/non-prescribers	48 hours
Non-life-threatening emergencies prescribers/non-prescribers	Within 1 hour
Psychiatric inpatient hospital (emergency involuntary)	4 hours
Psychiatric inpatient hospital (involuntary)	24 hours
Psychiatric inpatient hospital (voluntary)	24 hours
ASAM Level 3.3, 3.5 & 3.7	10 business days
Residential withdrawal management	24 hours when medically necessary
Psychiatric Residential Treatment Facility (PRTF)	20 calendar days
Additional Timely Access Appointments	
Emergency Care	24 hours, 7 days/week within 1 hour of request
Lab and X-ray services	Not to exceed 3 weeks for regular appointments and 48 hours for urgent or clinically indicated
In Office Waiting Times	
Scheduled appointments	Less than a 45-minute wait in office. If wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment.

Louisiana Healthcare Connections follows the standards for appointment availability for members outlined in the Model Contract with LDH, Attachment F: Provider Network Standards (https://ldh.la.gov/page/mco-contracts-louisiana-healthcare-connections-jan-1-2023-present). Network providers are to offer hours of operation in the same manner for members and non-Medicaid members.

REPORTING ADVERSE INCIDENTS

An adverse incident is defined as any occurrence which is not consistent with the routine operation of a behavioral health provider. It includes but is not limited to; injuries to members or member advocates, suicide/homicide attempt by a member while in treatment, death due to suicide/homicide, sexual battery, medication errors, member escape or elopement, altercations involving medical interventions, or any other unusual incident that has high risk management implications.

As mandated reporters, and as required by Louisiana's Children's Code Title VI, Article 603, and LDH, providers are required to submit the Adverse Incident Reporting Form **within ONE business day of discovery of the adverse incident** to Louisiana Healthcare Connections.

Providers are to use the AI Reporting Form and AI Reporting Form Instructions found on the Louisiana Healthcare Connections website:

- Adverse Incident Reporting Form: www.lahealth.cc/adverseincidentform
- Adverse Incident Reporting Form Instructions: www.lahealth.cc/adverseincidentforminstructions

LDH has provided the following example to clarify the "within one business day" reporting requirement:

> For example, if the time of discovery of the incident is on Friday at 4 p.m., and the reporting provider's office closes at 5 p.m., the provider will have until the following Monday at 4 p.m. to report the incident to the appropriate Healthy Louisiana health plan.

AI Reporting Form are to be submitted via fax to 1-866-704-3063.

If the incident is reportable to a protective agency, such as DCFS or APS, there must be documentation included in Section 4 of the AI Reporting Form that those agencies were informed immediately.

An adverse incident is defined as an unexpected occurrence that led to, or could have led to, serious unintended or unexpected harm, loss, or damage. Adverse incidents result in unintended harm to the member by an act of commission or omission, rather than by the underlying disease or condition. These include, but are not limited to death, abuse and/or neglect.

Providers must submit forms to Louisiana Healthcare Connections, not the state. Louisiana Healthcare Connections tracks and monitors providers to ensure compliance with the state's adverse incident reporting requirements.

Providers can register for Adverse Incident Reporting Training at no cost (and other free educational and training opportunities) by visiting **www.envolveu.com**.

MEMBER RIGHTS AND RESPONSIBILITIES

Louisiana Healthcare Connections members have the following **rights**:

- To be treated with respect and with consideration for his or her dignity and privacy.
- To receive the right to privacy and non-discrimination as required by law.
- To join their providers in making decisions about their healthcare.
- To refuse any medical service, diagnoses, treatment, or health service if the member or the member's parent/guardian objects based on religious grounds.
- To discuss treatment options, regardless of cost or benefit coverage.
- To seek a second opinion.
- To receive information about Louisiana Healthcare Connections, including but not limited to:
    - Benefits covered
    - Procedures for obtaining benefits, including any authorization requirements
    - Any cost sharing requirements
    - Service area
    - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care dentist, specialists, and hospitals
    - Any restrictions on member's freedom of choice among network providers
    - Providers not accepting new patients; and
    - Benefits not offered by Louisiana Healthcare Connections but available to members and how to obtain those benefits, including how transportation is provided.
    - Structure and operations
    - Services and service utilization plans
    - Practitioners and providers
    - Physician incentive plans
    - Member rights and responsibilities
- To receive a complete description of disenrollment rights at least annually.
- To make recommendations regarding Louisiana Healthcare Connections' member rights and responsibilities.
- To get information about available experimental treatments and clinical trials and how such research may be accessed.
- To obtain assistance with care coordination from provider(s).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in the federal regulations on the use of restraints and seclusion.
- To express a concern about or appeal a Louisiana Healthcare Connections decision or the care it provides and to get a response in a reasonable period of time.
- To look at and get a copy of their medical records as permitted by law (one copy free of charge each year) and request they be amended or corrected.
- To make an Advance Directive about the types of care the member wants to receive.

- To file a complaint with the Louisiana Department of Health if the member's Advanced Directive is not followed. To choose a provider who gives the care whenever possible and appropriate.
- To receive accessible health care services comparable in amount, duration and scope to those provided under Medicaid Fee for Service (FFS) and sufficient in amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished.
- To receive appropriate services not denied or reduced solely because of diagnosis, type of illness or medical condition.
- To receive all information (e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives) in a manner and format that may be easily understood.
- Freedom to exercise the rights described herein without any adverse effect on treatment by LDH, Louisiana Healthcare Connections, its providers or contractors.
- To receive all written member information from Louisiana Healthcare Connections:
- At no cost to the member
- In the prevalent non-English languages of its members in the service area.
- In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as "prevalent."
- To be notified that oral interpretation services are available and how to access them.
- To get help from both LDH and its Enrollment Broker in understanding the requirements and benefits of Louisiana Healthcare Connections.
- To receive notice of any significant changes in core benefits and services at least 30 days in advance.
- To receive information on grievance, appeal, and state fair hearing procedures and to request continuation of benefits during the hearing process.
- To receive detailed information on emergency and after-hours coverage, including but not limited to:
    - What constitutes an emergency medical condition, emergency services, and post-stabilization services
    - That emergency services do not require prior authorization
    - The process and procedures for obtaining emergency services
    - The locations of any emergency settings and other locations at which providers and hospitals furnish covered emergency services and post-stabilization services
    - Member's right to use any hospital or other setting for emergency care
    - Post-stabilization care services rules as detailed in 42 C.F.R. §422.113(c)
- To receive Louisiana Healthcare Connections policy on referrals for specialty care and other benefits not provided by the member's PCP.

Louisiana Healthcare Connections members have the following **responsibilities**:

- To inform Louisiana Healthcare Connections of the loss or theft of an ID card
- Present their member ID card when using healthcare services
- Be familiar with Louisiana Healthcare Connections procedures to the best of their abilities
- To call or contact us to obtain information and have questions clarified
- To provide participating network providers with accurate and complete medical information
- To follow the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible
- To make every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services
- To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
- To live healthy lifestyles and avoid behaviors known to be detrimental
- To provide accurate and complete information to all health care providers
- To become knowledgeable about Louisiana Healthcare Connections coverage provisions, rules, and restrictions
- To ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives, and then making care decisions after carefully weighing all pertinent factors
- To follow the grievance process established by Louisiana Healthcare Connections (and outlined in the Member Handbook) if there is a disagreement with a provider.

Quality Improvement

THE PURPOSE OF QUALITY IMPROVEMENT

Louisiana Healthcare Connections is committed to the provision of a well-designed and well-implemented Quality Assessment and Performance Improvement Program (QAPI Program). Our culture, systems, and processes are structured around our mission to improve the health of all enrolled members. The QAPI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, population health management, behavioral health, over- and under-utilization, continuity and coordination of care, member safety, and administrative, member, and network services.

We recognize our legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate setting. Louisiana Healthcare Connections provides for the delivery of quality care with the primary goal of improving the health status of the members. When a member's condition is not amenable to improvement, the health plan implements measures to prevent any further decline in condition or deterioration of health status or provides for comfort measures as appropriate and requested by the member. The QAPI Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, Louisiana Healthcare Connections' QAPI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members.

In order to fulfill our responsibility to members, the community and other key stakeholders, and regulatory and accreditation agencies, the health plan's Board of Directors has adopted the following QAPI Program Description. The program description is reviewed and approved at least annually by the Quality Assessment and Performance Improvement Committee (QAPIC) and Louisiana Healthcare Connections' Board of Directors.

Scope of the QAPI Program

The scope of the QAPI Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to Louisiana Healthcare Connections members including medical, behavioral health, dental, and vision care as included in the health plan's benefits. Louisiana Healthcare Connections incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality improvement activities, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care (as applicable per the health plan's products), and ancillary services. Louisiana Healthcare Connections' QAPI Program monitors the following:

- Acute, complex, and chronic care management
- Behavioral health care
- Behavioral health fidelity plans and criteria
- Care furnished to members with special health care needs
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight

- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member grievance and appeals system
- Member experience
- Member safety
- Primary care provider changes
- Pharmacy
- Primary care provider after-hours telephone accessibility Louisiana HealthcareConnections' Member Services after-hours telephone accessibility
- Provider appointment availability
- Provider complaints
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- Medical management
- Population health management
- Utilization management, to ensure proper member placement into the right level and type of care. This prevents over- and under-utilization of services.

Goals of the QAPI Program

Louisiana Healthcare Connections' primary quality goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered.

- QAPI Program goals include but are not limited to the following:
- A high level of health status and quality of life will be experienced by the members;
- Network quality of care and service will meet industry-accepted standards of performance;
- The health plan's services will meet industry-accepted standards of performance;
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement activities across functional areas;
- Member satisfaction will meet Louisiana Healthcare Connections' established performance targets;
- Preventive health and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with guidelines for immunizations, prenatal care, diabetes, asthma, Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT), etc.;

- Louisiana Healthcare Connections will measure specialized behavioral health providers' compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance. Compliance with all applicable regulatory requirements and accreditation standards is maintained.

Our QAPI Program **objectives** include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize management information systems in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes;
- To allocate personnel and resources necessary to: support the QAPI Program, including data analysis and reporting; meet the educational needs of members, providers, and staff relevant to quality improvement efforts; meet all regulatory and accreditation requirements;
- To seek input and work with members, providers and community resources to improve quality of care;
- To oversee peer review procedures that address deviations in medical management and health care practices and devise action plans to improve services;
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute focused quality studies in clinical and non-clinical areas, where appropriate;
- To incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; Plan-Do-Study-Act cycles or continuous quality improvement activities; member and/or provider surveys; and activities that address health disparities identified through data collection.
- Increase the use of outcome measurements for all patients receiving specialized behavioral health care services through means of developed strategies and annually report as per state requirements;
- To serve patients with complex health needs;
- To conduct and report annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and certified Healthcare Effectiveness Data and Information Set (HEDIS®) results for patients;
- To achieve and maintain NCQA accreditation and/or other applicable accreditations for appropriate products; and
- To monitor for compliance with regulatory and accreditation requirements.

Program Structure

The Louisiana Healthcare Connections Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to patients. The BOD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Assessment and Performance Improvement Committee (QAPIC) is a senior management committee with physician representation that is directly accountable to the Board of Directors. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to patients. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of patients, providers and staff regarding the QI, UM and Credentialing programs.

The following sub-committees report directly to the QAPIC:

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- CLAS Task Force
- Performance Improvement Team
- Patient, Provider, and community advisory committees
- Joint Operations Committees
- Peer Review Committee (Ad Hoc Committee)

Member Safety and Quality of Care

Member Safety is a key focus of Louisiana Healthcare Connections QAPI Program. Monitoring and promoting member safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of member care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a patient.

Louisiana Healthcare Connections employees, including medical management staff, member services staff, provider services, complaint coordinators, etc., panel practitioners, facilities or ancillary providers, patients or member representatives, Medical Directors or the BOD may advise the QI Department of potential quality of care issues. Adverse events may also be identified through claims based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

Louisiana Healthcare Connections QAPIC reviews and adopts an annual QAPI Program and Work Plan based on managed care Medicaid appropriate industry standards. The QAPIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Louisiana Healthcare Connections to monitor improvement over time.

Annually, Louisiana Healthcare Connections develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QAPIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QAPIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Louisiana Healthcare Connections communicates activities and outcomes of its QAPI Program to both patients and providers through avenues such as the member newsletter, provider newsletter and the Louisiana Healthcare Connections web portal at LouisianaHealthConnect.com.

At any time, Louisiana Healthcare Connections providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Louisiana Healthcare Connections progress in meeting the QAPI Program goals by contacting the Quality Improvement department.

MONITORING CLINICAL QUALITY

Each year, and at various intervals throughout the year, we audit and measure the following:

- Access standards for care
- Adherence to clinical practice guidelines
- Treatment record compliance
- Communication with PCPs and other behavioral health practitioners
- Adverse incidents
- Member safety
- High-risk member identification, management and tracking
- Discharge appointment timeliness and reporting
- Process standards and trends in grievances and complaints
- Potential over- and under-utilization
- Provider satisfaction
- Member satisfaction
- Completion of Functional Assessment
- Medical treatment record reviews
- Outcome tracking of treatment evaluations
- Appointment availability
- Discharge follow-up after inpatient or partial hospitalization reporting
- Crisis response
- Monitoring appropriate care and service
- Provider quality profiling
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and recredentialing)
- Behavioral healthcare (within benefits)
- Delegated entity oversight
- Continuity and coordination of care
- Compliance with member confidentiality laws and regulation
- Employee and Provider cultural competency
- Provider and Health Plan after-hours telephone accessibility
- Member enrollment and disenrollment
- PCP changes
- Department performance and service
- Marketing practices
- Provider compliance with the Medicaid Behavioral Health Services Provider Manual.

Findings are communicated to individual providers and practitioner groups for further discussion and analyzed to reinforce the goal of continually improving the appropriateness and quality of care rendered. We may request action plans from the Provider. Findings are considered during the re-credentialing process.

PROVIDER PARTICIPATION IN THE QI PROCESS

Louisiana Healthcare Connections recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Louisiana Healthcare Connections encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as but not limited to, the QAPIC, Credentialing Committee and select ad-hoc committees.

Providers are expected to meet our performance requirements and ensure member treatment is efficient and effective by:

- Cooperating with medical record reviews and reviews of telephone and appointment accessibility;
- Cooperating with our complaint review process;
- Participating in Provider satisfaction surveys; and
- Cooperating with reviews of quality-of-care issues and critical incident reporting.

In addition, providers are invited to participate in our QI Committees and in local focus groups.

Clinical Practice Guidelines

Louisiana Healthcare Connections clinical and quality programs are based on evidence-based preventive and clinical practice guidelines. Whenever possible, Louisiana Healthcare Connections adopts guidelines that are published by nationally recognized organizations or government institutions as well as statewide collaborative and/or a consensus of healthcare professionals in the applicable field.

Louisiana Healthcare Connections providers are expected to follow these guidelines, and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program.

Below is a sample of nationally recognized organizations from which CPGs are adopted by Louisiana Healthcare Connections:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- American Psychiatric Association
- American Society of Addiction Medicine (ASAM)
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

The list below is a sample of conditions for which LHCC has adopted CPGs. A full list can be found on our website, www.LouisianaHealthConnect.com:

- Attention Deficit Hyperactivity Disorder
- Adult and Pediatric Preventive Care
- Anxiety Disorder
- Asthma
- Bipolar Disorder
- COPD
- Diabetes
- Immunizations
- Major Depression
- Panic Disorders
- Post-Traumatic Stress Disorder
- Prenatal Care
- Psychotropic Medication
- Respiratory Illness
- Schizophrenia
- Substance Use Disorders

We have also adopted evidence-based practices for a variety of behavioral health services including:

- Assertive Community Treatment (ACT)
- Multi-systemic Therapy (MST)
- Homebuilders
- Functional Family Therapy (FFT)

For children, we have adopted guidelines for Depression in Children and Adolescents, Assessment and Treatment of Children and Adolescents with Anxiety Disorders and ADHD.

For the most current version of the guidelines adopted by Louisiana Healthcare Connections, visit our website at LouisianaHealthConnect.com. You may also request a paper copy of clinical and behavioral health evidence -based practices by contacting provider services.

Cultural Competency

Cultural competency is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It values differences and is responsive to diversity at all levels. Cultural competency is developmental, community focused and family oriented.

In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care.

Louisiana Healthcare Connections is committed to developing, strengthening, and sustaining healthy provider/member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk of receiving sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Evaluating Cultural Competency

As part of its credentialing process, Louisiana Healthcare Connections will also evaluate the cultural competency level of its network providers and provide access to training and toolkits to assist providers in developing culturally competent and proficient practices. Network providers must ensure:

- Members understand that they have access to medical interpreters and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the member's race/ethnicity and language and its impact/influence on the member's health or illness.
- Office staff that routinely interact with members have access to and participate in cultural competency training and development.
- Office staff that is responsible for data collection makes reasonable attempts to collect race and language specific member information.
- Office staff will explain race/ethnicity categories to members so that the members are able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender,

- sexual orientation and other characteristics that may influence the member's perspective on health care.
- Office sites have posted and printed materials in English and Spanish, and if required by LDH, any other required non-English language.
- Office sites comply with the Americans with Disabilities Act (ADA) and are assessed for accessibility such as designated disabled parking spaces and the presence of an elevator in multi-level buildings.

Providers are encouraged to use the Culturally and Linguistically Appropriate Services (CLAS) Standards, available at www.thinkculturalhealth.hhs.gov, and the ADA, available at www.ADA.gov, as guiding criteria for their practices. Please visit our website for a link to Continuing Education Credits (CEUs) in cultural competency.

Louisiana Healthcare Connections requires providers to be assessed on cultural competency on an ongoing basis, at least annually by providing a certificate of attendance either through Louisiana Healthcare Connections or other training organizations. Behavioral Health providers are required to receive training a minimum of three hours per year and as directed by the needs assessments.

Please visit our website under our "Provider Services" for a link to Continuing Education Credits (CE's) in cultural competency.

Assisting Individuals with Disabilities

Another aspect of cultural competency is sensitivity to individuals with disabilities. Louisiana Healthcare Connections encourages providers to be flexible with appointment schedules for members who need additional time to understand healthcare concerns or ask questions. Our Clinical Provider Trainers offer focused training sessions to providers and staff to further develop their capacity to meet with those members, if needed. Training sessions cover disability sensitivity, the importance of "People First" language and the social and personal barriers people with disabilities face and offer solutions to help accommodate their needs.

Health Literacy

Health literacy is another important component of Cultural Competency. Health literacy is the capacity to obtain, process and understand basic health information and services needed to make appropriate decisions. Patients' levels of health literacy can impact how and when they take their medications, their understanding of their health conditions, attendance at their appointments and the choices they make regarding treatment. Poor health literacy has been linked to poor health outcomes such as higher rates of hospitalization and less frequent use of preventative services. Some steps you can take to address poor health literacy include:

- Slowing down
- Use plain, non-medical language such as "skin doctor" instead of "dermatologist"
- Show or draw pictures
- Limit the amount of information provided and repeat it
- Use the "teach-back" technique
- Create a shame-free environment

Steps You Can Take

You can refer a Louisiana Healthcare Connections member to our Care or Disease Management teams if you feel they need a little extra help navigating their healthcare due to cultural, linguistic, health literacy or other difficulties. We may be able to assign them a Care Manager who is fluent in his or her language, can

take additional time to discuss their medical conditions or medications with them and/or can provide them with educational materials about their health condition that are translated into their preferred language or formatting needs.

You can also ask your Provider Representative for assistance in creating a more culturally competent and ADA-compliant practice or visit our website for more resources. Louisiana Healthcare Connections can provide you with demographic information about our membership in your area, assist with telephonic services for members who are deaf or hearing-impaired (such as TDD/TTY) or conduct cultural competency training at your office. Our online resources include a link to provider cultural competency training that provides CEUs from the U.S. Department of Health and Human Services' Office of Minority Health. Please contact us for more information at 1-866-595-8133.

MAINSTREAMING

Louisiana Healthcare Connections considers mainstreaming of its members into the broader health delivery system to be an important component of the delivery of care. Louisiana Healthcare Connections therefore must ensure that all providers accept members for treatment and that providers do not intentionally segregate members in any way from other persons receiving services.

To ensure mainstreaming of members, Louisiana Healthcare Connections shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference or identity, health status, income status, program membership, or physical or behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

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

When Louisiana Healthcare Connections becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the health plan shall develop a written plan for coming into compliance with the contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify LDH in writing.

Louisiana Healthcare Connections shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC & TREATMENT (EPSDT)

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21, a provision which is mandated by state and federal law. EPSDT services include periodic screening, vision dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged, either directly or through referral, even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population.

Louisiana Healthcare Connections and its providers will provide the full range of EPSDT services as defined in, and in accordance with, Louisiana state regulations and LDH policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care.

This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the periodic health screening assessment:

1. Comprehensive health and development history (including assessment of both physical and mental development)
2. Comprehensive unclothed physical examination or assessment
3. Immunizations appropriate to age and health history (unless medically contraindicated or parents/guardians refuse at the time.
4. Assessment of nutritional status
5. Laboratory tests (including finger stick hematocrit, urinalysis [dip-stick], sickle cell screen, if not previously performed, and blood lead levels that must be tested pursuant tothe EPSDT provider manual)
6. Developmental assessment
7. Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
8. Dental screening and services coordinated through FFS
9. Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
10. Health education and anticipatory guidance
11. Annual well-child visits for members under age 21

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member.

AUTISM SCREENING DURING EPSDT PREVENTION

In accordance with the American Academy of Pediatrics (AAP/Bright Futures periodicity schedule, Louisiana Healthcare Connections will cover developmental and autism screenings performed by primary care providers when administered at intervals outside EPSDT preventive visits if they are medically indicated for a member at-risk for, or with a suspected, developmental abnormality. Louisiana Healthcare Connections will reimburse the use of age-appropriate, caregiver-completed, and validated screening tools as recommended by the AAP. If a member screens positive on a developmental or autism screen, the provider must give appropriate developmental health recommendations, refer the member for additional evaluation, or both, as clinically appropriate. Providers must document the screening tool(s) used, the results of the screening, and any action taken, if needed, in the member's medical record. Providers will be reimbursed for one developmental screen and one autism screen per day of service. To receive reimbursement for both services performed on the same day, providers may submit claims for 2 units of the relevant procedure code.

PERINATAL DEPRESSION SCREENING

Louisiana Healthcare Connections will cover perinatal depression screening administered to a member's caregiver in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule. The screening can be administered from birth to 1 year during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) preventive visit, interperiodic visit, or E&M office visit. This service is a recommended, but not required, component of well-child care.

