Section (Primary Department) **Health Care Management - Utilization Management**		**SUBJECT (Document Title)** **Concurrent Review - LA**	
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Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nebraska	☐ South Carolina
☐ **Medicare/DSNP**	☐ California	☐ Kansas	☐ Nevada	☐ Tennessee
	☐ Colorado	☐ Kentucky	☐ New Jersey	☐ Texas
	☐ District of Columbia	☒ Louisiana	☐ New York	☐ Virginia
	☐ Florida	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Georgia	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Indiana	☐ Missouri	☐ Ohio	☐ Wisconsin

POLICY:

The purpose of this policy is to:

- Identify the telephonic concurrent review (CCR) process and protocols;
- Assess progress and needs during the inpatient stay;
- Coordinate needs prior to discharge;
- Facilitate transition from inpatient to discharge;
- Avoid delays in discharge due to unanticipated care needs; and
- Document all elements required for adjudication of claims consistent with medical necessity determinations.

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

Inpatient hospital services must be ordered by the:

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

Physicians responsible for an enrollee's care at the hospital are responsible for deciding whether the enrollee should be admitted as an inpatient. Place of treatment must be based on medical necessity. Each day of an inpatient stay must be medically necessary. Healthy Blue shall require prior authorization for out-of-state non-emergency hospitalization, unless the request for hospitalization is for a dual Medicare/Medicaid eligible enrollee. Additional service authorization requirements and exclusions are defined in the Contract.

The number of inpatient days of care is always in units of full days. A day begins at midnight and ends twenty-four (24) hours later. The midnight-to-midnight method is to be used in counting days of care for Medicaid reporting purposes. A partial day, including the day of admission, counts as a full day. However, the day of discharge or death is not counted as a day unless the discharge or death occurs on the day of admission. If admission and discharge or death occur on the same day, the day is considered the day of admission and counts as one (1) inpatient day.

DEFINITIONS:

** Denotes terms for which Healthy Blue must use the State-developed definition.*

Concurrent Review (CCR) – Process of obtaining clinical information to establish medical necessity for an inpatient stay throughout the member's hospitalization, to include review for extending a previously approved ongoing course of treatment over a period of time or number of treatments.

Criteria and Guidelines – Healthy Blue primarily utilizes current editions of Milliman Care Guidelines (MCG) and state-specific guidelines to review medical necessity and appropriateness of inpatient medical services. These guidelines provide a rules-based system for screening proposed medical and behavioral care based on member-specific, best medical care processes and consistently match medical services to patient needs based upon clinical appropriateness. MCG comprehensive level-of-care (LOC) alternatives are sensitive to the differing needs of adults, adolescents, and children. These guidelines are evidenced-based and supported by appropriate references in peer-reviewed literature.

Discharge Planning – Utilizing the concurrent review (CCR) process to coordinate a member's needs for psychosocial, economic, and other variables related to discharge planning:

- Discharge planning is expected to be ongoing throughout the treatment process, include member participation, and whenever possible, with the member's permission, input from family and other identified supports, including outpatient providers.
- Progress in discharge planning is addressed in CCR documentation and includes issues related to discharge readiness, barriers to discharge, specific individualized plans to support the member after discharge, and basic plans for aftercare.
- There is a plan in place to ensure the member has access to follow-up care after discharge from inpatient hospitalization as appropriate (**NOTE**: A member has the right to decline to seek or receive treatment).

Electronic Health/Medical Records (EHR/EMR)* – A computer-based record containing health care information. This technology, when fully developed, meets provider needs for

real-time data access and evaluation in medical care. Implementation of EMR increases the potential for more efficient care and speedier communication among providers and the health plan.

Medically Necessary Services* – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Qualified Practitioner* – An appropriately qualified practitioner who makes utilization management medical necessity denial decisions. Depending on the type of case, the qualified reviewer may be a physician, pharmacist, chiropractor, clinical psychologist, dentist, nurse practitioner, physical therapist, or other Louisiana licensed and qualified practitioner type as appropriate. Licensed health care professionals will include appropriately qualified practitioners in accordance with state laws. Only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. The individuals who make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the Medical Director or other qualified and trained professionals.

Utilization Management (UM)* – Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.

Utilization Review (UR)* – Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings, and ambulatory

review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.

PROCEDURE:

Acute Inpatient Admission Review Admission and continuing length-of-stay (LOS) approvals are determined by reviewing severity of illness and intensity of service utilizing the nationally recognized MCG criteria.

1) Initial review is initiated within twenty-four (24) hours (or one (1) calendar day) of notification and receipt of necessary information.
   a) Acute inpatient admission and CCR determinations are made within one (1) calendar day of obtaining the appropriate medical information that may be required.
   b) Standard (precertification) inpatient hospital service authorizations are made within two (2) calendar days of obtaining appropriate medical information.
   c) In the event a provider indicates, or the Healthy Blue determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Healthy Blue will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.
   d) Retrospective review determinations are made within thirty (30) calendar days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) calendar days from the date of receipt of request for Service Authorization.
2) Qualified, licensed professionals supervise all medical necessity decisions which are made in accordance with currently accepted medical or health care practices, taking into account special circumstances requiring deviation from the norm.
3) Efforts are made to obtain all necessary information, including pertinent clinical information and consult with the treating physician as necessary.
4) The reasons for decisions and the criterion utilized are clearly documented in the medical management system per documentation standards; criteria utilized is available upon request.
5) CCR associates are notified of admissions via:
   a) Phone call, e-mail, or fax to the Utilization Management Fax Team or the appropriate intake team;
   b) Web portal; or
   c) Health plan census reports and/or facility-specific census.
6) Upon notification of the acute inpatient admission, the CCR associate performs the following activities:
   a) Contacts the facility's attending physician or facility's UM staff, as necessary, to request clinical information or access electronic records (if access has been granted) to determine if the acute inpatient admission is medically necessary.

