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

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
11/02/2022		10/11/2023	~~04/18/2023~~10/11/2023
Department Approval/Signature:			

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

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

POLICY:

Healthy Blue has developed a utilization management (UM) program for all Managed Care Organization (MCO) Covered Services that facilitates the delivery of high quality, cost-efficient, and effective care.

Healthy Blue develops and maintains written program policies and procedures with defined structures and processes that meet National Committee for Quality Assurance (NCQA) standards. Healthy Blue submits written policies and procedures to the Louisiana Department of Health (LDH) or its designee for approval prior to any substantive changes.

Policies and procedures shall include, but not be limited to:

- The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;
- Provisions for ensuring confidentiality of clinical information;
- The reporting of fraud and abuse information identified through the program to LDH in accordance with 42 Code of Federal Regulations (CFR) §455.1(a)(1);
- Policies and procedures to maintain, or require providers and contractors to maintain, an individual health record for each enrollee, in accordance with the *MCO Manual*. Healthy Blue shall collect and provide health records to LDH upon request;
- Where applicable, the requirement that each enrollee's record includes information needed to perform utilization reviews. This information must include, at least, the following:
    - Identification of the enrollee;
    - The name of the enrollee's physician;
    - Date of admission, and dates of application for and authorization of Louisiana Medicaid Program benefits if application is made after admission;
    - The plan of care (POC) required under 42 CFR §456.80 and §456.180;
    - Initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133, §456.233 and §456.234;

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- Date of operating room reservation, if applicable; and
- Justification of emergency admission, if applicable.

All documentation and/or records maintained by Healthy Blue, its material subcontractors, and its network providers related to MCO Covered Services, charges, operations and agreements under the Contract shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the State or Federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the State or Federal government. Under no circumstances shall Healthy Blue or any of its material subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

All policies and procedures are reviewed at least annually to ensure that Healthy Blue's written policies reflect current practices. Reviewed policies are dated and signed by Healthy Blue's appropriate manager, coordinator, director, or Chief Executive Officer (CEO). Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All medical and quality management policies are approved and signed by Healthy Blue's Medical Director. All behavioral health policies are approved and signed by Healthy Blue's Behavioral Health Medical Director.

Healthy Blue submits UM reports as specified by LDH.

Healthy Blue complies, to the satisfaction of LDH, with:

- All requirements set forth in the Contract;
- All provisions of State and Federal laws, rules, regulations, policies, and procedures, the State Plan, and Waivers applicable to the Managed Care Program;
- The *MCO Manual*; and
- All settlement agreements, orders, and/or judgements rendered by a court of competent jurisdiction, including, but not limited to, those that arise from AJ v. LDH (Case 3:19-CV-00324), Chisholm v. Phillips (Case 2:97-cv-03274), and United States v. State of Louisiana (DOJ Agreement, Case-3:18-cv-00608), and subsequent implementation plans in accordance with the Contract, the *MCO Manual*, and as directed by LDH. LDH reserves the right to assess monetary penalties for failure to meet this requirement.

The Contract shall, to the extent possible, be construed to give effect to all provisions contained therein. However, in the event of any inconsistency or conflict among the document elements of the Contract, such inconsistency or conflict shall be resolved by giving precedence to the following documents in the following order:

- The body of the Contract with exhibits and attachments.
- The LDH Standard Contract Form – CF-1, exhibits, and other attachments incorporated therein, and amendments thereof.
- The MCO Manual ~~Request for Proposals (RFP) and any addenda and appendices.~~
- ~~The~~ Request for Proposals (RFP), attachments and exhibits incorporated therein, and addenda issued thereto.~~*MCO Manual.*~~
- The Proposal submitted by Healthy Blue in response to the RFP.

DEFINITIONS:

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

Adverse Benefit Determination* – Any of the following:

- The denial or limited authorization of a requested service, including, but not limited to, determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeal* – A request for a review of an adverse benefit determination.

Concurrent Review – Utilization review conducted during a continued hospital stay or course of treatment.

Emergency Medical Condition* – 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 impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Emergency Room (ER) Care* – Emergency services provided in an emergency department.

Emergency Services* – Covered inpatient and outpatient services that are as follows: (a) furnished by a provider that is qualified to furnish these services under Title 42 of the Code of

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Federal Regulations and Title XIX of the Social Security Act; and (b) needed to evaluate or stabilize an emergency medical condition.

Enrollee* – Beneficiary who is currently enrolled in an MCO, either by choice or automatic assignment by the Enrollment Broker.

Excluded Services* – Those services that enrollees may obtain under the State Plan or applicable waivers and for which Healthy Blue is not financially responsible.

Experimental Procedure or Service – A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific date may be limited or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

Fee-for-Service (FFS)* – A method of provider reimbursement based on payments for specific services rendered.

Hospital Outpatient Care* – Care in a hospital that usually doesn't require an overnight stay.

Hospitalization* – Admission to a hospital for treatment.

Managed Care Organization (MCO) Covered Services – Those Medicaid Covered Services that are required to be provided by the MCO to enrollees as specified in *Attachment B~~C~~, MCO Covered Services,* of the Contract.

Managed Care Organization (MCO) Manual – A compilation of policies, instructions, and guidelines established by LDH for the administration of the Managed Care Program.

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

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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."

Network Provider or Provider* – An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors that a signed provider agreement with Healthy Blue for the delivery of MCO Covered Services to the Healthy Blue's enrollees.

Post-Service or Retrospective Review – Utilization review conducted after treatment has been rendered and the enrollee has been discharged. Retrospective review does not include subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted.

Prior Authorization, Precertification or Prospective Review – The process of determining medical necessity for specific services before they are rendered. Utilization review is conducted prior to an admission or a course of treatment.

Qualified Practitioner*[1] – 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 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.

Service Authorization – A utilization management activity that includes pre-, concurrent, or post-review of a service by a qualified health professional to authorize, partially deny, or deny the payment of a service, including a service requested by the enrollee. Service authorization activities must consistently apply review criteria.

Subcontractor* – A person, agency, or organization with which Healthy Blue has subcontracted or delegated some of its management functions or other contractual

[1] LDH-approved definition developed May 202, in collaboration with Legal and Compliance, in accordance with State requirements.

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responsibilities to provide MCO Covered Services to its members. A network provider is not a subcontractor by virtue of the network provider agreement with Healthy Blue.

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:

General Service Authorization Requirements

1) The following services are subject to precertification (reference the precertification lookup tool (PLUTO) and appropriate resource files for specific authorization rules):
   a) Outpatient services and elective inpatient admissions;
   b) Specialty procedures (precertification is not required for specialty emergency services or treatment of any immediately life-threatening medical condition); and
   c) Non-emergent services rendered by an out-of-network practitioner or provider (with the exception of covered Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, family planning services, and women's preventive health services, unless excluded by State or Federal requirements).

~~1)~~2) Healthy Blue has clearly delineated service authorization procedures for prior authorization, concurrent authorization, and post-authorization that comply with 42 CFR §438.210 and any court-ordered requirements of LDH. For pharmacy service authorizations, see the *MCO Manual* and applicable pharmacy policies.

~~2)~~3) Healthy Blue may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. Healthy Blue must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

~~3)~~4) Healthy Blue is not required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making a service authorization determination, for that particular item or service. ~~When the provider fails to provide requested medical information, Healthy Blue may at its discretion, or shall as directed by LDH, impose financial penalties against the provider as appropriate.~~

~~4)~~5) All court-ordered behavioral health services are subject to medical necessity review. In order for the service to be eligible for reimbursement, Healthy Blue shall determine that the service is medically necessary and an MCO Covered Service.

~~5)~~6) Healthy Blue maintains written procedures including, but not limited to, the following:

a) A process for submission and processing of requests for initial and continuing authorizations of services;
   i) Healthy Blue is responsible for eliciting pertinent health record information from the treating health care provider(s), as needed and/or as requested by LDH, for purposes of making service authorization determinations.
   ii) Healthy Blue takes appropriate action when a treating health care provider does not provide complete medical history information within the requested timeframe.
b) The process to be followed in the event Healthy Blue determines the need for additional information not initially requested;
c) The process for conducting peer-to-peer reviews of adverse determinations;
d) A process to ensure that authorization requirements shall either be furnished to the healthcare provider within twenty-four (24) hours of a request for the requirements or posted in an easily searchable format, that includes the date of last review, on Healthy Blue's website.[2] Healthy Blue furnishes these requirements to providers in addition to the prior authorization information and training that must be furnished under the *Provider Services and Support* section of the Contract;
e) A process to arrange for another level of care if appropriate when Healthy Blue denies a service authorization request; and
f) A mechanism by which an enrollee may submit, verbally or in writing, a service authorization request. This process is included in the *Member Handbook* and incorporated in the grievance procedures.
   i) Healthy Blue maintains a toll-free enrollee service call center, physically located in the United States, with dedicated staff to respond to enrollee questions. The toll-free number must be staffed on business days between the hours of 7:00 am and 7:00 pm Central Standard Time (CST). The toll-free line has an automated system, available twenty-four (24) hours a day, seven (7) days a week.

~~6)~~7) Certain services and procedures require authorization. Clarification on whether or not a Current Procedural Terminology (CPT) code requires authorization can be obtained by contacting Healthy Blue and is available through Healthy Blue's website.

~~7)~~8) When requesting authorization of a procedure or service, providers must:
   a) Complete a request form; and
   b) Submit all documentation to warrant medical necessity.

~~8)~~9) When an enrollee becomes retroactively eligible for Medicaid, post-authorization may be obtained for those procedures that would normally require prior authorization. Such requests must be submitted within six (6) months from the date of Medicaid certification of retroactive eligibility.

~~9)~~10) A request is considered an emergency if a delay in obtaining the medical service, equipment, appliance or supplies would be life-threatening for the enrollee. Emergency requests may also be submitted for services required for a hospital discharge.

[2] Act 330 (House Bill 424) from the 2019 Regular Session to amend and reenact La. RS 46:460.71(C) and to enact RS 46:460.51(15) and 460.74 effective August 1, 2019.

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a) Emergency requests for authorization that are not truly emergencies will be denied as such, and the request will be processed as a routine request.

Service Authorization Process

1) The non-clinician MMS (may also be a non-clinician National Customer Care (NCC) associate, or other UM representative) receives a request for precertification via telephone, fax, or web portal.
2) The MMS performs the following actions:
   a) Checks for sanctions on every out-of-network (OON) provider requesting services (refer to *Exceptions*). At a minimum, the following shall be utilized to screen OON and/or non-participating providers:
      i) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
      ii) The System of Award Management (SAM);
      iii) Louisiana Adverse Actions List Search; and
      iv) Other applicable sites as may be determined by LDH.
   b) Validates the Medicaid ID number on every request indicated for OON providers;
   c) Verifies member eligibility, other health insurance (OHI), and benefits coverage;
   d) Creates the authorization shell with appropriate documentation in the UM system;
   e) Ensures appropriate systems are completed and updated per documentation standards; and
   f) Routes the request to the appropriate and qualified licensed UR for review and processing if needed.
3) The Licensed UR performs the following actions:
   a) Obtains additional information as needed regarding the network affiliation of the specialist or facility where the service or procedure is to be performed;
   b) Confirms timeliness of the request.
   c) Determines the clinical appropriateness of the service based upon medical necessity criteria, local delivery system, and the individual member's needs;
      i) In the case of an outpatient request, the Licensed UR will reference the Louisiana Medicaid criteria tracker awaiting LDH approval to ensure that the appropriate approved criteria is utilized for the review.
   d) Consults with the requesting provider when applicable based on the mode of communication the practitioner initiated the request (i.e., by telephone or facsimile);
   e) Updates the UM system per documentation standards and releases the reference number to the requesting/servicing provider if the submitted clinical information and requested services are medical necessary;
   f) Routes the request to the Medical Director (or qualified practitioner) for review and determination if the clinical information provided does not meet precertification due to any of the criteria listed below:
      i) Medical necessity is not established based on application of criteria against presenting clinical information, and/or services are not clinically appropriate;

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ii) The member is not eligible for the proposed procedure, or it is not a covered benefit or service;
iii) The member's benefit cap or maximum limitation has been met; or
iv) The specialist or facility is OON and the provider or member refuses re-direction to an in-network provider or facility.

g) If the clinical information provided does not meet precertification at the requested level of service, an appropriate, alternative service or level of care may be offered. If accepted by the provider, precertification of the alternative level of care is approved. If the alternative service is not accepted, the request is referred for review and determination by the Medical Director (or qualified practitioner).

h) If a health condition is identified during the precertification process that is amenable to planning and coordination of services prior to admission (i.e., operative procedures), the licensed UR documents the information so that appropriate services can proactively be coordinated to enhance the availability of care during the post-hospitalization period.

i) The licensed UR is responsible for ensuring all appropriate systems are completed and updated per documentation standards.

4) The following precertification requests require different or additional actions:

a) **Member not in the system:** Contact the Enrollment Area of Financial Operations to review the member's eligibility. Enrollment notifies the associate of the outcome. If the member is not enrolled with Healthy Blue, the requesting/servicing provider is informed that the "member is not enrolled with the organization per the current enrollment information in the system."

b) **OON specialist/facility:** If there is a specialist/facility within geo-access, and the member or provider refuses redirection to an in-network provider, the request requires review and determination by the Medical Director (or qualified practitioner). Upon request by the OON provider (or when applicable), approvals are routed to the health plan single case agreement (SCA) specialist for rate negotiation and completion of an SCA. If the OON provider accepts the Medicaid fee-for-service (FFS) or standard OON rate, there is no need for an SCA.

i) OON approvals pending an SCA can be released with the disclaimer that it is "Approved as medically necessary; however, pending rate negotiations. If services are rendered before rates are negotiated, the reimbursement will be applicable to the Fee Schedule and contract standards."

ii) Refer to *Out-of-Area, Out-of-Network Care – LA* and *Out-of-Network Authorization Process* for additional details regarding OON processes.

c) **Other health insurance (OHI) discrepancy:** The NCC or health plan associate obtains as much information about the OHI as offered by the provider or member. If there is a discrepancy between the information on file in the claims payment system and the information provided with the precertification request, the health plan associate notifies the Cost Containment Unit via email (ccuohi@amerigroupcorp.com) for review

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of the member's OHI. The NCC notifies the Cost Containment Unit by routing a request through Compass to the OHI team. The associate proceeds with processing the pre-certification request regardless of the member's OHI as long as the member is eligible.

d) **Precertification date span:** Precertification requests entered into the UM system are allowed extension of services up to six (6) months. If services are still required after the expiration of the authorization, the NCC or health plan associate enters a new precertification for services upon receipt of a new request.

e) **Services are not covered:** Refer to *Non-Covered Service Authorization Process* below

Retroactive Eligibility/Review

1) Individuals may be retroactively eligible for Medicaid. Retro-eligible individuals may be retroactively enrolled with Healthy Blue for a period not to exceed twelve (12) months.
2) In cases of retroactive eligibility, the effective date of enrollment may occur prior to either the individual or Healthy Blue being notified of the person's enrollment.
3) Healthy Blue is not liable for the cost of any covered services prior to the effective date of enrollment. Healthy Blue is responsible for the costs of covered core benefits and services obtained on or after 12:01 am CST on the effective date of enrollment. This includes reimbursement to a member for payments already made by the member for Medicaid payable services rendered during the retroactive eligibility period.
4) The Louisiana Department of Health (LDH) shall make monthly capitation payments to Healthy Blue from the effective date of a member's enrollment. Claims for dates of service prior to the effective date of enrollment shall be submitted by providers directly to the Medicaid Fiscal Intermediary for payment.
5) Except for applicable Medicaid cost sharing, Healthy Blue shall ensure members are held harmless for the cost of covered services provided as of the effective date of enrollment with Healthy Blue.
6) Healthy Blue shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is submitted within one hundred and eighty (180) days from the member's linkage to Healthy Blue.
   a) The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted by the latter of three hundred and sixty-five (365) calendar days from the date of service or one hundred and eighty (180) days from the member's linkage to Healthy Blue.
7) A member may be retroactively enrolled up to twelve (12) months before the member's Healthy Blue linkage date. Providers have up to twelve (12) months from the linkage date to submit claims for services with dates of service during the retrospective enrollment period.
   a) The linkage date is reported on the 834 file header.
   b) The provider shall not be required to submit the member's eligibility determination award letter.