Perinatal depression screening requires one of the following validated screening tools:

- Edinburg Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire 9 (PHQ-9)
- Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9

Documentation must include the tool used, the results, and any follow-up actions taken. If an enrollee's caregiver screens positive, the provider must refer the caregiver to available resources, such as their primary care provider, obstetrician, or mental health professional, and document the referral. If the screening indicated possible suicidality, concern for the safety of the caregiver or member, or another psychiatric emergency, then referral to emergency mental health services is required. Though screening is administered to the caregiver, Louisiana Healthcare Connections will reimburse the service under the child's Medicaid coverage. If 2 or more children under the age of one present to care on the same day (e.g., twins or other siblings both under age one) the provider must submit the claim under only one of the children. When performed on the same day as a developmental screening, providers must append modifier -59 to claims for perinatal depression screening.

IMMUNIZATION

Louisiana Healthcare Connections will see that all members that are provided Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well child preventive screenings are enrolled in the Vaccines for Children (VFC) program and utilize VFC vaccines for enrollees aged birth through 18 years of age.

Members will receive age-appropriate immunizations during their periodic or interperiodic preventive visit or other appropriate opportunity. The current Childhood Immunization Schedule recommended by Advisory Committee on Immunizations Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP), which is updated annually, must be followed. Providers are

responsible for obtaining current copies of the schedule. Louisiana Healthcare Connections will also provide a copy for our members.

CLINICAL TRAINING

Clinical Development and Training Teams will provide training for network providers and stakeholders within our network. Training opportunities will support provider's ability to provide quality services to members. All trainings are provided free of charge, and are conducted in person, group, regional, facility-based and/or remote webinar trainings. Training is available for behavioral health and physical health providers, stakeholder groups, and other non-clinical professions. Topics offered to providers include, but are not limited to:

- Motivational Interviewing (certified trainers)
- Mental Health First Aid (certified trainers)
- PCP Toolkits
- Behavioral health/physical health screening & referral
- Recovery Principles
- Integrated Healthcare
- Trauma Informed Care
- Diagnosis-specific Overviews
- Substance Use Models
- Stages of Change
- SMART Goals
- Cultural Humility/ Competency
- Poverty Competency
- Evidence Based Practices (including but not limited to)
- Trauma Focused Cognitive Behavioral Therapy
- Recovery Model
- Strengths Based Model
- Positive Psychology
- Behavioral Health 101
- Physical Health 101
- Psychiatric Medications
- Medical Necessity Criteria, including LOCUS/ CALOCUS/ ASAM Training

The Clinical Training and Development team is committed to achieving the following goals:

- Promoting provider competence and opportunities for skill-enhancement across disciplines
- Promoting member recovery through integrated, member-centered care
- Sustaining and expanding the use of Evidence Based Practices (e.g. Motivational Interviewing, Stages of Change, Positive Psychology, Trauma Focused Cognitive Behavioral Therapy
- Assisting providers in meeting Mandatory State or Licensure Requirements
- Providing Continuing Education credits when applicable

The opportunity to provide additional clinical trainings to providers is the responsibility of the Network, Quality, and Clinical Development and Training team. The Clinical Development and Training Team can be reached directly at BHProviderTraining@LouisianaHealthConnect.com to request any of the above training topics or request a new topic. Providers may also review the available trainings via the training catalog online: https://attendee.gototraining.com/2c781/catalog/8561012303909415424?tz=America/Chicago

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS is a set of standardized performance measures developed by the NCQA which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Louisiana State Medicaid contract.

As both the Louisiana and federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. Louisiana purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see Louisiana Healthcare Connections' website and HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who will conduct the Medical Record Reviews (MRR) for HEDIS?

Louisiana Healthcare Connections will contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf. MRR audits for HEDIS are usually conducted March February through May each year. At that time, you may receive a call from a medical record review representative if any of your patients are selected in the HEDIS samples. Your cooperation with the representative is greatly appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Louisiana Healthcare Connections which allows them to collect PHI on our behalf.

How can I improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill or report by encounter submission for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam and blood pressure.

If you have any questions, comments or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-866-595-8133.

Provider Satisfaction Survey

Louisiana Healthcare Connections conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, UM and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Louisiana Healthcare Connections, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related QI initiatives.

Member Experience

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well we are meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

As a provider, you are the most critical component of the patient experience. The Survey includes questions that evaluate the following areas:

- Getting Needed Care – Assesses the ease with which members received the care, tests, or treatment they needed. It also assesses how often they were able to get a specialist appointment scheduled when needed.
- Getting Care Quickly – Assesses how often members got the care they needed as soon as they needed it (urgent and non-urgent).
- How Well Doctors Communicate – Assesses members' perception of the quality of communication with their doctor. This also assesses how often their personal doctor explained things clearly, listened carefully, showed respect, and spent enough time with them. Consider using the Teach-Back method to ensure patients understand their health information.
- Enrollee's Ratings – Using a 10-point scale, assesses the member's overall quality of their:
- Healthcare
- Personal doctor
- Specialist
- Health plan

Behavioral health member satisfaction is measured annually through LDH using the Healthy Louisiana Behavioral Health Member Satisfaction Survey to measure member satisfaction with healthcare, including providers and health plans. This survey is distributed to randomly selected adult and child members with a behavioral health diagnosis who have received one or more specialized behavioral service.

The objectives of the Healthy Louisiana Behavioral Health Member Survey are to:

1. Obtain feedback on the following experience of care domains:
    - Access to care
    - Interaction with care providers
    - Self-reported behavioral/mental health status
2. Examples of questions on previous surveys:
    - How often did your personal doctor explain things in a way you could understand?
    - How often did your personal doctor listen carefully to you and show respect for what you had to say?
    - How often did your personal doctor spend enough time with you/
    - How often did you get services at days/times that were convenient for you?
    - How often were you seen within one hour when you had an appointment for treatment or counseling?
    - How often did the people you went to for treatment tell you what medication side effects to watch for?

Providers and clinical care experiences have a significant influence on member's overall perceptions of their care, their providers, and their health plan.

Communication Reminders

Communication tips to increase member compliance and satisfaction with their health care providers, including both primary care and specialists are listed below:

- Maintain eye contact when member is talking
- Use receptive body language, sit down, lean in, keep open body language
- Explain why tests, medications, treatments, referrals, and follow up visits are necessary
- Use simple, easy to understand words
- Offer pharmacist review of medications with members as an option to increase understanding and compliance with medications
- Avoid using medical terminology and abbreviations
- Review all treatment options with member and/or guardian and allow their input
- Review reasons why a member would want to take a medication, why they may not want to take a medication and ask member what they thought was best when starting or stopping a prescription medication
- Submit authorization requests and referrals timely
- Explain timeframes to expect with scheduling of appointments with a specialist

- Discuss preventive health tests and treatments, like flu and pneumonia injections and consider giving even when you see members for a sick visit
- Consider providing a preventive health care visit also when seeing a member for a sick visit
- Discuss risks of smoking/using tobacco, the medications and strategies used to help quit smoking or using tobacco
- Provide handouts, brochures, diagrams and other materials to help members understand about tests, medications, referrals and health prevention steps that are recommended
- Allow their input, questions and collaboration in their treatment
- Review the member's chart for any consults or treatment by specialists prior to seeing the patient to help facilitate coordination of care
- Explain after-hours access to the physician on call, after-hours nurse advice line, when to go to urgent care or seek emergency service

Provider Profiling and Incentive Programs

Over the past several years, it has been nationally recognized that incentive programs that include provider profiling are a promising strategy to improve the quality and cost-effectiveness of care. Louisiana Healthcare Connections operates a per-member per-month (PMPM) incentive program that includes physician profiling to improve care and services provided to Louisiana Healthcare Connections members.

The incentive program promotes efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA and National Quality Forum (NQF). More specifically, Louisiana Healthcare Connections rewards practices for a variety of quality measures, including managing members with complex health care needs, managing member ER utilization, having after hour availability, and meeting state HEDIS benchmarks.

The goals of Louisiana Healthcare Connections incentive programs are:

- Increase provider awareness of his/her performance in key areas
- Motivate providers to establish measurable performance improvement processes relevant to Louisiana Healthcare Connections member populations in their practices
- Use peer performance data and/or other established benchmarks to identify outlier provider practices that reflect best practices or less than optimal performance
- Increase opportunities for Louisiana Healthcare Connections to partner with providers to achieve measurable improvement in health outcomes by developing, implementing, and monitoring practice-based performance improvement initiatives

Louisiana Healthcare Connections will accomplish these goals by:

- Producing and distributing provider-specific reports containing meaningful, reliable, and valid data for evaluation by Louisiana Healthcare Connections and the provider.
- Creating incentives for provider implementation of practice-based performance improvement initiatives that are pertinent to Louisiana Healthcare Connections member populations linked with adopted evidence-based clinical practice guidelines and that yield measurable outcomes.
- Establishing and maintaining an open dialogue with profiled providers related to performance improvement.

Physicians, meeting a minimum panel threshold, will receive a monthly profile report with an individual score for each measure. Scores will be benchmarked per individual measure and compared to the Louisiana Healthcare Connections network average and as applicable, to the then available NCQA Quality Compass Medicaid mean. Provider profile indicator data is not risk adjusted and scoring is based on provider performance within the service area range.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Louisiana Healthcare Connections in publications such as newsletters, bulletins, press releases, and recognition in our provider directories, as well as being eligible for applicable financial incentive programs. Additionally, Louisiana Healthcare Connections offers several financial incentive programs such as claim-based incentive programs. To learn more about whether or not you qualify for the program, please contact the Provider Network Consulting department at 1-866-595-8133.

MEDICAL HOME MODEL

Louisiana Healthcare Connections is committed to supporting its network providers in achieving recognition as Patient-Centered Medical Homes (PCMHs) and will promote and facilitate the capacity of primary care practices to function as medical homes by using systematic, patient-centered and coordinated care management processes.

Louisiana Healthcare Connections will support providers in obtaining either the National Committee for Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or the Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation.

The purpose of the medical home program is to promote and facilitate a medical home model of care that will provide better healthcare quality, improve self-management by members of their own care and reduce avoidable costs over time. Louisiana Healthcare Connections will actively partner with our providers, community organizations and groups representing our members to increase the numbers of providers who are recognized as medical homes (or who are committed to becoming recognized).

Louisiana Healthcare Connections has dedicated resources to ensure its providers achieve the highest level of medical home recognition with a technical support model that will include:

- Readiness survey of contracted providers
- Education on the process of becoming certified
- Resource tools and best practices

Our secure Provider Portal offers tools to help support PCMH accreditation elements, including:

- Online Care Gap Notification
- Member Panel Roster including member detail information

For more information on the PCMH model or to how to become a medical home, contact your Provider Consultant.

Utilization Management for Effective Care

The Louisiana Healthcare Connections Utilization Management (UM) Program is designed to ensure members of Louisiana Coordinated Care Network receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive care, emergency care, primary care, specialty care, behavioral health care, acute care, short-term care, and ancillary care services.

Louisiana Healthcare Connections UM Program seeks to optimize our members' (and/or their families' and caregivers') health status, sense of well-being, productivity, resiliency, hope, and access to quality health care, while at the same time ensuring responsible stewardship of the State's healthcare resources. The UM Program aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care. The Utilization Management (UM) team is comprised of qualified health professionals whose education, training and experience are commensurate with the reviews they conduct.

Our program goals include:

- Ensuring treatment and services are specific to each members' condition, are effective and are provided at the least restrictive, most clinically appropriate level of care
- Monitoring utilization patterns to guard against inappropriate over- or under-utilization
- Developing clinical practice guidelines for providers to improve health outcomes and satisfaction
- Identifying members appropriate for care and/or disease management support
- Ensuring that all Louisiana Healthcare Connections members establish relationships with their PCPs to obtain preventive care
- Encouraging preventive services and chronic condition self-management
- Increasing behavioral health provider utilization of clinical guidelines.
- Increase continuity of care to ensure patients transfer to the next recommended level of care, where indicated.
- Increasing referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs), to increase the percentage of children with positive screens who:
    - Receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and
    - Receive specialized assessment or treatment

Medical Management Operations

Louisiana Healthcare Connections Medical Management department hours of operation are Monday through Friday from 8 a.m. to 5 p.m., CST (excluding holidays). After normal business hours, our 24/7 nurse advice hotline staff is available to answer questions about prior authorization.

Medical Management services include the areas of utilization management, care management, disease management and quality review. The department clinical services are overseen by the Louisiana Healthcare Connections Medical Director. The VP of Medical Management has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact Medical Management at 1-866-595-8133.

PRIOR AUTHORIZATION AND NOTIFICATIONS

Prior authorization is a request to the Louisiana Healthcare Connections Utilization Management (UM) department for approval of services on the prior authorization list before the service is delivered.

Authorization must be obtained prior to the delivery of certain elective and scheduled services.

Prior authorization should be requested at least seven (7) calendar days before the scheduled service delivery date or as soon as the need for service is identified. Please refer to the Covered Benefits section of this Manual for a list of services that require authorization. The provider should contact the UM department via telephone, fax or through our website. All prior authorization requests must be submitted on the appropriate prior authorization request form and must be submitted with appropriate supporting clinical information to request an authorization.

All out-of-network services require prior authorization except for family planning, ER and tabletop X-rays and will require Louisiana Healthcare Connections Medical Director review and approval.

ER and post stabilization services never require prior authorization. Providers should notify Louisiana Healthcare Connections of post stabilization services such as but not limited to the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery within two business days of the service initiation.

Providers should notify Louisiana Healthcare Connections of emergent inpatient admissions within one business day of the admission for ongoing concurrent review and discharge planning by phone, through our website, or by submitting an Inpatient Authorization Request Form via fax. Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service, however clinical information alone is not a valid form of notification.

Failure to obtain authorization may result in administrative claim denials. Louisiana Healthcare Connections providers are contractually prohibited from holding any Louisiana Healthcare Connections member financially liable for any service administratively denied by Louisiana Healthcare Connections for the failure of the provider to obtain timely authorization.

To Request Authorization

Authorization requests may be submitted by fax, phone, or secure web portal. Authorization determinations may be communicated to the provider by fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. When calling our prior authorization department, a referral specialist will initiate authorization process. For all services on the prior authorization list, documentation supporting medical necessity will be required.

To verify whether a prior authorization is necessary or to obtain a prior authorization, contact:

Louisiana Healthcare Connections
Medical Management / Prior Authorization
Phone: 1-866-595-8133
Fax: 1-877-401-8175
Online: LouisianaHealthConnect.com

Prior authorization requests may be done electronically following the ANSI X 12N 278 transaction code specifications. For more information on conducting these transactions electronically contact:

Louisiana Healthcare Connections c/o Centene EDI 1-800-225-2573, extension 25525
EDIBA@centene.com

Any prior authorization request that is faxed or sent via the website after normal business hours (8 a.m. –

5 p.m., Monday – Friday, excluding holidays) will be processed the next business day. In the event of an urgent request that cannot wait until the next business day, please contact our nurse hotline at 1-866-595-8133. The 24/7 nurse advice hotline does not make UM decisions, but they will contact the Louisiana Healthcare Connections nurse on call for urgent authorization requests.

CLINICAL DECISIONS

All UM decision-making is based on appropriateness of care and service and the existence of coverage. Louisiana Healthcare Connections does not reward employees, practitioners, or other individuals for issuing denials of service or care. UM staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director. Delegated providers must ensure that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member.

The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The provider, in consultation with the Louisiana Healthcare Connections Medical Director, is responsible for making UM decisions in accordance with the member's plan of covered benefits and established authorization criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

MEDICAL NECESSITY

Benefit coverage is not an entitlement to utilization of all covered benefits but indicates services that are available when medical necessity is satisfied. Member benefit limits apply for a calendar year regardless of the number of different practitioners providing treatment. Network providers are expected to work closely with our UM Department in exercising judicious use of a member's benefits and to explain the treatment plan to the member in relation to their benefits.

Medically Necessary Services is defined as those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

To be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity, or malfunction; and
- Services which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time.

Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." Our authorization of covered services is an indication of medical necessity, not a confirmation of member eligibility and not a guarantee of payment. All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order for the service to be eligible for payment, the service must be medically necessary and a covered service.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff bylaws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the member or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

REVIEW CRITERIA

Louisiana Healthcare Connections has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, behavioral health, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment.

We also use the American Society of Addiction Medicine Member Placement Criteria (ASAM) for substance use guidelines. Criteria for community-based behavioral health services were adopted from the Louisiana Behavioral Health Services Provider Manual. Rehabilitation services, such as CPST/PSR, ACT and PSH that were formerly a part of the 1915(i) and are approved based on Level of Care Utilization System (LOCUS) medical necessity criteria.

Our UM Department is under the direction of our licensed Medical Director or physician designee(s). The UM staff regularly confer with the Medical Director or physician designee on any cases where there are questions or concerns.

The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the patient's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting Medical Management at 1-866-595-8133. Clinical and payment policies are posted on our website at www.LouisianaHealthConnect.com/policies for review. Or providers can request the criteria via the PACriteriaRequest@LouisianaHealthConnect.com. Providers can request criteria used to make determinations for any reason. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted through Provider Services by calling Louisiana Healthcare Connections' main toll-free phone number at 1-866-595-8133 and asking for the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

Review criteria are reviewed on an annual basis by our Provider Advisory Committee that is comprised of network providers as well as our clinical staff.

Members or healthcare professionals with the member's consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Louisiana Healthcare Connections Complaint and Grievance Coordinator P.O. Box 84180
Baton Rouge, LA 70884
Fax 1-877-401-8170

CLINICAL INFORMATION

Louisiana Healthcare Connections clinical staff request clinical information minimally necessary for clinical decision-making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Louisiana Healthcare Connections is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations with the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's name, Member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate

If additional clinical information is required, clinical review personnel will notify the caller of the specific information needed to complete the authorization process.

Louisiana Healthcare Connections may not pay for a particular item or service when a provider does not provide requested medical information for purposes of making medical necessity determinations.

AUTHORIZATION DETERMINATION TIMELINES

We conduct UM in a timely manner to minimize any disruption in the provision of healthcare services. The timeliness of decisions adheres to specific and standardized time frames yet remains sufficiently flexible to accommodate urgent situations. Louisiana Healthcare Connections decisions are made as expeditiously as the member's health condition requires.

For standard service authorizations, the decision and notification will be made no more than two business days from receipt of necessary medical information (not to exceed a total 14 calendar days from receipt of the request unless an extension is requested). Notification for CPST/PSR services will be made no more than five calendar days. "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service.

NOTICE OF ACTION (ADVERSE DETERMINATION)

When we determine that a specific service does not meet criteria and will therefore not be authorized, we will submit a written notice of action to the treating network practitioner or provider rendering the service(s) and the member. The notification will include the following information/ instructions:

- The reason(s) for the proposed action in clearly understandable language.
- A reference to the criteria, guideline, benefit provision or protocol used in the decision, communicated in an easy-to-understand summary.
- A statement that the criteria, guideline, benefit provision or protocol will be provided upon request.
- Information on how the provider may contact the Peer Reviewer to discuss decisions and proposed actions. When a determination is made where no peer-to-peer conversation has occurred, the Peer Reviewer who made the determination (or another Peer Reviewer if the original Peer Reviewer is unavailable) will be available within one business day of a request by the treating provider to discuss the determination.
- Instructions for requesting an appeal including the right to submit written comments or documents with the appeal request; the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision.
- For all urgent precertification and concurrent review clinical adverse decisions, and instructions for requesting an expedited appeal.
- The right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

PEER CLINICAL REVIEW PROCESS

If the Utilization Manager is unable to certify the requested level of care based on the information provided, the Utilization Manager will initiate the peer review process.

For outpatient service requests, the clinical information submitted will be forwarded to an appropriate clinician of like specialty of the requesting provider for review and respond. When a determination is made where no peer-to-peer conversation has occurred, a provider can request to speak with the Clinical Consultant who made the determination within one business day.

As a result of the Peer Clinical Review process, we will make a decision to approve, modify or deny authorization for services. Treating practitioners may request a copy of the medical necessity criteria used in any denial decision. The treating practitioner may request to speak with the Peer Reviewer who made the determination after any denial decision. If you would like to discuss a denial decision, contact us at 1-866-595-8133.

There will be 3 (three) phone attempts to reach the provider to schedule an appointment for a peer call.

- Should all three attempts fail, the request for an informal reconsideration will be closed at 5:00 p.m. on the working day following the date of receipt of the request and the adverse determination may be appealed by the member or the provider on behalf of the member.

A request for consideration will be considered invalid in instances when the provider has failed to include clinical documentation in their request for prior authorization or in the case of a provider representing a member the provider failed to provide the member's written consent.

- The request for an informal reconsideration will be closed and the adverse determination may be appealed by the member or the provider on behalf of the member.

In an instance where a provider fails to call-in or calls in later than 15 minutes after their scheduled review time the denial decision will be upheld.

- The request for an informal reconsideration will be closed and the adverse determination may be appealed by the member or the provider on behalf of the member.

CONCURRENT REVIEW AND DISCHARGE PLANNING

Nurse Care Managers perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The Case Manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within one calendar day of receipt of clinical information. For length of stay extension request, clinical information must be submitted by 3 p.m. CST on the day review is due. Written or electronic notification includes the number of days of service approved and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review; however, the hospital must notify Louisiana Healthcare Connections within two business days of delivery with complete information regarding the delivery status and condition of the newborn.

RETROSPECTIVE REVIEW

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to Louisiana Healthcare Connections was not obtained due to extenuating circumstances (i.e., member was unconscious at presentation, member did not have his/her Medicaid card or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of request, not to exceed 180 calendar days from date of service.

RETROACTIVE AUTHORIZATION

By standard practice, we **do not** provide retroactive authorization; however, there are certain unique circumstances in which there may be an exception. Retroactive authorizations will only be granted in rare cases such as eligibility issues. All requests for retroactive authorizations must be submitted within 180 days of the date of service and should include a cover letter explaining why authorization was not obtained. You should provide medical records that will be used to determine if medical necessity was met for the services provided. Repeated requests for retroactive authorizations may result in termination from the provider network due to inability to follow policies and procedures. Retroactive authorizations may be submitted to 1-888-725-0101.

SECOND OPINION

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Louisiana Healthcare Connections network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network and in-network providers require prior authorization by Louisiana Healthcare Connections when performing second opinions.

NEW TECHNOLOGY

Louisiana Healthcare Connections evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the Louisiana Healthcare Connections population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-866-595-8133.

PHARMACY

Louisiana Healthcare Connections is committed to providing appropriate, high quality, and cost-effective drug therapy to all Louisiana Healthcare Connection members. We work with providers and pharmacists to ensure medications used to treat a variety of conditions and diseases are covered.

Louisiana Healthcare Connections covers prescription drugs and certain over the counter (OTC) drugs when ordered by a Louisiana Healthcare Connections provider. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or maximum quantities. This section provides an overview of Louisiana Healthcare Connections pharmacy program. For more detailed information, please visit our website at LouisianaHealthConnect.com.

