AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana

Provider Manual

Published Date: **December 2019**

Page left blank – Cover Page

CONTENTS

INTRODUCTION

FOREWARD

Welcome to AmeriHealth Caritas Louisiana. This Provider Manual was created as a guide to assist you and your office staff with providing services to our members, your patients. As a condition of providing services to AmeriHealth Caritas Louisiana members, providers agree to comply with the provisions in this manual.

No content found in this publication or in the AmeriHealth Caritas Louisiana's participating Network Provider Agreement is to be construed as encouraging providers to restrict medically-necessary covered services or to limit clinical dialogue between providers and their patients. Regardless of benefit coverage limitations, providers should openly discuss all available treatment options.

The provisions of this Provider Manual may be changed or updated periodically. AmeriHealth Caritas Louisiana will provide notice of the updates at: www.amerihealthcaritasla.com. Providers are responsible for checking regularly for updates.

Your review and understanding of this manual is essential, and we encourage you to contact our Provider Network Management department with any questions, concerns and/or suggestions regarding the Provider Manual.

Thank you for your participation with in the AmeriHealth Caritas Louisiana provider network.

ABOUT AMERIHEALTH CARITAS LOUISIANA

WHO WE ARE

AmeriHealth Caritas Louisiana is the Medicaid managed care program of AmeriHealth Caritas, Louisiana, Inc. and part of the AmeriHealth Caritas Family of Companies, one of the largest organizations of Medicaid managed care plans in the United States. AmeriHealth Caritas Louisiana, headquartered in Baton Rouge, Louisiana, is a mission-driven health care organization that helps people get care, stay well and build healthy communities.

OUR VALUES

Our service is built on:

Advocacy, Dignity, Diversity, Care for the Poor, Compassion, Hospitality and Stewardship.

OUR MISSION

We Help People:

Get Care
Stay Well
Build Healthy Communities

IMPORTANT AMERIHEALTH CARITAS LOUISIANA TELEPHONE NUMBERS

Department	Phone	Fax
Behavioral Health Member Crisis Intervention Center Hotline (Available 24/7)	1-844-211-0971	
Behavioral Health and Substance Use Utilization Management	1-855-285-7466	1-855-301-5356
Bright Start (Maternity Management)	1-888-913-0327	1-888-877-5925
Credentialing	1-888-913-0349	1-225-300-9199
Dental Benefits (Avesis~~DINA Dental~~, Ages 21 and older)	1-~~877-587-9331~~833-311-2252	
EDI Technical Support Hotline	1-866-428-7419	
Change Healthcare • EDI and ERA • EFT	 1-877-363-3666 1-866-506-2830	
Medical Necessity Appeals (Pre-Service)	1-888-913-0362	1-888-987-5830
Member Services	1-888-922-0004	
NaviNet www.navinet.net (Provider portal – care gaps, claim status, panel rosters and member eligibility)	1-888-482-8057	
Non-Emergency Medical and Behavioral Health Transportation (Southeastrans Inc) Provider/Facility Customer Service Member Transportation Line	 1-877-931-4748 1-888-913-0364	
Nurse Call Line for members (Available 24/7)	1-888-632-0009	
Pharmacy Benefits Provider Services (Perform Rx)	1-800-684-5502	1-855-452-9131
Pharmacy Benefits Member Services (Perform Rx)	1-866-452-1040 1-855-294-7047 TTY	
Provider Network Management (Contracting)	1-877-588-2248	1-225-300-9126
Provider Services	1-888-922-0007	1-866-426-7393
Radiology Utilization Management (National Imaging Associates, NIA)	1-800-424-4897	
Rapid Response (Care coordination, case management, EPSDT, member outreach, referrals, appointment scheduling and transportation assistance)	1-888-643-0005	
Utilization Management (Prior Authorization, Concurrent Review, Discharge Planning, Delivery Notification)	1-888-913-0350	1-866-397-4522
Vision Benefits ~~(VSP) www.vsp.com~~-Avesis	1-~~800-877-7195~~833-311-2252	

MEDICAID PROGRAM OVERVIEW

Medicaid provides medical coverage to eligible, low-income children, seniors, disabled adults and pregnant women. The state and federal governments share the costs of the Medicaid program. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare & Medicaid Services (CMS). Medicaid services in Louisiana are administered by the Louisiana Department of Health (LDH). For more information about Louisiana Medicaid covered services, visit LDH's website at
http://new.dhh.louisiana.gov/index.cfm/subhome/6.

AmeriHealth Caritas Family of Companies is one of the largest organizations of Medicaid managed care plans in the United States. We are proud to partner with the Louisiana Department of Health (LDH) under the Healthy Louisiana program to provide healthcare for Louisiana's most vulnerable residents. By offering Medicaid coordinated care in Louisiana, we are building and growing our vision and mission to lead in the provision of health care services to the underserved.

Our coordinated care approach, leading technology solutions, and innovative community outreach programs enable our members to achieve healthier lives. Working with dedicated health care providers, our programs offer improved outcomes for our members and help build healthy communities.

SECTION I: MEMBER ELIGIBILITY

Enrollment Process

Once LDH determines that an individual is an eligible Medicaid recipient, an Enrollment Specialist assists the recipient with the selection of a Plan. AmeriHealth Caritas Louisiana is informed on a daily basis of eligible recipients who have selected AmeriHealth Caritas Louisiana as their plan. If the recipient does not select a plan, he/she will be auto-assigned to a plan. The member is assigned an effective date by the state and this information is transmitted in the enrollment broker file.

During the enrollment process, members work with the enrollment broker to choose an AmeriHealth Caritas Louisiana PCP. If the member does not select a PCP at the time of enrollment or within 10 days of enrollment, the following AmeriHealth Caritas Louisiana process is used to ensure the member is assigned to a PCP:

- Identify the most recent PCP utilized by the member and determine whether that PCP is in the AmeriHealth Caritas Louisiana Network;
- Identify a PCP in the network used another AmeriHealth Caritas Louisiana member in same family. If appropriate, AmeriHealth Caritas Louisiana will assign the member to that PCP; or
- If none of these options are appropriate, AmeriHealth Caritas Louisiana will select a PCP from or close to the member's zip code.

Members can choose a different PCP at any time by calling Member Services at 1-888-756-0004.

The above process activates the release of an AmeriHealth Caritas Louisiana ID card and a Welcome Package to the member. Members are encouraged to keep the ID card with them at all times.

The AmeriHealth Caritas Louisiana Identification (ID) Card includes the following information:

- Member's Name
- AmeriHealth Caritas Louisiana Identification Number
- State ID Number
- Member's Sex and Date of Birth
- Effective Date of AmeriHealth Caritas Louisiana Coverage
- PCP's Name, Address and Phone Number

Verifying Eligibility

Each network provider is responsible for determining a member's eligibility with AmeriHealth Caritas Louisiana before providing services.

Verification of eligibility consists of a few simple steps:

- As a first step, all Providers should ask to see the member's AmeriHealth Caritas Louisiana Identification Card and the Louisiana Medicaid card with a picture ID. The picture ID is used to verify the person presenting the ID card is the same as the person named on the ID Card. Services may be refused if the provider suspects the presenting person is not the card owner and no other ID can be provided. Please report such occurrences to AmeriHealth Caritas Louisiana Fraud and Abuse Hotline at 1-866-833-9718.
- It is important to note that AmeriHealth Caritas Louisiana ID cards are not dated and do not need to be returned to AmeriHealth Caritas Louisiana should the member lose eligibility. Therefore, a card itself does not

indicate a person is currently enrolled with AmeriHealth Caritas Louisiana.

Since a card alone does not verify that a person is currently enrolled in AmeriHealth Caritas Louisiana, it is critical to verify eligibility through any of the following methods:

1. NaviNet - This free, easy to use web-based application provides real-time current and past eligibility status and eliminates the need for phone calls to AmeriHealth Caritas Louisiana. For more information or to sign up for access to NaviNet visit: https://navinet.navimedix.com/Main.asp.
2. Louisiana Department of Health - http://www.lamedicaid.com/provweb1/default.htm.
3. Louisiana Medicaid REVS Telephone Line: 1-800-776-6323. The 7-digit Louisiana Medicaid provider number or the 10-digit NPI number must be entered to begin the eligibility verification process.
4. AmeriHealth Caritas Louisiana's Automated Eligibility Hotline 24 hours/7 days a week, 1-888-922-0007.
    - Provides immediate real-time eligibility status with no holding to speak to a representative.
    - Verify a member's coverage with AmeriHealth Caritas Louisiana by their AmeriHealth Caritas Louisiana identification number, Social Security Number, name, birth date or Medicaid Identification Number.
    - Obtain the name and phone number of the member's PCP.

Panel/Linkages List

AmeriHealth Caritas Louisiana does not print and mail the panel listings. The panel listing is available through our secure provider portal, NaviNet, at www.navinet.net. However, if your practice is not set up with NaviNet or you need help accessing the monthly panel report, please contact your Account Executive with questions or to schedule training.

SECTION II: PROVIDER OFFICE STANDARDS & REQUIREMENTS

Provider Responsibilities

This section provides information for maintaining network privileges and sets forth expectations and guidelines for Primary Care Providers (PCPs), Specialists and Facility providers.

In general, the responsibilities, expectations and processes outlined in the Provider Manual pertain to all providers, including but not limited to behavioral health providers, unless otherwise indicated. For questions or for more information, please contact AmeriHealth Caritas Louisiana's Provider Services at **1-888-922-0007**.

All providers who participate in AmeriHealth Caritas Louisiana have responsibilities, including but not limited to the following:

- To manage the medical and health care needs of members so medically necessary services are made available in a timely manner;
- To provide the coordination necessary for the referral of members to specialists and for the referral of members to services available through Louisiana Medicaid. Coordination should include but is not be limited to:
    - Referring members to participating subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria
    - Communicate with other levels of care (primary care, specialty outpatient care, emergency and inpatient care) to coordinate, and follow up the care of individual members.
- To provide the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions;
- To monitor and follow-up on care provided by other medical service providers for diagnosis and treatment, to include services available under Louisiana Medicaid;
- To maintain a medical record of all services rendered;
- To coordinate case management services including, but not be limited to, performing screening and assessment, and developing a plan of care to address risks and medical needs;
- To coordinate the services AmeriHealth Caritas Louisiana furnishes with another Healthy Louisiana plan during transition of care;
- To share the results of identification and assessment of any member with special health care needs (as defined by LDH) with another Healthy Louisiana plan to which a member may be transitioning or has transitioned so that those activities are not duplicated;
- To ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164; and
- To ensure that AmeriHealth Caritas Louisiana members are not subject to discriminatory practices, such as separate waiting rooms or separate appointment days.

Members must be provided all covered services without regard to race, color, religion, sex, age, national origin, ancestry, nationality, creed, citizenship, alienage, marital or domestic partnership or civil union status, affectional or sexual orientation, physical, cognitive or mental disability, veteran status, whistleblower status, gender identity and/or expression, genetic information, health status, pre-existing condition, income status, source of payment, program memberships or physical or behavioral disability, except where medically indicated, or any other characteristic protected under federal, state, or local law.

- To coordinate and cooperate with other service providers who serve Medicaid members such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships, Early Intervention programs, Aging and Disability Councils and Areas on Aging and school based programs, as appropriate.

Providers may not deny to a member any covered service or availability of a facility.

All instructional materials provided to our members emphasize the role of the PCP and recommend they seek advice from their PCP before accessing non-emergency medical care from any other source.

Providers Who Qualify to Serve as PCPs

Providers who qualify to serve as PCPs are Medical Doctors or Doctors of Osteopathy from any of the following practice areas: General Practice, Family Practice, Internal Medicine, and Pediatrics. Advanced Practice Nurses (APRNs) and Physician Assistants (PAs) may also serve as a PCP when the APRN or PA is practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, or Pediatrics who also qualifies as a PCP under AmeriHealth Caritas. Specialists who are designated as a PCP with AmeriHealth Caritas Louisiana are required to adhere to the PCP responsibilities.

Your Role as PCP

AmeriHealth Caritas Louisiana understands a good relationship with a PCP is necessary. As a result, AmeriHealth Caritas Louisiana does not lock members into a PCP; they may change PCPs at any time. The PCP is the member's starting point for access to all health care benefits and services available through AmeriHealth Caritas Louisiana. Although the PCP will treat most of a member's health care concerns in his or her own practice, AmeriHealth Caritas Louisiana expects that PCPs will refer appropriately for both outpatient and inpatient services while continuing to manage the care being delivered.

- PCPs should provide the level of care and range of services necessary to meet the medical needs of its members, including those with special needs and chronic conditions.
- PCPs should monitor and follow-up on care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid FFS.
- PCPs should maintain a medical record of all services rendered by the PCP and other specialty providers
- PCP‘s should Coordinate case management services including, but not limited to, performing screening and assessment, developing a plan of care to address risks and medical needs and basic behavioral health services such as screening, prevention, early intervention, and medication management
- PCPs should coordinate the services AmeriHealth Caritas Louisiana furnishes to the member with the services the member receives from any another plan during transition of care.
- PCPs should share the results of identification and assessment of any member with special health care needs (as defined by LDH) with another MCO to which a member may be transitioning or has transitioned so that those activities need not be duplicated.

- PCPs should ensure that in the process of coordinating care, each enrollee's privacy is protected.
- PCPs are to contact all new panel members for an initial appointment. AmeriHealth Caritas Louisiana has Special Needs and Care Management Programs that contact members with the following conditions:
    - Pregnant members
    - Members with chronic conditions, including but not limited to:
        - Asthma
        - Diabetes
        - COPD
        - Heart Failure
        - Sickle Cell Disease.
- PCPs must inform AmeriHealth Caritas Louisiana if he/she learns that a member is pregnant so they can be included in the AmeriHealth Caritas Louisiana maternity program. Please call 1-888-913-0327 to refer a member to the AmeriHealth Caritas Louisiana Bright Start (Maternity) Program and/or for assistance in locating an OB/GYN practitioner.
- The waiting time for scheduled appointments must be no more than 45 minutes (including time in the waiting room and examining room) unless the PCP encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. In such cases, waiting time should not exceed one (1) hour. If a provider is delayed, patients will be notified immediately. If the wait is over ninety (90) minutes, the patient must be offered a new appointment.
- Walk-in patients with non-urgent needs should be seen if possible, or scheduled for an appointment consistent with the above standards.
- Patients must be scheduled at the rate of six (6) patients or less per hour.
- The PCP must have a "no show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments and documented in the medical record. PCPs should be aware that we offer transportation assistance for our members by calling our transportation unit at
- 1-877-931-4748. Should the PCP encounter members who habitually miss appointments, please contact our Rapid Response (RR) Team. Our RR Care Connectors will contact the member to counsel and educate them about the importance of keeping appointments. AmeriHealth Caritas Louisiana will also conduct quarterly surveys to monitor the no-show rate.
- Number of regular office hours must be greater than or equal to 20 hours.
- Member medical records must be maintained in an area that is not accessible to those not employed by the practice. Network providers must comply with all applicable laws and regulations pertaining to the confidentiality of member, including, obtaining any required written member consents to disclose confidential medical records.
- If a member changes PCPs or MCO plans, the PCP will forward a copy of the member's medical record and supporting documentation to the new PCP within ten (10) business days of the receiving PCP‘s request.
- PCP’s are prohibited from making referrals to healthcare entities with which, they or a member of their family has a financial relationship.
- PCP’s must comply with all cultural competency standards. This includes offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. AmeriHealth Caritas Louisiana offers Language Access Services for use by providers with members in need of these services.
- PCP office hours must be clearly posted and reviewed with members during the initial office visit.

Patient-Centered Medical Home

AmeriHealth Caritas Louisiana appreciates the tremendous commitment and progress the State of Louisiana has invested towards the establishment of Patient-Centered Medical Homes. AmeriHealth Caritas Louisiana shares the same goals and commitment and wants to work with our PCPs to help them receive Patient-Centered Medical Home certification through NCQA or JCAHO. Through this commitment, we will support and encourage efforts to monitor, track and improve the quality of the care provided to patients.

The Medical Home Concept is:

- An approach to providing comprehensive primary care
- Taking personal responsibility & accountability for the on-going care of patients
- Physicians accessibility to their patients on short notice (expanded hours and open scheduling)
- Physicians able to conduct consultations through email and telephone
- Utilizing the latest health information technology and evidence-based medical approaches as well as maintaining updated electronic personal health records
- Conducting regular check-ups with patients to assist in identifying health crises, and initiating treatment/prevention measures before costly, last minute emergency procedures are required
- Advising patients on preventive care based on environmental and genetic risk factors they face
- Helping patients make healthy lifestyle decisions
- Referring members to medically necessary specialty or sub-specialty care
- Coordinating care, when needed, such as helping members get procedures that are relevant, necessary and performed efficiently.

Access and Communication

Programs to assist providers in this area:

- Transportation assistance and coordination,
- Our Provider Service Contact Center is available seven days a week from 7:00 am – 7:00 pm (CST),
- Multi-cultural health information available online,
- Handbooks and website in multiple languages, and
- Translation and interpreter assistance.

Access Standards for PCPs*

AmeriHealth Caritas Louisiana has established standards for accessibility of medical care services. The standards apply to PCPs and are requirements of the PCP contract.

Appointment Accessibility Standards

Medical Care	Access Standard
Routine/Preventative (Care must be scheduled) Non-Urgent Sick Visits	Within 6 weeks of the member's call Within 72 hours or sooner if condition deteriorates
Urgent Medical Condition (Care must be scheduled)	Within 24 hours of the member's call
Emergency Medical Condition (Care must be seen)	Immediately upon the member's call or referred to an emergency facility
Specialty Care Consultation	within one (1) month of referral or as clinically indicated;
Family Planning Appointments	Within one (1) week or as clinically indicated

*Access and appointment standards for behavioral health services can be found in the Behavioral Health Addendum section of this manual.

After Hours Accessibility Standards

Medical Care	Access Standard
After-Hours Care by a PCP or a Covering PCP must be available *	24 hours/7 days a week

*When the PCP uses an answering service or answering machine to intake calls after normal business hours, the call must be answered by ten (10) rings and must be returned by a clinical provider within 30 minutes. If the PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP, someone must be available to answer the designated provider's telephone. Another recording is not acceptable.

- If the PCP's office telephone is transferred after office hours to another location where someone will answer the telephone, they must be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

- It is not acceptable to have a message on an answering machine that instructs the member to go to the emergency room for care without providing instructions on how to reach the PCP.

  The following information must be included in the message:
  1. Instructions for reaching the provider.
  2. Instructions for obtaining emergency care.

Member Reassignment Policy

How and when will providers be notified?

- AmeriHealth Caritas Louisiana will perform a quarterly PCP re-assignment analysis for the previous 12 months for all in-network PCPs.
- AmeriHealth Caritas Louisiana will distribute quarterly reports of the PCP reassignment analysis to providers.
- Providers will have **15 business days** to review and respond before any member is reassigned.
- If a provider does not respond, AmeriHealth Caritas Louisiana will begin the reassignment process.

How will AmeriHealth Caritas Louisiana determine member reassignments?

Members will be eligible for reassignment if:

- Member is over 19 linked to a Pediatrician/PCP with member age limitations; or
- Member has one or more visits to an unassigned PCP in claims history within the previous 12 months including wellness visits and sick visits; and
- Member has been assigned to current PCP for at least 90 days.

Members will not be reassigned if:

- Member has one or more visits to a PCP other than their PCP of record within the same TIN as their assigned PCP; or
- Member has not had a visit with their current PCP or any other PCP within the previous 12 months.

Where can you find reports to review your roster?

- Updated panel roster reports are available via NaviNet on the 15th of each month.
- The panel rosters can be pulled via PDF or Excel or CSV, which can be filtered and/or sorted per the provider's preference.

Transfer of Non-Compliant/Compliant Members (PCP or Member Request)

AmeriHealth Caritas Louisiana's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with his/her PCP.

PCP transfers can be requested as follows:

- By PCP request, any member whose behavior would preclude delivery of optimum medical care may be transferred from the PCP's panel, or
- By member request.

A written request on your letterhead asking for the removal of the member from your panel must be sent to:

AmeriHealth Caritas Louisiana
Provider Network Management Department
P.O. Box 83580
Baton Rouge, LA 70884

Or email to network@amerihealthcaritasla.com

The request must include the following:

- The member's full name and AmeriHealth Caritas Louisiana member identification number.
- The reason(s) for the requested transfer. (To ensure that AmeriHealth Caritas Louisiana members are not subject to discriminatory practices, such as separate waiting rooms or separate appointment days. Members must be provided all covered services without regard to race, color, religion, sex, age, national origin, ancestry, nationality, creed, citizenship, alienage, marital or domestic partnership or civil union status, affectional or sexual orientation, physical, cognitive or mental disability, veteran status, whistleblower status, gender identity and/or expression, genetic information, health status, pre-existing condition, income status, source of payment, program memberships or physical or behavioral disability, except where medically indicated, or any other characteristic protected under federal, state, or local law.)
- The requesting PCP's signature and AmeriHealth Caritas Louisiana provider identification number.

Member/Provider, Provider staff conflict issues will be reviewed on a case by case manner. Providers may not deny to a member any covered service or availability of a facility.

Provider will receive an automatic acknowledgment of plan receipt of request. Plan will review request, determine action, and send the provider a resolution letter. If approved for transfer, transfer will be accomplished within 30 days of receipt of the written request, during which time the PCP must continue to render any needed care.

The Provider Network Management Department will assign the member to a new PCP and will notify both the member and requesting PCP when the transfer is effective via letter. Requests for transfer of non-compliant members should be directed to PCPAssignment@amerihealthcaritas.com.

PCP Requesting a Freeze or Limitation of Your Member Linkages

AmeriHealth Caritas Louisiana recognizes that a PCP will occasionally need to limit the volume of patients in his/her practice in the interest of delivering quality care. Each PCP office must accept at least 50 members but may specify after 50, the number of members/PCP linkages they will accept from AmeriHealth Caritas Louisiana. Our system will automatically close the PCP Panel once a PCP has reached the specified number of linkages. A PCP may also forward a request to limit or stop assignment of members to his/her panel if his/her circumstances change.

We encourage our providers to offer evening and Saturday hours. AmeriHealth Caritas Louisiana will offer the additional reimbursement under the Medicaid Professional Fee Schedule adjunct codes.

Providers may contact the Provider Network Management Department to freeze or limit their member linkages, by written request and must include the following:

- The Group name, applicable practitioner and AmeriHealth Caritas Louisiana provider identification number. Practice location for which they are requesting review (if multi-site groups)
- Limitation requested & the requesting PCP's signature
- The Group name, applicable practitioner and AmeriHealth Caritas Louisiana provider identification number. Practice location for which they are requesting review (if multi-site groups)
- The requesting PCP's signature

Provider requests to freeze or limit member assignment should be directed to PCPAssignment@amerihealthcaritas.com.

Provider will receive an automatic acknowledgment of plan receipt of request. Plan will review request and send the provider a resolution letter. Freeze/panel limitation will be accomplished within 30 days of receipt of the written request, during which time the PCP must continue to render any needed care to assignment membership.

Provider Office Standards

Physical Environment

The following are examples of standards that must be met for AmeriHealth Caritas of Louisiana network participation:

1. Office must be wheelchair accessible/ADA compliant
2. Office must have visible signage
3. Office hours must be posted
4. Office must be clean and presentable
5. Office must have a waiting room with chairs
6. Office must have an adequate number of staff/personnel to handle patient load, with an assistant available for specialized procedures
7. Office must have at least two examination rooms that allow for patient privacy
8. Office must have the following equipment:
   - Examination table
   - Otoscope
   - Ophthalmoscope
   - Sphygmomanometer
   - Thermometers
   - Needle disposal system
   - Accessible sink/hand washing facilities
   - Bio-hazard disposal system

AmeriHealth Caritas of Louisiana Site Review Standards	
Category	**Description**
Physical Accessibility	Handicap parking is clearly designated Facility is wheelchair accessible/ADA compliant externally and internally All exits are clearly labeled and free of obstruction
Appearance and Cleanliness	Interior surroundings are clean; carpet and tile are secure Public areas are free from food, beverages and food containers Public areas are free from personnel belongings Office hours are clearly posted
Adequacy of Waiting Area	Waiting room is well lit Waiting room has adequate patient seating (i.e. seating accommodates 3-4 patients per practitioner per hour) Furniture is clean, secure and free of rips and tears Patient registration ensures confidentiality

AmeriHealth Caritas of Louisiana Site Review Standards	
Category	**Description**
Adequacy of Exam Rooms	Exam room is well lit and has adequate space for patient scheduling (i.e. at least two available exam rooms for each provider; each exam room can accommodate 3-4 patients per hour) Exam room ensures patient privacy and confidentiality Trash containers have appropriate liners (i.e. red for regulated waste) Sharp containers are present and not overfilled Exam room, table and equipment are clean, secure and free of rips and tears.

Americans with Disabilities Act (ADA)

Title III of the Americans with Disabilities Act (ADA, 42 U.S.C. 1201 et eq.) states that places of public accommodation must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations (such as health care providers) must specifically comply with, among other things, requirements related to effective physical accessibility, communication with people with hearing, vision, or speech disabilities, and other access requirements. For more information, you can go to the Department of Justice's ADA Home Page: http://www.ada.gov/

Mainstreaming and Member Access

AmeriHealth Caritas Louisiana requires all providers to accept members for treatment and not intentionally segregate members in any way from other persons receiving services. AmeriHealth Caritas Louisiana shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.

AmeriHealth Caritas Louisiana will monitor compliance and accessibility standards so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to the following:

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

When AmeriHealth Caritas Louisiana becomes aware of a provider's failure to comply with mainstreaming, AmeriHealth

Caritas Louisiana will work with the provider to develop a written plan for coming into compliance within thirty (30) calendar days and will notify the Louisiana Department of Health in writing.

Provider Monitoring Access

AmeriHealth Caritas Louisiana will monitor appointment waiting times using various mechanisms, including:

- Reviewing provider records during site reviews
- Monitoring administrative complaints and grievances
- Conducting an annual *Access to Care* survey to assess member access to daytime appointments and after care
- Performing after-hour calls to verify coverage availability
- Performing "Mystery Shopper" survey's to verify compliance

AmeriHealth Caritas Louisiana monitors compliance with appointment standards in a variety of ways: During visits by your Provider Network Account Executive, monitoring member complaints, telephone surveys, and mystery shopper calls. On an annual basis, AmeriHealth Caritas Louisiana monitors the compliance of all participating PCP Offices against the established Accessibility Standards. The data collected to monitor for compliance include Appointment Access to Data Only, After-Hours Access Data Only, and Appointment Access and After-Hours Access Data. All non-compliant providers are notified of all categories requiring improvement. The non-compliant providers are given a timeline for submitting a corrective action to meet the performance standards.

Reimbursement/Fee-for-Service Payment

AmeriHealth Caritas Louisiana will reimburse all contracted providers at fee-for-service rates described in the network provider's individual AmeriHealth Caritas Louisiana Provider Agreement.

After Hours Care on Evenings, Weekends, and Holidays

This policy is intended to facilitate enrollee access to services during non-typical hours primarily to reduce the inappropriate use of the hospital emergency department. The reimbursement for the evening, weekend, and holiday codes is intended to assist with coverage of the additional administrative costs associated with staffing during these times.

The *Current Procedural Terminology* (CPT) evening, weekend, and holiday codes are reimbursed in addition to the reimbursement for most outpatient evaluation and management (E/M) services when the services are rendered in settings other than hospital emergency departments during the hours of:

- Monday through Friday between 5 p.m. and 8 a.m. (when outside of regular office hours),
- Weekends (12 a.m. Saturday through midnight on Sunday), or
- State/Governor proclaimed legal holidays (12 a.m. through midnight).

Only one of the evening, weekend, and holiday codes may be submitted by a billing provider per day per enrollee. Providers should select the evening, weekend, and holiday procedure code that most accurately reflects the situation on a particular date. These codes are never reported alone, but rather in addition to another code or codes describing the

service related to that member's visit or encounter. The following examples illustrate the appropriate use of evening, weekend, and holiday procedure codes based on the situation described.

- If the existing office hours are Monday through Friday from 8 a.m. to 5 p.m., and the physician treats the member in the office at 7 p.m., then the provider may report the appropriate basic service (E/M visit code) and evening, weekend, and holiday code.
- If the existing office hours are Monday through Friday from 8:30 a.m. to 6:30 p.m., and the physician treats the member in the office at 6 p.m., then the provider may not report the evening, weekend, and holiday code.
- If a member is seen in the office on Saturday during existing office hours, then the provider may report the appropriate basic service (E/M visit code) and evening, weekend, and holiday code.

Documentation in the medical record relative to this reimbursement must include the time the services were rendered.

Reimbursement

The reimbursement for evening, weekend and holiday services is based on the following current CPT codes or their successors.

- 99050 (Services…at times other than regularly scheduled office hours…) or
- 99051 (Services …at regularly scheduled evening, weekend, or holiday hours…).

When used, these procedure codes must be submitted with the code(s) for the associated evaluation and management services on that date.

Specialist/Sub-Specialist Services

Specialists and Sub-specialists shall provide Medically Necessary covered services to AmeriHealth Caritas Louisiana members referred by the member's PCP. These services include:

- Ambulatory care visits and office procedures
- Arrangement or provision of inpatient medical care at an AmeriHealth Caritas Louisiana participating hospital
- Consultative Specialty Care Services 24 hours a day, 7 days a week.

Specialist Access & Appointment Standards

The office waiting time should be no more than 45 minutes including time in the waiting room and examining room), or no more than one (1) hour when the network provider encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. If a provider is delayed, patients will be notified immediately. If the wait is over ninety (90) minutes, the patient must be offered a new appointment. Scheduling procedures should ensure:

- Emergency appointments immediately upon request
- Urgent Care appointments within twenty-four (24) hours of request
- Routine appointments within one month of the request
- Non urgent Lab and diagnostic (x-ray) within three weeks

- Urgent lab and diagnostic (x-ray) within forty-eight(48) hours
- Family Planning visits within one (1) week of request

If a member presents to the Specialist in need of emergency behavioral health services the provider shall: (a) instruct the member to seek help from the nearest emergency medical provider by calling 911, and (b) contact Member Services at 1-888-756-0004, 24 hours a day, 7 days a week.

Access Standards for OB/GYNs

AmeriHealth Caritas Louisiana has established standards to assure accessibility of medical care services. The standards apply to OB/GYN's.

Initial Examination for Members	Appointment Scheduled with an OB/GYN Practitioner
Pregnant women in their 1st trimester	Within 14 business days of AmeriHealth Caritas Louisiana learning the member is pregnant
Pregnant women in their 2nd trimester	Within 7 business days of AmeriHealth Caritas Louisiana learning the member is pregnant
Pregnant women in their 3rd trimester	Within 3 business days of AmeriHealth Caritas Louisiana learning the member is pregnant
High risk-pregnant women	Within 3 days of AmeriHealth Caritas Louisiana learning the member is high risk or immediately if an Emergency Medical Condition exists.

PCP and Specialist Medical Record Requirements

Providers must follow the medical record standards outlined below, for each member's medical record, as appropriate:

- Maintain accurate and legible records
- Safeguard against loss, destruction, or unauthorized use and maintain in an organized fashion, for all members
    - evaluated or treated, and records are accessible for review and audit
- Ensure records provide medical and other clinical data required for Quality and Utilization Management review.
- Medical records should include, minimally, the following:
    - Member identifying information including name, identification number, date of birth, sex and legal guardianship (if applicable)
    - Primary language spoken by the member and any translation needs of the member
    - Services provided through the plan, date of service, service site, and name of provider
    - Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit
    - Members who are prescribed a controlled substance must have a patient specific query completed through the Prescription Monitoring Program (PMP). This should be completed upon writing the first prescription and annually. Additional queries can be performed at the prescriber's discretion. All PMP

queries should be printed and filed in the member's medical record.
- Referral information including follow-up and outcome of referral
- Documentation of emergency and/or after-hours encounters and follow-up;
- Signed and dated consent forms (as applicable)
- Documentation of immunization status
- Documentation of advance directives, as appropriate
- Documentation of each visit must include:
  - Date and begin and end times of service
  - Chief complaint or purpose of the visit
  - Diagnoses or medical impression
  - Objective findings
  - Patient assessment findings
  - Studies ordered an results of those studies (e.g. laboratory, x-ray, EKG)
  - Medications prescribed
  - Health education provided
  - Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and initials of providers must be identified with correlating signatures.

Documentation of EPSDT requirements include but are not limited to:
- Comprehensive health history
- Developmental history
- Unclothed physical exam
- Vision, hearing and dental screening
- Appropriate immunizations
- Appropriate lab testing including mandatory lead screening
- Health education and anticipatory guidance

Providers must maintain medical records for a period not less than 10 years from the close of the Network Provider Agreement and retained further if the records are under review or audit until the audit or review is complete.

PCP and Specialist Cultural and Linguistic Requirements

Section 601 of Title VI of the Civil Rights Act of 1964 states that:

No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance. Providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2).

