

Provider Manual

LOUISIANA HEALTHCARE CONNECTIONS



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Welcome

Welcome to Louisiana Healthcare Connections, and thank you for being part of our network of physicians, hospitals and other healthcare professionals. We look forward to working with you to transform the health of our state, one person at a time.

ABOUT US

Louisiana Healthcare Connections is the largest Louisiana Medicaid plan, with more than 475,000 members across our state trusting us to care for their health. We connect our members to quality healthcare through local, community-based partners.

And we connect our provider partners with generous incentive programs that improve Louisiana's healthcare delivery system and the health of our members – *your patients* – by rewarding preventive, accessible and coordinated care.

MISSION

Louisiana Healthcare Connections will provide the best benefits and programs possible in order to improve the health outcomes of the Louisiana families we serve. We strive to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind, and we look forward to working together to achieve them.

ABOUT THIS MANUAL

This manual contains comprehensive information about Louisiana Healthcare Connections operations, benefits, billing, and policies and procedures. The most up-to-date version can always be downloaded from LouisianaHealthConnect.com. You will be notified of updates via notices posted on our website and/or in Explanation of Payment (EOP) notices.

QUESTIONS?

If you have questions or would like a printed copy of this Provider Manual, please contact Provider Services at 1-866-595-8133.

Key Contacts

The following chart includes several important telephone and fax numbers available to your office. When calling Louisiana Healthcare Connections, please have the following information available:

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

Department	Telephone	Fax
Member Services	1-866-595-8133 TDD/TTY: 1-877-285-4514	1-866-768-9374
Authorization Request, Concurrent Review, Case Management	1-866-595-8133	1-877-401-8175 1-877-668-2080 1-877-668-2079
24/7 Nurse Advice Line for Members	1-866-595-8133	1-866-768-9374

PROVIDER RESOURCES

Department	Description	Contact
Provider Services	Answers provider questions, including verification of eligibility, authorization, claim inquiries and appeals	1-866-595-8133 Fax: 1-866-768-9374
Provider Relations Representatives	Local representatives who can assist in your community. They may visit provider offices, conduct webinars and other telephonic correspondence. Their primary focus is to provide administrative education and training. They will assist with projects and high level questions.	1-866-595-8133
Provider Demographic Updates	Submit demographic changes. These changes include: address, phone number, Tax Identification Number (TIN), office hours, billing information, etc.	LHC_PROVIDER_CREDENT@CENTENE.COM
Network Manager	Responsible for managing the provider relations team. Resolves high profile concerns and network development.	Steve Higgs, Vice President of Provider Network and Contracting Steven.L.Higgs@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: 1-844-466-1277
Clinical Trainers	Team of clinicians who are	1-866-595-8133

Provider Services: 1-866-595-8133 (TDD/TTY 1-877-285-4514)

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	located in the community. They provide in-depth provider education as it pertains to treatment plans and utilization management.	clinicaltraining@cenpatico.com
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CLAIMS AND APPEALS INFORMATION

<p>Paper Claims Submission</p> <p>Louisiana Healthcare Connections <i>ATTN: Claim Processing Department</i> P. O. Box 4040 Farmington, MO 63640-3800</p>	<p>Electronic Claims Submission</p> <p>Louisiana Healthcare Connections c/o Centene EDI 1-800-225-2573 Ext. 25525 Email: EDIBA@centene.com</p>
<p>Claim Appeals</p> <p>Louisiana Healthcare Connections <i>Attn: Claim Reconsiderations & Appeals</i> P.O. Box 4040 Farmington, MO 63640-3800</p>	<p>Medical Necessity Appeal</p> <p>Louisiana Healthcare Connections <i>Attn: Medical Necessity</i> 8585 Archives Ave., Suite 310 Baton Rouge, LA 70809</p>

STATE DEPARTMENTS

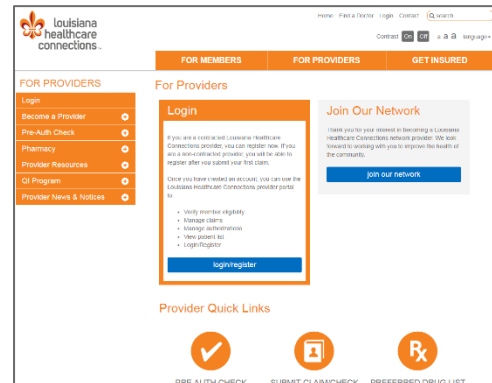
Department Name	Phone
Louisiana Department of Children and Family Services	1-888-524-3578
Louisiana Department of Health	1-225-342-9500
Louisiana Medicaid	1-888-342-6207
Office of Behavioral Health	1-225-342-9500
Office of Juvenile Justice	1-225-287-7900
Office of Education	1-877-453-2721
Office of Citizens with Developmental Disabilities	1-225-342-0095

Online Resources

Our website can significantly reduce the number of telephone calls providers need to make to the health plan. Utilizing the website allows immediate access to current provider and member information 24 hours, seven days a week.

Please contact your Provider Consultant or our Provider Services department at 1-866-595-8133 with any questions or concerns regarding the website.

Louisiana Healthcare Connections website is located at LouisianaHealthConnect.com.



Physicians can find the following information on the website:

- Prior Authorization List
- Forms
- Louisiana Healthcare Connections Plan News
- Clinical Guidelines
- Provider Bulletins
- Contract Request Forms
- Credentialing Information
- Provider Consultant Contact Information
- Provider Training Manual
- Provider Education Training Schedule

SECURE WEBSITE

Louisiana Healthcare Connections web portal services allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations and send messages to communicate with Louisiana Healthcare Connections staff. All providers and their office staff have the opportunity to register for our secure provider website in just four easy steps. Here, we offer tools that make obtaining and sharing information easy! It's simple and secure! Go to LouisianaHealthConnect.com to register. On the home page, select the Login link on the top right to start the registration process.

Through the secure site you can:

- Check member eligibility
- View Members' health record
- View the PCP panel (patient list)
- View and submit claims and adjustments
- Verify claim status

- Verify proper coding guidelines
- View payment history
- View and submit authorizations
- Verify authorization status
- View member health record
- View member gaps in care
- Contact us securely and confidentially
- Add/remove account users
- Determine payment/check clear dates
- Add/remove TINs from a user account
- EPSDT Reports
- View Per Member Per Month (PMPM) Quality Incentive Report
- View and print Explanation of Payment

Please contact a Provider Consultant for a tutorial on the secure provider portal.

Cultural Competency and Language Services

CULTURAL COMPETENCY

Cultural competency within Louisiana Healthcare Connections 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 is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. 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. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and system practices among providers and staff to ensure that services are delivered in a culturally competent manner.

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, signers 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.

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 and accessible equipment 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 Case 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.

LANGUAGE SERVICES

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 patient.

Staff may also use the language line as a three-way call function in order to call members for scheduling appointments or giving test results. For more information, please call Provider Services at 1-866-595-8133.

Populations

The Louisiana Department of Health (LDH) determines eligibility for Medicaid and Children's Health Insurance Program (CHIP) for all coverage groups with the exception of Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF) and Foster Care/Children in out-of-home placement.

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))
 - 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

6. Continued Medicaid Program

VOLUNTARY OPT-OUT POPULATIONS

Individuals in a voluntary opt-out population are automatically enrolled in Louisiana Medicaid, but may “opt-out” by choosing to disenroll. If you are a voluntary member, you may choose to leave Louisiana Healthcare Connections and return to Medicaid at any time during the 90-day period following your initial enrollment with Louisiana Medicaid. After 90 days, you may not change your Louisiana Medicaid plan of record until the next open enrollment period. Open enrollment occurs once each year. Members considered voluntary opt-out include:

- 1. Children under 19 years of age who are:
 - a. Eligible for SSI under Title XVI
 - b. Eligible under Section 1902(e) of the Social Security Act
 - c. In foster care or other out-of-home placement
 - d. Receiving foster care or adoption assistance
 - e. Receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a)(D) of Title V as defined by the LDH in terms of either program participation or special health care needs
 - f. Enrolled in the Family Opportunity Act Medicaid Buy-In Program
- 2. Native Americans who are members of federally recognized tribes except when the Managed Care Organization (MCO) is:
 - a. The Indian Health Service
 - b. An Indian health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the

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. Members considered voluntary opt-in include:

2. Individuals receiving services through any 1915(c) Home and Community Based Waiver, including:
 - 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)
 - g. Other Home and Community Based Services (HCBS) waivers as may be approved by the Center for Medicare and Medicaid Services (CMS)
3. 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

EXCLUDED POPULATIONS

Individuals in an "excluded population" may not enroll in a Louisiana Medicaid Plan. Excluded populations include:

1. Medical benefits on individuals residing in Nursing Facilities (NFs) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
2. Individuals who receive both Medicaid and Medicare
3. 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
4. Individuals with a limited eligibility period including:
 - a. Spend-down Medically Needy Program
 - b. Emergency Services Only

- c. Continued Medicaid Program
5. Individuals enrolled in and receiving family planning services only in the Take Charge Program, which provides family planning services to uninsured women ages 19-44 who are not otherwise eligible for any other Medicaid program

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.

VERIFICATION METHODS

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

1. **Log on to our Secure Provider Portal at [LouisianaHealthConnect.com](https://www.LouisianaHealthConnect.com).** Using our secure provider website, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of 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 member Medicaid ID and the month of service to check eligibility.
3. **Call Louisiana Healthcare Connections Provider Services.** If you cannot confirm a member'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 member name or member Medicaid ID to verify eligibility.

Through Louisiana Healthcare Connections' Secure Provider Portal, Primary Care Providers (PCPs) are able to access a list of eligible members who have selected their services or were assigned to them. The Patient 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 throughout the month and the Patient List does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on the date of service.

All new Louisiana Healthcare Connections members receive a Louisiana Healthcare Connections member ID card. Members will keep their state-issued ID card to receive services not covered by the plan (such as dental or hospice services). A new card is issued only when the information on the card changes, if a member loses a card or if a member requests an additional card.



Possession of a member ID card is not a guarantee of eligibility. Use one of the above methods to verify member eligibility on the date of service.

MEMBER IDENTIFICATION 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.

Member Rights and Responsibilities

MEMBER RIGHTS

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

- To be treated with respect and dignity.
- To receive the right to privacy and non-discrimination as required by law.
- To join your providers in making decisions about your healthcare.
- To refuse any medical service, diagnoses, treatment or health service if you or your 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:
 - Structure and operations
 - Services and service utilization plans
 - Practitioners and providers
 - Physician incentive plans
- 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 your provider(s).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- 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 your 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.
- To file any complaint about not following the Advance Directive with LDH.
- To choose a provider who gives you 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.
- 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 you.

- 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.

MEMBER RESPONSIBILITIES

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

- To inform Louisiana Healthcare Connections of the loss or theft of an ID card
- Present the Louisiana Healthcare Connections ID card when using healthcare services
- Be familiar with Louisiana Healthcare Connections procedures to the best of the member’s abilities
- To call or contact Louisiana Healthcare Connections 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.

Benefit Explanation and Limitations

Louisiana Healthcare Connections network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this provider manual, please contact Provider Services at 1-866-595-8133 from 7 a.m. to 7 p.m., Monday through Friday. A Provider Service Representative will be happy to assist you.

Louisiana Healthcare Connections covers, at a minimum, those core benefits and services specified in our agreement with LDH and are defined in the Louisiana Medical State Plan, administrative rules and department policies and procedure handbook. Additionally, we may offer value-added benefits and services, and cost-effective alternative services.

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.

TIP Use the *Pre-Authorization Required?* Tool at 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	Benefit Limitation	Prior Auth Required?	Comments
Abortion (Elective)	Covered only when medically necessary to save the life of mother or if pregnancy is the result of rape or incest	No	<i>Must submit Louisiana "Certification for Informed Consent - Abortion" with Claim</i>
Acute medical detoxification		See Comments	Urgent/emergent admissions require notification within 2 business days. Elective/scheduled admissions are managed by Magellan
Alere OB Home Health Services		Yes	17P administration, Hypertension, Preeclampsia, N&V (Zofran/Reglan pumps), DM, NST, Preterm labor management
Ambulance – Airplane		Yes	Prior authorization required for Fixed Wing (airplane) Ambulance Services for emergent and non-emergent use

Service	Benefit Limitation	Prior Auth Required?	Comments
Ambulance – Emergent		No	Includes emergency ground and emergency helicopter ambulance.
Ambulance-Non-Emergency		Yes	Prior authorization required
Ambulatory Surgery Center Services		See Comments	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
Basic Behavioral Health Services	Limited to services performed in PCP or medical office	No	Screening, prevention, early intervention, medication management and referral services. Behavioral health (BH) services performed by BH professionals are considered specialty services and are managed by Magellan.
BioPharmaceutical Drugs		See Comments	Prior Authorization required for selected J codes when administered/dispensed in a provider's office, outpatient facility or in the home
Breast Pump		No	ONLY covered for mothers with children in NICU and when requested within 6 months of delivery; Fax breast pump request directly to STL Medical Supply at 877-219-6077 or contact our Case Management Department at 866-595-8133 for assistance
Chiropractic Services	For members less than 21 years old	Yes	Prior authorization required. Covered codes 98940, 98941
C-Section		Maybe	A length of stay due beyond 4 days requires prior authorization.
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	Prior authorization required for cochlear implants (L8614, L8619, L8627-L8629). Batteries and ear molds do not require authorization.

Service	Benefit Limitation	Prior Auth Required?	Comments
Communicable Disease Services		No	Includes testing and treatment
Dental - General Anesthesia		No	
Dental – Emergency, Medical, Surgical		See Comment	Prior authorization is required for services performed by an oral surgeon in the office. Routine/preventive dental is covered by Louisiana Medicaid. As a value added benefit, dental services performed in FQHC is covered for >21 years of age
Dental – Non-Emergency Medical, Surgical		No	Coverage includes members under age 21 years and pregnant members
Dialysis		No	Includes free standing and outpatient hospital setting; Prior Authorization required for any biopharmacy and Non-Par provider
Durable Medical Equipment (DME)		See Comments	Prior Authorization required. See authorization list below: Apnea Monitor Bi-pap Bone Growth Stimulator C-pap Neuro Stimulator Wound Vacuum Wheelchairs Hospital beds Power and standard wheelchairs Traction equipment Gait Trainers Custom compression burn garments Infusion pumps Miscellaneous DME over \$2000
Early Periodic Screening Diagnosis and Treatment	For members less than 21 years old	No	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

Service	Benefit Limitation	Prior Auth Required?	Comments
Enteral & Parenteral Nutrition for Home Use		Yes	Prior authorization required.
Family Planning		No	Well woman exams, screenings, pregnancy testing, birth control pills, Mirena and other IUDs
FQHC & RHC Services		No	
Fluoride Varnish	Covered by PCP	No	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 Comments	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		Yes	Prior authorization required and limited to 50 visits per year; 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 Cenpatico. Home Health Extended for under age 21.
Hospice Care			Prior authorization is required.
Hyperbaric Oxygen Therapy		Yes	Prior authorization required.

Service	Benefit Limitation	Prior Auth Required?	Comments
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 Comments	Prior authorization required for those services and procedures noted elsewhere on this list (hysterectomy, potentially cosmetic, etc). Urgent/Emergent admissions require notification within 1 business day.
Laboratory Services	Must use Network Provider	No	See Prior Authorization List
Locum Tenen		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	Prenatal through Postpartum	No	Submit Notice of Pregnancy (NOP) form at first visit.
Neuro-Psychological Services		Yes	Prior authorization required for codes: 96118, 96119, 96120.
Nurse Midwife Services		No	
OB Ultrasound	76811 and 76812 may be billed by Perinatologist and Maternal Fetal Specialist only	No	
Observation		Yes	Prior authorization required for hospital observation admissions which exceed 30 hours; <i>however</i> , 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 Comments	Certain codes are age-specific; please refer to Prior Authorization list and fee schedule

Service	Benefit Limitation	Prior Auth Required?	Comments
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	Limited to Age 0-20	Yes	Prior authorization required for services, including pain/nerve blocks, epidural injections and neuro-stimulators (both in office and outpatient), except for acute post-operative pain.
Personal Care Services		Yes	
Physician, PA, NP, Office Visits		No	See out-of-network
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	<u>Specialty Drug Benefit and Office Administered Drugs</u> Prior authorization required for specialty medications in order for reimbursement to be issued to the provider. The <u>Specialty Drug Benefit</u> provides a list of medications and the process for requesting prior authorization for specialty drugs. Providers who wish to dispense from office stock should refer to the <u>Office Administered Drug Prior Authorization List</u> for a list of medications and the process for requesting prior authorization. Prescribers can submit requests for specialty medications to Louisiana Healthcare Connections by filling out the <u>Medication Prior Authorization Form</u> .		Managed by U.S. Script US Script, the Louisiana Healthcare Connections pharmacy benefit manager, processes pharmacy claims and administers the medication prior authorization process. The <u>Medication Prior Authorization Form</u> should be used when submitting prior authorizations or medical necessity requests. Refer to Preferred Drug List and Prior Authorization List.
Procedures, Surgery		See Comments	Prior authorization required for the following: Bariatric surgery, Blephoroplasty, Breast reconstruction, Breast reduction, Mammoplasty, Otoplasty, Rhinoplasty, Varicose Vein treatments. (All other potentially cosmetic services)
Prosthetics		See Comments	Prior authorization may be required for selected codes

Service	Benefit Limitation	Prior Auth Required?	Comments
Radiology and X-rays		See Comments	Prior authorization required for high-tech radiology including CT, MRI, MRA. Services managed by National Imaging Associates (NIA). No PA required for routine X-rays. See OB Ultrasound.
School-Based Clinic		No	Except as otherwise noted on list
Sleep Study		Yes	Prior authorization is required for study in outpatient or home setting
Specialty Injection and/ or Infusion Services		See Comments	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 <i>after Initial evaluation</i> . Submit treatment plan & goals for continued services. Must bill with appropriate G modifiers. Services managed by Cenpatico. Excludes specified early steps services.
Transplant Service		Yes	Prior authorization required for all transplant services including transplant evaluation, pre and post services.
Transportation Non-Emergency		See comments	For members who lack transportation to/from Medicaid covered services. Services managed by Logisticare.
Urgent Care Center		No	Place of Service/Location = 20
Vaginal Delivery		See Comments	Prior authorization required for any length of stay beyond 2 days.
Vision Services and Eyewear		See Comments	< 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.