Preferred Drug List (PDL)

Effective May 2019, Louisiana Healthcare Connections implemented a single preferred drug list (PDL) as required by the Louisiana Department of Health (LDH). The goal of this implementation was to improve member experience, to improve provider experience and to promote better health outcomes. The single PDL will be updated biannually at the direction of LDH. The most current single PDL is available on the Louisiana Healthcare Connections website at https://www.louisianahealthconnect.com/providers/pharmacy.html

Physician Administered Medication

Louisiana Healthcare Connections will cover medically necessary physician-administered medications that are reimbursable in Louisiana Medicaid. For those medications that are on the Louisiana Medicaid FFS fee schedules, Louisiana Healthcare Connections will also cover them in the medical benefit. Louisiana Healthcare Connections may also elect to cover these medications in the pharmacy benefit. For those medications that are not on the Louisiana Medicaid FFS fee schedules, Louisiana Healthcare

Connections may cover them in either the medical benefit, the pharmacy benefit, or both.

Physician administered medication that are included on the PDL shall have the same preferred status and prior authorization criteria as the PDL, even when billed and paid as a medical benefit (except Antiemetic/Antivertigo Agents therapeutic class). At a minimum, administration of the medication may be billed using the lowest level office visit (CPT 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. Louisiana Healthcare Connections will apply edits for physician-administered drugs, updated quarterly, based on the CMS NDC-HCPCS Crosswalk file.

Excluded Drugs

Louisiana Healthcare Connections will cover all medically necessary prescription medicines on the Covered Drug List (CDL). Louisiana Healthcare Connections may also cover additional pharmacy benefits, such as vaccines and compounded drugs. The following excluded drugs will not be covered:

- Agents when used for anorexia, weight loss, or weight gain, except orlistat.
- Agents when used to promote fertility, except vaginal progesterone when used for high-risk pregnancy to prevent premature births.
- Agents when used for symptomatic relief of cough and colds, except for antihistamine and antihistamine/decongestant combination products. Louisiana Healthcare Connections will cover the following drugs, with restrictions:
    - Agents used for cosmetic purposes or hair growth only when medical necessity has been determined.
    - Select drugs for erectile dysfunction, except when used for the treatment of conditions or indications other than erectile dysfunction as approved by the FDA.

Except for the use of LDH-approved generic drug substitution of branded drugs, under no circumstances will Louisiana Healthcare Connections permit the therapeutic substitution of a prescribed drug without a prescriber's authorization. Louisiana Healthcare Connections will refer to the Contract for requirements related to the CDL, including the Preferred Drug List (PDL) and Non-Preferred Drug List (NPDL).

Brand Name and Generic Drugs

Claims for multi-source “Brand Name Products” that are not included in the PDL/NPDL process (i.e., drugs not listed on the Preferred Drug List on the static link), will not be subject to prior authorization. Since the manufacturers of these brand name products have signed the federal rebate agreement, these drugs must have a potential payable status. In consideration of the mandatory generic substitution, LDH requires Louisiana Healthcare Connections to allow dispense as written (DAW) codes “1”, “5”, “8”, and “9” for brand name processing. LDH expects the following codes to accommodate the filling of a brand name product without use of prior authorization:

- DAW “1”: Brand name medically necessary from prescriber.
- DAW “5”: Substitution allowed-brand drug dispensed as a generic (should be allowed when the brand drug is less expensive for 340B providers).
- DAW “8”: Substitution allowed, generic drug not available in marketplace.
- DAW “9”: Preferred brand over generic drugs. Denials of brand drugs (unless the brand is a preferred drug—in or out of the process) should deny with an error code stating, “generic substitution required”, mapped to NCPDP 22 (M/I Dispense as written (DAW)/Product selection code).

The Single PDL describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered by Louisiana Healthcare Connections. The

PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the provider or pharmacist
- Relieve the provider or pharmacist of any obligation to the member or others.

The Single PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed on the non-preferred PDL column, on the last page of the single PDL or with a “CL” notation throughout the PDL.

Louisiana Uniform Prescription Drug Prior Authorization Form

The Louisiana Medicaid fee-for-service (FFS) pharmacy program and Medicaid’s managed care organizations (MCOs) require prescribers to use the Louisiana Uniform Prescription Drug Prior Authorization Form. This form can be found on our website at www.louisianahealthconnect.com/provider-resources

Psychiatric and Residential Substance Use Facility Medication

Upon patient admission and prior to discharge, a psychiatric facility and residential substance use facilities should notify Louisiana Healthcare Connections and provide the list of discharged medications. Louisiana Healthcare Connections works with Magellan Medicaid Administration to allow pharmacies to override or allow all behavioral health discharge medications to be dispensed by overriding prior authorization restrictions for a sixty (60) day period. This includes, but is not limited to, naloxone, Suboxone, and long-acting injectable anti-psychotics.

If Louisiana Healthcare Connections is not notified prior to discharge and the member presents at the pharmacy with a medication issued at the time of discharge, Louisiana Healthcare Connections will work with Magellan Medicaid Administration to allow pharmacies to provide a prior authorization override for a sixty (60) day period from the date of discharge as long as the member presents the prescription within sixty (60) days of being discharged from a psychiatric and/or residential substance use facility.

Working with the Pharmacy Benefit Manager (PBM)

Louisiana Healthcare Connections works with Magellan Medicaid Administration to administer pharmacy benefits, including the PA process. Certain drugs require PA to be approved for payment by Louisiana Healthcare Connections. These include:

- All non-preferred medications listed on the Non-Preferred Column of the Single PDL
- Some preferred drugs (designated with CL on the Single PDL)
- Some medications not addressed in the Single PDL but have Clinical Policy which require clinical reviews.

Drug prior authorization requests are available at Magellan Medicaid Administration Pharmacy Call Center (24/7/365) through phone, fax or online. PA decisions are made within 24 hours from when all clinical information is received from the prescriber.

Member and Pharmacy Help Desk Pharmacy Prior Authorizations

- Phone Number: 1-800-424-1664
- Fax Number: 1-800-424-7402

By fax:

a. Complete the Louisiana Uniform Medicaid Prescription Drug Prior Authorization Form found on the Louisiana Healthcare Connections website at LouisianaHealthConnect.com.

For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by submitting the 72-hour override in claims submission or by calling the

Web: https://www.lamcopbmpharmacy.com
Phone: 1-800424-1664

When calling, please have member information, including Medicaid ID number, member date of birth, complete diagnosis, medication history and current medications readily available.

If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific members to receive this specific drug.

If the request is denied, information about the denial will be faxed to the provider and mailed to the member.

Providers are requested to utilize the Single PDL when prescribing medication to Louisiana Healthcare Connections members. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the provider to request a change to a product included in the Louisiana Medicaid Single PDL.

In the event that a provider or member disagrees with the decision regarding coverage of a medication, the member or the provider on the member's behalf, (with the member's signed release) may submit an appeal, verbally or in writing. For additional information about appeals, please refer to the Appeals section herein.

Prescription Monitoring Program

Upon writing a first prescription or "first fill," defined as any medication that has not been filled within a 90-day period, for a controlled substance for a behavioral health patient, a physician should utilize, print and file a copy of the Prescription Monitoring Program (PMP) record of the member. This should be filed both initially and annually.

NOTE: Audits to verify compliance will be conducted randomly and annually.

PMP is governed by the Louisiana Board of Pharmacy. Additional information about the PMP can be found here: https://www.pharmacy.la.gov/

INPATIENT BEHAVIORAL HEALTH NOTIFICATION

Emergency behavioral healthcare requests indicate a condition in clinical practice that requires immediate intervention to prevent death or serious harm (to the member or others) or acute deterioration of the member's clinical state, such that gross impairment of functioning exists and is likely to result in compromise of the member's safety. An emergency is characterized by sudden onset, rapid deterioration of cognition, judgment or behavioral functioning and is time limited in intensity and duration (i.e., usually occurs in seconds or minutes, rarely hours, rather than days or weeks). Thus, elements of both time and severity are inherent in the definition of an emergency.

All inpatient admissions require notification within 24 hours of admission. Failure to provide notification may result in an administrative denial.

The number of initial days authorized is dependent on medical necessity, and continued stay is approved or denied based on the findings in concurrent reviews. The receiving hospital should also notify us of the admission to acute care when the member arrives and is admitted. The facility will be required to provide clinical review information the next business day and at subsequent intervals for concurrent review depending upon the consumer's specific symptoms and progress.

Members meeting criteria for inpatient treatment must be admitted to a contracted hospital or crisis stabilization unit. Members in need of emergency and/or after-hours care should be referred to the nearest participating facility for evaluation and treatment, if necessary.

The following information must be readily available for the Utilization Manager when requesting initial authorization for inpatient care:

- Name, age, health plan and identification number of the Member;
- Diagnosis, indicators, and nature of the immediate crisis;
- Alternative treatment provided or considered;
- Treatment goals, estimated length of stay, and discharge plans;
- Family or social support system; and
- Current mental status.

OUTPATIENT BEHAVIORAL HEALTH

For those outpatient services that require authorization, the provider must complete an Outpatient Treatment Request (OTR) form and submit online or fax the completed form for clinical review. Please refer to www.LouisianaHealthConnect.com/provider-resources to obtain the OTR form or to submit electronically. Providers may call the Customer Service Department to check the status of an OTR. Providers should allow up to 14 business days to process non-urgent requests.

- The OTR must be completed in its entirety. All clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delays and/or denials.
- We will not retroactively certify routine sessions. The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.
- Failure to submit a completed OTR can result in delayed authorization and may negatively impact your ability to meet the timely filing deadlines which will result in payment denial.
- It is the provider's responsibility to ensure that complete and accurate OTR forms are submitted in a timely manner to allow approval prior to the member's visit.

PSYCHOLOGICAL TESTING

Psychological testing must be prior-authorized for outpatient services. Testing, with prior-authorization, may be used to clarify questions about a diagnosis as it directly relates to treatment.

It is important to note:

- Testing will not be authorized by us for ruling out a medical condition.
- Testing is not used to confirm previous results that are not expected to change.
- A comprehensive initial assessment (90791) should be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the practitioner is contracted and credentialed with us.
- Providers should submit a request for psychological testing that includes the specific tests to be performed. Providers may access our Psychological Testing Authorization Request Form at www.louisianahealthconnect.com/provider-resources.
- Testing requested by the court or state agencies for the purpose of placement is not considered medically necessary and may not be reimbursed.

Applied Behavioral Analysis

Applied behavior analysis (ABA) is a form of adaptive behavioral treatment. ABA therapy is a set of behavior treatments that work to increase useful or desired behaviors. ABA applies scientific principles about learning and behavior to reduce behaviors that may be harmful or interfere with learning.

ABA treatment is rendered by an ABA assistant or technician under the supervision of a board-certified behavior analyst (BCBA). Louisiana Healthcare Connections works closely with patients on an integrated and holistic clinical approach with the assistance of PCPs, BCBAs, specialized care managers and dedicated ABA staff.

All ABA providers and services are subject to the same guidelines as other providers and services outlined throughout this manual including our utilization management guidelines. All Applied Behavior Analysis (ABA) services must be prior authorized by Louisiana Healthcare Connections. Prior authorization (PA) is a two-fold process.

1. An authorization is first requested for approval to perform a functional assessment and to develop a behavior treatment plan.

2. A second authorization is needed for approval to provide the ABA-based derived therapy services.

All service authorizations are completed by following the Louisiana Healthcare Connections Outpatient Treatment Request (OTR) processes on the Louisiana Healthcare Connections website. The OTR form lists the required documents to be included with the request (Individualized Educational Plan, waiver plan profile table, if applicable).

Services must be provided by, or under the supervision of, a behavior analyst who is currently licensed by the Louisiana Behavior Analyst Board, or a licensed psychologist or licensed medical psychologist, hereafter referred to as the licensed professional. Payment for services must be billed by the licensed professional. Please see the Louisiana Medicaid Applied Behavioral Analysis Fee Schedule on the Louisiana Medicaid website for CPT descriptions and rates.

For more details on service requirements and coverage, please refer to LDH's Applied Behavior Analysis Provider Manual at www.lamedicaid.com.

Comprehensive Diagnostic Evaluation for Applied Behavioral Analysis

When Autism Spectrum Disorder and related disorders may be identified, Louisiana Healthcare Connections will ensure that Qualified Health Care Professionals (QHCP) perform the Comprehensive Diagnostic Evaluation (CDE) within 30 days of request.

A QHCP is defined as a:

- Pediatric Neurologist;
- Developmental Pediatrician;
- Psychologist (which includes a Medical Psychologist);
- Psychiatrist (particularly Pediatric and Child Psychiatrist); or
- Licensed individual that has been approved by the Medicaid medical director as meeting the requirements of a QHCP when:
    - The individual's scope of practice includes differential diagnosis of Autism Spectrum Disorder and comorbid disorders for the age and/or cognitive level of the recipient; and
    - The individual has at least two years of experience providing such diagnostic assessments and treatments.

The CDE must include at a minimum:

- A thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history;
- Direct observation of the recipient, to include but not be limited to assessment of current functioning in the areas of social and communicative behaviors and play or peer interactive behaviors;
- A review of available records;
- A valid Diagnostic and Statistical Manual of Mental Disorders (DSM) V (or current edition) diagnosis;
- Justification/rationale for referral/non-referral for an ABA functional assessment and possible ABA services.
- Recommendations for any additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or any additional recommended standardized measures, labs, or other diagnostic evaluations considered clinically appropriate and/or medically necessary.

When the results of the screening are borderline, or if there is any lack of clarity about the primary diagnosis, comorbid conditions, or the medical necessity of services requested, the following categories of assessment should be included as components of the CDE and must be specific to the recipient's age and cognitive abilities:

- Autism specific assessments
- Assessments of general psychopathology
- Cognitive assessment
- Assessment of adaptive behavior

SPEECH THERAPY AND REHABILITATION SERVICES

Louisiana Healthcare Connections offers our members access to all covered, medically necessary outpatient physical, occupational and speech therapy services through National Imaging Associates (EVOLENT). Prior authorization is required for outpatient occupational, physical or speech therapy services and should be submitted to EVOLENT using the prior authorization form available at RadMD.com.

EVOLENT Outpatient Therapies Prior Authorization Fax: 1-866-784-6864

The OTR must be completed in its entirety. Failure to submit a completed request will result in an upfront rejection, and providers will be required to resubmit to be considered for authorization. The following are considered an incomplete submission:

- Name of provider is missing/illegible
- Contact name was not provided and/or is illegible
- Eligibility cannot be verified for the member with the information provided
- Physician signature on prescription or Plan of Care (POC) is missing, outdated or stamped (must be actual or electronic signature)
- Documentation of verbal order is missing or out of date (not required if there is a prescription)
- POC or evaluation missing or out of date
- For a POC, the specific requirements are as follows:
    - Home Health – must be updated and signed every 60 days
    - EPSDT – must be updated and signed every 6 months
- Physician prescription or physician signed POC must be included in submission
- Member already has an authorization on file for the same service with a different provider (transfer of provider letter from the member is required to process the request)
- Routine sessions will not be retroactively certified, except when:
    - Member did not have his/her Medicaid card or otherwise indicate Medicaid coverage (providers should check eligibility every 30 days)
    - Services authorized by another payer who subsequently determined member was not eligible at the time of services
    - Member received retro-eligibility from Department of Medicaid
    - Services occurred during a transition of care period
- The dates of the authorization request must correspond tothe dates of expected sessions. Treatment must occur within the dates of the authorization.

EVOLENT will make medical necessity decisions based on the clinical information supplied by practitioners/facilities providing physical medicine services. Decisions are made as quickly as possible from submission of all requested clinical documentation (one business day for urgent requests). Peer-to-peer telephone requests are available at any point during the prior authorization process.

EVOLENT‘s clinical review team consists of licensed and practicing Physical Therapists, Occupational Therapists, Speech Therapists and board-certified physicians. Decision determinations are rendered only by clinical peer reviewers with appropriate clinical experience and similar specialty expertise as the requesting provider. Clinical peer reviewers will be available for peer-to-peer requests as necessary consultation as needed.

The Louisiana Healthcare Connections appeals process will be available if a provider disagrees with a prior authorization determination.

Louisiana Healthcare Connections covers speech therapy, physical therapy, and occupational therapy services to members of any age and without restrictions to place of service.

INTERVENTIONAL PAIN MANAGEMENT

EVOLENT manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through EVOLENT for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through Louisiana Health Connect. To obtain authorization through EVOLENT, visit RadMD.com or call 1-866-595-8133.

ADVANCED DIAGNOSTIC IMAGING

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, Louisiana Healthcare Connections is using National Imaging Associates (EVOLENT) to provide prior authorization services and utilization. EVOLENT focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA

Key Provisions

- ER, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

To reach EVOLENT and obtain authorization, please call 1-866-595-8133 and follow the prompt for radiology authorizations. EVOLENT also provides an interactive website which may be used to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department.

CARDIAC SOLUTIONS

On July 1, 2016, Louisiana HealthCare Connections, in collaboration with EVOLENT, launched a cardiac imaging program for members over the age of 21 in order to promote health care quality for patients with possible cardiac disease.

Under this program, prior authorization is required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, EVOLENT addresses unnecessary procedures and promotes the least invasive, most medically appropriate approaches.

EVOLENT has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. EVOLENT also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

Managing cardiac studies promotes the use of optimal diagnostic methods in the assessment and

treatment of cardiac diseases. Based on criteria adapted from the ACC and American Medical Association (AMA), this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components include:

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient
- Consultations with cardiologists related to elective cardiac diagnostic imaging when needed
- Quality assessment of imaging providers to ensure technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for Louisiana Healthcare Connections members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography Stress Echocardiography

The following services do not require authorization through EVOLENT:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- ER radiology services

To reach EVOLENT and obtain authorization, please call 1-866-595-8133 and follow the prompt for radiology and Cardiac authorizations. EVOLENT also provides an interactive website, which may be used to obtain online authorizations. Please visit www.RadMD.com for more information.

CHIROPRACTIC SERVICES

The purpose of this “in lieu of” benefit is to provide coverage of chiropractic care by Louisiana Healthcare Connections for members age 21 and older. For members age 20 and younger, services need prior authorization. Chiropractic services to diagnose and treat neuromusculoskeletal conditions associated with the functional integrity of the spine are a medically appropriate and cost-effective substitute for services currently covered under the Louisiana Medicaid State Plan. Coverage of this “in lieu of” benefit is at the option of Louisiana Healthcare Connections, in accordance with 42 CFR § 438.3(e)(2)(iii).

Provider Qualification

- Current, valid, and unrestricted Louisiana chiropractic license

Nothing herein shall be construed to require Louisiana Healthcare Connections to execute an agreement with any qualified and willing provider. Louisiana Healthcare Connections reserves the right to execute agreements with qualified providers only as needed to successfully provide services, if Louisiana Healthcare Connections elects to offer this “in lieu of” benefit.

As part of this “in lieu of” benefit, chiropractic services for the purpose of diagnosing and treating neuromusculoskeletal conditions associated with the functional integrity of the spine are covered and considered medically necessary. The following requirements apply:

Evaluation and Management Services

The initial visit must include a treatment plan, including:

- Level of care (duration and frequency of visits);
- Treatment goals; and
- Measures to assess the effectiveness of treatment (qualitative and/or quantitative).

Follow-up visits must include information on the member’s progress in the treatment plan, along with the measures used to assess effectiveness.

The level of evaluation and management service shall be determined by using Current Procedural Terminology (CPT) guidelines.

Spinal X-rays

A spinal X-ray may be used to assess the member’s condition. Radiographs must be limited to the level(s) of suspected abnormality and the minimum number of views necessary to establish the diagnosis. Repeat X-rays are not considered medically necessary in the absence of a significant worsening of symptoms despite treatment, a change in the pattern of symptoms which may suggest an alternate diagnosis, or the development of new symptoms.

Spinal Manipulation

Spinal manipulation of up to five (5) regions is covered and considered medically necessary when included in the documented treatment plan.

Other Treatments

Other treatments refer to chiropractic treatments other than spinal manipulation. On each date of service, a maximum of two (2) other treatments are covered and must be tailored to the member’s condition and identified in the documented treatment plan.

- Mechanical traction
- Whirlpool therapy
- Ultrasound therapy
- Electrical stimulation
- Therapeutic exercises
- Neuromuscular reeducation
- Gait training
- Massage therapy
- Manual therapy
- Dry needling

Coverage Limitations

Louisiana Healthcare Connections reserves the right to cap or limit the number of members actively receiving “in lieu of” coverage of chiropractic services at any given time and for any reason. In addition, we will not require members to use this service, in accordance with 42 CFR § 438.3(e)(2)(ii).

Prior Authorization and Referral

Chiropractic services are covered without the requirement of prior authorization for up to eighteen (18) treatment sessions annually. Additional treatment sessions may be reimbursed with authorization by Louisiana Healthcare Connection. A treatment session is defined as all chiropractic services that occur on a single date of service. A referral from a primary care provider or any other provider is not required.

EMERGENCY CARE SERVICES

Louisiana Healthcare Connections defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairments of bodily functions; or
- Serious dysfunction of any bodily organ or part as per 42 CFR 438.114.(a).

Members may access emergency services at any time without prior authorization or prior contact with Louisiana Healthcare Connections. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their PCP and/or Louisiana Healthcare Connections’ 24 hour nurse advice hotline for assistance; however, this is not a requirement to access emergency services. Louisiana Healthcare Connections contracts with emergency services providers as well as non-emergency providers who can address the member’s non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by Louisiana Healthcare Connections when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Louisiana Healthcare Connections. Emergency services will cover and reimburse regardless of whether the provider is in Louisiana Healthcare Connections’ provider network and will not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition, or
- A representative from the plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, Louisiana Healthcare Connections requires notification for hospital admission or prior authorization for follow-up care as noted elsewhere in this handbook.

Emergency Room Utilization

Louisiana Healthcare Connections is committed to supporting providers in their efforts to reduce non-emergent ER utilization among our members. PCPs have extensive experience and knowledge about the health and healthcare of their patients, and they are Louisiana Healthcare Connections' best allies in promoting the value of the primary care setting for personalized, long-term care for members.

To assist providers in reducing non-emergent ER use, Louisiana Healthcare Connections provides a timely ER Utilization Alert to notify providers when a member of their member panel has been identified as a High Utilizer. A High Utilizer is defined as a member who has three or more ER visits within a 90-day period.

When a member assigned to a provider's member panel is identified as a High Utilizer, the provider will receive an ER Utilization Alert from Louisiana Healthcare Connections. These notifications are distributed as soon as Louisiana Healthcare Connections receives the information regarding the member's ER visit.