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

As a provider of health care services who receives federal financial payment through the Medicaid program, you are responsible for making arrangements for language services for members who are either Limited English Proficient (LEP) or Low Literacy Proficient (LLP) to facilitate the provision of health care services to such members.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/health care provider relationship. The key to equal access to benefits and services for LEP, LLP and sensory-impaired members is to make sure that our Network Providers can effectively communicate with these members**.** Plan providers are obligated to offer translation services to LEP and LLP members, and to make reasonable efforts to accommodate members with other sensory impairments.

Providers are required to:

Provide written and oral language assistance at no cost to Plan members with limited- English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request.

Upon request, provide members verbal or written notice, in their preferred language or format, about their right to receive free language assistance services; Post and offer easy-to-read member signage and materials in the languages of the common cultural groups in your service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats upon request.

Note: The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a member has been made aware of his/her right to receive free interpretation and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

Members should be advised that translation services from AmeriHealth Caritas Louisiana are available. When a member uses AmeriHealth Caritas Louisiana translation services, the provider must sign, date and complete documentation of the services provided in the medical record in a timely manner.

Health care providers who are unable to arrange for translation services for an LEP, LLP or sensory impaired member should contact AmeriHealth Caritas Louisiana Member Services department at 1-888-756-0004 and a representative will help locate a professional interpreter that communicates in the member's primary language. AmeriHealth Caritas Louisiana contracts with a competent telephonic interpreter service provider. These services are also available face-to-face at the physician's office at the time of the member's visit. If you need more information on using the telephonic interpreter service or face-to-face services, please visit our website at www.amerihealthcaritasla.com or contact the Plan's Member Services department.

Additionally under the Culturally Linguistically Appropriate Standards (CLAS) of the Office of Minority Health, Plan providers are strongly encouraged to:

- Provide effective, understandable and respectful care to all members in a manner compatible with the member's cultural health beliefs and practices of preferred language/format;
- Implement strategies to recruit, retain and promote a diverse office staff and organizational leadership representative of the demographics in your service area;
- Educate and train staff at all levels, and across all disciplines, in the delivery of culturally and linguistically appropriate services;

- Establish written policies to provide interpretive services for AmeriHealth Caritas Louisiana members upon request;
- Document preferred language or format, such as Braille, audio or large type in all member medical records.

AmeriHealth Caritas Louisiana requires all providers to have yearly trainings on cultural competence, including tribal awareness. Providers may meet this requirement by attending an AmeriHealth Caritas Louisiana offered training, or one offered by any other Healthy Louisiana plan or a governmental agency with proof of attendance. Providers are required to obtain a minimum of three (3) hours per year of cultural competence training.

The U.S. Department of Health & Human Services webpage, Think Cultural Health, offers training that meets this requirement, including:

- A Physician's Practical Guide to Culturally Competent Care
- Culturally Competent Nursing Care: A Cornerstone of Caring

This training may be found at: https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp

Preventive Health Guidelines

AmeriHealth Caritas Louisiana's Preventive Health Guidelines represent current professional standards, supported by scientific evidence and research. They are not intended to interfere with or supersede a Health Care Provider's professional judgment. The Preventive Health Guidelines are now available in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com or you can call your Provider Network Account Executive to request hard copies.

Clinical Practice Guidelines

AmeriHealth Caritas Louisiana has adopted clinical practice guidelines for use in guiding the treatment of AmeriHealth Caritas Louisiana members, with the goal of reducing unnecessary variations in care. AmeriHealth Caritas Louisiana clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual. AmeriHealth Caritas Louisiana's Clinical Practice Guidelines are available online in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com, or you may call your Provider Network Account Executive to request a hard copy. In support of the above guidelines, AmeriHealth Caritas Louisiana's Integrated Care Management program is available to assist you in the education and management of your patient with special health needs, chronic diseases or complex conditions. For additional information or to refer an AmeriHealth Caritas Louisiana member for Care Management Services, please call the Rapid Response team at 1-888-643-0005.

Advance Directives

All AmeriHealth Caritas Louisiana providers are required to comply with 42 C.F.R. 489.102 for individuals who are their

patients, our members, as defined in 42 C.F.R 489.100. An advance directive is a written instruction, such as a do not resuscitate (DNR) order, living will or declaration, or a durable power of attorney for health care (DPAHC), recognized under Louisiana law, relating to the provision of health care when an individual is incapacitated.

AmeriHealth Caritas Louisiana requires its network providers to maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advanced directives must be furnished by providers as required by Federal regulations:

- Hospital - At the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - At the time of the individual's admission as a resident.
- Home Health Agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Personal Care Services - In advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Hospice Program - At the time of initial receipt of hospice care by the individual from the program.

Providers and/or organizations are not required to:

- Provide care that conflicts with an advance directive.
- Implement an advance directive if, as a matter of conscience,
    a) the provider cannot implement an advance directive; and
    b) the law allows any health care provider or any agent of such provider to conscientiously object.

AmeriHealth Caritas Louisiana provides our members with information about advanced directives via the Member Handbook. The member handbook can be found on our website at www.amerihealthcaritasla.com under Getting Started on the Members tab.

Provider and Subcontractor Requirements

At the time of entry into a contract with AmeriHealth Caritas Louisiana, providers and subcontractors must adhere to ~~amembersa~~ members' [KG1] rights to file grievances and appeals, and request State Fair Hearings as per Section XI of this handbook.

Providers and subcontractors must report loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of receipt of notification, if required to be accredited.

Providers and subcontractors must immediately report cancellation of any required insurance coverage, licensure, or certification to AmeriHealth Caritas Louisiana.

SECTION III: COVERED BENEFITS

Covered Benefits

AmeriHealth Caritas Louisiana members are entitled to all of the benefits provided under the Louisiana Medicaid Program. There may be benefit limits or co-payments associated with the services mentioned in this section of the *Provider Manual*. Detailed Medicaid coverage information may be found in the Louisiana Medicaid fee schedules and Provider Manuals available at www.lamedicaid.com.

Physical Health Services include:*

- Allergy Testing and Allergen Immunotherapy
- Ambulatory Surgical Services
- ~~Anestheisa~~[KG2]Anesthesia
- Applied Behavioral Analysis Therapy (age 0-20)
- Ancillary Medical Services
- Audiology Services
- Bariatric Surgery
- Breast Surgery
- Chiropractic Services (Age 0-20)
- Clinic Services
- Cochlear Implant (Age 0-20)
- Communicable Disease Services
- Diabetes Education Management Training
- Diagnostic Services
- Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies
- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Age 0-20)
- Emergency and Non-emergency Medical Transportation
- Emergency Services
- End Stage Renal Disease Services
- Enhanced Dental for Adults*
- Eye Care and Vision Services
- Family Planning Services
- Federally Qualified Health Center (FQHC) Services (including behavioral services provided by FQHCs)
- Genetic Testing for Breast and Ovarian Cancer
- Gynecology
- Home Health Services
- Home Health-Extended Services (Age 0-20)
- Hospice
- Hyperbaric Oxygen Therapy
- Immunizations (Children and Adults)
- Inpatient Hospital Services
- Intrathecal Baclofen Therapy
- Lab and Radiology Services
- Limited Abortion Services
- Medical Transportation Services
- Medical and Surgical Dental Service
- Newborn Care and Discharge
- Nurse Midwife Services
- Nurse Practitioner Services
- Obstetrics

- Organ Transplant and Related Services Family Planning Services
- Outpatient Hospital Services
- Pediatric Day Healthcare Services (Age 0-20)
- Personal Care Services (EPSDT) (Age 0-20)
- Pharmacy Services (Prescription Medicines Dispensed)
- Physician/Professional Services
- Podiatry Services
- Pregnancy-Related Services
- Preventative Services for Adults (Age 21 and older)
- One well-woman gynecological examination per year for women aged 21 and over when performed by a primary care provider or gynecologist. This is in addition to the current service provision of one preventive medicine visit for adults aged 21 years and older. (These services allow women to receive the necessary primary care and gynecological components of their annual preventive screening visits. This additional service is not to facilitate duplicative services. Providers should continue to bill with the appropriate preventive medicine CPT codes with the visit reflecting the specific medical nature of the service.)
- Private Duty Nursing Services
- Rehabilitative Services
- Rural Health Clinic Services
- Sterilization
- Telemedicine
- Therapy Services (Physical, Occupational, Speech and Respiratory)
- Tobacco Cessation Services
- Vagus Nerve Stimulators

*See Behavioral Health Addendum for Behavioral Health covered services.

Enhanced Dental Care for Adults through ~~DINA Dental~~ Avesis (Total package value of $500 per year):

- $225 benefit package which includes 2 dental exams with cleaning and 1 set of x-rays per year
- Additional coverage of $275 /year for fillings & extractions

Adults are also eligible for the Adult Denture program with MCNA.

N O T E : Children's dental coverage provided by the Louisiana Department of Health (LDH LDH) through MCNA.

Enhanced Vision Care for Adults through AmeriHealth Caritas Louisiana's-Adult enhanced benefit (through Avesis~~VSP~~) provides one routine eye exam per year, with no co-pay, and up to $100 toward glasses or prescription contacts once a year.

N O T E : Medical eye care provided for all members. Specialty eye care services, Optician, and eyewear services are provided for children with no authorization needed.

Services Not Covered

Some services are not covered through AmeriHealth Caritas Louisiana, including but not limited to, the following:

- Dental for members under Age 21;
- ICF/DD Services;
- Nursing Facility Services;
- Individualized Education Plan (IEP) Services 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 OPH certified school-based health clinics);
- All Home & Community-Based Waiver Services;
- Personal Care Services for those ages 21 and older;
- Targeted Case Management Services including Nurse Family Partnership:
- Services provided through LDH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services);
- Elective abortions and related services;
- Experimental/investigational drugs, procedures or equipment, unless approved by the Secretary of LDH;
- Elective cosmetic surgery, and
- Services for treatment of infertility.
- Cardiac and Pulmonary Rehabilitation.
- Surgical procedures discontinued before completion.
- Harvesting of organs when a member is the donor of an organ to a non-Medicaid member.

When uncertain about whether AmeriHealth Caritas Louisiana will pay for health care services, please contact the Provider Services Department at 1-888-922-0007.

Private Pay for Non-Covered Services

Providers are required to inform members in writing about the costs associated with services that are not covered by AmeriHealth Caritas Louisiana, prior to rendering such services. Should the patient and provider agree the services will be rendered as a private pay arrangement, the provider must obtain a signed document from the member to validate the private payment arrangement. The document must provide:

- the nature of the service(s) to be rendered;
- that AmeriHealth Caritas Louisiana does not cover the services; and
- that the member will be financially responsible for the services if the member elects to receive the services.

Furthermore, Provider shall hold harmless AmeriHealth Caritas Louisiana and the member for any claim or expense arising from such services when the member has not been notified of the non-Covered Services as set forth herein.

Adverse Incident Reporting

For all network providers, it is the policy of AmeriHealth Caritas Louisiana to mirror as closely as possible the reporting requirements and categories outlined in the Louisiana Department of Health (LDH) contract. AmeriHealth Caritas Louisiana providers are expected and required to develop written policies and procedures for an incident management process, take strong measures to prevent the occurrence of adverse incidents, investigate and report on those that occur, and to take reasonable corrective action to prevent reoccurrence.

All providers are required to report critical adverse incidents to AmeriHealth Caritas Louisiana within 24 hours of the time the provider becomes aware of their occurrence.

The following events, when occurring during a member's term of care, will be defined as adverse incidents, and must be reported to AmeriHealth Caritas Louisiana by providers.

Adverse Incidents include, but are not limited to:

1. Death of a member.
2. ~~Suicide attempt.~~
3. ~~Medication error.~~
4. ~~Any event requiring the services of the fire department, or law enforcement agency.~~
2. Abuse or alleged abuse involving a member.
3. Neglect
4. Extortion
5. Exploitation
6. ~~Any injury or illness (non-psychiatric) of a member requiring medical treatment more intensive than first aid~~
7. ~~A member who is out of contact with staff for more than 24 hours without prior arrangement, or a member who is in immediate jeopardy because he/she is missing for any period of time.~~
8. ~~Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter in place or relocation of residents.~~
9. ~~Seclusion or restraint.~~
    - ~~Chemical restraint~~
    - ~~Mechanical restraint~~
    - ~~Manual restraint~~
    - ~~Time-out room~~
10. ~~Other incident identified by Provider~~[KF3]

Completed incident reports should be forwarded by providers to the AmeriHealth Caritas Louisiana ~~Quality Improvement Department~~ within one (1) business day from ~~24 hours of the occurrence or~~ discovery of the incident ~~occurrence~~. Due to the sensitive nature of the information and identification of the member, providers will submit the forms to AmeriHealth Caritas Louisiana via ~~first class US Mail or by~~ fax:

Fax to:

1-844-341-7641

~~**Mail to:**~~

~~AmeriHealth Caritas Louisiana~~
~~Attn: Adverse Incident Report – QI Dept.~~
~~10000 Perkins Rowe~~
~~Block G 4th Floor~~
~~Baton Rouge, LA 70810~~

Allergy Testing

AmeriHealth Caritas Louisiana covers allergy testing for children and adults who have symptoms that suggest they have an allergic disease. Allergy symptoms may include, but are not limited to:

- Respiratory symptoms: itchy eyes, nose, throat, nasal congestion, runny nose, watery eyes, chest congestion or wheezing
- Skin symptoms: hives, generalized itchiness or atopic dermatitis, and
- Other symptoms: anaphylaxis (severe life-threatening allergic reactions) or abdominal symptoms (cramping, diarrhea) that consistently follow particular foods or stinging insect reactions (other than large local swelling at the sting site).

Allergen Immunotherapy

AmeriHealth Caritas Louisiana's policy for allergen immunotherapy shall include the following:

- Allergen immunotherapy is only recommended for allergic asthma, allergic rhinitis and conjunctivitis, and stinging insect allergy. Immunotherapy for food allergies is not recommended. Decisions to initiate immunotherapy should be based on severity of allergy symptoms, other possible treatment options, and cost of treatment options.

- Five years of age is the youngest recommended age to begin immunotherapy. There is no upper age limit for receiving immunotherapy. However, before initiating immunotherapy in an older person, consideration must be given to other common medical conditions that could make immunotherapy more risky.

Ambulance– Transportation

AmeriHealth Caritas Louisiana is responsible to coordinate and reimburse for Medically Necessary transportation by ambulance for physical, psychiatric or behavioral health services.

AmeriHealth Caritas Louisiana has contracted with specific transportation providers throughout the service area and will reimburse for Medically Necessary transportation services. For ambulance transportation to be considered Medically Necessary, one or more of the following conditions must exist:

- The member is incapacitated as the result of injury or illness and transportation by van, taxicab, public transportation or private vehicle is either physically impossible or would endanger the health of the member
- There is reason to suspect serious internal or head injury
- The member requires physical restraints
- The member requires oxygen or other life support treatment en route
- The member is being transported to the nearest appropriate medical facility
- The member is being transported to or from an appropriate medical facility in connection with services that are covered under the MA Program

Members experiencing a medical emergency are instructed to immediately contact their local emergency rescue service, 911.

Non-Emergency Medical Transportation - (NEMT)

Non-emergency medical and behavioral transportation is a ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive AmeriHealth Caritas Louisiana -covered services from a medical or behavioral health provider. NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations. Members and providers can access AmeriHealth Caritas Louisiana NEMT services by calling 1-888-913-0364 (Where's My Ride). AmeriHealth Caritas Louisiana is financially responsible for payment of these services.

Members that do not qualify for non-emergency medical transportation services under Healthy Louisiana include: Members residing in nursing facilities and Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

Anesthesia Services

Surgical Anesthesia

AmeriHealth Caritas Louisiana covers surgical anesthesia services when provided by an anesthesiologist or certified registered nurse anesthetist (CRNA).

Coverage for surgical anesthesia procedures must be based on formulas utilizing base units, time units (1 unit = 15 min) and a conversion factor as identified in the Anesthesia Fee Schedule. Minutes must be reported on anesthesia claims.

Administration of anesthesia by the surgeon performing the surgical procedure for a non-obstetrical surgery shall not be covered.

AmeriHealth Caritas Louisiana shall require the following modifiers to be used to submit surgical anesthesia services:

Modifier	Servicing Provider	Surgical Anesthesia Service
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction* of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA	CRNA service with direction* by an anesthesiologist
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist

The following are acceptable uses of modifiers:

- Modifiers which can stand alone: AA and QZ;
- Modifiers which need a partner: QK, QX and QY; and
- Valid combinations: QK and QX, or QY and QX.

Medical Direction

Medical direction is defined as:

- Performing a pre-anesthetic examination and evaluation;
- Prescribing the anesthesia plan;

- Participating personally in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensuring that any procedures in the anesthesia plan that he/she does not perform are rendered by a qualified individual;
- Monitoring the course of anesthesia administration at frequent intervals;
- Remaining physically present and available for immediate diagnosis and treatment of emergencies; and
- Providing the indicated post-anesthesia care.

AmeriHealth Caritas Louisiana shall reimburse only anesthesiologists for medical direction.

Maternity-Related Anesthesia

AmeriHealth Caritas Louisiana shall cover maternity-related anesthesia services when provided by anesthesiologists, CRNAs, or the delivering physician.

AmeriHealth Caritas Louisiana shall require the delivering physician to use CPT codes in the Surgery Maternity Care and Delivery section of the CPT manual to bill for maternity-related anesthesia services.

Reimbursement for these services shall be a flat fee, except for general anesthesia for vaginal delivery.

AmeriHealth Caritas Louisiana shall require the following modifiers to be used when providing maternity-related anesthesia services:

Modifier	Servicing Provider	Service Performed
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction* of two, three, or four concurrent anesthesia procedures
QX	CRNA	CRNA service with medical direction* by an anesthesiologist
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist
47	Delivering Physician	Anesthesia provided by delivering physician
52	Delivering Physician or Anesthesiologist	Reduced services
QS	Anesthesiologist or CRNA	Monitored anesthesia care service The QS modifier is a secondary modifier only, and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA). The QS modifier indicates that the provider did not introduce the epidural for anesthesia, but did monitor the enrollee after catheter placement.

Add-on Codes for Maternity-Related Anesthesia

When an add-on code is used to fully define a maternity-related anesthesia service, AmeriHealth Caritas Louisiana shall require the date of delivery be the date of service for both the primary and add-on code.

An add-on code in and of itself is not a full service and typically cannot be reimbursed separately to different providers. The exception is when more than one provider performs services over the duration of labor and delivery.

A group practice frequently includes anesthesiologists and/or CRNA providers. One member may provide the pre-anesthesia examination/evaluation, and another may fulfill other criteria. AmeriHealth Caritas Louisiana shall require that the medical record indicate the services provided and identify the provider who rendered the service.

Maternity-Related Anesthesia

Reimbursement for maternity-related procedures, other than general anesthesia for vaginal delivery, shall be a flat fee.

AmeriHealth Caritas Louisiana shall ensure that minutes be reported on all maternity-related anesthesia claims.

AmeriHealth Caritas Louisiana shall require providers to follow the chart below when billing for maternity-related anesthesia.

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Vaginal Delivery General Anesthesia	01960	Valid Modifier	Formula	Anesthesiologist performs complete service, or direction of the CRNA
				CRNA performs complete service with or without direction by Anesthesiologist
Epidural for Vaginal Delivery	01967	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery only (epidural or general)	01961	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery after Epidural, for planned vaginal delivery	01967 + 01968	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services
Cesarean Hysterectomy after Epidural and Cesarean Delivery	01967 + 01969	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services
Epidural – Vaginal Delivery	59409 59612	47	Fee for delivery plus additional reimbursement for anesthesia	Delivering physician provides the entire service for vaginal delivery
Epidural – Vaginal Delivery	59409 59612	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician
Epidural – Vaginal Delivery	01967	AA and 52	Flat Fee	Introduction only by anesthesiologist

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Epidural – Vaginal Delivery	01967	AA and QS for MD; QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by anesthesiologist or CRNA
Cesarean Delivery	59514 59620	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician
Cesarean Delivery – after Epidural	01961	AA and 52	Flat Fee	Introduction only by the anesthesiologist
Cesarean Delivery-following Epidural for planned vaginal delivery	01967 + 01968	AA and 52	Flat Fee plus add-on	Introduction only by the anesthesiologist
Cesarean Delivery – after Epidural	01961	AA and QS for MD; QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by the anesthesiologist or CRNA
Cesarean Delivery-following Epidural for planned vaginal delivery	01967 + 01968	AA and QS for MD; QZ and QS or QX and QS for CRNA	Flat Fee plus add-on	Monitoring by the anesthesiologist or CRNA

Anesthesia for Tubal Ligation or Hysterectomy

Anesthesia reimbursement for tubal ligations and hysterectomies shall be formula-based, with the exception of anesthesia for cesarean hysterectomy (CPT code 01969).

The reimbursement for CPT codes 01967 and 01969, when billed together, shall be a flat fee. CPT code 01968 is implied in CPT code 01969 and should not be placed on the claim form if a cesarean hysterectomy was performed after C-section delivery.

Pediatric Moderate (Conscious) Sedation

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

Moderate sedation coverage shall be restricted to enrollees from birth to age 13. Exceptions to the age restriction shall be made for children who have severe developmental disabilities; however, no claims shall be considered for enrollees 21 years of age or older.

Moderate sedation includes the following services (which are not to be reported/billed separately):

- Assessment of the enrollee (not included in intra-service time);
- Establishment of intravenous (IV) access and fluids to maintain patency, when performed;
- Administration of agent(s);
- Maintenance of sedation;
- Monitoring of oxygen saturation, heart rate and blood pressure; and
- Recovery (not included in intra-service time).

Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

AmeriHealth Caritas Louisiana reimburses a second physician other than the healthcare professional performing the diagnostic or therapeutic when the second physician provides moderate sedation in a facility setting (e.g., hospital, outpatient hospital, ambulatory surgical center, skilled nursing facility). However, moderate sedation services performed by a second physician in a non-facility setting (e.g., physician office, freestanding imaging center) should not be reported.

Provider Claims Filing for Anesthesia

AmeriHealth Caritas Louisiana's policy for filing of claims related to anesthesia services shall include the following:

Anesthesia Time

Anesthesia time begins when the provider begins to prepare the enrollee for induction and ends with termination of the administration of anesthesia. Time spent in pre- and postoperative care may not be included in the total anesthesia time.

Multiple Surgical Procedures

Anesthesia for multiple surgical (non-OB) procedures in the same anesthesia session must be billed on one claim line using the most appropriate anesthesia code with the total anesthesia time spent reported in item 24G on the claim form. The only secondary procedures that are not to be billed in this manner are tubal ligations and hysterectomies.

Vaginal Delivery – Complete Anesthesia Service by Delivering Physician

The delivering physician should submit a claim for the delivery and anesthesia on a single claim line with modifier.

Applied Behavior Analysis (ABA)

AmeriHealth Caritas Louisiana shall coordinate and ensure continuity of care between behavioral health specialists, primary care physicians, and other healthcare specialists, including but not limited to, providers qualified to perform Comprehensive Diagnostic Evaluations (CDE), occupational therapists, physical therapists, and speech therapists as indicated and based on medical necessity criteria for such services.

AmeriHealth Caritas Louisiana shall ensure enrollee and provider call center staff and utilization management staff are knowledgeable in ABA services. Staff shall be capable of providing an explanation of ABA services, a list of ABA providers, and information regarding the prior authorization process to enrollees or providers seeking information.

ABA service shall not be denied solely because an enrollee does not have an Autism Spectrum Disorder (ASD) diagnosis.

Assistant Surgeon/Assistant at Surgery

AmeriHealth Caritas Louisiana shall reimburse for **only one** assistant at surgery. The assistant to the surgeon should be a qualified physician. However, in those situations when a physician does not serve as the assistant, qualified, enrolled, advanced practice registered nurses and physician assistants may function in the role of an assistant at surgery and submit claims for their services under their Medicaid provider number.

Physicians serving as the assistant are to use the modifier "80" on the procedure code(s) representing their services.

Advanced practice registered nurses, certified nurse midwives, and physician assistants are to use the modifier "AS" when reporting their services as the only assistant at surgery.

The reimbursement of claims for more than one assistant at surgery is not covered.

Bariatric Surgery

AmeriHealth Caritas Louisiana shall cover bariatric or weight loss surgery as an option only after a comprehensive and sustained program of diet and exercise with or without pharmacologic measures has been unsuccessful over time.

Bariatric surgery may consist of open or laparoscopic procedures that revise the gastro-intestinal anatomy to restrict the size of the stomach and/or reduce absorption of nutrients.

Eligibility Criteria

AmeriHealth Caritas Louisiana shall consider bariatric surgery medically necessary for enrollees who meet all of the following criteria:

- Be a minimum of 16 years of age;
- Have a documented weight in the morbidly obese range as defined by a body mass index greater than 40;
- Have at least three failed efforts at medical therapy and is experiencing the complications of obesity;
- Have current obesity-related medical conditions;
- Not have a psychiatric diagnosis as the cause of the obesity or which will act as a deterrent to successful treatment as evidenced by the results of a psycho-social evaluation;
- Not currently misusing alcohol or other substances; and
- Be capable of complying with the modified food intake regimen and follow-up program which will come after surgery.

Lipectomy or Panniculectomy Subsequent to Bariatric Surgery

AmeriHealth Caritas Louisiana shall consider a surgical lipectomy medically necessary under the following circumstances:

- Is being performed to correct an illness which was caused or aggravated by the pannus,
- Documentation supports that the enrollee has at least one of the following indications:
    - Intertriginous infections with documented evidence of serious problems with infection control;
    - The apron of the panniculus interferes with ambulation; or
    - The panniculus is causing prolapse of a ventral hernia.

Breast Reconstruction Post Mastectomy

AmeriHealth Caritas Louisiana shall consider reconstructive breast surgery medically necessary after a mastectomy or a lumpectomy that results in a significant deformity (i.e., mastectomy or lumpectomy for treatment of breast cancer).

Reconstruction of the affected/diseased breast and the contralateral unaffected breast to achieve symmetry is considered medically necessary.

AmeriHealth Caritas Louisiana shall cover breast reconstruction for enrollees who have a mastectomy with a diagnosis of breast cancer. Mastectomy includes:

- Partial (lumpectomy, tylectomy, quadrantectomy and segmentectomy);
- Simple;
- Modified radical; and
- Radical.

Breast reconstruction surgery is often considered after a mastectomy to correct deformity or reestablish symmetry caused by previous surgery and/or the effects of therapeutic treatments. Reconstruction procedures may involve multiple techniques and stages to recreate the breast mound through the use of prosthetic implants, tissue flaps or autologous tissue transfers, as well as nipple/areola reconstruction.

AmeriHealth Caritas Louisiana shall cover the following services:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, including nipple tattooing;
- Prosthesis (Implanted and/or external); and
- Treatment of physical complications of the mastectomy.

Clinical Guidelines and Criteria

AmeriHealth Caritas Louisiana shall base its determination of medical necessity for breast reconstruction on a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the procedure, including post-operative recovery. These include, but are not limited to, the following:

- A comprehensive medical history and physical exam has been conducted by a physician to evaluate the need for breast reconstruction surgery;

- The breast reconstruction surgery is intended to correct, restore or improve anatomical and/or functional impairments that result from therapeutic interventions (i.e., radiation) or disease of the breast;

- A surgical treatment plan that outlines the type of techniques and stages of the procedure(s) that will be performed has been developed; and

- The proposed surgery follows a mastectomy that has been performed to remove a malignant neoplasm or carcinoma in situ of the breast.

Covered Procedures

AmeriHealth Caritas Louisiana shall cover the following procedures for breast reconstruction following mastectomy or lumpectomy:

- Breast reconstruction procedures performed on the diseased/affected breast (i.e., breast on which the mastectomy/lumpectomy was performed), including:

- Areolar and nipple reconstruction;
- Areolar and nipple tattooing;
- Autologous fat transplant (i.e., lipoinjection, lipofilling, lipomodeling);
- Breast implant removal and subsequent re-implantation;
- Capsulectomy;
- Capsulotomy;
- Implantation of tissue expander;
- Implantation of U.S. Food and Drug Administration (FDA)-approved internal breast prosthesis;
- Oncoplastic reconstruction;
- Reconstructive surgical revisions; and
- Tissue/muscle reconstruction procedures (e.g., flaps), including, but not limited to, the following:
    - Deep inferior epigastric perforator (DIEP) flap;
    - Latissimus dorsi (LD) myocutaneous flap;
    - Ruben's flap;
    - Superficial inferior epigastric perforator/artery (SIEP/SIEA) flap;
    - Superior or inferior gluteal free flap;
    - Transverse rectus abdominus myocutaneous (TRAM) flap; and
    - Transverse upper gracilis (TUG) flap.

- Breast reconstruction procedures performed on the non-diseased, unaffected, contralateral breast, in order to produce a symmetrical appearance, including:

    - Areolar and nipple reconstruction;
    - Areolar and nipple tattooing;
    - Augmentation mammoplasty;
    - Augmentation with implantation of FDA-approved internal breast prosthesis when the unaffected breast is smaller than the smallest available internal prosthesis;
    - Autologous fat transplant (i.e., lipoinjection, lipofilling, lipomodeling);
    - Breast implant removal and subsequent reimplantation when performed to produce a symmetrical appearance;
    - Breast reduction by mammaplasty or mastopexy;
    - Capsulectomy;
    - Capsulotomy; and
    - Reconstructive surgery revisions to produce a symmetrical appearance.

- Reconstruction of the contralateral unaffected breast to achieve symmetry, including tattooing to correct color defects of the skin is limited to clients with a documented history of a breast reconstruction performed within the past 12 months.

Reduction Mammoplasty and Removal of Breast Implants

AmeriHealth Caritas Louisiana shall cover reduction mammoplasty when medically necessary.

The enrollee must meet the following weight and height criteria before the provider is to submit a request for evaluation and consideration for reduction mammoplasty services. The patient's total weight shall not exceed 120% of the weight limit established by the following formula.

Height	Pounds

5 feet	100
Each additional inch over 5 feet	5

Examples:

- A request for reduction mammoplasty services shall not be submitted for consideration for an enrollee who is 5 feet tall and weighs more than 120 pounds (100 pounds * 120%).
- An enrollee who is 5 feet, one inch tall shall weigh no more than 126 pounds (105 pounds * 120%) to be considered.
- An enrollee who is 5 feet, 5 inches tall shall weigh no more than 150 pounds (125 pounds * 120%) to be considered.

AmeriHealth Caritas Louisiana shall cover the removal of breast implants when medically necessary.

Chiropractic Services for Enrollees under Age 21

AmeriHealth Caritas Louisiana shall only cover chiropractic manipulative treatment for enrollees under 21 years of age when medically necessary and upon referral from an EPSDT medical screening primary care provider.

Cochlear Implant for Enrollees under Age 21

AmeriHealth Caritas Louisiana shall only cover cochlear implants for enrollees under 21 years of age when medically necessary. Am AmeriHealth Caritas Louisiana shall cover unilateral or bilateral cochlear implants when deemed medically necessary for the treatment of profound-to-total bilateral sensorineural hearing loss. Enrollees must be considered for a bilateral cochlear implantation when it has been determined that a unilateral cochlear implant with a hearing aid in the contralateral ear will not result in a binaural benefit.

Coverage Requirements

Coverage for cochlear implants shall include, but is not limited to, the following:

• Implantation of device;
• Preoperative speech and language evaluation;
• Postoperative rehabilitative costs (only to be provided by the audiologist);
• Subsequent speech, language and hearing therapy;
• Speech processor repairs, batteries, and headset cords;
• Replacement of the external speech processor if lost, stolen or irreparably damaged. Upgrade for cosmetic or technological advances in the hardware shall not qualify as a reason for replacement; and
• Post-operative programming and diagnostic analysis.
• The following are non-covered expenses:
• Service contract and/or extended warranties; and
• Insurance to protect against loss and theft.

Coverage Requirements

Coverage for cochlear implants shall include, but is not limited to, the following:

• Implantation of device;
• Preoperative speech and language evaluation;
• Postoperative rehabilitative costs (only to be provided by the audiologist);
• Subsequent speech, language and hearing therapy;
• Speech processor repairs, batteries, and headset cords;
• Replacement of the external speech processor if lost, stolen or irreparably damaged. Upgrade for cosmetic or technological advances in the hardware shall not qualify as a reason for replacement; and
• Post-operative programming and diagnostic analysis.
• The following are non-covered expenses:
• Service contract and/or extended warranties; and
• Insurance to protect against loss and theft.

Medical and Social Criteria

AmeriHealth Caritas Louisiana shall require the requestor to provide documentation that the candidate meets the following general criteria:

• Have a profound bilateral sensorineural hearing loss with pure tone average of 1000, 2000,and 4000Hz of 90dB HL or greater;
• Be a child age one year or older who is profoundly deaf or be a post linguistically deafened adult through the age of twenty years;
• Receive no significant benefit from hearing aids as validated by the cochlear implant team;
• Have a high motivation to be part of the hearing community as validated by the cochlear implant team;
• Have had radiologic studies that demonstrate no intracranial anomalies or malformations which contraindicate implantation of the receiver- stimulator or the electrode array;
• Have no medical contraindication for the undergoing implant surgery or post-implant rehabilitation; and
• Show that the enrollee and his/her family are well-motivated, have appropriate post-implant expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) guidelines.