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c) Healthy Blue shall not deny claims for timely filing, prior authorization, or precertification edits.
d) Healthy Blue may conduct post-service reviews for medical necessity and if it is determined the service was not medically necessary, Healthy Blue may deny the claim. The provider will have the right to appeal the denial.

Inpatient Retrospective Review Activity

1) Providers are instructed to notify the National Customer Care (NCC) Department within one (1) business day of an urgent/emergent inpatient admission for admission review. Elective admissions must be precertified prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.
2) Once notification is received and the request is entered in the medical management system, the admission appears on the census report and is reviewed by the assigned UM clinician.
3) If notification of the inpatient admission was made after the member was discharged, a post-service (retrospective) review is completed. A decision to approve the admission is based on company policy, medical necessity criteria, and/or discussion with the health plan/regional Medical Director (or appropriate practitioner). Refer to the *Medicaid Non Notification Grid (NNG)* and processing instructions.
   a) If notification was not received timely, and the member is still inpatient at the time of notification (not yet discharged), the request is considered concurrent and held to concurrent review processing standards (refer to *Concurrent Review (Telephonic and On-Site) – LA*). Coverage of services may be denied as result of the facility's non-compliance with notification requirements in accordance with company policy, the Contract, and applicable law.
   b) When notification and/or initial clinical is sent after discharge, the request is considered a retrospective review (it does not fall into the concurrent review category). The services have already been provided and Healthy Blue has no ability to impact the stay.
4) 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 and eighty (180) calendar days from the date of service.
5) For service authorization approval, the provider (whether a healthcare professional, 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 initial determination, and documented confirmation of such notification is provided to the provider within two (2) business days of making the determination.
   a) Healthy 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

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omission or misrepresentation about the member's health condition made by the provider.

b) Healthy Blue shall not use a policy with an effective date subsequent to the original service authorization request date to rescind its prior authorization.

6) For 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, the provider (whether a healthcare professional, facility, or both) is notified verbally or as expeditiously as the member's health condition requires but no more than one (1) business day of making the initial determination. The member, requesting provider, and servicing provider are notified in writing within two (2) business days of making the adverse determination (refer to *Health Care Management Denial – LA*).

Outpatient Retrospective Review Activity

1) If the provider contacts Healthy Blue after non-emergent outpatient care has been rendered and precertification was required, the following applies:
   a) The provider is advised that precertification must occur prior to the procedure or service being rendered.
   b) The request is routed to an UM clinical associate for administrative denial for lack of notification; medical necessity review is completed for current and/or future dates of service (refer to *Precertification of Requested Services – LA*).
   c) The requesting provider is informed of appeal and payment dispute options included as part of the claims review process.
2) If an outpatient procedure requires notification only (no medical necessity review), the NCC associate will redirect to the clinical team to enters and completes the notification in the medical management system. The provider is advised no precertification is required, and claims may be submitted for payment.

Service Authorization Clinical Information

1) Clinical information is material about a member's medical history or condition obtained directly or indirectly from a licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility. Clinical information includes, but is not limited to:
   - Office and/or hospital records;
   - A history of the presenting problem;
   - Clinical exam(s) results;
   - Results from diagnostic testing;
   - Treatment plans and progress notes;
   - Psychosocial history;
   - Consultations with the treating practitioner(s);
   - Evaluations from other health care practitioners and providers;
   - Photographs (MRIs, X-rays, Ultrasounds, ECGs, EEGs, etc.);

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- Laboratory results;
- Operative and pathological reports and results;
- Rehabilitation evaluations;
- Criteria related to request;
- Information regarding benefits for services and/or procedures;
- Information regarding the local delivery system;
- Member's characteristics and information;
- Information from responsible family member(s);
- Member's safety issues; and
- ~~1)~~ Diagnosis codes

2) Information necessary for review to substantiate medical necessity includes, but is not limited to:
   - Completed request form;
   - Medical information from the physician;
   - Written prescription, physician orders, or letter of medical necessity not more than twelve (12) months old from a licensed physician or physician's representative;
   - Diagnosis related to the request;
   - Length of time that services will be needed; and
   - Any other medical information or pertinent information to support the need for the requested service, such as measurements~~.~~;
   - Statement as to whether the beneficiary's age and circumstances indicate that they can adapt to or be trained to use the item effectively; and
   - Plan of care (POC) that includes a training program when any supplies or equipment requires skill and knowledge to use.
3) The fact that a provider has prescribed or recommended equipment, supplies or services does not, in itself, make it medically necessary or a medical necessity or a covered service.
4) It is the provider's responsibility to submit all clinical information necessary to justify both severity of illness and intensity of service. If the clinical submitted is inadequate, Healthy Blue may deny the request or request additional information.
5) When submitting additional documentation, providers should only submit the pertinent clinical information needed to justify severity of illness and intensity of service.
6) When Healthy Blue requests additional information, the turnaround time clock for review does not start until all necessary clinical information to make the decision to approve or deny initial or continued services is received.
7) 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.
8) The information required in order for Healthy Blue to make medical necessity determination is available to members and providers, and given verbally when requested.

Obtaining Additional Clinical Information

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The organization has a process for requesting clinical information from individuals identified by practitioners or their designees to ensure timely UM decision making and continuity of care and service for members, while avoiding unnecessary or excessive requests.

1) The health plan contacts appropriate individuals designated by the practitioner as a resource for the provision of routine clinical information. The clinical associate retains the right to contact the practitioner or their designee when a review may be unreasonably delayed or the designated individual is unavailable or unable to supply the requested clinical information.
2) When conducting routine utilization reviews, the clinical associate generally requests only relevant clinical information to pre-certify the admission, procedure, treatment, or length of stay and development of a discharge plan when appropriate. This includes identifying information about the member or the treating practitioner rendering care. It may also include clinical information, allowable by law or with permission, regarding diagnosis and treatment plan along with justification for the treatment plan. Second opinion information may be requested when applicable. This information should only be requested when relevant to the UR and should generally be obtained through established channels.
3) The clinical associate requires the practitioner to supply the minimum necessary clinical information for pre-certification to be considered. Practitioners are encouraged to supply numerically codified diagnoses or procedures, but are not required to do so for precertification.
4) The clinical associate may request copies of medical records for members if there is difficulty determining medical necessity, appropriateness of admission, or length of stay in some instances. In those instances, only the necessary or pertinent clinical information is required. Medical records will be secured in accordance with security and privacy policies and retained in accordance with the corporate document retention schedule.
5) If there is “significant lack of agreement” between the Medical Director (or qualified practitioner) and the provider, additional information may be requested as part of the adverse determination and/or appeal processes. Attempts may also be made by the Medical Director (or qualified practitioner) to consult with the treating practitioner in instances of “significant lack of agreement.”
6) Healthy Blue’s policies and procedures are designed to share all clinical and demographic information on a particular case with appropriate internal departments to prevent duplication of requests.
7) Healthy Blue does not require, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist’s process or progress notes. This does not preclude the health plan from requiring submission of a member’s medical record.

Insufficient Clinical Information

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When a request for service(s) has been initiated; but the clinical associate or health plan Medical Director (or qualified practitioner) is unable to render a fully informed medical necessity decision due to the provider not supplying the following:

1) Supporting clinical information; or
2) In the opinion of the clinical associate or health plan (or qualified practitioner), the clinical information supplied is incomplete or insufficient.

It is the provider's responsibility to submit all clinical information necessary to justify both severity of illness and intensity of service. If the clinical submitted is inadequate, Healthy Blue may deny the request or request additional information. When submitting additional documentation, providers should only submit the pertinent clinical information needed to justify the request. Healthy Blue requests additional information, the turnaround time clock for decision does not start until all necessary clinical information to make the decision to approve or deny is received. In cases where the provider or member will not release necessary information, Healthy Blue may deny authorization of requested services. The denial notificationcaiton will be made within two (2) business days of making a determination.

Service Authorization Criteria

1) Healthy Blue ensures that service authorization criteria are consistent with applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and waivers. Healthy Blue uses LDH's definition of medically necessary services.
2) Healthy Blue only uses criteria that:
   a) Are adopted in consultation with contracted healthcare providers;
   b) Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
   c) Consider the needs of the enrollees; and
   d) Are updated periodically as appropriate.
3) Healthy Blue clearly identifies the source of the criteria and include:
   a) The vendor if the criteria were purchased;
   b) The association if the criteria are developed/recommended or endorsed by a national or state health care provider association or society; and/or
   c) The guideline source if the criteria are based on a published clinical practice guideline.
4) Healthy Blue utilizes the following criteria when making medical necessity determinations:
   a) State established clinical and coverage policies, manuals, and requirements/mandates;
   b) Federal regulatory requirements/mandates;
   c) Member benefits;
   d) Company policies and procedures;
   e) Company Medical Policies and Clinical Guidelines;
   f) MCG Care Guidelines;
   g) Company Behavioral Health Medical Necessity Criteria;

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h) American Society of Addiction Medicine (ASAM) Criteria and Levels of Care; and
i) ~~AIM~~[BRL1] ~~Specialty Health~~ Carelon Medical Benefits Management Guidelines.

Service Authorization Determination and Timing of Notices

1) **NOTE:** The State turnaround time clock for decision-making does not start until all necessary clinical information to make the decision is received. However, NCQA measures timeliness of notification to the member and practitioner from the date when the organization receives the request, even if the organization does not have all the information necessary to make a decision. Where State or Federal time standards differ from NCQA, the more stringent time standard applies. Refer to Corporate-owned policies for NCQA standards.
2) **Standard Service Authorization (State Contract):**
   a) Healthy Blue makes eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed procedure, or service requiring a review determination, with the following exceptions:
      i) Healthy Blue makes all inpatient hospital service authorizations within two (2) calendar days of obtaining appropriate medical information; and
      ii) Healthy Blue makes all community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR) service authorizations within five (5) calendar days of obtaining appropriate medical information.
      ~~ii)~~iii) Healthy Blue makes all determinations for any 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.
   b) All standard service authorization determinations are made no later than fourteen (14) calendar days following receipt of the request for service.
   c) The service authorization determination may be extended up to an additional fourteen (14) additional calendar days if:
      i) The enrollee, or the provider, requests the extension; or
      ii) Healthy Blue justifies (to LDH upon request) a need for additional information and how the extension is in the enrollee's interest.
   d) Healthy Blue makes all concurrent review determinations within one (1) calendar day of obtaining the appropriate medical information that may be required.
3) **Expedited Service Authorization:**
   a) In the event a provider indicates, or Healthy Blue determines, that following the standard service authorization timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, Healthy Blue makes an expedited authorization determination and provides notice as expeditiously

as the enrollee's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

b) Healthy Blue extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the enrollee requests the extension or if Healthy Blue justifies to LDH a need for additional information and how the extension is in the enrollee's best interest.

4) **Post-Service Authorization:**
   a) Healthy Blue makes retrospective review determinations 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.
   b) Healthy 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 enrollee's health condition made by the provider.
   c) Healthy Blue cannot use a policy with an effective date subsequent to the original service authorization request date to rescind its prior authorization.
5) **Notices of Determinations:**
   a) **Service Authorization Approvals:**
      i) For service authorization approval for a non-emergency admission, procedure or service, Healthy Blue notifies the provider 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 provide written notification to the provider within two (2) business days of making the determination.
      ii) For service authorization approval for extended stay or additional services, Healthy Blue notifies the provider rendering the service, whether a health care professional or facility or both, and the enrollee receiving the service, 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 provides written notification to the provider within two (2) business days of making the determination.
   b) **Adverse Actions:**
      i) Healthy Blue notifies the enrollee, in writing using language that is easily understood by the enrollee, of determinations 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 *Enrollee Grievances, Appeals and State Fair Hearings* section of the Contract. The notice of action to enrollees is consistent with requirements in 42 CFR §438.404, §438.10 and §438.210, the *Marketing and Education* section of the contract for enrollee written materials, and any agreements that the Department may have entered into relative to the contents of enrollee notices of denial or partial denial of services, regardless of

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whether such agreements are related to legal proceedings or out-of-court settlements.

ii) Healthy Blue notifies the requesting provider of a determination 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. Healthy Blue provides written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) business days of making the determination.

iii) House Bill 424 of the 2019 Regular Session, relative to claim and prior authorization denials, requires MCOs to furnish prior authorization requirements to providers within twenty-four (24) hours of a request, or make requirements available online through the insurer's website. MCOs are required to give written notice of prior authorization denials within three (3) days of a denial determination. If a prior authorization or claim denial is based upon an opinion or interpretation of law, regulation, policy, procedure, or medical criteria or guideline, MCOs must provide in the written notice either instructions to access the source in the public domain or provide a copy of the source.[3]

c) **Informal Reconsideration (Peer-to-Peer Review):**

i) As part of Healthy Blue's appeal procedures, the informal reconsideration process allows the enrollee (or provider/agent on behalf of an enrollee) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing (refer to *Informal Reconsideration – LA*).

ii) In a case involving an initial determination or a concurrent review determination, Healthy Blue provides the enrollee or a provider acting on behalf of the enrollee and with the enrollee's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [42 CFR §438.402(c)(1)(ii)].

iii) The informal reconsideration occur within one (1) business day of the receipt of the request and are conducted between the provider rendering the service and Healthy Blue's 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.

iv) The informal reconsideration does not extend the thirty (30) calendar day required timeframe for a notice of appeal resolution.

v) **NOTE:** The enrollee is allowed sixty (60) calendar days from the date on Healthy Blue's notice of action or inaction to request a formal appeal. If an enrollee or provider requests a service or procedure that was previously denied within the last sixty (60) calendar days, refer the enrollee/provider to their appeals and State Fair Hearing rights; do not enter a new request. If an enrollee or provider requests a

[3] Act 330 (House Bill 424) from the 2019 Regular Session to amend and reenact La. RS 46:460.71(C) and to enact RS 46:460.51(15) and 460.74 effective August 1, 2019.