ER Utilization Alerts will provide the following information:

- Member identifier(s)
- Total number of ER visits
- Timeframe of the ER visit(s)
- Primary reason for the visit(s)

Providers are encouraged to use this information to schedule prompt follow-up care with the member and to provide the member with education about appropriate ER use.

Providers are also encouraged to use tools and resources made available by Louisiana Healthcare Connections to assist them in reducing non-emergent ER use. These tools and resources include:

- Care Management services for direct outreach and education for members
- A member-focused guide, "The Right Care at the Right Time from the Right Place," to educate patients about when to visit a PCP, Urgent Care Clinic, or an ER
- A provider-focused guide that includes tips and best practices for reducing ER visits as well as descriptions of operational incentives for increasing reimbursement rates
- Member access to a 24/7 nurse advice hotline for basic health education, nurse triage and answers to questions about urgent or emergency care access
- Provider referrals to MemberConnections® or Chronic Care Management programs

Common Observation Policy

Louisiana Healthcare Connections will reimburse up to 48 hours of medically necessary care for a member to be in an observational status. This timeframe is for the physician to observe the member and to determine the need for further treatment, admission to an inpatient status, or for discharge.

Observation and ancillary services do not require notification, precertification or authorization and will be covered up to 48 hours.

Hospitals should bill the entire outpatient encounter, including emergency department, observation, and any associated services, on the same claim with the appropriate revenue codes, and all covered services are to be processed and paid separately. Any observation service over 48 hours requires MCO authorization. For observation services beyond 48 hours that are not authorized, MCOs shall only deny the non-covered hours.

OUTPATIENT AMBULATORY SURGERY

Certain surgical procedures are usually covered if they are performed as outpatient services. Reimbursement to hospitals for the performance of these outpatient surgical procedures is made on a flat fee per service basis.

Outpatient surgical cases that have a physician order for outpatient status do not need to be pre-certified. There are no time limitations for an outpatient surgery.

Hospitals must bill all outpatient surgery charges for specified surgeries using revenue code “490”- Ambulatory Surgery Care. All other charges associated with the surgery, such as labs, observation, and radiology must be billed on the same claim form. The only revenue code that will be paid will be the flat rate fee for Ambulatory Surgery. The current payment rate for groupings and list of surgical procedures can be found on the Louisiana Medicaid website. The most appropriate CPT/HCPCS code for the surgical procedure must be entered in Form Locator 44 on the UB-04 claim form. Only one CPT/HCPCS code may be entered in the field.

Note: When more than one surgical procedure is performed on the same date of service, only the primary surgical procedure will be paid. The CPT/HCPCS code for the primary surgical procedure must be entered in Form Locator 44 on the UB-04 form.

Operating Room Services- Minor Surgery (HR361) is payable for billing minor surgeries that are medically necessary to be performed in the operating room, but the associate CPT code is not included in the ambulatory surgery listing.

Ambulatory surgery and other applicable revenue codes associated with the surgery may be billed as outpatient regardless of the duration of outpatient stay.

LONG-ACTING REVERSIBLE CONTRACEPTIVES IN THE OUTPATIENT HOSPITAL SETTING

For LARCs inserted in the outpatient hospital setting, hospitals receive an additional payment for the LARC device when it is inserted during an outpatient hospital visit. Payment for the LARC device in the outpatient hospital setting is an addition to the reimbursement for the outpatient hospital claim. Providers have been instructed to bill the outpatient claim for the outpatient visit on the UB-04 and the claim for the LARC devices on the CMS 1500 claim form.

Providers inserting LARCs in the hospital setting may bill the DME revenue code of 290 with the appropriate accompanying HCPCS code for the LARC device on the UB-04. Providers should consult the DME fee schedule for covered LARC’s and their reimbursement.

PREVENTIVE MEDICINE FOR WOMEN

Louisiana Healthcare Connections will reimburse for one well-woman gynecological examination per year for woman aged 21 and over, when performed by a primary care provider or gynecologist. This is in additional to the current service provision for one preventive medicine visit for adults aged 21 years and older. These services are in effect to allow women to receive the necessary primary care and gynecological components of their annual preventive screening visits. This is not to facilitate duplicative services. Providers should continue to bill with the appropriate preventive medicine CPT codes, with the visit reflecting the specific medical nature of the service.

In addition, members will have the freedom to receive family planning services and related supplies from an out-of-network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception and inter-conception care services.

Louisiana Healthcare Connections will make every effort to contract with all local family planning clinic and providers and will ensure reimbursement whether the provider is in or out of network.

Specifics regarding this policy can be found on www.lamedicaid.com under the Provider Manual link, within the Professional Services manual.

HEPATITIS B ADULT VACCINE

Louisiana Medicaid covers Hepatitis B adult 2 dose vaccine; billable CPT code is 90739. The Medicaid Adult Immunization Fee Schedule is on the Louisiana Medicaid website at http://www.lamedicaid.com to use this immunization procedure code.

SINUS PROCEDURES

Balloon ostial dilation and functional endoscopic sinus surgery are considered medically necessary for the treatment of chronic rhinosinusitis when all of the following criteria are met:

- Uncomplicated chronic rhinosinusitis limited to the paranasal sinuses without the involvement of adjacent neurological, soft tissue, or bony structures that has persisted for at least 12 weeks with at least two of the following sinonasal symptoms:
    - Facial pain/pressure
    - Hyposmia/anosmia
    - Nasal obstruction
    - Mucopurulent nasal discharge; and
- Sinonasal symptoms that are persistent after maximal medical therapy has been attempted, as defined by all of the following, either sequentially or overlapping:
    - Saline nasal irrigation for at least six weeks
    - Nasal corticosteroids for at least six weeks
    - Approved biologics, if applicable, for at least six weeks
    - A complete course of antibiotic therapy when an acute bacterial infection is suspected

- Treatment of concomitant allergic rhinitis, if present; and

- Objective evidence of sinonasal inflammation as determined by one of the following:
  - Nasal endoscopy
  - Computed tomography

Balloon ostial dilation and functional endoscopic sinus surgery are not covered and not considered medically necessary in the following situations:

- Presence of sinonasal symptoms but no objective evidence of sinonasal disease by nasal endoscopy or computed tomography;
- For the treatment of obstructive sleep apnea and/or snoring when the above criteria are not met;
- For the treatment of headaches when the above criteria are not met; and
- For balloon ostial dilation only, when sinonasal polyps are present.

Medical Records

MEDICAL RECORDS REVIEW (MRR)

Louisiana Healthcare Connections providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Louisiana Healthcare Connections to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location.

Louisiana Healthcare Connections requires providers to maintain all records for members for at least six years. See the Member Rights section of this handbook for policies on member access to medical records.

Required Information

- Medical records means the complete, comprehensive member records including, but not limited to, X-rays, laboratory tests, results, examinations and notes.
- These records should:
    - Be accessible at the site of the member's participating PCP or provider;
    - Document all medical services received by the member, including inpatient, ambulatory, ancillary and emergency care;
    - Be prepared in accordance with all applicable state rules and regulations; and
    - Be signed by the medical professional rendering the services.
    - Documented laboratory procedures provided less than six months prior to medical screening must not be repeated unless medically necessary.
    - Iron deficiency anemia screening when required is included in the medical screening fee and may not be bill separately

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed, or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with Louisiana Healthcare Connections' practice guidelines
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries and ER encounters
- For children and adolescents age 18 and younger, past medical history relating to prenatal care, birth, any operations and/or childhood illnesses
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis

- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed
- including instructions to the member
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services, and services for the treatment of sexually transmitted diseases (STDs)
- Health teaching and/or counseling is documented
- For members age 11 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of member information and records protected
- Evidence that an advance directive has been offered to adults 18 years of age and older

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Louisiana Healthcare Connections which allows them to collect PHI on our behalf.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Louisiana Healthcare Connections members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

Medical Records Audits

Louisiana Healthcare Connections will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists as well as the outcome of such services also may be assessed during a medical record audit. Louisiana Healthcare Connections will provide written notice prior to conducting a medical record review.

Prescription Monitoring Program

Upon writing a first prescription or "first fill," defined as any medication that has not been filled within a 90-day period, for a controlled substance for a behavioral health patient, a physician should utilize, print, and file a copy of the Prescription Monitoring Program (PMP) record of the member. This should be filed both initially and annually.

NOTE: Audits to verify compliance will be conducted randomly and annually.

PMP is governed by the Louisiana Board of Pharmacy. Additional information about the PMP can be found here: http://www.labp.com/index.cfm?md=pagebuilder&tmp=home&pid=5&pnid=0&nid=7

DOCUMENTATION AND RETENTION GUIDELINES

We require treatment records to be maintained in a manner that is current, detailed and organized and which permits effective and confidential member care and quality review. Treatment record standards are adopted that are consistent with the National Committee for Quality Assurance. The adopted standards facilitate communication, coordination and continuity of care and promote efficient, confidential, and effective treatment. Medical records must be prepared in accordance with all applicable state and federal rules and regulations and signed by the medical professional rendering the services. We require the confidentiality of medical records in accordance with 42 CFR, Part 431, Subpart F. This includes confidentiality of a minor's consultation, examination, and treatment for a STD in accordance with s.

384.30(2), CFR. Behavioral Health providers should reference the BH Provider Manual to review standards above and beyond what is listed.

Medical Record Guidelines

We require compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA). Our minimum standards for practitioners/provider medical record keeping practices include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of member information.

The following elements reflect a set of commonly accepted standards for behavioral health treatment record documentation:

- Each page in the treatment record contains the patient's name or ID number.
- Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- All entries in the treatment record are dated and include the responsible clinician's name, professional degree, and relevant identification number, if applicable.
- The record is legible to someone other than the writer.
- Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the member has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
- Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status and the results of a mental status exam, are documented.
- Special status situations, when present, such as imminent risk of harm, suicidal ideation or

elopement potential, are prominently noted, documented and revised in compliance with written protocols.

- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- A medical and psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic). For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
- A diagnosis is documented, using the most current DSM manual standards, consistent with the presenting problems, history, mental status examination and/or other assessment data.
- Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable. Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers, and health care institutions are included, as appropriate.
- Informed consent for medication and the patient's understanding of the treatment plan are documented.
- Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives. Documented interventions include continuity and coordination of care activities, as appropriate. Dates of follow-up appointments or, as applicable, discharge plans are noted.

Release of Information

Per 42 CFR § 431.306 (Release of information), the following requirements apply to all providers:

- The provider must have criteria specifying the conditions for release and use of information about applicants and recipients.
- Access to information concerning applicants or recipients must be restricted to persons or provider representatives who are subject to standards of confidentiality that are comparable to those of the provider.
- The provider must not publish names of applicants or recipients.
- The provider must obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility, and the amount of medical assistance payment under section 1137 of this Act and § 435.940 through § 435.965 of this chapter.
- If, because of an emergency situation, time does not permit obtaining consent before release, the provider must notify the family or individual immediately after supplying the information.
- The provider's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.

Laws Governing the Release of Behavioral Health Information

The release of certain information is governed by a myriad of federal and/or state laws. These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, substance use disorder treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that

covered entities, such as health plans and providers, release protected health information (PHI) only when permitted under the law, such as for treatment, payment, and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or “Part 2”). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the state level place further restrictions on the release of certain information such as mental health, communicable disease, etc.

For more information about any of these laws, refer to following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.gov and then select “Regulations and Guidance” and “HIPAA – General Information”
- Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: http://www.samhsa.gov/
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within our network are independently obligated to know, understand, and comply with these laws.

We take privacy and confidentiality seriously. We have established processes, policies, and procedures to comply with HIPAA and other applicable federal and/or state confidentiality and privacy laws.

Please contact the Louisiana Healthcare Connections Privacy Officer at 1-866-595-8133 or in writing (refer to the address below) with any questions about our privacy practices.

Louisiana Healthcare Connections
P.O. Box 84180
Baton Rouge, La 70884

Documentation

Providers need to retain all books, records and documentation related to services rendered to members as required by law and in a manner that facilitates audits for regulatory and contractual reviews.

Providers must also grant us and other regulatory agencies access to these documents to assure financial solvency and healthcare delivery capability and to investigate complaints and grievances, subject to regulations concerning confidentiality of such information. Access to documentation must be provided upon reasonable notice for all inpatient care. This provision shall survive the termination and or non-renewal of an agreement with us.

Bookkeeping and Retention

The clinical record is an important element in the delivery of quality treatment because it documents the information to provide assessment and treatment services. You may access sample forms that providers are encouraged to use for members on the Louisiana Healthcare Connections website.

As part of our ongoing quality improvement program, clinical records may be audited to assure the quality and consistency of Provider documentation, as well as the appropriateness of treatment. Before charts can be reviewed or shared with others, the member must sign an authorization for release. You may access this form via the Louisiana Healthcare Connections website.

Chart audits of member records will be evaluated in accordance with these criteria. Clinical records require documentation of all contacts concerning the member; relevant financial and legal information; consents for release/disclose of information; release of information to the member's PCP; documentation of member receipt of the Statement of Member's Rights and Responsibilities; the prescribed medications with refill dates and quantitates, including clear evidence of the informed consent; and any other information from other professionals and agencies. If the provider is able to dispense medication, the provider must conform to drug dispensing guidelines set forth in Louisiana's state drug formulary.

The provider shall retain clinical records for members for as long as required by applicable law. These records shall be maintained in a secure manner but must be retrievable upon request.

Claims and Encounters

BILLING AND CLAIMS SUBMISSION

Louisiana Healthcare Connections values our providers and appreciates the administrative and financial complexities of managing a health care practice. We are committed to being your plan for success, and processing claims timely to help you receive payment as quickly as possible.

Louisiana Healthcare Connections is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. Claims will be rejected or denied if not submitted correctly. In general, Louisiana Healthcare Connections follows the CMS billing requirements. For questions regarding billing requirements, contact a Louisiana Healthcare Connections Provider Services Representative at 1-866-595-8133.

Louisiana Healthcare Connections providers should refer to their contract for complete information regarding their obligations and mode of reimbursement. Such reimbursement shall be no less than the published Medicaid FFS rate in effect on the date of service or its equivalent, such as a Diagnosis Related Group (DRG) case rate, unless mutually agreed to by both Louisiana Healthcare Connections and the provider in the provider contract.

Required Billing Information

Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with Louisiana Healthcare Connections for payment of covered services. It is important that providers ensure Louisiana Healthcare Connections has accurate billing information on file. Please confirm with your Provider Consulting Department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Mailing location for all correspondence (including manual payments, if applicable)
- Billing name and address

We recommend that providers notify Louisiana Healthcare Connections as soon as possible, but no later than 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a provider's TIN and/or address are **not** acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service;
- The service provided is a covered benefit under the member's contract on the date of service; and
- Referral and prior authorization processes were followed, if applicable.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures as well as the billing guidelines outlined in this handbook and the provider billing manual located at www.LouisianaHealthConnect.com.

When required data elements are missing or are invalid, claims will be rejected or denied by Louisiana Healthcare Connections for correction and re-submission.

- For Electronic Data Interchange (EDI) claims, rejections happen through one of our EDI clearinghouses if the appropriate information is not contained on the claim.
- For paper claims, rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason for the rejection.
- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an EOP or Electronic Remittance Advice (ERA).

Claims for billable services provided to Louisiana Healthcare Connections members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

Bill with Individual NPI Number

Providers must bill with their individual NPI number in box 24Jb and group or pay to NPI# in box 33a. The servicing location information in box 32 must be completed when it is different than the billing provider information in box 33. The provider NPI may be completed in box 32a. Please note: Taxonomy requirements apply to boxes 24J and 33B on the CMS-1500 professional claim form and box 57 or box 81 on the CMS-1450/UB-04 facility claim. Claims missing the requirements will be returned, and a notice will be sent to the provider, which may result in payment delays. The only exception to the taxonomy requirement is if the provider has only one taxonomy on file. Such claims are not considered "clean" and therefore cannot be accepted into our system.

CLIA Number Information

Effective for dates of service on or after August 1, 2019, professional service and independent laboratory providers are required to include a valid CLIA number on all claims submitted for laboratory services, including CLIA-waived tests. Claims with an absent, incorrect, or invalid CLIA number will deny.

CLIA certification number is required in Box 23 of the CMS-1500 claim form or in the 2300 loop of an electronic billed claim form. Providers should refer to the CMS 1500 Billing Instructions under the Billing Information link at www.lamedicaid.com, where complete instructions are provided. The CLIA number is not required for UB-04 claims.

Example of valid CLIA number format: 19DXXXXXXX

- The first three characters are the two-digit state code followed by the letter D
- The remaining seven digits are the unique CLIA system number assigned to the provider
- Do not add the letters CLIA or CLIA to the ten-character CLIA number

CLIA Waiver certificates and provider-performed microscopy certificates require providers to bill a QW modifier for specific laboratory services, as indicated on the CMS CLIA Waived Tests list. If the CMS CLIA Waived Test list indicates that a QW modifier is required and a QW modifier is not billed, then the claim will deny.

Updating Coding Specifications

Louisiana Healthcare Connections will update CPT/HCPCS, ICD-9- CM and/or ICD-10 and other codes based on HIPAA standards and move to future versions as required. Louisiana Healthcare Connections will update CPT/HCPCS annually per LDH release of procedure codes.

Fee Schedule Configuration Timeframes

Louisiana Healthcare Connections understands the critical nature of fee schedule changes and will update our systems no later than 30 days after the Medicaid file is published. Any claims that are denied due to new rates or codes will be reprocessed no later than 15 days after the completion of the system updates, without addition action required from providers.

Claim Payment Timeframes

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

Within five business days of receipt of a claim, Louisiana Healthcare Connections will perform an initial screening, and either reject the claim or assign a unique control number and enter it into the system for processing and adjudication.

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90 percent of clean claims will be processed within 15 business days of receipt
- 99 percent of clean claims will be processed within 30 calendar days of receipt

Claims are processed per the Louisiana Medicaid Fee Schedule. Louisiana Healthcare Connections has a separate fee schedule for IV Infusion and DME.

Pending Claims

Louisiana Healthcare Connections will fully adjudicate (pay or deny) all pended claims within 60 calendar days of the date of receipt.

Payment to Providers

Louisiana Healthcare Connections will run two provider payment cycles per week, on Monday and Thursdays. Providers receiving payment via electronic fund transfer can expect payment on Tuesday and Friday. This schedule is subject to change when there is a state holiday, a declared state of emergency, or upon other notification posted to our website.

Providers are encouraged to submit and receive claims information through electronic data interchange (EDI).

Interest Calculations

Louisiana Healthcare Connections will pay providers interest at a rate of twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond thethirty

(30) day claims processing timeframe. Interest owed to the provider shall be paid the same daythat the claim is adjusted.

No interest will be owed on the below:

- Overriding timely filing
- Retro Authorization
- Retro fee schedules or contracts

- Updated information or policy changes by the state

Clean Claim Definition

A clean claim is defined as a claim received by Louisiana Healthcare Connections for adjudication, in a nationally accepted format in compliance with standard coding guidelines, and which requires no further information, adjustment or alteration by the provider of services in order to be processed by Louisiana Healthcare Connections.

The following exceptions apply to this definition:

- A claim for which fraud is suspected
- A claim for which a Third-Party Resource should be responsible

NOTE: It is the provider's responsibility to check their audit report to verify that Louisiana Healthcare Connections has accepted their electronically submitted claim.

Clean claims will be adjudicated (finalized as paid or denied) within 15 business days of the receipt of the claim. Non-clean claims will be adjudicated (finalized as paid or denied) within 30 days of receipt of the electronic claim.

Claims pended for additional information must be closed (paid or denied) by the 30th calendar day following the date the claim is pended if all requested information is not received prior to the expiration of the 30-day period. Louisiana Healthcare Connections will send providers written notification via the web or an Explanation of Benefits (EOB) for each claim denied, including the reason(s) for the denial, the date contractor received the claim and a reiteration of the outstanding information required from the provider to adjudicate the claim.

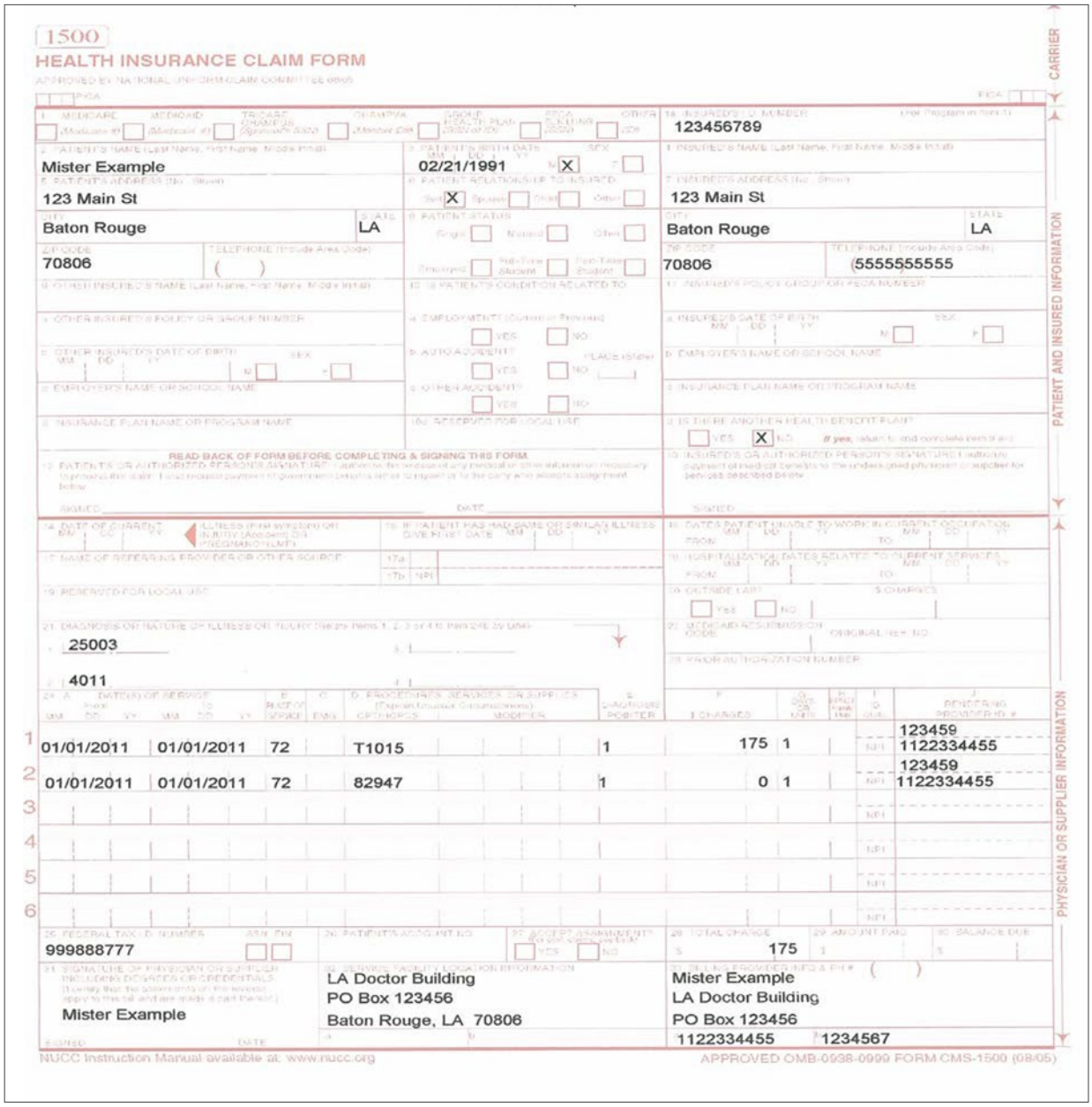
Non-Clean Claim Definition

A non-clean claim is defined as a submitted claim that requires further investigation or development beyond the information contained in the claim. The errors or omissions in the claim may result in:

- A request for additional information from the provider or other external sources to resolve or correct data omitted from the claim
- The need for review of additional medical records
- The need for other information necessary to resolve discrepancies

In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

CMS 1500 (HCFA) Claim Example



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

CARRIER

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER

1a. INSURED'S I.D. NUMBER: 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Mister Example

3. PATIENT'S BIRTH DATE: 02/21/1991 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Main St

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 123 Main St

CITY: Baton Rouge STATE: LA

8. PATIENT STATUS: Single Married Other / Employed Full-Time Student Part-Time Student

CITY: Baton Rouge STATE: LA

ZIP CODE: 70806 TELEPHONE (Include Area Code): ( )

ZIP CODE: 70806 TELEPHONE (Include Area Code): (5555555555)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH: SEX M F

b. OTHER INSURED'S DATE OF BIRTH: SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? Yes No $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 25003

2. 4011

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01/01/2011	01/01/2011	72		T1015		1	175	1		NPI	123459 1122334455
2 01/01/2011	01/01/2011	72		82947		1	0	1		NPI	123459 1122334455
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 999888777 SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ 175

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mister Example

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

LA Doctor Building
PO Box 123456
Baton Rouge, LA 70806

a. b.