Age Specific Criteria

Children – 1 Year through 9 Years

In addition to the documentation that candidates meet the above listed general criteria, AmeriHealth Caritas Louisiana shall require the requestor to provide documentation that the enrollee:

• Has a profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1,000, 2,000, and 4,000Hz of 90dB HL or greater;
• Had appropriate tests administered and no significant benefit from a hearing aid was obtained in the best aided conditions measured by age appropriate speech perception materials; and

• Had no responses obtained to Auditory Brainstem Response, otoacoustic emission testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation.

Children – 10 Years through 17 Years

In addition to the documentation that candidates meet the above listed general criteria, AmeriHealth Caritas Louisiana shall require the requestor to provide documentation that the enrollee**:**

• Has a profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1,000, 2,000, and 4,000Hz of 90dB HL or greater;
• Had appropriate tests administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age and language appropriate speech perception materials;
• Had no responses obtained to Auditory Brainstem Response, otoacoustic emission testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;
• Has received consistent exposure to effective auditory or phonological stimulation in conjunction with the oral method of education and auditory training;
• Utilizes spoken language as the primary mode of communication through one of the following: an oral/aural (re) habilitation program or total communications educational program with significant oral/aural; and
• Has at least six months experience with a hearing aid or vibrotactile device except in the case of meningitis (in which case the six month period will be reduced to three months).

Adults – 18 Years through 20 Years

In addition to the documentation that candidates meet the above listed general criteria, AmeriHealth Caritas Louisiana shall require the requestor to provide documentation that the enrollee**:**

• Is post linguistically deafened with severe to profound bilateral sensorineuralhearing loss which is pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;
• Has obtained no significant benefit from a hearing aid obtained in the best aided condition for speech/sentence recognition material;
• Had no responses obtained to Auditory Brainstem Response, otoacoustic emission testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;
• Has received consistent exposure to effective auditory or phonological stimulation or auditory communication;
• Utilizes spoken language as his primary mode of communication through either an oral/aural (re)habilitation program or a total communications educational program with significant oral/aural training; and
• Has at least 6 months experience with hearing aids or vibrotactile device except in the case of meningitis in which case 3 months experience will be required.

Covered and Non-Covered Inpatient Hospital Days

AmeriHealth Caritas Louisiana will require hospitals to bill covered days and their associated ancillary charges. Covered days are days that have been approved through the precertification process.

AmeriHealth Caritas Louisiana will permit hospitals to bill non-covered days and their associated ancillary charges but these must be billed separately from covered days and their associated ancillary charges. Non-covered days are days that are not certified or approved by AmeriHealth Caritas Louisiana.

When AmeriHealth Caritas Louisiana receives an inpatient claim (electronic or paper) that includes dates of service that exceed approved days, AmeriHealth Caritas will deny the entire claim. The provider must resubmit the inpatient claim for covered days only.

For example: If a provider obtains approval for a 10-day stay, and submits a claim for 12 days, the claim must be billed for the 10 approved days only.

Dental Services

Medically Necessary dental treatment services for members are covered under AmeriHealth Caritas Louisiana's medical benefit when rendered in an inpatient or ASC setting, and when appropriately authorized by AmeriHealth Caritas Louisiana's Utilization Management Department.

AmeriHealth Caritas Louisiana also offers an expanded benefit for our adult members. Expanded services are handled through our dental vendor, Avesis ~~DINA Dental~~ at 1-833-311-2252~~877-587-9331~~.

AmeriHealth Caritas Louisiana PCPs will conduct initial EPSDT dental screenings and AmeriHealth Caritas Louisiana will assist in coordinating follow up care through the Medicaid dental network managed by MCNA. MCNA may also be reached at 1-855-702-6262.

Diabetes Self-Management Training

Diabetes self-management training (DSMT): A collaborative process through which enrollees with diabetes gain knowledge and skills needed to modify behavior and successfully manage the disease and its related conditions.

Covered DSMT programs, at a minimum, must include the following:

- Instructions for blood glucose self-monitoring;
- Education regarding diet and exercise;
- Individualized insulin treatment plan (for insulin dependent enrollees); and
- Encouragement and support for use of self-management skills.
- DSMT must be aimed at educating enrollees on the following topics to promote successful self-management:
- Diabetes overview, including current treatment options and disease process;
- Diet and nutritional needs;
- Increasing activity and exercise;
- Medication management, including instructions for self-administering injectable medications (as applicable);
- Management of hyperglycemia and hypoglycemia;
- Blood glucose monitoring and utilization of results;

- Prevention, detection, and treatment of acute and chronic complications associated with diabetes (including discussions on foot care, skin care, etc.);
- Reducing risk factors, incorporating new behaviors into daily life, and setting goals to promote successful outcomes;
- Importance of preconception care and management during pregnancy;
- Managing stress regarding adjustments being made in daily life; and
- Importance of family and social support.

All educational material must be pertinent and age appropriate for each enrollee. Enrollees under the age of 18 must be accompanied by a parent or legal guardian. Coverage of DSMT for enrollees under the age of 18 must be provided through the child's coverage, not the parent or legal guardian.

Provider Qualifications

AmeriHealth Caritas Louisiana shall require providers of DSMT services to be:

- Enrolled as a Louisiana Medicaid provider;
- Employed by an enrolled Louisiana Medicaid provider; or
- Contracted to provide services by an enrolled Louisiana Medicaid provider.

Providers must be enrolled through the Louisiana Medicaid Professional Services (Physician Directed Services), Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), or Outpatient Hospital programs and must meet all of the required criteria. DSMT is not a separately recognized provider type; therefore, Louisiana Medicaid will not enroll a person or entity for the sole purpose of performing DSMT.

Accreditation

DSMT programs must be accredited as meeting quality standards by a national accreditation organization. AmeriHealth Caritas Louisiana shall recognize the following as approved accreditation organizations:

- American Diabetes Association (ADA),
- American Association of Diabetes Educators (AADE), and
- Indian Health Service (IHS).

Services provided by a program without accreditation from one of the listed organizations shall **not be covered**. AmeriHealth Caritas Louisiana shall require providers to maintain and provide proof of accreditation when requested.

At a minimum, the instructional team must consist of a registered dietician, a registered nurse, an advanced practice registered nurse, or a pharmacist. Each enrollee of the instructional team must be a certified diabetes educator (CDE) or have recent didactic and experiential preparation in education and diabetes management, and at least one enrollee of the instructional team must be a CDE who has been certified by the National Certification Board for Diabetes Educators (NCBDE). AmeriHealth Caritas Louisiana shall require provider to maintain and provide proof of certification, as requested, for staff members.

AmeriHealth Caritas Louisiana shall require all DSMT programs adhere to the National Standards for Diabetes Self-Management Education.

Coverage Requirements

AmeriHealth Caritas Louisiana shall cover DSMT for eligible enrollees who have a written order from their primary care provider and have been diagnosed with Type 1, Type 2, or gestational diabetes.

AmeriHealth Caritas Louisiana shall require the ordering provider to maintain a copy of all DSMT orders. Each written order must be signed and must specify the total number of hours being ordered, not to exceed the following coverage limitations:

- A maximum of 10 hours of initial training (one hour of individual and nine hours of group sessions) are allowed during the first 12 month period beginning with the initial training date.
- A maximum of two hours of individual sessions are allowed for each subsequent year.

If special circumstances occur in which the ordering provider determines an enrollee would benefit from individual sessions rather than group sessions, the order must also include a statement specifying that individual sessions would be more appropriate, along with an explanation.

If a DSMT order must be modified, the updated order must be signed by the primary care provider and copies must be retained in the medical record.

Medicaid Enrollees Not Eligible for DSMT

AmeriHealth Caritas Louisiana shall not cover DSMT for the following enrollees:

- Enrollees residing in an inpatient hospital or other institutional setting such as an nursing care facility or a residential care facility; or
- Enrollees receiving hospice services.

Initial DSMT

AmeriHealth Caritas Louisiana's policy for initial DSMT shall include the following:

- Initial DSMT may begin after receiving the initial order. DSMT is allowed for a continuous 12- month period following the initial training date. In order for services to be considered initial, the enrollee must not have previously received initial or follow up DSMT.
- The 10 hours of initial training may be provided in any combination of 30-minute increments over the 12-month period. Sessions lasting less than 30 minutes are not covered.
- Group sessions may be provided in any combination of 30-minute increments. Sessions less than 30 minutes are not covered. Each group session must contain between 2-20 enrollees.

Follow-Up DSMT

After receiving 10 hours of initial training, an enrollee shall be eligible to receive a maximum of two hours of follow-up training each year, if ordered by the primary care provider. AmeriHealth Caritas Louisiana shall cover additional training for enrollees under age 21 if determined to be medically necessary.

Follow-up training is based on a 12-month calendar year following completion of the initial training. If an enrollee completes 10 hours of initial training, the enrollee shall be eligible for two hours of follow-up training for the next calendar year. If all 10 hours of initial training are not used within the first calendar year, then the enrollee shall have 12 months to complete the initial training prior to follow up training.

AmeriHealth Caritas Louisiana shall encourage providers to communicate with enrollees to determine if the enrollee has previously received DSMT services or has exhausted the maximum hours of DSMT services for the given year.

DSMT coverage shall **only** include up to 10 hours of initial training (for the first 12 months) and two hours of follow-up training (for each subsequent year) regardless of the providers of service.

Provider Responsibilities for DSMT

AmeriHealth Caritas Louisiana shall require its providers to ensure that the enrollee meets one of the following requirements:

- Is a newly diagnosed diabetic, gestational diabetic, pregnant with a history of diabetes, or has received no previous diabetes education,
- Demonstrates poor glycemic control (A1c>7),
- Has documentation of an acute episode of severe hypoglycemia, hyperglycemia occurring in the past 12 months, or
- Has received a diagnosis of a complication, a diagnosis of a co-morbidity, or prescription for new equipment such as an insulin pump.

AmeriHealth Caritas Louisiana shall require its providers to maintain the following documentation:

- A copy of the order for DSMT from the enrollee's primary care provider;
- A comprehensive plan of care documented in the medical record;
- Start and stop time of services;
- Clinical notes, documenting enrollees progress;
- Original and ongoing pertinent lab work;
- Individual education plan;
- Assessment of the individual's education needs;
- Evaluation of achievement of self-management goals;
- Proof of correspondence with the ordering provider regarding the enrollee's progress; and
- All other pertinent documentation.

Enrollee records, facility accreditation, and proof of staff licensure, certification, and educational requirements must be kept readily available to be furnished, as requested, to Louisiana Medicaid, its authorized representatives, or the state's Attorney General's Medicaid Fraud Control Unit.

Durable Medical Equipment

AmeriHealth Caritas Louisiana members are eligible to receive medically necessary durable medical equipment (DME), prosthetics, orthotics, certain supplies, appliances and assistive devices including but not limited to hearing aids for enrollees under the age of 21. DME for those under 21 includes disposable incontinence supplies and enteral formula. All DME purchases $750 and over, all DME rentals, and all wheelchairs (both rental and sale), wheelchair accessories and components, regardless of cost or member age must be Prior Authorized.

Enteral Nutritional Supplements must be prior authorized.

Because members may lose eligibility or switch plans, DME Providers are encouraged to access NaviNet for verification of the member's continued Medicaid eligibility and continued enrollment with AmeriHealth Caritas Louisiana when equipment is authorized for more than a one month period of time. Failure to do so could result in claim denials.

Occasionally, additional information is required and the network provider will be notified by AmeriHealth Caritas Louisiana of the need for such information. If you have questions regarding any DME item or supply, please contact the Utilization Management at 1-888-913-0350 or the Provider Services Department at 1-888-922-0007.

Emergency Admissions, Surgical Procedures and Observation Stays

Members often present to the ER with medical conditions of such severity, that further or continued treatment, services, and medical management is necessary. In such cases, the ER staff should provide stabilization and/or treatment services, assess the member's response to treatment and determine the need for continued care. To obtain payment for services delivered to members requiring admission to the inpatient setting, the hospital is required to notify AmeriHealth Caritas Louisiana of the admission and provide clinical information to establish medical necessity. Utilization Management determines medical necessity after clinical information is provided, including history of injury or illness, treatment provided in the ER and patient's response to treatment, clinical findings of diagnostic tests, and interventions taken. An appropriate level of care, for an admission from the ER, may be any one of the following:

- ER Medical Care
- Emergency Surgical Procedure Unit (SPU) Service
- Emergent Observations Stay Services - Maternity & Other Medical/Surgical Conditions
- Emergency Inpatient Admission
- Emergency Medical Services

Emergency Medical Care

Emergency Medical Services

Emergency Room Policy

"An Emergency Medical Condition" is a medical condition manifesting itself by acute 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 immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions (or)
- Serious dysfunction of any bodily organ or part

Prior Authorization/Notification for ER Services/Payment

AmeriHealth Caritas Louisiana does not require Prior Authorization or prior notification of services rendered in the ER. ER

staff should immediately screen all members presenting to the ER and provide appropriate stabilization and/or treatment services. Reimbursement for Emergency Services will be made at the contracted rate. AmeriHealth Caritas Louisiana reserves the right to request the emergency room medical record to verify the Emergency Services provided.

PCP Contact Prior to ER Visit

Members are encouraged to contact their PCP to obtain medical advice or treatment options about conditions that may/may not require ER treatment. Prior Authorization or prior notification of services rendered in the ER is not required.

Authorization of Inpatient Admission Following ER Medical Care

If a member is admitted as an inpatient following ER medical care, notification to the Utilization Management Department is required through NaviNet, fax 866-397-4522 or phone call to 1-888-913-0350. Please refer to the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com for a copy of the Notification of Emergent Hospital Admission form. The facility staff should be prepared to provide information to support the need for continued inpatient medical care beyond the initial stabilization period. The information should include treatment received in the ER; the response to treatment; result of post-treatment diagnostic tests; and the treatment plan. All ER charges are to be included on the inpatient billing form. Reimbursement for authorized admissions will be at the established contracted inpatient rate or state Medicaid fee schedule (if a non-network provider) with no separate payment for the ER Services. The inpatient case reference number should be noted on the bill.

Emergency SPU Services

Emergency SPU Services are when trauma, injury or the progression of a disease is such that a member requires:

- Immediate surgery, and
- Monitoring post-surgery usually lasting less than twenty-four (24) hours, with
- Rapid discharge home, and
- Which cannot be performed in the ER

The ER staff should provide Medically Necessary services to stabilize the member and then initiate transfer to the SPU.

Authorization of Emergency SPU Services

Prior Authorization of an Emergency SPU service is not required. However, the hospital is responsible for notifying AmeriHealth Caritas Louisiana's Utilization Management Department within twenty-four (24) hours or by the next business day following the date of service for all Emergency SPU Services. Notification can be given either through NaviNet, or fax to 866-397-4522, utilizing the Hospital Notification of Emergency Admissions form. Please visit the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com for a copy of the Hospital Notification Emergency Admissions form. Providers may also call 1-888-913-0350.

Authorization of Inpatient Admission Following Emergency SPU Services

If a member is admitted as an inpatient following Emergency SPU Services, notification is required through NaviNet, or fax to 866-397-4522 or call to the Utilization Management Department at 1-888-913-0350 for authorization. The facility SPU staff should be prepared to provide additional information to support the need for continued medical care beyond 24 hours such as: procedure performed, any complications of surgery, and immediate post-operative period vital signs, pain

control, wound care etc. All ER and SPU charges are to be included on the inpatient billing form. Reimbursement will be at the established contracted inpatient rate or state Medicaid fee schedule (if a non- network provider) with no separate payment for the ER and/or SPU services. The inpatient case reference number should be noted on the bill.

Emergent Observation Stay Services

AmeriHealth Caritas Louisiana considers Observation Care to be an outpatient service. Observation Care is often initiated as the result of a visit to an ER when continued monitoring or treatment is required. Observation Care can be broken down into two categories:

- Maternity Observation, and
- Medical Observation (usually managed in the outpatient treatment setting)

Maternity/Obstetrical Observation Stay

A Maternity Observation Stay is defined as a stay usually requiring less than forty-eight (48) hours ~~thirty (30) hours~~ [KG4] of care for the monitoring and treatment of patients with medical conditions related to pregnancy, including but not limited to:

- Symptoms of premature labor
- Abdominal pain
- Abdominal trauma
- Vaginal bleeding
- Diminished or absent fetal movement
- Premature rupture of membranes (PROM)
- Pregnancy induced hypertension/Preeclampsia
- Hyperemesis
- Gestational Diabetes

Members presenting to the ER with medical conditions related to pregnancy should be referred, whether the medical condition related to the pregnancy is an emergency or non-emergency, to the Labor and Delivery Unit (L & D Unit) for evaluation and observation. Notification is requested for Maternity/Obstetrical Observation at participating facilities. ER Medical Care rendered to a pregnant member that is unrelated to the pregnancy should be billed as an ER visit, regardless of the setting where the treatment was rendered, i.e., ER, Labor & Delivery Unit or Observation. Please see "Claims Filing Instructions" in the appendix this *Provider Manual* for claim submission procedures.

Authorization of Inpatient Admission Following OB Observation

If a member is admitted after being observed, notification is required to the Utilization Management Department through NaviNet, or by fax, or by calling 1-888-913-0350 for authorization. If the hospital does not have an L&D Unit, the hospital ER staff will include in their medical screening a determination of the appropriateness of treating the member at the hospital versus the need to transfer to another facility that has an L&D Unit, as well as Level II (Level III preferred) nursery capability. For members who are medically stable for transfer and who are not imminent for delivery, transfers are to be made to the nearest AmeriHealth Caritas Louisiana participating hospital. Hospitals where members are transferred should have an L&D Unit, Perinatology availability, as well as Level II (Level III preferred) nursery capability. In situations where the presenting hospital does not have an L&D Unit and transfer needs to occur after normal business hours or on a

weekend, the hospital staff should facilitate the transfer and notify AmeriHealth Caritas Louisiana's Patient Care Management Department via NaviNet, a phone call or fax the first business day following the transfer.

A case reference number will be issued for the inpatient stay, which conforms to the protocols of this policy and member eligibility. All ER and Observation Care charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER and/or Observation Stay Services. The inpatient case reference number should be noted on all Claims related to the inpatient stay.

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Claims Disputes and Provider Complaint Procedures" in Section VI of this *Provider Manual*.

Medical Observation Stay

A Medical Observation Stay is defined as a stay requiring less than ~~thirty~~forty-eight ~~-~~(48) hours [KG5]of care for the observation of patients with medical conditions including but not limited to:

- Head Trauma
- Chest Pain
- Post trauma/accidents
- Sickle Cell disease
- Asthma
- Abdominal Pain
- Seizure
- Anemia
- Syncope
- Pneumonia

Members presenting to the ER with Emergency Medical Conditions should receive a medical screening examination to determine the extent of treatment required to stabilize the condition. The ER staff must determine if the member's condition has stabilized enough to warrant a discharge or whether it is medically appropriate to transfer to an "observation" or other "holding" area of the hospital, as opposed to remaining in the ER setting. Authorization is not required for a Medical Observation Stay at participating facilities.

Authorization of Inpatient Admission Following Medical Observation

If a member is admitted as an inpatient following a Medical Observation Stay, notification is required to the Utilization Management Department through NaviNet, by fax to 866-397-4522 or by calling 1-888-913-0350 for authorization. Hospital ER or Observation unit staff should include in their medical screening a determination of the appropriateness of treating the member as an inpatient versus retention in the Observation Care setting of the facility. If the member is admitted as an inpatient, all ER and Observation charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or state Medicaid fee schedule (if a non-participating hospital), with no separate payment for the ER and/or Observation Stay Services. The inpatient care case reference number should be noted on all claims related to the inpatient stay.

Observation Billing Guidelines are available in the online "Claims Filing Instructions," located in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

Emergency Inpatient Admissions

Emergency Admissions from the ER, Surgical Procedure Unit (SPU), or Observation Area

If a member is admitted after being treated in an observation, SPU, or ER setting of the hospital, the hospital is responsible for notifying AmeriHealth Caritas Louisiana's Utilization Management Department within twenty-four (24) hours or by the next business day (whichever is later) following the date of service (admission). Notification can be given either through NaviNet, by fax to UM at 866-397-4522 or telephone to 1-888-913-0350 utilizing the Hospital Notification of Emergency Admissions form (available online in the Provider Forms section of www.amerihealthcaritasla.com). The observation, SPU or ER charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate with no separate payment for the observation, SPU, or ER services. The inpatient case reference number should be noted on the bill.

Emergency Services Provided by Non-Participating Providers

AmeriHealth Caritas Louisiana will reimburse health care providers who are not enrolled with AmeriHealth Caritas Louisiana when they provide Emergency Services for an AmeriHealth Caritas Louisiana member. The Health Care Provider, however, must obtain a Non-Participating Provider number in order to be reimbursed for services provided.

The Non-Participating Provider Demographic Information form is available on www.amerihealthcaritasla.com or by calling Provider Services at 1-888-922-0007; completion and submission of this form will allow you to obtain a non-participating provider ID number.

Non-Participating Providers can find the complete Non-Participating Emergency Services Payment Guidelines online in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

Please note that applying for and receiving a Non-Participating Provider number after the provision of Emergency Services is for reimbursement purposes only. It does not create a participating provider relationship with AmeriHealth Caritas Louisiana and does not replace provider enrollment and credentialing activities with AmeriHealth Caritas Louisiana (or any other health care plan) for new and existing network providers.

Family Planning Services

Members are covered for family planning services without a referral and do not require prior authorization for either participating or non-participating providers.

Hysterectomies, abortion or sterilization services are NOT considered family planning.

Family planning services, include but not limited to:

- Comprehensive medical history and physical exam at least once per year. This visit includes anticipatory guidance and education related to enrollees' reproductive health/needs;
- Contraceptive counseling to assist enrollees in reaching an informed decision (including natural family planning, education follow-up visits, and referrals);

- Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health;

- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered;

- Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration;

- Male and female sterilization procedures provided in accordance with 42 C.F.R. Part 441, Subpart F;

- Treatment of major complications from certain family planning procedures such as: treatment of perforated uterus due to intrauterine device insertion; treatment of severe menstrual bleeding caused by a medroxyprogesterone acetate injection requiring dilation and curettage; and treatment of surgical or anesthesia-related complications during a sterilization procedure; and

- Transportation services to and from family planning appointments provided all other criteria for Non-Emergency Medical Transportation (NEMT) are met.

Family planning services also include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection, or treatment of sexually transmitted infections (STIs), and age-appropriate vaccination for the prevention of HPV and cervical cancer. Prior authorization shall not be required for treatment of STIs.

AmeriHealth Caritas Louisiana does not provide assisted reproductive technology for treatment of infertility.

Genetic Testing

Genetic Testing for Breast and Ovarian Cancer

BRCA1 and BRCA2: Human genes that produce tumor suppressor proteins.

AmeriHealth Caritas Louisiana does consider genetic testing for BRCA1 and BRCA2 mutations in cancer-affected individuals and cancer-unaffected individuals medically necessary if the member meets the following eligibility criteria:

Patients with Cancer Diagnosis

Genetic testing for BRCA1 and BRCA2 mutations in cancer-affected individuals shall be considered medically necessary under any of the following circumstances:

- Individual from a family with a known BRCA1/BRCA2 mutation;

- Personal history of breast cancer and ≥1 of the following:

    - Diagnosed age ≤45 years;
    - Two primary breast cancers when the first breast cancer diagnosis occurred age ≤50 years;

  - Diagnosed age ≤50 years AND: ≥1 1st-, 2nd-, or 3rd-degree relative with breast cancer at any age;
  - Unknown or limited family history;
  - Diagnosed age ≤60 years with a triple negative (ER–, PR–, HER2–) breast cancer;
  - Diagnosed any age AND ≥1 1st-, 2nd-, or 3rd-degree relative with breast cancer diagnosed ≤ 50 years;
  - Diagnosed any age AND ≥2 1st-, 2nd-, or 3rd-degree relatives with breast cancer at any age;
  - Diagnosed any age AND ≥1 1st-, 2nd-, or 3rd-degree relative with epithelial ovarian/fallopian tube/primary peritoneal cancer;
  - Diagnosed any age AND ≥2 1st-, 2nd-, or 3rd-degree relatives with pancreatic cancer or prostate cancer at any age;
  - 1st-, 2nd-, or 3rd-degree male relative with breast cancer; or
  - Ethnicity associated with deleterious founder mutations (e.g., Ashkenazi Jewish);

- Personal history of epithelial ovarian/fallopian tube/primary peritoneal cancer;

- Personal history of male breast cancer; or

- Personal history of pancreatic cancer or prostate cancer at any age AND ≥2 1st-, 2nd-, or 3rd-degree relatives with any of the following at any age. For pancreatic cancer, if Ashkenazi Jewish ancestry, only one additional affected relative is needed.

  - Breast cancer;
  - Ovarian/fallopian tube/primary peritoneal cancer; or
  - Pancreatic or prostate cancer.

Patients without Cancer (Testing Unaffected Individuals)

Genetic testing for BRCA1 and BRCA2 mutations of cancer-unaffected individuals shall be considered medically necessary under any of the following circumstances:

- Individual from a family with a known BRCA1/BRCA2 mutation;

- 1st- or 2nd-degree blood relative meeting any criterion listed above for patients with cancer; or

- 3rd-degree blood relative with breast cancer and/or ovarian/fallopian tube/primary peritoneal cancer AND ≥2 1st-, 2nd-, or 3rd-degree relatives with breast cancer.

For the purpose of familial assessment, 1st-, 2nd-, and 3rd-degree relatives are blood relatives on the same side of the family (maternal or paternal):

  - 1st-degree relatives are parents, siblings, and children;
  - 2nd-degree relatives are grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings; or
  - 3rd-degree relatives are great-grandparents, great-aunts, great-uncles, great grandchildren and first cousins.

For the purpose of familial assessment, prostate cancer is defined as Gleason score ≥7. Testing for Ashkenazi Jewish or other founder mutation(s) must be performed first (see guidelines: High risk ethic groups).

NOTE: Generally, genetic testing for a particular disease is performed once per lifetime; however, there are rare instances in which testing may be performed more than once in a lifetime (e.g., previous testing methodology is inaccurate or a new discovery has added significant relevant mutations for a disease).

Investigational Genetic Testing

Unless the above eligibility criteria is met, genetic testing either for those affected by breast, ovarian, fallopian tube, or primary peritoneal cancer or for unaffected individuals, including those with a family history of pancreatic cancer, is considered investigational.

Genetic testing in minors for BRCA1 and BRCA2 mutations is considered investigational, thus is not a covered service.

High-Risk Ethnic Groups

Testing in eligible individuals who belong to ethnic populations in which there are well- characterized founder mutations should begin with tests specifically for these mutations. For example, founder mutations account for approximately three quarters of the BRCA mutations found in Ashkenazi Jewish populations. When the testing for founder mutations is negative, comprehensive mutation analysis should then be performed.

Testing Unaffected Individuals

In unaffected family members of potential BRCA mutation families, most test results will be negative and uninformative. Therefore, it is strongly recommended that an affected family member be tested first whenever possible to adequately interpret the test. Should a BRCA mutation be found in an affected family member(s), DNA from the unaffected family member can be tested specifically for the same mutation of the affected family member without having to sequence the entire gene. Interpreting the test results for an unaffected family member without knowing the genetic status of the family may be possible in the case of a positive result for an established disease-associated mutation, but leads to difficulties in interpreting negative test results (uninformative negative) or mutations of uncertain significance because the possibility of a causative BRCA mutation is not ruled out.

Prostate Cancer

Enrollees with BRCA mutations have an increased risk of prostate cancer, and patients with known BRCA mutations may therefore consider more aggressive screening approaches for prostate cancer. However, the presence of prostate cancer in an individual, or in a family, is not itself felt to be sufficient justification for BRCA testing.

Genetic Testing for Familial Adenomatous Polyposis

AmeriHealth Caritas Louisiana covers genetic testing for adenomatous polyposis colic (APC) gene mutation to diagnose Familial Adenomatous Polyposis (FAP) medically necessary, once in a lifetime, if the enrollee meets the following criteria.

FAP is caused by a hereditary genetic mutation in the APC tumor suppressor gene which leads to development of adenomatous colon polyps.

Eligibility Criteria

- Personal history of > 20 cumulative adenoma; or
- Known deleterious APC mutation in first-degree family member.

NOTE: Testing in an unaffected first-degree family member will focus on the same mutation found in affected family member.

Genetic Testing for Lynch Syndrome

AmeriHealth Caritas Louisiana covers genetic testing for Lynch Syndrome, once in a lifetime, for enrollees who meet the following criteria:

- Amsterdam II criteria; or
- Revised Bethesda Guidelines; or
- Estimated risk ≥ 5% based on predictive models (MMRpro, PREMM5, or MMRpredict).

Amsterdam II Criteria All of the following criteria must be met.

There must be at least three relatives with a Lynch Syndrome associated cancer (e.g., cancer of the colorectal, endometrium, small bowel, ureter or renal pelvis) and all of the following criteria should be present:

- One must be a first-degree relative to the other two;
- Two or more successive generations must be affected;
- One or more must be diagnosed before 50 years of age;
- Familial adenomatous polyposis should be excluded in the colorectal cancer; and
- Tumors must be verified by pathological examination.

Revised Bethesda Guidelines

One or more criterion must be met:

- Colorectal or uterine cancer diagnosed in a patient who is less than 50 years of age;
- Presence of synchronous (coexist at the same time), metachronous (previous or recurring) colorectal cancer, or other Lynch Syndrome associated tumors*;
- Colorectal cancer with the MSI-H** histology*** diagnosed in a patient who is less than 60 years of age;
- Colorectal cancer diagnosed in one or more first-degree relatives with a Lynch syndrome related tumor, with one of the cancers being diagnosed under 50 years of age; and/or
- Colorectal cancer diagnosed in two or more first- or second-degree relatives with Lynch Syndrome related tumors, regardless of age.

*Hereditary nonpolyposis colorectal cancer (HNPCC)-related tumors include colorectal, endometrial, stomach, ovarian, pancreas, ureter and renal pelvis, biliary tract, and brain (usually glioblastoma as seen in Turcot syndrome) tumors, sebaceous gland adenomas and keratoacanthomas in Muir-Torre syndrome, and carcinoma of the small bowel.

**MSI-H - microsatellite instability–high in tumors refers to changes in two or more of the five National Cancer Institute-recommended panels of microsatellite markers

***Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern.

Gynecology

Gynecologic services include:

- Contraceptive implants;
- Saline infusion sonohysterography or hysterosalpingography;
- Intrauterine contraceptive systems;
- Pap smears;
- Pelvic examinations; and
- Hysterectomies.

Limitations may apply.

Contraceptive Implants

AmeriHealth Caritas Louisiana covers the insertion and removal of all FDA approved contraceptive implants.

Saline Infusion Sonohysterography or Hysterosalpingography

AmeriHealth Caritas Louisiana covers saline infusion sonohysterography or hysterosalpingography, limited to the assessment of fallopian tube occlusion or ligation following a sterilization procedure.

AmeriHealth Caritas Louisiana does not cover assistive reproductive technology for treatment of infertility.

Intrauterine Contraceptive System

AmeriHealth Caritas Louisiana covers the insertion and removal of all FDA approved intrauterine contraceptive systems.

Policy For Papanicolaou (PAP) Test / Cervical Cancer Screenings

Eligibility Criteria (for those under age 21)

The MCO shall consider cervical cancer screening (including repeat screening) medically necessary for enrollees under 21 years of age if they meet the following criteria:

- Were exposed to diethylstilbestrol before birth;
- Have human immunodeficiency virus;
- Have a weakened immune system;
- Have a history of cervical cancer or abnormal cervical cancer screening test; or
- Meet other criteria subsequently published by ACOG.

As a value added service, AmeriHealth Caritas Louisiana will cover Pap Tests (or cervical cancer screenings) for pregnant members under 21 regardless of ACOG criteria. The claim must be submitted with a pregnancy diagnosis (O00.XX-O99.XX) or it will deny.

Repeat cervical cancer screenings for recipients under the age of 21 may also be covered for members who are currently being treated for abnormal cervical cancer screening test results with dates of service prior to January 1, 2017. For these cases, claims filed for repeat screenings must include hard copy supporting documentation.

Reimbursement for PAP Tests

AmeriHealth Caritas Louisiana includes the collection of cytopathologic vaginal test (Pap test) specimens in the reimbursement of the Evaluation and Management service.

AmeriHealth Caritas Louisiana reimburses a claim for a Pap test only if the provider submitting the claim has the necessary laboratory equipment to perform the test in their office or facility.

For those enrollees under the age of 21, AmeriHealth Caritas Louisiana requires the treating provider to submit the required documentation needed for billing to the laboratory provider.

Pelvic Examinations

AmeriHealth Caritas Louisiana covers routine pelvic examinations in the reimbursement for the evaluation and management service. Therefore routine pelvic examinations are not allowed to be billed as separate procedures.

Pelvic examinations under anesthesia may be medically necessary for certain populations. AmeriHealth Caritas Louisiana requires the provider to indicate the medical justification for the pelvic examination under anesthesia in the member's medical record.