i) If the clinical information provided meets the guidelines for medical necessity and LOC placement, the CCR associate approves the request at the time of the review (refer to *Goal Length of Stay (GLOS)* in MCG).
ii) If the request does not meet inpatient LOC, but meets observation LOC, the CCR associate contacts the facility and discusses the LOC (refer to the *SLOS QRG)*.
   (1) Healthy Blue utilizes a common hospital observation policy that was developed and is maintained collectively by the Managed Care Organizations (MCOs) with approval of the Louisiana Department of Health (LDH) (refer to the Observation section within this policy and *Observation – LA*).
   (2) If the facility agrees to convert to an observation LOC, the observation conversion process is followed.
   (3) If the facility does not agree to the conversion to observation LOC, the CCR associate refers the request to the Medical Director (or appropriate qualified practitioner) for review (MDR).
   (4) Length of stay alone should not be the determining factor in denial of an inpatient stay/downgrading to observation stay.
iii) If the attending physician or facility cannot supply the necessary clinical information or the information obtained does not meet the guidelines for medically necessity or LOC placement, the CCR associate refers the request to MDR for determination based on the available clinical information and documents the following per documentation standards:
   (1) The reason the case is being referred to MDR;
   (2) Why the request is not medically necessary or does not meet criteria; and
   (3) Clinical summary.

b) Upon determination, notifies the attending physician or facility of the decision and the availability of the Medical Director (or appropriate qualified practitioner) to discuss a denial decision in a peer-to-peer informal reconsideration review.
   i) The provider is notified verbally or as expeditiously as the enrollee's health condition requires but not more than one (1) business day of making the initial determination and provided written notification within two (2) business days of making the determination.
c) Supports reduction of inappropriate and duplicative use of healthcare service, including but not limited to, potentially preventable hospital emergency department (ED) visits and inpatient readmissions.
d) Ensures the discharge planning process has been initiated, this includes coordination of care needs for psychosocial, economic, and other variables related to discharge planning.

Acute Inpatient Concurrent Review Continued LOS authorization is provided at each CCR interval if the acute inpatient stay continues to meet medical necessity.

1) If the information obtained from the attending physician and/or facility does not meet the guidelines for continued LOS medical necessity or placement, the CCR associate may offer an alternative LOC. If an alternative LOC is not appropriate and agreeable, the request is referred for MDR, to include all required elements and documentation standards.
   a) Continuation of higher-level services (e.g., inpatient hospital) cannot be denied for failure to meet medical necessity unless Healthy Blue can provide the service through an in-network or out-of-network provider at a lower LOC.
   b) Skilled nursing facility (SNF) services and post-acute rehabilitative care is provided at the discretion of Healthy Blue when it is cost-effective to do so in place of continued inpatient care, as an in lieu of service (refer to *Non-Covered and Cost-Effective Alternative Services – LA* for information regarding in lieu of services).
2) Upon determination, the attending physician or facility is notified of the decision and the availability of the Medical Director (or appropriate qualified practitioner) to discuss a denial decision in a peer-to-peer informal reconsideration review.
3) Discharge planning continues through discharge.

Neonatal Intensive Care Unit (NICU) Admission and Continued Stay Review

1) If less than thirty-two (32) weeks gestation, the CCR associate performs a minimum of weekly reviews and discharge planning focused on:
   a) Mom, and support system for mom and baby;
   b) Identifying significant social issues;
   c) Referrals of infants less than 1,200 grams for Supplemental Security Income (SSI) and transition to applicable programs (e.g., Medicaid Fee-For-Service (FFS)); and
   d) Home health care assessments.
2) At thirty-two (32) weeks adjusted gestational age forward, the CCR associate may perform reviews from once a week to daily depending upon the clinical readiness of the infant for discharge.
   a) Infants who have morbidities (e.g., apnea, chronic lung disease with oxygen dependency) or intervening clinical conditions that would necessitate additional prolonged hospitalization (i.e., sepsis, neonatal necrotizing enterocolitis, major surgery) the CCR associate performs a weekly review. The timing of reviews should be discussed at NICU rounds.
   b) Infants approaching discharge criteria (e.g., clinical stability, maintaining body weight in an open crib, nippling all feeds and having a pattern of weight gain) the CCR associate reviews should increase in frequency in order to detect and mitigate avoidable delays in the infant's clinical progression towards discharge.
      i) If the information obtained from the attending physician and/or the facility does not meet the medical necessity criteria, the CCR associate submits the case to MDR for approval or denial determination.

(1) NICU Progression of Care references may be utilized as secondary to assess progression of care and identify the need for pro-active intervention in preparation for a timely and clinically appropriate discharge.

ii) The attending physician or facility is notified of the decision as policy requires, and the availability of the Medical Director (or appropriate qualified practitioner) to discuss denial determinations in a peer-to-peer informal reconsideration review.

c) The CCR associate refers members to the NICU Case Manager as indicated by the NICU/Pediatric Case Management (CM) referral-trigger list or Medical Director (or appropriate qualified practitioner).

i) NICU infants are referred to CM two (2) to four (4) weeks prior to the anticipated discharge date.

ii) The NICU CM referral trigger list includes but is not limited to:

(1) ≤ 34 weeks gestation with multiple needs;
(2) Complex genetic conditions requiring multispecialty follow post-discharge;
(3) Complex medical conditions requiring multispecialty follow up and/or surgery;
(4) Complex home health needs;
(5) Durable medical equipment (DME) needs, such as monitors, vents, oxygen, or tube feeding;
(6) Failure to thrive (admission and discharge weights required);
(7) Neonatal abstinence syndrome (NAS) on medication post-discharge;
(8) Preemie > 1,200 grams with complex needs;
(9) Unresolved state agency issues requiring intervention post-discharge;
(10) Private duty nursing;
(11) Teen mothers under eighteen (18) years of age; and
(12) Other per Medical Director (or appropriate qualified practitioner).

d) The CCR associate continually monitors member eligibility and provides information on waiver programs where applicable.

e) NICU review patterns may vary based upon review methodology, contractual requirements, and/or birth weight review processes.