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service or procedure that was previously denied greater than sixty (60) calendar days, enter a new service authorization request.

NCQA Precertification Standards

1) Non-urgent pre-service decisions and notifications are made within fourteen (14) calendar days of receipt of the request;
2) Urgent pre-service decisions and notifications are made within seventy-two (72) hours (or three (3) calendar days) of receipt of the request.
   a) The following criteria must be met to qualify for an urgent review: A member, or any physician (regardless of whether the physician is affiliated with Healthy Blue), may request that the health plan expedite a determination when the member or his/her physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.
   b) A date of service is less than fourteen (14) calendar days from the request date, does not solely justify or meet criteria for an expedited/urgent/STAT review.
   c) The urgent pre-service timeframe may be extended due to lack of necessary information, once, up to fourteen (14) calendar days, under the following conditions:
      i) The member requests the extension.
      ii) Healthy Blue justifies (to the State agency, upon request) a need for additional information and how that extension is in the member's best interest.
      iii) Healthy Blue documents it made at least (1) attempt to obtain the necessary information.
   d) The member or the member's authorized representative is notified of the decision no later than the expiration of the extension. Non-urgent pre-service requests that lack necessary information (this includes situations beyond the plan's control (e.g., waiting for an evaluation by a specialist) may be extended once, up to fourteen (14) calendar days, under the following conditions:
      i) Within fourteen (14) calendar days of the request, the member or authorized representative is notified of what specific information is required to make the decision.
      ii) The member or authorized representative is given at least forty-five (45) calendar days to provide the information.
      iii) The fourteen (14) calendar day extension period, within which a decision must be made, begins when the additional information is received (even if all requested information is incomplete or not provided), or at the end of the forty-five (45) calendar days given when no response is received.
      iv) Healthy Blue may deny the request if it does not receive the information within the timeframe, and the member may appeal the denial.

~~v)~~

~~d)~~ **Continuation of Benefits:**

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~~i)~~1) Healthy Blue continues to provide benefits and services during the appeal if all of the following occur:

a) The request for an appeal is filed timely as defined in the Contract in accordance with applicable Federal and State laws, regulations, rules, policies, procedures, and manual. As used in this section, "timely"' filing means filing on or before the later of the following:

i) Within ten (10) calendar days of the mailing the notice of adverse benefit determination; or

ii) The intended effective date of Healthy Blue's proposed action.

b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

c) The services were ordered by an authorized provider;

d) The original period covered by the original authorization has not expired; and

e) The enrollee timely files for continuation of benefits.

~~ii)~~2) If, at the enrollee's request, Healthy Blue continues or reinstates the enrollee's benefits while the appeal is pending, the benefits shall be continued until one of following occurs:

a) The enrollee withdraws the appeal;

b) Ten (10) calendar days pass after Healthy Blue mails the notice providing the resolution of the appeal adverse to the enrollee, unless the enrollee, within the ten (10) calendar day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;

c) Following a State Fair Hearing, the administrative law judge issues a hearing decision adverse to the enrollee; or

d) The time period or service limits of a previously authorized service has been met.

~~6)~~ **Written Materials:**

~~a)~~1) Healthy Blue complies with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.). Healthy Blue also complies with the requirements outlined in 42 CFR §438.10, 42 USC §1396u-2(d)(2)(A)(i), and 42 USC §1396u-2(a)(5):

a) All member materials are in a style and reading level that accommodates the reading skills of MCO enrollees. In general, the writing is at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to ensure accuracy.

i) Flesch – Kincaid;

ii) Fry Readability Index;

iii) PROSE The Readability Analyst (software developed by Educational Activities, Inc.);

iv) Gunning FOG Index;

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v) McLaughlin SMOG Index; or

~~i)~~vi) Other computer generated readability indices accepted by LDH

~~ii)~~b) All written materials are clearly legible with a minimum font size of twelve (12) point, with the exception of MCO Member ID Cards, and or otherwise approved by LDH in writing.

~~iii)~~c) All multi-page written member materials notify the enrollee that real-time oral and American Sign Language interpretation is available for any language at no expense to them and provide information on how to access those services. Alternative forms of communication are provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives are provided at no expense to the enrollee.

Service Authorization Requirements for New Enrollees

1) **General Requirements:**
   a) Healthy Blue does not require service authorization for the continuation of medically necessary MCO 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, Healthy Blue may require prior authorization of services beyond thirty (30) calendar days.
   b) For the first thirty (30) calendar days of enrollment, Healthy Blue is prohibited from denying a prior authorization solely on the basis of the provider being an out-of-network provider.
2) **Pregnancy:**
   a) In the event a new enrollee is in the first trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of enrollment, Healthy Blue is responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of authorization needed and without regard to whether such services are being provided by a network or non-network provider until such time as Healthy Blue can reasonably transfer the enrollee to a network provider without impeding service delivery that might be harmful to the enrollee's health.
   b) In the event a new enrollee is in her second or third trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of enrollment, Healthy Blue is responsible for providing continued access to the prenatal care provider (whether network or non-network provider) for sixty (60) calendar days postpartum, provided the enrollee remains covered through Healthy Blue, or referral to a safety net provider if the enrollee's eligibility terminates before the end of the postpartum period.
   c) In the event a new enrollee is actively receiving medically necessary MCO Covered Services other than prenatal services at the time of Enrollment, Healthy Blue is responsible for the costs of continuation of such medically necessary services, without

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any form of authorization needed and without regard to whether such services are being provided by network or non-network providers. Healthy Blue provides continuation of such services up to ninety (90) calendar days or until the enrollee may be reasonably transferred to an in-network provider without disruption, whichever is less. Healthy Blue may require prior authorization for continuation of the services beyond thirty (30) calendar days; however, Healthy Blue is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

d) Healthy Blue ensures that the enrollee is held harmless by the provider for the costs of the above medically necessary MCO Covered Services.

3) **Special Health Care Needs (SHCN):**
   a) Where a new enrollee with special health care needs (SHCN) is actively receiving medically necessary MCO Covered Services at the time of enrollment, Healthy Blue provides continuation/coordination of such services up to ninety (90) calendar days or until the enrollee may be reasonably transferred to a network provider without disruption, whichever is less. Healthy Blue may require prior authorization for continuation of the services beyond thirty (30) calendar days; however, Healthy Blue is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.
4) **Maintenance Medications:**
   a) Healthy Blue shall submit for approval, a transition of care program that ensures enrollees can continue treatment of maintenance medications for at least sixty (60) calendar days after enrollment with Healthy Blue or switching from one plan to another. Healthy Blue shall continue any treatment of antidepressants and antipsychotics for at least sixty (60) calendar days after enrollment with Healthy Blue. Additionally, an enrollee that is, at the time of enrollment with Healthy Blue, receiving a prescription drug that is not on the Preferred Drug List (PDL) is permitted to continue to receive that prescription drug if medically necessary for at least sixty (60) calendar days.
5) **Durable Medical Equipment, Prosthetics, Orthotics, and Certain Supplies (DMEPOS):**
   a) In the event an enrollee who is newly enrolled with Healthy Blue is actively receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies (DMEPOS) services at the time of enrollment, whether such services were provided by another MCO or Fee-for-Service (FFS), Healthy Blue is responsible for the costs of continuation of these services, without any form of authorization and without regard to whether such services are being provided by network or non-network providers. Healthy Blue provides continuation of such services for up to ninety (90) calendar days or until the enrollee may be reasonably transferred to a network provider (within the timeframe specified in the Contract) without disruption, whichever is less.

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b) Healthy Blue also honors any prior authorization for DMEPOS services issued while the enrollee was enrolled in another MCO or FFS for a period of ninety (90) calendar days after the enrollee's enrollment.

Other Service Authorization Requirements

1) The Medicaid Executive Director, in consultation with the Medicaid Medical Director, may require Healthy Blue to authorize services on a case-by-case basis.
2) Healthy Blue shall not deny continuation of higher-level services (e.g., inpatient hospital or psychiatric residential treatment facilities) 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 level of care.
3) Healthy Blue utilizes a common hospital observation policy that is developed and maintained collectively by the MCOs with approval by LDH in writing. Any revisions shall be reviewed and approved by LDH in writing at least thirty (30) calendar days prior to implementation (refer to *Observation – LA*).
4) 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.
5) Healthy Blue ensures that initial and concurrent inpatient psychiatric hospital utilization reviews are completed by a licensed mental health professional (LMHP) or psychiatrist for each enrollee.
6) Healthy Blue should coordinate the development of service authorization policies with other MCOs where appropriate to avoid providers receiving conflicting policies from different MCOs.
7) Healthy Blue does not require service authorization for:
   a) Emergency services or post-stabilization services as described in the Contract whether provided by an in-network or out-of-network provider;
   b) Non-emergency inpatient hospital admissions for normal newborn deliveries; and
   c) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services.

Emergency and Post-Stabilization Services

1) Healthy Blue reimburses providers for emergency services rendered without a requirement for service authorization of any kind.
2) Healthy Blue's protocol for provision of emergency services specifies that emergency services shall be covered when furnished by a provider with whom Healthy Blue does not have a network provider agreement or referral arrangement.
   a) Healthy Blue shall make payment for covered emergency and post-stabilization services that are furnished to enrollees by providers that have no contractual arrangements with the Healthy Blue for the provision of such services.

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3) Healthy Blue may not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.
4) Healthy Blue shall not deny payment for treatment obtained under either of the following circumstances:
   a) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or
   b) A representative of Healthy Blue instructs the enrollee to seek emergency services.
5) Healthy Blue shall not refuse to cover emergency services based on the emergency room (ER) provider, hospital, or fiscal agent's failure to notify the enrollee's primary care physician (PCP) or Healthy Blue of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services.
6) Healthy Blue is financially responsible for emergency services, including transportation, and shall not retroactively deny a claim for emergency services, including transportation, to an emergency provider because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, was subsequently determined to be non-emergent in nature.
7) Healthy Blue is financially responsible for post-stabilization care services, as specified in 42 CFR §438.114(e) and §422.113(c), obtained within or outside the network that are:
   a) Pre-approved by a network provider or other Healthy Blue representative; or
   b) Not pre-approved by a network provider or other Healthy Blue representative, but:
      i) Administered to maintain the enrollee's stabilized condition within one (1) hour of a request to Healthy Blue for pre-approval of further post-stabilization care services;
      ii) Administered to maintain, improve or resolve the enrollee's stabilized condition if Healthy Blue:
         (1) Does not respond to a request for preapproval within one (1) hour;
         (2) Cannot be contacted; or
         (3) Healthy Blue's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a network physician is not available for consultation. In this situation, Healthy Blue shall give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 42 CFR §422.113(c)(3) is met.
      iii) Are for post-stabilization hospital-to-hospital ambulance transportation of enrollees with a behavioral health condition, including hospital to behavioral health specialty hospital.
8) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or

discharge, and that determination is binding on Healthy Blue as responsible for coverage and payment as per 42 CFR §438.114(d). Healthy Blue's financial responsibility ends for post-stabilization care services it has not pre-approved when:

a) A network physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
b) A network physician assumes responsibility for the enrollee's care through transfer;
c) A representative of Healthy Blue and the treating physician reach an agreement concerning the enrollee's care; or
d) The enrollee is discharged.

9) In any instance when the enrollee presents to the network provider, including calling Healthy Blue's toll-free number listed on the MCO Member ID Card, and an enrollee is in need of emergency behavioral health services, Healthy Blue instructs the enrollee to seek help from the nearest emergency medical provider. Healthy Blue initiates follow-up with the enrollee within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.
10) Louisiana Medicaid is not obligated to pay for non-emergency (routine) care provided in the ER, 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.
11) Hospitals are required by the Emergency Medical Treatment and Labor Act (EMTALA) to perform a Medical Screening Exam (MSE) on all persons who present to the ER for services. If the MSE does not reveal the existence of an emergency medical condition, the enrollee should be advised that Medicaid does not cover routine/non-emergent care provided in the ER when the presenting symptoms do not meet the prudent layperson standard of an emergency condition and that he/she may receive a bill if they are treated in the ER. The enrollee should be referred back to his/her PCP for follow-up and evaluation.
12) When an emergency visit results in an inpatient admit, providers must bill all charges associated with the emergency visit on the inpatient bill. This policy applies to enrollees admitted from the ER or if the enrollee has been seen in the ER within twenty-four (24) hours either prior to admit or after the inpatient discharge.

Hospital Services

1) Authorization is required for inpatient hospital services. Inpatient hospital care is defined as care needed for the treatment of an illness or injury, which can only be provided safely and adequately in a hospital setting and includes those basic services that a hospital is

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expected to provide. Payment is not be made for care that can be provided in the home or for which the primary purpose is of a convalescent or cosmetic nature.

2) Inpatient hospital services must be ordered by the following:
   a) Attending physician;
   b) An ER physician; or
   c) Dentist (if the patient has an existing condition which must be monitored during the performance of the authorized dental procedure).
3) 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.
   a) Medicaid allows up to forty-eight (48) hours for a beneficiary to be in an outpatient status without authorization. This timeframe is for the physician to observe the patient and to determine the need for further treatment, admission to an inpatient status or for discharge (refer to *Observation – LA* for details).
4) 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.
5) **Notification and Clinical Submission Deadline:**
   a) 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.
   b) 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.
   c) 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.
   d) Providers submitting clinical information for concurrent review, have a submission deadline of 3:00 pm CST, with a ten (10) minute grace period.
   e) It is the provider's responsibility to submit clinical information for review by the specified "Next Review" date and deadline of 3:00 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 3:00 pm CST on the next business day to submit clinical information.

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f) Healthy Blue has implemented a ten (10) minute grace period to alleviate time discrepancies on fax and voicemail machines. 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.

g) Receipt of administrative denial is based on timely notification, not medical necessity. Upon receipt of this denial, providers have until 3:00 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.

h) 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 concurrent review 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.

i) Normal deliveries, vaginal or cesarean section, do not fall into the concurrent review category. The inpatient days for these stays are authorized by Federal and State guidelines; however, notification of admission for delivery is required.