Hysterectomies

Non-elective, medically necessary hysterectomies are covered by AmeriHealth Caritas Louisiana if the following requirements are met:

- The person securing authorization to perform the hysterectomy has informed the individual and her representative (if any), both orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and
- The individual or their representative (if any) has signed a written acknowledgement of receipt of that information.

NOTE: These regulations apply to all hysterectomy procedures, regardless of the member's age, fertility, or reason for surgery.

Hysterectomies are not covered if one of the following applies:

- If it is performed solely for the purpose of terminating reproductive capability; or
- There is more than one purpose for performing the hysterectomy, but the procedure would not be performed except for the purpose of rendering the individual permanently incapable of reproducing.

Policy for Consent for Hysterectomy

- The Acknowledgement of Receipt of Hysterectomy Information (hysterectomy consent form) (available online at www.amerihealthcaritasla.com) must be signed and dated by the member on or before the date of the hysterectomy. The consent must include signed acknowledgement from the member stating the member has been informed orally and in writing that the hysterectomy will make the member permanently incapable of reproducing. Members who undergo a covered hysterectomy must complete a hysterectomy consent form but are not required to complete a sterilization consent form.

- The physician who obtains the consent must share the consent form with all providers involved in that member's care (e.g., attending physician, hospital, anesthesiologist, and assistant surgeon).

- When billing for services that require a hysterectomy consent form, the name on the Medicaid file for the date of service in which the form was signed should be the same as the name signed at the time consent was obtained. If the member's name is different, the provider must attach a letter from the physician's office from which the consent was obtained. The letter must be signed by the physician and must state that the member's name has changed and must include the member's social security number and date of birth. This letter must be attached to all claims requiring consent upon submission for claims processing.

- A witness signature is needed on the hysterectomy consent when the member meets one of the following criteria:

    - Member is unable to sign their name and must indicate "x" on the signature line; or
    - There is a diagnosis on the claim that indicates mental incapacity.

- If a witness signs the consent form, the signature date must match the date of the member's signature. If the dates do not match, or the witness does not sign and date the form, claims related to the hysterectomy will deny.

Exceptions:

Obtaining consent for a hysterectomy is unnecessary in the following circumstances:

- The individual was already sterile before the hysterectomy, and the physician who performed the hysterectomy certifies that the individual was already sterile at the time of the hysterectomy and states the cause of sterility.

- The individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician certifies in his own writing that the hysterectomy was performed under these conditions and includes in his narrative a description of the nature of the emergency.

- The individual was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy certifies in his own writing that the individual was informed before the operation that the hysterectomy would make the member permanently incapable of reproducing. In addition, if the individual was certified retroactively for benefits, and the hysterectomy was performed under one of the two other conditions listed above, the physician must certify in writing that the hysterectomy was performed under one of those conditions and that the member was informed, in advance, of the reproductive consequences of having a hysterectomy.

Reimbursement for Hysterectomy

The hysterectomy consent form or a physician's written certification (see Exceptions section) must be obtained before providers may be reimbursed. Ancillary providers and hospitals may submit claims without the hard copy consent. However, providers may only be reimbursed if the surgeon submitted a valid hysterectomy consent and was reimbursed for the procedure.

Incident to Services

"Incident to" a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. "Incident to" services include those provided by aides or nurses, but exclude those provided by an advanced practice registered nurse (APRN) and physician assistant (PA). The physician, under whose provider number a service is provided, must perform or be involved with a portion of the service provided.

Physician involvement may take the form of personal participation in the service or may consist of direct personal supervision coupled with review and approval of the service notes at a future point in time. Direct personal supervision by the physician must be provided when the billed service is performed by auxiliary personnel. Direct personal supervision in an office means the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the service is performed.

When an APRN or PA provides all parts of the service independent of a supervising or collaborating physician's involvement, even if a physician signs off on the service or is present in the office suite, the service does not meet the requirements of Medicaid "incident to" billing. Instead, the service must be billed using the provider number of the APRN or PA as the rendering provider and must meet the specific coverage requirements of the APRN's or PA's scope of practice.

It would be inappropriate for a physician to submit claims for services provided by an APRN or PA with the physician listed as the rendering provider when the physician is only supervising, reviewing, and/or "signing off" on the APRN's or PA's records.

Multiple Surgical Reduction Reimbursement

Multiple surgery reduction is the general industry term applied to the practice of paying decreasing pay percentages for multiple surgeries performed during the same surgical session. When more than one surgical procedure is submitted for a patient on the same date of service, the 51 modifier should be appended to the secondary code(s). Certain procedure codes are exempt from this process due to their status as "add-on" or "modifier 51 exempt" codes as defined in CPT.

Secondary Bilateral Surgical Procedures

Multiple modifiers may be appended to secondary surgical procedure codes when appropriate. Billing multiple surgical procedures and bilateral procedures during the same surgical session should follow Medicaid policy for each type of modifier.

Bilateral secondary procedures are submitted with modifiers 50/51 and at a minimum be reimbursed at 75% of the Medicaid allowable fee or the submitted charges, whichever is lowest.

Modifiers

The modifiers in the table in this section indicate modifiers that impact reimbursement or policy to establish minimum payment amounts. The below is an exclusive list of modifiers allowed for the purposes of establishing minimum reimbursement rates. The MCO may not mandate the use of modifiers that result in a reimbursement rate that is below the rate established by the fee schedules and these allowed modifiers.

Modifier	Use/Example	Special Billing Instructions	Minimum Reimbursement

22 Unusual Service	Service provided is greater than that which is usually required (e.g., delivery of twins); not to be used with visits or lab codes		125% of the fee on file or billed charges whichever is lower
24 Unrelated evaluation and management service by the same physician during the post-op period			Lower of billed charges or fee on file
25 Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service		When a suspected condition identified during a screening visit and diagnosed/treated by the screening provider during the same visit, only lower level E&M appended with modifier 25 allowable; otherwise claim will deny Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program.	Lower of billed charges or fee on file
26 Professional Component	Professional portion only of a procedure that typically consists of both a professional and a technical component (e.g., interpretation of laboratory or x-ray procedures performed by another provider)		Lower of billed charges or 40% of the fee on file
TC Technical Component		MCOs may not reimburse the technical component only on laboratory and radiology claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.	
50 Bilateral Procedure			Lower of billed charges or 150% of the fee on file
51 Multiple Procedures			Lower of billed charges or 100% of the fee on file for primary/ 50% of the fee on file for all others

52 Reduced Services			Lower of billed charges or 75% of the fee on file
53 Discontinued Procedure	Only for use by Free Standing Birthing Centers (FSBC's) when the member is transferred prior to delivery		50% of the FSBC's facility fee or billed charges, whichever is lower
54 Surgical Care Only	Surgical procedure performed by physician when another physician provides pre- and/or postoperative management		Lower of billed charges or 70% of the fee on file
55 Postoperative Management Only	Postoperative management only when another physician has performed the surgical procedure		Lower of billed charges or 20% of the fee on file
56 Preoperative Management Only	Preoperative management only when another physician has performed the surgical procedure		Lower of billed charges or 10% of the fee on file
57 Evaluation and management service resulting in the initial decision to perform the surgery			Lower of billed charges or fee on file
59 Distinct procedural services performed; separate from other services rendered on the same day by the same provider		Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program.	Lower of billed charges or fee on file
62 Two Surgeons			Lower of billed charges or 80% of the fee on file for each surgeon.
63 Infants less than 4 kg			Lower of billed charges or 125% of the fee on file
66 Surgical Team	Performance of highly complex procedure requiring the concomitant services of several physicians (e.g., organ transplant)	Documentation must clearly indicate the name of each surgeon and the procedures performed by each.	Lower of billed charges or 80% of the fee on file for each surgeon.
79			Lower of billed charges or fee on file

Unrelated procedure or service by the same physician during the postoperative period			
80 Assistant Surgeon (MD)			Lower of billed charges or: MD's - 20% of the full service physician fee on file.
AS Assistant at Surgery (Physician Assistant or APRN)			Lower of billed charges or 80% of MD's 'Assistant Surgeon' fee
NOTE: *The list of codes acceptable with the 80/AS modifier is posted on the Louisiana Medicaid website.			
AT Acute Treatment	Chiropractors use this modifier		Lower of billed charges or fee on file
GT/95 Telemedicine	Services provided via interactive audio and video telecommunications system	Modifier should be appended to all services provided via telemedicine and be documented in the clinical record at both sites	Lower of billed charges or 100% of the fee on file
Q5 Reciprocal Billing Arrangement	Services provided by a substitute physician on an occasional reciprocal basis not over a continuous period of longer than 60 days. Does not apply to substitution within the same group.	The regular physician submits the claim and receives payment for the substitute. The record must identify each service provided by the substitute.	Lower of billed charges or 100% of the fee on file
Q6 Locum Tenens	Services provided by a substitute physician retained to take over a regular physician's practice for reasons such as illness, pregnancy, vacation, or continuing education. The substitute is an independent contractor typically paid on a per diem or fee-for- time basis and does not provide services over a period of longer than 60 days.	The regular physician submits claims and receives payment for the substitute. The record must identify each service provided by the substitute	Lower of billed charges or 100% of the fee on file
TH Prenatal Services			Lower of billed charges or fee for prenatal services
QW Laboratory	Required when billing certain laboratory codes		Lower of billed charges or fee on file

Site Specific Modifiers

Unless specifically indicated otherwise in CPT, providers should use site-specific modifiers to accurately document the anatomic site where procedures are performed when appropriate for the clinical situation.

E1	Upper left, eyelid Lower left, eyelid	LT*	Left side
E2	Upper right, eyelid	RT*	Right side
E3	Lower right, eyelid	LC	Left circumflex, coronary artery
E4	Left hand, thumb	RC	Right coronary artery
FA	Left hand, second digit	LD	Left anterior descending coronary artery
F1	Left hand, third digit	TA	Left foot, great toe
F2	Left hand, fourth digit	T1	Left foot, second digit
F3	Left hand, fifth digit	T2	Left foot, third digit
F4	Right hand, thumb	T3	Left foot, fourth digit
F5	Right hand, second digit	T4	Left foot, fifth digit
F6	Right hand, third digit	T5	Right foot, great toe
F7	Right hand, fourth digit	T6	Right foot, second digit
F8	Right hand, fifth digit	T7	Right foot, third digit
F9	Upper left, eyelid Lower left, eyelid	T8	Right foot, fourth digit
		T9	Right foot, fifth digit

***** When "bilateral" is part of the procedure code description, **RT/LT or -50 shall not be used.**

Same-Day Outpatient Visits

Members under Age 21

When medically necessary, two same-day outpatient visits per specialty per member are allowed; however, the second same-day outpatient visit is payable for only the two lowest level Evaluation and Management (E/M) codes.

If an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening has been paid, only the two lowest level E/M codes are payable for the same member , on the same date of service and by the same attending provider. In these circumstances, when it is clinically appropriate, providers may use the correct modifier to allow both services to be covered

A same day follow up office visit for the purpose of fitting eyeglasses is allowed, but no higher level office visit than the lowest level E/M code is reimbursable for the fitting. Appropriate modifier usage may be required.

Exclusions

Same-day outpatient visit policy does not apply when:

- The member is a child in state-funded foster care (aid category 15)

Members Age 21 and Over

If a preventive medicine E/M service has been paid, only the two lowest level E/M codes are reimbursable for the same member, on the same date of service, and by the same attending provider.

Sterilization

Sterilization is defined as any medical treatment or procedure that renders an individual permanently incapable of reproducing. Federal regulations contained in 42 CFR §§441.250 -441.259 require that a consent form be completed before a sterilization procedure can be performed. Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing. The individual seeking sterilization must voluntarily give informed consent on the approved Sterilization Consent Form (available online at www.amerihealthcaritasla.com).:

In accordance with federal regulations, AmeriHealth Caritas Louisiana covers sterilization if the following requirements are met:

- The individual is at least 21 years of age at the time the consent is obtained;
- The individual is not a mentally incompetent individual;
- The individual has voluntarily given informed consent in accordance with all federal requirements; and
- At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since an enrollee gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Hysterectomies performed solely for the purpose of terminating reproductive capability are not covered.

Sterilization Consent Form Requirements

The current sterilization consent form must be used (HHS-687 available in English and HHS-687-1 available in Spanish) from the U.S. Department of Health and Human Services website [link].

AmeriHealth Caritas Louisiana requires the consent form to be signed and dated by:

- The individual to be sterilized,
- The interpreter, if one was provided,
- The person who obtained the consent, and
- The physician performing the sterilization procedure.

NOTE: If the physician who performed the sterilization procedure is the one who obtained the consent, the physician must sign both statements.

The physician who obtains the consent must share the consent form with all providers involved in that member's care (e.g., attending physician, hospital, anesthesiologist, and assistant surgeon).

Members who undergo a covered hysterectomy must complete a hysterectomy consent form but are not required to complete a sterilization consent form.

Sterilization Consent Form and Name Changes

For services requiring a sterilization consent form, the member's name on the Medicaid file for the date of service must be the same as the name signed at the time of consent. If the member's name is different, the provider must attach a letter from the provider's office from which the consent was obtained. The letter must be signed by the physician and must state the member's name has changed and must include the member's social security number and date of birth.

Correcting the Sterilization Consent Form

The informed consent must be obtained and documented prior to the performance of the sterilization.

Errors in the following sections can be corrected, but only by the person over whose signature they appear:

- "Consent to Sterilization,"
- "Interpreter's Statement,"
- "Statement of Person Obtaining Consent," and
- "Physician's Statement".

If either the member, the interpreter, or the person obtaining consent returns to the office to make a correction to his/her portion of the consent form, the medical record must reflect his/her presence in the office on the day of the correction.

To make an allowable correction to the form, the individual making the correction must line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction. Erasures, "write-overs," or use of correction fluid in making corrections are unacceptable.

Only the member can correct the date to the right of their signature. The same applies to the interpreter, to the person obtaining consent, and to the doctor. The corrections of the member, the interpreter, and the person obtaining consent must be made before the claim is submitted.

The date of the sterilization may be corrected either before or after submission by the doctor over whose signature it appears. However, the operative report must support the corrected date.

Reimbursement for Sterilization

The sterilization consent form or a physician's written certification must be obtained before providers may be reimbursed. Ancillary providers and hospitals may submit claims without the hard copy consent. However, providers may only be reimbursed if the surgeon submitted a valid sterilization consent and was reimbursed for the procedure

Abortion Limitations

This policy describes induced, threatened, incomplete, or missed abortions. AmeriHealth Caritas Louisiana does not reimburse providers for elective abortions and related services. **Induced Abortion**

Coverage of induced abortions is restricted to that which meets the following criteria:

- A physician has found, and so certifies in a written certification of medical necessity in his/her own handwriting, that on the basis of his/her professional judgment, the life of the pregnant woman would be endangered if the fetus was carried to term.

- AmeriHealth Caritas Louisiana has received the completed certification of medical necessity, which must contain the name and address of the member, attached to the claim form. The diagnosis or medical condition which makes the pregnancy life endangering must be specified on the claim.

OR

In the case of an induced abortion due to rape or incest, the following requirements shall be met:

- The enrollee shall report the act of rape or incest to a law enforcement official;

- The report of the act of rape or incest to a law enforcement must be submitted to AmeriHealth Caritas Louisiana along with the treating physician's claim for reimbursement for performing an abortion;

- The member shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician; and

- The Certification of Informed Consent--Abortion form, which may be obtained from the Louisiana Office of Public Health via a request form [link] or by calling (504) 568-5330, shall be witnessed by the treating physician.

- These reporting requirements shall be waived if the treating physician certifies in writing that, in the physician's professional opinion, the victim was too physically or psychologically incapacitated to comply with the requirements. The treating physician's certification shall be submitted to AmeriHealth Caritas Louisiana along with the treating physician's claim for reimbursement for performing an abortion.

Claims associated with an induced abortion, including those of the attending physician, hospital, assistant surgeon, and anesthesiologist shall be accompanied by a copy of the attending physician's written certification of medical necessity or the Certification of Informed Consent--Abortion form. Therefore, it is required that providers submit only hard-copy claims for payment consideration.

All claim forms and attachments are retained by AmeriHealth Caritas Louisiana and copies of claims and accompanying documentation will be forwarded to LDH if requested.

Threatened, Incomplete, or Missed Abortion

AmeriHealth Caritas Louisiana's coverage of threatened, incomplete, or missed abortion shall be supported by documentation of the member's history and complete documentation of treatment of the threatened, incomplete or missed abortion.

Supportive documentation that will substantiate coverage may include, but is not limited to, one or more of the following:

- Sonogram report showing no fetal heart tones;
- History indicating passage of fetus at home, en route, or in the emergency room;
- Pathology report showing degenerating products of conception; or
- Pelvic exam report describing stage of cervical dilation.

All claim forms and attachments will be retained by AmeriHealth Caritas Louisiana.

Home Health Services

AmeriHealth Caritas Louisiana encourages home health services as an alternative to hospitalization when medically appropriate. Home health services are recommended:

- To allow an earlier discharge from the hospital
- To avoid unnecessary admissions of members who could effectively be treated at home
- To allow members to receive care in greater comfort, because they are in familiar surroundings

AmeriHealth Caritas Louisiana covers the following home health services:

- Skilled Nursing (intermittent or part-time)
- Home Health Aide Services, in accordance with the plan of care as recommended by the attending physician.
- Extended Skilled Nursing Services (also referred to as Extended Home Health), as part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, is extended nursing care by a registered nurse or a licensed practical nurse (LPN) and may be provided to enrollees under age 21 who are considered “medically fragile”.
- Rehabilitation Services are physical, occupational and speech therapies, including audiology services.
- Medical Supplies, Equipment, and Appliances, as recommended by the physician, required in the POC for the enrollee and suitable for use in any setting in which normal life activities take place are covered under the Durable Medical Equipment (DME) program when approved by the Prior Authorization Unit (PAU).

NOTE: A face-to-face encounter between the patient and the physician or an allowed non-physician provider (NPP) should occur no more than 90 days prior to, or 30 days after, admission to the home health agency.

For High Risk Pregnancy needs, call Alere, our contracted vendor, for information or to refer a member: 1-800-950-3963 or www.Alere.com.

AmeriHealth Caritas Louisiana's Utilization Management Department will coordinate medically necessary home health and home infusion needs with the PCP, attending specialist, hospital home care departments and other providers of home care services. Contact AmeriHealth Caritas Louisiana's Utilization Management Department through NaviNet or fax to 866-397-4522 or call 1-888-913-0350 to obtain an authorization.

Due to possible interruptions of the member’s State Medicaid coverage, it is strongly recommended that Providers call for verification of the member’s continued eligibility the 1st of each month. If the need for service extends beyond the initial authorized period, the Provider must re-verify eligibility through NaviNet.

Hospice Care

Hospice is covered by AmeriHealth Caritas Louisiana and can assist you in coordinating services for members in need of this service. Hospice offers a comprehensive program of care to patients and families facing a life threatening illness. Hospice emphasizes palliative care which is a multidisciplinary approach to specialized medical care for people with serious illnesses. The goal of such therapy is to improve quality of life for both the patient and the family.

Criteria for Hospice – the recipient must be terminally ill with a medical prognosis that life expectancy is six months or less based on letting the illness run its course. Persons under 21 years of age can receive both palliative and curative care.

Services must be approved by the Utilization Department and to avoid denials please follow the guidelines when submitting for assistance. Please refer to the appendix for the Hospice Notice of Election and Hospice Certificate of Terminal Illness forms.

For the duration of an election of hospice care, a recipient waives all rights to the following Medicaid covered services:

- Hospice care provided by a hospice provider other than the hospice provider designated by the recipient;
- Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that is equivalent to hospice care, except for services provided by:
  - The designated hospice provider; either directly or under arrangements;
  - Another hospice provider under arrangements made by the designated hospice provider; and
  - The recipient's attending physician if that physician is not an employee of the designated hospice provider or receiving compensation from the hospice provider for those services.

Hospital Transfer Policy

When a member presents to the ER of a hospital not participating with AmeriHealth Caritas Louisiana and the member requires admission to a hospital, AmeriHealth Caritas Louisiana may require that the member be stabilized and transferred to an AmeriHealth Caritas Louisiana participating hospital for admission. When the medical condition of the member requires admission for stabilization, the member may be admitted, stabilized and then transferred within twenty-four (24) hours of stabilization to the closest AmeriHealth Caritas Louisiana participating facility.

Elective inter-facility transfers must be prior authorized by AmeriHealth Caritas Louisiana's Utilization Management Department at 1-888-913-0350.

These steps must be followed by the Health Care Provider:

- Complete the authorization process
- Approve the transfer
- Determine prospective length of stay
- Provide clinical information about the patient

Either the sending or receiving facility may initiate the Prior Authorization, however, the original admitting facility will be able to provide the most accurate clinical information. Although not mandated, if a transfer request is made by an AmeriHealth Caritas Louisiana participating facility, the receiving facility may request the transferring facility obtain the Prior Authorization before the case will be accepted. When the original admitting facility has obtained the Prior

Authorization, the receiving facility should contact AmeriHealth Caritas Louisiana to confirm the authorization, obtain the case reference number and provide the name of the attending Health Care Provider.

In emergency cases, notification of the transfer admission is required within forty-eight (48) hours or by the next business day (whichever is later) by the receiving hospital. Lack of timely notification may result in a denial of service. Within 24 hours of notification of inpatient stay, the hospital must provide a comprehensive clinical review, initial assessment and plans for discharge.

Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy: Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

AmeriHealth Caritas Louisiana limits reimbursement for hyperbaric oxygen (HBO) therapy to what is administered in a chamber. HBO therapy shall be considered medically necessary for the following conditions:

- Aute carbon monoxide intoxication;
- Decompression illness;
- Gas embolism;
- Gas gangrene;
- Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
- Crush injuries and suturing of severed limbs. HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened;
- Progressive necrotizing infections (necrotizing fasciitis);
- Acute peripheral arterial insufficiency;
- Preparation and preservation of compromised skin grafts (not for primary management of wounds);
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management;
- Osteoradionecrosis as an adjunct to conventional treatment;
- Soft tissue radionecrosis as an adjunct to conventional treatment;
- Cyanide poisoning; and
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.

Immunizations

AmeriHealth Caritas Louisiana covers immunizations for members under the age of 21 in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices (ACIP). Immunizations shall be given in conjunction with EPSDT/Well Child visits or when other appropriate opportunities exist.
All members 21 years of age and older are also covered for all vaccines and immunizations in accordance with ACIP.

Combination Vaccines

AmeriHealth Caritas Louisiana encourages combination vaccines in order to maximize the opportunity to immunize and to reduce the number of injections a child receives in one day. Providers shall not be reimbursed for a single-antigen vaccine

and its administration if a combined-antigen vaccine is medically appropriate and the combined vaccine is approved by the Secretary of the U.S. Department of Health and Human Services.

Reimbursement for Immunizations/Vaccines

Providers must indicate the CPT code for the specific vaccine in addition to the appropriate administration CPT code(s) in order to receive reimbursement for the administration of appropriate immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) in the current immunization schedule. The listing of the vaccine on the claim form is required for federal reporting purposes.

Vaccines from the Vaccines for Children (VFC) Program are available at no cost to the provider and are required to be used for members who are birth through 18 years of age. Therefore, encounters with CPT codes for vaccines available from the VFC Program shall be submitted at zero ($0) for a member from birth through 18 years of age.

Providers must submit claims with their usual and customary charge for the vaccine for members 19 through 20 years of age. AmeriHealth Caritas Louisiana reimburses these claims at the fee on file or the billed charges, whichever is lower.

Vaccines for ~~Chidren~~Children[KG6]

Providers that provide EPSDT well child preventative screenings must be enrolled in the VFC program and utilize VFC vaccines for members aged birth through 18 years of age.

Providers can obtain a VFC enrollment packet by calling the Office of Public Health's (OPH) Immunization Section [link] at (504) 568-2600.

Declared Pediatric Flu Vaccine Shortage Plan

AmeriHealth Caritas Louisiana's policy includes the following provisions regarding flu vaccine shortages:

- If a Medicaid provider does not have the VFC pediatric influenza vaccine on hand to vaccinate a **high priority** VFC Medicaid eligible child, the provider should not turn away, refer or reschedule the member for a later date if the vaccine is available from private stock. The provider should use pediatric influenza vaccine from private stock and replace the dose(s) used from private stock with dose(s) from VFC stock when the VFC vaccine becomes available.

- If a Medicaid provider does not have the VFC pediatric influenza vaccine on hand to vaccinate a **non-high priority or non-high risk** VFC Medicaid eligible member, the member can:

    - Wait for the VFC influenza vaccine to be obtained, or

    - If the member chooses not to wait for the VFC influenza vaccine to be obtained, and the provider has private stock of the vaccine on hand, the MCO shall reimburse only the administration of the private stock vaccine.

        - If the provider intends to charge the member for the vaccine, then prior to the injection the provider shall inform the member/guardian that the actual vaccine does not come from the VFC program and the member will be responsible for the cost of the vaccine. In these situations, the

provider shall obtain signed documentation that the member is responsible for payment of the vaccine only.

Louisiana Immunization Network (LINKS)

Louisiana Immunization Network (LINKS) is a computer-based system designed to track immunization records for providers and their patients by:

- Consolidating immunization information among all healthcare providers,
- Assuring adequate immunization coverage levels, and
- Avoiding duplicative immunizations.

AmeriHealth Caritas Louisiana accesses LINKS directly to obtain immunization reports. LINKS can be accessed through the OPH website [direct link].

Providers must report the required immunization data into the Louisiana Immunization Network (LINKS).

Medical Supplies

Certain medical supplies are available with a valid prescription through AmeriHealth Caritas Louisiana's medical benefit, and are provided through participating pharmacies and durable medical equipment (DME) suppliers. Such as:

- Vaporizers (one per calendar year)
- Humidifiers (one per calendar year)
- CPAP supplies (once every six (6) months)
- Diapers/Pull-Up Diapers may be obtained as follows:
    - Members over the age of three (3) are eligible to obtain diapers/pull-up diapers when Medically Necessary
    - A written prescription from participating practitioner is required
    - The quantity limit is 200 diapers/pull-up diapers (pediatric and adult) per month
    - Generic diapers/pull-up diapers must be dispensed
    - Brand diapers/pull-up diapers require Prior Authorization
    - Prior Authorization must be obtained for quantities greater than 200 diapers/pull- up diapers per month, or for diapers/pull-up diapers to be supplied by a DME network provider by calling 1-~~1~~-888-913-0350[KG7]
- Blood pressure monitors are covered by AmeriHealth Caritas Louisiana with a prescription. Coverage is currently limited to one (1) unit per 365 days.

Newborn Care and Discharge

AmeriHealth Caritas Louisiana assumes financial responsibility for services provided to newborns of mothers who are active members. However, these newborns are not automatically enrolled in AmeriHealth Caritas Louisiana at birth.

AmeriHealth Caritas Louisiana will contact members who are expectant mothers 60 calendar days prior to the expected date of delivery to encourage the mother to choose a PCP for her newborn.

Hospitals must report the births of newborns within 24 hours of birth for enrolled members using LDH's web-based Request for Newborn Manual system. (See Appendix section of this handbook). If the mother has selected a HEALTHY LOUISIANA plan and/or PCP, this information shall be reported. If no selection is made, the newborn will be automatically enrolled in the mother's HEALTHY LOUISIANA plan. Enrollment of newborns shall be retroactive to the date of the birth.

Hospitals must also register all births through LEERS (Louisiana Electronic Event Registration System) administered by LDH/Vital Records Registry. LEERS information and training materials are available at: http://www.dhh.louisiana.gov/offices/page.asp?id=252&detail=9535

Circumcisions are covered by AmeriHealth Caritas Louisiana as an expanded benefit in the hospital or physician's office setting up to 30 days after birth without an authorization. Any circumcision provided after 30 days will require an authorization for medical necessity. These services must be billed under the newborn's Medicaid ID.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) screens must be completed on every newborn, and submitted to AmeriHealth Caritas's Claims department. Please refer to the Pediatric Preventive Health Care program in this section of the handbook for EPSDT instructions.

Physicians billing for initial newborn care must use the appropriate procedure codes for history and examination of normal newborn when the service provided meets the criteria for the initial examination rendered. This procedure is limited to one per lifetime of the member.

The procedure code for subsequent hospital care, normal newborn, per day should be billed for each day of normal newborn care rendered subsequent to the date of birth other than the discharge date. AmeriHealth Caritas Louisiana covers a minimum of three normal newborn subsequent hospital care days.

Newborn Discharge Services

AmeriHealth Caritas Louisiana's policy for discharge services shall include the following:

- When the date of discharge is subsequent to the admission date, the provider shall submit claims for newborn hospital discharge services using the appropriate hospital day management code.
- When newborns are admitted and discharged from the hospital or birthing room on the same date, the provider shall use the appropriate code for services rendered within the first 24 hours of the child's life.

Detained Newborns and Other Newborn Admissions

AmeriHealth Caritas Louisiana requests notification on all newborns. AmeriHealth Caritas Louisiana regards a baby **detained** after the mother's discharge as a new admission requiring separate authorization. The admission must be reported to AmeriHealth Caritas Louisiana's Utilization Management department and a new case reference number will be issued for the detained baby. Reimbursement for the higher level of care for the baby will revert to the day the baby is admitted to the higher level of care, based on meeting criteria.

Facilities are required to notify AmeriHealth Caritas Louisiana of all admissions to an **intensive care** or **transitional nursery** facility within 24 hours of the admission (even if the admission does not result in the baby being detained).

Facilities are also required to notify AmeriHealth Caritas Louisiana of all newborn admissions where the payment under

their contract will be at other than the newborn rate (even if the baby is not detained or admitted to an intensive care or transitional nursery facility).

Facilities should report through NaviNet, or Fax to 866-397-4522 or call the Utilization Management department at **1-888-913-0350** and follow prompts. When reporting a detained baby or other newborn admission notifications, please be prepared to leave the following information:

- Mother's first and last name
- Mother's AmeriHealth Caritas ID #
- Baby's first and last name
- Baby's date of birth (DOB)
- Baby's sex
- Admission date to intensive care/transitional nursery
- Baby's diagnosis
- First and last name of baby's attending practitioner
- Facility name and AmeriHealth Caritas Louisiana ID #
- Caller's name and complete phone number

Upon review, a Utilization Management Coordinator will contact the facility and provide the authorization number assigned for the baby's extended stay or other admission. **All facility and associated practitioner charges should be billed referencing this authorization number.**

AmeriHealth Caritas Louisiana will pay detained newborn or other newborn admission charges according to established hospital-contracted rates for the bed-type assigned (e.g., NICU) commencing with the day the mother is discharged from the hospital. A new admission with a new case reference number will be assigned for the detained newborn or newborn admitted for other reasons. All detained baby or other newborn admission charges must be billed on a separate invoice.

Nursing Facility

If a member needs to be referred to a Nursing Facility, the PCP should contact AmeriHealth Caritas Louisiana's Utilization Management Department. AmeriHealth Caritas Louisiana will coordinate necessary arrangements between the PCP, the referring facility, and the Nursing Facility in order to provide the needed care. Reimbursement for long term care placement in a Nursing Facility is not covered by AmeriHealth Caritas Louisiana. AmeriHealth Caritas Louisiana covers placement in a Nursing Facility for rehabilitation, skilled nursing or short term needs for nursing facility services. If a member is entering a Nursing Facility for long-term care needs they will be transitioned out of the Healthy Louisiana program by LDH and AmeriHealth Caritas Louisiana will not be
responsible for those charges.

Obstetrics

AmeriHealth Caritas Louisiana requires that all prenatal outpatient visit evaluation and management (E&M) codes be modified with TH. The TH modifier is not required for observation or inpatient hospital physician services.

AmeriHealth Caritas Louisiana covers a hospital stay following a normal vaginal delivery of at least 72 hours for both the mother and newborn child, and at least 120 hours following a cesarean section delivery for both the mother and newborn

child. All medically necessary services are the responsibility of AmeriHealth Caritas Louisiana regardless of primary or secondary mental health diagnosis.

Initial Prenatal Visits

AmeriHealth Caritas Louisiana covers two initial prenatal visits per pregnancy (270 days). These two visits cannot be performed by the same attending provider.

AmeriHealth Caritas Louisiana considers the member a "new patient" for each pregnancy whether or not the member is a new or established patient to the provider or practice.

Coverage of the initial prenatal visit shall include, but is not limited to, the following:

- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy below.);
- Identification of patient at risk for complications including those with prior preterm birth. The risk assessment shall include a screen for tobacco, alcohol, and substance use, HIV, and syphilis during the first and third trimesters;
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

AmeriHealth Caritas Louisiana's policy for billing the initial prenatal visit shall include the following:

- The appropriate level E&M CPT procedure code from the range of codes for new patient "Office or Other Outpatient Services" must be used with the TH modifier.
- A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis.
- If the pregnancy is not verified, or if the pregnancy test is negative, the service can only be billed at the appropriate level E&M service without the TH modifier.

Follow-Up Prenatal Visits

Coverage of follow-up prenatal visits shall include, but is not limited to, the following:

- The obstetrical (OB) examination;
- Routine fetal monitoring (excluding fetal non-stress testing);
- Diagnosis and treatment of conditions both related and unrelated to the pregnancy; and
- Routine dipstick urinalysis.