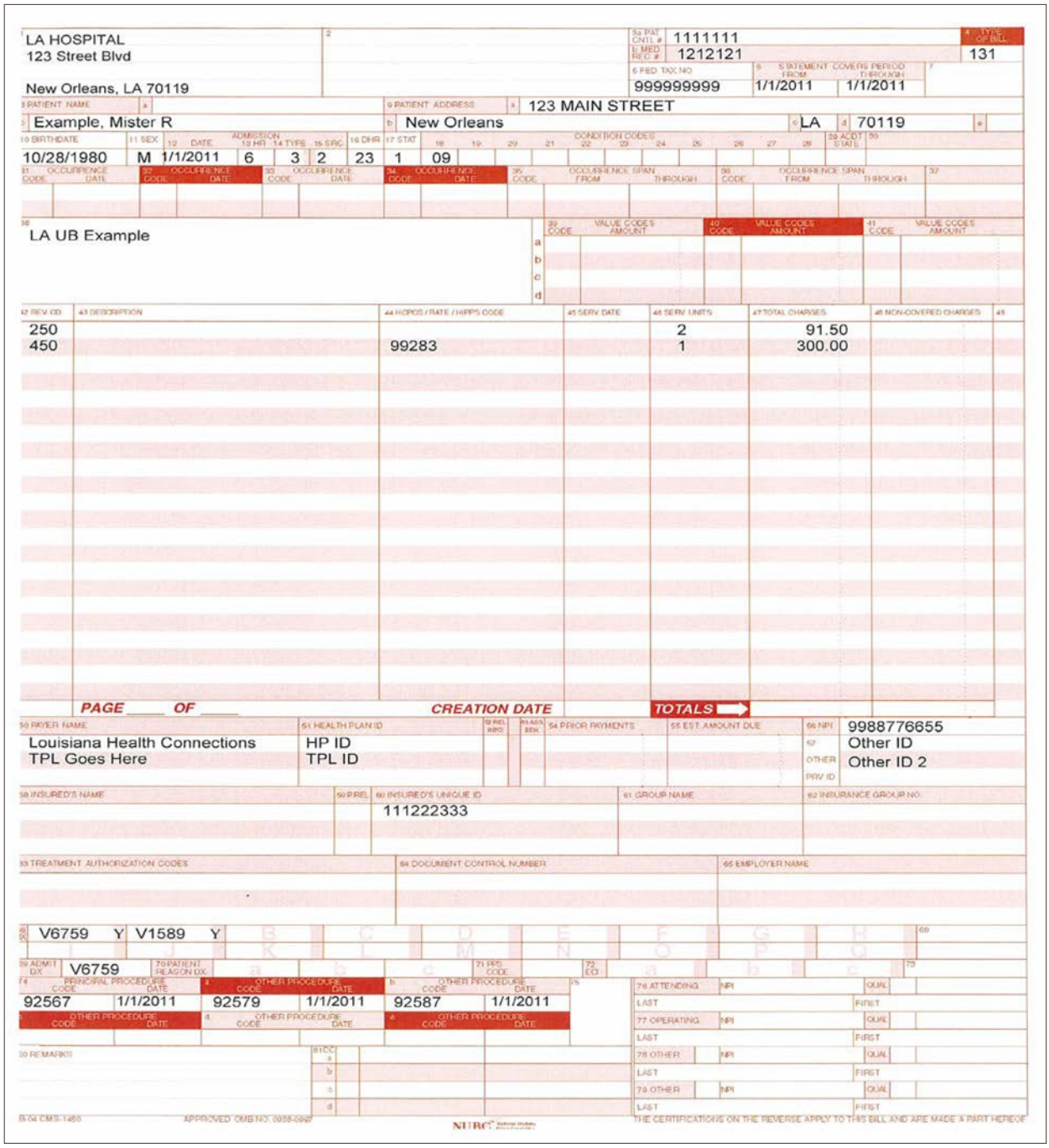
33. BILLING PROVIDER INFO & PH # ( )

Mister Example
LA Doctor Building
PO Box 123456
1122334455 1234567

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CMS 1450 (UB-04) Claim Example



LA HOSPITAL
123 Street Blvd
New Orleans, LA 70119

1 PAT CNTL # 1111111
2 MED REC # 1212121
4 TYPE OF BILL 131
5 FED TAX NO 999999999
6 STATEMENT COVERS PERIOD FROM 1/1/2011 THROUGH 1/1/2011

a PATIENT NAME: Example, Mister R
9 PATIENT ADDRESS: a 123 MAIN STREET; b New Orleans; c LA; d 70119

10 BIRTHDATE 10/28/1980 | 11 SEX M | 12 ADMISSION DATE 1/1/2011 | 13 HR 6 | 14 TYPE 3 | 15 SRC 2 | 16 DHR 23 | 17 STAT 1 | CONDITION CODES 09 | 29 ACDT STATE

LA UB Example

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
250				2	91.50	
450		99283		1	300.00	

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: Louisiana Health Connections / TPL Goes Here
51 HEALTH PLAN ID: HP ID / TPL ID
66 NPI 9988776655; 67 Other ID; OTHER PRV ID Other ID 2

58 INSURED'S NAME
60 INSURED'S UNIQUE ID 111222333
61 GROUP NAME
62 INSURANCE GROUP NO

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

67a V6759 Y | 67b V1589 Y

69 ADMIT DX V6759

74 PRINCIPAL PROCEDURE CODE / DATE	74a OTHER PROCEDURE CODE / DATE	74b OTHER PROCEDURE CODE / DATE
92567 / 1/1/2011	92579 / 1/1/2011	92587 / 1/1/2011

74c OTHER PROCEDURE CODE / DATE | 74d OTHER PROCEDURE CODE / DATE | 74e OTHER PROCEDURE CODE / DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81 CC

APPROVED OMB NO. 0938-0997
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Electronic Funds Transfers and Electronic Remittance Advices

Louisiana Healthcare Connections provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straight forward reconciliation of payments. Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically. As a provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or member accounting systems, eliminating the need for manualre-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep total control over the destination ofclaim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments withelectronic remittance advices quickly and easily

For more information, please visit our provider can visit:

- our website at www.LouisianaHealthConnect.com
- www.payspan.com or contact Payspan Provider Services at 1-800-733-0908.
- If further assistance is needed, please contact Provider Services 1-866-595-8133.

Initial Claims, Corrected Claims and Requests for Reconsideration

Louisiana Healthcare Connections
Attention: Claims
P.O. BOX 4040
Farmington, MO 63640-3826

NOTE: Please use the Claim Appeal Form located at LouisianaHealthConnect.com

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

Louisiana Healthcare Connections is always the payer of last resort. Louisiana Healthcare Connections providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Louisiana Healthcare Connections members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third-party resources, the provider shall inform Louisiana Healthcare Connections that efforts have been unsuccessful. Louisiana Healthcare Connections will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Louisiana Healthcare Connections will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Cost Avoidance

Except for “pay and chase” claims identified in this section, Louisiana Healthcare Connections shall cost-avoid a claim if it establishes the probable existence of another health insurance at the time the claim is filed. Louisiana Healthcare Connections shall deny the claim for coordination of benefits (COB) and return it back to the provider noting the third party which is believed to be legally responsible for payment. If a balance remains after the provider bills the liable third party or the claim is denied payment for a substantive reason, the provider may submit a claim to Louisiana Healthcare Connections for payment of the balance up to the maximum allowable Medicaid reimbursement amount.

Pay and Chase vs. Wait and See

The “pay and chase” method occurs when payment is made by Louisiana Healthcare Connections for submitted claims even if a third party is likely liable, and Louisiana Healthcare Connections then seeks to recoup payments from the liable third party.

Louisiana Healthcare Connections shall reimburse no less than the full amount allowed under Medicaid’s payment schedule, and then seek recovery of payment from the third party within 60 days after the end of the month in which payment is made (or within 60 days after the end of the month that Louisiana Healthcare Connections learns of the existence of a liable third party) when:

The service is Preventive Pediatric Care (PPC), including Early and Preventive Screening, Diagnostic, and Treatment (EPSDT), EPSDT referral and when well-baby procedure codes 99460, 99462, and 99238 are billed with diagnosis codes Z38 through Z38.8.

NOTE: Louisiana Healthcare Connections shall use the pay and chase method of payment for preventive pediatric services for individuals under the age of 21 with other Health Insurance when the pediatric preventive diagnosis code is reported in the primary position of the claim. Hospitals are not included and must continue to file claims with the health insurance carriers. Primary preventive diagnoses are confined to those listed on www.lamedicaid.com. EPSDT referral is indicated as “Y” in block 24H of the CMS-1500 claim form or “A1” as a condition code on the UB-04 (form locators 18-28).

Section 53102(a)(1) of the Bipartisan Budget Act of 2018 removes prenatal care from pay and chase services.

Louisiana Healthcare Connections must “wait and see” on claims for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV D agency. “Wait and see” is defined as payment of a claim only after the documentation is submitted to Louisiana Healthcare Connections demonstrating that 100 days have elapsed since the provider billed the responsible third party and remains to be paid. Louisiana Healthcare Connections shall identify third party liability enforced by the State Title IV-D agency by initiator code 02 in TPL files transmitted by LDH’s fiscal intermediary.

The provider can only bill Medicaid for the balance not paid for by the liable third party and payment can only be made for up to the Medicaid allowable amount.

Verification of Information

All claims filed with Louisiana Healthcare Connections are subject to verification procedures. These include but are not limited to verification of the following:

- All required fields are completed on the current industry standard CMS 1500 (HCFA), CMS 1450 (UB-04) paper claim form, or EDI electronic claim format.
    - It is highly recommended all inpatient facilities submit a Present on Admission (POA) indicator (diagnosis member had upon admission). Please reference the CMS billing guidelines regarding POA for more information and for excluded facility types.
- All inpatient facilities are required to submit diagnosis codes that represent newborn weight.
- A member's Medicaid identification number is required.
- 9-digit billing zip code
- The rendering provider NPI should be billed in box 24J of a CMS-1500 (HCFA) claim form.
    - Unlicensed behavioral health staff must obtain and use their individual NPI.
- All Diagnosis, Procedure, Modifier, Location (place of service), Revenue, Type of Admission and Source of Admission Codes are valid for the date of service.
    - All Diagnosis, Procedure, Modifier (See Modifier Appendix Section IX), and Location (place of service) Codes are valid for provider type/specialty billing.
    - **NOTE:** Please ensure location (place of service) is correct before claim submission as this may result in a denial during adjudication.
- All Diagnosis, Procedure and Revenue Codes are valid for the age and/or sex for the date of the service billed.
        - All Diagnosis Codes are to their highest number of digits available (4th or 5th digit).
- Principle Diagnosis billed reflects an allowed Principle Diagnosis as defined in the current volume of ICD-9 CM, or ICD-10 CM for the date of service billed.
    - For a HCFA (CMS 1500) claim form, these criteria looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary and that code is not valid as a primary diagnosis code, that line will be denied.
- National Drug Code (NDC) is billed in the appropriate fields on all claim forms for a HCPCS beginning with J, Q, and S and all Internal Therapy codes beginning with the B including the number of units associated with the NDC. These requirements pertain to physician, outpatient hospital and DME claims.
    - *NOTE: Provider must use NDC listed on the Louisiana Medicaid Website at* www.lamedicaid.com.

Required Consent Forms

Required Consent Forms are included with the claim during the time of submission or if there is an existing consent form already on file. Consent forms can be located at the LDH website at:

- Abortion Certification Form
  http://ldh.la.gov/assets/docs/BayouHealth/RFP2014/Appendices/AppendixN_AbortionCertification-of-InformedConsent.pdf
- **Sterilization Consent Form**
  http://ldh.la.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CCNPAppendices/AppendixM_SterilizationConsentForm.pdf
- **Hysterectomy Consent Form**
  http://ldh.la.gov/assets/docs/BayouHealth/RFP2014/Appendices/AppendixL_HysterectomyConsentFormfill.pdf

These forms are required at the time of claim submission. If the forms are not completed and signed before submission, all related claims will deny.

The following fields must be completed on the Acknowledgment of Receipt of Hysterectomy Information form in order for claims to be processed:

- Recipient Name
- MEDS Person Number
- Physician Name
- Provider Number
- Signature of Recipient and Date
- Signature of Representative, if any
- Member's Name
- Member's Record Number
- Name of physician performing service
- Providers TIN number
- Member's signature and date
- Not required if not applicable

NOTE: If an incomplete form is submitted, it will result in the following denials:

EX CODE	DESCRIPTION
CF	PEND: *Waiting for consent form*
DD	DENY: *Signed, paper consent form has not been received*
DQ	DENY: *Member under 21 years of age when signing consent form*
HQ	DENY: *EDI claim must be submitted in hard copy with consent form (EDI)*
K2	DENY: *Abortion certification form is not valid/missing information*
NV	DENY: *Sterilization consent form not valid or missing information*
Z1	DENY: *Abortion necessity form required for processing*

Sterilization Form Instructions

In order to be successfully submitted, the Sterilization Consent Form must include the following information as defined below:

FIELD	DESCRIPTION / CRITERIA
Doctor or Clinic	Name of physician/clinic performing sterilization procedure
Specify Type of Operation	Name of procedure performed; Abbreviations acceptable
Birth Date	Recipient's month, day & year of birth clearly indicated
Name of Member	Recipient's name must be legible; Initials for first & middle name acceptable
Doctor or Clinic	Name of physician/doctor/affiliate/associate is acceptable; Recipient must initial any corrections made to this field
Specify Type of Operation	Medical name of sterilization procedure; Abbreviations acceptable
Signature	Recipient's signature (similar name in line 4) required; Initials for first & middle name acceptable.
Date	Date recipient signed form
Race & Ethnic Designation	Not required field
Interpreter's Statement	If applicable
Interpreter's Signature	If applicable
Date	If applicable
Name of Member	Name of recipient legible; Initials for first & middle name acceptable.; Name can be typed
Specify Type of Operation	Medical name of sterilization procedure; Recipient must initial any corrections made to this field.
Signature of Person Obtaining Consent	Signature of person who counseled Member & explained nature of sterilization operation
Date	Date of signature matches date of Members' signature above
Facility	Name of facility/provider obtaining consent
Address	Complete address of facility/provider obtaining consent
Name of Member	Name of recipient legible; Initials for first & middle name acceptable
Date of Sterilization	Date of procedure
Specify Type of Operation	Name of procedure performed; Abbreviations acceptable
Select the appropriate Paragraph	If applicable, paragraph not used crossed out
Physician's Signature	Signed after sterilization procedure performed; Physician signature stamps not acceptable
Date	Dated on/after sterilization procedure performed

Claims Filing Deadlines

Original claims (first time claims) must be submitted to Louisiana Healthcare Connections within 365 calendar days from the date services were rendered or compensable items were provided. Claims received outside of this timeframe will be denied for untimely submission. If proof is received to show original submission to another MCO or LDH's Fiscal intermediary, Molina, occurred within the required 365 days, reconsideration will be given to the provider and timely filing may be overturned.

When Louisiana Healthcare Connections is the secondary payer, claims must be received within 365 calendar days of the final determination of the primary payer.

The above timelines also apply to EPSDT claims though providers are encouraged to submit their EPSDT claims within 60 days of service.

All corrected claims, request for reconsiderations and/ or claim appeals must be received within 180 calendar days from the date of notification of payment or denial is issued.

If corrected claims, reconsiderations and/or appeals are received after the 180-day timeframe of the original denial and/ or payment, the original claim decision will be upheld. No adjustments can be made for that claim, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Mechanical or administrative delays or errors by Louisiana Healthcare Connections or LDH– State of Louisiana.
- The member was eligible however the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
    - The provider's records document that the member refused or was physically unable to provide their ID card or information.
    - The provider can substantiate that he continually pursued reimbursement from the member until eligibility was discovered.
    - The provider can substantiate that a claim was filed within 180 days of discovering plan eligibility.
    - The provider has not filed a claim for this member prior to the filing of the claim under review.

Louisiana Healthcare Connections shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. In situations of third-party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.

If the provider has a qualifying circumstance, please contact the Customer Service Department for assistance with timely approvals.

Claims Adjustments & Appeals

All claim requests for corrected claims, reconsideration, or claim disputes must be received within 180 calendar days from the date of notification of payment or denial was issued.

If a provider has questions with the information they have received related to a claim, there are two effective ways in which the provider can contact Louisiana Healthcare Connections.

1. Review the claim in question on the secure Provider Portal
   Providers, who have registered for access to the secure provider portal, can access claims to obtain claim status, submit claims, or submit a corrected claim.
2. Contact a Provider Service Representative at 1-866-595-8133.
   Providers may inquire about claim status, payment amounts, denial reasons,

Corrected Claims

When submitting an Adjusted or Corrected Claim to Louisiana Healthcare Connections, they must clearly indicate they are corrected in one of the following ways:

1. Submit corrected claim via the secure Provider Portal

   a. Follow the instructions on the portal for submitting a correction

2. Submit corrected claim electronically via Clearinghouse

The 837 TR3 defines what values submitters must use to signal to payers that the inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification

Values supported for corrections and reversals are:

- 5 = “Late Charges Only” Claim
- 7 = Replacement of Prior Claim

  Note: When Utilizing Claim Frequency Code 7 the provider must place all service lines from the original claim not just the specific service line the provider wants corrected. Failure to follow this format will cause the entire claim to be recouped.
- 8 = Void/Cancel of Prior Claim

Louisiana Healthcare Connections
Attention: Claims
P.O. BOX 4040
Farmington, MO 63640-3826

Please use the Claim Appeal Form located at LouisianaHealthConnect.com.

Important Claim Notes

- We cannot accept copied, downloaded or handwritten HCFA-1500 and UB-04 forms. We accept original red and white HCFA-1500 UB-04 claims forms.
- Failure to include the original claim number (or include the EOP) may result in the claim being denied as a duplicate claim, delayed claim adjudication, or denial for exceeding the timely filing

limit.

- The previous claim number you want corrected must be indicated in field 64 of the UB-04 and in field 22 of the HCFA 1500. This requirement is part of the National Uniform Claim Committee (NUCC) guidelines. The appropriate frequency code/resubmission code should also be included in field 64 of the UB-04 and in field 22 of the HCFA 1500.
- When Utilizing Claim Frequency Code 7 the provider must place all service lines from the original claim not just the specific service line the provider wants corrected.
- Medical records will not go to the Medical Review Unit team if: there is no claim form attached; there is no original claim number listed on the corrected claim form; there is no reconsideration form attached; and the original claim did not deny asking for medical records.

Mail corrected claims to:

Louisiana Healthcare Connections
Attn: Corrected Claim
PO Box 4040
Farmington, MO 63640-3826

ELECTRONIC CLAIM PROCEDURES

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs
  - Eliminates the need for paper claim submission
  - Reduces claim re-work (adjustments)
- Receipt of clearinghouse reports as proof of claim receipt
- Faster transaction time for claims submitted electronically
- Validation of data elements on the claim format
- No charge to provider by Louisiana Healthcare Connections for electronically billed claims.

All the same requirements for paper claim filing apply to electronic claim filing. Claims not submitted correctly or not containing the required field data will be rejected and/or denied.

Electronic Claim Submission

Providers are encouraged to participate in our electronic claims/encounter filing program. We are capable of receiving an ANSI X12N 837 professional, institution or encounter transaction, as well as to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

For more information on electronic filing and the clearinghouses Louisiana Healthcare Connections has partnered with, contact:

Louisiana Healthcare Connections c/o Centene EDI
1-800-225-2573, extension 25525
or by e-mail to EDIBA@centene.com

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Louisiana Healthcare Connections' Payer ID is 68069, and we work with the following clearinghouses:

- Emdeon
- Availity
- Capario
- Smarta Data
- Allscripts/Payerpath
- IGI
- Physicians CC
- Claimsource
- Claim Remedi
- First Health Care
- Viatrack
- GHN Online
- Medassets/exactimed (pending)
- Practice Insight
- SSI
- Trizetto Provider Solutions, LLC.
- Relay/Mckesson
- MDonLine
- CPSI
- Dekalb

Providers are encouraged to participate in Louisiana Healthcare Connections' Electronic Claims/Encounter Filing Program through Centene. Louisiana Healthcare Connections' (Centene) has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, Louisiana Healthcare Connections (Centene) has the capability to generate an ANSI X12N 835 electronic remittance advice known as an EOP.

For more information on electronic filing, contact:

Louisiana Healthcare Connections c/o Centene EDI Department 1- 800-225-2573 (ext 25525)

EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Compliance with encounter reporting and claims submission requirements is required to avoid penalties for non-reporting, untimely reporting, or inaccurate reporting.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this booklet. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements. The companion guide is located on Louisiana Healthcare Connections website at www.LouisianaHealthConnect.com.