NON-EMERGENT MEDICAL TRANSPORTATION

For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, Louisiana Healthcare Connections will require the transportation provider to schedule transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home. Louisiana Healthcare Connections requests its participating providers including its transportation vendor to inform our Member Services department when a member misses a transportation appointment so that it can monitor and educate the member on the importance of keeping medical appointments.

Non-Covered Services	Comments
Acupuncture	Not Covered
Cosmetic Surgery	Not Covered
Dental Care Services	Routine and preventive dental care services covered by LDH on FFS basis
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 on FFS basis
Institutional Long-Term Care Facilities / Nursing Homes / ICF/DD Services	Covered by LDH on FFS basis
School Based IEP Services	Covered by LDH on FFS basis
Specialty Behavioral/Mental Health	Services performed by Behavioral Health practitioner, including inpatient psychiatric. Covered by LDH on FFS basis. If performed in FQHC/RHC setting, service is covered.

Primary Care Providers (PCPs)

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 patient safety, and leads to elimination of redundant services and ultimately more cost-effective care and better health outcomes.

Louisiana Healthcare Connections offers a robust 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).

We request that PCPs inform our Member Service department when a Louisiana Healthcare Connections member misses an appointment so we can monitor and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of Emergency Room services.

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.

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.

These ratios apply to all MCOs and Medicaid fee-for-service (FFS) members assigned to a PCP or 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 patient 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, 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.

Procedure

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. These concerns will be recorded in CRM.
- 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.
- Louisiana Healthcare Connections will first attempt to call the member three times before placing the member with a new PCP.
- The member's new PCP will be selected based upon the following criteria:
 - Louisiana Healthcare Connections will attempt to contact the member and place the member with a desired PCP.
 - 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 has claims history on file with Louisiana Healthcare Connections, move to ii. However, 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. Also, U.S.M.M. will be given the member's information for outreach and education.
 - 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.

APPOINTMENT ACCESSIBILITY STANDARDS

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:

- Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times, and an appointment shall be arranged within one (1) hour of request.
- Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral healthcare, 24 hours per day, seven days per week. Urgent care may be provided directly by the PCP or directed by Louisiana Healthcare

Connections through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request.

- Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition.
- Routine, non-urgent or preventive care visits within six weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral.
- Specialty care consultation within one (1) month of referral or as clinically indicated.
- Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated.
- Maternity Care: Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmarked date that Louisiana Healthcare Connections mails the member's welcome packet for members whose basis of eligibility at the time of enrollment with the health plan is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date Louisiana Healthcare Connections or a subcontracted provider becomes aware of the pregnancy: within their first trimester within 14 days; within the second trimester within seven days; within their third trimester within three days; high risk pregnancies within three days of identification of high risk by Louisiana Healthcare Connections or maternity care provider, or immediately if an emergency exists.
- Follow-up to ED visits in accordance with ED attending provider discharge instructions.
- In-office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

Type of Appointment	Scheduling Time Frame
Emergent	Immediately
Urgent Care	Within twenty four (24) hours
Non -Urgent Sick Care	Within seventy two (72) hours
Routine, Non-Urgent or Preventive Care	Within six (6) weeks
Specialty Care Consultation	Within one (1) month of referral or as clinically indicated
Lab and X-ray Services	Not to exceed three (3) weeks for regular appointments and forty eight (48) hours for urgent care or as clinically indicated
Follow Up To ED Visits	In accordance with ED attending provider discharge instructions
In-office waiting time for scheduled appointments	Not to exceed forty-five (45) minutes-If a provider is delayed patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment
Walk-In, Non-Urgent Care	Consistent with written scheduling procedures
Maternity Care*	
Within First Trimester	Within fourteen (14) Days from the postmark date of the member's welcome packet
Within Second Trimester	Within seven (7) days

Within Third Trimester	Within three (3) days
High Risk Pregnancies	Within three (3) days of identification of high risk by LHCC or by the maternity care provider or immediately if an emergency exists
Behavioral Health Services	
Emergent, crisis or emergency behavioral health services	At all times and appointment should be arranged within 1 hour of request
Urgent behavioral healthcare	24 hours per day, 7 days per week and appointment shall be arranged within 48 hours of the request
Behavioral healthcare, routine, non-urgent	Within 14 Days of the referral

**Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the above timetable*

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;
 - 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 member 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.

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 accessibility of 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.

Louisiana Healthcare Connections will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

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.

The PCP must obtain prior authorization from Louisiana Healthcare Connections Plan for referrals to certain specialty providers as noted on the prior authorization list. All out-of-network services require prior authorization as further described herein 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.

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.

SPECIALIST RESPONSIBILITIES

Louisiana Healthcare Connections encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves. This 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 specialty physician may order diagnostic tests without PCP involvement by following Louisiana Healthcare Connections referral guidelines.

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.

The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from Louisiana Healthcare Connections Medical Management Department if needed before providing services
- 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)

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.

Louisiana Healthcare Connections providers should refer to their contract for complete information regarding providers' obligations or contact their Provider Consultant with any questions or concerns.

HOSPITAL RESPONSIBILITIES

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 in the Request For Proposal (RFP).

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).
- Submit Admit Discharge Transfer (ADT) data to LaHIE.
- 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 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.

ADVANCED DIRECTIVES

Louisiana Healthcare Connections is committed to ensuring that its members are aware of and are able to avail themselves of their rights 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 documented in 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 mental health 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.

VOLUNTARILY 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 the plan's 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 within the past two years. 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, 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 5-7 business days of the change.
- The PCP Panel/Patient 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.

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, health status, income status, program membership, or physical or behavioral 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.

Credentialing and Re-Credentialing

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.

NOTE: In order to maintain a current provider profile, providers are required to notify Louisiana Healthcare Connections if any relevant changes to their credentialing information in a timely manner.

Physicians 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

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 activity including Medicare/Medicaid services (OIG-Office of Inspector General)

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

Providers must be credentialed prior to accepting or treating members without authorization. PCPs cannot accept member assignments until they are fully credentialed.

We will completely process credentialing applications from all provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement.

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 insures 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.

MANDATORY DISCLOSURES BY PROVIDERS

All network providers are required to notify Louisiana Healthcare Connections of changes or updates to their credentialing information, including:

- Reporting loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of receipt of notification, if required to be accredited.
- Reporting cancellation of any required insurance coverage, licensure, or certification immediately.

PROVIDER DIRECTORY UPDATES

The accuracy of provider directory data is critically important to our members' ability to quickly and effectively access needed care. All network providers are required to submit updated provider directory data any time a change occurs. This includes active practitioners, addresses, phone numbers, status as a primary care provider, acceptance of new patients, acceptance of Medicaid, and all other provider demographic data submitted to Louisiana Healthcare Connections as part of contracting and credentialing.

Both Louisiana Healthcare Connections and the Louisiana Department of Health frequently audit provider directory data. The Department of Health holds Louisiana Healthcare Connections to a 90% accuracy rate for provider directory data.

Repeated failure to submit updated and accurate provider data can result in corrective actions up to and including termination from the network.

TERMINATION DUE TO EXCLUSION

Should a providers be excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program, Louisiana Healthcare Connections will not contract, or will terminate its contract with that provider. This includes providers undergoing any of the following conditions identified through LDH proceedings:

- Revocation of the provider's home and community-based services license or behavioral health service license;
- Exclusion from the Medicaid program;
- Termination from the Medicaid program;
- Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41);
- Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or
- The Louisiana Attorney General's Office has seized the assets of the service provider.

Provider Rights and Responsibilities

PROVIDER RIGHTS

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

- Be treated by their patients 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
- Expect members to follow their directions
- 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 RESPONSIBILITIES

Louisiana Healthcare Connections is required to ensure that network PCPs fulfill their responsibilities, including but not limited to the following:

- Manage and coordinate the medical and behavioral healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions.
- Communicating with other levels of medical care to coordinate and follow up the care of individual patients.
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid.
- Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care.
- Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33 in the RFP (continuity of care for individuals with special health care needs).

- Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes
- Providing 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.
- Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at a Louisiana Healthcare Connections participating hospital.
- Working with Louisiana Healthcare Connections case managers to develop plans of care for members receiving case management services.
- Participating in Louisiana Healthcare Connections' case management team, as applicable and medically necessary.
- Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs) and substance use to determine whether the member needs behavioral health services.
- 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 of any updates necessary to the physician directory such as new address, new phone number, or change in group practice affiliation.
- 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 record (PHR).
- Working with our case managers to develop plans of care for members receiving case management services.
- Participating with our case management team as applicable and medically necessary.

- Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use to determine whether the member needs behavioral health services.

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)

The Louisiana Healthcare Connections Preferred Drug List (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 Louisiana Healthcare Connections PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed with a "PA" notation throughout the PDL.

Whenever a change or update is made to the PDL, we will notify providers of the changes at least 30 days before the effective date of the change.

WORKING WITH THE PHARMACY BENEFIT MANAGER (PBM)

Louisiana Healthcare Connections works with US Script to administer pharmacy benefits, including PA process. Certain drugs require PA to be approved for payment by Louisiana Healthcare Connections.

These include:

- All medications not listed on the PDL
- Some Louisiana Healthcare Connections preferred drugs (designated PA on the PDL)

Drug prior authorization requests are available at US Script through phone, fax or online.

1. **US Script Telephonic PA:1-855-757-6565**
2. **FAX**

- a. Complete the Louisiana Healthcare Connections/US Script form: Medication Prior Authorization Request Form found on the Louisiana Healthcare Connections website at LouisianaHealthConnect.com.
 - b. Fax to US Script at 1-866-399-0929.
 - c. Once approved, US Script notifies the prescriber by fax.
 - d. If the clinical information provided does not explain the reason for the requested PA medication, US Script responds to the prescriber by fax, offering PDL alternatives.
- 3. Online PA**
- a. CoverMyMeds is an online drug prior authorization (PA) program through US Script that allows prescribers to begin the PA process electronically. Prescribers locate the correct form, complete it online, and then submit it to US Script via fax. CoverMyMeds simplifies the PA submission process by automating drug prior authorizations for any medication
 - b. CoverMYMeds can be found at <https://www.usscript.com/covermymeds>

For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the US Script Pharmacy Help Desk at: 1-800-460-8988.

US Script Contacts Prior Authorization

Fax: 1-866-399-0929

Web: www.usscript.com

Phone: 1-888-929-3790 (Monday - Friday 7 a.m. - 8 p.m.)

Mailing Address

US Script
2425 W Shaw Avenue
Fresno, CA 93711

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 provided to the provider and the member.

Providers are requested to utilize the 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 Healthcare Connections 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, may submit an appeal, verbally or in writing. For additional information about appeals, please refer to the Appeals section herein.

Speech Therapy and Rehabilitation Services (STRS)

Louisiana Healthcare Connections offers our members access to all covered, medically necessary outpatient physical, occupational and speech therapy services through Cenpatico Specialty Therapy and Rehabilitative Services (STRS).

Prior authorization is required for outpatient occupational, physical or speech therapy services and should be submitted to Cenpatico STRS using the Outpatient Treatment Request (OTR) form located at Cenpatico.com.

Cenpatico STRS Outpatient Therapies Prior Authorization
Fax: 1-855-846-2706

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)
- Cenpatico will not retroactively certify routine sessions. Exceptions:
 - 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
 - Services occurred during a transition of care period
- The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.

Cenpatico STRS applies medical necessity criteria that was developed using the Clinical Practice Guidelines of the physical, occupational and speech Professional Associations as well as InterQual Criteria for both Adults and Pediatrics guidelines. The criteria can be found on the Cenpatico website at: Cenpatico.com. Cenpatico STRS utilizes Occupational, Physical and Speech Therapists to process Outpatient Treatment Request. Our specialized approach allows for interaction in real time with the provider to best meet the overall therapeutic needs of the members.

In the event that the practitioner is unable to provide timely access for a member, Cenpatico will assist in securing authorization to a practitioner to meet the member's needs in a timely manner.

Title 50: The Medicaid Program provides reimbursement to freestanding physical therapy, occupational therapy and speech therapy rendered in rehabilitation clinics to recipients under the age of 21. Adults over the age of 21 will not be covered for these services at freestanding clinics.

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 (NIA) to provide prior authorization services and utilization. NIA 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 NIA and obtain authorization, please call 1-866-595-8133 and follow the prompt for radiology authorizations. NIA 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 NIA Magellan, 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 will be 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, NIA Magellan addresses unnecessary procedures and promotes the least invasive, most medically appropriate approaches.

NIA Magellan 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. NIA Magellan 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 will promote 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 the highest 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 NIA Magellan:

- Inpatient advanced radiology services

- Observation setting advanced radiology services
- ER radiology services

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

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;
3. Immunizations appropriate to age and health history;
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 to the 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; and
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.

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:

1. 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;
2. Serious impairments of bodily functions; or
3. 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:

1. 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
2. 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.

Women's Health Care

Louisiana Healthcare Connections will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive health care services in addition to the member's PCP if the provider is not a women's health specialist. Members are allowed to utilize their own PCP or any family planning service provider for family planning services without the need for a referral or a prior authorization.

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.

Value-Added Services

Our members have many questions about their health, their PCP and/or access to emergency care. Our health plan offers a nurse line service to help members proactively manage their health needs, decide on the most appropriate care and encourage members to talk with their physician about preventive care.

24/7 NURSE ADVICE HOTLINE

All Louisiana Healthcare Connections members have access to our 24-hour nurse advice hotline. Registered nurses provide basic health education, nurse triage and answer questions about urgent or emergency access through this service. 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 referred to case management for education and encouragement 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. If you have any additional questions, please call Provider Services at 1-866-595-8133.

HEALTHY REWARDS PROGRAM

The goal of the Healthy Rewards program is to increase appropriate utilization of preventive services by rewarding members for practicing a targeted healthy behavior. 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 credits to purchase nutritious foods and healthcare items, such as OTC medications that they might otherwise not be able to afford. Services that will qualify for rewards through the program include completion of annual adult well visits, EPSDT visits, certain disease-specific screenings and prenatal and postpartum care.

How does it work? Members will receive a prepaid debit card. Credit will be added to the account balance once the member receives certain screenings or preventive care. Members may use the cards to purchase approved a wide range of items at select stores.

ADULT DENTAL COVERAGE

Louisiana Healthcare Connections' adult members now have coverage for dental services performed at a FQHC or RHC.

What services are covered and who is eligible?

Louisiana Healthcare Connections members age 21 and older can receive up to two dental visits per calendar year, covering the following services:

- Oral exams and cleaning
- Bite wing X-rays
- Simple tooth extractions
- Dental hygiene supplies (includes toothbrush, toothpaste, floss and mouthwash)

ADULT VISION COVERAGE

Effective Feb. 1, 2015, Louisiana Healthcare Connections' vision services for adults ages 21 and over are now covered. These benefits include one preventive exam and one pair of eyeglasses per calendar year. Provider should submit vision service claims to Envolve Managed Vision.

NEWBORN CIRCUMCISIONS

Effective Feb. 1, 2015, 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 adult ages 21 and over, up to two (2) skilled nursing visits per day and up to 75 skilled nursing visits per year.

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 the clinical practice guidelines adopted by Louisiana Healthcare Connections:

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- 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

For links to the most current version of the guidelines adopted by Louisiana Healthcare Connections, visit our website at LouisianaHealthConnect.com.

Quality Improvement

Louisiana Healthcare Connections culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs.

This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Louisiana Healthcare Connections recognizes its 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 settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health status of its members.