Discharge Planning

1) During the course of treatment (whether hospital, nursing facility, intermediate care facility, residential facility, or inpatient), the CCR associate reviews and documents the status of the discharge plan at each review. The discharge plan is reviewed for appropriateness, based on the individual's needs; the CCR associate makes every effort to ensure that:

a) The plan is realistic, comprehensive, timely and concrete;

b) For readmissions, the plan evaluates factors that may have contributed to the readmissions and includes strategies to address those factors;

c) Transition from one LOC to another is coordinated;

d) The plan incorporates actions to assure continuity of existing therapeutic relationships, as desired by the member;
e) The member, parent or guardian understands the discharge plan and receives a signed copy;
f) A copy of the discharge plan is sent to the outpatient provider(s), as appropriate;
g) Transportation issues are addressed as appropriate;
h) Psychopharmacological needs are addressed, including any potential formulary issues;
i) Collaboration with medical and behavioral health practitioners has occurred, as necessary;
j) The member has timely access to the recommended aftercare services including date and time of first provider appointment, with whom and location;
k) For behavioral health, the CCR confirms that an aftercare appointment with a behavioral health provider has been scheduled to occur within seven (7) calendar days after discharge, including documentation of provider contact information in the discharge notes;
l) Support systems are outlined and incorporated into the plan, as appropriate; and
m) Community services and/or self-help groups are recommended, as appropriate.

2) Upon discharge of the member, the CCR associate ensures the documentation is completed in the medical management system to include the following per documentation guidelines:
   a) Discharge date entered and episode of care is closed (discharge plan is also documented);
   b) All objective medical facts pertinent to the case;
   c) All relevant information obtained via telephone conversations;
   d) All conversations with any individuals who supply relevant facts concerning the case;
   e) All documentation must be dated;
   f) Identification of reviewer must be included and the names of all individuals consulted in the case must be documented;
   g) Documentation entry is expected at the time of the initial review and ongoing throughout the process;
   h) Completes applicable fields in the medical management system;
      i) If the admission or continued LOS is not authorized, a denial letter that includes reasons for the denial decision, appeal rights and expedited appeal information is issued to the hospital facility, the attending physician and the member based on specific National Committee Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), Balanced Budget Act (BBA), state or federal requirements.
      ii) A copy of the denial letter is maintained in a secure location per Healthy Blue processes for future reference and/or appeal information.
   i) When appropriate, the CCR associate refers members for CM services for continued follow-up post-discharge and documents referrals in the medical management system.

   j) If at any time a potential quality issue is identified through the review process, an appropriate referral is made to the Quality Management (QM) department.
3) A member is considered discharged from an inpatient or outpatient hospital when:
   a) The recipient is formally discharged from the hospital; or
   b) The recipient dies in the hospital.
4) The date of discharge or the date of death for an inpatient hospital stay is not reimbursed unless the date of discharge/death is the same date as the date of admission.
5) Non-medically necessary circumstances are not considered in determining the discharge time; therefore, hospitals will not be reimbursed under these circumstances (e.g., recipient does not have a ride home, does not want to leave, etc.).
   a) If non-medical circumstances arise and the recipient does not leave the hospital when he/she is discharged and the hospital is not reimbursed, the recipient may be billed but only after hospital personnel have informed him/her that Medicaid will not cover that portion of the stay.
6) If the member is readmitted to a different hospital than the discharging hospital on the same day as discharge, the readmitting hospital must enter the name of the discharging hospital, as well as the discharge date, in the appropriate field on the claim form.
7) **NOTE:** Hospitalized beneficiaries are covered by the type coverage in effect at the time of admission, either FFS or MCO, until discharge. For example, if a FFS beneficiary is hospitalized on December 31 at 12:00 am but is enrolled in an MCO effective January 1, the hospitalization is covered by FFS.

Notification and Clinical Submission Deadline

1) Notification of admission to Healthy Blue is the essential first step for the provider in the authorization process. It is important to remember that the notification step is separate from the submission of clinical for review. Providers should only submit notification and clinical information to the number(s) specified by Healthy Blue.
2) Providers are required to notify Healthy Blue of an emergent inpatient admission within one (1) business day of admission. If the provider does not notify Healthy Blue of an emergent inpatient admission within one (1) business day of admission, Healthy Blue is allowed to deny a claim for payment based solely on lack of notification.
   a) Healthy Blue must be notified of a NICU/boarder baby admission within 48 hours of a vaginal delivery and within 96 hours of caesarean section. If Healthy Blue is not notified within the specified timeframe, the request may be administratively denied for late notification.
3) Healthy Blue is held accountable by LDH to meet turnaround time deadlines, and therefore has the authority to implement and require adequate processing time for submitted clinical information by providers.
   a) Providers submitting clinical information for CCR, have a submission deadline of 3:00 pm Central Standard Time (CST), with a ten (10) minute grace period.

b) It is the provider's responsibility to submit clinical information for review by the specified "Next Review" date and deadline of 3:10 pm CST. If the "Next Review" date notification sent by Healthy Blue to the provider is a past date, retrospective, or the same day of receipt, provider has until 3:10 pm CST on the next business day to submit clinical information.
c) Proof of a fax confirmation for the transmittal of documentation prior to the specified time, will be accepted as meeting the deadline. If clinical information is not submitted within the required timeframe, the length of stay extension will be denied.

4) Receipt of administrative denial is based on timely notification, not medical necessity. Upon receipt of this denial, providers have until 3:10 pm CST the next business day to submit clinical information for the days following the denied day to be considered for medical necessity and minimize additional denied days.
5) In some cases, notification and/or initial clinical is sent on the day of discharge or after discharge. These cases do not fall into the CCR category but fall into the retrospective or post-service authorization category as the service has already been provided and Healthy Blue has no ability to impact the stay. The turnaround time for post-service authorizations is within thirty (30) calendar days of obtaining any appropriate medical information that may be required.
6) Normal deliveries, vaginal or cesarean section, do not fall into the CCR category. The inpatient days for these stays are authorized by federal and state guidelines. It is important to note that notification of admission for delivery is required.