Treatment for conditions such as minor vaginal problems and routine primary care issues, including infections, sinusitis, etc., is considered an essential part of maternal care during pregnancy and shall be covered.

For the subsequent prenatal visits, AmeriHealth Caritas Louisiana requires the provider to use the appropriate level E&M CPT code from the range of procedure codes for an established patient in the "Office or Other Outpatient Services" along with the TH modifier.

Delivery Codes

Amerihealth Caritas Louisiana's policy for coding deliveries shall include the following:

- The most appropriate "delivery only" CPT code should be billed. Delivery codes inclusive of the antepartum care and/or postpartum visit are not covered except in cases related to third party liability. (Refer to the **Third Party Liability** section of this Manual for additional information.)

- For multiple births:

    - The diagnosis code must indicate a multiple birth and delivery records must be attached. A -22 modifier for unusual circumstances must be used with the most appropriate CPT code for a vaginal or Cesarean section (C-section) delivery when the method of delivery is the same for all births.

    - If the multiple gestation results in a C-section delivery and a vaginal delivery, the provider must bill the most appropriate "delivery only" CPT code for the C-section delivery and also bill the most appropriate vaginal "delivery only" procedure code with modifier -51 appended.

Postpartum Care Visit

AmeriHealth Caritas Louisiana covers a minimum of one postpartum visit per 270 days. Coverage of the postpartum care visit shall include:

- Physical examination;
- Body mass index (BMI) assessment and blood pressure check;
- Routine dipstick urinalysis;
- Follow up plan for women with gestational diabetes;
- Family planning counseling;
- Breast feeding support and assessment, including appropriate referral for lactation support and/or to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), if needed;
- Screening for postpartum depression and intimate partner violence; and
- Other counseling and or services associated with releasing a patient from obstetrical care.

AmeriHealth Caritas Louisiana requires providers to use the postpartum care CPT code (which must NOT be modified with –TH) for the postpartum care visit when performed.

Obstetric Laboratory Services

AmeriHealth Caritas Louisiana covers one laboratory obstetric panel per pregnancy. Additional obstetric panels shall be covered if medically necessary.

Ultrasounds

AmeriHealth Caritas Louisiana covers three medically necessary ultrasounds per pregnancy (270 days). This includes OB ultrasounds performed by all providers regardless of place of treatment. AmeriHealth Caritas Louisiana requires obstetrical providers to utilize the obstetrical ultrasound section of CPT.

Louisiana Medicaid anticipates that three medically necessary ultrasounds will have been performed by the end of the second trimester of the pregnancy, one for determination of gestational age and two for survey of fetal anatomy.

AmeriHealth Caritas Louisiana cautions providers not to maximize reimbursement by performing more than the medically necessary number of ultrasounds per pregnancy. Abuse of the ultrasound limit to maximize reimbursement is subject to review and possible recoupment and/or sanctions.

AmeriHealth Caritas Louisiana covers additional ultrasounds when medically necessary.

AmeriHealth Caritas Louisiana restricts reimbursement for CPT codes 76811 and 76812 to maternal fetal medicine specialists. (These are not included in the two per pregnancy limit described previously for the attending OB provider.)

17-Alpha Hydroxyprogesterone Caproate

AmeriHealth Caritas Louisiana covers 17-alpha hydroxyprogesterone caproate (17P) when substantiated by an appropriate diagnosis and all of the following criteria are met:

- Pregnant woman with a history of pre-term delivery before 37 weeks gestation;
- No symptoms of pre-term in the current pregnancy;
- Current singleton pregnancy; and
- Treatment initiation between 16 weeks 0 days and 23 week 6 days gestation.

Fetal Testing

Fetal Oxytocin Stress Test

A fetal oxytocin stress test is payable in an office setting to those professionals who have the capacity to perform the procedure in their office.

- The full service is payable to physicians only when the service is performed in the office setting. The full service is not payable to physicians if the place of service is in an inpatient or outpatient hospital.
- The “professional component only” aspect of this code is payable to all physicians, regardless of the place of service.

Fetal Non-Stress Test

AmeriHealth Caritas Louisiana covers a fetal non-stress test only in the following instances:

- Post-date/post-maturity pregnancies (after 41 weeks gestation).
- The treating physician has reason to suspect potential fetal problems in a “normal” pregnancy. If so, the diagnosis must reflect this.
- High-risk pregnancies, including but not limited to diabetic patient, toxemia, pre-eclampsia, eclampsia, multiple gestation, and previous intrauterine fetal death. The diagnosis mustreflect high risk.

In addition, if the place of service is either in an inpatient or outpatient hospital, or the billing physician is rendering the “interpretation only” in his/her office, AmeriHealth Caritas Louisiana requires only the professional component (modifier-26) to be used.

Fetal Biophysical Profile

AmeriHealth Caritas Louisiana considers fetal biophysical profiles medically necessary when two of the three criteria listed below are present:

- Gestation period is at least 28 weeks;
- Pregnancy must be high-risk, if so, the diagnosis must reflect high risk; or
- Uteroplacental insufficiency must be suspected in a normal pregnancy.

Perinatal Services

AmeriHealth Caritas Louisiana has policies to address prematurity prevention and improved perinatal outcomes which may include, but are not limited to, the following:

- Routine cervical length assessments for pregnant women;
- Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy. AmeriHealth Caritas Louisiana does not require prior authorization of progesterone for the prevention of premature birth unless written approval from the Medicaid Medical Director is obtained. AmeriHealth Caritas Louisiana provides progesterone access to eligible members in a timely fashion;
- Incentives for vaginal birth after cesarean (VBAC);
- Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery; and
- Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age.

Ophthalmology Services

Non-Routine Eye Care Services

When a member requires non-routine eye care services resulting from accidental injury or trauma to the eye(s), or treatment of eye diseases, AmeriHealth Caritas Louisiana will pay for such services through the medical benefit. The PCP should initiate appropriate authorizations for all non- routine eye care services.

Please see “Vision Care” in this section of this *Provider Manual* for a description of AmeriHealth Caritas Louisiana’s routine eye care services. AmeriHealth Caritas Louisiana's routine eye care services for children under 21 and enhanced benefits for adults are administered through a vision vendor. Covered routine eye exams and corrective lens claims should not be submitted to AmeriHealth Caritas Louisiana for processing.

Questions concerning benefits available for Ophthalmology Services should be directed to the Provider Services Department at 1-888-922-0007.

Independent Laboratories

The Medicaid Independent Laboratories Program provides for payment of medically necessary clinical laboratory procedures provided in freestanding laboratory facilities to Medicaid eligible members. An independent laboratory

performs diagnostic tests and is independent of both the attending physician's office and/or the hospital where services are rendered.

AmeriHealth Caritas Louisiana requires independent laboratories to comply with the conditions and requirements in this section in order for their services to be covered.

Covered Services for Independent Laboratories

AmeriHealth Caritas Louisiana reimburses laboratories only for those services they are certified by the Clinical Laboratory Improvement Act (CLIA) to perform and for those services ordered by a physician or other qualified licensed practitioner.

AmeriHealth Caritas Louisiana allows hospitals to contract with an independent laboratory for performance of outpatient laboratory services. However, both the physician who performs the professional service and the laboratory that performs the technical service must meet all state and federal requirements. One such requirement is that both the physician and laboratory have a valid Clinical Laboratory Improvement Amendments (CLIA) number.

When a hospital contracts with a freestanding laboratory for the performance of the technical service only, AmeriHealth Caritas Louisiana requires the hospital to pay the laboratory. AmeriHealth Caritas Louisiana does not reimburse the laboratory because there is no mechanism in the system to pay a technical component only to a freestanding laboratory.

Independent Laboratories Requirements

Providers must be participating as independent laboratories that are licensed and certified by the appropriate licensing agency and meet Medicare/Medicaid participation requirements.

All laboratory testing sites must be freestanding clinical laboratories certified under the Clinical Laboratory Improvements Amendments (CLIA). Providers are limited to billing the lab services that they are CLIA-certified to perform.

Independent Laboratories Reimbursement

AmeriHealth Caritas Louisiana requires all independent laboratory providers to include a valid Clinical Laboratory Improvement Amendments (CLIA) number on all claims submitted for laboratory services, including CLIA waived tests.

AmeriHealth Caritas Louisiana applies CLIA claim edits to all claims for laboratory services that require CLIA certification and denies those claims that do not meet the required criteria.

AmeriHealth Caritas Louisiana edits claims to ensure payment is not made to:

- Providers who do not have a CLIA certificate;
- Providers submitting claims for services rendered outside the effective dates of the CLIA certificate; and providers submitting claims for services not covered by their CLIA certificate.

NOTE: The CLIA number is not required for UB-04 claims.

In an effort to provide high quality laboratory services in a managed care environment for our members, AmeriHealth Caritas Louisiana has made the following arrangements:

- AmeriHealth Caritas Louisiana encourages network providers to perform venipuncture in their office. Providers should then contact laboratory provider to arrange pick-up service

- Providers with CLIA Certification, or a waiver of a certificate of registration along with a CLIA identification number, may perform approved labs in their offices and be reimbursed for those lab services

- Except for STAT laboratory services, AmeriHealth Caritas Louisiana requires that network providers utilize a network laboratory (unless the provider has CLIA certification) when outpatient laboratory studies are required for their AmeriHealth Caritas Louisiana members.

Skilled Nursing Facilities (SNF)

AmeriHealth Caritas Louisiana covers all services, including periods in which the member is admitted to a SNF for rehabilitative purposes.

Intrathecal Baclofen Therapy

AmeriHealth Caritas Louisiana cover surgical implantation of a programmable infusion pump for the delivery of intrathecal baclofen (ITB) therapy for individuals four years of age and older who meet medical necessity for the treatment of severe spasticity of the spinal cord or of cerebral origin.

The following diagnoses are considered appropriate for ITB treatment and infusion pump implantation:

- Meningitis;
- Encephalitis;
- Dystonia;
- Multiple sclerosis;
- Spastic hemiplegia;
- Infantile cerebral palsy;
- Other specified paralytic syndromes;
- Acute, but ill-defined, cerebrovascular disease;
- Closed fracture of the base of skull;
- Open fracture of base of skull;
- Closed skull fracture;
- Fracture of vertebral column with spinal cord injury;
- Intracranial injury of other and unspecified nature; or
- Spinal cord injury without evidence of spinal bone injury.

Criteria for Member Selection for ITB

Implantation of an ITB infusion pump is considered medically necessary, when the candidate is four years of age or older with a body mass sufficient to support the implanted system, and one or more of the following criteria is met:

- Inclusive Criteria for Candidates with Spasticity of Cerebral Origin

- There is severe spasticity of cerebral origin with no more than mild athetosis;
- The injury is older than one year;
- There has been a drop in Ashworth scale of 1 or more;
- Spasticity of cerebral origin is resistant to conservative management; or
- The candidate has a positive response to test dose of ITB.

- Inclusive Criteria for Candidates with Spasticity of Spinal Cord Origin

  - Spasticity of spinal cord origin that is resistant to oral antispasmodics or side effects unacceptable in effective doses;
  - There has been a drop in Ashworth scale of 2 or more; or
  - The candidate has a positive response to test dose of intrathecal baclofen.

Caution should be exercised when considering ITB infusion pump implantation for candidates who:

- Have a history of autonomic dysreflexia;
- Suffer from psychotic disorders;
- Have other implanted devices; or
- Utilize spasticity to increase function such as posture, balance, and locomotion.

Exclusive Criteria for ITB Candidates

Consideration shall not be made if the candidate:

- Fails to meet any of the inclusion criteria;
- Is pregnant, or refuses or fails to use adequate methods of birth control;
- Has a severely impaired renal or hepatic function;
- Has a traumatic brain injury of less than one year pre-existent to the date of the screening dose;
- Has history of hypersensitivity to oral baclofen;
- Has a systematic or localized infection which could infect the implanted pump; or
- Does not respond positively to a 50, 75, or 100 mcg intrathecal bolus of baclofen during the screening trial procedure.

AmeriHealth Caritas Louisiana covers outpatient bolus injections given to candidates for the ITB infusion treatment if medically necessary even if the member fails the screening trial procedure.

Laboratory and Radiological Services

AmeriHealth Caritas Louisiana covers inpatient and outpatient diagnostic laboratory testing, therapeutic radiology, and radiological services ordered and/or performed by network providers.

Laboratory or radiological services that may be required to treat an emergency or to provide surgical services for an excluded service, such as dental services are also covered.

AmeriHealth Caritas Louisiana covers clinical laboratory services and portable (mobile) x-rays for members who are unable to leave their place of residence without special transportation or assistance to obtain PCP-ordered laboratory services and x-rays.

AmeriHealth Caritas Louisiana may require service authorization for diagnostic testing and radiological services ordered or performed by any provider for members. Please refer to **Authorization Requirements** section in this manual.

The following policies are specific to the performance of laboratory and radiology procedures in a physician's office. Providers will not be reimbursed for the full service of laboratory and radiology services that are not performed in the providers' own offices, including tests which are sent to other facilities for processing.

NOTE: Refer to the Independent Laboratories section of this Manual for additional information.

Clinical Laboratory Improvement Amendments (CLIA) Certification[KG8][BL9]

AmeriHealth Caritas Louisiana requires all professional service providers to include a valid CLIA number on all claims submitted for laboratory services, including CLIA waived tests.

AmeriHealth Caritas Louisiana applies CLIA claim edits to all claims for laboratory services that require CLIA certification and denies those claims that do not meet the required criteria.

AmeriHealth Caritas Louisiana edits claims to ensure payment is not made to:

- Providers who do not have a CLIA certificate;
- Providers rendering services outside the effective dates of the CLIA certificate; and
- Providers submitting claims for services not covered by their CLIA certificate.

Providers with waiver or provider-performed microscopy (PPM) certificate types may be paid for only those waiver and/or PPM codes approved for billing by CMS.

NOTE: The CLIA number is not required for UB-04 claims.

Please refer to the AmeriHealth Caritas Louisiana Claims Filing Instructions for details on how to submit a CLIA number on the CMS 1500 claim form.

Specimen Collection

Physicians collecting specimens during the course of an evaluation and management service and forwarding them to an outside laboratory shall not be separately reimbursed by AmeriHealth Caritas Louisiana for collection of the specimen. The collection of the specimen is considered incidental to the evaluation and management service.

Portable X-Rays

AmeriHealth Caritas Louisiana covers specific diagnostic radiology services for an eligible member to be provided in the member's place of residence by an enrolled portable x-ray provider.

Covered radiographs shall be limited to:

- Skeletal films of an enrollee's limbs, pelvis, vertebral column or skull;
- Chest films which do not involve the use of contrast media; and
- Abdominal films which do not involve the use of contrast media.

NOTE: Technical components of these services are not reimbursed as a separate part of the service. Providers billing for these services must bill a full component only.

Transportation of portable x-ray equipment is covered only when the equipment used is actually transported to the location where x-ray services are provided.

Only a single transportation payment per trip to a facility or location for a single date of service is reimbursed.

The physician's order is required to clearly state the following:

- Suspected diagnosis or the reason the x-ray is required;
- Area of the body to be exposed;
- Number of radiographs ordered; and
- Precise views needed.

Member Qualifications

Members must be home bound. Members are considered to be homebound when a medical condition causes them to be unable to leave their place of residence without the use of special transportation or the assistance of another person.

The member's place of residence is defined as:

- The member's private home;
- A nursing facility; or
- An intermediate care facility for the developmentally disabled.

Provider Requirements for Portable X-Rays

AmeriHealth Caritas Louisiana requires providers to comply with the following regarding portable x-rays:

- Comply with all Medicare guidelines for portable x-ray providers;
- Maintain certification to practice radiology in the state of Louisiana;
- Enroll with Louisiana Medicaid as a portable x-ray provider; and
- Exist independently of any hospital, clinic, or physician's office.

Portable x-ray services must be provided under the general supervision of a licensed physician who is qualified by advanced training and experienced in the use of diagnostic x-rays. The supervising physician is responsible for the ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of non-physician personnel that use the equipment. Any non-physician personnel utilized by the portable x-ray provider to perform tests must demonstrate the basic qualifications and possess appropriate training and proficiency as evidence by licensure or certification.

Outpatient Renal Dialysis

AmeriHealth Caritas Louisiana does not require a referral or Prior Authorization for Renal Dialysis services rendered at Freestanding or Hospital-Based outpatient dialysis facilities.

Free-Standing Facilities

The following services are payable without Prior Authorization or referrals for Free-Standing facilities:

- Training for Home Dialysis
- Back-up Dialysis Treatment
- Hemodialysis - In Center
- Home Rx for CAPD Dialysis (per day)
- Home Rx for CCPD Dialysis (per day)
- Home Treatment Hemodialysis (IPD)

Hospital Based Outpatient Dialysis

AmeriHealth Caritas Louisiana will reimburse Hospital Based Outpatient Dialysis facilities for all of the above services including certain lab tests and diagnostic studies that, according to Medicare guidelines, are billable above the Medicare composite rate. Please refer to Medicare Billing Guidelines for billable End Stage Renal Disease tests and diagnostic studies.

Associated provider services (Nephrologist or other Specialist) do not require a referral. The following services require Prior Authorization through AmeriHealth Caritas Louisiana's Utilization Management Department:

- Supplies and equipment for home dialysis patients (Method II)
- Home care support services provided by an RN or LPN
- Transplants and transplant evaluations
- All inpatient dialysis procedures and services

Outpatient Testing

When a Specialist determines that additional diagnostic or treatment procedures are required during an office visit, he/she must follow AmeriHealth Caritas guidelines for obtaining an authorization.

When a diagnostic test or treatment procedure not requiring Prior Authorization will be performed in an Outpatient Hospital/Facility, the specialist should note the member‘s information and procedures to be performed on his/her office prescription form. Please refer to the “When a patient presents to the hospital for any outpatient services not requiring a Prior Authorization, he/she must bring a copy of the ordering Health Care Provider's prescription form.

Outpatient Therapies

Physical, Occupational, and Speech

All Physical therapy, occupational therapy, and speech therapy services require authorization.

Pediatric Preventive Health Care Program

Liaisons in the EPSDT Department, working with the AmeriHealth Caritas Louisiana EPSDT Coordinator assist the parents or guardians of all members younger than twenty-one (21) years of age in receiving EPSDT screens, treatment, and follow-ups, to the Early Intervention Program when appropriate. The EPSDT liaison also facilitates and ensures EPSDT compliance, provides follow-up concerning service issues, educates non-compliant members on AmeriHealth Caritas Louisiana's rules and regulations, and assists members in accessing care.

The quantity of Medically Necessary, Title XIX eligible services for enrolled children younger than twenty-one (21) years of age are not restricted or limited providing the service meets medical necessity.

EPSDT Screens

Under EPSDT, State Medicaid agencies must provide and/or arrange for the promotion of services to eligible children younger than twenty-one (21) years of age that include comprehensive, periodic preventive health assessments. All Medically Necessary immunizations are required. Age appropriate assessments, known as screens, must be provided at intervals following defined periodicity schedules. Additional examinations are also required whenever a health care provider suspects the child may have a health problem. Treatment for all medically necessary services discovered during an EPSDT screening is also covered.

EPSDT Medical Screenings must include the following:

- A comprehensive health and developmental history, including both physical and mental health development;
- A comprehensive unclothed exam;
- Appropriate immunizations according to age and health history (unless medically contraindicated or parents/guardians refuse at the time);
- Laboratory tests (including appropriate neonatal, iron deficiency anemias and blood lead level screening); and
- Health education including anticipatory guidance

Neonatal/Newborn Screenings for Genetic Disorders

Newborn screening (via heel stick) includes testing for conditions recommended by the American College of Medical Genetics (ACMG) and Louisiana Revised Statute 40:1299.1-3, which requires hospitals with delivery units to screen all newborns before discharge regardless of the newborn's length of stay at the hospital. The Louisiana Administrative Code Title 48, Part V, Subpart 18, Chapter 63 provides the requirements related to newborn screenings. AmeriHealth Caritas's policy for newborn screenings shall include these requirements.

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

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

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

EPSDT Vision Screenings

The purpose of the vision screening is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malfunctions, eye diseases, strabismus, amblyopia, refractive errors, and color blindness.

Subjective Vision Screening

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of any:

- Eye disorders of the child or the child's family;
- Systemic diseases of the child or the child's family which involve the eyes or affect vision;
- Behavior on the part of the child that may indicate the presence or risk of eye problems; and
- Medical treatment for any eye condition

Objective Vision Screening

Objective vision screenings may be performed by trained office staff under the supervision of a licensed physician, physician assistant, registered nurse, advanced practice registered nurse, or optometrist. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, physician assistant, registered nurse, or advanced practice registered nurse.

Objective vision screenings begin at age three. The objective vision screening must include tests of:

- Visual acuity (Snellen Test or Allen Cards for preschoolers and equivalent tests such as Titmus, HOTV or Good Light, or Keystone Telebinocular for older children);
- Color perception (must be performed at least once after the child reaches the age of six using polychromatic plates by Ishihara, Stilling, or Hardy-Rand-Ritter); and
- Muscle balance (including convergence, eye alignment, tracking, and a cover- uncover test).

EPSDT Hearing Screenings

The purpose of the hearing screening is to detect central auditory disorders, including sensorineural, bilateral, or conductive. There are some congenital abnormalities, or a history of conditions which may increase the chances of deafness or hard of hearing in infants. Early hearing detection and intervention is extremely important to identify so newborns can get the help they need, and development of language and communication skills can occur.

Subjective Hearing Screening

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of:

- The child's response to voices and other auditory stimuli;
- Delayed speech development;
- Chronic or current otitis media; and
- Other health problems that place the child at risk for hearing loss or impairment.

Objective Hearing Screening

The objective hearing screenings may be performed by trained office staff under the supervision of a licensed audiologist or speech pathologist, physician, physician assistant, registered nurse, or advanced practice registered nurse. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, physician assistant, registered nurse, or advanced practice registered nurse.

Objective hearing screenings must be performed in accordance with recommendations as indicated by the National Center for Hearing Assessment and Management (NCHAM) and the National Early Hearing Detection and Intervention (EHDI) standards.

Dental EPSDT Screening

An oral health risk assessment must be performed per the Bright Futures periodicity schedule.

EPSDT-Immunizations

Appropriate immunizations (unless medically contraindicated or the parents/guardians refuse) are a federally required medical screening component.

The current Childhood Immunization Schedule recommended by Advisory Committee on Immunizations Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP), which is updated annually, must be followed. Providers are responsible for obtaining current copies of the schedule. The MCO shall ensure that enrollees receive immunizations per the schedule.

EPSDT-Lab

Age-appropriate laboratory tests are required at selected age intervals. Documented laboratory procedures provided less than six months prior to the medical screening must not be repeated unless medically necessary**.** Iron deficiency anemia screening when required is included in the medical screening fee and must not be billed separately.

EPSDT-Blood Lead Screening

Based on surveillance data gathered by the State Childhood Lead Poisoning Prevention Program and review by the state health officer and representatives from medical schools in the state, all parishes in Louisiana are identified as high risk for lead poisoning.

AmeriHealth Caritas Louisiana shall ensure children ages six months to 72 months are screened in compliance with Louisiana Medicaid EPSDT requirements and in accordance with practices consistent with current Centers for Disease Control and Prevention guidelines, which include the following specifications:

- Administer a risk assessment questionnaire at every well child visit;

- Use a blood test to screen all children at ages 12 months and 24 months or at any time from ages 36 months to 72 months, if they have not been previously screened; and
- Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels ≥15 ug/dl.

Medical providers must report a lead case to the Office of Public Health's Childhood Lead Poisoning Prevention Program [link] **within 24 working hours**. A lead case is indicated by a blood lead test result of >15 ug/dl (micrograms per deciliter). The original lead case reporting form shall be mailed within five business days.

All results of blood lead testing of children less than 72 months of age, regardless of the blood lead level, must be reported to the Louisiana Childhood Lead Poisoning Prevention Program [link] by electronic transmission.

Screening Periodicity Restrictions

Screenings performed on children under two years of age must be performed at least 30 days apart. Screenings performed after the child's second birthday must be at least six months apart.

Off-Schedule Screenings

If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring the child up to date at the earliest possible time. However, all screenings performed on children who are under two years of age must be at least 30 days apart, and those performed on children age two through six years of age must be at least six months apart.

Interperiodic Screenings

Interperiodic screenings may be performed if medically necessary. The parent/guardian or any medical provider or qualified health, developmental, or education professional that comes into contact with the child outside the formal healthcare system may request the interperiodic screening.

An interperiodic screening should only be provided if the enrollee has received an age-appropriate medical screening. If the medical screening has not been performed, then the provider should perform an age-appropriate medical screening.

An interperiodic screening includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education and other age-appropriate procedures.

An interperiodic screening may be performed and billed for a required Head Start physical or school sports physical, but must include all of the components required in the periodic screening.

Documentation must indicate that all components of the screening were completed. Medically necessary laboratory, radiology, or other procedures may also be performed and must be billed separately. A well diagnosis is not required.

Diagnosis and Treatment

Screening services are performed to assure that health problems are found, diagnosed, and treated early before becoming more serious and treatment more costly. Providers are responsible for identifying any general suspected conditions and reporting the presence, nature, and status of the suspected conditions.

AmeriHealth Caritas Louisiana must ensure that a screening visit includes all required components and all components of the screening are documented.

AmeriHealth Caritas Louisiana's policy shall include the following diagnosis and treatment guidelines. The MCO shall ensure that these guidelines are followed by its providers.

Diagnosis

When a screening indicates the need for further diagnosis or evaluation of a child's health, the child must receive a complete diagnostic evaluation within 60 days of the screening or sooner as medically necessary.

It is the responsibility of the provider to coordinate and make any necessary referrals of the enrollee to a specialist.

Initial Treatment

Medically necessary health care, initial treatment, or other measures needed to correct or ameliorate physical or mental illnesses or conditions discovered in a medical, vision, or hearing screening must be initiated within 60 days of the screening or sooner if medically necessary.

Providing or Referring Enrollees for Service

Providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the enrollee for care without delay. Providers who perform the diagnostic and/or initial treatment services should do so at the screening appointment when possible, but must ensure that enrollees receive the necessary services within 60 days of the screening or sooner if medically necessary.

Providers who refer the enrollee for care must make the necessary referrals at the time of screening. This information must be maintained in the enrollee's record.

It is the responsibility of the provider to coordinate and make any necessary referrals of the enrollees to a specialist.

EPSDT Covered Services

The following services are covered under the EPSDT Program:

- Comprehensive screens according to a predetermined periodicity schedule (found in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com):
    - Children ages birth through 30 months should have screening visits at the following intervals: by 1 month, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months
    - Children and adolescents ages 3 years to 21 years of age are eligible for annual screens.
- After completion of a screen, members are entitled to all services included in the approved Medicaid State Plan for diagnosing and treating a discovered condition. Such services may include:
    - Eye Care
    - Hearing Care, including hearing aids
    - Dental Care (dental screenings are required annually for all children aged 3 years and older as part of a complete EPSDT screen)

In addition, AmeriHealth Caritas Louisiana will pay for routine health assessments, diagnostic procedures, and treatment services provided by network providers and clinics, as well as vision and hearing services, and dental care, AmeriHealth

Caritas Louisiana complies with the relevant OBRA provisions regarding EPSDT by implementing the following:

- Health education is a required component of each screening service. Health education and counseling to parent (or guardian) and children is designed to assist in understanding what to expect in terms of the child's physical and cognitive development. It is also designed to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention.
- Screening services are covered at intervals recommended by the Academy of Pediatrics and the American Dental Association. An initial screening examination may be requested at any time, without regard to whether the member's age coincides with the established periodicity schedule.
- Payment will be made for Medically Necessary diagnostic or treatment services needed to correct or ameliorate illnesses or conditions discovered by the screening services, whether or not such diagnostic or treatment services are covered under the State Medicaid Plan and provided that it is covered under Title XIX of the Social Security Act. However, network providers should be aware that any such service must be prior-authorized and that a letter of medical necessity is required.

Screening Eligibility and Required Services

For screening eligibility information and services required for a complete EPSDT screen, please consult the:

- EPSDT Program Periodicity Schedule and Coding Matrix
- Recommended Childhood Immunization Schedule

(Both schedules are available online in a printable PDF format in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.)

You may direct EPSDT program specific questions to AmeriHealth Caritas Louisiana's Provider Services Department at 1-888-922-0007 or for more information visit LDH's website at http://new.dhh.louisiana.gov/index.cfm/subhome/6

Federally Qualified Health Center (FQHC) Well-Child Visit Requirements

Upon presentation at the clinic, a full mental, physical, and dental assessment shall be performed and include a written plan for each identified problem noted in the history and physical exam. Any health problems identified must be addressed to the highest degree possible. Encounters for recipients under the age of 21 must include all the aspects of a well-child screening visit.

If the provider determines that a child must receive the well-child screening at a subsequent visit, it must properly document the reason for the bi-furcation of visits and must document which services were provided during each encounter. If an FQHC either fails to provide sufficient documentation, or if the MCO subsequently determines that the FQHC improperly unbundled the visits, the MCO may recoup funds from the FQHC in accordance with its policies and provider contracts.

Family and Medical History for EPSDT Screens

It is the responsibility of each network provider to obtain a Family and Medical History as part of the initial well-child examination.

The following are the Family and Medical History categories, which should be covered by the network provider: Family History

- Hereditary Disorders, including Sickle Cell Anemia
- Hay fever - Eczema - Asthma
- Congenital Malformation
- Malignancy - Leukemia
- Convulsions - Epilepsy
- Tuberculosis
- Neuromuscular disease
- Mental Retardation
- Mental Illness in parent requiring hospitalization
- Heart disease
- Details of the pregnancy, birth and neonatal period
- Complication of pregnancy
- Complication of labor and delivery
- Birth weight inappropriate for gestational age
- Neonatal illness
- Medical History
- Allergies, Asthma, Eczema, Hay Fever
- Diabetes
- Epilepsy or convulsions
- Exposure to tuberculosis
- Heart Disease or Rheumatic Fever
- Kidney or Bladder problems
- Neurological disorders
- Behavioral disorders
- Orthopedic problems
- Poisoning
- Accidents
- Hospitalizations/Operations
- Menstrual history
- Medication

Height

Height must be measured on every child at every well-child visit. Infants and small children should be measured in the recumbent position, and older children standing erect. The height should be recorded in the child's medical record and should be compared to a table of norms for age. The child's height percentile should be entered in the child's medical record. Further study is indicated in a child who has deviated from his/her usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th or below the 3rd percentile).

Weight

Weight must be measured on every child at every well-child visit. Infants should be weighed with no clothes on, small

children with just underwear and older children and adolescents with ordinary house clothes (no jackets or sweaters) and no shoes. The weight should be recorded in the child's medical record, and should be compared to a table of norms for age. The child's weight percentile should also be entered in the child's medical record. Further study is indicated for a child who has deviated from his usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th percentile or below the 3rd percentile).

Body Mass Index

Body Mass Index (BMI) should be calculated at every well-child visit using the below formula or one of the many online calculators, such as the one available from the National Heart Lung and Blood Institute (NHLBI) at http://www.nhlbi.nih.gov/ .

Table: Imperial BMI Formula

$$BMI = \frac{(\text{weight in pounds} \times 703)}{\text{height in inches}^2}$$

Head Circumference

Head circumference should be measured at every well-child visit on infants and children up to the age of two years. Measurement may be done with cloth, steel or disposable paper tapes. The tape is applied around the head from the supraorbital ridges anteriorly, to the point of posteriorly giving the maximum circumference (usually the external occipital protuberance). Further study is indicated for the same situations described in height and weight, and findings should be recorded in the child's medical record.

Blood Pressure

Blood pressure must be done at every visit for all children older than the age of three (3) years, and must be done with an appropriate-sized pediatric cuff. It may also be done under the age of three years when deemed appropriate by the attending network provider. Findings should be recorded in the child's medical record.

Dental Screening

Per the American Academy of Pediatric Dentistry, the first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. Repeat every 6 months or as indicated by the child‘s risk status/susceptibility to disease. All children ages 3 and above must be referred for an annual dental exam as part of each EPSDT Screening. Providers should check for the following and initiate treatment or refer as necessary:

- Cavities
- Missing Permanent Teeth
- Fillings present
- Oral infection
- Other Oral Concerns

In completing a dental exam for all children age 3 and above, providers should advise the child's parent or guardian that the dental exam is required according to the periodicity schedule. The provider should then contact AmeriHealth Caritas Louisiana Member Services at 1-888-756-0004 while the member is in the office, or within four (4) business days to notify them that the child is due for a dental referral as part of a complete EPSDT screen. AmeriHealth Caritas Louisiana Member Services will then coordinate with the member and their family and LDH to locate a participating dentist and arrange an appointment for an exam for the child.

Documentation of the dental referral should be recorded in the child's medical record and the EPSDT Referral Code YD should be entered in field 10d on the CMS-1500 claim form or field 37 on the UB-04 form.

Dental Treatment

Fluoride Varnish Application

Fluoride varnish applications are covered when provided in a physician office setting (including RHCs and FQHCs) once every six months for enrollees six months through five years of age. Providers eligible for reimbursement of this service include physicians, physician assistants, and nurse practitioners who have reviewed the Smiles for Life fluoride varnish training module [link] and successfully completed the post assessment. Physicians are responsible to provide and document training to their participating staff to ensure competency in fluoride varnish applications.