Where the member's condition is not amenable to improvement, Louisiana Healthcare Connections will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Whenever possible, the Louisiana Healthcare Connections QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

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 members. 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 members. 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 members, 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
- Member, Provider and community advisory committees
- Joint Operations Committees
- Peer Review Committee (Ad Hoc Committee)

PRACTITIONER INVOLVEMENT

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.

QAPI PROGRAM SCOPE AND GOALS

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the Louisiana Healthcare Connections members. Louisiana Healthcare Connections' QAPI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care (depending upon the product) and ancillary services, and operations.

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

To that end, the Louisiana Healthcare Connections QAPI Program monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- 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
- Utilization Management, including under and over utilization
- Compliance with member confidentiality laws and regulation
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Health Plan after-hours telephone accessibility

- Member satisfaction
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- PCP changes
- Department performance and service
- Patient safety
- Marketing practices

PATIENT SAFETY AND QUALITY OF CARE

Patient Safety is a key focus of Louisiana Healthcare Connections QAPI Program. Monitoring and promoting patient 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 patient 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 member.

Louisiana Healthcare Connections employees, including medical management staff, member services staff, provider services, complaint coordinators, etc., panel practitioners, facilities or ancillary providers, members 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 members 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.

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 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 prompt cooperation with the representative is greatly needed and 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.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDER

SYSTEMS (CAHPS) SURVEY

The 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.

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 Consulting department at 1-866-595-8133.

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.

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 10 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.

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. These tools include:

- 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.

ASSIGNMENT OF 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.

Network Development and Maintenance

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). Physicians who may serve as PCPs include: Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners.

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

- 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
- 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
- Surgery (General)
- Surgery (Subspecialties)
 - Cardiac/Thoracic
 - Plastic (limited)
 - Pediatric
 - Vascular Surgery (General)
 - Surgery of the Hand
 - Surgical Critical Care

** Require both adults and pediatric providers*

In the event Louisiana Healthcare Connections' network is unable to provide medically necessary services required under the contract, Louisiana Healthcare Connections shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

For assistance in making a referral to a specialist or subspecialties for a Louisiana Healthcare Connections member, please contact our Medical Management team at 1-866-595-8133 and we will identify a provider to make the necessary referral.

GEO ACCESS TOOLS

With the use of GEO access tools, Louisiana Healthcare Connections will monitor its access to all specialists and will ensure the number of Louisiana Healthcare Connections members per specialist does not exceed the State of Louisiana's requirements. Louisiana Healthcare Connections goal is to exceed the state's minimum requirements, listed below:

Specialty	Number of Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
Nephrology	50,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000

TERTIARY CARE

Louisiana Healthcare Connections offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical sub-specialists available 24-hours per day in the geographical service area. In the event Louisiana Healthcare Connections' network is unable to provide the necessary tertiary care services required, Louisiana Healthcare Connections shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

Medical Management

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, case 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.

UTILIZATION MANAGEMENT

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, acute care, short-term care and ancillary care services.

Louisiana Healthcare Connections UM Program seeks to optimize a member's health status, sense of well-being, productivity and access to quality health care, while at the same time actively managing cost trends. 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.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under-utilization.
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.
- Identification and provision of case and/or disease management for members at risk for significant health expenses or ongoing care.
- Development of an infrastructure to ensure that all Louisiana Healthcare Connections members establish relationships with their PCPs to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self-management.
- Creation of partnerships with members/providers to enhance cooperation and support for UM Program goals.

Referrals: As promoted by the Medical Home concept, PCPs should coordinate the healthcare services for Louisiana Healthcare Connections members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, paper referrals are not required. To better coordinate a members' healthcare, Louisiana Healthcare Connections encourages specialists to communicate to the PCP

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the need for a referral to another specialist rather than making such a referral themselves.

Notifications: A provider is required to promptly notify Louisiana Healthcare Connections when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

Prior Authorizations: Some services require prior authorization from Louisiana Healthcare Connections in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization except for family planning, ER and tabletop X-rays.

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

Louisiana Healthcare Connections
Medical Management/Prior Authorization
Telephone 1-866-595-8133
Fax 1-877-401-8175
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
Or by e-mail to: EDIBA@centene.com

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. Services that require authorization by Louisiana Healthcare Connections are listed in the Benefits and Services requiring Authorization Table in this manual. The PCP should contact the UM department via telephone, fax or through our website 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.

Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service.

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.

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.

AUTHORIZATION DETERMINATION TIMELINES

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). "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.

The service authorization decision may be extended up to 14 additional calendar days if the member or provider request the extension, or if we justify (to LDH upon request) a need for additional information and that the extension is in the member's best interest. For urgent/expedited pre-service requests, a decision and notification is made within 72 hours of receipt of the request. For urgent concurrent review of ongoing inpatient admission and services such as outpatient rehabilitation, home care or ongoing specialty care, decisions are made within one business day of receipt of clinical information. The notification of determination will include the number of days of service approved and the next review date.

When a service authorization decision has been made, we will notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification. If the decision is to deny or partially deny a service reauthorization, we will also provide notification in this way. If the decision is to deny or partially deny a service authorization, we will also notify the member in writing using easily understood language.

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.

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 patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

CLINICAL INFORMATION

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.

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, a nurse or medical service representative will notify the

caller of the specific information needed to complete the authorization process.

CLINICAL DECISIONS

Louisiana Healthcare Connections affirms that UM decision-making is based on appropriateness of care and service and the existence of coverage. Louisiana Healthcare Connections does not reward practitioners or other individuals for issuing denials of service or care.

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 physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, 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 PC criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

MEDICAL NECESSITY

Medical necessity is defined for Louisiana Healthcare Connections members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness or injury
- In accordance with the standards of good medical practice consistent with evidence-based and clinical practice guidelines
- Not primarily for the personal comfort or convenience of the member, family or provider
- The most appropriate services, supplies, equipment or level of care that can be safely and efficiently provided to the member
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
- Not experimental or investigational or for research or education

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 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. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member'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. 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 case manager may also coordinate communication between the Medical Director and requesting practitioner.

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
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809
Fax 1-877-401-8170

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.

NOTIFICATION OF PREGNANCY

Members that become pregnant while covered by Louisiana Healthcare Connections may remain a Louisiana Healthcare Connections member during their pregnancy. The managing physician should notify the Louisiana Healthcare Connections prenatal team by completing the Notification of Pregnancy (NOP) form within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. See the Case Management section for information related to our Start Smart for Your Baby® program and our 17-P program for women with a history of early delivery.

CONCURRENT REVIEW AND DISCHARGE PLANNING

Nurse Case 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 business 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.

Case Management Program

Louisiana Healthcare Connections' case management model is designed to help your Louisiana Healthcare Connections members obtain needed services, whether they are covered within the Louisiana Healthcare Connections array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary case management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. It is the PCP's responsibility to contact Case Management (CM) for updates. We will coordinate access to services not included in core benefit package such as behavioral health, dental and pharmacy 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.

A CM team is available to help all providers manage their Louisiana Healthcare Connections members. Listed below are programs and components of special services that are available and can be accessed through the case management team. We look forward to hearing from you about any Louisiana Healthcare Connections members that you think can benefit from the addition of a Louisiana Healthcare Connections CM team member.

To contact a case manager call: 1-866-595-8133.

HIGH RISK PREGNANCY PROGRAM

The OB CM Team will implement our *Start Smart for Your Baby*® Program (Start Smart), which incorporates case 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 follows 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 case management to high and moderate risk members through the postpartum period. A nurse case manager with obstetrical experience will serve as lead case 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 such as 17 alpha-hydroxyprogesterone caproate (17-P).

Louisiana Healthcare Connections offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. The prescription is sent to the Louisiana Healthcare Connections case manager who will check for eligibility. The case manager will assist the member with finding a pharmacy to fill the prescription as well as coordinate transportation to and from the physician's office. The nurse manager will contact the member and do an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period.

Contact the Louisiana Healthcare Connections CM department for enrollment in the obstetrical program.

COMPLEX TEAMS

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. The complex teams will manage care for 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 case management.

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 CM department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

MEMBERCONNECTIONS® PROGRAM

MemberConnections® is Louisiana Healthcare Connections outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable.

The program components are integrated as a part of our CM program in order to link Louisiana Healthcare Connections and the community it serves. The program recruits staff from the communities serviced to establish a grassroots support and awareness of Louisiana Healthcare Connections within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections® through numerous sources. Members who

call the Louisiana Healthcare Connections Customer Service Department may be referred for more personalized discussion on the topic about which they are inquiring. Case managers may identify members who would benefit from one of the many MemberConnections® components and complete a referral request.

Providers may request MemberConnections® referrals directly to the MemberConnections® Representative or their assigned case manager. Community groups may request that a MemberConnections® Representative come to their facility to present to groups they have established or at special events or gatherings.

Various components of the program are described below.

Community Connections

MemberConnections® Representatives are available to present in group settings during events initiated by state entities, community groups, clinics or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care is all about, overview of services offered by Louisiana Healthcare Connections, how to use the health plan and access services, the importance of obtaining primary preventive care and other valuable information related to obtaining services from providers and Louisiana Healthcare Connections.

Home Connections

MemberConnections® Representatives are available on a full-time basis whenever a need arises or a request is received from a case manager member or provider. All home visits are unscheduled due to the fact that the case manager has been unable to make contact with the member. Some home visits can be scheduled when it involves them delivering a cell phone to the member in order to have easier access to the member. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive health care, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation and how to contact the health plan for assistance.

Phone Connections

MemberConnections® Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

Connections Plus®

MemberConnections® Representatives work together with the high risk OB team or case management team for high risk members who do not have safe, reliable phone access. When a member qualifies, a Connections Representative visits the member's home and gives them a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan case manager, PCP, specialty physician, 24/7 nurse advice hotline, 911 or other members of their health care team.

To contact the MemberConnections® Team call: 1-866-595-8133.

CHRONIC CARE/DISEASE MANAGEMENT PROGRAMS

As a part of Louisiana Healthcare Connections services, Chronic Care Management Programs (CCMP) is offered to members. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Louisiana Healthcare Connections programs include but are not limited to: asthma, 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.

Not all members having the 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 case management program evaluation.

To refer a member for chronic care management:

- Call: Louisiana Healthcare Connections Health Coaches 1-866-595-8133
- Online: LouisianaHealthConnect.com

Provider Consultants

Provider Consultants are designed around the concept of making your experience a positive one by being your advocate within Louisiana Healthcare Connections. Provider Consultants are responsible for providing the services listed below which include but are not limited to:

- 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

The goal of the Provider Consultant is to provide you and your staff with the necessary tools to deliver the highest quality of healthcare to our members. To contact the Provider Consultant for your area, call 1-866-595-8133. Provider Services Representatives work with Provider Consultants as your advocates to ensure you receive necessary support and maintain satisfaction with Louisiana Healthcare Connections.

TOP REASONS TO CONTACT A PROVIDER CONSULTANT

1. Report any changes to your practice (locations, NPI, TIN numbers)
2. Initiate credentialing of a new practitioner
3. Schedule an in-service training for new staff
4. Conduct ongoing education for existing staff
5. Obtain clarification of policies and procedures
6. Obtain clarification of a provider contract
7. Request fee schedule information
8. Obtain membership roster
9. Obtaining Provider Profiles
10. Learn how to use electronic solutions on web authorizations, claims submissions and member eligibility
11. Open/close patient panel

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.

Sources

A provider complaint can originate from a phone call, fax, e-mail, field report, letter, through the web portal or through another Louisiana Healthcare Connections department.

Timeframes

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.

To File a Provider Complaint:

- Phone: 1-866-595-8133
- Online: provider.louisianahealthconnect.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 get a timely response through the health plan escalation process, LDH has offered a direct contact email address as a final step. Providers may e-mail LDH staff at ProviderRelations@la.gov. LDH requests that providers be sure to 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 that LDH staff can follow up with any questions. When emailing personal health information (PHI) to the MCO or Healthy Louisiana, providers must use secure email.

Billing and Claims Submission

Louisiana Healthcare Connections processes its claims in accordance with applicable state prompt pay requirements.

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 us 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)
- Billing name and address

Providers must bill with their individual NPI number in box 24Jb and group or pay to NPI# in box 33a. The servicing location information must be completed in box 32a. We encourage our providers to also bill their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the requirements will be returned, and a notice will be sent to the provider, which may result in payment delays. Such claims are not considered "clean" and therefore cannot be accepted into our system.

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.

At such time that LDH presents recommendations concerning claims billing and processing that are consistent with industry norms, we shall comply with said recommendations within 90 calendar days from notice by LDH.

Louisiana Healthcare Connections updates CPT, HCPCS, ICD-10 and other codes based on HIPAA standards and move to future versions as required by CMS or LDH. Updates to code sets will be complete no later than 30 days after notification, unless otherwise directed by LDH. This includes annual and other fee schedule updates. We will notify as to when the updates will be in

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production and of the process for recycling of denied claims that are due to the system update delays. The recycle of these denied claims will be complete no later than 15 days after the system update.

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

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 1450 (UB-04) Claim Example

LA HOSPITAL 123 Street Blvd		2		52 PAT CNTL # 1111111		4 TYPE OF BILL 131	
New Orleans, LA 70119		53 MED RES # 1212121		5 FED TAX NO 999999999		6 STATEMENT COVERS PERIOD FROM 1/1/2011	
7 PATIENT NAME Example, Mister R		8 PATIENT ADDRESS 123 MAIN STREET		9 LA		10 70119	
11 BIRTHDATE 10/28/1980	12 SEX M	13 DATE 1/1/2011	14 ADMISSION HR 6	15 TYPE 3	16 S/PC 2	17 DHR 23	18 STAT 1
19 09		20 21		22 23		24 25	
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602 603		604 605		606 607		608 609	
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626 627		628 629		630 631		632 633	
634 635		636 637		638 639		640 641	
642 643		644 645		646 647		648 649	
650 651		652 653		654 655		656 657	
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842 843		844 845		846 847		848 849	
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858 859		860 861		862 863		864 865	
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1114 1115		1116 1117		1118 1119		1120 1121	
1122 1123		1124 1125		1126 1127		1128 1129	
1130 1131		1132 1133		1134 1135		1136 1137	
1138 1139		1140 1141		1142 1143		1144 1145	
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1162 1163		1164 1165		1166 1167		1168 1169	
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1186 1187		1188 1189		1190 1191		1192 1193	
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1250 1251		1252 1253		1254 1255		1256 1257	
1258 1259		1260 1261		1262 1263		1264 1265	
1266 1267		1268 1269		1270 1271		1272 1273	
1274 1275		1276 1277		1278 1279		1280 1281	
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TIMELY FILING

Providers must submit all original claims (first time claims) and encounters to Louisiana Healthcare Connections within 365 calendar days of the date of service.

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

All corrected claims, requests for reconsideration or claim disputes must be received within 180 calendar days from the date of notification of payment or denial is issued.

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.

ELECTRONIC CLAIMS SUBMISSION

Network providers are encouraged to participate in Louisiana Healthcare Connections' electronic claims/encounter filing program. The plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, it has the ability 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/Change Healthcare
- Availity
- Medavant/Caprio/Emdeon
- Smart Data Solutions
- Allscripts/PayerPath
- Experian
- Eligibility

- Practice Insight
- InMediata
- Encoda
- Viatrack
- MD On-line/Ability
- GHN-Online/Greenway
- Practice Insight
- SSI
- Gateway EDI/Trizetto
- Relay Health/Mckesson
- ZirMed

Infedi

PAPER CLAIMS SUBMISSION

Initial Claims and Corrected Claims

Louisiana Healthcare Connections
 Attention: Claims
 P.O. BOX 4040
 Farmington, MO 63640-3800

Claim Disputes

Louisiana Healthcare Connections
 Attention: Claim Reconsiderations & Appeals
 P.O. BOX 4040
 Farmington, MO 63640-3800

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

ELECTRONIC FUNDS TRANSFERS (EFT) AND ELECTRONIC REMITTANCE ADVICES (ERA)

Louisiana Healthcare Connections provides an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). 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 patient accounting systems, eliminating the need for manual re-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 of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information, please visit our provider home page on our website at www.LouisianaHealthConnect.com. If further assistance is needed, please contact Provider Services 1-866-595-8133.

CLAIM PAYMENT

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.
- Process and pay or deny, as appropriate, at least ninety percent (90%) of all clean claims for each claim type, within fifteen (15) business days of the receipt.
- Process and pay or deny, as appropriate, at least ninety-nine percent (99%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.
- Louisiana Healthcare Connections will fully adjudicate (pay or deny) all pended claims within 60 calendar days of the date of receipt.
- We will pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) day claims processing deadline. Interest owed to the provider will be paid the same date that the claim is adjudicated,

CLAIMS REPROCESSING

If it is discovered that we made errors when a claim was adjudicated, we will make corrections and reprocess the claim within thirty (30) calendar days of discovery. If circumstances exist that prevent us from meeting this time frame, a specified date shall be approved by LDH. We will automatically recycle all impacted claims for all providers and will not require providers to resubmit the impacted claims.