Insufficient Clinical Information

1) It is the provider's responsibility to submit all clinical information necessary to justify both severity of illness and intensity of service.
2) If the clinical submitted is inadequate, Healthy Blue may deny the request or request additional information.
3) When submitting additional documentation, providers should only submit the pertinent clinical information needed to justify severity of illness and intensity of service.
4) When Healthy Blue requests additional information, the turnaround time clock for CCR does not start until all necessary clinical information to make the decision to approve or deny initial or continued inpatient stay is received.
5) In cases where the provider or member will not release necessary information, Healthy Blue may deny authorization of requested services within two (2) business days.
6) The information required in order for Healthy Blue to make medical necessity determination is available to members and providers and given verbally when requested.

Timing of Service Authorization Decisions and Notice of Action *(**NOTE:** Where State or Federal time standards differ from the NCQA time standards, the more stringent time standard applies.)*

1) CCR and Standard Service Authorization Decisions:

a) All CCR determinations are made within one (1) calendar day of obtaining the appropriate medical information that may be required.
b) All standard (precertification) inpatient hospital service authorizations are made within two (2) calendar days of obtaining appropriate medical information.
c) All determinations for behavioral health crisis response services that require Prior Authorization as expeditiously as the enrollee's condition requires, but no later than one (1) Calendar Day after obtaining appropriate clinical documentation.

2) Expedited Service Authorization Decisions:
   a) In the event a provider indicates, or Healthy Blue determines, that following the standard service authorization timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, an expedited authorization decision is made and notice provided as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.
   b) The seventy-two (72) hour time period may be extended up to fourteen (14) calendar days if the member requests the extension or Healthy Blue justifies to LDH a need for additional information and how the extension is in the member's best interest.
3) Post-Service Authorization Decisions:
   a) Retrospective (post-service) review determinations are made within thirty (30) calendar days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) calendar days from the date of service.
   b) Health Blue shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.
   c) Healthy Blue shall not use a policy with an effective date subsequent to the original Service Authorization request date to rescind its Prior Authorization.
4) Approval Notice of Action:
   a) For service authorization approval for a non-emergency admission, procedure or service, the provider is notified ~~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 provided documented confirmation of such notification within two (2) business days of making the determination.
   b) For service authorization approval for extended stay or additional services, the provider rendering the service (whether a health care professional or facility or both) and the member receiving the service are notified verbally or as expeditiously as the member's health condition requires, but not more than one (1) business day of making the initial determination; documented confirmation of such notification is made to the provider within two (2) business days of making the determination.

5) Adverse Notice of Action:
   a) The member is notified in writing, using language that is easily understood by the member, of a decision to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the Contract.
      i) The notice of action to members must be consistent with requirements in 42 CFR §438.404, §438.10, and §438.210, the Contract for member written materials, and any agreements that LDH may have entered into relative to the contents of member notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.
   b) The requesting provider is notified of a decision to deny an authorization or reauthorization request, or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested and include the denial reason. Healthy Blue provides written notification to ~~T~~the provider rendering the service (whether a health care professional or facility or both) ~~is notified verbally or as expeditiously as the member's health condition requires, but not more than one (1) business day of making the determination; documented confirmation of such written notification is made to the provider~~ within two (2) business days of making the determination.

Reconsideration (Peer-to-Peer Review)

1) As part of appeal procedures, the informal reconsideration process allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing.
2) In a case involving an initial determination or a concurrent review determination, the member (or a provider acting on behalf of the member and with the member's written consent) is provided an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination per 42 CFR §438.402(c)(1)(ii).
   a) In any case where a provider is required to obtain authorization on a concurrent or post-service basis, the consent of the member who received the service shall not be required in order for the provider to dispute the denied authorization for service.
3) The informal reconsideration occurs within one (1) business day of the receipt of the request and is conducted between the provider rendering the service and a Healthy Blue physician authorized to make adverse determinations or a clinical peer designated by the Medical Director if the physician who made the adverse determination cannot be available within one (1) business day.
4) The informal reconsideration does not extend the thirty (30) calendar day required timeframe for a Notice of Appeal Resolution.

Observation (Inpatient vs. Outpatient Status)

1) Healthy Blue must ensure that inpatient services are not reimbursed as outpatient, even if the stay is less than twenty-four (24) hours. Federal regulations are specific in regard to the definition of both inpatient and outpatient services. The following requirements apply:
   a) All outpatient services except outpatient therapy performed within twenty-four (24) hours of an inpatient admission shall be included on the inpatient claim.
   b) All outpatient services except outpatient therapy performed within twenty-four (24) hours before an inpatient admission and twenty-four (24) hours after the discharge shall be included on the inpatient claim. This includes outpatient services that are either related or unrelated to the inpatient stay.
   c) If an inpatient member in one hospital has outpatient services performed at another hospital, the inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may reflect the outpatient charges on its claim.
2) If a member is treated in the emergency room and requires surgery, which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided the enrollee is not admitted as an inpatient.
3) Physicians responsible for a recipient's care at the hospital are responsible for deciding whether the recipient should be admitted to inpatient status. Place of treatment should be based on medical necessity.
   a) Physicians should use a twenty-four (24) hour period as a benchmark; i.e., they should order admission for patients who are expected to need hospital care for twenty-four (24) hours or more and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment, which can be made only after the physician has considered a number of factors.
   b) Admissions of particular enrollees are not covered or non-covered solely on the basis of the length of time the recipient actually spends in the hospital.
4) Healthy Blue reimburses up to forty-eight (48) hours when medically necessary for a recipient to be in an outpatient status (observation) without authorization. This timeframe is for the physician to observe the patient and determine the need for further treatment, admission to an inpatient status, or discharge. If the member is admitted as inpatient, the admit date will go back to the beginning of the outpatient services.
5) Observation and ancillary services do not require notification, precertification or authorization and are covered up to forty-eight (48) hours. Any observation services over forty-eight (48) hours require authorization. For observation services beyond 48 hours that are not authorized, Healthy Blue shall only deny the non-covered hours.
6) If a member is anticipated to be in observation status beyond 48 hours, the hospital must notify Healthy Blue as soon as reasonably possible for potential authorization of an extension of hours. Healthy Blue and the provider shall work together to coordinate the provision of additional medical services prior to discharge of the enrollee as needed.