6) **Hospital Definition of Discharge:**

a) An enrollee is considered discharged from an inpatient or outpatient hospital when:
   i) The beneficiary is formally discharged from the hospital; or
   ii) The beneficiary dies in the hospital.

b) 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.

c) Non-medically necessary circumstances are not considered in determining the discharge time; therefore, hospitals will not be reimbursed under these circumstances (e.g., enrollee does not have a ride home, does not want to leave, etc.).

d) If non-medical circumstances arise and the enrollee does not leave the hospital when he/she is discharged and the hospital is not reimbursed, the enrollee may be billed but only after hospital personnel have informed him/her that Medicaid will not cover that portion of the stay.

e) 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.

f) **NOTE:** Hospitalized beneficiaries are covered by the type coverage in effect at the time of admission, either FFS or MCO, until discharge. If an enrollee is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective on the date of enrollment into the receiving MCO. However, the relinquishing MCO is

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responsible for the enrollee's hospitalization until the enrollee is discharged. The receiving MCO is responsible for all other care.

i) 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 revert to the receiving MCO, effective at 12:01 am CST on the calendar day after the relinquishing MCO's contract ends. LDH identify and addresses any exceptions to this provision in the *MCO Manual*.

7) **Surgeries Performed on an Inpatient Basis:**
   a) Healthy Blue covers 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. Outpatient procedures performed on an inpatient ~~dme~~basis and planned inpatient hospital stays require precertification.
   b) Healthy Blue may approve inpatient performance of these procedures when one (1) or more of the following exception criteria exists:
      i) Documented medical conditions exist that make prolonged pre-and/or post-operative observation by a nurse or skilled medical personnel a necessity.
      ii) The procedure is likely to be time consuming or followed by complications.
      iii) An unrelated procedure is being performed simultaneously that requires hospitalization.
      iv) There is a lack of availability of proper post-operative care.
      v) Another major surgical procedure could likely follow the initial procedure (e.g., mastectomy).
      vi) Technical difficulties, as documented by admission or operative notes, could exist.
      vii) The procedure carries high enrollee risk.
   c) Reimbursement for the performance of 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.

MCO Covered Services

1) Healthy Blue provides enrollees all medically necessary MCO Covered Services specified in *Attachment ~~C~~ B, MCO Covered Services,* as those services are defined in the State Plan and the *MCO Manual*. Healthy Blue possesses the expertise and resources to ensure the delivery of quality healthcare services to its enrollees in accordance with the Contract and prevailing medical community and national standards.
2) MCO Covered Services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS, as set forth in 42 CFR §440.230, and for enrollees under the age of twenty-one (21), as set forth in 42 CFR Part 441, Subpart B [42 CFR §438.210(a)(2)].

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3) Healthy Blue ensures that MCO Covered Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. Healthy Blue does not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the enrollee [42 CFR §438.210(a)(3)].
4) In accordance with 42 CFR §438.210(a)(4), Healthy Blue may place appropriate limits on a service that are:
    a) On the basis of criteria applied under the State Plan, such as medical necessity; or
    b) For the purpose of utilization control, provided that:
        i) The services furnished can reasonably be expected to achieve their purpose;
        ii) The services support enrollees with ongoing or chronic conditions and are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and
        iii) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.
5) Healthy Blue provides MCO Covered Services in accordance with LDH's definition of medically necessary services (see Glossary), including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the *MCO Manual* [42 CFR §438.210(a)(5)(i)].
    a) A public health quarantine or isolation order or recommendation also establishes medical necessity of healthcare services.
6) Healthy Blue covers medically necessary services that address:
    a) The prevention, diagnosis and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;
    b) The ability for an enrollee to achieve age-appropriate growth and development; and
    c) The ability for an enrollee to attain, maintain, or regain functional capacity.
7) Healthy Blue ensures that each enrollee has an ongoing source of care appropriate to their needs as required under 42 CFR §438.208(b)(1) and formally designates a PCP as primarily responsible for coordinating services accessed by the enrollee, as further described in the *Provider Network, Contracts, and Related Responsibilities* section of the Contract.
8) Healthy Blue does not avoid costs for services covered in its Contract by referring enrollees to publicly supported health care resources [42 CFR §457.1201(p)].
9) Healthy Blue shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services, including, but not limited to, potentially preventable hospital emergency department visits and inpatient readmissions.
10) Healthy Blue does not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an Advance Directive [42 CFR §438.3(j)(1) and (2); 42 CFR §489.102(a)(3)].
11) Healthy Blue and its providers shall deliver services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic

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backgrounds, disabilities, and regardless of gender, sexual orientation, ~~or gender identity~~ and provide for cultural competency and linguistic needs, including the enrollee prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c).

12) In the event that LDH determines that Healthy Blue failed to provide one or more MCO Covered Services, LDH shall direct Healthy Blue to provide such service. If Healthy Blue continues to refuse to provide the MCO Covered Service(s), LDH shall authorize the enrollees to obtain the MCO Covered Service from another source and shall notify Healthy Blue in writing that Healthy Blue shall be charged the actual amount of the cost of such service.
    a) In such event, the charges to Healthy Blue shall be obtained by LDH in the form of deductions from the next monthly capitation payment made to Healthy Blue or a future payment as determined by LDH. With such deductions, LDH shall provide a list of the enrollees for whom payments were deducted, the nature of the service(s) denied, and payments LDH made or will make to provide the medically necessary MCO Covered Services.
    b) In addition to the deduction, Healthy Blue may be assessed a monetary penalty per incident of non-compliance (see *Attachment G, Table of Monetary Penalties*).

Availability and Furnishing of MCO Covered Services

1) If Healthy Blue is unable to provide the necessary services to an enrollee within their network, Healthy Blue adequately and timely covers these services out-of-network for the enrollee for as long as Healthy Blue's provider network is unable to provide the services. Healthy Blue ensures coordination with respect to authorization and payment issues in these circumstances to ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network [42 CFR §438.206(b)(4) and (5)].
2) Healthy Blue ensures parity in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in accordance with 42 CFR §438.910(d)(3).
3) Healthy Blue may require prior authorization for out-of-network services, unless services are required to treat an emergency medical condition.
4) Healthy Blue shall not make payment for CPST or PSR services that are furnished to enrollees by providers that are out-of-network. Healthy Blue may make payment for CPST or PSR services only to those providers who are credentialed and participating in the provider network of Healthy Blue for the provision of such services, or who are licensed and accredited and have a single case agreement (SCA) with Healthy Blue for provision of such services.
5) As permitted by Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and applicable Waivers, telemedicine may be used to facilitate access to MCO Covered Services by licensed professionals. Any MCO Covered Service

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provided via telemedicine must be medically necessary, and the procedure individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the enrollee's needs. Healthy Blue may not utilize national telemedicine providers except in temporary or emergency situations (e.g., pandemics, natural disasters) if approved by LDH in writing.

6) Relative to the payment of claims made prior to credentialing, Healthy Blue considers a new healthcare provider joining an in-network group or facility to be an in-network or participating provider for the purposes of UM or prior authorization processes[4]. The new provider is referred to as a "joining provider (JP)" prior to being fully credentialed (FC).
7) **Trade Area:**
   a) In-state provider resources must be utilized prior to referring a enrollee to out-of-state providers.
   b) Acute care out-of-state providers in "trade areas" are treated the same as in-state providers. Trade areas are defined as being counties located in Mississippi, Arkansas and Texas that border the State of Louisiana. Acute care out-of-state providers in the above states that are not located in counties that border Louisiana are required to obtain prior authorization for all inpatient and outpatient services unless it is of an emergent nature.
   c) The following counties are located in the trade area:
      i) Arkansas: Chicot, Ashley, Union, Columbia, Lafayette, and Miller
      ii) Mississippi: Hancock, Pearl River, Marion, Walthall, Pike, Amite, Wilkerson, Adams, Jefferson, Claiborne, Washington, Issaquena, and Warren
      iii) Texas: Cass, Marion, Harrison, Panola, Shelby, Sabine, Newton, Orange, and Jefferson
   d) A referral or transfer made by a trade area hospital to another hospital does not constitute approval by Louisiana Medicaid unless it is to either a Louisiana hospital or another trade area hospital. Prior authorization is required for all other non-emergency referrals or transfers.
8) **Out-of-Network Protocols:**
   a) Healthy Blue maintains and utilizes protocols to address situations when the provider network is unable to provide an enrollee with appropriate access to MCO Covered Services as defined in the Contract and the *MCO Manual*. Healthy Blue's protocols ensure, at a minimum, the following:
      i) If Healthy Blue is unable to provide a particular MCO Covered Service through a network provider, it will be adequately covered in a timely manner out-of-network;
      ii) That the particular service will be provided by a qualified and clinically appropriate provider;

[4] Act No. 79 from the 2021 Regular Session to amend and reenact La. RS 22:1874(A)(5)(a)(introductory paragraph) and (ii) and RS 46:460.62(A)(introductory paragraph) and (2) and to enact RS 22:1874(A)(5)(a)(iii)) effective June 4, 2021

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iii) That the provider is located within the shortest travel time of the enrollee's residence, taking into account the availability of public transportation to the location;
iv) That the provider is licensed by the state of Louisiana or, if located in another state, the provider is licensed by that state; and
v) That the provider is licensed and accredited by an LDH approved accrediting organization, if required by Louisiana State or Federal requirements.

9) **Exclusion from Participation:**
a) Healthy Blue shall not pay claims to or execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either 42 USC §1320a-7 or §1320a-7a [42 CFR §438.214(d)] or state funded health care programs. Healthy Blue may access a list of providers excluded from federally funded health care programs using the sources provided in the *MCO Manual*.
i) Healthy Blue must conduct all required exclusion screenings. The list of entities excluded from federally funded health care programs can be found on the following websites:
(1) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
(2) System for Award Management (SAM);
(3) Louisiana Adverse Actions List Search (LAALS); and
(4) Health Integrity and Protection Data Bank.
b) Healthy Blue shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to 42 USC §1320a-7 or 42 USC §1320c-5 or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers currently undergoing any of the following conditions identified through LDH proceedings:
i) Revocation of the provider's license;
ii) Exclusion from the Medicaid program;
iii) Termination from the Medicaid program;
iv) Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review Subsystems (SURS) Rule (LAC 50:I.Chapter 41);
v) Provider fails to timely renew its license; or
vi) The Louisiana Attorney General's Office has seized the assets of the service provider.
c) Healthy Blue shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.
d) In accordance with 42 CFR §438.610, Healthy Blue and its subcontractors abide by all prohibited affiliations (employing or contracting, directly or indirectly) as directed by LDH in the *Fraud, Waste, and Abuse Prevention* section of the Contract.

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~~d)~~e) Healthy Blue ensures that physicians and all other professionals abide by the professional guidelines set forth by their certifying and licensing agencies in addition to complying with Louisiana Medicaid regulations.

~~e)~~f) In order to receive reimbursement, providers must meet all licensing and/or certification requirements inherent to his/her profession and comply with all other requirements in accordance with the Federal and State laws and Bureau of Health Services Financing (BHSF) policies. Licensed professionals seeking reimbursement for services provided to Medicaid beneficiaries must be enrolled with Louisiana Medicaid and accept the Medicaid payment as payment in full for Medicaid covered services. Services reimbursed by Medicaid may be subject to post-payment review and recoupment of any overpayments.

~~f)~~g) Healthy Blue shall not remit payment for services provided under the Contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any US territories (Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa).

10) Pursuant to Federal and State law, the Louisiana Medicaid Program is intended to be the payer of last resort. This means all other liable third parties must meet their legal obligation to pay claims before Healthy Blue pays for the care of an enrollee.
    a) Healthy Blue is always the payer of last resort, except when Healthy Blue is responsible for payment as primary payer for Medicaid Covered Services not covered by commercial insurance as primary payer (e.g., mental health and transportation services).
    b) The services listed below are typically not reimbursed by commercial health plans. Healthy Blue accepts the following claims billed directly from the provider without requiring an explanation of benefits from the primary carrier and pay as primary payer:
        i) Therapeutic Group Home (H0018);
        ii) Assertive Community Treatment per diem (H0039);
        iii) Crisis Stabilization (H0045);
        iv) Psychosocial Rehabilitation Services (H2017);
        v) Community Psychiatric Support and Treatment (H0036);
        vi) Multi-Systemic Therapy (H2033);
        vii) Crisis Intervention Service, per 15 minutes (H2011);
        ~~vii)~~viii) Behavioral Health Crisis Care (S9484);
        ~~viii)~~ix) Crisis Intervention Mental Health Services (S9485);
        ~~ix)~~x) EPSDT Personal Care Services (T1019); and
        ~~x)~~xi) Pediatric Day Health Care (T1025, T1026, T2002).

Excluded Services

1) The following services are available to enrollees under the State Plan or applicable waivers, but are excluded from the Contract and not provided through Healthy Blue. Healthy Blue informs enrollees how to access excluded services, provide all required

referrals and assist in the coordination of scheduling such services. Healthy Blue implements procedures to coordinate the services it provides to the enrollee with the services the enrollee receives in FFS.

a) Adult dental services with the exception of surgical dental services and emergency dental services;

b) Services to individuals in Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IIDs), except for coverage for the following comprehensive dental care for adults 21 and older:
   i) Diagnostic services (excluding codes D0120, D0150, D0210, D0240, D0272 and D0330 provided by the ICF)
   ii) Preventive services
   iii) Restorative services
   iv) Endodontics
   v) Periodontics
   vi) Prosthodontics
   vii) Oral and maxillofacial surgery
   viii) Orthodontics
   ~~b)~~ix) Emergency care;

c) Personal care services for those ages twenty-one (21) and older;

d) Nursing facility services, with the exception of post-acute rehabilitative care provided at the discretion of Healthy Blue when it is cost-effective to do so in place of continued inpatient care as an approved in lieu of service;

e) Individualized Education Plan (IEP) services, including physical therapy, occupational therapy, speech/language therapy, audiology and some psychological therapy, provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by Office of Public Health (OPH) certified school-based health clinics);

f) All home & community-based waiver services;

g) Targeted case management services;

h) Services provided through LDH's EarlySteps Program; and

i) The following excluded drugs:
   i) Select agents when used for symptomatic relief of cough and colds, not including prescription antihistamine and antihistamine/decongestant combination products;
   ii) Select agents when used for anorexia, weight loss, or weight gain, not including orlistat;
   iii) Select agents when used to promote fertility, not including vaginal progesterone when used for high-risk pregnancy to prevent premature births;
   iv) Drug Efficacy Study Implementation (DESI) drugs; and
   v) Select nonprescription drugs, not including over-the-counter (OTC) antihistamines, antihistamine/decongestant combinations, or polyethylene glycol.