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.

MEMBERS DIS-ENROLLED TO OTHER MEDICAID MCOS

For members dis-enrolled due to the validation of a duplicate Medicaid ID, we will not recover claim payments under the retroactively dis-enrolled member'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.

PROVIDERS LOCATED OUTSIDE THE UNITED STATES

As required by our contract with the state of Louisiana, we shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.

PROVIDER PREVENTABLE CONDITIONS

Louisiana Healthcare Connections will deny payment to providers for Provider Preventable Conditions as defined by LDH in Section 25.8 of the Louisiana Medicaid Program Hospital Services Provider Manual. All providers are required to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Louisiana Healthcare Connections will report all identified provider preventable conditions to LDH.

RECOUPMENTS

Should a payment recoupment be necessary, we will provide written prior notification to a provider of our intent to recoup any payment. The notification shall include:

- The name of the patient;
- Date of birth or Medicaid identification number;
- The date or dates of healthcare services rendered;
- A complete listing of the specific claims and amounts subject to the recoupment;
- The specific reasons for making the recoupment for each of the claims subject to recoupment;
- The date the recoupment is proposed to be executed;
- The mailing address or electronic mail address where a provider may submit a written response;
- The date LDH notified the MCO of the member disenrollment via the ASC X12N 834 Benefit Enrollment and Maintenance Transaction, when applicable; and
- Effective date of disenrollment

Before the recoupment is executed, the provider shall have forty-five (45) days from the receipt of written notification of recoupment to submit a written response as to why the recoupment should not be put into effect on the date specified in the notice.

Upon receipt of a written response as to why the recoupment should not be put into effect, we will, 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. We will provide written notice of determination to each written response that include the rationale for the determination. If a recoupment is valid, the provider shall remit the amount to Louisiana Healthcare Connections or permit the amount to be deducted from future payments due to the provider.

Procedures for Claim Submission

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.

REQUIRED BILLING INFORMATION

It is important that our providers ensure Louisiana Healthcare Connections has accurate billing information on file. Please confirm with our 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 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.

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.

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 patient 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.

NOTE: The group NPI should NOT be billed in box 24J. This will cause erroneous rejections.

- 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 look 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 Enteral 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. Consent forms can be located at the LDH website at:

- Abortion Certification Form
http://new.ldh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CCNPAppendices/AppendixNAbortionCertificationofInformedConsent.pdf
- Sterilization Consent Form
http://new.ldh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CCNPAppendices/AppendixM_SterilizationConsentForm.pdf
- Hysterectomy Consent Form
http://new.ldh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CCNPAppendices/AppendixLHysterectomyConsentFormfill.pdf

These forms are required at the time of claim submission. If the forms are not completed and signed before submission, all claims will deny.

NOTE: If an incomplete form is submitted to Louisiana Healthcare Connections, it will result in the following denials below:

EX Code	Description
CF	PEND: <i>Waiting for consent form</i>
DD	DENY: <i>Signed, paper consent form has not been received</i>
DQ	DENY: <i>Member under 21 years of age when signing consent form</i>
HQ	DENY: <i>EDI claim must be submitted in hard copy with consent form (EDI)</i>
K2	DENY: <i>Abortion certification form is not valid/missing information</i>
NV	DENY: <i>Sterilization consent form not valid or missing information</i>
Z1	DENY: <i>Abortion necessity form required for processing</i>

Appropriate authorizations were obtained for the services performed. We do not pay secondary to Medicare coverage or other third party coverage clearly identified and accompanied by

appropriate TPL information with claim submission.

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 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 90 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 90 calendar days from the date of notification of adjudication.

If corrected claims, reconsiderations and/or appeals are received after the 90 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 patient 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.

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, and denial reasons.

INDEPENDENT REVIEW

This 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. A 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. If the independent reviewer decides in favor of the provider, the MCO is responsible for paying the fee. Conversely, if the independent reviewer finds in favor of the MCO, the provider is responsible for paying the fee.

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 that 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 a MCO. In lieu of requesting independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute.

To learn more about the independent review process, visit: <http://ldh.la.gov/index.cfm/page/2982>.

To initiate an independent review, use the "Louisiana Department of Health Independent Review Form" found in the Provider Resources of our website, www.LouisianaHealthConnect.com.

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**

Important 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

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 Provider Dispute Form must be completed and should include other supporting correspondence that supports the provider claim (patient medical records).

NOTE: The Medical Records will **not** go to the MRU team if there is no Provider Dispute Form attached or if the original claim did not deny asking for medical records.

Mail Requests for Reconsideration to:

Louisiana Healthcare Connections
Attn: Claim Reconsiderations & Appeals
PO Box 4040
Farmington, MO 63640- 3800

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:

- Provider Dispute Form (www.LouisianaHealthConnect.com)
- Response received from Request for Reconsideration letter or EOP
- Any supporting documentation supporting the request for an appeal

NOTE: The medical records will **not** go to the MRU if there is no Provider Dispute Form attached or if the original claim did not deny asking for medical records.

Mail your Provider Dispute Form and all other attachments to:

Louisiana Healthcare Connections
Attn: Claim Reconsiderations & Appeals
PO Box 4040
Farmington, MO 63640-3800

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 .

CLAIM PAYMENT

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.

Indiana Health Care Providers (IHCPs) will be reimbursed at the annual rates published in the Federal Register by the Indian Health Service (IHS). IHS issues the payment rate based on a calendar year that will be effective retroactive to January 1st of that year. We will recycle claims for the calendar year to capture the adjusted rate.

Louisiana Healthcare Connections has a separate fee schedule for IV Infusion and DME.

CLEAN CLAIM DEFINITION

A clean claim means 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 the services in order to be processed by Louisiana Healthcare Connections. The following exceptions apply to this definition: (a) a claim for which fraud is suspected; and (b) 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 pending for additional information must be closed (paid or denied) by the 30th calendar day following the date the claim is pending 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.

Procedures for Electronic Submission

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 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)
 Or by e-mail at 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.

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 <i>Below should come from the primary payer's Explanation of Payment</i>	837I – INSTITUTIONAL <i>EDI Segment and Loop</i>	837P – PROFESSIONAL <i>EDI Segment and Loop</i>
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: <i>this segment can have 6 occurrences. Tibco will validate all.</i>	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 & Important General Information

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 that require 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:	<ul style="list-style-type: none"> • Emdeon/Change Healthcare • Gateway EDI/Trizetto • Experian • Smart Data Solutions • Allscripts/PayerPath • Eligibility • Practice Insight • InMediata • Encoda • ViaTrack • MD On-line/Ability • Infinedi • ClaimRemedi

TOPIC	CONTACT
	<ul style="list-style-type: none"> • GHN-Online/Greenway • SSI • Relay Health/Mckesson • ZirMed Medavant/Capario/Emdeon
Louisiana Healthcare Connections Payer ID:	68069 Refer to individual vendor provider manuals at LouisianaHealthConnect.com for their payer IDs (MCNA, Envolve, etc.)
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 secure Provider Portal at LouisianaHealthConnect.com
Provider Payee, NPI, Tax ID, Payment Address Changes: MUST include W9	Notify Provider Services in writing at: Louisiana Healthcare Connections 8585 Archives Avenue, Suite 310 Baton Rouge, LA 70809 Or via Fax to: 1- 866- 768- 9374

IMPORTANT STEPS TO 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.

EFT AND ERA

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. 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 patient accounting systems, eliminating the need for manual re-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 of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information on our EFT and ERA services, please visit www.payspan.com or contact Payspan Provider Services at 1-800 -733-0908.

Online Claim Submission

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 user name and password and you must select the Claims Role Access module. To register, please go directly to

LouisianaHealthConnect.com. If you have technical support questions, please contact Provider Services at 1-866- 595- 8133.

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 Submission Requirements

Submit claims to Louisiana Healthcare Connections at the following address:

Louisiana Healthcare Connections
ATTN: Claim Processing Department
P. O. Box 4040
Farmington, MO 63640-3800

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-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-10 diagnosis code missing the 4th or 5th digit as appropriate.
- A deleted ICD-10 code was used.
- The ICD indicator is missing in the small box next to ICD Ind in the upper right portion of Field 21 on the 1500 claim form or the tiny box underneath Box 66 on the 1450 (UB04). Use 9 for ICD-9 or 0 for ICD-10.
- 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/HCPCS 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.

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 on the 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

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

As accountable and fiscally responsible stewards of public funds, we take the prevention and detection of waste, fraud, and abuse very seriously. Louisiana Healthcare Connections has a management contract with its parent organization, Centene Corporation (Centene) in which Centene conducts routine post-processing claims audits on behalf of Louisiana Healthcare Connections. These audits are designed to ensure that billing codes and practices are correct and that Louisiana Healthcare Connections has paid health care providers appropriately. In addition to provider reviews, Centene also investigates members who appear to be abusing the Medicaid and Louisiana Healthcare Connections programs.

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. 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.

All providers are required to report if they have received an overpayment, to return the overpayment within sixty (60) calendar days of the date on which the overpayment was identified, and to notify Louisiana Healthcare Connections in writing of the reason for the overpayment.

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, condyle 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/patient &/or family.	Disallow
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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 patient 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
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99215	Spend 40 minutes face-to-face with patient 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 patient during a visit.
- Procedure 99222 is used to report an evaluation and management service for a hospital admission for a patient 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 -26. When 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 unclear 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 2.

Encounters

WHAT IS AN ENCOUNTER VERSUS A CLAIM?

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 date of 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.

PROCEDURES FOR FILING A CLAIM/ENCOUNTER DATA

Louisiana Healthcare Connections encourages all providers to file claims/encounters electronically. See the Electronic Claims Submission and Billing sections of your Provider Manual for more information on how to initiate electronic claims/encounters.

BILLING THE MEMBER

Louisiana Healthcare Connections reimburses only services that are medically necessary and covered through Louisiana's Coordinated Care Network. Providers can bill a member for non-covered services only if they provide proof that they notified the member—in advance of rendering the service—that it was non-covered.

MEMBER ACKNOWLEDGEMENT STATEMENT

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 the following condition is met.

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgement statement signed by the client 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 Coordinated Care Network 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.

For more detailed information on Louisiana Healthcare Connections billing requirements, please refer to the billing section of your Provider Manual.

Grievances and Appeals Process

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. Louisiana Healthcare Connections shall acknowledge receipt of each grievance in the manner in which is received. The member may file a grievance at any time.

Any individuals who make a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance 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]

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.

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 TIMEFRAME

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 enrollee. 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
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

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 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, may request an appeal either orally or in writing. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution.

The member will be allowed 60 calendar days from the date of notice of action or inaction to request an appeal. Appeals within the standard time frame will be resolved within 30 days of the receipt of the appeal.

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 to 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. 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. Louisiana Healthcare Connections shall make reasonable efforts to provide the member 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:

- a) The decision reached by Louisiana Healthcare Connections;
- b) The date of decision;
- c) 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; and
- d) 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
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

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 in the 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 written consent. (13.2.2.1.2.) 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

Waste, Abuse and Fraud

Louisiana Healthcare Connections takes the detection, investigation and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with Louisiana and federal laws. Louisiana Healthcare Connections, in conjunction with its management company, Centene, successfully operates a waste, abuse and fraud unit. Louisiana Healthcare Connections performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this handbook. Louisiana Healthcare Connections performs retrospective audits which, in some cases, may result in taking actions against those providers, individually or as a practice, commit waste, abuse and/or fraud. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common WAF practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary Current Procedural Terminology (CPT)
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential WAF hotline at 1-866-685-8664. Louisiana Healthcare Connections and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

NOTE: Due to the evolving nature of wasteful, abusive and fraudulent billing, Louisiana Healthcare Connections and Centene may enhance the WAF program at any time. These enhancements may include but is not limited to creating, customizing or modifying claim edits, upgrading software, modifying forensic analysis techniques or adding new subcontractors to help in the detection of adherent billing patterns.

AUTHORITY AND RESPONSIBILITY

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.

The Louisiana Healthcare Connections provider network will readily make medical records for review and submission in the event a provider is randomly selected for audit. Failure to comply with the submission of requested medical records can result in the recoupment of previously paid claims.

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.

The Louisiana Healthcare Connections provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

Behavioral Health Addendum

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Introduction

Cenpatico is the administrator of mental health and substance use disorder benefits for Louisiana Healthcare Connections.

Behavioral health covered services are for the treatment of mental, emotional and substance use disorders. We recruit and maintain a robust network of behavioral providers including psychiatrists, nurse practitioners, psychologists, social workers, licensed professional counselors, licensed marriage family therapists (LMFTs), behavioral health providers, hospitals, FQHCs and Local Governing Entities (LGEs). Cenpatico works closely with Louisiana Healthcare Connections to develop an integrated care management program with medical providers and social service providers to treat the members holistically.

HOW TO JOIN OUR PROVIDER NETWORK

Providers who offer specialized behavioral health services may contact us directly to inquire about joining our network at www.LaHealth.CC/Network.

For individual and/or group practices we work directly with Council for Affordable Quality Healthcare (CAQH) to receive the application and credentialing documentation. The provider will need to complete the following required documents:

- 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

You may contact CAQH directly at 1-888-599-1771 or visit website at www.CAQH.org/about/contact.

Once completed you may begin the credentialing process by visiting us at www.Cenpatico.com and completing the application under “[Join Our Network](#).”

If you are already contracted with Louisiana Healthcare Connections or Cenpatico, you do not have to complete another application.

Providers will need to make sure they have an active account with CAQH and update their information every 120 days.

Be sure to provide access for us to obtain the information. Once the process is completed the provider may grant access to other payers which will streamline the duplication of work and make the process easier for a provider to be added to our network.

Once information is received and you meet our requirements, an agreement will be forwarded 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

You will receive a welcome letter once you are approved. The letter will have 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. Please reference the Covered Services Authorization Guidelines (CSAG) for more detailed information. If you have any questions, you may reach out to provider services at 1-866-595-8133.

This credentialing process will need to be completed every three years. It's important that you maintain your CAQH information to ensure that we are able to complete the process without any interruption to your agreement.

NON-DISCRIMINATION

We do not limit the participation of any provider or facility in the network and/or otherwise discriminate against any provider or facility based solely on any characteristic protected under state or federal discriminate laws.

Furthermore, we do not and have never had a policy of terminating any provider who:

- advocated on behalf of a member
- filed a complaint against us
- appealed a decision of ours

PRACTICE INFORMATION

Changes to your practice demographics should be submitted to LABHNetwork@cepatico.com. It's important that we receive your information in writing. All demographic updates should be submitted to us in writing within 10 business days of the change date.

PROVIDER STANDARDS OF PRACTICE

Providers are requested to:

- 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 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 critical incidents
- 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)
- 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

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, health status, income status, program membership, or physical or behavioral 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.

PROVIDER REQUIREMENTS

- Verify member eligibility prior to service delivery.
- Refer Members with known or suspected physical health concerns or disorders to the PCP for examination and treatment.
- Only provide health care applicable to your provider license.
- Schedule outpatient follow up and/or continuing treatment prior to discharge for all Members that have received inpatient psychiatric services.
- Ensure outpatient 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).

A qualified provider of mental health targeted case management must:

- Demonstrated competency in the work performed; and
- Possess a 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).

Behavioral Health Service	Appointment Time	Explanation
Emergent, Crisis or Emergency Visits	Within 1 hour of request	Emergency services available at all times
Urgent Care (may be directed by PCP or Louisiana Medicaid Plan)	Within 24 hours per day, 7 days per week	Appointments shall be arranged within 48 hours of request
Non-Urgent, routine	14 days of referral	Appointments shall be arranged within 14 days of request
Follow-up to ED visits		According with ED attending provider discharge instructions

In-office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately.

If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

Member Rights and Responsibilities

MEMBER RIGHTS

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

- To be treated with respect and dignity.
- To receive the right to privacy and non-discrimination as required by law.
- To join your providers in making decisions about your healthcare.
- To refuse any medical service, diagnoses, treatment or health service if you or your 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:
 - Structure and operations
 - Services and service utilization plans
 - Practitioners and providers
 - Physician incentive plans
- 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 your provider(s).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- 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 your 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.
- To file any complaint about not following the Advance Directive with LDH.
- To choose a provider who gives you 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.
- 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 you.
 - 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.

MEMBER RESPONSIBILITIES

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

- To inform Louisiana Healthcare Connections of the loss or theft of an ID card
- Present the Louisiana Healthcare Connections ID card when using healthcare services
- Be familiar with Louisiana Healthcare Connections procedures to the best of the member's abilities
- To call or contact Louisiana Healthcare Connections 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.

Provider Rights and Responsibilities

PROVIDER RIGHTS

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

- Be treated by their patients 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
- Expect members to follow their directions
- 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 RESPONSIBILITIES

Louisiana Healthcare Connections is required to ensure that network behavioral health providers fulfill their responsibilities, including but not limited to the following:

- 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 patient safety at all times including members with special needs and chronic conditions.
- Communicating with other levels of medical care to coordinate and follow up the care of individual patients.
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid.
- Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care.
- Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33 in the RFP (continuity of care for individuals with special health care needs).
- Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes
- Providing 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.
- Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at a Louisiana Healthcare Connections participating hospital.