7) All observation status conversions to inpatient hospital admission require notification within one (1) business day of the order to admit. Healthy Blue is prohibited from including any observation hours in the inpatient admission notification period.
8) Members should not be automatically converted to inpatient status at the end of the forty-eight (48) hours. Length of stay alone should not be the determining factor in denial of an inpatient stay/downgrading to observation stay.
9) All hospital facility charges on hospital day one (1) are included in the inpatient stay and billed accordingly inclusive of emergency department/observation facility charges.
    a) Hospitals should bill the entire outpatient encounter, including emergency department, observation, and any associated services on the same claim with the appropriate revenue codes, and all covered services are to be processed and paid separately.
    b) Professional charges should continue to be billed separately.

Surgeries Performed on an Inpatient Basis

1) Healthy Blue shall cover certain surgical procedures only when performed as outpatient unless it is medically necessary for the procedure to be performed on an inpatient basis. These procedures are usually performed on an outpatient basis but can be performed inpatient if it is medically necessary. A list of outpatient procedures requiring approval to be performed on an inpatient basis may be found on the Medicaid FFS fee schedules.
2) Healthy Blue may approve inpatient performance of these procedures when one (1) or more of the following exception criteria exists:
    a) Documented medical conditions exist that make prolonged pre-and/or post-operative observation by a nurse or skilled medical personnel a necessity.
    b) The procedure is likely to be time consuming or followed by complications.
    c) An unrelated procedure is being performed simultaneously that requires hospitalization.
    d) There is a lack of availability of proper post-operative care.
    e) Another major surgical procedure could likely follow the initial procedure (e.g., mastectomy).
    f) Technical difficulties, as documented by admission or operative notes, could exist.
    g) The procedure carries high enrollee risk.
3) Reimbursement for the performance of these specified surgical procedures on an outpatient basis will be made on a flat FFS basis. Reimbursement for surgical procedures approved for an inpatient performance will be made in accordance with the prospective reimbursement methodology for acute care inpatient hospital services.

Hospital Services Furnished Under Arrangements

1) Hospitals are allowed by Medicaid to contract or make arrangements with an outside supplier, including another provider such as an independent laboratory, for performance of medically necessary services for their patients.

2) It is the responsibility of the hospital to ensure that the outside supplier or other provider meets all applicable state and federal requirements.
3) When a hospital contracts with an outside supplier or another provider for the performance of a routine service or ancillary provider component (technical component of a service), the supplier/provider bills the hospital and is paid by the hospital. Only the hospital is allowed to submit claims to Healthy Blue for services furnished under this arrangement. The services are covered hospital services and reimbursement is included in the hospital reimbursement rates. Healthy Blue may not separately reimburse the outside supplier for services performed on enrollees who are hospital patients.
4) This policy applies to both inpatient and outpatient hospital services.

Emergency Services

1) Healthy Blue shall provide emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. If an emergency medical condition exists, Healthy Blue is obligated to pay for the emergency service.
2) Healthy Blue covers and pays for emergency services regardless of whether the provider that furnishes the emergency services is part of Healthy Blue's provider network.
3) Coverage of emergency services cannot be refused based on the emergency room provider, hospital, or fiscal agent's failure to notify the member's primary care provider or Healthy Blue of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.
4) A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
5) Healthy Blue is not obligated to pay for non-emergency (routine) care provided in the emergency room, unless the person has presenting symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:
    a) Placing the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
    b) Serious impairment of bodily function; or
    c) Serious dysfunction of any organ or body part.

Maternity and Newborn Services

1) Notification of admission for delivery is required, and inpatient days are authorized according to federal and state guidelines.
    a) If a member is admitted for an induction of labor and fails to deliver by day two of the admission, the hospital is required to submit clinical for the first two days of admission for medical necessity review.

2) Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than forty-eight (48) hours for both the mother and newborn child, and no less than ninety-six (96) hours following a cesarean section delivery for both the mother and newborn child.
3) All medically necessary services are the responsibility of Healthy Blue regardless of primary or secondary mental health diagnosis appearing on the claim.
    a) Healthy Blue does not reimburse for deliveries occurring before thirty-nine (39) weeks without a medical indication.
4) Healthy Blue may require notification by the provider of obstetrical admissions exceeding 48 hours after vaginal delivery. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding 48 hours after vaginal delivery. In this case, Healthy Blue may only deny the portion of the claim related to the inpatient stay beyond 48 hours.
5) Healthy Blue may require notification by the provider of obstetrical admissions exceeding 96 hours after Caesarean section. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, Healthy Blue may only deny the portion of the claim related to the inpatient stay beyond 96 hours.
6) Healthy Blue is responsible for assuring that hospital providers report the births of newborns within twenty-four (24) hours of birth for enrolled members via the LDH Self-Service Provider Portal.
    a) The hospital is required to submit birth information to Healthy Blue. Providers may use standard reporting forms specific to their hospital as long as the following required information is included:
        i) Indicate whether a live birth
        ii) Newborn's birth weight
        iii) Gestational age at birth
        iv) Apgar scores
        v) Disposition at birth
        vi) Type of delivery (vaginal or cesarean); if a cesarean, the reason the cesarean was required
        vii) Date of birth
        viii) Gender
        ix) Single/multi birth
        x) Garvida/para/ab for mother
        xi) EDC and if NICU admission was required
7) Healthy Blue requires its hospital providers to register all births within fifteen (15) calendar days through the Louisiana Electronic Event Registration System (LEERS) administered by LDH/Vital Records Registry.
8) LDH provides Healthy Blue a one-time supplemental lump sum payment for each obstetrical delivery (maternity kick payment). This kick payment is intended to cover the

cost of prenatal care, the delivery event, and post-partum care and normal newborn hospital costs.