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Prohibited and Non-Covered Services

1) The following services are not Medicaid Covered Services and shall not be provided to enrollees under the Contract:
   a) Elective abortions (those not covered in *Attachment ~~C~~ B, MCO Covered Services* and the *MCO Manual*) and related services;
   b) Experimental/investigational drugs, procedures or equipment, unless approved by the Secretary of LDH in writing;
   c) Elective cosmetic surgery; and
   d) Assisted reproductive technology for treatment of infertility.
2) The following non-exhaustive list of services are additionally excluded from MCO covered services and/or otherwise limited by Louisiana Medicaid:
   a) Any service (drug, device, procedure, or equipment) that is not medically necessary. Louisiana Medicaid does not reimburse for services that are not medically necessary including services that are not approved by the FDA, experimental or investigational services, and cosmetic services.
   b) Cosmetic drugs, devices, procedures, or equipment.
   c) Surgical procedures discontinued before completion. Medicaid will not pay professional, operating room, or anesthesia charges for an aborted surgical procedure, regardless of the reason.
   d) Services not provided or not documented. Providers shall not bill Medicaid or the enrollee for a missed appointment or any other services not actually provided. Services that have not been documented are considered services not rendered and are subject to recoupment.
   e) Never events. Medicaid will not pay for "never events" or medical procedures performed in error that are preventable and have a serious, adverse impact to the health of the Medicaid beneficiary. Reimbursement will not be provided when the following "never events" occur:
      i) The wrong surgical procedure is performed on a beneficiary;
      ii) The surgical or invasive procedures are performed on the wrong body part; or
      iii) The surgical or invasive procedures are performed on the wrong beneficiary.
   f) Services related to non-covered services. Louisiana Medicaid does not reimburse for services related to a non-covered service. Any payment received for non-covered and related services is subject to post-payment review and recovery.
   g) Infertility services. Louisiana Medicaid does not pay for services relating to the diagnosis or correction of infertility, including sterilization reversal procedures. This policy extends to any surgical, laboratory, or radiological service when the primary purpose is to diagnose infertility or to enhance reproductive capacity.
   h) Harvesting of organs when a Louisiana Medicaid enrollee is the donor of an organ to a non-Medicaid enrollee.
   i) Provider preventable conditions (PPCs), described in *Managed Care Organization (MCO) Manual – LA*.

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Non-Covered Service Authorization Process

1) The provider, member, or an associate may initiate a request for non-covered services. The Medicaid Prior Authorization (MPA) team or Healthy Blue HCM associate must obtain clinical records and supporting documentation from the provider to substantiate the need for the service.
2) Once all necessary supporting documentation is received, the request is forwarded to the appropriate Healthy Blue Medical Director for review and determination within contracted timing of service authorization decision and notification standards.
3) The Medical Director reviews the request and supporting documentation and makes a determination based on the member's needs, medical necessity guidelines, and a cost benefit analysis.
   a) If the Medical Director indicates an approval of the non-covered service, the provider and member are notified of the approval of the non-covered service per contractual and accreditation guidelines. The request is routed for a provider network single case agreement (SCA) when applicable.
   b) If the Medical Director determines a denial of the non-covered service, the provider and member are notified of the denial of the non-covered service per contractual and accreditation guidelines.

~~i)~~

~~j) Epidurals given to alleviate chronic, intractable pain are not covered; chronic pain management is not a covered service. Funds reimbursed for this purpose are subject to recoupment.~~

~~i) If an enrollee requests treatment for chronic intractable pain, the provider may submit a claim for the initial office visit. Subsequent services that are provided for the treatment or management of this chronic pain are not covered and are billable to the enrollee. Claims paid inappropriately are subject to recoupment.~~

3) **Prohibited Payments:**
   a) Healthy Blue denies payment to providers for deliveries occurring before thirty-nine (39) weeks without a medical indication.
   b) Healthy Blue denies payment to providers for PPCs that meet the following criteria:
      i) Is identified in the State Plan;
      ii) 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;
      iii) Has a negative consequence for the enrollee;
      iv) Is auditable; and
      v) 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.

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c) Payment for items or services provided under the Contract will not be made to any entity located outside of the United States.
d) Additionally, payment for the following shall not be made:
   i) Organ transplants, unless the State Plan has written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees.
   ii) Non-emergency services provided by or under the direction of an excluded individual.
   iii) Any amount expended for which funds may be not used under the Assisted Suicide Funding Restriction Act of 1997 (42 USC §14401, et seq.).
   iv) Any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan.
   v) Any amount expended for home health care services unless Healthy Blue ensures that the provider meets the appropriate surety bond requirements.

In Lieu of Services

1) Healthy Blue may, at its option, cover services or settings for enrollees that are in lieu of MCO Covered Services if the following conditions are met, as required in 42 CFR §438.3(e)(2)(i)-(iii):
   a) LDH determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State Plan;
   b) The enrollee is not required by Healthy Blue to use the alternative service or setting; and
   c) The approved in lieu of services are authorized and identified in ~~*Attachment D, Actuarial Rate Certification Letter.*~~ Attachment C, *In Lieu of Services.*
2) The utilization and actual cost of in lieu of services is taken into account in developing the component of the Capitation Rates that represents the MCO Covered Services, unless a statute or regulation explicitly requires otherwise.
3) Healthy Blue shall submit all in lieu of services for LDH approval in accordance with the *MCO Manual*. Specific information regarding ILOS can be found in the Healthy Blue *Managed Care Organization (MCO) Manual- LA policy.*
4) Healthy Blue shall have a plan for identifying and reporting the utilization of In Lieu of Services to LDH in accordance with the MCO Manual. The plan shall be submitted to LDH or its designee during Readiness Review and upon any subsequent LDH approval of additional In Lieu of Services.
5) Healthy Blue shall utilize a consistent process to ensure that its licensed clinical staff or Network Provider uses their professional judgement to determine and document that the In Lieu of Service is medically appropriate for the specific Enrollee, based on the clinically oriented target population.

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Value-Added Benefits (VAB)

1) As permitted under 42 CFR §438.3(e)(1), Healthy Blue may offer value-added benefits (VAB) which are not Medicaid Covered Services or prohibited services. VABs are provided at Healthy Blue's expense, are not included in the Capitation Rate, and identified as VABs in encounter data in accordance with the *MCO Manual* and the *MCO System Companion Guide*.
2) At a minimum, Healthy Blue offers the VAB(s) proposed in its response to the RFP and agreed upon by LDH, consistent with the Contract. Additional VABs may be offered, at Healthy Blue's option. All VABs are reported in accordance with the *MCO Manual* and the *MCO System Companion Guide*.
3) At Healthy Blue's discretion, it may provide or assist enrollees with transportation to access a VAB. Encounters for transportation related to VAB are identified as such.
4) Healthy Blue may propose to add to or expand upon the VAB(s) proposed in Healthy Blue's RFP response as pre-approved in writing by LDH. Deletions or reductions to the VAB(s) may be proposed on an annual basis and shall be submitted to LDH for approval at least six (6) months in advance of the ~~effective date of enrollment resulting from the~~ enrollment period.
5) Annually, for the VAB(s) proposed in Healthy Blue's RFP response, and as amended, Healthy Blue shall:
   a) Indicate the per member, per month (PMPM) actuarial value of the VAB(s), individually and in aggregate, based on enrollment projections for Healthy Blue's plan, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information; and
   b) Include a statement of commitment to provide the VAB(s) for the year.
6) Healthy Blue shall be directed by LDH in writing to revise its proposed PMPM based on any feedback from LDH, following an independent review of any statements of actuarial value provided by Healthy Blue.
7) The proposed monetary value of the VAB(s) is considered a binding Contract deliverable. If for any reason, including, but not limited to, lack of enrollee participation, the aggregated annual PMPM proposed is not expended by Healthy Blue, LDH reserves the right to require Healthy Blue to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.
8) VABs are not subject to appeal and State Fair Hearing rights. A denial of these benefits is not considered an adverse benefit determination for purposes of enrollee grievances and appeals. Healthy Blue sends the enrollee a notification letter if a VAB is not approved.

Moral or Religious Objections

1) If Healthy Blue elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, Healthy Blue must furnish information about the services that it does not cover, in accordance with 42 USC §1396u-2(b)(3)(B) and 42 CFR §438.102(b)(1), by notifying:

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a) LDH with its Proposal, or whenever it adopts the policy during the term of the Contract;
b) Potential enrollees before and during enrollment with Healthy Blue;
c) Enrollees at least thirty (30) calendar days prior to the effective date of the policy with respect to any particular service; and
d) Enrollees through the inclusion of the information in the *Member Handbook*.

2) If Healthy Blue elects not to provide, reimburse for, or provide coverage of an MCO Covered Service described in the Contract because of an objection on moral or religious grounds, Healthy Blue's monthly Capitation Payment will be adjusted accordingly.

Mental Health Parity

1) Healthy Blue complies with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. Healthy Blue complies with all requirements set forth in 42 CFR Part 438 Subpart K, for all enrollees.
   a) Healthy Blue must comply with parity requirements for aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits, including prescription drugs as specified in 42 CFR §438.905.
   b) All financial requirements or treatment limitations, including nonquantitative treatment limitations (NQTL), to mental health or substance use disorder benefits shall not be more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits, in accordance with 42 CFR §438.910. Financial requirements cannot accumulate separately for medical/surgical benefits and mental health/SUD benefits.
2) Healthy Blue develops and maintains internal controls to ensure mental health parity. Healthy Blue's utilization practices such as prior authorization, standards for medical necessity determination, and network policy, procedures and practices comply with the Federal regulations referenced above.
   a) Healthy Blue conducts a parity analysis as directed by LDH, based on benefit classifications for parity as defined by LDH. If an enrollee is provided mental health or substance use disorder benefits in any classification of benefits, mental health and substance use disorder benefits must be provided to the enrollee in every classification in which medical/surgical benefits are provided.
   b) Healthy Blue covers, in addition to MCO Covered Services, any service necessary for compliance with the requirements for parity in mental health and substance use disorder benefits based on parity analysis. As directed by LDH as part of ongoing parity review, Healthy Blue may be required to cover or change services necessary for compliance, including type and amount, duration and scope of services and change policy or operational procedures in order to achieve and maintain compliance with parity requirements.

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c) Healthy Blue ensures enrollees receive a notice of adverse benefit determination per 42 CFR §438.915(b) and the Contract which extend notice requirements beyond denials. Healthy Blue makes available in hard copy upon request at no cost to the requestor and available on Healthy Blue's website, the criteria for medical necessity determinations for mental health and substance use disorder benefits to any enrollee, potential enrollee, or provider per 42 CFR §438.236(c) and 438.915(a).

3) Healthy Blue requires that ~~all providers and~~ all subcontractors take such actions as are necessary to ensure compliance with mental health parity requirements. To the extent that Healthy Blue delegates oversight responsibilities for behavioral health services to a material subcontractor, Healthy Blue requires that the material subcontractor complies with provisions of the Contract relating to mental health parity. The compliance and review are in conjunction with parity analysis on the medical/surgical benefit administration. ~~Healthy Blue requires mental health parity disclosure on provider Enrollment forms as mandated by LDH.~~
   a) If at any time, the State moves to a single delivery system and any remaining benefits from FFS are completely provided through managed care, it shall be the responsibility of Healthy Blue to review mental health and substance user disorder and medical/surgical benefits and conduct the complete parity analysis to ensure the full scope of services available to all enrollees of Healthy Blue complies with the requirements set forth in 42 CFR Part 438, Subpart K. Healthy Blue shall be required to provide documentation to the State and public.
4) Healthy Blue provides LDH and its designees, which may include auditors and inspectors, with access to Healthy Blue service locations, facilities, or installations, including any and all electronic and hardcopy records and files. Access described in this section shall be for the purpose of examining, auditing, or investigating mental health parity.
5) Healthy Blue complies with all other applicable Federal and State laws, regulations, rules, policies, procedures, and manuals relating to mental health parity.

Provider Services and Support

1) Healthy Blue has trained provider relations staff dedicated to the Contract and available to providers to address provider issues Monday through Friday from 7:00 am to 7:00 pm CST and to handle emergent provider issues and non-routine prior authorization requests twenty-four (24) hours per day seven (7) days per week.
2) Outside of business hours, the provider toll-free telephone line includes the capability of providing information regarding business hours and instructions for verifying enrollment for any enrollee with an emergency or urgent medical condition.
3) Healthy Blue has a process in place to handle after-hours inquiries from providers seeking to verify enrollment for an enrollee in need of urgent or emergency services. Healthy Blue and its providers do not require such verification prior to providing emergency services.

4) Healthy Blue develops and maintains a provider handbook which includes specific information about MCO Covered Services, non-MCO Covered Services, and other requirements of the Contract relevant to provider responsibilities.
5) Healthy Blue develops and offers specialized initial and ongoing training in the areas including, but not limited to, billing procedures and service authorization requirements.
~~5)~~6) Healthy Blue has a provider website. Healthy Blue maintains forms on its provider website to allow submittal of complaints, disputes, Grievances, and Appeals electronically. In addition, Healthy Blue shall provide providers with an address to submit Grievances and Appeals in writing and a phone number to submit Grievances and Appeals by telephone.

~~6)~~ **Clinical Practice Guidelines:**

a) Healthy Blue complies with the requirements specified in 42 CFR § 438.236. Clinical practice guidelines refer to educational materials aimed at informing providers of best practices and evidence-based standards. Clinical practice guidelines are distinct from authorization criteria and shall not be used to make coverage, medical necessity, or reimbursement determinations.
b) Healthy Blue shall adopt clinical practice guidelines for at least the conditions listed below:
   i) Schizophrenia;
   ii) ADHD;
   iii) Autism Spectrum Disorder;
   iv) Depression;
   v) Generalized Anxiety Disorder;
   vi) Post-Traumatic Stress Disorder;
   vii) Suicidal Behavior;
   viii) Oppositional Defiant Disorder;
   ix) Bipolar Disorder; and
   x) Substance Use Disorders.
c) Healthy Blue shall adopt clinical practice guidelines that meet the following requirements:
   i) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
   ii) Consider the needs of the Contractor's Enrollees.
   iii) Are adopted in consultation with network providers.
   ~~a)~~iv) Are reviewed and updated periodically as appropriate
~~b)~~d) Healthy Blue should coordinate the development of clinical practice guidelines with other MCOs where appropriate to avoid providers receiving conflicting guidelines from different MCOs.
e) Healthy Blue disseminates the clinical practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

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~~c)~~f) Healthy Blue ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the clinical practice guidelines.

~~d)~~g) Healthy Blue should encourage adoption of the clinical practice guidelines by providers and measure compliance with the guidelines through provider monitoring.

~~e)~~h) Healthy Blue should employ provider incentive strategies, such as financial and non-financial incentives, to improve compliance.