- Working with Louisiana Healthcare Connections case managers to develop plans of care for members receiving case management services.
- Participating in Louisiana Healthcare Connections' case management team, as applicable and medically necessary.
- Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs) and substance use to determine whether the member needs behavioral health services.
- 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 of any updates necessary to the physician directory such as new address, new phone number, or change in group practice affiliation.
- 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 record (PHR).
- Working with our case managers to develop plans of care for members receiving case management services.
- Participating with our case management team as applicable and medically appropriate.
- Conducting screens for common behavioral issues including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs) and substance use to determine whether the member needs behavioral health services.

RIGHT TO DISMISS MEMBER FROM PANEL

A provider may request a member's disenrollment from his/her panel and the reassignment of that member to a new provider. 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 provider'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 provider to furnish services to the member or others

- Transfer requests shall not be based on race, color, national origin, disability, age or gender.

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

Procedure

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. These concerns will be recorded in CRM.
- The provider 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.
- Louisiana Healthcare Connections will first attempt to call the member three times before placing the member with a new provider.
- The member's new provider will be selected based upon the following criteria:
 - Louisiana Healthcare Connections will attempt to contact the member and place the member with a desired provider.
 - If the member was previously a plan member, assignment shall be made to the previous provider.
 - If a family member has a historical provider relationship with a provider, assignment shall be made to the same provider, provided that the provider 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 has claims history on file with Louisiana Healthcare Connections, move to ii. However, 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. Also, U.S.M.M. will be given the member's information for outreach and education.
 - 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 provider, 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 provider through the automated process.
- Members will receive a Member ID card including their new provider 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 provider 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 provider change selection within the plan at any time.

Behavioral Health Coverage and Benefits

COVERAGE GROUPS

Within Louisiana Medicaid, there are four broad coverage groups, depending upon which of the above populations a member falls into and whether (if permitted), they decide to voluntarily opt-in for full coverage. The categories of coverage are as follows:

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, Medicare Dual Eligibles 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 non-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)

Members who are eligible for CSOC services will receive physical health, primary behavioral health and pharmacy coverage from Louisiana Healthcare Connections. Their specialized behavioral health services will be covered by Magellan. They will also receive specialized CSOC services, including:

- Parent support and training
- Youth support and training
- Independent living/skills building

- Short term respite care
- Crisis stabilization

COVERAGE AND BENEFITS OVERVIEW

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

- Psychiatrist (for members of all ages)
- Licensed Mental Health Professionals (LMHP)
 - Medical Psychologists
 - Licensed Psychologists
 - Licensed Clinical Social Workers (LCSW)
 - Licensed Professional Counselors (LPC)
 - Licensed Marriage and Family therapists (LMFT)
 - Licensed Addiction Counselors (LAC)
 - Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & mental Health, Family Psychiatric & Mental health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric & Mental Health, Child Adolescent Mental Health)
- 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
 - Homebuilders birth to 18 years
 - Assertive Community Treatment (limited to 18 years and older)
 - Psychosocial Rehabilitation (PSR)
 - Crisis Intervention
 - Therapeutic Group Homes (under age 21): Therapeutic Group Homes have a non-Medicaid funded room and board component that must be addressed prior to placement.
 - Crisis stabilization (under age 21)
- Psychiatric Residential Treatment Facilities (under age 21)
- Inpatient hospitalization (age 21 and under; 65 and older) for Behavioral Health Services
- Outpatient and Residential Substance Use Services in accordance with the American Society of Addiction Medicine (ASAM) levels of care
- Screening for services, including the Coordinated System of Care (CSoC), may take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care. We will also ensure (using care management protocols and/or proactive discharge planning by providers) that screening takes place while a youth resides in an out-of-home level of care (such as inpatient, PRTF or TGH) and is prepared for discharge to a home and community-based setting. For settings such as PRTF and TGH with lengths of stay allowing sufficient time for comprehensive and deliberate discharge and aftercare planning, we will ensure that screening for CSoC takes place at least 30 days and up to 90 days prior to the anticipated discharge date. If CSoC screening shows appropriateness, referral to CSoC up to 90 days prior to discharge from a residential setting shall occur, as it is expected to assist in comprehensive discharge and treatment

planning, prevent disruption, and improve stabilization upon reentry to a home and community environment.

- Pending CMS approval for the coverage of Methadone to treat opiate addiction, we shall contract with the Opioid Treatment Programs (OTP) for the administration of Methadone and clinical treatment services for members in accordance with state and federal regulations. These services may also be provided via an in lieu of service for other members at our discretion.
- Pending CMS approval of the 1115 SUD Demonstration waiver and associated State Plan Amendments for the implementation plan, coverage may include, but is not limited to adoption of additional services in the following categories:
 - Outpatient;
 - Intensive outpatient services;
 - Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state);
 - Intensive levels of care in residential and inpatient settings; and
 - Medically supervised withdrawal management.

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 removed from their home, 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 your family to develop one plan to help you provide for your 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 emotional challenges, as well as youth with personal experience living with behavior challenges. 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 go to live somewhere else because of behavior problems
- Child has tried to hurt himself or someone else
- Child is getting suspended and/or expelled from school
- Child is getting into trouble with the police

If you think CSoC might be right for one of your patients, or you want more information, call the CSoC office toll-free at 1-800-424-4399.

NON-EMERGENT MEDICAL TRANSPORTATION

Members 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 member, call us at **1-855-369-3723** (Hearing loss: 1-866-288-3133) with this information:

- Member Name
- Member ID number from their Louisiana Healthcare Connections 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.

The member should be ready to leave one hour before the scheduled appointment. The driver will pick them up sometime during the hour before the appointment.

Non-emergency transportation over 50 miles (one-way) requires prior authorization.

If your medical appointment is cancelled and you have scheduled a ride with us, please call **1-855-369-3723** as soon as possible to cancel your transportation.

“Where’s My Ride?” If the ride is late or you have questions, comments or concerns, you may call the *Where’s My Ride?* line at 1-855-369-3724.

If you are having difficulty scheduling a ride, please contact Member Services at 1-844-677-7553 (Hearing loss: 1-800-846-5277) and we will be happy to assist you.

***For members residing in nursing facilities:** non-emergency medical transportation for members residing in nursing facilities 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 us to request authorization and schedule the transportation:

Phone: 1-866-595-8133 | Fax: 1-888-590-4183

Call if it is urgent.

Please call at least 48 hour ahead of time. If a patient requires **emergency** transportation, call 911.

Clinical Training

Clinical Development and Training Teams will provide training for network providers, stakeholders, and caregivers 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, caregivers 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)
- Screening Brief Intervention and Referral to Treatment (certified trainers)
- CPI Dementia Training (certified trainers)
- Alzheimer's Training (certified to offer train-the-trainer courses)
- PCP Toolkits
- Behavioral health/physical health screening & referral
- Recovery Principles
- Integrated Healthcare
- Trauma Informed Care
- Diagnosis-specific Overviews
- Substance Abuse Overview
- Stages of Change
- SMART Goals
- Behavioral Management & De-escalation
- Behavioral Management in the Long Term Care Population
- HIPAA and Privacy Laws
- Cultural Competency
- Poverty Competency
- Person Centered Approach
- Evidence Based Practices (including but not limited to)
- Trauma Focused Cognitive Behavioral Therapy
- Recovery Model
- Strengths Based Model
- Positive Psychology
- Peer Support
- When to refer to Primary Care
- Referral for Care Management
- Behavioral Health 101
- Physical Health 101
- Psychiatric Medications
- Medical Necessity Criteria

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, Impact Model, 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 clinicaltraining@cenpatico.com to request any of the above training topics or request a new topic.

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 psychiatric program available to all Medicaid eligible children with significant functional impairments resulting from an identified mental health or substance use disorder diagnosis. 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.

SERVICE COMPONENTS

- Prior to being referred to CS a preliminary assessment of risk, including crisis resolution and debriefing, mental status and medical stability and the need for further evaluation or other mental health services must be conducted.
- Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis is included.
- Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- The assessment includes contact with the client, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.
- The child or adolescent must require a service that includes direct monitoring by professional behavioral health staff that would not be able to be provided by a less restrictive service.
- Follow-up with the individual and, as necessary, with the individuals' caretaker and/or family members.
- Transportation is provided between the child's/youth's place of residence and other services sites and places in the community, and the cost of transportation is included in the rate paid to providers of these services.

SERVICE EXCLUSIONS

The following services shall be excluded from Medicaid coverage and reimbursement:

- Components that are not provided to or directed exclusively toward the treatment of the Medicaid eligible individual.
- Services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient's needs.
- Any services or components in which the basic nature of which are to supplant housekeeping, homemaking or basic services for the convenience of an individual receiving services.
- Services rendered in an institute for mental disease.
- Crisis stabilization shall not be provided simultaneously with short-term respite care and shall not duplicate any other Medicaid State Plan service or service otherwise available to the recipient at no cost.
- Medicaid is not claimed for the cost of room and board. The minimum daily rate on file is an all-inclusive rate.

PROVIDER TYPES

Respite Care Services Agency: Licensed as a Home and Community Based Services (HCBS) provider/In-Home Respite Agency per Revised Statute 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 48:I Chapter 50 found at the following website:

<http://www.doa.la.gov/Pages/osr/lac/Code.aspx>

Center-Based Respite: Licensed as an HCBS provider/Center-Based Respite per Revised Statute 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 48:I Chapter 50 found at the following website: <http://www.doa.la.gov/Pages/osr/lac/Code.aspx>

Child Placing Agency (Therapeutic Foster Care): Licensed as a Child Placing Agency by the Department of Child and Family Services (DCFS) (R.S. 46:1401-142).

http://www.dcfslouisiana.gov/assets/docs/searchable/Licensing/Residential/201603_ChildPlacing.pdf

Crisis Receiving Center: Licensed per Revised Statute 40:2180.12 et seq. and Louisiana Administrative Code (LAC) 48:I Chapters 53 and 54 found at the following website:

<http://www.doa.la.gov/Pages/osr/lac/Code.aspx>

PROVIDER QUALIFICATIONS

- Providers of this service must operate within their scope of practice license required for the facility or agency to practice in the state of Louisiana.
- Services must be provided by an agency licensed by the LDH or Department of Children and Family Services (DCFS).
- Providers must maintain medical records that include a copy of the plan of care or treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan.
- Staff providing CS services must use clinical programming and a training curriculum approved by LDH prior to delivering services.

Comprehensive Diagnostic Evaluation

Louisiana Healthcare Connections will ensure that Qualified Health Care Professionals (QHCP) perform the Comprehensive Diagnostic Evaluation (CDE) within 30 days of request and pay clean claims for all medically necessary testing services. The qualifications for CDE providers and CDEs include the following:

The recipient must have documentation indicating medical necessity for the services through a completed CDE which has been performed by a QHCP.

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; and
- Recommendations for any additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or any additional recommended standardized measures, labs, or other diagnostic evaluations considered clinically appropriate and/or medically necessary.

When the results of the screening are borderline, or if there is any lack of clarity about the primary

diagnosis, comorbid conditions, or the medical necessity of services requested, the following categories of assessment 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; and
- Assessment of adaptive behavior.

Integrated Care

Our approach to Integrated Behavioral Health focuses on the comprehensive care management of youth and adult behavioral health concerns typically treated by PCPs, or in the member's primary care setting. The Integrated Behavioral Health approach utilizes a holistic approach, focusing on *the whole person*, and includes integrating needed covered, carved out, and community-based services in its approach to care.

We use a multi-disciplinary Integrated Care Team to offer and coordinate integrated care. Our staff coordinates care with all necessary members of the designated care team, including the member's primary and specialty providers, other care team members, 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 (ACEs). We work to increase the percentage of children with positive screens who 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.

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, because it more effectively engages members and allows staff to provide information that can address member questions 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 Behavioral Health interventions and information meet each member's unique circumstance, and will vary from one member to another, including those with the same diagnosis.

COMMUNICATION WITH PRIMARY CARE PHYSICIAN

Louisiana Healthcare Connections requires PCPs to consult with their member's behavioral health providers. 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 who 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.

We provide a form for your convenience in communicating with PCPs and other providers (available at www.LaHealth.CC/ProviderResources) and recommend that you use all available means to coordinate treatment for members in your care. 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.

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 several types:

- Continuity of information, which ensures that information on prior events is used to give care that is appropriate to the patient's 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.

OUTPATIENT NOTIFICATION PROCESS

Providers must adhere to the Covered Services & Authorization Guidelines (CSAG) located on the website at www.LaHealth.CC/ProviderResources when rendering services. We do not retroactively authorize treatment.

OUTPATIENT TREATMENT REQUEST (OTR)

Requesting Additional Sessions

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.LaHealth.CC/ProviderResources 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.

IMPORTANT:

- 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.

Our utilization management decisions are based on Medical Necessity and established clinical practice guidelines. We do not reimburse for unauthorized services and each agreement with us precludes providers from balance billing, or billing a member directly, for covered services with the exception of copayment and/or deductible collection, if applicable. Our authorization of covered

services is an indication of medical necessity, not a confirmation of member eligibility and not a guarantee of payment.

GUIDELINES FOR 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.LaHealth.CC/ProviderResources.
- Testing requested by the court or state agencies for the purpose of placement is not considered medically necessary and may not be reimbursed.

OUR UTILIZATION MANAGEMENT PROGRAM

The Utilization Management (UM) team is comprised of qualified behavioral health professionals whose education, training and experience are commensurate with the UM reviews they conduct. 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 (ACEs).

We work 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

The UM Program strives to ensure that:

- Member's care meets our Medical Necessity Criteria;
- Treatment is specific to the member's condition, is effective and is provided at the least restrictive, most clinically appropriate level of care;
- Services provided comply with our QI requirements, and UM policies and procedures are systematically and consistently applied; and
- Focus for members and their families' centers on promoting resiliency and hope.

The purpose of our UM Program's procedures and clinical practice guidelines is to ensure treatment is specific to the member's condition, effective and provided at the least restrictive, most clinically appropriate level of care. In order to meet our objectives, providers must participate and adhere to our programs and guidelines.

Our utilization review decisions are made in accordance with currently accepted behavioral

healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Our medical necessity criteria are used for the approval of medical necessity; plans of care that do not meet medical necessity guidelines are referred to a licensed physician advisor or psychologist for review and peer to peer discussion.

We conduct UM in a timely manner to minimize any disruption in the provision of behavioral healthcare services. The timeliness of decisions adheres to specific and standardized time frames yet remains sufficiently flexible to accommodate urgent situations. UM files includes the date of receipt of information and the date and time of notification and resolution.

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 UM Department's decision making process is based on appropriateness of care and service and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials of coverage or services. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

MEDICAL NECESSITY

Member 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 behavioral health practitioners providing treatment for the Member. Network providers are expected to work closely with our UM Department in exercising judicious use of a member's benefit and to carefully explain the treatment plan to the member in accordance with the member's benefits offered by Louisiana Healthcare Connections.

We use InterQual Criteria for mental health for both adult and pediatric guidelines and the American Society of Addiction Medicine Patient Placement Criteria (ASAM) for substance abuse MNC. InterQual is a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes the appropriate use of services and improved health outcomes. Criteria for community-based services were adopted from the Louisiana Services Definition Manual. Rehabilitation services that were formerly a part of the 1915(i) will now be approved based on Level of Care Utilization System (LOCUS) medical necessity criteria.

ASAM and the McKesson InterQual criteria sets are proprietary and cannot be distributed in full, however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. We are committed to the delivery of appropriate service and coverage, and offer no organizational incentives, including compensation, to any employed or contracted UM staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and UM staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director. The OTR form can be located on our website at www.LaHealth.CC/ProviderResources.

INPATIENT NOTIFICATION PROCESS

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 consumer 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.

For a listing of providers participating in our Louisiana network, please refer to our online Provider Directory at www.LaHealth.CC/FindADoc. You can also contact your network representative by calling 1-866-595-8133.

OUTPATIENT NOTIFICATION PROCESS

Network providers need to adhere to the Covered Services & Authorization Guidelines located at www.LaHealth.CC/ProviderResources when rendering services. Please refer to the Covered Services & Authorization Guidelines to identify which services require authorization. When authorizations are required, network providers must contact us to obtain authorized sessions for continued services. We do not retroactively authorize treatment.

For prior authorizations during normal business hours, network providers should call or contact us at: 1-866-595-8133.

OTR/REQUESTING ADDITIONAL SESSIONS

When requesting sessions for those outpatient services that require authorization, the network practitioner must complete an OTR form and fax the completed form to us at 1-844 466-1277 or submit electronically for clinical review. Network practitioners may call the Customer Service Department at 1-866-595-8133 to check status of an OTR. Network practitioners should allow up to two (2) business days to process non-urgent requests. OTR forms for services requiring

authorization are located at www.LaHealth.CC/ProviderResources.