Electronic Secondary Claims

Louisiana Healthcare Connections has the ability to receive Coordination Of Benefit (COB or Secondary) claims electronically. The field requirements for successful electronic COB submission are below (4010 Format):

COB FIELD NAME ***Below should come from the primary payer's Explanation of Payment***	**837I – INSTITUTIONAL** ***EDI Segment and Loop***	**837P – PROFESSIONAL** ***EDI Segment and Loop***
COB Paid Amount	2400/SVD02	2400/SVD02
COB Allowed Amount	If 2320/AMT01 = B6, map AMT02	If 2320/AMT01 = B6, map AMT02
COB Patient Liability Amount	If 2300/CAS01 = PR, map CAS02 NOTE: *this segment can have 6 occurrences. Tibco will validate all.*	If 2320/AMT01 = F2, map AMT02
COB Discount Amount	CAS02 = 44 (Prompt Pay discount)	If 2320/AMT01 = D8, map AMT02
COB Patient Paid Amount	If 2320/AMT01 = C4, map AMT02	If 2320/AMT01 = F5, map AMT02
Total Claim Before Taxes Amount	If 2320/AMT01 = T3, map AMT02	If 2320/AMT01 = T2, map AMT02
COB Claim Adjudication Date	IF 2330B/DTP01 = 573, map DTP03	IF 2330B/DTP01 = 573, map DTP03
COB Claim Adjustment Indicator	IF 2330B/REF01 = T4, map REF02	IF 2330B/REF01 = T4, map REF02

Electronic Claim Flow Description

In order to send claims electronically to Louisiana Healthcare Connections, all EDI claims must first be forwarded to one of Louisiana Healthcare Connections' clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report.

It is very important to review this error report daily to identify any claims that were not transmitted to Louisiana Healthcare Connections.

The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Louisiana Healthcare Connections, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Louisiana Healthcare Connections by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the

rejection back to its trading partner (the intermediate EDI clearinghouse or provider). **It is very important to review this report daily.** The report shows rejected claims and these claims need to be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Louisiana Healthcare Connections.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to clearly mark your claim as a corrected claim per the instructions above.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Louisiana Healthcare Connections must first pass the clearinghouse proprietary edits and plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Louisiana Healthcare Connections. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 365 calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Our companion guides to billing electronically are available on our website at LouisianaHealthConnect.com. See section on Electronic Claim Filing for more details.

Exclusions

Excluded Claim Categories:

- Excluded from EDI Submission Options
- Must be Filed Paper
- Applies to Inpatient and Outpatient Claim Types
- Claim records requiring supportive documentation or attachments (Certification of Informed Consent-Abortion, consent forms, medical records, etc.)
    - **NOTE:** COB claims can be filed electronically, but if they are not all paper claims submitted with EOB payment information must mirror current EDI edits thatrequire appropriate data in 9, 9a, 9d, and 11d on the CMS 1500.
- Claim for services requiring clinical review (e.g. complicated or unusual procedure)
- Provider is required to submit medical records with the claim.
- Claim for services needing documentation and requiring Certificate of Medical Necessity
- Oxygen, Motorized Wheelchairs

Electronic Billing Inquiries

TOPIC	CONTACT
Clearinghouses submitted directly to Louisiana Healthcare Connections:	• Emdeon • Availity • Capario • Smarta Data • Allscripts/Payerpath • IGI • Physicians CC • Claimsource • Claim Remedi • First Health Care • Viatrack • GHN Online • Medassets/exactimed (pending) • Practice Insight • SSI • Trizetto Provider Solutions, LLC. • Relay/Mckesson • MDonLine • CPSI • DeKalb
Louisiana Healthcare Connections Payer ID:	68069
General EDI Questions:	EDI Support at 1-800-225-2573 Ext. 25525 Via e-mail at EDIBA@centene.com.
Claims Transmission Report Questions:	Your clearinghouse technical support area
Claim Transmission Questions *(Has my claim been received or rejected?):*	EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
Remittance Advice Questions:	Louisiana Healthcare Connections Provider Services at 1-866-595-8133 or the Providers.LouisianaHealthConnect.com
Provider Payee, NPI, Tax ID, Payment, Address Changes: MUST include W9	Notify Provider Services in writing at: Louisiana Healthcare Connections P.O. Box 84180Baton Rouge, LA 70884 Or via Fax to: 1-866-768-9374

Successful Submission of EDI Claims

1. Select clearinghouse to utilize.
2. Contact clearinghouse to inform them you wish to submit electronic claims to Louisiana Healthcare Connections.
3. Inquire with the clearinghouse what data records are required.
4. Verify with Louisiana Healthcare Connections Customer Service Department that the provider is set up in the Louisiana Healthcare Connections system before submitting EDI claims.
5. You will receive two reports from the clearinghouse. **Always** review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Louisiana Healthcare Connections and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Louisiana Healthcare Connections. **Always** review the acceptance and claim status reports for rejected claims. If rejections are noted, correct and resubmit.
6. Most importantly, all claims must be submitted with provider identifying numbers. See the CMS 1500 (8/05) and UB-04 1450 claim form instructions and claim forms for details.

NOTE: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the fields are empty.

ONLINE CLAIM PROCEDURES

For providers who have internet access and choose not to submit claims via EDI or paper, Louisiana Healthcare Connections has made it easy and convenient to submit claims directly to us on our secure provider portal at LouisianaHealthConnect.com. You must request access to our secure site by registering for a username and password and you must select the Claims Role Access module.

Once you have access to the secure portal, you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view and correct any previously processed claims.

PAPER CLAIM PROCEDURES

Submit claims to Louisiana Healthcare Connections at the following address:

Louisiana Healthcare Connections
ATTN: Claim Processing Department
P. O. Box 4040
Farmington, MO 63640-3826

Louisiana Healthcare Connections encourages all providers to submit claims electronically. Our companion guides to billing electronically are available on our website at LouisianaHealthConnect.com.

Claim Forms

Louisiana Healthcare Connections only accepts the CMS 1500 (8/05) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (8/05) form and institutional providers complete the CMS 1450 (UB-04) claim form. Louisiana Healthcare Connections does not supply claim forms to providers. Providers should purchase these from a supplier of their choice.

Note: Louisiana Healthcare Connects cannot accept copied, downloaded or handwritten CMS-1500 and UB-92 claim forms. These claims will be rejected and returned. We continue to accept red and white CMS-1500 and original UB-92 claim forms. If you have questions regarding what type of form to complete, contact Provider Services at 1-866-595-8133.

Coding of Claims/Billing Codes

Louisiana Healthcare Connections requires claims to be submitted using codes from the current version of ICD-9-CM, ICD-10, ASA, DRG, CPT4, and HCPCS Level II for the date of service was rendered.

These requirements may be amended to comply with federal and state regulations as necessary. Below are some code-related reasons a claim may be rejected or denied:

- CPT/HCPCS code billed is missing, invalid or deleted at the time of service.
- CPT/HCPCS code inappropriate for the age or sex of the member.
- ICD-9cm diagnosis code missing the 4th or 5th digit as appropriate.
- A deleted ICD-9cm code was used.
- Procedure code pointing to a diagnosis code that may not reflect medical necessity of procedure performed. For a HCFA 1500 claim form, this criteria looks at all procedure codes billed and if the diagnosis code is pointing to a procedure code and the diagnosis code is invalid and/or does not

support medical necessity, the claim line will be denied.

- Using a secondary only designated as the primary diagnosis code on the claim as a primary diagnosis the service line on the claim will deny.
- CPT/HCPCS code billed is inappropriate for the location or specialty billed.
- CPT code billed is a part of a more comprehensive code billed on same date of service.
- Rev Code/HCPC Code combination billed not appropriate

Written descriptions, itemized statements, medical records, and invoices may be required for Unlisted CPT/HCPCS codes upon submission of a claim or at the request of Louisiana Healthcare Connections.

NOTE: When sending requested medical records, providers should also attach the original claim form and/or claim number to medical records. If original claim form or claim number is not submitted with the medical records, the MRU will not review medical records.

For more information regarding billing codes, coding, and code auditing and editing contact a Louisiana Healthcare Connections Customer Services Representative at 1-866- 595-8133.

Code Auditing and Editing

Louisiana Healthcare Connections uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier and place of service codes. Claims billed in a manner that do not adhere to the standards of the code editing software will be denied.

The code editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site and other sources.
- CMS National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based onthe most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

POST-PROCESSING CLAIMS AUDIT

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. Louisiana Healthcare Connections is contractually obligated to have procedures in place to detect waste, fraud, and abuse. This is achieved through:

- Claims editing
- Post-processing review of claims
- Provider profiling and credentialing
- Quality control
- Utilization management

To start the audit, Auditors request medical records for a defined review period. Providers have two weeks to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider.

NOTE: If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Louisiana Healthcare Connections will recover all amounts paid for the services in question.

Auditors review cases for potential unbundling, upcoding, mutually exclusive procedures, incorrect procedures and/or diagnosis for member's age, duplicates, incorrect modifier usage, and other billing irregularities. They consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness.

If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report which identifies all records reviewed during the audit. If the Auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Louisiana Healthcare Connections will seek recovery of all overpayments.

The following provides conditions where the software will make a change on submitted codes:

Unbundling of Services

Identifies services that have been unbundled

EXAMPLE: Unbundling lab panels. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim.

CODE	DESCRIPTION	STATUS
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

EXPLANATION: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

CODE	DESCRIPTION	STATUS
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Add

EXPLANATION: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and CPT code 80050 is added to a new service line and recommended for reimbursement.

Bilateral Surgery

Identical Procedures Performed on Bilateral Anatomical Sites during Same Operative Session Example:

CODE	DESCRIPTION	STATUS
69436 DOS = 01/01/10	Tympanostomy	Disallow
69436 50 DOS = 01/01/10	Tympanostomy billed with modifier 50 (bilateral procedure)	Allow

EXPLANATION: identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure) along with the number “1” the units field.

NOTE: Modifiers RT (right), or LT (left) should not be billed for bilateral procedures.

Duplicate Services

Submission of same procedure more than once on same date of service that cannot be or are normally not performed more than once on the same day

EXAMPLE: Excluding a Duplicate CPT

CODE	DESCRIPTION	STATUS
72010	Radiologic exam, spine, entire, survey study, anteroposterior and lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior and lateral	Disallow

EXPLANATION:

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the

entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.

- It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services (E/M)

Submission of E/M Service either within a global surgery period or on the same date of service as another E/M service

Global Surgery

Procedures that are assigned a 90-day global surgery period are designated as major surgical procedures; those assigned a 10-day or 0-day global surgery period are designated as minor surgical procedures.

- Evaluation and Management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures (0-day), are not recommended for separate reporting or reimbursement because these services are part of the global service unless the service is a service listed on the state Fee Schedule with an asterisk.

EXAMPLE: Global Surgery Period

CODE	DESCRIPTION	STATUS
27447 DOS = 05/20/09	Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	**Allow**
99213 DOS = 06/02/09	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/member and/or family.	**Disallow**

EXPLANATION:

- Procedure code 27447 has a global surgery period of 90 days.
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

EXAMPLE: Global Surgery Period

CODE	DESCRIPTION	STATUS
11000 DOS = 01/23/10	Debridement of extensive eczematous or infected skin; up to 10% of body surface.	**Allow**
99213 DOS = 01/23/10	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face- to-face with member and/or family.	**Disallow**

EXPLANATION:

- Procedure 11000 (0-day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

Same Date of Service

Only one Evaluation and Management service is recommended for reporting on a single date of service

EXAMPLE: Same Date of Service

CODE	DESCRIPTION	STATUS
99215	Spend 40 minutes face-to-face with member and/or family.	**Disallow**
99222	Initial hospital care, per day (Inpatient Admission/ H&P), for the evaluation and management of a patient, which requires these three components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Usually, problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	**Allow**

EXPLANATION:

- Procedure 99215 is used to report an evaluation and management service provided to an established member during a visit.
- Procedure99222 is used to report an evaluation and management service for a hospital admission for a member with medical decision making of moderate.
- Separate reporting of an evaluation and management service with an office visit by a single

provider indicates a duplicate submission of services.

- Interventions, provided during an evaluation and management service, typically include the components of the hospital admission.

NOTE: Please also reference Modifier Appendix Section IX

Modifier -24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.

Modifier -25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

When modifiers -24 and -25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended.

Modifiers – codes added to a procedure code to indicate the service has been altered by a specific circumstance: modifiers are added to reflect supplemental information or to adjust the description to provide extra details concerning a procedure or service provided by the provider.

Modifier -26 (professional component)

DEFINITION: identifies the professional component of a test or study.

- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line and same procedure code and the modifier -26 appended.

EXAMPLE

CODE	DESCRIPTION	STATUS
78278 POS = Inpatient	Acute gastrointestinal blood loss imaging	**Disallow**
78278-26 POS = Inpatient	Acute gastrointestinal blood loss imaging	**Allow**

EXPLANATION:

- Procedure code 78278 is valid with modifier -26.
- Modifier -26 will be added to procedure code 78278 when submitted without modifier -26hen performed in a facility setting.

Modifier -80 and -AS (assistant surgeon)

DEFINITION: This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

EXAMPLE

CODE	DESCRIPTION	STATUS
42820-81	Tonsillectomy and adenoidectomy; under age 12	**Disallow**

EXPLANATION:

- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance this procedure.

Ambulance Services Modifier ET (emergency services only)

EXAMPLE

CODE	DESCRIPTION	STATUS
A0434-ET	Specialty care transport (SCT) [with modifier ET]	**Allow**
A0434	Specialty care transport (SCT) [without modifier ET]	**Disallow**

EXPLANATION:

Providers should also use the “ET” modifier to report emergency transportation services. Please note that some Ambulance services may still require authorization.

NOTE: Ambulance supply lines must be billed on one line.

CPT® Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

Code Editing Assistant

A web-based code auditing reference tool designed to “mirror” how Louisiana Healthcare Connections code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers. This allows Louisiana Healthcare Connections to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted
- Proactively determine the appropriate code/code combination representing the service for accurate billing purposes

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a 'what if' or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.

The tool will not take into consideration individual fee schedule reimbursement, authorization requirements or other coverage considerations.

REJECTIONS VERSUS DENIALS

All paper claims sent to the claims office must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

Rejection

A REJECTION is defined as an unclean claim containing invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at LouisianaHealthConnect.com.

A list of common upfront rejections with explanations can be located in Appendix 1. Rejections will not enter our claims adjudication system, so there will be no Explanation of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

Denial

If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A DENIAL is defined as a claim having passed minimum edits and entered into the system but has been billed with invalid or inappropriate information causing the claim to be denied. An EOP (Explanation of Payment) including the denial reason will be sent. A list of common delays and denials with explanations can be located in Appendix II.

PAYMENT RECOUPMENTS

Louisiana Healthcare Connections will provide written prior notification to providers of its intent to recoup any payment. Before the recoupment is executed, the provider shall have sixty (60) calendar days from receipt of written notification of recoupment to submit a written response as to why the recoupment shall not be put into effect on the date specified in the notice. If the provider fails to submit a written response within the time-period provided, Louisiana Healthcare Connections may execute the recoupment on the date specified in the notice.

Upon receipt by Louisiana Healthcare Connections of a written response as to why the recoupment should not be put into effect, the MCO shall within thirty (30) days from the date the written response is received, consider the statement, including any pertinent additional information submitted by the provider, together with any other material bearing upon the matter, and determine whether the facts justify recoupment. Louisiana Healthcare Connections shall provide a written notice of determination to each written response that includes the rationale for the determination.

If a recoupment is valid, the provider shall remit the amount to Louisiana Healthcare Connections or

permit Louisiana Healthcare Connections to deduct the amount from future payments due to the provider.

LDH reserves the right to review and prohibit any recoupment.

For patients dis-enrolled due to the invalidation of duplicate Medicaid ID, Louisiana Healthcare Connections will not recover claim payments under the retroactively dis-enrolled patient's ID if the remaining valid ID is linked to another MCO or FFS. We will subrogate to the MCO that paid the claim(s) for the dates of service.

If the patient's aid category and/or type case changed from MCO eligible to MCO excluded, previous capitation payments for excluded months will be recouped from the MCO. Louisiana Healthcare Connections shall initiate recoupments of payments to providers within 60 days of the date LDH notifies us of the change.

ENCOUNTERS VS. CLAIMS

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services, he/she provided our members. For example, if you are the PCP for a Louisiana Healthcare Connections member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a proxy claim) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter, or proxy claim, is paid at zero-dollar amounts.

It is mandatory that your office submits encounter data. Louisiana Healthcare Connections utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by CMS. Encounters do not generate an EOP.

FQHC/RHC providers will bill using an encounter code for all services. Louisiana Healthcare Connections will reimburse contracted FQHC/RHC the Prospective Payment System (PPS) rate in effect on the dateof service for each encounter. No prior authorization is required for this provider type.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to a Louisiana Healthcare Connections member.

BILLING A MEMBER

Louisiana Healthcare Connections reimburses only services that are medically necessary and covered through Louisiana's Medicaid program.

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if: prior to rendering the service, the provider has obtained and kept a signed member acknowledgement stating:

> *I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Louisiana's Medicaid program as*

being reasonable and medically necessary for my care. I understand that Louisiana Healthcare Connections, through its contract with the Louisiana Department of Health, determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

Providers may not balance bill members for covered services with the exception of copayment collection, if applicable.

SELF-DISCLOSURE PROVIDER OVERPAYMENTS

Louisiana Healthcare Connections and LDH encourage providers to conduct routine self-audits to ensure receipt of accurate payment(s) from the health plan. A provider who identifies an overpayment shall report the overpayment and return the entire amount to Louisiana Healthcare Connections within 60 days after it is identified. Providers should utilize the self-disclosure protocol to report the following self-identified items:

- Provider billing system errors or issues that result in overpayments
- Potential violations of federal, state, or local laws
- Potential violations of regulations
- Potential violations of billing, coding, or other healthcare policies

This is not an all-inclusive list of potential errors or issues that may be reported. Errors or overpayments that are the result of technical issues with our claims payment processing system do not need to be reported through this self-disclosure process.

The voluntary disclosure process requires providers to submit the following information:

- How the error was discovered
- A description of the corrective action plan implemented to ensure the error does not occur again
- The reason for the overpayment
- Overpaid claims identified (copy of EOP or other documentation)
- Patients impacted by the overpayment (copy of EOP or other documentation)
- The timeframe and total amount of overpayments during the period when the problem existed that caused the overpayments
- National Provider Identification Number/Service Location (NPI/SL) Providers may return improper

or overpaid funds to:

Louisiana Healthcare Connections
P.O. Box 959112
St. Louis, MO 63195-9112

If a provider prefers, the improper payment or overpayment may be recouped from future claim payments.

PRIVATE THIRD-PARTY LIABILITY (TPL) AND MEDICARE ADVANTAGE PLAN UPDATE REQUEST

The following changes aim to increase access to care for Medicaid beneficiaries while providing a more administratively efficient and consistent process for providers.

General Private TPL and Medicare Advantage Plan Update Requests

- Providers must submit all private TPL and Medicare Advantage Plan general update requests to Gainwell Technologies.
- Providers must discontinue submitting general, private TPL and Medicare Advantage Plan updates to Healthy Louisiana Managed Care Organizations (MCOs) and the Louisiana Department of Health (LDH).
- Private TPL and Medicare Advantage Plan general update requests sent to MCOs and LDH will not be processed.

All general private TPL and Medicare Advantage Plan update requests must be submitted to Gainwell Technologies via fax, email, or phone.

Fax: 1 (877) 204-1325
Email: latpr@gainwelltechnologies.com
Phone: 1 (877) 204-1324

Gainwell Technologies Hours of Operation: Monday through Friday, 8 a.m. – 5 p.m. Louisiana state holidays are excluded.

Download the Private TPL and Medicare Advantage Plan Update Request Change Form

Questions should be addressed to Gainwell Technologies at 1 (877) 204-1324.

Traditional Medicare Update Requests:

All TPL update requests for traditional Medicare should continue to be faxed to LDH at (225) 342-1376.

Download the Traditional Medicare TPL Update Request Change Form

Questions concerning traditional Medicare updates should be addressed to the LDH TPL unit at (225) 342-8662. TPL hours of operation are 8 a.m. – 4:30 p.m. Louisiana state holidays are excluded.

Urgent Private TPL and Urgent Medicare Advantage Plan Update Requests

- Providers must submit urgent TPL requests for members who are enrolled with a Healthy Louisiana MCO for pharmacy and medical benefits to the member's Healthy Louisiana MCO.
- Providers must submit urgent TPL requests for members who are enrolled with fee-for-service (legacy) Medicaid for pharmacy and medical benefits to Gainwell Technologies, using the above contact information.

LDH defines urgent TPL requests 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.

Urgent TPL requests for members enrolled with Healthy Louisiana MCOs for pharmacy and medical benefits must be submitted to Louisiana Healthcare Connections via fax, email, or phone.

Fax: 1-844-316-0290
Phone: 1-866-595-8133
Email: OICRequest@centene.com

Member Grievances, Provider Complaints, Claims Disputes

PROVIDER COMPLAINTS

A provider complaint is any contact from a provider voicing dissatisfaction with a policy, process, decision, communication, or response from Louisiana Healthcare Connections not immediately resolved or when a provider remains dissatisfied after a resolution is provided. A provider complaint can originate from a phone call, fax, e-mail, field report, letter, or through another Louisiana Healthcare Connections department.

All provider complaints will be acknowledged within three business days. When possible, Louisiana Healthcare Connections will resolve the complaint within 30 days and notify the provider of the decision/determination. In the event that the complaint cannot be resolved within 30 days, a status report will be sent to the provider and LDH notifying of outstanding issues, including a timeline for resolution and reason for the extension of time.

To File a Provider Complaint:

- Phone: 1-866-595-8133
- Email: ProviderComplaints@LouisianaHeatlthConnect.com

You can check the status of a complaint by calling the Louisiana Healthcare Connections Provider Complaint Coordinator at 1-866-595-8133.

LDH Escalation

If a provider is unable to reach satisfactory resolution or receive a timely response through the escalation process, providers may contact LDH by email at ProviderResolutions@la.gov. Providers should include details on attempts to resolve the issue at the health plan level as well as contact information (contact name, provider name, e-mail and phone number) so LDH staff can follow up with any questions.

Acknowledgement

Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the member, representative or provider, the staff will document the resolution details. The Grievance and Appeal Coordinator will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five business days of receipt. Member notification of the grievance resolution shall be made in writing within two business days of the resolution.

Grievance Resolution Time Frame

Grievance resolution will occur as expeditiously as the member's health condition requires, not to exceed 90 calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the Grievance and Appeal Coordinator, in coordination with other Louisiana Healthcare Connections staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the member, representative or provider filing the grievance.