Hold Harmless as to Enrollees

1) Notwithstanding State Plan approved cost sharing, Healthy Blue hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for MCO Covered Services that are rendered to such enrollees by Healthy Blue and its subcontractors.
2) Healthy Blue further agrees that the enrollee shall not be held liable for payment for covered services furnished under a network provider agreement, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the enrollee would owe if Healthy Blue provided the service directly. Healthy Blue agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by Healthy Blue and insolvency of Healthy Blue.
3) Healthy Blue further agrees that the enrollee shall not be held liable for the costs of any and all services provided by a provider whose service is not covered by Healthy Blue or who does not obtain timely approval or required prior-authorization.
4) Healthy Blue further agrees that this provision shall be construed to be for the benefit of the enrollees, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Healthy Blue and its enrollees, or persons acting on their behalf.
5) Providers may bill an enrollee for services that have been determined as non-covered or exceeding the services limit for recipients over twenty-one (21) years of age. Recipients are also responsible for all services rendered after their eligibility has ended.
   a) In order to bill an enrollee for a non-covered service, the provider must inform the recipient both verbally and in writing that he/she will be responsible for payment of the services.
   b) The following is a non-inclusive list of situations when a recipient may be billed for services rendered:
      i) The Medicaid recipient was ineligible on the date of service;
      ii) The service is not covered under the scope of the Medicaid Program or exceeds the program benefit limitations; and
      iii) The recipient may be liable for the entire claim or a portion of the claim when it is determined that the services were not medically necessary.

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iv) **NOTE:** A provider can only bill an enrollee for non-covered services, if the recipient was informed in advance, verbally and in writing, that the service(s) were not covered by Medicaid and the recipient agrees to accept the responsibility for payment. The provider should obtain a signed statement or form which documents that the recipient was verbally informed of the out-of-pocket expense.

c) The following is a non-inclusive list of situations when the provider cannot bill the enrollee for services rendered:
   i) Charges above the Medicaid maximum allowable fee amount;
   ii) Claims denied due to provider error;
   iii) Errors made by BHSF, the fiscal intermediary (FI), or the third party liability (TPL) collections contractor or changes in State and Federal mandates;
   iv) Service(s) denied because the provider failed to request prior authorization or failed to meet procedural requirements;
   v) Claim balances remaining after another third party source such as Medicare or other health insurance has made payments;
   vi) Completion and submission of a Medicaid claim form;
   vii) Telephone calls and missed appointments; and
   viii) Costs associated with copying medical records.

Confidentiality of Patient and Enrollee Records

1) Healthy Blue complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) and the rules and regulations promulgated thereunder (45 CFR Parts 160, 162, and 164). Healthy Blue ensures compliance with all HIPAA requirements across all systems and services related to the Contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations. Healthy Blue protects the privacy and confidentiality of medical records and any and all other health and Enrollment information relating to enrollees or potential enrollees, which is provided to or obtained by or through Healthy Blue's performance under the Contract, whether verbal, written, electronic file, or otherwise, as required by applicable provisions of 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and other State and Federal laws, or the Contract. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify particular individuals.
2) Healthy Blue complies with the requirements of 42 USC §290dd-2 and its implementing regulations, 42 CFR Part 2. Healthy Blue strictly maintains the confidentiality of patient records of drug, alcohol, and other drug treatment programs in addition to treatment and assessment for pathological or compulsive gambling.
   a) Healthy Blue ensures that every enrollee treated by a provider that is a covered Part 2 Program, as defined in 42 CFR §2.11, is offered the opportunity to sign a consent form

for the disclosure of substance use treatment information to the enrollee's PCP for the purpose of health care integration in accordance with 42 CFR Part 2, Subpart C.

b) Healthy Blue has the ability to track provider compliance with offering consent forms for enrollees receiving substance use services from Part 2 Programs, including the number of enrollees receiving substance use services by each provider and the number of consent forms offered and signed. Healthy Blue shall report this information to LDH upon request.

c) When substance use information is subject to the requirements of 42 CFR Part 2, any disclosure of that information without the written consent of the patient shall comply with 42 CFR Part 2 and shall be accompanied by a statement notifying the recipient of the prohibition against re-disclosure.

d) Healthy Blue has developed policies and procedures which outline HIPAA requirements and 42 CFR Part 2 requirements for the purpose of health care integration. These policies and procedures outline instances in which 42 CFR Part 2 requirements override HIPAA requirements.

e) Healthy Blue educates contracted network providers on protocols for requesting and receiving patient records in accordance with 45 CFR Parts 160 and 164 (HIPAA) and 42 CFR Part 2.

3) **Release of Records:**

a) Healthy Blue releases medical records upon request by enrollees or their authorized representatives, as may be directed by authorized personnel of LDH, appropriate agencies of the State of Louisiana, or Federal agencies. Release of medical records is consistent with the provisions of confidentiality as set forth in the Contract. The ownership and procedure for release of medical records is controlled by the State and Federal law and regulations, including but not limited to, La. RS 40:1165.1, La. RS 13:3734, and La. CE art. 510 and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) and subject to reasonable charges. Healthy Blue does not charge LDH or its designee for any copies of medical records requested.

4) Healthy Blue has established written safeguards that restrict the use and disclosure of information concerning enrollees or potential enrollees to purposes directly connected with the performance of the Contract. Healthy Blue's written safeguards:

a) Are comparable to those imposed upon the LDH by 42 CFR Part 431, Subpart F, and La. RS 46:56;

b) State that Healthy Blue will identify and comply with any stricter state or Federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) Require a written authorization from the enrollee or potential enrollee before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR §164.508;

d) Do not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

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e) Specify appropriate personnel actions to sanction violators.

Health Record Review

1) By sampling or other methods and on a regular basis, Healthy Blue verifies that services for which reimbursement was made were provided to enrollees as billed (refer to applicable Quality Management policies and processes).
2) Healthy Blue maintains a written strategy for conducting health record reviews, reporting results and the corrective action process. The strategy shall be provided to LDH or its designee for approval as part of Readiness Review and sixty (60) calendar days prior to the implementation of any updates. The strategy includes, at a minimum, the following:
   a) Designated staff to perform this duty;
   b) The method of case selection;
   c) The anticipated number of reviews by practice site;
   d) The tool Healthy Blue uses to review each site;
   e) How Healthy Blue links the information compiled during the review to other Healthy Blue functions (e.g., quality improvement (QI), credentialing, peer review, etc.); and
   f) Schedule of reviews by provider type.
3) The standards, which shall include all health record documentation requirements addressed in the Contract, are distributed to all providers.
4) Healthy Blue conducts reviews at all PCP sites with fifty (50) or more linked enrollees and practice sites which include both individual offices and large group facilities. Healthy Blue reviews each site at least one (1) time during each two (2) year period.
5) Healthy Blue reviews a reasonable number of records at each site to determine compliance. Five to ten (5-10) records per site is a generally accepted target. For large group practices (six (6) or more providers in the group), three (3) record reviews per provider are required.
6) Healthy Blue reports the results of health record reviews to LDH quarterly with an annual summary.

Service Authorization Staffing Requirements

Below are the requirements identified for individuals performing utilization review (UR) activities.[TOR2]

1) Healthy Blue is required to have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. All utilization management (UM) denials, based on medical necessity or clinical appropriateness, are made by licensed physicians (or appropriate practitioners), as appropriate to the scope of their expertise and training. UM denials based on administrative criteria may be made by qualified healthcare professionals as defined in this policy.

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2) Medical disciplines that may have the qualifications, education, and/or experience to successfully perform UR activities consistent with state and federal regulations include:
   a) Medical Doctor (MD) and Doctor of Osteopathic Medicine (DO);
   b) Physician's Assistant (PA);
   c) Advanced practice nurse (APRN);
   d) Registered nurse (RN);
   e) Licensed practical nurse (LPN) and licensed vocational nurse (LVN);
   f) Independently licensed behavioral health (BH) professionals – includes psychologist, licensed clinical social worker (LCSW), licensed mastered social worker (LMSW), licensed professional counselors (LPC), licensed mental health counselor (LMHC), and licensed marriage and family therapists (LMFT); and
   g) Licensed occupational, physical, speech and language pathologists.

~~1)~~3) Healthy Blue ensures that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary MCO Covered Services to any enrollee in accordance with 42 CFR §438.3(i) and 42 CFR §422.208.

~~2)~~4) Healthy Blue ensures that only licensed clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease ~~and training in the use of any required assessments~~ determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. Only licensed clinical professionals with appropriate training in the use of any required assessments determine service authorization denials or authorize a service in an amount, duration or scope that is less than requested.

   a) The individual making determinations shall attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of the individual's expertise.
   b) **Ensuring Adverse Determinations are Made Within the Individual's Clinical Expertise:**
      i) When a Medical Director reviews a service authorization request, he/she will determine if the medical procedure or service is within their scope of clinical expertise to review for medical necessity.
      ii) If the procedure or service is within their scope of clinical expertise to review for medical necessity, he/she shall attest as follows: "I attest that I have the clinical expertise to review this medical procedure/service."
      iii) If the procedure or service is outside of their scope of clinical expertise to review for medical necessity, he/she will identify a physician from the Louisiana or ~~Anthem~~ Corporate Physician Roster that has the clinical expertise and consult with that physician or seek approval for that physician to complete the medical necessity review and determination.
      iv) Consultations are documented in the clinical note of the medical management system.
   c) **Ensuring Appropriate Clinical Expertise:**

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~~i) Physical Health UM reviewers identify cases as adult (twenty-two (22) years of age and older) or pediatric (birth through twenty-one (21) years of age) before referring service authorization requests to a Medical Director for secondary review.~~

~~ii) Adult and pediatric queues are available in the medical management system.~~

~~iii)~~i) Designated physicians with adult clinical expertise (e.g., Internal Medicine, Emergency Medicine or Family Practice) review adult service authorization requests and designated physicians with pediatric clinical expertise (e.g., Pediatrician, Emergency Medicine or Family Practice) review pediatric service authorization requests.

~~iv)~~ii) When the pediatric clinical expertise physician completes all available pediatric reviews, he/she assists by reviewing adult service authorization requests, which require attestation by an appropriate and qualified adult clinical expertise physician.

~~v)~~iii) The pediatric clinical expertise physician notifies (via the Louisiana Medical Director Microsoft Teams) an adult clinical expertise physician on the Louisiana Physician Roster to attest to the adult service authorization requests he/she has reviewed.

(1) The service authorization request requiring attestation is labeled "MDR Approval/Denial Needing Attestation."

(2) The attesting physician attestation note is labeled "MDR Attestation."

~~vi)~~iv) The attesting adult clinical expertise physician reviews the service authorization request and uses the following attestation statement if he/she agrees with a denial recommendation: "This is to attest that I have reviewed the clinical information submitted for this episode of care in its entirety, and the recommendation completed by Dr. (Name), (Credentials) on (Date), and agree with the denial determination and rationale based upon the health plan's guideline cited. I attest that I have the clinical expertise to review this medical procedure/service."

~~vii)~~v) The attesting physician appropriately routes the determination based on service type (i.e., concurrent or precertification) and determination (i.e., approval or denial).

~~viii)~~vi) If the attesting physician does not agree with an approval recommendation, a denial note with rationale must be completed and routed to the appropriate denial queue.

~~ix)~~vii) This process continues until the delegated adult clinical expertise physician notifies the Louisiana Physician Team that the applicable queues are cleared and completed for the day.

d) **Ensuring Appropriate Clinical Expertise During a Peer-to-Peer Review:**

i) Informal reconsiderations or peer-to-peer reviews require the physician performing the review to have clinical expertise with children (i.e., Pediatrician, Emergency Medicine or Family Practice) for members under the age of twenty-two

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(22); and Internal Medicine, Emergency Medicine or Family Practice clinical expertise for members age twenty-two (22) and older.

ii) The physician who performed the initial adverse determination or attested to the adverse determination completes the peer-to-peer review. If that physician is not available, a designated clinical peer meeting the age requirement clinical expertise described above may complete the peer-to-peer review.

~~3)~~5) Healthy Blue ensures that staff consistently and correctly apply authorization criteria and make appropriate determinations, including a process to ensure staff performing below acceptable thresholds on inter-rater reliability (IRR) tests are not permitted to make independent authorization determinations until such time that the staff member can be retrained, monitored, and demonstrate performance that meets or exceeds the acceptable threshold;

~~4)~~6) The individual(s) making determinations have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

~~5)~~7) Healthy Blue provides staff specifically assigned to:

a) Specialized behavior healthy services (SBHS); and
b) Permanent supportive housing (PSH) to ensure appropriate authorization of tenancy services.

~~6)~~8) **General Staffing Requirements:**

a) Healthy Blue has an organizational and governance structure capable of fulfilling all Contract requirements. Healthy Blue recruits, develops, and retains a diverse and qualified staff in numbers appropriate to Healthy Blue's Enrollment, as described in the Contract.
b) Healthy Blue's staffing and resource allocation is adequate to achieve positive outcomes and comply with the requirements of the Contract and the *MCO Manual*, including the requirement for providing culturally competent services. If Healthy Blue does not achieve the desired outcomes or maintain compliance with contractual obligations, non-compliance action(s) may be employed by LDH, including but not limited to, requiring Healthy Blue to hire additional staff and the application of Monetary Penalties as specified in *Attachment G, Table of Monetary Penalties*.
c) Healthy Blue shall provide and have a staffing plan approved by LDH in writing that describes how Healthy Blue will maintain the staffing level to ensure the successful accomplishment of all contractual duties.
d) Healthy Blue does not employ or subcontract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any federal healthcare program. Healthy Blue screens all potential employees and subcontractors to determine whether any of them have been excluded from

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participation in federal healthcare programs utilizing, at a minimum, the following websites:

i) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
ii) Louisiana Adverse Actions List Search (LAALS);
iii) System of Award Management (SAM); and
iv) Other applicable sites as may be determined by LDH.

e) Healthy Blue complies with LDH Policy 47.1, "Criminal History Records Check of Applicants and Employees," which requires LDH contractors to conduct criminal background checks on potential and current employees or subcontractors who have access to enrollee Protected Health Information (PHI). Healthy Blue shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of the Contract.

f) On an ad hoc basis when changes occur or as directed by LDH in writing, Healthy Blue shall submit to LDH an overall organizational chart that includes senior and mid-level managers for the organization. The organizational chart shall include the organizational staffing for behavioral health services and activities. If such behavioral health services and activities are provided by a material subcontractor, Healthy Blue shall submit the organizational chart of the behavioral health material subcontractor which clearly demonstrates the relationship with the material subcontractor and Healthy Blue's oversight of the material subcontractor to support the functional integration of physical and behavioral health. For all organizational charts, Healthy Blue shall indicate any staff vacancies and provide a timeline for when such vacancies will be filled.

g) Healthy Blue shall remove or reassign, upon written request from LDH, any employee or subcontractor employee that LDH deems to be unacceptable. Healthy Blue shall hold LDH harmless for actions taken as a result hereto.

h) Healthy Blue may terminate any of its employees designated to perform work or services under the Contract, as permitted by applicable law.

i) Healthy Blue's key personnel assigned to the Contract shall not be replaced without the prior written consent of the State. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any Healthy Blue personnel become unavailable due to resignation, illness, or other factors, excluding assignment to a project outside the Contract, outside of Healthy Blue's reasonable control, as the case may be, Healthy Blue shall be responsible for providing an equally qualified replacement in time to avoid delays in completing tasks. Healthy Blue will make every reasonable attempt to assign the personnel listed in its proposal.