IMPORTANT:

- The OTR must be completed in its entirety. The diagnoses as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delay 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.

Our UM decisions are based on medical necessity and established clinical practice guidelines. We do not reimburse for unauthorized services, and each provider agreement with us precludes network providers from balance billing, or billing a member directly, for covered services with the exception of copayment and/or deductible collection, if applicable. Our authorization of covered services is an indication of medical necessity, not a confirmation of member eligibility and not a guarantee of payment.

RETRO AUTHORIZATION

By standard practice, we **do not** provide retro authorization; however, there are certain unique circumstances in which there may be an exception. Retro authorizations will only be granted in rare cases such as eligibility issues. All requests for retro 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 retro authorizations may result in termination from the provider network due to inability to follow policies and procedures. You should submit your retro authorizations to 1-844-466-1277.

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.

APPEAL PROCESS

A member, or provider acting on the member's behalf with written consent, may appeal an action. An appeal must be filed 90 calendar days from the action. To file an appeal, referring to the appeals process as described in your denial letter is the appropriate means of resolution.

CONTINUITY OF CARE

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.

CARE MANAGEMENT (CM)

The Care Management (CM) Department provides a unique function. The essential function of the department is to increase community tenure, reduce recidivism, improve treatment compliance and facilitate positive treatment outcomes through the proactive identification of members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desirable outcomes. Care Managers are licensed behavioral health professionals with at least 3 years' experience in the mental health field.

Our Intensive 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; and
- For members not hospitalized but in need of assistance with overcoming barriers to obtaining behavioral health services or compliance with treatment, we offer Care Coordination.
- Per 1915 (c), 1915 (b3), CSoC will all be coordinated within the Integrated Behavioral Health team with dedicated liaisons and resources.

Our Care Coordinators are not licensed clinical staff and cannot make clinical decisions about what level of care is needed or assess members who are in crisis. 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.

Quality

We are dedicated to providing quality services and programs to improve the lives of our members. Our state contract requires us to put in place measures to ensure that members are receiving the highest level of care.

The Quality Improvement (QI) program utilizes the principles of Continuous Performance Improvement (CPI). This approach allows us to implement focused, rapid improvement interventions that are data driven and member focused. Our QI Program is highly integrated with clinical services; access issues pertaining to providers and services; credentialing; utilization; member satisfaction; provider satisfaction; PCP communications; and administrative office operations as well as Louisiana Healthcare Connections QI Program. Each key task and core process is monitored for identification and resolution of problems and opportunities for improvement and intervention.

We embrace a culture of quality across the organization. The systematic approach to the use of industry standard quality metrics allows for creative, targeted initiatives designed to continually drive performance and improve member outcomes. We are committed to providing quality care and clinically appropriate services for our members. In order to meet our objectives, providers must participate and adhere to our programs and guidelines.

Our website, www.LouisianaHealthConnect.com, contains a wealth of information about our Quality Program. This includes descriptions of our clinical and service quality initiatives and an evaluation of our performance.

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
- Critical Incidents
- Member safety
- Member confidentiality
- High-risk member identification, management and tracking
- Discharge appointment timeliness and reporting
- Grievance procedures
- Potential over- and under-utilization
- Provider satisfaction
- Member satisfaction
- Completion of Functional Assessment

HOW WE MONITOR QUALITY

We conduct surveys and conducts initiatives that monitor quality. These activities may include any of the following:

- Provider satisfaction surveys
- Medical treatment record reviews
- Grievance investigation and trending
- Review of potential over- and under-utilization
- Member Satisfaction Surveys
- Outcome tracking of treatment evaluations
- Access to care reviews
- Appointment availability
- Discharge follow-up after inpatient or partial hospitalization reporting
- Crisis response
- Monitoring appropriate care and service
- Provider quality profiling
- Outcome of functional assessments

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 MONITORING PLAN AND REPORTING

Additionally, we monitor specialized behavioral health providers and facilities across all levels of care. Our quality monitoring includes (but is not limited to):

- Member interviews and onsite reviews
- Random sampling that will result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The sample shall be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient /residential. Additional levels of care may be added at the discretion of LDH.
- Inter-rater reliability testing methods.
- Adherence to clinical practice guidelines;
- Member rights and confidentiality, including advance directives and informed consent;
- Cultural competency;
- Patient safety;
- Compliance with adverse incident reporting requirements;
- Appropriate use of restraints and seclusion, if applicable;
- Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment plan is individualized and appropriate for the enrollee and includes goals, Specific,

Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective; individualized crisis plan; members'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the member changes; the treatment plan includes the involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member; and

- Continuity and coordination of care, including adequate discharge planning
- Adoption of clinical practice guidelines and measure compliance with the guidelines
- Corrective actions based on the degree of non-compliance with review criteria elements on both an individual and systemic basis
- Appropriate corrective action is taken when a provider furnishes inappropriate or substandard services, when a provider does not furnish a service that should have been furnished, or when a provider is out of compliance with federal and state regulations.
- Outcome Assessment for Specialized Behavioral Health Services
- Treatment progress and effectiveness for both children and adults using standardized clinical outcome tools and measures, according to the guidelines specified by LDH.
- Adequate training and/or certification in the use of such tools and such training/certification is current.

PROVIDER PARTICIPATION IN THE QI PROCESS

Providers are expected to monitor and evaluate their own compliance with performance requirements to assure the quality of care and service provided.

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

We have adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services. Clinical practice guidelines adopted for adults include but are not limited to treatment of:

- Major Depressive Disorder
- Bipolar Disorder
- Substance Use Disorders

- Schizophrenia
- Post-Traumatic Stress Disorder (PTSD)
- Panic Disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Psychotropic Medication

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

Clinical practice guidelines may be accessed through our website, or you may request a paper copy of the guidelines by contacting your Network Manager. Copies of our evidence-based practices can be obtained in the same manner.

VALUE ADDED SERVICE: MYSTRENGTH®

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.

FEDERAL AND STATE LAWS GOVERNING THE RELEASE OF 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, alcohol /substance abuse 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 Cenpatico Privacy Officer at 1-512-406-7200 or in writing (refer to the address below) with any questions about our privacy practices.

Cenpatico Compliance Department
12515-8 Research Blvd., Suite 400
Austin, TX 78759

Medical Records

We require treatment records to be maintained in a manner that is current, detailed and organized and which permits effective and confidential patient 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), F.S.

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 patient 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 patient 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 DSM-IV diagnosis is documented, 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 patient 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 § 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.

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 quantities, 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.

Waste, Abuse and Fraud

We are committed to the ongoing detection, investigation, and prosecution of waste, abuse and fraud (WAF).

- Waste – Use of healthcare benefits or dollars without a real need. For example, prescribing a medication for thirty (30) days with a refill when it is not known if the medication will be needed.
- Abuse – Practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the health plan program, including, but not limited to, services that are not medically necessary, or that fail to meet professionally recognized standards for healthcare. It also includes enrollee practices that result in unnecessary cost to the health plan program.
- Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the health plan program to himself, the corporation or some other person. It also includes any act that constitutes fraud under applicable federal or state healthcare fraud laws. Examples of provider fraud include: lack of referrals by PCPs to specialists; improper coding; billing for services never rendered; inflating bills for services and/or goods provided; and providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of enrollee fraud include improperly obtaining prescriptions for controlled substances and card sharing.

In conjunction with its management company, our corporation operates a WAF unit. If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664. We take reports of potential WAF seriously and investigate all reported issues.

ABUSE AND NEGLECT REPORTING

Providers are required to report all incidents that may include abuse and neglect consistent with the department of Human Services ACT, the Adults with Disabilities Domestic Abuse Intervention Act, the Abused and Neglect Child Reporting Act and requirements of Star law. To report incidents involving children, call 1-888-4LA-KIDS (1-855-452-5537) toll free 24 hours per day, 365 days per year. Reports regarding elderly members who are over the age of 60 will be reported to the state Governor's Office of Elderly Affairs by calling 1-800-898-4910. We will offer training to providers about the signs of abuse or neglect.

MEMBER CONCERNS ABOUT PROVIDERS

Members who have concerns about our providers are encouraged to contact us to register their concerns. All concerns are investigated, and feedback is provided on a timely basis. It is the provider's responsibility to provide supporting documentation to us if requested. Any validated concern will be taken into consideration when re-credentialing occurs and can be cause for termination from our provider network.

MONITORING SATISFACTION

We conduct periodic satisfaction surveys of our members and providers. These surveys enable us to gather useful information to identify areas for improvement. Providers may be requested to participate in the annual survey process. The survey includes a variety of questions designed to address multiple facets of the providers experience with our delivery system should call the Provider Relations department to address concerns as they arise. Feedback from providers enables us to continuously improve systems, policies and procedures.

CRITICAL INCIDENT REPORTING

A critical 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.

Providers will follow the LDH/OBH process and requirements for submission of all critical incidents. Upon receipt and notification of critical incident review requests, we may require providers to participate in the quality review process.

Appendices

Appendix I: 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)
- **Patient 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

Appendix II: 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
- **DRG code** is missing or invalid
- **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 patient 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

Appendix III: Common Explanation of Payment, Denial Codes and Descriptions

EX CODE	DESCRIPTION	PAY/ DENY
18	DENY: DUPLICATE CLAIM SERVICE	DENY
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED	DENY
35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED	DENY
46	DENY: THIS SERVICE IS NOT COVERED	DENY
92	PAID ACCORDING TO CONTRACT/STATE PROCESSING GUIDELINES	PAY
A1	DENY: AUTHORIZATION NOT ON FILE	DENY
DD	DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED	DENY
L6	DENY: BILL PRIMARY INSURER 1ST—RESUBMIT WITH EOB	DENY
MG	DENY: SIGNATURE MISSING FROM BOX 31—RESUBMIT	DENY
MQ	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NO MATCH—RESUBMIT	DENY
MX	PAY: MAXIMUM ALLOWABLE HAS BEEN PAID BY PRIME INSURERE	PAY
NT	DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE—DO NOT BILL PATIENT	DENY
VI	PAY: REIMBURSEMENT INCLUDED IN GLOBAL FEE	PAY
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE	DENY
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED	DENY
xa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE	DENY

Appendix IV: 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.

Appendix V: HIPAA Compliant EDI Rejection 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	41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
2	Invalid Mbr	42	Invalid Mbr; Invalid Prv; Invalid Proc
6	Invalid Prv	43	Mbr not valid at DOS; Invalid Proc
7	Invalid Mbr DOB & Prv	44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
8	Invalid Mbr & Prv	46	Prv not valid at DOS; Invalid Proc
9	Mbr not valid at DOS	48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
10	Invalid Mbr DOB; Mbr not valid at DOS	49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
12	Prv not valid at DOS	51	Invalid Diag; Invalid Proc
13	Invalid Mbr DOB; Prv not valid at DOS	52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
14	Invalid Mbr; Prv not valid at DOS	53	Invalid Mbr; Invalid Diag; Invalid Proc
15	Mbr not valid at DOS; Invalid Prv	55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv	57	Invalid Prv; Invalid Diag; Invalid Proc
17	Invalid Diag	58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
18	Invalid Mbr DOB; Invalid Diag	59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
19	Invalid Mbr; Invalid Diag	60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
21	Mbr not valid at DOS; Prv not valid at DOS	61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS	63	Prv not valid at DOS; Invalid Diag; Invalid Proc
23	Invalid Prv; Invalid Diag	64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag	65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
25	Invalid Mbr; Invalid Prv; Invalid Diag	66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
26	Mbr not valid at DOS; Invalid Diag	67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag	72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
29	Prv not valid at DOS; Invalid Diag	73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag	74	Services performed prior to Contract Effective Date
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag	75	Invalid units of service
32	Mbr not valid at DOS; Prv not valid; Invalid Diag	76	Original Claim Number Required
33	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag	81	Invalid units of service, Invalid Prv
34	Invalid Proc	83	Invalid units of service, Invalid Prv, Invalid Mbr
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		

Appendix VI: 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

Appendix VII: FQHC/RHC

Services, including dental services included, 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
- **99050/99051**—Adjunct services are reported in addition to an encounter when these services are rendered during evenings, weekends, or holidays hours.

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	EM G	PROCEDURES, SERVICES OR SUPPLIES	DIAGNOSIS POINTER	CHARGES	DAY S/ UNIT	EPS DT	ID QUA L/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 should include the code T1015 with correct place of service code (50 or 72) with the encounter rate.

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.

Appendix VIII: 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.

CMS 1500 Claim Form (HCFA)

CMS 1500 Claim Form

1. MEDICARE <input type="checkbox"/> (Medicare #)		1. MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE CHAMPUS (Spouse's SSN) <input type="checkbox"/>		CHAMPVA (Member ID#) <input type="checkbox"/>		GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>		FECA BENEFIT (SSN) <input type="checkbox"/>		OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER <input type="checkbox"/> (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE (MM/DD/YY)			SEX (M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)					
CITY				STATE		8. PATIENT STATUS (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY				STATE			
ZIP CODE				TELEPHONE (Include Area Code)				Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE				TELEPHONE (Include Area Code)	

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Enter "X" in the box noted Medicaid (Medicaid #).	R
1a	INSURED I.D. NUMBER	The 13-digit Medicaid identification number on the member's Louisiana Healthcare Connections ID card.	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Louisiana Healthcare Connections ID card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE / SEX	Enter the patient's 8-digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M = Male F = Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's Louisiana Healthcare Connections ID card.	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line -In the designated block, enter the city and state. Third line -Enter the zip code and phone number. When entering a 9- digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). NOTE: Patient's Telephone does not exist in the electronic 837 Professional 4010A1	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line -In the designated block, enter the city and state. Third line -Enter the zip code and phone number. When entering a 9- digit zip code (zip+4 code),	NOT REQUIRED

include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).
NOTE: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.

8 PATIENT STATUS

NOT
REQUIRED

CMS 1500 Claim Form (HCFA) – continued

<p>9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9</p>		<p>10 IS PATIENT'S CONDITION RELATED TO: 10</p>		<p>11 INSURED'S POLICY GROUP OR FECA NUMBER 11</p>		<p>PATIENT AND INSURED INFO</p>
<p>a. OTHER INSURED'S POLICY OR GROUP NUMBER 9a</p>		<p>a. EMPLOYMENT? (Current or Previous) 10a</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>a. INSURED'S DATE OF BIRTH 11a</p> <p>MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/></p>		
<p>b. OTHER INSURED'S DATE OF BIRTH 9b</p> <p>MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/></p>		<p>b. AUTO-ACCIDENT? 10b</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____</p>		<p>b. EMPLOYER'S NAME OR SCHOOL NAME 11b</p>		
<p>c. EMPLOYER'S NAME OR SCHOOL NAME 9c</p>		<p>c. OTHER ACCIDENT? 10c</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>c. INSURANCE PLAN NAME OR PROGRAM NAME 11c</p>		
<p>d. INSURANCE PLAN NAME OR PROGRAM NAME 9d</p>		<p>10d. RESERVED FOR LOCAL USE</p>		<p>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 11d</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i></p>		
<p>12 READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM</p>				<p>13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits of the undersigned physician or supplier for services described below.</p>		
<p>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.</p>				<p>SIGNED _____ DATE _____</p>		
<p>SIGNED _____ DATE _____</p>				<p>SIGNED _____</p>		

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	OTHER INSURED'S BIRTH DATE / SEX	REQUIRED if # 9 is completed. Enter the 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate sex/gender. M = Male F = Female for the person listed in box 9.	C
9c	EMPLOYER'S NAME OR SCHOOL NAME	Enter the name of employer or school for the person listed in box 9. NOTE: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.	C
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if # 9 is completed. Enter the other insured's (name of person listed in box 9) plan or program name.	C
10a, b, c	IS PATIENT'S CONDITION RELATED TO:	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	R
10d	RESERVED FOR LOCAL USE		NOT REQUIRED
11	INSURED'S POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	INSURED'S DATE OF BIRTH / SEX	Same as field 3.	C
11b	EMPLOYER'S NAME OR SCHOOL NAME	REQUIRED if Employment is marked Yes in box 10a.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance Health Plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete # 9a-d and #11c.	R
12	PATIENT'S OR AUTHORIZED	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the	C

	PERSON'S SIGNATURE	member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	
13	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Obtain signature if appropriate.	NOT REQUIRED

CMS 1500 Claim Form (HCFA) – continued

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 14		15. OTHER DATE QUAL. MM DD YY 15		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY 16 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17		17a. 17a		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 18 TO MM DD YY	
17b. NPI 17b				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO 20	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 19				22. RESUBMISSION CODE 22 ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ 21 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				23. PRIOR AUTHORIZATION NUMBER 23	

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
14	DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM/DD/YYYY) or 8-digit (MM/DD/YYYY) date reflecting the first date of onset for the: --Present illness --Injury --LMP (last menstrual period) if pregnant	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE		NOT REQUIRED
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		NOT REQUIRED
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials).	NOT REQUIRED
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		NOT REQUIRED
19	RESERVED FOR LOCAL USE		NOT REQUIRED
20	OUTSIDE LAB / CHARGES		NOT REQUIRED
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9/ICD-10 CM Volume 1 for the date of service. Diagnosis codes submitted must be valid ICD-9/ICD-10 codes for the date of service and carried out to its highest digit - 4 TH or "5". "E" codes are NOT acceptable as a primary diagnosis. Enter the appropriate ICD indicator in the small box above the D field next to ICD Ind. Use 9 for ICD-9 and 0 for ICD-10. NOTE: Claims missing or with invalid diagnosis codes and/or ICD indicator will be denied for payment.	R
22	MEDICAID RESUBMISSION CODE/ORIGINAL REF. NO.	For re-submissions or adjustments, enter the appropriate resubmission code followed by the original claim number.	C
23	PRIOR	Enter the Louisiana Healthcare Connections authorization or referral number. Refer to the	NOT REQUIRED

AUTHORIZATION NUMBER

Louisiana Healthcare Connections Provider Manual for information on services requiring referral and/or prior authorization.