Expedited grievance reviews will be available for members in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within 72 hours.

Notice of Resolution

The Grievance and Appeal Coordinator will provide written resolution to the member, representative or provider within the timeframes noted above. The letter will include the resolution and LDH requirements, including the right to a second level review by the Grievance Appeal Committee (GAC) if the member is not satisfied.

The grievance response shall include, but not be limited to, the decision reached by Louisiana Healthcare Connections, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the member. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for six years.

Grievances may be submitted by written notification to:

Louisiana Healthcare Connections
Grievance and Appeal Coordinator
P.O. Box 84180
Baton Rouge, LA 70884

APPEALS

An appeal is the request for review of a "Notice of Adverse Action." A Notice of Adverse Action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a member's request to exercise his/her right under 42 CFR 438.52(b)(ii) to obtain services outside the Louisiana Healthcare Connections network. Members may request that Louisiana Healthcare Connections review the Notice of Adverse Action to verify if the right decision has been made.

The appeals process allows the member, the member's authorized representative (family member, etc.), or the provider acting on the member's behalf, to file an appeal either orally or in writing. The member's written consent must be given to file an appeal. The member will be allowed 60 calendar days from the date of notice of action or inaction to file an appeal.

Appeals within the standard time frame will be resolved within 30 days of receipt of the appeal. Any individuals who make a decision on appeals will not be involved in any previous level of review or decision making. In any case where the reason for the appeal involves clinical issues or relates to denial of expedited resolution of an appeal, Louisiana Healthcare Connections shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease. [42 CFR § 438.406]

Acknowledgement

Louisiana Healthcare Connections shall acknowledge receipt of each appeal in the order in which it is received. Staff will document the substance of the appeal and date stamp written appeals upon initial receipt. Staff receiving appeals will acknowledge the appeal orally and in writing. The Clinical Appeal Coordinator will send an acknowledgment letter, which includes a description of the appeal procedures and resolution time frames, within five business days of receipt.

Expedited Appeals

Expedited appeals may be filed when either Louisiana Healthcare Connections or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred in the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. The member or provider acting on behalf of the member is to send any additional documentation that would support reconsideration of a denied prior authorization request as soon as a decision for filing for an appeal is made. Louisiana Healthcare Connections may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Louisiana Healthcare Connections provides evidence satisfactory to the LDH that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, Louisiana Healthcare Connections shall provide written notice to the member of the reason for the delay.

Notice of Appeal Decision

Louisiana Healthcare Connections shall make reasonable efforts to provide the member and provider with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up within two calendar days with a written notice of action.

Written notice shall include the following information:

- The decision reached by Louisiana Healthcare Connections
- The date of decision
- For appeals not resolved wholly in favor of the member the right to request a State fair hearing and information as to how to do so
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the Louisiana Healthcare Connections decision.

Call or mail all appeals to:

Louisiana Healthcare Connections
Grievance and Appeal Coordinator
P.O. Box 84180
Baton Rouge, LA 70884

1-877-401-8170

State Fair Hearing Process

Louisiana Healthcare Connections will include information in the Member Handbook, online and via the appeals process to members of their right to appeal directly to the LDH. A Louisiana Healthcare Connections member can request a State Fair Hearing only after exhausting the Louisiana Healthcare Connections internal appeal process and receiving an adverse Notice of Disposition.

Any adverse action or appeal that is not resolved wholly in favor of the member by Louisiana Healthcare

Connections may be appealed by the member or the member's authorized representative to the LDH for a fair hearing conducted in accordance with 42 CFR § 431 Subpart E. Adverse actions include reductions in service, suspensions, terminations, and denials. Louisiana Healthcare Connections denial of payment for Louisiana Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed. Appeals must be requested in writing by the member or the member's representative within 120 days of the member's receipt of notice of adverse action unless an acceptable reason for delay exists. The following list of reasons may be considered reasonable for granting extensions, but the circumstances of each case will ultimately dictate whether an extension is granted:

- Appellant was seriously ill and was prevented from contacting Louisiana Healthcare Connections
- Appellant did not receive notice of the Louisiana Healthcare Connections decision
- Appellant sent the request for appeal to another government agency in good faith within time limit
- Unusual or unavoidable circumstances prevented a timely filing
- Additionally, if Louisiana Healthcare Connections notice is defective (i.e., does not contain the required elements), cause may exist

For member appeals, Louisiana Healthcare Connections is responsible for providing to LDH and the member an appeal summary describing the basis for the denial. A network provider may file a grievance or request a State Fair Hearing on behalf of the member with the member's written consent. Upon notification from the Division of Administrative Law (DAL) of the receipt of a request for a State Fair Hearing, the member record must be reviewed promptly by the plan's representative in a supervisory capacity to determine if adjustments are necessary. The claimant/appellant may be contacted within two business days to offer a Health Plan Conference to the member.

If an action, proposed action, or inaction was incorrect, the error must be immediately corrected and the claimant/appellant must be notified in writing and a copy of this notification, along with the State Fair Hearing Cover Memorandum must be sent to the DAL. If the appeal originates with the DAL, Louisiana Healthcare Connections must provide the State Fair Hearing packet within seven calendar days of receipt of request for the Summary of Evidence to the member and to LDH.

The DAL will schedule all State Fair Hearings. The claimant/appellant, authorized representative and Louisiana Healthcare Connections will be notified by the DAL at least 10 days in advance of the time, place, and date of the State Fair Hearing.

Louisiana Healthcare Connections shall comply with the LDH's fair hearing decision. The LDH's decision in these matters shall be final and shall not be subject to appeal.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if the Louisiana Healthcare Connections or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Louisiana Healthcare Connections will authorize the disputed services promptly and as expeditiously as the member's health condition requires. Additionally, in the event that services were continued while the appeal was pending, Louisiana Healthcare Connections will provide reimbursement for those services in accordance with the terms of the final decision rendered by the LDH and applicable regulations.

To file a Medicaid State Fair Hearing:

Division of Administrative Law – Health & Hospitals Section

P.O. Box 4189
Baton Rouge, LA 70821

CLAIMS DISPUTES

Requests for Reconsideration of a Claim

All claim requests for claim reconsideration must be received within 180 calendar days from the date of notification of payment or denial was issued.

A Request for Reconsideration is a communication (i.e., a typed letter) from the provider about a disagreement in the way a claim was processed. A Reconsideration Request should include:

- The written reconsideration request must include a detailed description of the reason requested.
- Sufficient identifying information which includes, at a minimum, the member name, and member ID number, date of service, total charges and provider name.
- Original Claim Form
- The provider should submit other supporting correspondence that supports the provider claim (member medical records).

NOTE: The Medical Records will **not** go to the MRU team if: there is no claim form attached; there is no original claim number listed on the corrected claim form; there is no reconsideration form attached; and the original claim did not deny asking for medical records.

Mail Requests for Reconsideration to:

Louisiana Healthcare Connections
Attn: Reconsideration
PO Box 4040
Farmington, MO 63640-3826

Claim Appeal

In order to file an appeal, the provider **must** have received an unsatisfactory response to a request for reconsideration.

Submit the following items when filing an appeal:

- Claim Appeal Form (www.LouisianaHealthConnect.com)
- Original Request for Reconsideration letter and response
- Any supporting documentation supporting the request for an appeal

NOTE: The medical records will **not** go to the MRU if: there is no claim form attached; there is no original claim number listed on the corrected claim form; there is no reconsideration form attached; and the original claim did not deny asking for medical records.

Mail your Claim Appeal Form and all other attachments to:

Louisiana Healthcare Connections
Attn: Claim Appeal
PO Box 4040
Farmington, MO 63640-3826

If a provider's submission of a corrected claim, request for reconsideration or claim appeal results in an adjusted claim, the provider will receive a revised EOP.

If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Louisiana Healthcare Connections shall process and finalize all corrected claims, requests for reconsideration and appeals to an “upheld,” “approved,” “paid” or “denied” status within 30 calendar days of receipt of the corrected claim, request for reconsideration or claim appeals.

Administrative Hearing

Louisiana Healthcare Connections shall allow a provider who has exhausted all the internal processes above, the option either to pursue the administrative law hearing or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution, within 15 business days of the date of disposition of the disputed claim(s) response. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless Louisiana Healthcare Connections and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney’s fees, shall be shared equally by the parties.

Request for Administrative Hearing should be mailed to:

Louisiana Healthcare Connections
Attn: Grievance and Appeals Coordinator
P.O. Box 84180
Baton Rouge, LA 70884

INDEPENDENT RECONSIDERATION REVIEW REQUEST

The Louisiana Department of Health (LDH) created the Independent Reconsideration Review Form for Louisiana Managed Care Organizations (MCOs) as a final reconsideration process before submitting a dispute to a third party for Independent Review.

- A provider has 180 days from one of the following dates to request reconsideration from Louisiana Healthcare Connections: The date on which Louisiana Healthcare Connections transmits the remittance advice or other notice electronically, OR
- Sixty (60) days from the date the claim was submitted to Louisiana Healthcare Connections if the provider receives no notice from Louisiana Healthcare Connections, either partially or totally, denying the claim, OR
- The date on which Louisiana Healthcare Connections recoups monies remitted for a previous claim payment.

Louisiana Healthcare Connections will acknowledge receipt of the Independent Reconsideration Review in writing within 5 calendar days and will render a decision within 45 days of receipt.

If Louisiana Healthcare Connections reverses the reconsideration, the payment of disputed claims shall be made no later than 20 days from the date of Louisiana Healthcare Connections’ decision. If Louisiana Healthcare Connections upholds the adverse determination, or does not respond to the reconsideration request within the timeframes allowed, the provider has 60 days to request an Independent Review with a

third party panel.

To file an Independent Reconsideration Review, please complete the Independent Reconsideration Review Form (PDF), include all supporting documentation, and submit to Louisiana Healthcare Connections via mail to the address below:

Louisiana Healthcare Connections
Attn: Provider Solutions
P.O. Box 84180
Baton Rouge, LA 70884

Act 204 of the 2021 Regular Legislative Session directed the Department of Health to promulgate Rules granting mental health rehabilitation service providers the right to an independent review of an adverse determination taken by Louisiana Healthcare Connections that results in a recoupment of the payment of a claim based on a finding of **waste** or **abuse**.

Independent Review Process

The Independent Review process was established by La-RS 46:460.81, et seq. to resolve claims disputes when a provider believes a Managed Care Organization (MCO) has partially or totally denied claims incorrectly. An MCO's failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the MCO's receipt of the claim is considered a claims denial.

Effective Jan. 1, 2018, there is a $750 fee associated with an independent review request. The MCO is responsible for initial payment of the fee. If the independent reviewer decides in favor of the provider, the MCO is responsible for the fee. Conversely, if the independent reviewer finds in favor of the MCO, the provider is responsible for reimbursing the MCO within 10 business days.

The Louisiana Department of Health (LDH) administers the independent review process, but does not perform the independent review of the disputed claims. When a request for independent review is received, LDH determines if the disputed claims are eligible for independent review based on the statutory requirements. If the claims are eligible, LDH will forward the claims to a reviewer that is not a state employee or contractor, and is independent of both the MCO and the provider. The decision of the independent reviewer is binding unless either-party to the dispute appeals the decision to any court having jurisdiction to review the independent reviewer's decision.

The independent review process is only one option a provider has to resolve claims payment disputes with the MCO. In lieu of requesting independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute.

To request an Independent Review with a third -party panel, complete the appropriate Independent Review Form:

Independent Review Request Form – Aggregated Claims Independent Review Request Form – Non-Aggregated Claims

All supporting documentation should be enclosed when submitting via mail to the address below:

LDH/Health Plan Management
P.O. Box 91030, Bin 24
Baton Rouge, LA 70821-9283
Attn: Independent Review

MEMBER GRIEVANCES

A member grievance is defined as any member expression of dissatisfaction about any matter other than an adverse action, such as denying or partially denying a requested service including type or level of service. A provider complaint is any provider expression of dissatisfaction about any matter other than a claims dispute.

NOTE: Throughout the manual, we will consider the term “grievance” to refer to both member grievances and provider complaints as the resolution processes are the same. Provider complaints include disputes regarding policies, procedures or any aspect of Louisiana Healthcare Connections administrative functions including proposed actions.

The grievance process allows the member, or the member’s authorized representative (family member, etc.) acting on behalf of the member, or provider acting on the member’s behalf with the member’s written consent, to file a grievance either orally or in writing. A grievance can be filed at any time. Louisiana Healthcare Connections shall acknowledge receipt of each grievance in the manner in which is received.

Louisiana Healthcare Connections values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member’s behalf. Louisiana Healthcare Connections will provide assistance to both members and providers with filing a grievance by contacting our Member/Provider Services Department at 1-866-595-8133.

Fraud, Waste and Abuse

Louisiana Healthcare Connections is committed to the prevention, detection and reporting of health care fraud, waste, and abuse according to applicable federal and state statutory, regulatory, and contractual requirements. Harmony has developed an aggressive, proactive fraud waste and abuse ("FWA") program designed to collect, analyze, and evaluate data in order to identify suspected fraud, waste and abuse.

Detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement and Louisiana Healthcare Connections vigorously investigate incidents of suspected FWA. Providers are cautioned that unbundling, up-coding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD-CM), Physicians' Current Procedural Terminology (CPT) Health Care Common Procedure Coding System, (HCPCS) and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

We use a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as providers and members, shares the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, and data analysis.

In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure and/or civil and/or criminal prosecution, fines, and other penalties.

Providers, including Provider employees and /or Provider sub-contractors, must report to Louisiana Healthcare Connections any suspected fraud, waste or abuse, misconduct, or criminal acts by any Provider, including Provider employees and/or Provider sub-contractors, or by Louisiana Healthcare Connections Members. If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan, with state approval.

The Louisiana Healthcare Connections' Vice President of Compliance & Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Louisiana Healthcare Connections is committed to identifying, investigating, sanctioning, and prosecuting suspected fraud and abuse.

Definitions of Fraud, Waste and Abuse

Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of Fraud, Waste and Abuse

Some of the most common coding and billing issues are:

- Billing for services not rendered
- Billing for services at a frequency that indicates the provider is an outlier as compared with their peers.
- Billing for non-covered services using an incorrect CPT, HCPCS and/or Diagnosis code in order to have services covered
- Billing for services that are actually performed by another provider
- Up-coding
- Modifier misuse, for example modifiers 25 and 59
- Unbundling
- Billing for more units than rendered
- Lack of documentation in the records to support the services billed
- Services performed by an unlicensed provider but billed under a licensed providers name
- Alteration of records to get services covered
- Member Fraud and Abuse:
- Obtaining unnecessary medications or products and selling them
- Providing false information to apply or qualify for services
- “Doctor shopping” to get multiple prescriptions
- Using someone else’s insurance, or allowing someone else to use your own, coverage to receive services
- Forging or altering receipts
- Filing claims for services not rendered or products not received

How to Report Fraud, Waste, and Abuse

If you suspect fraud, waste or abuse in the Medicaid healthcare system, you must report it to Louisiana Healthcare Connections and we will investigate.

To report suspected fraud, waste, or abuse, you can contact Louisiana Healthcare Connections in one of these ways:

- Phone: 1-866-685-8664
- E-mail: special_investigations_unit@centene.com
- Mail: Louisiana Healthcare Connections, Special Investigation Unit, P.O. Box 84180, Baton Rouge, LA 70884
- Ethics Help Line: 1-800-345-1642
- Ethics Help Line Reporting website
- You have the option for your report to remain anonymous. All information received or discovered by the Special Investigations Unit (SIU) will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, Centene corporate law department, medical directors or senior management).

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste, and abuse, and in responsible to investigate cases of alleged fraud, waste and abuse. With a total staff of approximately 150 individuals, the SIU is comprised of experienced, full-time investigators, clinical investigators, analysts, supporting management, administrative staff and legal.

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract including those that subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all the appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include but is not limited to:

- Contact with relevant parties to gather information: This may include contacting members to get a better understanding of the situation. For example, we may contact a member to ask about a visit with his or her physician. We may ask the member to describe the services provided, who provided the care, how long the member was at the office, etc.
- Medical record audit: Requests for medical, behavioral health, dental, vision or pharmacy records. We do this to validate that the records support the services billed. It is important that the health care provider submit complete records as requested. We rely on this information to make a fair and appropriate decision.
- Notification of suspected fraud and abuse: When SIU suspects fraud and abuse, we notify the Medicaid Fraud Control Unit and the Louisiana Department of Health. SIU will also present the provider to contract and credentialing for disciplinary action, including provider termination.
- Written education and/or overpayment letter: We send letters to the provider documenting the issues and the need for improvement. Letters may include education, requests for recoveries or may advise of further action.

Appeal of Overpayment

Providers may contest either the amount of the overpayment or the methodology used to identify the overpayment by filing an appeal within 30 calendar days of the date of receipt of the letter with supporting documentation. The following must include the following information:

- Name, address, and phone number of the provider of service.
- Louisiana Healthcare Connections individual provider identification number, if applicable.
- A complete and accurate explanation of the issue.
- Supporting documentation including copies of claims (if applicable), claim numbers, medical records, or other documentation to challenge the findings.

The appeal letter with supporting documentation must be sent to:

Centene Corporation
Attn: SIU Louisiana
1370 Timberlake Manor Parkway
Chesterfield, MO 63017
Fax: (877) 851-3996

If no appeal is filed or if it is not timely filed: If the provider does not contest the amount of the overpayment, the methodology used to identify the overpayment determination, repay the amounts due, or contact Louisiana Healthcare Connections to make payment arrangements within thirty (30) calendar days of receipt of this letter, Louisiana Healthcare Connections will offset the overpayment amount against future claims.

Arbitration

If either the Provider or Louisiana Healthcare Connections wishes to pursue the Dispute as provided in the contract such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in the contract, or the date of notice of termination.

SIU Tools and Resources

Louisiana Healthcare Connections Special Investigation Unit (SIU) utilizes software tools that help find and prevent health care fraud. This fraud detection software also allows us to review our claims for possible fraud before payment.

SIU references the following resources to support its investigations:

- Medical, Behavioral Health, Pharmacy, Dental, and Vision Coverage Policies and Manuals
- Medicaid Coverage Database – Centers for Medicare & Medicaid Services National Coverage Determination (NCD) and Local Coverage Determination (LCD)
- American Medical Association (AMA) Current Procedural Terminology (CPT®), International Classification of Diseases, Ninth Revision (ICD-10) and Tenth Revision (ICD-10) and Healthcare Common Procedure Coding System (HCPCS) coding references.

PUBLIC NOTICE AND STATE APPROVAL OF POLICIES

Per House Bill Number 424, Act Number 319, Louisiana Healthcare Connections will submit all new or revised policies or procedures to Louisiana Department of Health (LDH) for review. LDH will publish proposed policies on their website for a period of no less than forty-five days for the purpose of soliciting public comments. Proposed policies and procedures will not be implemented by Louisiana Healthcare Connections unless LDH has provided its express written approval after the expiration of the public notice period.

If LDH finds that an imminent peril to the public health, safety or welfare requires immediate approval of a proposed policy or procedure without otherwise publishing to the website, LDH may implement the policy or procedure with a written statement that details its reason for finding an imminent peril.

LDH Managed Care Policies & Procedures website: http://www.ldh.la.gov/index.cfm/page/3686

Appendices

A: COMMON CAUSES OF UPFRONT REJECTIONS

- **Unreadable Information** - The ink is faded, too light or too bold; bleeding into other characters or beyond the box; the font is too small, or hand written information is not legible
- **Member Date of Birth** is missing
- **Member Name or Identification Number** is missing
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number **is missing**
- **Attending provider information** missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22 or 72 or missing from box 48 on the paper UB claim form
- **Date of Service** is not prior to the received date of the claim (future date of service)
- **Date of Service or Date Span** is missing from required fields
    - Example: “Statement From” or “Service From” dates
- **Type of Bill** is invalid
- **Diagnosis Code** is missing, invalid, or incomplete
- **Service Line Detail** is missing
- **Date of Service** is prior to member’s effective date
- **Admission Type** is missing (Inpatient Facility Claims – UB-04, field 14)
- **Member Status** is missing (Inpatient Facility Claims – UB-04, field 17)
- **Occurrence Code/Date** is missing or invalid
- **Revenue Code** is missing or invalid
- **CPT/Procedure Code** is missing or invalid
- **Incorrect Form Type** used

B: COMMON CAUSES OF CLAIMS PROCESS DELAYS/DENIALS

- **Diagnosis Code** is missing the 4th or 5th digit
- **Procedure or Modifier Codes** entered are invalid or missing
    - This includes GN, GO or GP modifier for therapy services
- **Explanation of Benefits (EOB)** from the primary insurer is missing or incomplete
- **Third Party Liability (TPL)** information is missing or incomplete
- **Member ID** is invalid
- **Place of Service Code** is invalid
- **Provider TIN and NPI** does not match
- **Revenue Code** is invalid
- **Revenue Code** submitted without CPT/HCPCS
- **Dates of Service (DOS)** span do not match the listed days/units
- **Physician Signature** is missing
- **TIN** is invalid
- **Patient's Claim History**—additional member specific information to adjudicate the claim (medical records) is needed
- **Mental Health Claim** submitted to Louisiana Healthcare Connections when covered by the LDH Behavioral Health Vendor
- **NDC Code** is missing/invalid for J-Codes, Q-Codes, B-codes and S-Codes as required

C: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

CMS-1500 (8/05) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (8/05) form field 24A-G:

- Anesthesia duration
- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number–Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council–Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products

The following qualifiers are to be used when reporting these services:

7 Anesthesia information

ZZ Narrative description of unspecified/miscellaneous/unlisted codes

N4 National Drug Codes (NDC)

The following qualifiers are to be used when reporting NDC units:

F2 International Unit

GR Gram **ML** Milliliter **UN** Unit

OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)

VP Vendor Product Number- Health Industry Business Communications Council (HIBCC) Labeling Standard

To enter supplemental information, begin at 24A by entering the qualifier and then the information.

DO NOT enter a space between the qualifier and the supplemental information.

DO NOT enter hyphens or spaces within the NDC, HIBCC or GTIN number/code.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

More than one supplemental item can be reported in a single shaded claim line IF the information is related to the un-shaded claim line item it is entered on. When entering more than one supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three blank spaces and then the next qualifier and number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code.

EXAMPLES

Unlisted, Non-specific, or Miscellaneous CPT or HCPC Code

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached									
								NPI	

Vendor Product Number—HIBCC

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
VPA123ABC7D9E1F									
								NPI	

Product Number Health Care Uniform Code Council—GTIN

D: HIPAA COMPLIANT EDI REJECTIONS CODES

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Please see Louisiana Healthcare Connections' list of common EDI rejections to determine specific actions you may need to take to correct your claims submission.