a) Only one (1) maternity kick payment will be made per delivery event. Multiple births during the same delivery will result in one (1) maternity kick payment being paid. The maternity kick payment will be paid for both live and still births. A kick payment will not be reimbursed for abortions or spontaneous abortions (as defined in state law).
b) The kick payment will be paid to Healthy Blue upon submission of satisfactory evidence of the occurrence of a qualifying delivery.
c) Maternity Kick Payments may be differentiated between early elective delivery events (deliveries occurring before thirty-nine (39) weeks without a medical indication), and all other delivery events. the amount of the kick payment will be determined by LDH's actuary in accordance with LDH policy.

9) Mother and newborn claims must be billed separately. The claim is to only include the mother's room/board and ancillary charges. A separate claim for the newborn must only include nursery and ancillary charges for the baby. This newborn claim shall be paid at zero as opposed to being denied in order to be counted as a covered service in encounter data.
   a) The appropriate current procedural terminology (CPT) codes for the initial care of the normal newborn may be paid when the service provided meets the criteria as defined by CPT. This service is limited to once per lifetime of the enrollee.
   b) The CPT code for subsequent care of the normal newborn may be paid for each day care is rendered subsequent to the date of birth, other than the discharge date. The MCO shall cover up to three (3) normal newborn subsequent care days.
10) When a newborn remains hospitalized after the mother's discharge, the claim must be split billed. The first billing of the newborn claim should be for charges incurred on the dates that the mother was hospitalized. The second billing should be for the days after the mother's discharge. The newborn assumes the mother's discharge date as his/her admit date and the hospital will be required to obtain precertification.
11) Healthy Blue must cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another in-network or out-of-network provider.

Behavioral Health Services

1) Healthy Blue performs prior authorization and concurrent utilization review for admissions to inpatient general hospitals, and concurrent utilization review for psychiatric admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals. Healthy Blue ensures that initial inpatient psychiatric hospital and concurrent utilization reviews are completed by a Licensed Mental Health Professional (LMHP), psychiatrist, or registered nurse with appropriate clinical expertise for each member. Healthy Blue complies with the requirements set forth in the Inpatient Psychiatric Services Rule (Louisiana Register, Vol. 21, No. 6, Page 575).

2) Healthy Blue shall have a sufficient number of LMHPs, including licensed addiction counselors (LACs), as well as a board-certified psychiatrist and a board-certified addictionologist. If an addictionologist cannot be retained full-time due to limited availability, Healthy Blue shall contract with a qualified consultant. With the exception of the addictionologist who shall be available at least 10 hours per week, the other LMHPs shall be available 24 hours per day, 7 days per week. Healthy Blue shall provide UM staff, both experienced and specifically assigned to children, youth, adults, and older adults, and permanent support housing (PSH).
3) In accordance with Act 390 of the 2015 Regular Legislative Session, the MCOs and Magellan are required to pay claims for behavioral health services provided to persons committed under an emergency certificate to an inpatient or residential facility regardless of medical necessity. Emergency certificates are inclusive of Physician's Emergency Certificates, Coroner's Emergency Certificates, and Judicial Certificates.
4) This payment requirement shall be for a maximum period of twenty-four (24) hours from the time of admission to the inpatient or residential facility, as long as the following conditions are met:
    a) The admitting physician and the evaluating psychiatrist or medical psychologist shall offer the subject of the emergency certificate the opportunity for voluntary admission; and
    b) Any person committed under an emergency certificate shall be evaluated by a psychiatrist or medical psychologist in the admitting facility within twenty-four (24) hours of arrival at the admitting facility.
5) After the psychiatric evaluation has been completed, payment of claims shall be determined by medical necessity. If the subject of the emergency certificate does not receive a psychiatric evaluation within the required timeframe, Healthy Blue is only required to pay behavioral health claims within the first twenty-four (24) hours of admission. Payment for any subsequent claim shall be determined by medical necessity.
6) Inpatient psychiatric or substance abuse treatment in out-of-state hospitals are covered for a maximum of two (2) days in the case of a medical emergency, to allow time for the member to be stabilized and transferred to a Louisiana psychiatric hospital when appropriate.
    a) Outpatient psychiatric and substance abuse services provided by an out-of-state hospital are not covered.
7) Service authorization criteria for specialized behavioral health services are consistent with state and federal laws, regulations, rules, the State Plan, and waivers applicable to managed care. Healthy Blue shall screen enrollees to determine level of need for the purpose of service authorization based on medical necessity. Based on this medical necessity determination, Healthy Blue shall authorize specialized behavioral health services as appropriate. Criteria for screening protocols and determining whether an individual meets the criteria for behavioral health services may be determined by LDH and

based on factors relating to age, diagnosis, disability (acuity), and duration of the behavioral health condition.

8) All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order to be eligible for payment, the service must be medically necessary and a covered benefit/service, as determined by Healthy Blue within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.
9) Healthy Blue may not deny continuation of higher-level services (e.g., inpatient hospital or Psychiatric Residential Treatment Facility (PRTF)) for failure to meet medical necessity unless the service can be provided through an in-network or out-of-network provider at a lower LOC.
10) Healthy Blue collaborates with DCFS, the Office of Juvenile Justice (OJJ), and the Department of Education (DOE) to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a Wraparound Agency (WAA) if indicated.
11) Members with co-occurring behavioral health and developmental disabilities should have the same reasonable access to behavioral health services as someone without a co-occurring developmental disability. If a member qualifies for services through the Office for Citizens with Developmental Disabilities (OCDD), the Healthy Blue shall coordinate with Local Governing Entities, Support Coordination Agencies, Office of Health Title V Children and Special Health Care Needs for those who are under 21, and/or OCDD concerning the care of the enrollee. A statement of approval from OCDD shall not preclude services from the MCO.
12) Refer to Behavioral Health-specific policies and procedures for additional information.