~~7)~~9) **Key Personnel Requirements:**

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a) Healthy Blue shall identify the individuals serving as key personnel. Unless Healthy Blue requests and receives a written exception from LDH, all key personnel shall be full-time employees (minimum forty (40) hours per week), based in Louisiana, dedicated one hundred percent (100%) to the Contract, and serve in only one (1) key personnel position.

i) If an individual is not required to, and does not, serve exclusively in their key personnel position, Healthy Blue shall provide to LDH, in writing, a description of the individual's other responsibilities. Such description shall also be provided with Healthy Blue's request for an exception from LDH, if applicable.

ii) Healthy Blue must inform LDH in writing within five (5) business days when an employee in a key personnel position provides notice of resignation regardless of the reason for departure or when the plan has terminated an employee in a key personnel position. Healthy Blue shall inform LDH in writing as early as practicable when an employee in a key personnel position resigns without notice. The name of the individual serving in that role on an interim basis shall be provided prior to the departure date when possible.

~~a)~~iii) Healthy Blue shall seek prior written approval from LDH for all key personnel positions before a candidate is hired.

b) The following UM positions are designated as key personnel and shall be located in Louisiana:

i) The **Medical Director/Chief Medical Officer (CMO)** shall be a physician with a current, unencumbered license through the Louisiana State Board of Medical Examiners. The CMO shall have at least three (3) years of training in a medical specialty and five (5) years of post-training experience providing clinical services. The CMO shall have achieved board certification in his or her specialty. The CMO shall be involved in all major clinical and quality management components of Healthy Blue's activities. The CMO shall be responsible for ensuring timely medical decisions, including after-hours consultation, as needed. During periods when the CMO is not available, Healthy Blue shall have physician staff available to provide competent medical direction. The CMO shall serve exclusively in this position and may not function in an executive capacity for another insurance product. All medical and quality management policies shall be approved and signed by Healthy Blue's Medical Director. The CMO shall attend meetings in person, when requested. The CMO shall be responsible for:

(1) Development, implementation, and medical interpretation of clinical policies and procedures, including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, utilization management and medical review included in the MCO Grievance System;
(2) Administration of all medical management activities of Healthy Blue;
(3) Coordinating with the Behavioral Health Medical Director to integrate the administration and management of behavioral and physical health services;

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(4) Serving as member of and participating in person in every meeting of the Medicaid Quality Committee. The CMO may designate a representative with a working understanding of the clinical and quality issues impacting the Louisiana Medicaid Program; and
(5) Serving as the chairman of the Utilization Management Committee (UMC) and chairman or co-chairman of the Quality Assessment and Performance Improvement (QAPI) Committee.

ii) The **Behavioral Health Medical Director** shall be a physician with a current, unencumbered license through the Louisiana State Board of Medical Examiners. The Behavioral Health Medical Director shall be board-certified in psychiatry with at least three (3) years of training in a medical specialty. The Behavioral Health Medical Director shall ensure timely medical decisions, including after-hours consultation, as needed. During periods when the Behavioral Health Medical Director is not available, Healthy Blue shall have physician staff available to provide competent medical direction. The Behavioral Health Medical Director shall serve exclusively in this position and may not function in an executive capacity for another insurance product. The Behavioral Health Medical Director shall attend meetings in person, when requested. The Behavioral Health Medical Director shall share responsibility for the management of the behavioral health services delivery system, including the 24-hour behavioral health crisis line, with the Healthy Blue's Behavioral Health Coordinator, and shall be actively involved in all major clinical and quality management components of the behavioral health services of Healthy Blue. The Behavioral Health Medical Director shall meet regularly with the CMO. All behavioral health policies shall be approved and signed by Healthy Blue's BH Medical Director. The Behavioral Health Medical Director's responsibilities shall include, but not be limited to, the following:
(1) Oversee, monitor, and assist with the management of psychopharmacology pharmacy benefits manager (PBM) activities, including the establishment of prior authorization, clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrollees under the age of eighteen (18);
(2) Provide clinical case management consultations and clinical guidance for contracted PCPs treating behavioral health-related concerns not requiring referral to behavioral health specialists;
(3) Develop comprehensive care programs for the management of youth and adult behavioral health concerns typically treated by PCPs, such as ADHD and depression;
(4) Develop targeted education and training for contracted PCPs to screen for mental health and substance use disorders using evidence-based tools (e.g., AUDIT-C, PHQ-9 and GAD-7), perform diagnostic assessments, provide

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counseling and prescribe pharmacotherapy when indicated, and build collaborative care models in their practices;

(5) Coordinate with the Medical Director to integrate the administration and management of behavioral and physical health services;

(6) Oversee, monitor and assist with effective implementation of the Quality Management (QM) program; and

(7) Work closely with the UM of services and associated appeals related to children and youth and adults with mental illness and/or substance use disorders (SUD).

(8) Serves as member of the Utilization Management Committee and the Quality Assessment and Performance Improvement Committee.

c) In addition to the key personnel requirements, Healthy Blue must have these additional UM staff:

i) **Maternal Child Health/EPSDT Coordinator** shall be a Louisiana licensed registered nurse, advanced practice registered nurse, physician, or physician's assistant; or has a Master's degree in health services, public health, or healthcare administration or other related field and/or a CPHQ or CHCQM. This position shall be located in Louisiana. Staffing under this position should be sufficient to meet quality and performance measure goals. The primary functions of the MCH/EPSDT Coordinator include:

(1) Ensuring delivery of EPSDT services;

(2) Ensuring delivery of maternal and postpartum care;

(3) Promoting family planning services;

(4) Promoting preventive health strategies;

(5) Identifying and coordinating assistance for identified enrollee needs specific to maternal/child health and EPSDT;

(6) Interfacing with community partners; and

(7) Interfacing with the Office of Public Health-Bureau of Family Health and other child-serving state health agencies to coordinate resource and information sharing around provision of EPSDT services.

ii) **Medical Management Coordinator** shall be a Louisiana-licensed RN, APRN, PA, or physician if required to make medical necessity determinations; or have a master's degree in health services, healthcare administration, or business administration, if not required to make medical necessity determinations, to manage all required Medicaid management requirements under LDH policies, rules and the Contract. This position shall be located in Louisiana. The primary functions of the Medical Management Coordinator include:

(1) Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;

(2) Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted;

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(3) Developing, implementing and monitoring the provision of care coordination, disease management and case management functions;
(4) Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over- or under-utilization of services; and
(5) Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards.

iii) **Behavioral Health Coordinator** shall meet the requirements for an LMHP and have at least seven (7) years' experience in managing behavioral healthcare operations. The BH Coordinator shall have responsibility for clinical program development and oversight of staff and services related to the delivery of covered mental health and addiction services to children/youth, adults with serious mental illness and/or with substance use disorders in compliance with federal and state laws and the requirements set forth in the Contract, including the 24-hour behavioral health crisis line, and all documents incorporated by reference. The BH Coordinator will share responsibility to manage the specialized BH services delivery system including crisis response services implemented via the Louisiana Crisis Response System, with the BH Medical Director. The BH Coordinator shall regularly review integration performance, network adequacy, performance improvement projects, and surveys related to integration and shall work closely with the Performance/Quality Improvement Coordinator Behavioral Health Network Director, and QM Coordinator, and BH QM Coordinator. Additionally, the Behavioral Health Coordinator shall participate in statewide coalitions regarding the implementation of crisis response services through the Louisiana Crisis Response System and ensure Healthy Blue participation in regional coalitions developed through this initiative. This position shall be based in Louisiana.

iv) An **Addictionologist or Addiction Services Manager (ASM)** shall meet the requirements of a licensed addiction counselor (LAC) or LMHP with at least seven (7) years of clinical experience with addiction treatment of adults and children experiencing substance use problems and disorders. The ASM shall be responsible for oversight and compliance with the addiction principles of care and application of American Society of Addiction Medicine (ASAM) placement criteria for all addiction program development. The ASM will work closely with the Chief Operating Officer, the BH Coordinator, the QM Coordinator, and the BH Medical Director in assuring quality, appropriate utilization management, and adequacy of the addiction provider network. This position shall be located in Louisiana.

v) **Prior Authorization Staff** to authorize health care twenty-four (24) hours per day, seven (7) days per week. This staff shall include a Louisiana licensed registered nurse, advanced practice registered nurse, physician or physician's assistant. The staff will work under the direction of a Louisiana-licensed RN, APRN, PA or physician.

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vi) **Concurrent Review Staff** to conduct inpatient concurrent review. This staff shall include and work under the direction of a Louisiana licensed RN, APRN, PA or physician.

vii) **Licensed Mental Health Professionals (LMHPs)** staff must be trained to determine the medical necessity criteria as established by the State. LMHPs shall be certified in administering the Level of Care Utilization System (LOCUS). LMHPs must be available to accept and respond to calls via warm transfer from the 24-hour behavioral health crisis line.

(1) Healthy Blue shall have a sufficient number of LMHPs, including 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 ten (10) hours per week, the other LMHPs shall be available twenty-four (24) hours per day, seven (7) days per week. Healthy Blue shall provide UM staff, both experienced and specifically assigned to children, youth, adult, and older adult specialized behavioral health services, and permanent supportive housing (PSH) to ensure appropriate authorization of tenancy services.

(2) Healthy Blue shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. Healthy Blue shall comply with the requirements set forth in state administrative rules.

(3) Healthy Blue shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to-face interview with the child/youth, in addition to the recommendations of the team specified at 42 CFR §441.156.

(4) To perform PASRR Level II evaluations upon referrals from OBH to assess the appropriateness of nursing facility placement and the need for, and facilitation of, behavioral health services. PASRR Level II evaluations must be performed by an LMHP independent of OBH and not delegated to a nursing facility or an entity that has a direct or indirect affiliation or relationship with a nursing facility as per 42 C.F.R. § 483.106. Whether through subcontract or direct employment, the MCO shall maintain appropriate levels of LMHP staff to ensure adequate local geographic coverage for in field face-to-face contact with enrollees in need of such evaluations. These staff must be administratively separate from staff performing utilization review but may be the same staff as listed under the "Licensed Mental Health Professionals (LMHP)" additional staff requirement.

viii) **24-Hour Behavioral Health Crisis line staff** -whether through subcontract, if prior approved by LDH, or direct employment, Healthy Blue shall have an adequate

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number of staff to answer the behavioral health crisis line twenty-four (24) hours per day, seven (7) days per week, with sufficient capacity to preclude the use of answering machines, third-party answering services, and voicemail. Staff shall participate in OBH approved trainings.

~~(7)~~

~~8)~~10) **Additional Required Staff:**

a) Healthy Blue has a sufficient number of qualified staff with sufficient experience and expertise to meet both physical health services and behavioral health services responsibilities, and provides dedicated staff where necessary to meet this obligation including all required timeframes and geographic coverage outlined in the Contract.
b) Healthy Blue shall maintain at least fifty percent (50%) of its staff within the state of Louisiana.
c) Healthy Blue complies with additional staffing requirements included in the *MCO Manual* (refer to *Managed Care Organization (MCO) Manual – LA*).

~~9)~~11) **Staff Training, Licensure, and Meeting Attendance:**

a) Healthy Blue ensures that all staff members, including subcontractors, have met any applicable State or Federal licensure and/or certification requirements and have received appropriate training, education, experience and orientation to fulfill their requirements of the position. Healthy Blue prohibits any staff person and/or subcontractor who has failed to comply with any requirement in the preceding sentence from performing any work under the Contract unless and until the staff person and/or subcontractor has achieved compliance with all requirements. LDH may require additional staffing for Healthy Blue that has substantially failed to maintain compliance with any provision of the Contract.
b) Healthy Blue provides initial and ongoing staff training that includes an overview of contractual, State and Federal requirements specific to individual job functions. Healthy Blue ensures that all staff members having contact with enrollees or providers receive initial and ongoing training on health equity and social determinants of health, beyond Culturally and Linguistically Appropriate Services (CLAS) requirements and with regard to the appropriate identification and handling of quality of care concerns.
c) Healthy Blue educates all staff members about its policies and procedures on Advance Directives.
d) New and existing transportation, prior authorization, provider services and enrollee service representatives are trained in the geography of Louisiana, as well as its culture and the correct pronunciation of cities, towns, and surnames. They have access to GPS or mapping search engines for the purposes of authorizing services in, and recommending providers and transporting enrollees to, the most geographically appropriate location.
e) Healthy Blue complies with all cybersecurity training requirements.
f) Additional staff training requirements shall include, but not be limited to:

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i) For staff members having contact with enrollees or providers – initial and ongoing training with regard to the appropriate identification and handling of quality of care concerns.

ii) For staff members working directly with enrollees – crisis intervention training.

~~ii)~~iii) For 24-hour behavioral health crisis line staff – participation in OBH-approved trainings related to the Louisiana Crisis Response System.

g) LDH reserves the right to assign mandatory training for key staff, other staff, and subcontractors. Healthy Blue may be required to submit documentation that all staff have completed LDH assigned mandatory training, education, professional experience, orientation, and credentialing, as applicable, to perform assigned job duties.

h) LDH reserves the right to attend all training programs and seminars conducted by Healthy Blue. Healthy Blue shall provide documentation of meetings and trainings, including staff and provider trainings, upon written request. Meeting minutes, agendas, invited attendee lists, and sign-in sheets, along with action items, shall be provided upon written request.

i) Healthy Blue provides subject appropriate staff to attend and participate in meetings or events, which may be on-site, scheduled by LDH. All meetings shall be considered mandatory unless otherwise indicated.

Associates Performing Utilization Review

1) Health Care Management (HCM), Behavioral Health (BH), and Government Business Division (GBD) Prior Authorization (PA) Team and clinical leaders are accountable for the hiring, training, assigning, monitoring, and managing of associates performing UR for their respective departments.
2) Healthcare professionals (as defined in this policy) must possess the education and current unrestricted licensure to perform UR functions.
3) The appropriate HCM, BH, GBD PA clinical leader may identify other licensed professionals (non-RN, such as LPN/LVNs) with sufficient experience and expertise for hiring consideration, to collect data for precertification, concurrent, and retrospective review and to approve services for which there are explicit criteria. Exceptions for hiring these individuals are based on the licensed associate meeting one (1) or more of the following criteria:
   a) Documented experience conducting UR prior to joining the organization;
   b) Certification as a Managed Care Nurse (CMCN), Certified Professional in Healthcare Quality (CPHQ), or similar certification; and/or
   c) Experience in training or instruction of UM practices and activities.
4) When an exception is made, the HCM, BH, GBD PA clinical leader is responsible for ensuring:
   a) The individual is licensed, properly trained, and supervised; and
   b) The individual has an identified licensed clinical resource to provide oversight and direction.