Fluoride varnish applications may only be applied by the following disciplines:

- Appropriate dental providers;
- Physicians;
- Physician assistants;
- Nurse practitioners;
- Registered nurses;
- Advanced practice registered nurses;
- Licensed practical nurses; or
- Certified Medical Assistants.

Vision Testing

The chart should be affixed to a light-colored wall, with adequate lighting (10-30 foot candles) and no shadows. Ordinary room lighting usually does not provide this much light and the chart will need a light of its own. The 20-foot line on the chart should be set at approximately the level of the eyes of a six (6) year old. Placement of the child must be exactly at 20-feet. Sites that do not have a 20-foot distance at which to test should obtain a 10-foot Snellen chart rather than convert to the 20-foot chart. The eye not being tested must be covered with an opaque occluder; several commercial varieties are available at minimal cost, or the network provider may improvise one. The hand may not be used, as it leads to inaccuracies. In older children who seem to have difficulty or in young children, bring the child up to the chart (preferably before testing), explain the procedure and be sure the child understands.

For screening, the tester should start with the big E (20-foot line) and then proceed down rapidly line-by-line, as long as the child reads one letter per line, until the child cannot read. At this critical level, the child is tested on every letter on

that line or adjacent line. Passing is reading a majority of letters in a line. It is not necessary to test for every letter on the chart. Tests for hyperopia may be done but are not required.

Referral Standards

Children seven (7) years of age and older should be referred if vision in either eye is 20/30 or worse. Those six (6) and younger should be referred if vision in either eye is 20/40 or worse. A child may be referred if parental complaints warrant or if the doctor discovers a medical reason. (Generally, sitting close to television, without other complaints and with normal acuity, is not a reason for referral.) Children failing a test for hyperopia may be referred.

Children already wearing glasses should be tested with their glasses. If they pass, record measurement and nothing further need be done. If they fail, refer for re-evaluation to an AmeriHealth Caritas Louisiana participating Specialist, preferably to the vision provider who prescribed the lenses, regardless of when they were prescribed.

If the network provider is unable to render an eye examination, in a child nine (9) years of age or older, because of the child's inability to read the chart or follow directions (e.g., a child with Mental Retardation), please refer this child to a participating Ophthalmologist.

Hearing Screening

Hearing Screening must be administered to every child 3 years of age and older.

Tuning forks and uncalibrated noisemakers are not acceptable for hearing testing. For children younger than five (5) years of age, observation should be made of the child's reactions to noises and to voices, unless the child is sufficiently cooperative to actually do the audiometry. For audiometry, explain the procedure to the child. For small children, present it as a game. Present one tone loud enough for the child to hear, and explain that when it is heard, the child should raise his/her hand and keep it raised until the sound disappears. Once the child understands, proceed to the test. Doing one ear at a time, set the decibel level at 25, and testing at 500 HZ. Then go successively to 1000, 2000, 4000 and 6000. Repeat for the other ear. The quietest room at the site should be used for testing hearing.

Referral Standards

Any cooperative child failing sweep audiometry at any two frequencies should be referred to an otorhinolaryngologist or audiologist. If a child fails one tone, retest that tone with threshold audiometry to be certain it is not a severe single loss. To be certain of the need for referral, the network provider should immediately retest all failed tones by threshold audiometry, or, if there is question about the child's cooperation or ability at the time of testing, bring the child back for another sweep audiometry before referring. Please remember that audiometers should be periodically (at least yearly) calibrated for accuracy.

Development/Behavior Appraisal

Since children with slow development and abnormal behavior may be able to be successfully treated if treatment is begun early, it is important to identify these problems as early as possible. Questions must be included in the history that relate to behavior and social activity as well as development. Close observation is also needed during the entire visit for clues to deviations in those areas. The completion of a structured developmental screen is required for ages 9 –11 months, 18 months and 30 months. Use procedure code 96110 to report the completion of this screen.

Younger than five (5) years of age

In addition to history and observation, some sort of developmental evaluation should be done. In children who are regular patients of the network provider site, this may consist of on-going recording, in the child's chart, of development milestones sufficient to make a judgment on developmental progress. In the absence of this, the site may elect to do a Denver Developmental Test as its evaluation.

- Marked slowness in any area should be cause for a referral to a participating Specialist, e.g., developmental center, a MH/MR agency, a development Specialist, a pediatric neurologist or a psychologist. If only moderate deficiencies in one or more areas are found, the child should be re-tested in 30-60 days by the network provider
- Social Activity/Behavior - Questions should be asked to determine how the child relates to his family and peers and whether any noticeable deviation in any of his/her behavior exists. The network provider should observe for similar behavior in the office
- Speech Development - Attention should be paid to the child's speech pattern to see whether it is appropriate for age. The DASE test may be used as an evaluation

For information on the Early Intervention System, please refer to the "Special Needs and Case Management" section of this *Provider Manual*.

Five (5) years of age and older

Since the usual developmental tests are not valid at this age, observation and history must be used to determine the child's normality in the areas listed below. Each child should be checked and recorded appropriately. Major difficulty in any one area, or minor difficulty in two or more areas, should be cause for referral to a participating mental health professional for further diagnosis.

- Social Activity/Behavior - Does the child relate with family and peers appropriately?
- School - Is the child's grade level appropriate for his/her age? Has the child been held back in school?
- Peer Relationships
- Physical/Athletic Dexterity
- Sexual Maturation -Tanner Score
- Speech - DASE Test if there is a problem in this area record accordingly, refer appropriately

Autism Screening

A structured autism screen is required at ages 18 months and 24 months. Use procedure code 96110, and modifier U1 to report the completion of this screen.

Applied Behavioral Analysis (ABA): ABA-based services are available to Medicaid recipients under 21 years of age who[WR10][WR11]:

- Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (e.g., aggression, self-injury, elopement, etc.);
- Have been diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder, by a qualified health care professional;
- Had a comprehensive diagnostic evaluation by a qualified health care professional; and
- Have a prescription for ABA-based therapy services ordered by a qualified health care professional.

NOTE: All of the above criteria must be met to receive ABA-based services

Anemia Screening

Initial measurement of hemoglobin or hematocrit is recommended between 9 and 11 months of age, and required by the 12-month screen. After this, a hematocrit should only be performed if indicated by risk assessment and/or symptoms. All premature or low-birth weight infants should have hemoglobin or hematocrit done on their first well- visit and then repeated according to the schedule above. The results of the test should be entered in the child's medical record.

Diagnosis of anemia should be based on the doctor's evaluation of the child and the blood test. It is strongly suggested that a child with 10 grams of hemoglobin or less (or a hematocrit of 30% or less) be further evaluated for anemia. However, even though 10 grams may represent the lower limit of norm for most of childhood, it should be realized that in early infancy and adolescence these levels should be higher. For those network providers who use charts to evaluate hemoglobin/hematocrit normals, it should be emphasized that or mean hemoglobin/hematocrit for age is not the level to determine anemia, but rather two standard deviations below the mean.

Sickle Cell

Infants younger than 8 months of age with African-American, Puerto Rican, or Mediterranean parentage should have a sickle test on their first well-child visit, to determine the possibility of sickle cell disease being present. After that age, all children of African-American, Puerto Rican, or Mediterranean parentage should have a sickle test only if they exhibit symptoms of anemia or have a hemoglobin/hematocrit below the normal levels outlined above, unless they have already been tested and the results are known.

Tuberculin (TB) Test

It is the responsibility of the PCP's office to secure the results of the TB Test forty-eight to ninety-six (48-96) hours after it has been administered. TB Testing should begin at twelve (12) months, or first well-child visit thereafter, and then at two (2) year intervals, (or yearly, if high risk). Results should be entered in the child's medical record.

The American Academy of Pediatrics recommends that a child at high risk for TB exposure should be tested for tuberculosis annually, using the Mantoux test.

High risk is identified as:

- Contacts with adults with infectious tuberculosis

- Those that are from, or have parents from, regions of the world with high prevalence of tuberculosis
- Those with abnormalities on chest roentgenogram suggestive of tuberculosis
- Those with clinical evidence of tuberculosis
- HIV seropositive persons
- Those with immunosuppressive conditions
- Those with other medical risk factors: Hodgkin's disease, lymphoma, diabetes mellitus, chronic renal failure, malnutrition
- Incarcerated adolescents
- Children frequently exposed to the following adults: HIV infected individuals, homeless persons, users of intravenous and other street drugs, poor and medically indigent city dwellers, residents of nursing homes, migrant farm workers

Children with no risk factors who live where TB is not common do not need TB tests. Children at high risk (see list above) should be tested every year.

Children who live in places where TB is common or whose risk is uncertain should receive Mantoux tests at 1, 4, 6 and 16 years of age at least.

Albumin and Sugar

Tests for urinary albumin and sugar should be done on every child at every well-visit. Dip sticks are acceptable. Positive tests should be suitably followed up or referred for further care. A 1+ albumin (or trace) with no symptoms need not be referred, as it is not an unusual finding.

Cholesterol Screening

Cholesterol (Dyslipidemia) screening is a required component at 18 years of age; if not completed at the 18 year screening it must be done at either the 19 or 20 year screening.

Lead Level Screening

The incidence of asymptomatic Undue Lead Absorption in children six (6) months to six (6) years of age is much higher than generally anticipated. The Centers for Medicare and Medicaid Services (CMS) and Louisiana have stringent requirements for Lead Toxicity Screening for all Medicaid eligible children.

- All Medicaid eligible children are considered at risk for lead toxicity and MUST receive blood lead level screening tests for lead poisoning. This service is covered for PCP's when Louisiana guidelines, as appropriate, are followed;

PCPs are required (regardless of responses to the lead screening questions) to ensure that children receive a blood lead level screening test by their 2nd birthday or at any time between their 3rd through sixth birthday, if they have not been tested previously. Risk questions should be asked at every visit thereafter.

Our representatives are available to you for any questions regarding this problem, its screening details, its diagnosis or its follow-up by calling the EPSDT Outreach Program at 1-888-922-0007.

Gonorrhea, VDRL, Chlamydia and Pap Smear

These tests are to be performed when, in the judgment of the PCP, they are appropriate. Adolescents should be questioned about sexual activity and given assistance, diagnosis, treatment or information as the situation requires. Adolescents who are sexually active should be tested for Chlamydia.

Bacteriuria

Tests for bacteriuria must be done on any child who has symptoms relating to possible urinary tract involvement. At every screen the simple Nitrate Test by dip stick is acceptable for bacteriuria testing. Although it is best done on a first morning specimen, it may be done on a random specimen. A single dipstick is available to test for albumin, sugar, and bacteria.

Immunizations

Both State and Federal regulations request that immunizations be brought up to date during health screenings and any other visits the child makes to the office. The importance of assessing the correct immunization status cannot be overly stressed. In all instances, the network provider's records should show as much immunization history as can be elicited, especially the date of all previous immunizations. This will provide the necessary basis for further visits and immunizations.

The American Academy of Pediatrics (AAP) recommended immunization schedule is available online in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

AmeriHealth Caritas Louisiana will reimburse for vaccines not provided under other programs or vaccines administered to members over the age of 18.

Personal Care Services EPSDT

AmeriHealth Caritas Louisiana is responsible for Personal Care Services for children under 21 years of age. Recipients are eligible when physical limitations due to illness or injury require assistance with personal care. These services do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. All criteria and guidelines will be closely followed as outlined in the Louisiana Medicaid Personal Care Services Manual. All personal care services will require prior authorization before the services can be rendered. Please call the Utilization Management Department at 1-888-913-0350.

Preventive Services for Adults

AmeriHealth Caritas Louisiana covers preventive medicine services for adults, aged 21 years and older. This is limited to one preventive medicine service per member per calendar year.

The policy for preventive services shall include the following:

- Providers are to use the appropriate Preventive Medicine Services "New Patient" or "Established Patient" Current Procedural Terminology (CPT) code based on the age of the enrollee when submitting claims for the services.

- The information gathered during the preventive medicine visit is to be forwarded to any requesting provider in order to communicate findings and prevent duplicative services.

- Preventive medicine services CPT codes are comprehensive in nature and should reflect age and gender specific services. Separately reported screening procedures performed by the physician, or referrals for those services, must be based on nationally recognized standards of care/best practices (e.g., screening mammography, prostate cancer screening, etc.).

- The medical record documentation must include, but is not limited to:

    - Physical examination;
    - Medical and social history review;
    - Counseling/anticipatory guidance/risk factor reduction intervention; and
    - Screening test(s) and results.

In addition, one preventive gynecological examination per calendar year is covered for members aged 21 and over when performed by a primary care provider or gynecologist. This is to allow members to receive the necessary primary care and gynecological components of their annual preventive screening visits. The visit must include:

- Examination;
- Sexually Transmitted Infection (STI) screening and counseling;
- Breast and pelvic examination;
- Pap smear, if appropriate; and
- Contraceptive methods and counseling, as age appropriate.

If an abnormality or pre-existing problem is encountered and treatment is significant enough to require additional work to perform the key components of a problem oriented Evaluation and Management (E/M) service on the same date of service by the provider performing the preventive medicine service visit, any additional office visit of a higher level than CPT code 99212 is not covered.

Screening Mammography

AmeriHealth Caritas Louisiana covers one screening mammogram (either film or digital) per calendar year for females at least 40 years of age. Providers must perform the most clinically appropriate method (film or digital) specific to the member.

Podiatry Services

AmeriHealth Caritas Louisiana members are eligible for all Medically Necessary podiatry services, including x-rays, from a podiatrist in the Network. It is recommended that the PCP use discretion in referring members for routine care such as nail clippings and callus removal, taking into consideration the member's current medical condition and the medical necessity of the podiatric services. Podiatry Services/Orthotics

Network providers may dispense any Medically Necessary orthotic device compensable under the Medicaid health plan upon receiving Prior Authorization from the AmeriHealth Caritas Louisiana's Utilization Management Department at 1-1-888-913-0350. Questions regarding an item should be directed to the Provider Services Department at 1-888-922-0007.

Preventable Serious Adverse Events Payment Policy

This sets forth AmeriHealth Caritas Louisiana's payment policy regarding Preventable Serious Adverse Events. It is AmeriHealth Caritas Louisiana's policy to deny payment for Preventable Serious Adverse Events (PSAEs) that occur during an inpatient admission.

Definitions

AmeriHealth Caritas Louisiana has adopted the following definitions:

- Preventable. Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.
- Serious. Describes an event that results in death or loss of a body part, disability or loss of bodily function lasting more than seven (7) days or still present at the time of discharge from an inpatient facility; or when referring to other than an Adverse Event, an Event the occurrence of which is not trivial.
- Adverse. A negative consequence of care that results in unintended injury or illness, which may or may not have been Preventable.
- Event. Means a discrete, auditable, and clearly defined occurrence.

Case Identification

The following processes will be followed to identify cases warranting further review to determine whether a PSAE has occurred:

- Case Review; Outlier and Quality Review. Serious Adverse Events may be identified by AmeriHealth Caritas Louisiana through case review, outlier and quality reviews and other claims reviews by our utilization management and quality management staff, to determine whether the Event constituted a PSAE. The National Quality Forum's (NQFs) Serious Reportable Events in Health Care is a list of never events that would trigger such a review; this list has been adapted and is available online at www.amerihealthcaritasla.com.

- Claims Review. Claims with one or more of the identified codes listed in Preventable Serious Adverse Event Screening Codes (ICD-9/10 and E Codes), not present at the time of admission, but appearing on the claim at discharge, will be flagged for review. A list of these codes, called "Preventable Serious Adverse Event Screening Codes" is available online at www.amerihealthcaritasla.com. If a claim is flagged for review, the member's entire inpatient medical record, as appropriate, will be requested.

    - In order to make a payment determination concerning the PSAE, AmeriHealth Caritas Louisiana must receive the medical record within thirty (30) days of the request. AmeriHealth Caritas Louisiana may deny the claim, or recover any payment already made on the claim, for failure to

submit records within the requested timeframe.

- Upon receipt of the complete medical record, AmeriHealth Caritas Louisiana will conduct a medical review in conjunction with the submitted claim, to ensure that payment is made only for services unrelated to the PSAE and that payment, if necessary, is adjusted.
- If the record substantiates that the payment conditions outlined below have been met, provider payment will be denied or adjusted accordingly.
- AmeriHealth Caritas Louisiana will provide a written notice of its decision as to whether or not a Preventable Event has occurred and whether other payment conditions have been met so as to warrant a denial or adjustment of payment. The notice will provide the reason(s) for the decision and will outline the hospital's appeal rights and instructions for requesting a Formal Provider Appeal.

These are among the primary means that AmeriHealth Caritas Louisiana will use to identify possible PSAEs; however, they are not the only means, and the diagnosis codes and events are not intended to be exclusive or exhaustive lists.

Payment Conditions

AmeriHealth Caritas Louisiana will recover, reduce or deny payment to acute care hospitals if the following criteria are met:

- The Event is Preventable.
- The Event is within control of the hospital. The hospital has policies and procedures in place to assure appropriate patient treatment and safety based on nationally accepted standards of care (e.g., JCAHO, NQF, AOA, CMS), but the Event represents a break in the hospital's policies or procedures.
- The Event must occur during an inpatient hospital admission.
- The Event must be Serious.
- AmeriHealth Caritas Louisiana will recover, reduce or deny payment only for the care made necessary by the PSAE. To ensure appropriate payment, please do the following:
  - If a condition described as a never event (please refer to the NQF Serious Reportable Events in Health Care – available online at www.amerihealthcaritasla.com) leads to a hospitalization, the hospital should include the Present on Admission‖ (POA) indicator on the claim submitted for payment.
  - When submitting a claim that includes treatment as a result of a PSAE, hospitals are to include the appropriate ICD-9/10 diagnosis codes, including applicable external cause of injury or E codes on the claim. .
  - If during an acute care hospitalization, a PSAE causes the death of a patient, the claim should reflect the Patient Status Code 20 Expired.

Rehabilitation

If a member requires extended care in a non-hospital facility for rehabilitation purposes, AmeriHealth Caritas Louisiana's Utilization Management Department will provide assistance by coordinating the appropriate placement, thus ensuring receipt of Medically Necessary Care. Prior Authorization is required prior to the members transfer. Concurrent Review will follow the initial authorization. The Utilization Management Department can be reached at 1-1-888-913-0350.

Vision Care

AmeriHealth Caritas Louisiana's routine vision benefit for children and enhanced benefit for adults is administered through Avesis~~Vision Service Plan (VSP)~~. Inquiries regarding routine eye care and eyewear should be directed to the ~~Vision Provider Relations Department~~ Avesis at 1-833-311-2252~~800-877-7195 or you may want to visit the website at www.VSP.com.~~ Practitioners who are not part of the vision Network can call ~~VSP's Professional Affairs Department~~Avesis ~~at 1-800-615-1883~~ for general inquiries. Medical treatment of eye disease is covered directly by AmeriHealth Caritas Louisiana. These inquiries should be directed to AmeriHealth Caritas Louisiana's Provider Services Department at 1--888-922-0007.

Corrective Lenses for Children (Younger Than 21 Years of Age):

Members younger than 21 years of age are eligible for routine eye examinations once every calendar year, or more often if medically necessary. No referrals are needed for routine eye exams. Members are also eligible to receive two pairs of prescription eyeglasses, every 12 months, or more often if medically necessary. Members younger than 21 years of age are also eligible to get prescription contact lenses.

If the prescription eyeglasses are lost, stolen or broken, AmeriHealth Caritas Louisiana will pay for them to be replaced, if approved. Please contact Avesis~~VSP's Provider Relations Department~~ at 1-833-311-2252~~800-877-7195~~ to obtain an approval. Lost, stolen or broken prescription contact lenses will be replaced with prescription eyeglasses.

- Members may choose from two select groups of eyeglass frames at no charge; or
- They may choose from a select group of premier eyeglass frames for a co-payment of $25.00; or
- They may choose eyeglass frames that are not part of the select groups and AmeriHealth Caritas Louisiana will pay a portion of the cost, up to $40.00, whichever is less.
- If prescription contact lenses are chosen, AmeriHealth Caritas Louisiana will pay for the cost of the prescription lenses or $75.00, whichever is less.

Eye Care Benefits for Adults (21 Years of Age and Older):

- Routine eye exams are covered once per year. No referral is needed for the first routine eye exam. AmeriHealth Caritas Louisiana will offer a $100 allowance toward the purchase of eyeglasses (frame and lenses) or contact lenses every 24 months. There are no other adult optician/eyewear benefits.

Substitute Physician Billing

AmeriHealth Caritas Louisiana allows both the reciprocal billing arrangement and the locum tenens arrangement when providers utilize substitute physician services.

Reciprocal Billing Arrangement

A reciprocal billing arrangement occurs when a regular physician or group has a substitute physician provide covered services to a Medicaid member on an occasional reciprocal basis. A physician can have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

The member's regular physician may submit the claim and receive payment for covered services which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if:

- The regular physician is unavailable to provide the services.
- The substitute physician does not provide the services to Medicaid enrollees over a continuous period of longer than 60 days.

NOTE: A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid members of the regular physician, and ends with the last day on which the substitute physician provides these services to the members before the regular physician returns to work. This period continues without interruption on days on which no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work. If the regular physician does not come back after the 60 days, the substitute physician must bill for the services under his/her own Medicaid provider number.

- The regular physician identifies the services as substitute physician services by entering the Healthcare Common Procedure Coding System (HCPCS) modifier - Q5 after the procedure code on the claim. By entering the -Q5 modifier, the regular physician (or billing group) is certifying that the services billed are covered services furnished by the substitute physician for which the regular physician is entitled to submit Medicaid claims.
- The regular physician must keep on file a record of each service provided by the substitute physician and make the record available to Louisiana Medicaid or its representatives upon request.

This situation **does not apply** to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the service must be identified.

Locum Tenens Arrangement

A locum tenens arrangement occurs when a substitute physician is retained to take over a regular physician's professional practice for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician generally has no practice of his/her own. The regular physician usually pays the substitute physician a fixed amount per diem, with the substitute physician being an independent contractor rather than an employee.

The regular physician can submit a claim and receive payment for covered services of a locum tenens physician who is not an employee of the regular physician if:

- The regular physician is unavailable to provide the services.
- The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis.

- The substitute physician does not provide the services to Medicaid enrollees over a continuous period of longer than 60 days.

NOTE: A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid members of the regular physician, and ends with the last day on which the substitute physician provides these services to the members before the regular physician returns to work. This period continues without interruption on days on which no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work. If the regular physician does not come back after the 60 days, a new 60-day period can begin with a different locum tenens doctor.

- The regular physician identifies the services as substitute physician services by entering HCPCS modifier -Q6 after the procedure code on the claim.

- The regular physician must keep on file a record of each service provided by the substitute physician and make the record available to AmeriHealth Caritas Louisiana or its representatives upon request.

Telemedicine

Telemedicine: The use of medical information exchanges from one site to another via electronic communications to improve an member's health.

Electronic communications: The use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the member at the originating site, and the physician or practitioner at the distant site.

Distant site: The site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

Originating site: The location of the member at the time the services being furnished via a telecommunications system occurs.

AmeriHealth Caritas Louisiana only covers services that are provided by the distant site provider for services provided via telemedicine.

NOTE: The distant site provider must be enrolled as an AmeriHealth Caritas Louisiana provider to receive reimbursement for covered services rendered to members.

The member's clinical record at both the originating and distant sites must reflect that the service was provided through the use of telemedicine.

Therapy Services

AmeriHealth Caritas Louisiana covers audiological services, speech and language therapy, physical therapy, and occupational therapy services to enrollees of any age and without restrictions to place of service.

Vagus Nerve Stimulators (VNS)

AmeriHealth Caritas Louisiana covers implantation of the vagus nerve stimulator (VNS) when the treatment is considered medically necessary, the enrollee meets the published criteria, and the enrollee has a diagnosis of medically intractable epilepsy.

Criteria for VNS

The following criteria shall be used to determine medical necessity of the VNS:

- Partial epilepsy confirmed and classified according to the International League Against Epilepsy (ILAE) classification. The member may also have associated generalized seizures, such as tonic, tonic-clonic, or atonic. The VNS may have efficacy in primary generalized epilepsy as well;
- Age 12 years or older, although case by case consideration may be given to younger children who meet all other criteria and have sufficient body mass to support the implanted system;
- Seizures refractory to medical anti-epilepsy treatment, with adequately documented trials of appropriate standard and newer anti-epilepsy drugs or documentation of member's inability to tolerate these medications;
- Member has undergone surgical evaluation and is considered not to be an optimal candidate for epilepsy surgery;
- Member is experiencing at least four to six identifiable partial onset seizures each month. Member must have had a diagnosis of intractable epilepsy for at least two years. The two-year period may be waived if waiting would be seriously harmful to the member to six identifiable partial onset seizures each month. Member must have had a diagnosis of intractable epilepsy for at least two years. The two-year period may be waived if waiting would be seriously harmful to the member;
- Member must have undergone quality of life (QOL) measurements. The choice of instruments used for the QOL measurements must assess quantifiable measures of daily life in addition to the occurrence of seizures; and
- In the expert opinion of the treating physician, there must be reason to believe that QOL will improve as a result of implantation of the VNS. This improvement should occur in addition to the benefit of seizure frequency reduction. The treating physician must document this opinion clearly.

Exclusion Criteria for VNS

Regardless of the criteria for member selection, VNS implantation is not covered if the member has one or more of the following criteria:

- Psychogenic seizures or other non-epileptic seizures;
- Insufficient body mass to support the implanted system;
- Systemic or localized infections that could infect the implanted system; or
- A progressive disorder contraindicated to VNS implantation (e.g., malignant brain neoplasm, Rasmussen's encephalitis, Landau-Kleffner syndrome and progressive metabolic and degenerative disorders).

Place of Service Restriction for VNS

AmeriHealth Caritas Louisiana restricts coverage of the surgery to implant the VNS to an outpatient hospital, unless medically contraindicated.

VNS Coverage Requirements

Coverage for Vagus Nerve Stimulation shall include, but is not limited to, the following:

- Vagus Nerve Stimulator;
- Implantation of VNS;
- Programming of the VNS; and
- Battery replacement.

SECTION IV: PHARMACY SERVICES

Pharmacy Services

Our Pharmacy Benefit Manager, PerformRx, manages AmeriHealth Caritas Louisiana's pharmacy services. Through valid prescriptions, AmeriHealth Caritas Louisiana covers all medically necessary prescription medicines on the Louisiana Medicaid Single Preferred ~~Covered~~ Drug List. Licensed providers may prescribe a maximum 30-day supply of medically-necessary pharmaceuticals to AmeriHealth Caritas Louisiana members. AmeriHealth Caritas Louisiana also covers certain ~~over-the- counter (OTC) drugs, vaccines, and~~ diabetic supplies. A list of those ~~medications~~ supplies can be at http://www.amerihealthcaritasla.com/pdf/pharmacy/preferred-diabetic-supplies.pdf ~~http://www.amerihealthcaritasla.com/pdf/pharmacy/value-add-medications.pdf~~. For provider-administered injectable drugs, providers are reimbursed using specific HCPCS CODES, units, amounts and NDC codes. (Note: NDC Codes are required on all claims, in addition to specific HCPCS Codes). These drugs are reimbursed at the Louisiana Medicaid fee schedule amounts. A listing of those provider-administered medications that are not listed on the fee schedule, but are payable and require prior authorization is located at http://www.amerihealthcaritasla.com/pdf/provider/resources/priorauth/hcpcs-codes-requiring-authorization.pdf. If the provider-administered drug is not on the Louisiana Medicaid fee schedule, but is covered by AmeriHealth Caritas Louisiana, then reimbursement is set at the current Louisiana Medicaid reimbursement methodology outlined in the State Plan. More information on pharmacy services and formulary can be found at http://www.amerihealthcaritasla.com/pharmacy/index.aspx. Direct all questions related to pharmacy services, including those about claims and prior authorizations, to PerformRx Provider Services at 1-800-684-5502 or fax to 1-855-452-9131.

Preferred Drug List

AmeriHealth Caritas Louisiana maintains a Preferred Drug List (PDL) established by the Louisiana Department of Health (LDH). The PDL indicates the preferred and non-preferred status of covered drugs. All non-preferred medications will require prior authorization. AmeriHealth Caritas Louisiana utilizes LDH's prior authorization criteria. Please visit the website for a complete list of preferred products at http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf.

Direct requests for prior authorization medications to AmeriHealth Caritas Louisiana /PerformRx Pharmacy Services at 1-800-684-5502 or fax to 1-855-452-9131.

NOTE: Experimental drugs, procedures or equipment not approved by Medicaid are excluded.

Coverage of Brand Name Products

There shall be a mandatory generic substitution for all drugs when there are "A"-rated, therapeutically equivalent, less costly generics available. Unless the brand is justified with applicable DAW codes or the brand is preferred, prior authorization is required for brand name products. Prescribers who wish to prescribe brand name products must furnish documentation of generic treatment failure prior to dispensing. The treatment failure must be directly attributed to the patient's use of a generic form of the brand name product.

Please refer to the formulary posted on AmeriHealth Caritas Louisiana website at http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf.

Pharmacy Prior Authorization

In a continuing effort to improve patient care and pharmaceutical utilization, AmeriHealth Caritas Louisiana, in conjunction with PerformRx, has implemented a prior authorization (PA) program for ~~the initial prescription of~~ certain medications. AmeriHealth Caritas Louisiana utilizes the LDH prior authorization criteria for determining the medical necessity of a medication. Requests for PA medications should be directed to PerformRx at 1-800-684-5502 or faxed to 1-855-452-9131. Providers may also submit Prior Authorization requests using the Online PA request form at http://www.amerihealthcaritasla.com/pharmacy/priorauth.aspx.

In most cases where the prescribing health care professional/provider has not obtained prior authorization, members will receive a three-day supply of the medication and Perform Rx may make a request for clinical information to the prescriber. All clinical information requests must be completed within three days from initial request.

In the instances when a member is receiving a prescription medication that is removed from the PDL and will now require a prior authorization, both the provider and member will be notified. The member will be allowed to continue on that prescription medication for at least 60 days in which time a prior authorization must be submitted for the member to continue beyond that timeframe. Also, if a member is discharged from a psychiatric facility or residential substance use facility, and AmeriHealth Caritas Louisiana is notified of the behavioral health discharge medications, then prior authorization restrictions will be overridden for a ninety (90) day period. This includes, but is not limited to, naloxone, Suboxone, and long-acting injectable anti-psychotics.

To obtain the statewide universal prior authorization request form, go to AmeriHealth Caritas Louisiana pharmacy~~'s~~ website at ~~—~~http://www.amerihealthcaritasla.com/pharmacy/priorauth.aspx~~http://www.amerihealthcaritasla.com~~. Prescribers may request copies of the criteria used to make the Prior Authorization determination by contacting PerformRx at 1-800-684-5502.

Appeal of Prior Authorization Denials for Pharmacy

The prescriber or the PCP, with the member's written consent, may ask for reevaluation on any denied prior authorization request or suggested alternative by contacting AmeriHealth Caritas Louisiana's Appeals verbally or in writing at:

AmeriHealth Caritas Louisiana
Attn: Member Appeals
P.O. Box 7328
London, KY 40742

Continuity of Care (Transition Supply)

AmeriHealth Caritas Louisiana will provide coverage of prescriptions taken on a regular basis for chronic conditions (maintenance medicines) that are not on the PDL for at least 60 days after the member's transition from the fee-for-service pharmacy program or another Managed Care Organization. AmeriHealth Caritas Louisiana will provide supplies of antidepressant and antipsychotic medicines for at least 90 days after the transition.

Prescription Co-payments

Some adult members (21 years of age or older) are subject to a sliding copay per prescription. The following table shows the co-payment amounts:

$0.50	$10.00 or less

$1.00	$10.01 to $25.00
$2.00	$25.01 to $50.00
$3.00	$50.01 or more

Copayments do not apply to the following members

- Less than 21 years of age
- Pregnant
- Receiving emergency services
- Residing in long-term care facilities or other institutions
- Federally-recognized as Native Americans or Alaskan Eskimos
- Members of a Home and Community Based Waiver
- Women whose basis of Medicaid Eligibility is Breast or Cervical Cancer
- Members receiving hospice services

Members must pick up medications at a pharmacy that is within AmeriHealth Caritas Louisiana network. A list of participating pharmacies may be found online at http://www.amerihealthcaritasla.com/pharmacy/index.aspx.

SECTION V: AUTHORIZATION REQUIREMENTS

Authorization and Eligibility

Due to possible interruptions of a member's State Medicaid coverage, it is strongly recommended that Providers call for verification of a member's continued eligibility on the 1st of each month when a Prior Authorization extends beyond the calendar month in which it was issued. If the need for service extends beyond the initial authorized period, the Provider must call AmeriHealth Caritas Louisiana's Utilization Management Department to obtain Prior Authorization for continuation of service.

Referrals

Referrals are not required for specialty services. However, we encourage PCPs and specialists to coordinate member care.

Out-of-Plan Services

Occasionally, a member's needs cannot be provided through the AmeriHealth Caritas Louisiana Network. When the need for "out-of-plan" services arises, the provider should contact the Utilization Management Department for Prior Authorization. Every effort will be made to locate a Specialist within easy access to the member.