Provider Preventable Conditions

1) Louisiana Medicaid is mandated to meet the requirements of 42 CFR §447.26 with respect to non-payment for provider preventable conditions (PPCs). Healthy Blue is required to implement procedures for non-payment for these events when applicable to its enrollees.
2) PPCs are defined into two (2) separate categories:
   a) Healthcare Acquired Conditions (HCACs), meaning a condition occurring in any inpatient hospital setting, identified as a hospital acquired condition (HAC) in accordance with 42 CFR §447.26; and
   b) Other Provider Preventable Conditions (OPPCs), meaning a condition occurring in any health care setting in accordance with 42 CFR §447.26.
3) The current listing of Hospital Acquired Conditions (HACs) and associated diagnoses can be found here.
   a) Louisiana Medicaid considers HACs as identified by Medicare, other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

b) It is the responsibility of Healthy Blue to determine if the HCAC was the cause for any additional days added to the length of stay. Healthy Blue may not reimburse for services related to HCAC.

4) Healthy Blue shall deny payment to providers for PPCs that meet the following criteria:
   a) Is identified in the State Plan;
   b) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
   c) Has a negative consequence for the member;
   d) Is auditable; and
   e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.
5) Healthy blue is prohibited from reimbursing providers for any days that attributable to an OPPC in any setting. OPPCs refer to surgery on a wrong body part or patient, and include the following:
   a) Wrong surgical or other invasive procedure performed on a patient;
   b) Surgical or other invasive procedure performed on the wrong body part; or
   c) Surgical or other invasive procedure performed on the wrong patient.
6) Healthy Blue shall not impose a reduction in reimbursement for a PPC when the condition defined as a PPC for a particular enrollee existed prior to the initiation of treatment for the enrollee by that provider.
7) Reductions in provider reimbursement may be limited to the extent that the following apply:
   a) The identified PPCs would otherwise result in an increase in reimbursement.
   b) It is practical to isolate for non-payment the portion of the reimbursement directly related to treatment for, and related to, the PPC.
8) Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.
9) Healthy Blue requires all providers to report PPCs associated with claims for payment or member treatments for which payment would otherwise be made.
10) Healthy Blue reports all identified PPCs to LDH on the encounter file via the Present on Admission (POA) indicators.
   a) POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered POA.
   b) Refer to the CMS website for the current listing of diagnoses that are exempt from POA reporting requirements.

Inpatient Concurrent Care

1) Healthy Blue shall cover inpatient concurrent care when an enrollee's condition requires the care of more than one (1) provider on the same day and the services rendered by each individual provider are medically necessary and not duplicative.
2) Healthy Blue shall separately reimburse providers from different specialties/subspecialties, whether from the same group or a different group. Each provider from a different specialty/subspecialty can be reimbursed for one (1) initial hospital visit per admission plus a maximum of one (1) subsequent hospital visit per day.
3) Within the same specialty/subspecialty, only one (1) provider can be reimbursed for one (1) initial hospital visit per admission and, subsequently, only one (1) provider can be reimbursed for a maximum of one (1) subsequent hospital visit per day.
4) Healthy Blue shall reimburse only the provider responsible for discharging the enrollee for hospital discharge services on the discharge day.

Care Coordination, Continuity of Care, and Care Transition

1) Healthy Blue is responsible for the coordination and continuity of care of health care services for all members consistent with 42 CFR §438.208 (refer to *Coordination of Care – LA* and *Continuity of Care – LA*). In addition, Healthy Blue shall be responsible for coordinating with LDH, including the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, to ensure integrated support across behavioral health services and long-term supports and services.
2) If an enrollee is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the member is discharged. The receiving MCO is responsible for all other care.
    a) In the event that the relinquishing MCO's contract is terminated prior to the enrollee's discharge, responsibility for the remainder of the hospitalization charges reverts to the receiving MCO, effective at 12:01 am CST on the day after the relinquishing MCO's contract ends.
3) Service authorization is not required for the continuation of medically necessary covered services of a new enrollee transitioning into Healthy Blue, regardless of whether such services are provided by an in-network or out-of-network provider, however, prior authorization of services may be required beyond thirty (30) calendar days. During transition, Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.
4) Special consideration is given, but not limited to, the following:
    a) Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;

b) Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow-up visits, therapies to be provided after transition or out-of-area specialty services;
c) Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were born prematurely; and
d) Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last thirty (30) calendar days, the need for organ or tissue transplantation, or chronic illness resulting in hospitalization.

REFERENCES:

- Behavioral Health Emergency Care
- Behavioral Health Hospital Discharge Coordination Process for Pharmacy – LA
- CFR Title 42
- Clinical Criteria for Utilization Management Decision — Core Process
- Continuity of Care – LA
- Concurrent Review (Telephonic and On Site) and On site Review protocol Process – Core Process
- Court-Ordered Services – Core Process
- Emergency and Post-Stabilization Services – LA
- Health Care Management Denial– LA
- ~~Health Plan Advisory 12-9~~
- ~~Health Plan Advisory 15-23~~
- ~~Health Plan Advisory 16-34~~
- ~~Health Plan Advisory 18-9~~
- ~~Health Plan Advisory 20-6~~
- ~~Health Plan Advisory 20-22~~
- Informal Reconsideration – LA
- ~~Informational Bulletin 12-3~~
- ~~Informational Bulletin 12-28~~
- Louisiana Medicaid Hospital Services Provider Manual
- Louisiana Medicaid Managed Care Organization (MCO) Manual
- Louisiana State Contract
- Managed Care Organization (MCO) Manual – LA
- NCQA Accreditation Standards and Guidelines
- Observation – LA
- Out-of-Area, Out-of-Network Care – LA
- Out-of-Network Authorization Process
- Post-Discharge Management – LA
- Use of Board Certified Consultants (Medical/Behavioral Health)