CMS 1500 Claim Form (HCFA) – continued

24 A	DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.	PHYSICIAN OR SUPPLIER INFORMATION		
MM	DD	YY	MM	DD	YY	PLACE OF SERVICE	EMG	(Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS POINTER	\$ CHARGES	DAYS OF SERVICE	UNIT	SPOT		PERCENT	RENDERING PROVIDER ID.#

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
24a-j GENERAL INFORMATION		Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-24G, 24H, 24J and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Medicaid Number qualifier. Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail.	
24a-g Shaded	SUPPLEMENTAL INFORMATION	Shaded top portion of each service claim line is used to report supplemental information for: NDC Anesthesia Start/Stop time & duration Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. HIBCC or GTIN number/code. For detailed instructions and qualifiers refer to Appendix 4 of this manual.	C
24a Un-shaded	DATE(S) OF SERVICE	Enter the date the service listed in 24D was performed (MM/DD/YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line.	R
24b Un-shaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website.	R
24c Un-shaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	NOT REQUIRED
24d Un-shaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes	R

will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim. The following National Modifiers are recognized as modifiers that will impact the pricing of your claim:

National Modifiers

24	26	50	51	52
53	54	55	62	66
76	78	79	80	81
82	99	AA	AD	FP
LL	LT	NU	OK	QS
QX	QY	QZ	RR	RT
SB	TC	UE		

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
24e Un-shaded	DIAGNOSIS CODE	Enter the numeric single digit diagnosis pointer (1,2,3,4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9/10 codes for the date of service or the claim will be rejected/denied.	R
24f Un-shaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24g Un-shaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.	R
24h Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.	C
24h Un-shaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit	C
24i Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use 1D qualifier for Medicaid ID, if an Atypical Provider	C

24j Shaded	NON-NPI PROVIDER ID#	Enter as designated below the Medicaid ID number or taxonomy code. Typical Providers: Enter the Provider taxonomy code or number that corresponds to the qualifier entered in 24i shaded. Use ZZ qualifier for taxonomy code. Atypical Providers: Enter the 6-digit Medicaid Provider ID number.	R
24k Un-shaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If provider is billing as a member of a group, rendering individual provider's 10-character NPI ID may be entered. Enter billing NPI if services are not provided by an individual (e.g. DME, Independent Lab, Home Health.)	R

CMS 1500 Claim Form (HCFA) – continued

25. FEDERAL TAX I.D. NUMBER SSN/EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <small>(For gov. claims, see back)</small>	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ()			
SIGNED	DATE	a. 32a	b. 32b	a. 33a	b. 33b

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID Number (TIN) and mark the box labeled EIN.	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	R
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments.	R
28	TOTAL CHARGES	Enter the total charges for all claim line items billed - claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Louisiana Healthcare Connections. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
30	BALANCE DUE	REQUIRED when #29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid the claim will be returned unprocessed. NOTE: Does not exist in the electronic 837P.	R
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box #'s are not acceptable here.) First line—Enter the business/facility/practice name. Second line—Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line—In the designated block, enter the city and state. Fourth line—Enter the zip code and phone number. When entering a 9- digit zip code (zip+4 code), include the hyphen.	C
32a	NPI - SERVICES RENDERED	Typical Providers ONLY : REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). Atypical Providers: Enter the 2-character qualifier 1D followed by the (no spaces).	C

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
33	BILLING PROVIDER INFO & PH #	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line—Enter the business/facility/practice name. Second line—Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line—In the designated block, enter the city and state. Fourth line—Enter the zip code and phone number. When entering a 9- digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414).	R
33a	GROUP BILLING NPI	Typical Providers ONLY : REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHER ID	Enter as designated below the taxonomy code. Typical Providers: Enter the Provider taxonomy code. Use ZZ qualifier. Atypical Providers: Enter the 6-digit Medicaid Provider ID Number	C

CMS-1450 CLAIM FORM (UB-04)

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital claims, to include hospital-based ASCs and technical services, charges for reimbursement by Louisiana Healthcare Connections. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), home health agencies, nursing home admissions, inpatient hospice services and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for corrections.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500-claim form
- Include the appropriate CPT code next to each revenue code.

EXCEPTIONS

Please refer to your provider contract with Louisiana Healthcare Connections or to the LDH Medicaid Provider Procedures Manual for Revenue Codes that do not require a CPT 4 code.

UB-04 Outpatient & Ambulatory Surgery Claim Documentation

Additional specific information may be required in order to finalize a claim and should be submitted to Louisiana Healthcare Connections upon request.

UB-04 Claim Instructions

Please also refer to the Louisiana Healthcare Connections Provider Manual for additional listing of required data elements on the UB-04 claim form.

CMS-1450 CLAIM FORM (UB-04)

UB-04 Claim Form

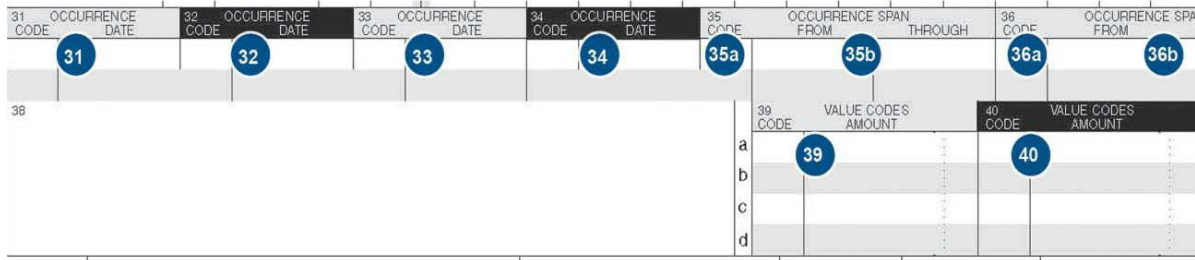
FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
1	UNLABELED FIELD	Line 1: Enter the complete provider name. Line 2: Enter the complete mailing address. Line 3: Enter the City, State, ZIP + 4 code (include hyphen). Line 4: Enter the area code and phone number	R
2	UNLABELED FIELD	Enter the Pay-To Name and Address.	NOT REQUIRED

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
3a	PATIENT CONTROL NUMBER	Enter the facility patient account/control number.	R
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate 3-digit type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" (zero) is not needed. Digits should be reflected as follows: 1 st digit—indicating type of facility 2 nd digit—indicating type of care 3 rd digit—indicating billing sequence	R
5	FEDERAL TAX I.D. NUMBER (TIN)	Enter the 9-digit number assigned by the Federal Government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MM/DD/YYYY).	R
7	UNLABELED FIELD	Not Used	NOT REQUIRED
8a-b	PATIENT NAME	8a—Enter the patient's 13-digit Medicaid ID number from their Louisiana Healthcare Connections Member ID card. 8b—Enter the patient's last name, first name and middle initial as it appears on the Louisiana Healthcare Connections Member ID card. Use a comma or space to separate the last and first names. Titles: Mr., Mrs., etc. should not be reported in this field. Prefixes: No space should be left after the prefix of a name. e.g. McKendrick. H Hyphenations: Both names should be capitalized and separated by a hyphen (no space). e.g. SMITH-JONES	R
9a-e	PATIENT ADDRESS	Enter the patient's complete mailing address. Line a: Street Address Line b: City Line c: State Line d: ZIP Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MM/DD/YYYY)	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and Date of Service for outpatient claims.	R
13	ADMISSION HOUR	Enter time using 2-digit military (00-23) for the time of inpatient admission or time of treatment for outpatient services: 00-12:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59	R

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
		05-05:00 to 05:59 17-05:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	
14	ADMISSION TYPE	Required for inpatient admissions (TOB 11X, 118X, 21X, 41X). Enter the 1-digit code indicating the priority of the admission using one of the following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	C
15	ADMISSION SOURCE	Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes: For Type of Admission 1,2,3 or 5 1 Physician Referral 2 Clinic Referral 3 Health Maintenance Referral (HMO) 4 Transfer from a hospital 5 Transfer from Skilled Nursing Facility (SNF) 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law enforcement 9 Information not available For Type of Admission 4 (newborn) 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	C
16	DISCHARGE HOUR	Enter time using 2-digit military (00-23) for the time of inpatient or outpatient discharge: 00-12:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00 to 05:59 17-05:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	C
17	PATIENT STATUS	REQUIRED for inpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 1 Routine Discharge 2 Discharged to another short-term general hospital 03 Discharged to SNF 4 Discharged to ICF	C

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
		5 Discharged to another type of institution 6 Discharged to care of home health service organization 07 Left against medical advice 8 Discharged/transferred to home under care of a Home IV provider 9 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (used when the client has been in facility for 30 consecutive days if payment based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] Hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/Transferred within this institution to a hospital-based Medicare-approved swing bed 62 Discharged/Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/Transferred to a Medicare-certified long-term care hospital (LTCH) 64 Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/Transferred to a Psychiatric hospital or Psychiatric distinct part unit of a hospital 66 Discharged/Transferred to Critical Access Hospital	
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		NOT REQUIRED
30	UNLABELED FIELD	Not used.	NOT REQUIRED

CMS-1450 Claim Form (UB - 04) - continued



FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
31-34 a-b	OCCURRENCE CODE AND OCCURRENCE DATE	Occurrence Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MM/DD/YYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE AND OCCURRENCE DATE	Occurrence Span Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual Occurrence Span Date: REQUIRED when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MM/DD/YYYY format.	C
37	UNLABELED FIELD	REQUIRED for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with "RESUBMISSION" to avoid denials for duplicate submission.	C
38	RESPONSIBLE PARTY NAMES AND ADDRESS		NOT REQUIRED
39-41 a-d	VALUE CODES	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a Value Code is entered. Enter the	C

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
		dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	

CMS-1450 Claim Form (UB - 04) – continued

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
42	43	44	45	46	47

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
42-47 GENERA LINFO	SERVICE LINE DETAIL	The following UB-04 fields 42-47: <i>--Have a total of 22 service lines for claim detail information. --Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.</i>	
42 LINE 1- 22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 LINE 22	REV CD	Enter 0001 for total charges.	R
43 LINE 1- 22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42	R
43 LINE 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted enter a "1" in both	R

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
		fields (i.e. PAGE "1" OF "1").	
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract with Louisiana Healthcare Connections or to the LDH Medicaid Provider Procedures Manual	C
45 LINE 1- 22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MM/DD/YYYY) Multiple dates of service may not be combined for outpatient claims	R
45 LINE 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted. (MM/DD/YYYY)	R
46	SERVICE UNITS	Enter the number of units, days, hours, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed. For observation stays, enter the number of hours.	R
47 LINE 1- 22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 LINE 23	TOTALS	Enter the total charges for all service lines.	R
48 LINE 1- 22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. DO NOT LIST NEGATIVE AMOUNTS.	C
48 LINE 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	UNLABELED FIELD	Not used	NOT REQUIRED

CMS-1450 Claim Form (UB - 04) – continued

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 AS/G BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
50	51	52	53	54	55	57 OTHER PRV ID
58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANC		
58	59	60	61			
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME				
63	64	65				

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
50 A-C	PAYER	Enter the name for each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary.	R
51 A-C	HEALTH PLAN IDENTIFICATION NUMBER		NOT REQUIRED
52 A-C	REL. INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y."	R
53	ASG. BEN.	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid/Louisiana Healthcare Connections is listed as secondary or tertiary	C
55	ESTIMATED AMOUNT DUE		NOT REQUIRED
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter provider's 10-character NPI ID	R
57	OTHER PROVIDER ID	Enter the TPI number (non NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		NOT REQUIRED
60	INSURED'S UNIQUE ID	REQUIRED: Enter patient's Insurance/Medicaid ID exactly as it appears on patient's ID card. Enter Insurance/Medicaid ID in the order of liability listed in field 50.	R
61	GROUP NAME		NOT REQUIRED
62	INSURANCE GROUP NUMBER		R
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	R
64	DOCUMENT CONTROL NUMBER	Enter the 12-character Document Control Number (DCN) of the paid HEALTH claim when submitting a replacement or void on the corresponding A, B, C line reflecting Louisiana Healthcare Connections from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim). <i>*Please refer to Request for Reconsideration of a Claim on page 63</i>	C
65	EMPLOYER NAME		NOT REQUIRED

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
66	DX VERSION QUALIFIER	Required: Enter the appropriate ICD indicator 9 for ICD-9 or 0 for ICD-10.	R

CMS-1450 Claim Form (UB- 04) - continued

The image shows a grid of the CMS-1450 Claim Form (UB-04) with various fields highlighted and numbered. The grid includes sections for diagnosis codes (66-67), procedure codes (74), patient reason (70), ICD-9/10 codes (71), and attending/operating physician information (75-79).

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1 & 3 for the date of service. Diagnosis code submitted must be a valid ICD-9/10 code for the date of service and carried out to its highest level of specificity- 4 th or "5" digit. "E" and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1 & 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest level of specificity - 4 th or "5" digit. "E" and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with incomplete or invalid diagnosis codes will be denied.	C
68	UNLABELED	Not used	NOT REQUIRED
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1 & 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9/10 codes for the date of service and carried out to its highest level of specificity-4 th or "5" digit. "E" codes and most "V" are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied.	R
70 a, b, c		Enter the ICD-9/10-CM code that reflects the patient's reason for visit at the time of outpatient	R

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
		<p>registration. 70a requires entry, 70b-70c are conditional. Diagnosis codes submitted must be valid ICD-9/10 codes for the date of service and carried out to its highest digit-4th or "5" digit. "E" codes and most "V" are NOT acceptable as a primary diagnosis.</p> <p>NOTE: Claims with missing or invalid diagnosis codes will be denied.</p>	
71	PPS/DRG CODE		NOT REQUIRED
72 a, b, c	EXTERNAL CAUSE CODE		NOT REQUIRED
73	UNLABELED		NOT REQUIRED
74	PRINCIPAL PROCEDURE CODE DATE	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>CODE: Enter the ICD-9/10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of C code. It is implied.</p> <p>DATE: Enter the date the principal procedure was performed (MM/DD/YYYY). REQUIRED for EDI Submissions.</p>	C
74 a-e	OTHER PROCEDURE CODE DATE	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>CODE: Enter the ICD-9 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to 5 ICD- C</p> <p>9 procedure codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied.</p> <p>DATE: Enter the date the principal procedure was performed (MM/DD/YYYY)</p>	C
75	UNLABELED		NOT REQUIRED
76	ATTENDING PHYSICIAN	<p>Enter the NPI and Name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code</p> <p>QUAL: Enter one of the following qualifiers and ID number</p> <p>OB - State License #</p> <p>1G - Provider UPIN</p> <p>G2 - Provider Commercial #</p> <p>ZZ - Taxonomy Code</p> <p>LAST: Enter the attending physician's last name</p> <p>FIRST: Enter the attending physician's first name.</p>	R
77	ATTENDING PHYSICIAN	<p>REQUIRED when a surgical procedure is performed:</p> <p>NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code</p> <p>QUAL: Enter one of the following qualifiers and ID</p>	C

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
		number 0B - State License # 1G - Provider UPIN G2 - Provider Commercial # ZZ - Taxonomy Code LAST: Enter the attending physician's last name FIRST: Enter the attending physician's first name.	
78 & 79	OTHER PHYSICIAN	Enter the Provider Type Qualifier (PTQ), NPI, and Name of the physician in charge of the patient care. (Blank Field): Enter one of the following PTQs: DN - Referring Provider ZZ - Other Operating MD 82 - Rendering Provider NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifiers and ID number 0B - State License # 1G - Provider UPIN G2 - Provider Commercial # LAST: Enter the attending physician's last name FIRST: Enter the attending physician's first name.	C
80	REMARKS		NOT REQUIRED
81	CC	A: taxonomy of billing provider. Use ZZ qualifier	C

A clean claim is a claim submitted on an approved or identified claim format (CMS or UB) containing all data fields required by Louisiana Healthcare Connections and the state for final adjudication of the claim. The required data fields must be complete and accurate. A clean claim must also include health plan published requirements for adjudication such as Medicaid number, TIN, NPI and taxonomy or medical records, as appropriate.