1 Invalid Mbr DOB
2 Invalid Mbr
6 Invalid Prv
7 Invalid Mbr DOB & Prv
8 Invalid Mbr & Prv
9 Mbr not valid at DOS
10 Invalid Mbr DOB; Mbr not valid at DOS
12 Prv not valid at DOS
13 Invalid Mbr DOB; Prv not valid at DOS
14 Invalid Mbr; Prv not valid at DOS
15 Mbr not valid at DOS; Invalid Prv
16 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17 Invalid Diag
18 Invalid Mbr DOB; Invalid Diag
19 Invalid Mbr; Invalid Diag
21 Mbr not valid at DOS; Prv not valid at DOS
22 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23 Invalid Prv; Invalid Diag
24 Invalid Mbr DOB; Invalid Prv; Invalid Diag
25 Invalid Mbr; Invalid Prv; Invalid Diag
26 Mbr not valid at DOS; Invalid Diag
27 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29 Prv not valid at DOS; Invalid Diag
30 Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31 Invalid Mbr; Prv not valid at DOS; Invalid Diag
32 Mbr not valid at DOS; Prv not valid; Invalid Diag
33 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
34 Invalid Proc
35 Invalid Mbr DOB; Invalid Proc
36 Invalid Mbr; Invalid Proc
38 Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40 Invalid Prv; Invalid Proc
41 Invalid Mbr DOB, Invalid Prv; Invalid Proc
42 Invalid Mbr; Invalid Prv; Invalid Proc
43 Mbr not valid at DOS; Invalid Proc
44 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46 Prv not valid at DOS; Invalid Proc
48 Invalid Mbr; Prv not valid at DOS; Invalid Proc
49 Mbr not valid at DOS; Invalid Prv; Invalid Proc
51 Invalid Diag; Invalid Proc
52 Invalid Mbr DOB; Invalid Diag; Invalid Proc
53 Invalid Mbr; Invalid Diag; Invalid Proc
55 Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57 Invalid Prv; Invalid Diag; Invalid Proc
58 Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59 Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60 Mbr not valid at DOS; Invalid Diag; Invalid Proc
61 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63 Prv not valid at DOS; Invalid Diag; Invalid Proc
64 Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65 Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66 Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72 Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74 Services performed prior to Contract Effective Date
75 Invalid units of service
76 Original Claim Number Required
81 Invalid units of service, Invalid Pvr
83 Invalid units of service, Invalid Pvr, Invalid Mbr

E: INSTRUCTIONS FOR SUBMITTING NDC INFORMATION

Entering the NDC

CMS requires the 11-digit National Drug Code (NDC); therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, which can be found on the vial of medication. The NDC must include the NDC Unit of Measure and NDC quantity/units.

When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug.

For electronic submissions, which is highly recommended and will enhance claim reporting/adjudication processes, report in the LIN segment of Loop ID-2410.

For paper, use Form Locator 43 of the CMS1450 and the red shaded detail of 24A on the CMS1500 line detail. Do not enter a space, hyphen or other separator between N4, the NDC code, Unit Qualifier and number of units.

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size. **If you are given an NDC that is less than 11 digits, add the missing digits as follows:**

- For a 4-4-2 digit number, add a zero (0) to the beginning
- For a 5-3-2 digit number, add a zero (0) as the sixth digit.
- For a 5-4-1 digit number, add a zero (0) as the tenth digit.

Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:

F2—International Unit **GR**—Gram **ML**— Milliliter **UN**—Unit

F: FEDERALLY QUALIFIED HEALTH CENTER

Services provided by an FQHC and /or RHC should be billed with appropriate codes, modifiers, and correct Location (Place of Service) codes.

- **T1015**—Medical Encounter
- **T1015EP**—EPSDT Encounter
- **T1015TH**—OB Encounter
- **H2020**—BH Encounter
- **99050/99051**—Adjunct services are reported in addition to an encounter when these services are rendered during evenings, weekends, or holidays hours.

Medicaid received approval from the Centers for Medicare and Medicaid Services (CMS) to reimburse services rendered by qualified Community Health Workers (CHW) in federally qualified health centers (FQHC) and rural health clinics (RHC) effective for dates of service on or after January 1, 2022.

CHW service reimbursement is based on an alternative payment methodology, which allows reimbursement outside of the current Prospective Payment System rate for CHW services provided in FQHC and RHC settings. Providers will receive payment for services at the rate on file for the date of services as published on the Professional Service fee schedule on www.lamedicaid.com.

FQHC and RHC claims must include a Healthcare Common Procedure Coding System (HCPCS) for the visit, an evaluation and management code, and the corresponding Current Procedural Terminology (CPT) code for the CHW services to receive reimbursement. HCPCS T1015, H2020, and D0999 are allowed on the claim for the CHW services to be reimbursed.

The policy regarding CHW services is pending. The policy will be located in the Professional Services Provider Manual on www.lamedicaid.com.

FQHC and RHC policy regarding the billing of CHW services is also pending. The policy will be located on www.lamedicaid.com in the respective provider manuals.

Fee-for-service (FFS) system updates are pending, and this notice will be updated once system changes are implemented. Claims will be recycled upon implementation.

Louisiana Healthcare Connections is updating our system and will recycle any claims that were paid incorrectly according to this change within 60 days of this notice. Denied claims will be recycled with no action needed by the provider.

Questions regarding FFS claims processing should be directed to Gainwell Technologies Provider Services at (800) 473-2783 or (225) 924-5040. Providers can contact their dedicated Provider Network Consultant or Provider Services at 1-866-595-8133 with questions regarding managed care claims processing.

Location (Place of Service) codes for FQHC and RHCs are as follows:

- **50** Federally Qualified Health Center
- **72** Rural Health Clinic

NOTE: If the provider performs services in one of the locations listed above, the provider **must** use one of the above-mentioned Location (Place of Service) codes on each line of the applicable claim or the claim

will deny.

When RHC and/or FQHC providers perform services outside of the facility (RHC/FQHC TIN), those services must be claimed on a separate claim form using the appropriate Location (Place of Service) code.

EXAMPLE: If the provider performs a service in the inpatient setting of the hospital, the correct Location (Place of Service) code should be 21.

FQHCs & RHCs: Secondary Claims Filing Instruction for T1015 EXAMPLE:

DATES OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	DIAGNOSIS POINTER	CHARGES	DAYS / UNITS	ID QUAL/NPI
01/01/2016	50 or 72	T1015	1	111.88	1	#####
01/01/2016	50 or 72	99213	1	0.00	1	#####

Line one must include the code T1015 with correct place of service code (50 or 72) with the encounter code. If the encounter code is not billed on the first service line this will cause the claim to deny.

All other claim lines, should indicate all other services performed at the time of the encounter visit with a billed $0 amount and a place of service code (50 or 72).

When filing secondary claims, the provider **must** submit the primary payer EOB with the claim form with services matching those all other services lines as indicated above. The T1015 line is not billed to the primary but the primary paid amount will be applied to the entire claim.

G: CLAIM FORM INSTRUCTIONS

Billing Guide for a CMS-1500 (HCFA) and CMS-1450 (UB-04)

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

NOTE: Effective Dec. 1, 2016, Louisiana Healthcare Connections implemented the following claims processing edits on all claims with service dates Dec. 1, 2016, and beyond.

- All providers (group and individual must have a taxonomy on file with Louisiana Healthcare Connections.
- If a provider has multiple taxonomies on file, submitted claims must specify a taxonomy.
- The taxonomy on submitted claims must match one taxonomy in Louisiana Healthcare Connections' registry.
- Only providers who have a single taxonomy on file with Louisiana Healthcare Connections may submit claims without a taxonomy.
- Taxonomy requirements apply to boxes 24J and 33B on the CMS-1500 professional claim form and box 57 or box 81 on the CMS-1450/UB-04 facility claim.
- Requirements do not apply to atypical provider types that do not require an NPI.
- Effective Feb. 3, 2017, the taxonomy code requirement applies to the attending provider on the CMS-1450/UB-04.

If a provider does not have a taxonomy on file with Louisiana Healthcare Connections, or if a claim includes a taxonomy that does not match the taxonomy on file, the claim will be rejected with Rejection Code 91: Invalid or Missing Taxonomy Code.

H: COMMON MODIFIERS

Listed in this Appendix are common modifiers that may be necessary when billing specific services.

Physical, Speech, and Occupational Therapy Services Modifiers

The following modifiers are required for Physical, Occupational and Speech therapy services per CMS guidelines. These modifiers are required to ensure the authorization in the system matches to the appropriate service line on your claim:

- GP – Physical Therapy
- GN – Speech Therapy
- GO – Occupational Therapy

Prenatal Obstetrical Services

Modifier “TH” obstetrical treatment/ services, prenatal or postpartum should be appended to all Prenatal Obstetrical Services.

Ambulance Services

Modifier “ET” (Emergency Transportation) should be used on certain ambulance service codes to report that services were an emergency.

EXAMPLE: A0434 - ET Specialty Care Transport (SCT)

EPSDT Services

Providers should use the appropriate modifier to indicate that services were provided during an EPSDT encounter.

Modifier “EP” should be appended to covered EPSDT screening services.

> EXAMPLE: When providers are performing a visual screening test (99173) providers should append an EP modifier to indicate this screening was a part of the member’s EPSDT service.

Modifier “TD” should be appended to the E/M code if the service was performed by an RN. Modifier “TS”

should be appended to all Interperiodic Screening Visits.

Modifier “25” Providers should report when services are significant and separately identifiable Evaluation and Management (See Modifier 25 explanation on following page).

CPT Modifier 25 Qualifiers

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

How Do I Claim a CPT Modifier 25?

Documentation is critical to whether or not the additional work qualifies for an additional E/M visit code with CPT Modifier 25. IF criteria are met:

- Bill the primary or well E/M service on the first line with the appropriate primary or well diagnosis.
- Bill the lower-level E/M code with the 25 modifier on the second line with the appropriate sick diagnosis (make sure supporting documentation is provided with the paper claim).
- Pediatricians
- May bill for EPSDT or other preventive service on the same day as CPT's 99201, 99211, 99202, and 99212 with a modifier 25.
- Well-child or E&M visit (billed with a modifier 25) in conjunction with an administration code and an immunization are allowed.
- Louisiana Healthcare Connections chose not to turn on the additional Procedure-to-Procedure edits published by the National Correct Coding Initiative (NCCI) with an original effective date of January 1, 2013. This edit was to be applied to all Evaluation and Management (E&M) service codes in the office setting where there was a Well-Child or E&M visit (billed with a modifier 25) in conjunction with an administration code and an immunization. We have allowed—and will continue to allow—for those Pediatric E&M services.

Health Care Informatics (HCI) Claims Editing Software Review Process

Claims submitted to Louisiana Healthcare Connections are adjudicated using the HCI claim editing system. This process determines appropriate adjudication of claims such as those submitted with CPT Modifier 25:

- HCI edits are clinically reviewed by a team of expert coders/clinicians using claim information such as diagnoses and procedures in addition to the patient's overall history to determine separate payment for the office visit.
- If the claim information and member history do not support that a significantly separately identifiable procedure was performed unrelated to the primary E/M procedure, the modifier 25 is not supported and the service is denied as "unbundled from the primary E/M procedure."
- If, after clinical review, it is determined the modifier 25 was not clinically supported in the claims information, then the provider may exercise his or her appeal rights by submitting supporting documentation indicating a "Significantly Separately Identifiable" procedure was performed above and beyond the scope of the primary E/M procedure.

Do Not Use A CPT Modifier 25 if:

- Service is an insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service,
- Does not require additional work, and
- Does not contain the key components of a problem-oriented E/M service.

UNACCEPTABLE USE EXAMPLES

- If, during a well woman exam, the physician notes a yeast infection and writes a prescription.

- If, during a routine physical for a man, the physician notes chronic hypertension is under control and refills a prescription.
- A dermatologist sees an established member with a diagnosis of 706.1 (Acne, other) for a follow-up U/V light therapy treatment and also performs destruction of benign lesions (CPT code 17110). A separate E/M visit is not payable.

DO USE A CPT MODIFIER 25 IF:

- Service is a significant problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service,
- Requires additional work, and
- Contains the key components of a problem-oriented E/M service.

NOTE: These situations could qualify for an additional E/M code and Modifier 25.

ACCEPTABLE USE EXAMPLES

- If, during a well woman exam, the physician notes a breast lump and after further work-up, orders diagnostic tests and schedules a follow-up visit to discuss results and/or treatment options.
- If, during a routine physical on a man, the physician discovers previously controlled hypertension is no longer controlled and so orders further diagnostic tests, writes a new prescription, and schedules a follow-up visit.
- A dermatologist sees an established member and diagnoses a sebaceous cyst not previously reported. The physician treats the cyst and existing conditions. A separate E/M is supported.

A dermatologist sees a new member and diagnoses urticaria. The physician treats the urticaria (17111-destruction of benign lesions) and bills a level 3 E/M with a modifier 25.

I: EPSDT SERVICES

EPSDT: Early Periodic Screening, Diagnosis & Treatment

"EPSDT services are designed to provide a framework for routine health, mental health and developmental screening of children from birth through age 20 plus evaluation and treatment for illnesses, conditions or disabilities." - LA Medicaid Provider Manual, EPSDT Ch 20, Sct 20.0

A Well-Child Check-Up requires these E/M (evaluation and management or office visit) codes:

MEMBER AGE RANGE	NEW PATIENT	ESTABLISHED PATIENT
Under 12 months	99381	99391
1- 4 years	99382	99392
5 - 11 years	99383	99393
12 - 17 years	99384	99394
18 - 39 years	99385	99395

NOTE:

- The modifier TD must be appended to the E/M code if the child is seen by an RN rather than a physician, PA or NP.
- If a child is seen for a well visit between (scheduled) periodic visits, a modifier TS needs to be added to the E/M code to indicate an Interperiodic Screening visit.

If, during a Well-Child Check-Up, the provider diagnoses an illness or other problem, the provider CAN bill for up to a Level II E/M (99201-99202 or 99211-99212), but the "sick visit" **MUST** have a modifier **25** in order to be adjudicated.

Note: Louisiana Healthcare Connections has deactivated the unbundling edit from CPT 99201, 99211, 99202 and 99212 (sick visits) when billed with modifier 25 and any preventive service for pediatric specialty on the same date of service for the same member.

CPT defines a **New Member** as "one who has not received any professional services from the physician **or another physician of the same specialty who belongs to the same group practice**, within the past three years."

Louisiana Healthcare Connections pays for unlimited Well-Child Check-Ups.

J: OBSTETRICAL SERVICES

Visit LouisianaHealthConnect.com for more information and access to the following forms:

- Notification of Pregnancy
- Delivery Notification
- Inpatient Prior Authorization
- Outpatient Prior Authorization
- LDH Consent for Sterilization
- Nextra Health Supply Breast Pump Request
- OptumReferral (used for in-home administration of 17P injections by an RN)

There are two ways to Submit Prior Authorization for 17P Administration:

1. Optum Referral Form (used for in-home administration of 17P injections by an RN)
   Fill out the Optum Referral Form and fax the form and clinical data to 866-252-4293. Optum will submit a Prior Authorization Form to Louisiana Healthcare Connections on your behalf.
2. Louisiana Healthcare Connections Prior Authorization Form
   Fill out our Prior Authorization Form and fax to Louisiana Healthcare Connections at 1-877-401-8175.

NOTE: Please use a proper 17P procedure code when billing (J3490 with a TH modifier).

Obstetric Ultrasounds

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

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

For maternal fetal medicine specialists, there shall be no prior authorization or medical review required for reimbursement of obstetric ultrasounds. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. In all cases, obstetric ultrasounds must be medically necessary to be eligible for reimbursement.

For more detail reference Clinical Policy LA.CP.MP.38.

Prenatal Services

A maximum of two initial prenatal visits per pregnancy (270 days) shall be reimbursed. These two visits may not be performed by the same attending provider.

It is considered the enrollee a ‘new patient’ for each pregnancy whether or not the enrollee is a new or established patient to the provider/practice. The provider must ensure the appropriate level E&M CPT

procedure code 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. Reimbursement for the initial prenatal visit, which must be modified with TH, shall include, but is not limited to, the following:

- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy LA.CP.MP.38.);
- Identification of patient at risk for complications including those with prior preterm birth;
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

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.

Fetal Non-Stress Test

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

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

Fetal Biophysical Profile

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

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

Postpartum Services

Care Management conducts postpartum outreach in the 4–6-week period following delivery. Postpartum outreach encompasses a postpartum assessment including a screening for postpartum depression. The purpose of the outreach is to screen for postpartum complications, ensure the member schedules and completes a postpartum MD follow-up appointment and a pediatrician is selected, and follow-up is addressed.

Remote Patient Monitoring

Remote patient monitoring is the use of medical devices to measure and transmit health data from a member to a provider, who can then analyze the data to make treatment recommendations. The MCO may cover remote patient monitoring for the management of hypertension and diabetes for pregnant members.

Donor Human Milk (Inpatient)

Louisiana Healthcare Connections will cover donor human milk provided in the inpatient hospital setting for certain medically vulnerable infants. This coverage will be provided without restrictions or the requirement for prior authorization. Donor human milk is considered medically necessary when all of the following criteria are met:

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

Reimbursement

Louisiana Healthcare Connections will reimburse donor human milk separately from the hospital reimbursement for inpatient services. The minimum reimbursement for the donor human milk is the fee on file on the Louisiana Medicaid Durable Medical Equipment (DME) Fee Schedules.

Hospitals must bill the donor human milk claim using the Healthcare Common Procedure Coding System (HCPCS) procedure code T2101 (1 unit per ounce) on a CMS 1500 claim form.

Donor Human Milk (Outpatient)

Donor human milk is covered outpatient for use by medically vulnerable infants.

Eligibility Criteria

Donor human milk is considered medically necessary when the following criteria are met:

1. The member is less than 12 months of age with one or more of the following conditions:
    a. Post-surgical nutrition
    b. Organ transplantation
    c. Renal disease
    d. Short gut syndrome
    e. Malabsorption syndrome
    f. Feeding or formula intolerance
    g. Failure to thrive
    h. Inborn errors of metabolism
    i. Immunologic disorders
    j. Congenital heart disease or other congenital anomalies
    k. Neonatal abstinence syndrome.

2. The member's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding; or the beneficiary is medically or physically unable to receive caregiver breast milk or participate in breastfeeding; and

3. The member's caregiver has received education on donor human milk, including the risks and benefits; and

4. A bank accredited by, and in good standing with, the Human Milk Banking Association of North America supplied the donor human milk.

Reimbursement

Prescriptions for donor human milk must include the following:

1. Number of prescribed calories per ounce;
2. Total ounces prescribed per day;
3. Total number of weeks donor human milk is required;
4. Total allowable refills; and
5. Reason for prescribing donor human milk, including beneficiary’s diagnoses.

Prior authorization is not required for donor human milk. Donor human milk is, however, subject to post payment medical review.

The DME provider must submit a prescription containing all required documentation along with a hard copy claim to the department’s fiscal intermediary. Failure to provide required documentation, or if the documentation submitted fails to establish medical necessity, will result in recoupment of the payment for the donor human milk.

Human Milk Storage Bags

Effective February 1, 2022, Louisiana Healthcare Connections will cover human milk storage bags for lactating beneficiaries. The following criteria will be applied for coverage of human milk storage bags:

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

Tobacco Cessation Counseling Services

Louisiana Healthcare Connections will cover tobacco cessation counseling services for enrollees who use tobacco products or who are being treated for tobacco use when provided by, or under the supervision of, the enrollee's primary care provider or other appropriate healthcare professionals. We will cover up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

Providers rendering tobacco cessation counseling services must be an enrolled Medicaid provider. Health care professionals who may provide tobacco cessation counseling include physicians, advanced practice registered nurses, and physicians' assistants, as well as mental health providers who are licensed to practice independently. Other professional or paraprofessional healthcare practitioners must have completed training in the provision of tobacco cessation counseling and must provide services under the supervision of a licensed practitioner.

Minimum reimbursement for tobacco cessation counseling will be based on the applicable current procedural terminology (CPT) code on the Professional Services Fee Schedule and will need to be supported by appropriate documentation.

Tobacco Cessation Counseling During Pregnancy

Louisiana Healthcare Connections will cover tobacco cessation counseling for pregnant members when provided by the members' PCP or OB provider. Tobacco cessation counseling may be provided by other appropriate healthcare professionals upon referral from the members' PCP or OB provider, but all care must be coordinated. During the prenatal period through 60 days postpartum, Louisiana Healthcare Connections will cover up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

Minimum reimbursement for tobacco cessation counseling shall be based on the applicable current procedural terminology (CPT) code on the Professional Services Fee Schedule and must be supported by appropriate documentation. Louisiana Healthcare Connections will require 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.

OBGYN Billing Guidelines

Service	Prior Auth Needed?	Comment	Codes
Ultrasound	(No)	Three allowed in nine months; Additional ultrasound requires authorization; No authorization required for ultrasound by Maternal Fetal Specialist or Perinatologist Specialist only	
Maternity Services	NO	Provider must provide Notification of Pregnancy Form to Louisiana Healthcare Connections after the patient's first visit	
Family			
Planning Services	NO	Well woman exams, screenings, pregnancy testing, birth control pills, Mirena and other IUDs	
Vaginal Delivery		2 day LOS (LOS > 2 days requires PA)	
C-section		4 day LOS (LOS > 4 days requires PA)	
Sterilization Procedures	NO	Must submit LDH "Consent for Sterilization" form	
Abortion (Elective)	YES	Covered only when medically necessary to save the life of the mother or if pregnancy is a result of rape or incest	Must submit Louisiana "Certification for Informed Consent-Abortion" with Claim
17P Injections	YES	Must submit an Optum or Louisiana Healthcare Connections Prior Authorization Form with any documentation of member history of preterm labor/delivery.	J3490 with TH modifier
Breast Pump	NO	See previous section or contact our Care Management Department at 866-595-8133.	NOTE: Pump may be delivered to provider, hospital, or member home
Human Milk Storage Bags	YES	Limit 100 bags per month and the Medicaid fee on file is for a one-month supply of storage bags	
LaHart	NO	Must register via assessment by contacting your Provider Consultant at 866-595-8133	H0049 (Screening Code with reimbursement of $14.49) and H0050 (Brief Intervention Code with a reimbursement of $33.81) with TH modifier
Antepartum Care	NO	Must be billed as individual visit services are rendered, not global antepartum or global delivery codes	
Optum OB Home Health Services	YES	17P administration, Hypertension, Preeclampsia, Hyperemesis (Zofran/Reglan pumps), Non-Stress Test, Gestational Diabetes, Preterm labor management	

P.O. Box 84180
Baton Rouge, LA 70884
1-866-595-8133 (TTY: 711)
Monday – Friday, 7 a.m. – 7 p.m.
LouisianaHealthConnect.com

1-855-229-6848
Healthy.LA.Gov