- Utilization Management- LA
- Utilization Management Responsibilities (Health Plan/Region)
- Transplant Approval Policy – Solid Organ/BMT/Stem Cell
- Women's Health and Family Planning Services – LA

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management - Utilization Management

Secondary Department(s): Behavioral Health
Claims
Medicaid Quality and Accreditation

EXCEPTIONS:

Exceptions to Requirements

1) Healthy Blue shall not require service authorization for emergency services or post-stabilization services as described in the Contract, whether provided by an in-network or out-of-network provider.
2) Healthy Blue shall not require hospital service authorization for nonemergency inpatient admissions for normal newborn deliveries.
3) Healthy Blue shall not require service authorization or referral for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program screening services.
4) Healthy Blue shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the plan, regardless of whether such services are provided by an in-network or out-of-network provider, however, prior authorization of services may be required beyond thirty (30) calendar days.
5) Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first thirty (30) days of a newly enrolled member's linkage to the plan.
6) Healthy Blue shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the plan for routine and preventive women's healthcare services and prenatal care.
7) Healthy Blue shall not require a PCP referral for in-network eye care and vision services.
8) Healthy Blue may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.
9) Healthy Blue may require notification by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding forty-eight (48) hours after vaginal delivery. In this case, only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours is denied.

10) Healthy Blue may require notification by the provider of obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours is denied.
11) Healthy Blue may require notification by the provider of inpatient emergency admissions within one (1) business day of admission. Healthy Blue is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission if the provider does not notify of inpatient emergency admission within one (1) business day of admission.
12) Healthy Blue shall require prior authorization for out-of-state non-emergency hospitalization unless the request for hospitalization is for a dual Medicare/Medicaid eligible enrollee. Healthy Blue shall require prior authorization for dual eligible enrollees only if transportation services are being requested in addition to the hospitalization.

Trade Area

1) Acute care out-of-state providers in the trade area are treated the same as in-state providers. Trade area is defined as the counties located in Mississippi, Arkansas, and Texas that border the state of Louisiana.
2) The following is a list of counties located in the trade area:
   a) Arkansas counties: Chicot, Ashley, Union, Columbia, Lafayette, and Miller
   b) Mississippi counties: Hancock, Pearl River, Marion, Walthall, Pike, Amite, Wilkerson, Adams, Jefferson, Claiborne, Washington, Issaquena, and Warren
   c) Texas counties: Cass, Marion, Harrison, Panola, Shelby, Sabine, Newton, Orange, and Jefferson
3) A referral or transfer made by a trade area hospital to another hospital does not constitute approval unless it is to either a Louisiana hospital or another trade area hospital. Prior authorization is required for all other nonemergency referrals or transfers.
4) Healthy Blue shall not remit payment for items or services provided under the Contract will to any entity or provider located outside of the United States. The term “United States” means the fifty (50) states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

REVISION HISTORY:

Review Date	Changes
05/20/2015	• Revised corporate version to reflect Louisiana Plan only
06/17/2016	• Annual review • Definitions placed in alphabetical order • References placed in alphabetical order
03/06/2017	• Off cycle review

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management - Utilization Management	**Concurrent Review - LA**

Review Date	Changes
	• EQRO Rebuttal; State Contract Amendment 7 verbiage • References updated
07/11/2017	• For annual review • Update to procedure section • References placed in alphabetical order
03/13/2018	• Off cycle review • State Contract Amendment 11 verbiage added
06/12/2018	• Annual review • Update to Procedure section with current contract language
05/01/2019	• Annual review • State Contract through Amendment 16 verbiage added
03/27/2020	• Annual review • Policy name change from "Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – LA" to "Concurrent Review (Telephonic and On-Site) – LA" • Updates made to the policy, definitions, procedure sections, exceptions, and references • Claims and NCC added as secondary departments
02/11/2021	• Annual Review • "Appropriate Practitioner" definition replaced by the State-approved "Qualified Practitioner" definition; "appropriate qualified practitioner" replaced "appropriate practitioner" throughout • Definitions placed in alphabetical order • All other revisions exclusively comprised of State-specific Emergency Contract Amendment 3 and MCO Manual verbiage • Policy, Definitions, Procedure, Exceptions, and References updated • Updated the "Effective Date" from 06/26/1996 to 05/20/2015 as the LA plan went live in 2012 & this also reflects the original policy creation date noted in the Revision History (this is a LA-specific policy created from a corporate policy version)
01/27/2022	• Annual Review; no changes
02/03/2023	• Annual Review • Specified Concurrent Review Staff work under the direction of a Louisiana licensed practitioner • Behavioral Health Services updated to include LMHP, addictionologist, permanent support housing (PSH) requirements • Updated Medically Necessary Services and Qualified Practitioner

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management - Utilization Management	**Concurrent Review - LA**

Review Date	Changes
	definitions • Updated procedure to remove references to NCC (now managed by Utilization Management Fax Team) • Updated Behavioral Health Services procedure section • Removed NCC as a secondary department
09/15/2023	• Off cycle review • Policy, Definitions, Procedure, References and Exceptions section updated • Added Concurrent Review Core Process to Reference section • Updated policy to align with current contract and MCO manual verbiage
01/29/2024	• Annual Review; no changes
05/01/2024	• Off Cycle Review • Edits made to Policy and Definitions sections • Updated Procedure section and removed on-site review to align with current business process • Removed retired policies and added Utilization Management-LA to References section • Added Medicaid Quality and Accreditation department as a Secondary department • Policy name changed from “Concurrent Review (Telephonic and On-Site) – LA” to “Concurrent Review- LA”
03/21/2025	• Annual Review • Updated Procedure to add verbiage regarding notification of NICU/boarder baby admission to align with current business process
02/09/2026	• Annual Review • Removed retired Health Plan Advisories and Informational Bulletins from References section • Updated Procedure to reflect state contract Amendment 12