5) UM supervisors, who are licensed health care professionals, provide oversight and supervision of UM staff, including:
   a) Providing day-to-day supervision of assigned UM staff;
   b) Participating in staff training;
   c) Monitoring for consistent application of UM criteria by UM staff, for each level and type of decision;
   d) Monitoring documentation for adequacy; and
   e) Being available to UM staff on-site or by telephone.[5]
6) Oversight of associates conducting UR includes, at minimum, a documented quarterly review of records by the supervisor to assess the quality, accuracy, and appropriateness of the work product.
7) All associates conducting UR participate annually in the company-wide Inter-Rater Reliability (IRR) program (refer to *Inter-Rater Reliability (IRR) Assessments*).
8) Health plan Medical Directors may refer a case to an outside (external) Medical Consultant to assist in making medical necessity determinations.
   a) Medical Consultants are required to be board-certified and have an unrestricted current medical license, and may require state approval.
   b) Medical Consultants may be consulted for matters that include, but are not limited to:
      i) Situations involving unusually complex cases; the facts are not clearly defined, and there are alternative decisions that can be made based upon assessment of the clinical condition of the situation;
      ii) Cases requiring special expertise in order to determine medical necessity; and expertise is not readily available within the network of credentialed practitioners to provide a non-biased and evidence-based review;
      iii) For the most appropriate management approach or discordance between the treating provider and the health plan Medical Director about the treatment plan; or
      iv) An appeal decision mandates an external objective opinion to ensure credibility of the process.
      v) NCQA does not consider it delegation if a board-certified consultant reviews a case and makes a recommendation for the health plan to make the final medical necessity determination. If the consultant makes the final medical necessity determination, NCQA considers this to be delegation.[6]
9) A list of board certified physicians is maintained by the health plan and accessible by Medical Directors for consultation on complex UM cases.
   a) Corporate HCM – UM Operations staff maintains the national list of board-certified medical consultants and contracted Independent Review Organizations (IRO) for each health plan on the MD Resource SharePoint site. The designated health plan HCM staff notifies UM Operations of updates to their board-certified medical consultants or contracted IRO.

[5] NCQA UM 4, Element A, Factor 1
[6] NCQA UM 4, Element F

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Material Subcontracts/Subcontractors

1) Prior to contracting with a material subcontractor, Healthy Blue shall evaluate the prospective material subcontractor's ability to perform the activities to be subcontracted. Healthy Blue shall request prior approval of all material subcontracts, amendments, and substitutions from LDH. To obtain such approval, Healthy Blue shall submit a written request and a completed material subcontractor checklist using the template provided by LDH included in the MCO Manual. The request shall also describe how Healthy Blue will oversee the material subcontractor and identify whether the proposed subcontractor is part of an organization related to Healthy Blue.
2) All subcontracts shall:
    a. Be written;
    b. Specify, and require compliance with, all applicable requirements of the Contract and the activities and reporting responsibilities the subcontractor is obligated to provide;
    c. Provide for imposing penalties, up to and including contract termination, if the State or Healthy Blue determines that the subcontractor's performance is inadequate or non-compliant;
    d. Require the subcontractor to comply with all applicable contract requirements, applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, waivers, and applicable subregulatory guidance;
    e. Stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the Subcontractor is based and Louisiana law.
    f. Comply with the requirements set forth in 42 CFR §438.230(c)(3)and CFR§438.3(k).
3) The State, including LDH, MFCU, and the Louisiana Legislative Auditor (LLA), and the Federal government, including, CMS, OIG, and the Comptroller General, or their designees, shall have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under the Contract at any time.
    a. This right exists for ten (10) years from the termination of the Contract for Healthy Blue and any Subcontractors or from the date of completion of any audit, whichever is later; provided, however that if any of the entities above determine that there is a reasonable possibility of Fraud or similar risk, they may audit, evaluate, and inspect at any time;
    b. Healthy Blue and any Subcontractors shall make their premises, facilities, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described immediately above;
    c. Healthy Blue and any Subcontractors shall retain, as applicable, Enrollee Grievance and Appeal records under 42 CFR §438.416; base data under 42 CFR §438.5(c); MLR reports under 42 CFR §438.8(k); and the data, information, and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610 for a period of no less than ten (10) years following termination of the Contract.

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4) Healthy Blue shall monitor any material subcontractor's performance on an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH. If any deficiencies or areas for improvement are identified, Healthy Blue shall require the material subcontractor to take corrective action. Healthy Blue shall provide LDH with a copy of the annual review and any corrective action plans developed as a result. If there are corrective active plans put in place, Healthy Blue shall provide ongoing updates to LDH on the material subcontractor's activities to improve the performance pursuant to the corrective action plan.
5) Upon notifying any material subcontractor, or upon being notified by such material subcontractor, of the intention to terminate such subcontract, Healthy Blue shall notify LDH in writing no later than the same day as such notification,and shall otherwise support any necessary Enrollee transition or related activities as described in the Continuity of Care section of the State Contract. In the event of a transition between subcontractors during the term of the contract, Healthy Blue must ensure that the original subcontractor fulfills all subcontractual obligations, including those that survive the subcontract termination or expiration. In the event that the contract terminates or expires, Healthy Blue must ensure that any existing subcontractor fulfills its subcontractual obligations including those that survive contract termination.
6) Notwithstanding any relationship Healthy Blue may have with a subcontractor, including material subcontractors, Healthy Blue shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. No subcontractor will operate to relieve the Contractor of its legal responsibilities under the Contract. As required by 42 CFR §438.3(k), §438.230(a) and § 438.230(b)(1),(2), Healthy Blue shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor.

Utilization Management Committee (UMC)

1) The UM program includes a UM Committee that integrates with other functional units of Healthy Blue as appropriate and supports the QAPI program as defined by the *Quality Management and Quality Improvement* section of the Contract.
2) The Utilization Management Committee (UMC) provides utilization review and monitoring of UM activities of both Healthy Blue and its providers and is directed by Healthy Blue's Medical Director. The UMC convenes no less than quarterly and shall make meeting minutes available to LDH upon request. LDH representatives, as appointed by LDH, shall be included as members of the UMC, if requested.
3) UMC responsibilities include:
   a) Reviewing, updating, and approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;
   b) Monitoring the medical appropriateness and necessity of health care services provided to its enrollees;

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c) Monitoring providers' requests for prior authorization of health care services to its enrollees;
d) Monitoring consistent application of service authorization criteria;
e) Monitoring over and underutilization;
f) Review of Outliers; and
g) Monitoring of health record reviews.

Systems and Technical Requirements

1) Healthy Blue maintains an automated Management Information System (MIS) which accepts and processes provider claims, verifies eligibility, collects and reports encounter data, and validates prior authorization and pre-certification that complies with LDH and Federal reporting requirements. Healthy Blue ensures that its MIS meets the requirements of the Contract, the *MCO Manual*, and all applicable Federal and State laws, regulations, rules, and policies, including, but not limited to, Medicaid confidentiality, HIPAA, and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.
2) If Healthy Blue uses different Management Systems for physical health services and behavioral health services, these systems shall be interoperable. In addition, Healthy Blue shall have the capability to integrate data from the different systems.
3) Healthy Blue complies with LDH electronic visit verification (EVV) requirements for personal care services (PCS) and home health care services.
4) Healthy Blue has a secure online web-based portal that allows providers and state agencies (DCFS, LDOE, LDH, and OJJ) to submit and receive responses to referrals and prior authorizations for services.
5) Healthy Blue encourages all hospitals, physicians, and other providers in its network to adopt certified electronic health record technology (CEHRT) and comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC).
6) Healthy Blue requires all emergency departments in its network to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and Care Management. The visit registry shall consist of three (3) basic attributes: 1) the ability to capture and match patients based on demographics information, 2) the ability to identify the facility at which care is being sought, and 3) at minimum, the chief complaint of the visit. These three (3) pieces of information are commonly available through the Health Level Seven (HL7) ADT message standard and in use by most ED admission systems in use today across the country. This data shall be available in real-time in order to assist providers and systems with up-to-date information for treating patients appropriately.
7) Healthy Blue requires all network hospitals to comply with the data submission requirements of La. RS 40:1173.1 through 1173.6, including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:II.105). Healthy

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Blue encourages the use of HIEs where direct connections to public health reporting information systems are not feasible or are cost prohibitive.

8) Healthy Blue shall notify LDH staff of changes to its MIS as directed by LDH. Major changes, upgrades, modification or updates to application or operating software associated with core production systems include, but is not limited to, service authorization management.

REFERENCES:

- Louisiana Medicaid Durable Medical Equipment Provider Manual
- Louisiana Medicaid General Information and Administration Provider Manual
- Louisiana Medicaid Hospital Services Provider Manual
- Louisiana Medicaid Managed Care Organization Contract
- Louisiana Medicaid Managed Care Organization Manual
- Louisiana Medicaid Professional Services Provider Manual

Related Policies:

- Durable Medical Equipment – LA
- GBD-HCM-001 Associates Performing Utilization Reviews – Core Process
- GBD-HCM-002 Clinical Criteria for UM Decisions – Core Process
- GBD-HCM-003 Clinical Information for Utilization Management Reviews – Core Process
- GBD-HCM-004 Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process – Core Process
- GBD-HCM-005 Emergency Services – Core Process
- GBD-HCM-006 Health Care Management – Clinical Training Compliance
- GBD-HCM-007 High Cost DME, Prosthetic or Orthotic Purchases
- GBD-HCM-009 Inter-Rater Reliability (IRR) Assessments
- GBD-HCM-010 Non-Covered and Cost Effective Alternative Services
- GBD-HCM-011 Out-of-Network Authorization Process
- GBD-HCM-012 Precertification Committee
- GBD-HCM-013 Sleep Management Program
- GBD-HCM-014 Specialty Referral
- GBD-HCM-015 Utilization Management Support Staff
- GBD-UM-001 Annual Audit of Health Plan Utilization Management Denial Files
- GBD-UM-002 Audit of Medical Management System Controls
- GBD-UM-003 Clinical Staff Conflict of Interest Policy
- GBD-UM-005 Continuity of Care During a Disaster or Emergency Declaration – Core Process
- GBD-UM-006 Coverage for Post Stabilization Care Services
- GBD-UM-007 Governance of Utilization Management Practice

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- GBD-UM-008 Health Care Management Denial – Core Process
- GBD-UM-009 Large Case Identification
- GBD-UM-010 Lost, Stolen or Destroyed Durable Medical Equipment
- GBD-UM-011 Medical Management System Controls (ACMP)
- GBD-UM-013 Medical Operations Committee
- GBD-UM-014 Out-Of-Area, Out-of-Network Care
- GBD-UM-015 Over Under-Utilization of Services
- GBD-UM-017 Pre-Certification of Requested Services – Core Process
- GBD-UM-018 Prohibiting the Use of Financial Incentives When Making Medical Necessity Determinations – Core Process
- GBD-UM-019 Resolving Pended Claims and ActionGrams
- GBD-UM-020 Retrospective Review
- GBD-UM-022 Staff Availability – Core Process
- GBD-UM-023 Standard for Medical Records Review
- GBD-UM-024 Updating and Auditing Notice of Proposed Action (Denial) Letters Appeals Review
- GBD-UM-025 Use of Board Certified Consultants (Medical/Behavioral Health) – Core Process
- GBD-UM-026 Utilization Management Clinicians Responsibilities (Health Plan/Region)
- GBD-UM-027 Utilization Management Exception Programs (including Gold Card Program)
- GBD-UM-028 Utilization Management Training
- Guidelines for Use of the Fax Server
- Health Care Management Audit Policy – LA
- Home Health Services – LA
- Informal Reconsideration – LA
- Managed Care Organization (MCO) Manual – LA
- Medical Transportation – LA
- Observation – LA
- Pediatric Day Health Care and Personal Care Services – LA
- Prior Authorization Liaison (PAL) Policy – LA
- Second Opinion
- Standing Referrals – LA
- 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

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Utilization Management – LA**

Secondary Department(s):
Behavioral Health
GBD Intake and Prior Authorization Teams
Marketing
National Customer Care
Operations – Claims
Pharmacy
Provider Network and Relations
Quality Management

EXCEPTIONS:

- Refer to the *Managed Care Organization (MCO) Manual – LA* for *MCO Manual* utilization management requirements.
- See Behavioral Health policies for details regarding behavioral health services and utilization management procedures.

Exceptions to Staffing Requirements
Requests for exceptions to mandatory staffing requirements must be submitted in writing to LDH for prior approval. Healthy Blue must address the reason for the request, the organization's ability to furnish services as contractually required with the exception in place, and duration of exception period requested. Healthy Blue shall provide and have an LDH-approved staffing plan that describes how the staffing level will be maintained to ensure the successful accomplishment of all duties including specialized behavioral health related functions. Healthy Blue may propose to LDH a staffing plan that combines positions and functions outlined in the Contract with other positions, provided it describes how staffing roles delineated in the Contract will be addressed.

Obstetrical Admissions
If the NCC receives notification/request for obstetric (OB) global precertification after the mother has delivered, the NCC enters the precertification for the delivery only, and the case is routed to the health plan to assign the days. Every effort is made by the NCC to obtain the newborn information to complete the newborn assessment at the time of notification. If an OB claim is received and there is no authorization in the medical management system, the NCC enters the authorization so that the claim pays accordingly.

REVISION HISTORY:[GS3]

Review Date	Changes
10/11/2023	• Off Cycle Review

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Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Utilization Management – LA**

Review Date	Changes
	• Revised Policy, Definitions, Procedure, and Exceptions sections • Added language from LDH Alert #46833 Informational Bulletin 23-7 regarding dental care for (ICF/IID) • Updated policy to include language from previously replaced policies • Updated policy to align with current state contract language and contract amendments per LDH Alert # 47607 and Amendment 4
04/18/2023	• New P&P created for Model Contract RFP LA Rebid 2023 readiness review • Replacing the plan-specific policies: ○ Associates Performing Utilization Reviews – LA ○ Clinical Information for Utilization Review – LA ○ Concurrent Review (Telephonic and Onsite) – LA ○ Health Care Management Denial – LA ○ Non-Covered and Cost-Effective Alternative Services – LA ○ Out-of-Area, Out-of-Network Care – LA ○ Precertification of Requested Services – LA ○ Retrospective Review – LA

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