If a Non-Participating Provider is prior authorized, that provider must obtain a Non-Participating Provider number in order to be reimbursed for services provided.

Prior Authorization Requirements

The most up to date list of services requiring prior authorization can be found in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

Notification Requested

Maternity Obstetrical Services (after the first visit) and outpatient care (includes 4830-Hour Observations)[KG12][BL13]

Services Requiring Prior Authorization:

The following is a list of services requiring prior authorization review for medical necessity and place of service.*

- All out of network services (except emergency room services, urgent care facilities, family planning services, EPSDT preventive routine screenings, post stabilization services, and continuity of care services for new enrollees.)
- Air ambulance
- Abortions
- In-patient services
    - All inpatient hospital admissions, including medical, surgical and rehabilitation
    - Obstetrical admissions/newborn deliveries exceeding 72 hours after vaginal delivery and 120 hours after caesarean section
    - In-patient medical detoxification
    - Elective transfers for inpatient and/or outpatient services between acute care facilities
    - Long-term care initial placement if still enrolled with the plan
- Home-based services
    - Home health care (PT, OT, ST) and skilled nursing visits (after 6 combined visits regardless of modality)
    - Private duty nursing - extended nursing services (covered when medically necessary for under age 21)
    - Personal care services (covered when medically necessary for under age 21)

  - Home health extended services
  - Home infusions and injections $250 and over
  - Enteral feedings, including related DME
- Hospice services
- HPV immunizations for members finishing the series at 46 years of age
- Therapy and related services
  - Speech therapy, occupational therapy, and physical therapy
  - Initial evaluations or re-evaluations do not require prior authorization but are limited to every 6 months. Any additional evaluations or re-evaluations outside of those parameters would require prior authorization.
  - Chiropractic care (covered for ages 0-20)
  - Cardiac Rehabilitation
- Transplants, including transplant evaluations
- All DME rentals
- Durable Medical Equipment for billed charges $750 and over,
  - Diapers/Pull-ups (ages 4 through 20) who qualify:
    - for quantities over 200 per month for diapers and/or pull-ups
    - Brand specific diapers
- Hyperbaric Oxygen
- Implants (billed charges over $750)
- Medications: Prior authorization requirements for provider-administered medications are based on the medication's HCPCS.
- Moderate sedation (ages 14-20)
- Cochlear implantation
- Gastric bypass/vertical band gastroplasty
- Surgical services that may be considered cosmetic, including
  - Blepharoplasty
  - Mastectomy for gynecomastia
  - Mastoplexy
  - Maxillofacial
  - Panniculectomy
  - Penile prosthesis
  - Plastic surgery/cosmetic dermatology
  - Reduction mammoplasty
  - Septoplasty
- Hysterectomy*
- Once per lifetime procedures that are performed a second time because of medical necessity.
- Pain management – external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation and nerve blocks.
- Radiology services**:
  - CT scan
  - MRI
  - MRA
  - Nuclear cardiac imaging
- All unlisted and miscellaneous codes

*Hysterectomies, sterilization services, and abortions require a completed Member Consent form that can be found at www.amerihealthcaritasla.com.

** Prior Authorization for, CT Scans, MRIs/MRAs and Nuclear Cardiology services are required for outpatient services

only. *Please note - the review of prior authorization requests for non-emergent, advanced, outpatient imaging services is provided by National Imaging Associates, Inc. (NIA); those requests must be directed to NIA at* 1-800-424-4897.The ordering physician is responsible for obtaining a Prior Authorization number for the study requested. Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call. (Outpatient studies ordered after normal business hours or on weekends should be conducted by the ordering facility as requested by the ordering physician. However, the ordering physician must contact UM within 48 hours or the next business day to obtain proper authorization for the studies, which will be subject to medical necessity review.) Emergency room, Urgent Care, Observation Care and inpatient imaging procedures do not require Prior Authorization.

Denied Prior Authorization requests may be appealed to the Medical Director or his/her designee. Please see "Member Grievances and Appeals in Section XI".

*For behavioral services authorization requirements, please refer to Behavioral Health Addendum.

Services that do not require prior authorization

- Emergency room services and urgent care facilities (in-network and out-of-network).
- Sterilizations (tubal ligations or vasectomies in-network).
- 48-hour Observations (in-network). All procedures (other than advanced imaging) that normally require an authorization still require an authorization if the admit to Observation was not through the emergency department.
- Dialysis services rendered at freestanding or hospital-based outpatient dialysis facilities (which would include supplies used at the facilities for the dialysis).
- Low-level plain films — X-rays, EKGs.
- Family planning services (in-network and out-of-network).
- Post stabilization services (in-network and out-of-network).
- EPDST screening services.
- Women's health care by in-network providers (OB-GYN services).
- Continuation of covered services for a new member transitioning to the plan the first 30 calendar days of continued services.
- Routine vision services.
- DME billed charges under $750 (except **custom orthotics and prosthetics** which would **require an authorization** regardless of the billed amount). The provider must be credentialed to provide DME services, except for podiatrists. For a list of DME codes that podiatrists are allowed to bill without being credentialed as a DME provider, please refer to the Claims Filing Instructions Manual Opens a new window (PDF).

Medically Necessary Services[KG14][WM15]

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:

- 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

- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.

Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed not medically necessary. The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his or her discretion on a case-by-case basis.

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective, or exception basis, must be documented in writing.

The determination is based on medical information provided by the member, the member's family/caretaker and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the member. All such determinations must be made by qualified and trained practitioners. Any decision to deny or reduce in amount, duration or scope a request for covered services will be made by clinical professionals who possess an active, unrestricted license and have the appropriate education, training, or professional experience in medical or clinical practice.

Letters of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, health care providers are required to supply supporting documentation to substantiate medical necessity when Services require prior authorization.

Supporting medical documentation should be directed to the Utilization Management staff that is managing the case of the patient in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The member's name and AmeriHealth Caritas Louisiana ID number
- The diagnosis for which the treatment or testing procedure is being sought
- The goals of the treatment or testing for which progress can be measured for the member
- Other treatment or testing methods which have been tried but have not been successful, along with the duration of the treatment
- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure, which is being requested.

Providers are advised that failure to provide medical documentation or respond to requests for medical documentation to establish medical necessity will result in the denial of Prior Authorization. Claims submitted without required authorization will be denied. AmeriHealth Caritas Louisiana considers it a Quality of Care issue if a member is in need of medically necessary services and the service is not provided because of lack of Prior Authorization when that lack of Prior Authorization is a direct result of the provider's failure to supply medical documentation. Quality of Care issues will be

referred to the Quality Management Department.

Medical Necessity Decision Making

Requests for benefit coverage or medical necessity determinations are made through staff supervised by a Registered Nurse. Decisions to approve coverage for care may be made by utilization management staff when falling within AmeriHealth Caritas Louisiana's written guidelines. Any request that is not addressed by, or does not meet, Medical Necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure or extension of stay, based on Medical Necessity, or to approve a service in an amount, duration or scope that is less than requested is made by a Medical Director or other designated practitioner under the clinical direction of the Regional Medical Director.

Medical Necessity decisions made by a Medical Director are based on the Department of Health and Hospital's definition of Medical Necessity [as defined in LAC 50:1.101 (Louisiana Register, Volume 37, Number 1)], in conjunction with the member's benefits, medical expertise, AmeriHealth Caritas Louisiana Medical Necessity guidelines, and/or published peer-review literature. At the discretion of the Medical Director, participating board-certified physicians from an appropriate specialty or other AmeriHealth Caritas Louisiana will not retroactively deny reimbursement for a covered service provided to an eligible member by a provider who relied on written or oral authorization from AmeriHealth Caritas Louisiana or an agent of AmeriHealth Caritas Louisiana, unless there was material misrepresentation or fraud in obtaining the authorization.

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

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and
- Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.
- 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 recipient requires at that specific point in time.
- Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."
- ~~AmeriHealth Caritas Louisiana shall not deny continuation higher level services for failure to meet medical necessity unless the service can be provided through an in-network or out-of-network provider for a lower level of care.~~
- AmeriHealth Caritas Louisiana shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless ACLA can provide the service through an in-network or out-of-network provider for a lower level of care.

AmeriHealth Caritas Louisiana will provide its Utilization Management (UM) criteria to network providers upon request. To obtain a copy of AmeriHealth Caritas Louisiana UM criteria:

- Call the UM Department at 1-888-913-0350
- Identify the specific criteria you are requesting
- Provide a fax number or mailing address

You will receive a faxed copy of the requested criteria within 24 hours or written copy by mail within five business days of your request.

Providers may also request prior authorization requirements used to make a medical necessity determination by sending an email to: DLACFCHB424Request@amerihealthcaritas.com. Prior authorization requirements will be furnished to the requesting provider within 24 hours of request.

Please remember that AmeriHealth Caritas Louisiana has Medical Directors and Physician Advisors who are available to address UM issues or answer your questions regarding decisions relating to Prior Authorization, DME, Home Health Care and Concurrent Review. To contact these resources call the Peer-to-Peer Hotline at: 1-866-935-0251.

Additionally, AmeriHealth Caritas Louisiana would like to remind health care providers of our affirmation statement regarding incentives:

- Utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage;
- Providers, associates or other individuals conducting utilization review are not rewarded by AmeriHealth Caritas Louisiana for issuing denials of c overage or service; and
- Financial incentives for UM decision makers do not encourage decisions that result in under- utilization.

Hours of Operation

AmeriHealth Caritas Louisiana provides and maintains a toll free number for health care providers, and members to contact AmeriHealth Caritas Louisiana's UM staff. The toll free number is 1-888-913-0350. AmeriHealth Caritas Louisiana's UM Department is available to answer calls from health care providers during normal business hours, 8:00 a.m.-5:00 pm (CST). Translation services are available as needed.

After business hours and on weekends and holidays, health care providers, practitioners and members are instructed to contact the on call clinician through the toll free number 1-888-913-0350. Callers will automatically be routed to the Member Services' department. A member services representative will assist in connecting the provider to the appropriate on call clinician.

Timeliness of UM Decisions

Several external standards guide AmeriHealth Caritas Louisiana's timelines for UM decisions and notifications. These include NCQA, Local requirements and accompanying regulations, and other applicable state and federal laws and regulations. When standards conflict, AmeriHealth Caritas Louisiana adopts the more rigorous of the standards. The table below identifies AmeriHealth Caritas Louisiana's timeliness standards.

Table: Timeliness Of UM Decisions

Case Type	Decision	Initial Notification	Written Confirmation

Urgent Prior Authorization	As expeditiously as the member's health requires, no later than 72 hours from receipt of the request	As expeditiously as the member's health requires, no later than 72 hours from receipt of the request	Within the earlier of 2 business days from the decision or 72 hours of the request
Non-Urgent Prior Authorization	Within 2 business days of receiving the necessary information or 14 calendar days from receipt of the request	As expeditiously as the member's health requires, no later than 1 business day of making the decision	Within the earlier of 2 business days from the decision or 14 calendar days of the request
Concurrent Review	Within 1 business day from receipt of the request	Within 1 business day from receipt of the request	Within 1 business day from receipt of the request
Retrospective Review	30 calendar days from receipt of the request; no later than 180 days from the date of service	Not Applicable	Within 30 calendar days from receipt of the request

The timeframes for decisions and notification may be extended if additional information is needed to process the request. In these instances, the member and requesting Health Care Provider are notified of the required information in writing.

Physician Reviewer Availability to Discuss Decision

If a practitioner wishes to discuss a medical necessity decision, AmeriHealth Caritas Louisiana's physician reviewers are available to discuss the decision with the practitioner. Calls to discuss the determination are accepted

- Within 3 business days of verbal notification. All requests must be completed within 1 business day of request. Up to 48 hours or the end of the second (2nd) business day after the member's discharge date, whichever is later
- Up to 48 hours or until the end of the second (2nd) business day after a determination of a retrospective review has been rendered, whichever is later.

A dedicated Peer-to - Peer reconsideration line is available for practitioners to call at 1-866-935-0251. A physician reviewer is available at any time during the business day to interface with practitioners. If a practitioner is not satisfied with the outcome of the discussion with the physician reviewer, then the practitioner may file a formal provider dispute of a Medical Necessity Decision.

Denial Reasons

All denial letters include specific reasons for the denial, the rationale for the denial, and a summary of the UM criteria. If an authorization is denied based upon an interpretation of a law, regulation, policy, procedure, or medical criteria guideline,; then the denial letter must contain instructions for accessing the criteria or include a copy. In addition, if a different level of care is approved, the clinical rationale is also provided. These letters incorporate a combination of NCQA standards and Louisiana Department of Health requirements. Denial letters are available in six languages for members with Limited English Proficiency. Letters are translated into other languages upon request. This service is available through the cooperation of Member Services and Utilization Management.

Appeal Process

All denial letters include an explanation of the member's rights to appeal and the processes for filing appeals through the AmeriHealth Caritas Louisiana Medical Necessity Appeal Process and the Fair Hearing Process. Members contact the Member Service Unit to file Grievances or Appeals; a member advocate is available to assist members as needed.

Evaluation of New Technology

When AmeriHealth Caritas Louisiana receives a request for new or emerging technology, it compiles clinical information related to the request and reviews available evidence-based research and/or technology assessment group guidelines. AmeriHealth Caritas Louisiana Medical Directors make the final determination on coverage.

SECTION VI: CLAIMS FILING GUIDELINES

Claims Filing Guidelines

This section provides a general overview of AmeriHealth Caritas Louisiana's claims filing process. More details and guidelines for claim filing are outlined in the AmeriHealth Caritas Louisiana Claims Filing Instructions which is an appendix to this handbook and available on the website at www.amerihealthcaritasla.com

Encounter

An Encounter is defined as "an interaction between an individual and the health care system." An Encounter is any health care service provided to an AmeriHealth Caritas Louisiana member. Encounters must result in the creation and submission of an Encounter record (CMS-1500 or UB-04 form or electronic submission) to AmeriHealth Caritas Louisiana. The information provided on these records represents the Encounter data that will be provided to the Louisiana Medicaid Program by AmeriHealth Caritas Louisiana.

Completion of Encounter Data

Providers must submit electronically an 837P format for professional or 837I format for institutional claims. Providers who bill hardcopy should complete and submit a CMS-1500 claim form or UB-04 claim form each time an AmeriHealth Caritas Louisiana member receives covered services. AmeriHealth Caritas Louisiana will not accept emailed claim forms with no exception. Completion of the CMS-1500 or UB-04 form or electronic claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services
- It allows AmeriHealth Caritas Louisiana to gather statistical information regarding the medical services provided to AmeriHealth Caritas Louisiana members

AmeriHealth Caritas Louisiana accepts claim submissions via paper or electronically via Electronic Data Interchange (EDI). For more information on electronic claim submission and how to become an electronic biller, please refer to the Claims Filing Instructions available in the Provider area of AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

AmeriHealth Caritas Louisiana monitors encounter data submissions for accuracy, timeliness and completeness through claims processing edits and through network provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely or incomplete information. Network providers will be notified of the rejection or denial and are expected to resubmit corrected information to:

AmeriHealth Caritas Louisiana
Claims Processing Department
P.O. Box 7322
London, KY 40742

AmeriHealth Caritas Louisiana Network providers may also be subject to sanctioning by the Louisiana Department of Health and AmeriHealth Caritas Louisiana for failure to submit accurate Encounter data in a timely manner.

Procedures for Claim Submission

AmeriHealth Caritas Louisiana is required by state and federal regulations to capture specific data regarding services

rendered to its members. All billing requirements must be adhered to by the provider for timely processing of claims.

When required data elements are missing or are invalid, claims will be **rejected** by AmeriHealth Caritas Louisiana for correction and re-submission. Rejected claims are not identified in our claims adjudication system.

Claims for billable services provided to AmeriHealth Caritas Louisiana members must be submitted by the provider who performed the services.

Claims filed with AmeriHealth Caritas Louisiana are subject to the following procedures:

1. Verification that all required fields are completed on the CMS-1500 or UB-04 forms.
2. Verification that all Diagnosis and Procedure Codes are valid for the date of service.
3. Verification of member eligibility for services under AmeriHealth Caritas Louisiana during the time period in which services were provided.
4. Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible member.
5. Verification that the provider is eligible to participate with the Medicaid Program at the time of service.
6. Verification that an authorization has been given for services that require prior authorization by AmeriHealth Caritas Louisiana.
7. Verification of whether there is any other third-party resources and, if so, verification that AmeriHealth Caritas Louisiana is the "payer of last resort" on all claims submitted to AmeriHealth Caritas Louisiana.

IMPORTANT:
Rejected claims are defined as claims with invalid or required missing data elements, such as the provider tax identification number or member ID number, that are returned to the provider or EDI* source without registration in the claim processing system.

- Rejected claims are not registered in the claim processing system and can be resubmitted as a new claim.

Denied claims are registered in the claim processing system but do not meet requirements for payment under AmeriHealth Caritas Louisiana guidelines. They should be resubmitted as a corrected claim.

- Denied claims must be re-submitted as corrected claims within 180 ~~365~~ calendar days from the date of denial~~service~~ if the error is a repairable edit. [KG16]
- Set the claim frequency code correctly and send the original claim number. These are required elements and the claim will be rejected if not coded correctly.
- The remittance advice for claims denied based upon an interpretation of a law, regulation, policy, procedure or medical criteria or guidelines contains instructions for accessing the criteria or include a copy.

Note: These requirements apply to claims submitted on paper or electronically.

* For more information on EDI, review the section titled Electronic Data Interchange (EDI) for Medical and Hospital Claims in this booklet

Claims Editing Policy

AmeriHealth Caritas Louisiana's claim payment policies, and the resulting edits, are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Louisiana Medicaid and professional medical societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common

Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may include, but are not limited to: benefit coverage, legislative mandates, provider contract terms, and/or member eligibility.

Claim Mailing Instructions

Submit claims to AmeriHealth Caritas Louisiana at the following address:

AmeriHealth Caritas Louisiana Claims Processing Department
P.O. Box 7322
London, KY 40742

AmeriHealth Caritas Louisiana encourages all providers to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or **Change Healthcare's** (formerly Emdeon) **Provider Support Line at 1-877-363-3666** to arrange transmission.

Any additional questions may be directed to the AmeriHealth Caritas Louisiana Provider Services at **1-866-428-7419**.

Claims Filing Deadlines

All claims must be submitted to AmeriHealth Caritas Louisiana within 365 calendar days from the date services were rendered or compensable items were provided.

Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 180 ~~365~~ calendar days from the date of ~~service.~~the denial. [KG17]

Claims that do not need additional investigation are generally processed more quickly. A large percentage of EDI claims submitted to AmeriHealth Caritas Louisiana are processed within 10 to 15 days of their receipt. AmeriHealth Caritas Louisiana shall pay ninety percent (90%) of all Clean Claims of each provider type within fifteen (15) business days of receipt. Ninety-nine percent (99%) of all Clean Claims of each provider type will be paid within thirty (30) calendar days of receipt. The date of receipt is the date AmeriHealth Caritas Louisiana receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

Please refer to the Claims Filing Instructions for electronic billing information at www.amerihealthcaritasla.com: click Providers; Billing and Claims.

Cost Avoidance

As a Healthy Louisiana Plan under the Louisiana Medicaid program, AmeriHealth Caritas Louisiana is intended to be the payer of last resort pursuant to state and federal law. This means all available Third Party Liability (TPL) resources must meet their claim payment obligations before AmeriHealth Caritas Louisiana makes payment on a claim. Cost Avoidance refers to a method of paying claims in which the provider is not reimbursed until the provider has demonstrated that all available TPL resources have been exhausted.

Providers must report primary payments and denials for AmeriHealth Caritas Louisiana members with TPL to avoid rejected claims. A provider who has been paid by AmeriHealth Caritas Louisiana and subsequently receives reimbursement from a third party must repay AmeriHealth Caritas Louisiana the difference between the primary carrier's contractual obligation and the patient liability.

If a balance remains after the provider bills the liable third party or the claim is denied payment for a substantive reason, the provider may submit a claim to AmeriHealth Caritas Louisiana for payment of the balance up to the maximum allowable Medicaid payment amount.

Post-Payment Recoveries (TPL/COB/Encounters/Claim Audits)

AmeriHealth Caritas Louisiana reviews TPL information and audits claim payments on a routine basis.

Providers will receive notification of our intent to recover overpayments identified during the course of these reviews and audits. To assist the provider in reconciling claims, AmeriHealth Caritas Louisiana will send a letter to the provider detailing the claims impacted by TPL coverage. This letter will indicate the 60 day timeline ~~a specific timeframe~~ for the provider to submit a check or dispute the TPL information. [KG18][WM19][WM20][KG21][BL22] If a response is not received within ~~the stated timeframe,~~60 days, the recoupment process will initiate. ~~/~~

AmeriHealth Caritas Louisiana strives to identify and recover claim overpayments within 365 days from the claim's last date of service; however, this timeframe may be extended in the following circumstances:

- There is evidence of fraud,
- There is an established pattern of inappropriate billing,
- Member retro-enrollment, or
- A system error is identified.

Third Party Liability (TPL)

- AmeriHealth Caritas Louisiana will seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party.

- AmeriHealth Caritas Louisiana will seek recovery from the provider where dates of services (DOS) are 10 months or less from the date stamp on the provider recovery letter.

- AmeriHealth Caritas Louisiana will not seek[KC23] recovery from the provider where DOS is older than 10 months but shall seek recovery directly from liable third parties. AmeriHealth Caritas Louisiana may utilize Act 517 of the 2008 Regular Legislative Session to seek recovery of reimbursement from liable third parties for up to 36 months from the date of service reported on the claim.

- Providers shall have 60 days from the date stamp of the recovery letter to refute the recovery, otherwise recoupment from future RAs shall occur.

- Providers shall be given an additional 30 day extension at their request when the provider billed the liable third party and hasn't received an EOB.

- If after 60 days of the recovery letter, or 90 days if a 30 day extension was requested, AmeriHealth Caritas Louisiana hasn't received a response from the provider, the recovery shall be initiated.

- AmeriHealth Caritas Louisiana accepts Global Maternity Procedure codes for claims ONLY when billed as secondary payer. Claims billed for Global Maternity Codes as primary payer shall be denied.

Third Party Liability and Global Maternity Procedure Codes

- Add on codes for maternity related anesthesia shall not apply to claims billed with Global Maternity codes, therefore, AmeriHealth Caritas Louisiana bypasses add-on rates when modifiers 47 and 52 are reported on the claim.

- Global Maternity Care includes pregnancy-related antepartum care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care. Other antepartum services are not considered part of global maternity services. They are reimbursed separately. An initial visit, confirming the pregnancy, is not part of the global maternity care services.

The provider should bill prenatal, delivery and/or postpartum services separately if the member's Medicaid eligibility terminates prior to delivery.

If a provider disagrees with the recovery and would like to dispute the findings, AmeriHealth Caritas Louisiana must be notified in writing with the following information enclosed:

- A copy of the recovery letter including the Project Number
- The reason for your dispute
- Documentation supporting your position

Send your correspondence to:

AmeriHealth Caritas of Louisiana
Cost Containment and TPL Department
P.O. Box 7320
London, KY 40742

If a provider agrees with the findings, a check may be submitted to AmeriHealth Caritas Louisiana for the amount of the overpayment. The check must be accompanied by a copy of the recovery letter including the Project Number and should be submitted to:

AmeriHealth Caritas of Louisiana
Cost Containment and TPL Department
P.O. Box 7322
London, KY 40742

Note: **Checks received without a copy of recovery letter including the Project Number will be returned and the overpayment will be recovered from future payments.**

Exclusions to Post Payment Recoveries from providers

- Pay and chase claims will always be referred directly to the liable third parties (refer to 4.13.3)

- Claims billed with EOB denial from other health insurance.
- If the liable third party is traditional Medicare, Tricare, or Champus VA, and more than 10 months have passed since the DOS, the MCO shall recover from the provider.
- Point of Sale (POS) will always be referred directly to liable third parties.

Refunds for Claims Overpayments or Errors [KG24][WM25]

AmeriHealth Caritas Louisiana and LDH encourage providers to conduct routine self-audits to ensure receipt of accurate payment(s) from the health plan. As a Medicaid managed care organization, funds disbursed by AmeriHealth Caritas Louisiana must be promptly returned to the plan when identified as improperly paid or overpaid. AmeriHealth Caritas Louisiana will complete all reviews and/or audits of a provider claim no later than one (1) year after the date of payment, regardless of whether the provider participates in the network. This[KT26] includes an "automated" review, which is one for which an analysis of the paid claim is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the provider to determine the existence of an overpayment. If a provider identifies improper payment or overpayment of claims from AmeriHealth Caritas Louisiana, the improperly paid or overpaid funds must be returned to AmeriHealth Caritas Louisiana within 60 days from the date of discovery of the overpayment and the provider must notify AmeriHealth Caritas Louisiana in writing of the reason for the overpayment. Providers may return improper or overpaid funds to the health plan by:

Submitting the refund check with member's name and ID, date of service and Claim ID by mail to the claims processing department:

AmeriHealth Caritas Louisiana
PO Box 7322
London, KY 40742

If a provider prefers the improper payment or overpayment be recouped from future claim payments, the overpayment must be reported to AmeriHealth Caritas Louisiana by calling Provider Services at 1-888-922-0007 or send the request to the following address:

Claims Processing Department
AmeriHealth Caritas Louisiana
P. O. Box 7322
London, KY 40742

If the improper payment or overpayment is related to a subrogation issue—slip and fall, worker's compensation or motor vehicle accident (MVA)—send the completed subrogation overpayment worksheet or any related documentation to subrogation@amerihealthcaritas.com.

Additional Claims Information:

- **Clean Claim Interest Payment**

AmeriHealth Caritas Louisiana shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) day claims processing deadline. Interest owed is paid the same date that the claim is adjudicated.

- **Weekly Check Cycles**

  AmeriHealth Caritas Louisiana runs two (2) provider payment cycles per week, (Mondays and Wednesdays). On occasion, there may be one check run for the week due to an AmeriHealth Caritas Louisiana recognized holiday.

- **Claims System Updates**

  AmeriHealth Caritas Louisiana updates its Claims Adjudication system within 30 days of receiving new fee schedules from the Louisiana Department of Health and claims are recycled within 15 days after the system updates.[KG27][BL28]

SECTION VII: PROVIDER NETWORK MANAGEMENT

Provider Network Management

Provider Network Management is responsible for building and maintaining a robust Provider Network for members. Contracting staff is responsible for negotiating contracts with hospitals, physicians; ancillary, DME and other providers to assure our Network can treat the full range of Medicaid covered benefits in an accessible manner for our members. The primary contact for network providers with AmeriHealth Caritas Louisiana is the Provider Network Management Account Executives (AE). The AE's function as a provider relations team to advise and educate AmeriHealth Caritas Louisiana providers, and can help providers become familiar with policies, processes and AmeriHealth Caritas Louisiana initiatives. Providers will, from time to time, be contacted by AmeriHealth Caritas Louisiana representatives to conduct meetings that address topics including, but not limited to:

- Contract Terms
- Credentialing or AmeriHealth Caritas Louisiana's Re-credentialing Site Visits
- Health Management Programs
- Marketing Compliance
- The Plan's Model of Care Orientation, Education and Training Program Updates and Changes Provider Complaints
- Provider Responsibilities
- Quality enhancements
- Self-Service tools

Provider Network Management, in collaboration with the Utilization Management Department, negotiates rates for Non-Participating Providers and facilities when services have been determined to be Medically Necessary and is Prior Authorized by AmeriHealth Caritas Louisiana.

Call **Provider Services at 1-888-922-0007:**

- Arrange for orientation or in-service meetings for network providers or staff
- Respond to any questions or concerns regarding your participation with AmeriHealth Caritas Louisiana
- Report any changes in your status, e.g.:
    - Phone number
    - Address
    - Tax ID Number
    - Additions/deletions of physicians affiliated with your practice

NaviNet (AmeriHealth Caritas Louisiana's secure provider portal)

NaviNet offers your practice full-circle services from visit to claim payment and beyond at no charge! Using NaviNet reduces the time spent on paperwork and allows you to focus on more important tasks patient care. NaviNet is a one- stop service that supports your office's clinical, financial and administrative needs.

NaviNet provides the following services:

- Eligibility and Benefits Inquiry
- Care Gaps and Care Gaps Reports
- Member Clinical Summary
- Provider Data Information Form
- Claims Management Functions, including the Claims Inquiry Tool

Log on to www.navinet.net or contact NaviNet Customer Service at 1-888-482-8057 to help you get started.

Provider Demographic Information

Network Providers are required to notify AmeriHealth Caritas Louisiana **at least sixty (60) days, and in no event not less than five (5) days**, **prior to** any change to its name, address, telephone number, medical specialty, hospital affiliations, and other similar information relevant to inclusion in the provider directory. Providers should contact their Provider Network Account Executive or Provider Services with changes to their demographic information, or submit changes via the Provider Data Information Form (PDIF) in our secure provider portal, Navinet. Network providers may verify their demographic data at any time using the real-time Provider Network directory at www.amerihealthcaritasla.com. If any corrections are necessary, we ask that these corrections are made immediately.

Accurate provider information is imperative to successful participation in our network. Accuracy of provider demographics associated with service location addresses, telephone numbers, languages spoken, current staff rosters and status of accepting new Medicaid referrals are necessary for our members to make appointments and find your office location. Correct NPIs, Tax IDs and remit addresses are necessary for you to be properly reimbursed for your services.

Requests for changes to address, phone number, Tax I.D., or additions and/or deletions to group practices can be made by completing the Provider Change Form. This form is available online at www.amerihealthcaritasla.com; complete it and return by mail to the Provider Network Management Department at:

AmeriHealth Caritas Louisiana Health Plan
Provider Network Management Department
PO Box 83580
Baton Rouge, LA 70884

AmeriHealth Caritas Louisiana providers also have the ability to attest to the accuracy of practice data and submit demographic changes directly through via the **PDIF** feature. Note: This feature is only available to professional provider groups.

Provider Validation and Attestation of Demographic Information

The Provider Data Information Form feature in our secure provider portal, NaviNet, allows you to review your demographic and practice information on file, attest to the accuracy of the information, and make any necessary changes.

Demographic changes will be reflected within the online provider directory within 14 business days. If the change is not reflected in 14 days, please contact your Provider Network Management account executive.

Upon request, providers will be asked to review current demographic information as it is listed in the directory and submit updates or corrections. **Please note: Providers will be given 30 days to attest to the accuracy of the information or submit any changes. Failure to respond in the specified time frame may result in claim denials.**

If your practice is not registered with NaviNet, we highly recommend registering. To register, please visit our website at **www.amerihealthcaritasla.com** **> Providers > NaviNet** and sign up or contact your provider account executive. For additional guidance on this new feature, please refer to the Provider Data Information Form User Guide also available on our website.

Email

AmeriHealth Caritas Louisiana has the ability to send to you, via email, contracts, documents and amendments for your review and signature. It is important that we have the correct email for the person in your practice who is responsible for office management and who will route information to the correct person.

Provider Services Department

AmeriHealth Caritas Louisiana's Provider Services Department operates in conjunction with the Provider Network Management Department, answering network provider concerns and offering assistance. Both departments make every attempt to ensure all network providers receive the highest level of service available.

The Provider Services Department can be reached between 7:00 am – 7:00 pm (CST) daily. Calls received after business hours, on weekends and holidays are answered by our off-hours team. The Off-Hours team will contact the on-call UM nurse for any urgent issues. A Medical Director is also on-call to address any medical necessity determination requests.

Call the Provider Services Department at 1-888-922-0007 to:

- Ask policy and procedure questions
- Report member non-compliance
- Obtain the name of your Provider Network Account Executive
- Request access/information about centralized services such as:
    - Outpatient laboratory services
    - Vision
    - Dental (limited coverage)
- Request help accessing services not covered by AmeriHealth Caritas Louisiana but covered by the FFS system for Medicaid recipients, such as:

- Specialized Behavioral Health services
- Pharmacy Services

New Provider Orientation

Upon completion of AmeriHealth Caritas Louisiana's 'contracting and credentialing processes, the provider is sent a welcome letter, which includes the effective date and the Account Executive's contact information. The welcome letter refers all AmeriHealth Caritas Louisiana providers to online resources, including the Provider Orientation Training information and this Provider Manual. The Provider Manual serves as a source of information regarding AmeriHealth Caritas Louisiana's covered services, policies and procedures, selected statutes, and regulations, telephone access and special requirements intended to assist the provider to comply with all provider contract requirements. The welcome letter explains how a hard copy of the Provider Manual may be obtained by contacting the Provider Network Management Department.

Provider Education and Ongoing Training

AmeriHealth Caritas Louisiana's training and development are fundamental components of continuous quality and superior service. AmeriHealth Caritas Louisiana offers ongoing educational opportunities for providers and their staff. AmeriHealth Caritas Louisiana has a commitment to provide appropriate training and education to help providers achieve compliance with AmeriHealth Caritas Louisiana's standards, as well as federal and state regulations. This training may occur in the form of an on- site visit or in an electronic format, such as online training sessions or interactive training sessions. Detailed training information is available in the "Provider" section of our website at www.amerihealthcaritasla.com. Plan providers also have access to the Provider Services Department at 1-888-922-0007 and your Account Executive for questions.