Appendix IX: 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.

EXAMPLE: J3490-TH (17-P injection) by adding the “TH” modifier services now indicate that this service was for 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 patient 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 patient 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 patient 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 patient and diagnoses urticaria. The physician treats the urticaria (17111- destruction of benign lesions) and bills a level 3 E/M with a modifier 25.

Appendix X: Behavioral Health Services

LDH MEDICAID INFORMATIONAL BULLETIN 16-03 (REV. SEPTEMBER 1, 2017)

Issue: Billing for Behavioral Health Services for Non-CSoC Healthy Louisiana Members

This bulletin outlines the policies, procedures, and guidance relative to behavioral health billing to either Healthy Louisiana or Molina, for dates of service on or after Dec. 1, 2015. For services rendered March 1, 2015 to Nov. 30, 2015, refer to [Informational Bulletin 15-7](#). The only exception to this guidance would be when Medicaid recipients are retroactively enrolled into a Managed Care Plan prior to Dec. 1, 2015. In these instances, behavioral health billing should be billed to the Managed Care Plan.

Effective Dec. 1, 2015 all specialized behavioral health services (mental health and substance use treatment) are now provided through five statewide full-risk managed care organizations (MCOs). The five MCOs are: Aetna Better Health, Healthy Blue (previously Amerigroup prior to Sept. 1, 2017), AmeriHealth Caritas of Louisiana, Louisiana Healthcare Connections and UnitedHealthcare Community Plan.

In almost all non-emergency instances, to bill any of the Managed Care Plans or Molina, a provider must be contracted with the appropriate MCO or Louisiana Medicaid on the date of service, or prior authorized to provide out of network services. Providers must obtain required pre-certification or prior authorization when required for the reimbursement of those specific services.

Please refer to the electronic Medicaid Eligibility Verification System (eMEVS) to identify whether the recipient has (1) physical health, specialized behavioral health services, and non-emergency medical transportation (NEMT) through a Managed Care Plan, or (2) specialized behavioral health and NEMT benefits only through a Managed Care Plan. For these recipients, all non-specialized behavioral health claims should be directed to Molina or the primary payer, such as Medicare, if Medicaid is secondary.

LDH MEDICAID INFORMATIONAL BULLETIN 16-6 (MARCH 17, 2016)

Issue: Billing/Claims Submission Process for Specialized Behavioral Health Services for Members Enrolled in One or More of the Following: Healthy Louisiana, Magellan or Fee-For-Service Medicaid

This bulletin outlines the policies and procedures relative to behavioral health billing for dates of service on or after Dec. 1, 2015 for Healthy Louisiana, Magellan and fee-for-service Medicaid members.

This bulletin provides guidance to providers who are delivering and submitting claims to a Managed Care Organization (MCO) for behavioral health services for a member who is referred to the Coordinated System of Care (CSoC). This guidance informs providers when to stop billing the MCO and when to start billing the CSoC contractor (Magellan of Louisiana).

Note: This guidance only applies to members enrolled in a Managed Care Plan who are receiving behavioral health services at the time of referral for CSoC services or begins behavioral health services with a Managed Care Plan during the CSoC assessment process.

Background:

Effective Dec. 1, 2015, Louisiana Medicaid changed the way members get behavioral health services (treatment for mental illness and substance use) and integrated behavioral and physical healthcare under the management of the Managed Care Plans. Unlike other behavioral health services, the CSoC will remain carved out of Healthy Louisiana for CSoC waiver recipients and will be managed by Magellan of Louisiana.

Provider Participation in the Child and Family Team Meetings:

The wraparound facilitator from the wraparound agency (WAA) will contact provider(s) working with the child and family and invite them to the initial and subsequent Child and Family Team (CFT) meetings. This will allow providers to work with all other team members, including at minimum, the parent/caregiver, youth, other providers and stakeholders to create one unified cohesive plan of care based on assessed needs and strengths of the youth and family.

During the CFT meeting, a plan of care (POC) will be developed to include the goals, objectives, services and names of each provider. The WAA submits the POC, which serves as the request for authorization for services, to Magellan. If a provider is not present at the CFT, the provider submits the initial authorization or reauthorization request to the WAA.

Submitting Claims During Month of CSoC Referral:

If an MCO member is receiving behavioral health services and a referral is made for CSOC services after the FIRST calendar day of the month, the provider (excluding CSoC service providers) should submit service claims to the member's Managed Care Plan until the end of the month. If the member remains in the CSoC eligibility/assessment process, or has been determined eligible, by the **first** calendar day of the following month, all behavioral health service claims should be submitted to the CSoC contractor (Magellan Providers should check the Electronic Medicaid Eligibility Verification System (eMEVS) to determine which Health Plan is responsible for the payment of claims.) Providers are encouraged to check eMEVS on every date of service to verify a member's eligibility and to identify which Health Plan is responsible for the date of service. Although DHH does not routinely change a member's linkage during the middle of a month, there are retroactive corrections that can occur that may impact claims and responsibility.

Submitting Claims During Months of CSoC Enrollment:

For any month that a recipient is enrolled in CSoC on the **first** calendar day of the month, the CSoC Contractor shall be responsible for paying providers for specialized behavioral health services rendered during the entire month. As stated above, provider should check eMEVS to determine which Managed Care Plan or if Magellan is responsible for the payment of claims.

Submitting Claims During Month of Discharge:

During the month that a member is discharged from CSoC, all specialized behavioral health service providers will submit claims to Magellan through the end of that month. The Managed Care Plan will assume responsibility for payment of all specialized behavioral health services on the **first** calendar day of the following month.

Exclusions:

Payment to providers for the provision of one of the five CSoC waiver services (i.e., Parent Support and Training, Youth Support and Training, Independent Living/Skills Building, Crisis Stabilization or Respite Care) shall be the responsibility of Magellan for any date of service upon which a child/youth is enrolled in CSoC. The child/youth's Managed Care Plan will not be responsible for payment to providers for the provision of waiver services to CSoC enrolled recipients.

Payment to providers for the provision of residential treatment, including Psychiatric Residential Treatment Facilities (PRTF), Therapeutic Group Homes (TGH) and Substance Use Residential treatment shall not be the responsibility of Magellan for any date of service. The child/youth's Managed Care Plan will retain responsibility for the payment of providers for the provision of these services to CSoC enrolled recipients.

Payment to providers for the provision of Inpatient Psychiatric Treatment will be determined based upon which Plan was responsible (per the above guidance) as of the recipient's admission date. The Plan will maintain responsibility for payment throughout the period that was prior authorized, or through the date of discharge, whichever occurs first.

Members enrolled with Magellan will continue to receive their physical health services from their Managed Care Plan or fee for service Medicaid.

PROFESSIONAL CLAIMS

Louisiana Medicaid MCOs

Professional claims for providers who are **NOT** Licensed Mental Health Professionals (LMHPs) should be submitted to the member's Louisiana Medicaid MCO or Molina for recipients not enrolled in a Louisiana Medicaid MCO.

Magellan SMO

Professional claims for LMHPs should be submitted to Magellan. LMHPs include the following providers:

- Psychiatrists
- Doctor of Osteopathy (DO) (psychiatric specialty only)
- Medical or Licensed Psychologist
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselors (LPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Addiction Counselors (LAC)
- Nurse Practitioner and Nurse Practitioner Group (psychiatric specialty only)
- Clinical Nurse Specialist (psychiatric specialty only)
- Physician Assistant (psychiatric specialty only)

FACILITY CLAIMS

Louisiana Medicaid MCOs

Facility claims, inclusive of all ancillary charges, for general hospitals should be billed to the member's Louisiana Medicaid MCO, regardless of rendering provider or Molina for recipients not enrolled in a Louisiana Medicaid MCO.

Magellan SMO

Facility claims, inclusive of all ancillary charges, for freestanding mental health hospitals and distinct part psychiatric units (DPPU) should be billed to Magellan regardless of rendering provider. This distinction makes it imperative that DPPU claims are not billed using the coding for the associated general hospital.

The DPPU unique coding MUST be submitted on the claim.

LAB AND RADIOLOGY CLAIMS

Louisiana Medicaid MCOs

All lab and radiology services provided in a general hospital (inpatient or outpatient) or in a free standing lab should be submitted to the member's Louisiana Medicaid MCO or Molina for recipients not enrolled in a Louisiana Medicaid MCO.

Magellan SMO

Claims that include lab and radiology services should be submitted to Magellan ONLY when billed as part of an inpatient psychiatric hospital stay (freestanding or DPPU).

FQHC AND RHC CLAIMS

Note: Currently FQHCs and RHCs are paid an established daily encounter rate for services that include all services except dental. An individual encounter may include both specialized behavioral health services and physical health services.

Louisiana Medicaid MCOs

FQHC and RHC providers should submit any claim WITHOUT an LMHP listed as the rendering

provider on the claim to the member's Louisiana Medicaid MCO or Molina for recipients not enrolled in a Louisiana Medicaid MCO.

Magellan SMO

FQHC and RHC providers should submit claims to Magellan ONLY if a behavioral health service was provided during the encounter AND an LMHP is indicated as the rendering provider on the claim. If a recipient is seen by an LMHP and non-LMHP during the same encounter, the LMHP should be indicated as the rendering provider on the claim, and it should be sent to Magellan.

EMERGENCY DEPARTMENT (ED) CLAIMS

Louisiana Medicaid MCOs

Hospitals should submit ED facility claims to a member's Louisiana Medicaid MCO or Molina for recipients not enrolled in a Louisiana Medicaid MCO. All professional claims associated with an ED stay should be submitted to a member's Louisiana Medicaid MCO or Molina for recipients not enrolled in a Louisiana Medicaid MCO except when the rendering provider is an LMHP.

Magellan SMO

ONLY professional claims for an LMHP for services provided as part of an ED stay should be submitted to Magellan. ALL other claims should be submitted to the member's Louisiana Medicaid MCO or Molina for recipients not enrolled in a Louisiana Medicaid MCO.

NO facility claims for an ED visit should be submitted to the Magellan SMO as all EDs in the state of Louisiana are classified as general hospital EDs.

ACUTE DETOX CLAIMS

Note: Revenue codes of 116, 126, 136, 146, 156 as well as 202 and 204 with DT diagnoses to accommodate for Delirium Tremens are utilized in billing for Acute Detox.

Louisiana Medicaid MCOs

Providers should submit claims for acute detox to a member's Louisiana Medicaid MCO or Molina for recipients not enrolled in a Louisiana Medicaid MCO if the service is performed in a general hospital.

Magellan SMO

Providers should submit claims for acute detox to Magellan if performed in a freestanding mental health hospital or DPPU.

CPT CODES FOR NEUROPSYCHOLOGICAL TESTING AND BEHAVIORAL ASSESSMENT CLAIMS

Louisiana Medicaid MCOs

Hospitals should NOT submit claims for procedure codes 96118, 96150-96155 to a member's Louisiana Medicaid MCO or Molina for recipients not enrolled in a Louisiana Medicaid MCO.

Magellan SMO

Providers should submit claims for procedure codes 96118, 96150-96155 to Magellan. These specific codes are payable by Magellan even if no psychiatric diagnosis is present but a neuropsychological condition is suspected or present.

NON-EMERGENCY MEDICAL TRANSPORTATION COST

Upon referral by a Magellan provider, all non-emergency medical transportation (NEMT) for members to and from a contracted provider (or providers operating under an approved single/ad hoc case agreement) shall be reimbursed through the Louisiana Medicaid MCO. All Medicaid-eligible NEMT shall be coordinated in conjunction with state Medicaid for fee-for-service/legacy Medicaid recipients (i.e., single state broker, state contractor) or Louisiana Medicaid, as applicable.

PHARMACY CLAIMS

All Pharmacy Services including behavioral health medications will be provided through each Louisiana Medicaid MCO or Molina for recipients not enrolled in a Louisiana Medicaid MCO.

[ISSUE DATE: May 7, 2012, Louisiana Medicaid (Program Page 3,4 of 5) PREVIOUS REVISION DATES: February 18, 2013]

Appendix XI: 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 to 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:

PATIENT 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:

1. 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.
2. 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 Patient** 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 through age 20.

Some of the most common EPSDT services include:

SERVICE	CPT CODE	COMMENTS
Vision Screen	99173-EP	For children ≥4 years of age & must include EP modifier.
Hearing Screen	92551	For children ≥4 years of age.
Hemoglobin testing	85018	
Hematocrit testing	85014	
Lead testing	83655	
Immunization Administration	90471-90474	Payable even when billed with an E/M code.
DtaP Immunizations (or components of)	90698, 90700, 90721, 90723	<i>Subject to Vaccinations for Children guidelines.</i>
IPV(Polio) Immunizations	90698, 90713, 90723	<i>Subject to Vaccinations for Children guidelines.</i>
HiB (Hemophilus influenza B) Immunizations	90645-90648, 90698, 90721, 90748	<i>Subject to Vaccinations for Children guidelines.</i>
Hepatitis B Immunizations	90723, 90740, 90744, 90747, 90748	<i>Subject to Vaccinations for Children guidelines.</i>
MMR Immunizations (or components of)	90704-90710	<i>Subject to Vaccinations for Children guidelines.</i>
Varicella (VZV) Immunizations	90710, 90716	<i>Subject to Vaccinations for Children guidelines.</i>
Pneumococcal Conjugate Immunization	90669, 90670	<i>Subject to Vaccinations for Children guidelines.</i>
Meningococcal Conjugate Immunization	90733, 90734	<i>Subject to Vaccinations for Children guidelines.</i>
Tdap/Td Immunization	90703, 90714, 90715, 90718, 90719	<i>Subject to Vaccinations for Children guidelines.</i>
Flu Vaccine	90655-90658, 90660-90662	<i>Subject to Vaccinations for Children guidelines.</i>

Appendix XII: Obstetrical Services

START SMART FOR YOUR BABY PROGRAM

Louisiana Healthcare Connections' approach to improving overall pregnancy and birth outcomes is driven by our Start Smart for Your Baby® Program (SSFYB). This specialized program offers a range of care management techniques designed to extend the gestational period and reduce the risk of pregnancy complications, premature delivery and infant disease, which can result from high-risk pregnancies.

Should your patients want more information regarding our SSFYB program, please have them contact Member Services at 1-866-595-8133 (TDD/TTY 1-877-285-4514). Pregnant members may also access the SSFYB program website at www.startsmartforyourbaby.com for enrollment information.

The *Start Smart for Your Baby* program includes:

Comprehensive case management by a RN who provides education and identifies appropriate resources for high, medium and low risk pregnant members to ensure a healthy pregnancy.

- RN case managers who target members with a history of risk factors related to preterm labor and/or delivery through education and collaboration with physicians to initiate 17 alpha hydroxyprogesterone caproate.
- A partnership with Alere to provide 17P injections and home monitoring for other high risk conditions.
- A breastfeeding program with Medela electric breast pumps for patients who are separated from neonates detained in the NICU, breastfeeding education and assistance accessing breast pumps through the WIC program.
- Measures such as providing financial incentives through our CentAccount® program to improve member compliance with prenatal, postpartum and preventative care.

Visit LouisianaHealthConnect.com for more information and access to the following forms:

- Notification of Pregnancy
- Delivery Notification
- Inpatient Prior Authorization
- Outpatient Prior Authorization
- LDHConsent for Sterilization
- STL Medical Supply Breast Pump Request
- Alere Referral (used for in-home administration of 17P injections by an RN)

There are two ways to Submit Prior Authorization for 17P Administration:

1. Alere Referral Form (used for in-home administration of 17P injections by an RN)

Fill out the Alere Referral Form and fax the form and clinical data to 866-252-4293. Alere 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).

POSTPARTUM SERVICES

Case 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.

OBGYN BILLING GUIDELINES GRID

OB SERVICES	PRIOR AUTH NEEDED?	COMMENTS	CODES/NOTES
Ultrasound	(No)	Two allowed in nine months; Additional ultrasound requires authorization; No authorization required for ultrasound by Maternal Fetal Specialist or Perinatologist Specialist	
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)	NO	Covered only when medically necessary to save the life of the mother or if pregnancy is a result of rape or incest	
17P Injections	YES	Must submit an Alere or Louisiana Healthcare Connections Prior Authorization Form with any documentation of patient history of preterm labor/delivery	J3490 with TH modifier

Breast Pump	NO	ONLY covered for mothers with neonate detained in NICU and when requested within 6 months of delivery; Fax breast pump request directly to STL Medical Supply at 877-219-6077 or contact our Case Management Department at 866-595-8133 for assistance	NOTE: Pump may be delivered to provider, hospital or member home
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	
Alere OB Home Health Services	YES	17P administration, Hypertension, Preeclampsia, Hyperemesis (Zofran/Reglan pumps), Non Stress Test, Gestational Diabetes, Preterm labor management	



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