AmeriHealth Caritas Louisiana will conduct initial training within thirty calendar days of placing a newly contracted providers or provider groups on active status. AmeriHealth Caritas Louisiana's also conducts ongoing provider education and training on an annual basis. Orientation and training topics will include

- Billing and claims filing, and encounter data reporting
- Electronic funds transfers/remittance advice
- Covered services, benefit limitations and value-added services
- Credentialing
- Cultural competency
- Fraud, Waste and Abuse
- Policies and procedures
- Provider responsibilities
- Plan's Model of Care
- Medicaid compliance
- Provider inquiry and complaint process
- Quality enhancement programs / Community resource capability
- Utilization Management, Quality Assurance Performance Improvement (QAPI) and

- Integrated Care Management Programs.

Claims Issues

The Provider Services Department will also assist you with claims questions and adjustments. Some of the claims- related services include:

- Review of claim status (Note: claim status inquiries can also be done online via NaviNet)
- Research on authorization, eligibility and coordination of benefits (COB) issues related to denied claims
- Clarification of payment discrepancies
- On-line adjustments to incorrectly processed claims
- Assistance in reading remark, denial and adjustment codes from the remittance advice

Additional administrative services include:

- Explanation of Plan policies in relation to Claim processing procedures
- Explanation of authorization issues related to Claim payment
- Information on billing and Claim coding requirements
- Assistance in obtaining individual network provider numbers for network providers new to an existing AmeriHealth Caritas Louisiana group practice.

Call the Provider Claim Services Unit at 1-888-922-0007or look online in the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

Provider Complaints & Claim Disputes

DEFINITIONS & EXAMPLES:

Provider Complaint ~~—~~ Any verbal or written expression by a provider indicating dissatisfaction with an AmeriHealth Caritas Louisiana policy, procedure, ~~or any other aspect of administrative functions~~claims processing and/or payment or any other communication or action by AmeriHealth Caritas Louisiana, (excluding requests for reconsideration ~~of a claim~~ or appeal~~or prior authorization denials/reductions~~ for specific individual claims) [KG29]filed by phone, in writing or in person with AmeriHealth Caritas Louisiana.

Examples of provider complaints include:

- Claims processing issues, such as lack of timely payment
- Insufficient reimbursement rates
- Prior authorization issues, including dissatisfaction AmeriHealth Caritas Louisiana's prior authorization process or turnaround times
- PCP linkage concerns, including PCP auto-assignment methodology and patient linkage policies, procedures, or results
- Provider enrollment and/or credentialing issues, such as lack of timely processing or allegation of a discriminatory practice or policy
- Lack of access to providers or services, such as difficulty in locating specialty providers that will agree to treat members

- Provider directory or database issues, including incorrect information or lack of information in AmeriHealth Caritas Louisiana s system and/or directory
- Lack of information or response, including failure by AmeriHealth Caritas Louisiana to return a provider's calls, infrequency of site visits by AmeriHealth Caritas Louisiana Network Management Account Executives, or lack of provider network orientation / education by AmeriHealth Caritas Louisiana

How To File A Complaint

- **By phone:**
  Call Provider Services at **1-888-922-0007** from 7 a.m. to 6 p.m. Central Time, Monday through Friday.

- **In writing:**
  By mail:

  Attn: Provider Complaints
  AmeriHealth Caritas Louisiana
  P.O. Box 7323
  London, KY 40742

  By email:

  Network@amerihealthcaritasla.com

- You may also request an on-site meeting to discuss your complaint. You may file a complaint with your Provider Network Management Account Executive.

Claim Disputes – A claim dispute is a request for post-service review of claims that have been previously denied, underpaid, or otherwise limited claim by AmeriHealth Caritas Louisiana

Examples of claim disputes include:

- Inaccurate payment ~~due to wrong agreement type or updated Medicaid fee schedule~~[KG30]
- Claims denied for missing information, such as invalid coding or failure to include tax ID number
- Claims denied administratively for untimely filing or failure to include prior authorization information
- Payment limitations, including iHealth or NCCI edits and TPL misinformation

How To File A Claim Dispute

You may file a claim dispute by submitting a completed Provider Claim Dispute Form (Opens in a new window) (PDF), which can be found in the provider forms section.

Mail your completed form to:

AmeriHealth Caritas Louisiana
Attn: Provider Disputes
P.O. Box 7323
London, KY 40742

Claim disputes should be marked “first-level" or "second-level" claim dispute on the outer envelope and in the correspondence.

- **First-level claim dispute**: an initial written request for post-service review of claims.
- **Second-level claim dispute**: a secondary written request for review of first-level claim dispute resolution.

Multiple claims with different denial reasons should not be submitted on the same form.

If several claims are impacted by the same issue, you may submit the claim dispute via the multiple claims project spreadsheet (Opens in a new window) (PDF).

Claim Dispute Time Frames

Claim disputes are acknowledged by AmeriHealth Caritas Louisiana within three business days.

First-level claim disputes

First-level claim dispute requests must be received within 180 calendar days of the remittance advice or denial. A determination will be made within 30 calendar days of receipt of the claim dispute by AmeriHealth Caritas Louisiana.

Second-level claim disputes

If you are dissatisfied with the first-level claim dispute resolution, you may file a second-level claim dispute within 30 calendar days of the date on the first-level claim dispute determination letter.

Second-level claim disputes will be reviewed and decided upon by a second-level claim dispute committee comprised of at least three members of AmeriHealth Caritas Louisiana leadership or their designees.

A determination will be made within 30 calendar days of receipt of the claim dispute by AmeriHealth Caritas Louisiana.

Independent Review Process

Step 1: Request for ~~claim~~ independent review reconsideration

~~Claim~~ Independent review reconsideration allows providers dissatisfied with an adverse claim determination to request additional review.

- Must be submitted in writing on the LDH-required form within 180 days of one of the following:
    - the transmittal date of an electronic remittance advice (RA) or the postmark date of a paper RA
    - 60 days from the claim submission date if no RA is received
    - the date of claim recoupment
- Must be mailed to AmeriHealth Caritas Louisiana at:

  AmeriHealth Caritas Louisiana
  Attn: Provider Disputes
  PO Box 7323
  London, KY 40742

- Providers may initiate a reconsideration using the Independent Review Provider Reconsideration Form, which can be found in the provider forms section.
- Will be acknowledged within 5 days of receipt.
- Will be resolved by AmeriHealth Caritas Louisiana within 45 days of receipt[KG31]

Step 2: Request for Independent Review

If a provider is still not satisfied with the determination after the ~~claim~~[KG32] independent review reconsideration ~~process~~request process, a request for independent review may be submitted to the Louisiana Department of Health (Opens in a new window). Independent review allows providers dissatisfied with an MCO's reconsideration decision to uphold an adverse claim determination to request independent review.

- Must be submitted in writing on the Louisiana Department of Health-required form within 60 days of one of the following:
    - the date of the MCO's reconsideration decision
    - the last day of the MCO's 45-day time period to enter a reconsideration decision, if no decision is received
- Must be mailed to LDH at:

~~Louisiana Department of Health~~
~~Attn: Health Plan Management~~
LDH/Health Plan Management
PO Box ~~91283, Bin 32~~[KG33]91030, Bin 24
Baton Rouge, LA 70821-9283
Attn: Independent Review

- Will be resolved by the independent reviewer within 60 days (or longer if a medical necessity determination is ~~of~~required) of receipt of all documentation[KG34][BL35].
- Costs $750 and is paid for by the MCO; however, the provider must reimburse the MCO if the adverse determination is upheld by the independent reviewer
- The required Request for Independent Review form is available at ldh.la.gov > Provider & Plan Resources > Independent Review.

Arbitration

If you are not satisfied with AmeriHealth Caritas Louisiana's internal claim dispute resolution, you have the option to request binding arbitration by a private, independent arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. Arbitration requests must be submitted in writing to AmeriHealth Caritas Louisiana within 30 days of the Second Level Dispute determination letter to:

AmeriHealth Caritas Louisiana
Market President
Attn: Arbitration
10000 Perkins Rowe

Block G, 4th Floor
Baton Rouge, LA 70810

Arbitration regarding a claim dispute is binding on all parties. The arbitrator will conduct a hearing and issue a final ruling within 90 calendar days of being selected, unless you and AmeriHealth Caritas Louisiana mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, are shared equally by the parties. You must exhaust AmeriHealth Caritas Louisiana's internal claim dispute process before proceeding to arbitration. You do not have the right to a state fair hearing for claim issues.

Disputes about Non AmeriHealth Caritas Louisiana Covered Services

Louisiana's Healthy Louisiana plans provide Medicaid-covered services for members in the Healthy Louisiana program; however, not all Medicaid services are included in the plans core benefits. For example, specialized behavioral health services are covered by Magellan. This section outlines provider complaint systems involving AmeriHealth Caritas Louisiana-covered services; however, there may be times when a provider has a dispute regarding non-AmeriHealth Caritas Louisiana services. Our Provider Services department can assist a provider in identifying whether the issue in dispute is a plan or LDH responsibility.

Provider Contract Terminations

AmeriHealth Caritas Louisiana Provider Agreements specify termination provisions that comply with CMS requirements. Provider terminations are categorized as follows:

Provider Initiated
Plan Initiated "For Cause"
Plan Initiated "Without Cause" Mutual

Aside from those requirements identified in the Provider Agreement, AmeriHealth Caritas Louisiana will comply with the following guidelines, based on category of termination.

Provider Initiated

The provider must provide written notice to AmeriHealth Caritas Louisiana if intending to terminate from the AmeriHealth Caritas Louisiana Network. Written notice must be provided at least 90 days before the termination date in accordance with the method(s) specified in your Network Provider Agreement, and the termination letter must reflect the signature of an individual authorized to make the decision to terminate the agreement.

AmeriHealth Caritas Louisiana Initiated "For Cause"

AmeriHealth Caritas Louisiana may initiate termination of a Provider Agreement if the provider breaches the AmeriHealth Caritas Louisiana Network Provider Agreement. A "for cause" termination may also be implemented when there is an immediate need to terminate a provider's contract. If terminating a Provider Agreement for cause, AmeriHealth Caritas Louisiana will:

- Send applicable termination letters in accordance with the notification provisions of the Network Provider Agreement;
- Notify provider(s), CMS and the member immediately in cases where a AmeriHealth Caritas Louisiana member's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an

action of the State Board of Medicine or other governmental agency;
- Offer appeal rights for physicians as applicable.

AmeriHealth Caritas Louisiana Initiated "Without Cause"

AmeriHealth Caritas Louisiana may terminate a Provider Agreement "without cause" for various reasons (e.g., provider relocation or dissolution of a medical practice). If this occurs, AmeriHealth Caritas Louisiana will:

- Send applicable termination letters in accordance with the notification provisions of the Network Provider Agreement;
- Notify AmeriHealth Caritas Louisiana Network provider and members in active care 90 calendar days before the effective date of the termination;
- Offer Coordination of Care to transition members to new providers.

Mutual Terminations

A Mutual Termination is a termination of a Provider Agreement(s) in which the effective date is agreed upon by both parties. The termination date may be other than the required days' notice specific to the AmeriHealth Caritas Louisiana Network's Provider Agreement language.

- All mutual termination letters require signatures by both parties.
- Regarding mutual terminations of any AmeriHealth Caritas Louisiana Network Provider Agreement, the termination date should provide a minimum number of required days in order to provide notice to members and effectuate continuity of care. A mutual agreement termination date should not be a retroactive date.
- AmeriHealth Caritas Louisiana will notify all members in active care at least 30 calendar days before the effective date of the termination.
- Offer Coordination of Care to transition members to new providers.

Summary Actions Permitted

The following summary actions can be taken, without the need to conduct a hearing, by the Regional President of AmeriHealth Caritas Louisiana, the Market President of AmeriHealth Caritas Louisiana or the AmeriHealth Caritas Louisiana Medical Director:

- Suspension or restriction of AmeriHealth Caritas Louisiana participation status for up to 14 days, pending an investigation to determine the need for formal sanctioning process, or
- Immediate suspension or revocation, in whole or in part, of panel membership or participating practitioner/provider status, subject to subsequent notice and hearing, when it is determined that failure to take such action may result in immediate danger to the health and/or safety of any individual. A hearing will be held within thirty (30) days of the summary action to review the basis for continuation or termination of this action.

Adverse Action Reporting

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986 with governing regulations codified at 45 CFR Parts 60 and 61, AmeriHealth Caritas Louisiana sends information on reportable events as outlined in the NPDB and HIPDB reporting manual instructions to the respective entity and to the Louisiana State Board of Medical or Dental Examiners, as appropriate.

All review outcomes, including actionable information, are incorporated in the practitioner/provider credentialing file and database.

Provider Marketing Activities and Compliance

All health care providers delivering services to Louisiana Medicaid and LaCHIP recipients enrolled in Healthy Louisiana plans are welcome to inform their patients of the Healthy Louisiana plans they have chosen to participate with, but Healthy Louisiana has strict prohibitions against patient steering, which all providers must observe.

- Providers may inform their patients of all Health Plans in which they participate, and can inform patients of the benefits, services and specialty care services offered through the Health Plans in which they participate.
- Providers are not allowed to disclose only some of the Health Plans in which they participate. Disclosure of Health Plan participation must be all or nothing.
- Providers can display signage, provided by the Health Plan, at their location indicating which Health Plans are accepted there, but must include all Health Plans in which they participate in this signage.
- If a provider participates in only one Healthy Louisiana Plan, the provider can display signage for only one Health Plan and can tell a patient that is the only Health Plan accepted by that provider.
- Providers MAY NOT RECOMMEND one Health Plan over another Health Plan, MAY NOT OFFER patients incentives for selecting one Health Plan over another, or MAY NOT ASSIST IN ANY WAY (faxing, using the office phone, computer in the office, etc.) the patient in deciding to select a specific Health Plan.
- Patients who need assistance with their Health Plan services should call the Member Services Hotline for the Plan in which they are enrolled, and those who wish to learn more about the different Health Plans should contact the Healthy Louisiana Enrollment Broker at 1-855-229-6848 to receive assistance in making a Health Plan decision.
- Under NO CIRCUMSTANCES is a provider allowed to change a member's Health Plan for him/her, or request a Health Plan reassignment on a member's behalf. Members who wish to change Health Plans for cause must make this request to Medicaid themselves through the Healthy Louisiana Enrollment Broker.
- If a provider or Health Plan is found to have engaged in patient steering, they may be subject to sanctions such as, but not limited to monetary penalties, loss of linked patients and/or excluded from enrollment in Medicaid/Healthy Louisiana Plan network opportunities.

Site Visits Resulting from Receipt of a Complaint and/or Ongoing Monitoring

Member Dissatisfaction Regarding Office Environment

Provider Network Management or the Credentialing department may identify the need for a site is it due to receipt of a member dissatisfaction regarding the provider's office environment. At the discretion of the Provider Network Management representative a site visit to address the specific issue(s) raised by a member may occur. Follow-up site visits are conducted as necessary.

Communication of Results

The Provider Network Management Representative reviews the results of the Site Visit Evaluation Form (indicating all deficiencies) with the office contact person.

- If the site meets and/or exceeds the passing score, the Site Visit Evaluation Form is signed and dated by both AmeriHealth Caritas Louisiana and the office contact person.
- If the site does not receive a passing score AmeriHealth Caritas Louisiana follows the procedures outlined below to

follow-up on identified deficiencies.

Follow-Up Procedure for Identified Deficiencies

1. The Provider Network Management Representative requests a corrective action plan from the Louisiana within one week of the visit.
2. The Provider Network Management Representative schedules a re-evaluation visit with the provider office, to occur within 30 days of the initial site visit to review the site and verify that the deficiencies were corrected.
3. The Provider Network Management Representative reviews the corrective action plan with the office contact person.
4. The Provider Network Management Representative reviews the results of the follow-up Site Visit Evaluation Form (including a re-review of previous deficiencies) with the office contact person
    a. If the site meets and/or exceeds the passing score, the Provider Network Management Representative, the Site Visit Evaluation Form is signed and dated by both AmeriHealth Caritas Louisiana's and the office contact person.
    b. If the site does not receive a passing score, the Provider Network Management Representative follows the procedures outlined below for follow-up for secondary deficiencies.

Follow-Up Procedure for Secondary Deficiencies

1. The Provider Network Management Representative will re-evaluate the site monthly, up to three times (from the first Site Visit date).
2. If after four (4) months, there is evidence the deficiency is not being corrected or completed, then the office receives a failing score unless there are extenuating circumstances.
3. Further decisions as to whether to pursue the Credentialing process or take action to terminate participation of a provider who continues to receive a failing Site Visit Evaluation score will be handled on a case by case basis by the AmeriHealth Caritas Louisiana Medical Director and Credentialing Committee.

Fraud & Abuse

AmeriHealth Caritas Louisiana receives state and federal funding for payment of services provided to our members. In accepting claims payment from AmeriHealth Caritas Louisiana, health care providers are receiving state and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or abuse against the Medicaid program. As a provider you are responsible to know and abide by all applicable State and Federal Regulations.

AmeriHealth Caritas Louisiana is dedicated to eradicating fraud and abuse from its programs and cooperates in fraud and abuse investigations conducted by state and/or federal agencies, including CMS, the Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, HHS, Office of Inspector General (OIG), State Auditor's Office, General Accounting Office (GAO), Comptroller General, as well as local authorities.

Examples of fraudulent/abusive activities:

- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not Medically Necessary
- Misrepresenting the services rendered
- Submitting a claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failure to perform services required under a capitated contractual arrangement

False Claims and Self Auditing

AmeriHealth Caritas Louisiana takes the identification and reporting of fraud, waste and abuse seriously and holds members and providers accountable for reporting all concerns of fraud, waste and abuse. Providers are responsible for self-auditing and reporting any findings that may result in an over or underpayment.

The False Claims Act is an important tool U.S. taxpayers have to recover money stolen through fraud. Under the False Claims Act, those who knowingly submit or cause another entity to submit false claims for payment of government funds are liable for government damages plus civil penalties. If you suspect fraud or wish to report suspicious activities please call the AmeriHealth Caritas Louisiana Fraud & Abuse Hotline 1-866-833-9718.

Contact Information

To report or refer suspected cases of fraud and please contact AmeriHealth Caritas Louisiana's Fraud and Abuse Hotline by calling 1-866-833-9718 or by sending correspondence to:

Program Integrity
AmeriHealth Caritas Louisiana
200 Stevens Drive
Philadelphia, PA 19113

The Program Integrity department utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from AmeriHealth Caritas Louisiana or, on behalf of AmeriHealth Caritas Louisiana, regarding payment or recovery of potential overpayments. You may be asked to provide supporting documentation including the medical record or itemized bill to support the review of the claim. In addition, you may be informed that your claim submission patterns vary from industry standards when reviewed and compared to your peer's submission of similar claims; if this were to occur you would be notified and additional action may be required on your behalf. Should you have any questions regarding the communication received relating to these requests, please use the contact information provided in the communication to expedite a response to your question or concerns. Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas Louisiana reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued and the service was provided.

Member Fraud, Waste & Abuse

Unfortunately, there may be times when you see members involved in fraud, waste or abuse. If you have knowledge of member FWA, please report the circumstances to AmeriHealth Caritas Louisiana or the Louisiana Department of Health (LDH) as outlined below. You do not have to give your name and, if you do, you will not be identified to the member you are reporting.

Some examples of FWA by a member are:

- Members selling or lending their ID cards to other people.
- Members abusing their benefits by seeking drugs or services that are not medically necessary.

You can report fraud and abuse by calling the AmeriHealth Caritas Louisiana Hotline number at **1-866-833-9718** or **fraudtip@amerihealthcaritas.com.** You can also report fraud and abuse to the Louisiana Department of Health through any of the following:

You may report provider or recipient FWA to the LDH via their website, **http://new.dhh.louisiana.gov/index.cfm/page/219**. You may also report FWA to LDH via the following:

Medicaid recipient FWA reporting:

Call toll-free to **1-888-342-6207**.

By mail to:

Customer Service Unit
Louisiana Louisiana Department of Health
P.O. Box 91278
Baton Rouge, LA 70821-9278

Provider's Bill of Rights

Each provider who contracts with AmeriHealth Caritas Louisiana to furnish services to the members shall be assured of the following rights:

- A Health Care Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and State Fair Hearing procedures.
- To have access to AmeriHealth Caritas Louisiana policies and procedures covering the authorization of services.
- To be notified of any decision by AmeriHealth Caritas Louisiana to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge, at the request of the Medicaid/CHIP member on their behalf, the denial of coverage of, or payment for, medical assistance.
- AmeriHealth Caritas Louisiana provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.

Note: The provider shall not be prohibited or otherwise restricted from advising an AmeriHealth Caritas Louisiana member about the health status, medical care or treatment of member's condition or disease, regardless of whether benefits for such care or treatment are provided under AmeriHealth Caritas Louisiana's contract, if provider is acting with the lawful scope of practice.

SECTION VIII: PROVIDER CREDENTIALING

Introduction to Credentialing

Health care providers are selected to participate in the AmeriHealth Caritas Louisiana network based on an assessment and determination of network need.

AmeriHealth Caritas Louisiana is responsible for the credentialing and re-credentialing of its provider network including practitioners, behavioral health providers, facilities, and organizational providers. AmeriHealth Caritas Louisiana credentialing/re-credentialing criteria and standards are consistent with Louisiana requirements, Federal regulations, and the National Committee for Quality Assurance (NCQA). Practitioners, behavioral health providers, facilities, and organizational providers are re-credentialed at least once every three years.

The criteria, verification methodology and processes used by AmeriHealth Caritas Louisiana are designed to credential and re-credential practitioners and providers in a non-discriminatory manner, with no attention to race, ethnic/national identity, gender, age, sexual orientation, specialty or procedures performed.

Practitioner Requirements

The following types of professional providers (practitioners) require initial credentialing and re-credentialing (every 3 years):

- Audiologists
- Speech and Language Therapists
- Physicians (DOs and MDs)
- Physician Assistants
- Certified Nurse Midwife
- Occupational Therapists
- Podiatrists
- Chiropractors
- Oral Surgeons
- Nurse Practitioners
- Physical Therapists
- Dentists
- Optometrists (who provide medical care)
- Allied Health Practitioners
- School-Based Practitioners
- Applied Behavioral Analysts
- Registered Dieticians
- Psychiatrists
- Licensed Mental Health Professionals (LMPH)
    - Medical Psychologists
    - Licensed Psychologists
    - Licensed Clinical Social Workers (LCSW)
    - Licensed Professional Counselors (LPC)
    - Licensed Marriage and Family therapists (LMFT)
    - Licensed Addiction Counselors (LAC)

- Advanced Practice Registered Nurses (must be a Nurse Practitioner Specialist in Adult Psychiatric & Behavioral Health, Family Psychiatric & Behavioral health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric & Mental Health, Child Adolescent Mental Health)

Please note, hospital-based practitioners are not required to be independently credentialed if those practitioners serve AmeriHealth Caritas Louisiana's members only through the hospital. Hospital based practitioners include but are not limited to:

- Pathologists
- Anesthesiologists
- Radiologists
- Emergency Medicine
- Neonatologists
- Hospitalists

The following criteria must be met, as applicable, in order to be credentialed as a qualified network practitioner:

- All practitioners must submit a correct, complete, and legible, signed/dated application and attestation/release form. Applications are accepted through the Council for Affordable Quality Healthcare (CAQH) or via an AmeriHealth Caritas Louisiana or State of Louisiana paper application. The signature and date on the attestation must not be older than 305 calendar days at the time of the credentialing decision.
- Valid and current Medicaid, Medicare, and/or Individual National Provider ID numbers, as applicable.
- A current, active license. AmeriHealth Caritas Louisiana will consider a practitioner if the license is in "probationary" status. Pursuant to Section 1.R.S.46:460.63, AmeriHealth Caritas Louisiana will never enforce any conditions in its credentialing program that are more restrictive than those conditions established by the State of Louisiana's Medicaid program or by State or Federal guidelines.
- A valid and current DEA and CDS/CSC license, if applicable.
- Proof of education and training that supports the requested specialty or service, as well as the degree credential of the practitioner. For example, proof of practitioner's medical school graduation, completion of residency, and/or other postgraduate training. Foreign trained practitioners must submit an Education Commission for Foreign Medical Graduates (ECFMG) certificate or number with the application.
    - Board certification is not required for practitioners; however, if a practitioner reports to be board certified, then current certification is verified. Practitioners must be able to demonstrate competency or training in the specialty that he or she is requesting.
- Work history containing current employment, as well as explanation of any gaps greater than six (6) months within the last five (5) years.
- History of professional liability claims including an explanation of all cases in the past five (5) years.
- A detailed explanation to any questions on the application answered affirmatively, including but not limited to, inability to perform the essential functions of the position, illegal drug use, loss of licensure, felony convictions, loss of limitation or privileges, or disciplinary actions. Practitioners are expected to provide dates of each incident, as well as a detailed description of events.
- A current copy of the professional liability insurance face sheet (evidencing coverage); a minimum of $1M per occurrence and $3M aggregate OR additional PCF is required.
- Practitioners, including PCPs, CRNPs, and CNMs, must have hospital affiliation with an institution that

participates with AmeriHealth Caritas Louisiana. As an alternative, those practitioners who do not have hospital privileges, but require them, may enter into an admitting agreement with a practitioner who is able to admit.

- A current CLIA (Clinical Laboratory Improvement Act) certificate or waiver of a certificate of registration along with a CLIA identification number, if applicable.
- All Nurse Practitioners (NPs) and Physician Assistants (PAs) must have their national certification to participate with AmeriHealth Caritas. NPs and PAs must also have a collaborative or supervision agreement with a physician preceptor who is participating with the plan.
- Completed and signed Ownership Disclosure, if applicable.

As part of the practitioner credentialing process, AmeriHealth Caritas Louisiana will:

- Process completely within 60 calendar days of receipt of a completed application including all necessary documentation and attachments, and a signed provider contract.
- Request information on practitioner sanctions prior to making a credentialing or re- credentialing decision. Information from the National Practitioner Data Bank (NPDB), Health Integrity Provider Data Bank (HIPDB), System for Award Management (SAM), EPLS (Excluded Parties Links System), and HHS Office of Inspector General (OIG) (Medicare exclusions), Federation of Chiropractic Licensing Boards (CIN-BAD), and State Disciplinary Action report will be reviewed as applicable.
- Performance review of complaints, quality of care issues and utilization issues will be included in provider re-credentialing.
- Maintain confidentiality of the information received for the purpose of credentialing and re-credentialing. Safeguard all credentialing and re-credentialing documents, by storing them in a secure location, only accessed by authorized plan employees.

Facility and Organizational Provider Requirements

Facility and organizational providers include those such as hospitals or ancillary providers where the facility or organization undergoes credentialing instead of the individual practitioner. The following types of facilities and organizational providers require initial credentialing and re-credentialing (every 3 years):

- Hospitals (Acute Care and Acute Rehabilitation)
- Home Health Agencies/Home Health Hospice
- Skilled Nursing Facilities (SNFs)
- Skilled Nursing Facilities Providing Sub-Acute Services
- Clinical Laboratories (CMS-issued CLIA certification or hospital-based exemption from CLIA)
- Nursing Homes
- Ambulatory Surgery Centers (ASCs)
- Sleep Center/Sleep Lab – Free Standing
- Free Standing Radiology Centers
- Durable Medical Equipment Suppliers (DME)
- Home Infusion
- ESPDT Clinics
- Louisiana Office of Public Health (OPH) – Certified School Based Health Clinics (SBHCs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

- Personal Care Services Agency
- Hospice Agency
- Pharmacies
- Providers of End-Stage Renal Disease Services
- Providers of Outpatient Diabetes Self-Management Training
- Portable X-Ray Suppliers/Imaging Centers
- Psychiatric Residential Treatment Facilities (PRTF)
- Free-Standing Psychiatric Hospitals and Distinct Part Psychiatric (DPP) Units (age 21 and under; 65 and older)
- Substance Use Service Providers
- Home and Community Based Services Providers
- Opioid Treatment Clinics
- Hospital/Inpatient Facilities
- Certified Outpatient Clinics

The following criteria must be met, as applicable, in order to be credentialed as a qualified network facility or organizational provider:

- All facility and organizational providers must submit a correct, complete, and legible, signed/dated application and supporting documents. For providers with multiple locations, one application documenting every address, with supporting licensure and accreditation information for each location, is acceptable. In addition to the application, facilities and organizational providers must submit:
    - An attestation of the correctness and completeness of the information supplied.
    - An unrestricted and current State license, if applicable.
    - A copy of accreditation certificate from a recognized accrediting body. If the provider is not accredited, a CMS State Survey or letter stating the provider has been certified by CMS may be accepted for credentialing. If the provider is not accredited and cannot provide a CMS State Survey or letter, or if the most recent survey is older than three (3) years, AmeriHealth Caritas Louisiana will conduct a site visit.
    - Evidence of eligibility with State and Federal regulatory bodies, including Medicare and Medicaid, as applicable.
    - A copy of the current malpractice insurance face sheet and history of liability; minimum limit requirement of $1M per occurrence/$3M aggregate.
    - Documentation of any history of disciplinary actions, loss or limitation of license, Medicare/Medicaid sanctions, or loss limitation, or cancellation of liability insurance.
    - An active Medicaid ID number and/or enrollment and/or certification, as applicable.
    - An active Medicare ID number, as applicable.
    - Attach Ownership Disclosure which must include the name, DOB, SSN, and email address of each owner.

As part of the facility and organization provider credentialing process, AmeriHealth Caritas Louisiana will:

- Confirm that the facility is in good standing with all state and regulatory agencies, including the Louisiana Department of Health, and has been reviewed by an accredited body, as applicable.
- Conduct a site visit only if no governmental agency, such as CMS, has conducted a onsite visit in the past 3 years. Satisfactory survey results from the last licensure survey may be accepted in place of a site visit by AmeriHealth Caritas Louisiana.
- Request information on facility sanctions prior to rendering a credentialing or re-credentialing decision, by obtaining information from the National Practitioner Data Bank (NPDB), Health Integrity and Protection Data Bank (HIPDB), EPLS (Excluded Parties Lists System), System for Award Management (SAM) to identify those excluded from receiving Federal contracts and financial benefits, and HHS Office of Inspector General (OIG) (Medicare exclusions).

- Performance reviews may include a site visit from AmeriHealth Caritas Louisiana, review of complaints and quality of care issues as a requirement of re-credentialing.
- Maintain confidentiality of the information received for the purpose of credentialing and re-credentialing.
- Safeguard all credentialing and re-credentialing documents, by storing them in a secure location, only accessed by authorized plan employees.

Using CAQH to Submit Electronic Credentialing Applications

Through CAQH, credentialing information is provided to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH.

There is no charge to providers to participate in CAQH or to submit applications. AmeriHealth Caritas Louisiana encourages all providers to utilize this service.

Submit your application to participate with AmeriHealth Caritas Louisiana via CAQH (www.caqh.org):

- Register for CAQH.
- Grant authorization for AmeriHealth Caritas Louisiana to view your information in the CAQH database.
- Contact your Provider Network Management Account Executive to provide your CAQH ID number to continue the credentialing process.

Credentialing Rights

After the submission of the application, health care providers have the following rights:

- Have the right to review the information submitted to support their credentialing application, with the exception of recommendations, references, and peer protected information obtained by ACLA.
- Have the right to correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information the Provider provided, the Credentialing Department will notify the Health Care Provider to correct the discrepancy. The Provider will have 10 calendar days from the date of the notification to correct the erroneous information. All requests for the above information must be made in writing by the practitioner.
- Have the right, upon request, to be informed of the status of their credentialing or re-credentialing application. The Credentialing department will share all information with the provider with the exception of references, recommendations or peer-review protected information (i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the provider.
- Have the right to be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision.
- Have the right to appeal any credentialing/re-credentialing denial within 30 calendar days of receiving written notification of the decision.

*To request or provide information for any of the above, the provider should contact the AmeriHealth Caritas Corporate Credentialing department at the following address: AmeriHealth Caritas, Attn: Credentialing Department, 200 Stevens Drive, Philadelphia, PA 19113.

Re-Credentialing for Practitioners

AmeriHealth Caritas Louisiana re-credentials network practitioners at least once every 36 months. All practitioners will receive their first notice of re-credentialing requirement no more than six (6) months prior to the expiration of the practitioner's current credentialing. The notice will include the effective date of termination if the practitioner fails to meet the requirements and deadlines of AmeriHealth Caritas Louisiana's re-credentialing process. A total of four (4) notices will be sent prior to the expiration of the current credentialing cycle. The 2nd notice will be sent four (4) months prior to the expiration of the file, the 3rd notice will be sent 60 days prior to the expiration of the file, and the 4th and final notice will be sent to the provider at least 15 days prior to the expiration date of the file. The plan will also attempt to retrieve an application from CAQH if the practitioner has granted access for same. All notices will be sent to the last known credentialing contact address provided by the practitioner as well as via email. Practitioners failing to respond to these notices may be terminated from the plan for non-compliance with re-credentialing requirement. Termination notice will be sent via certified mail to the provider's last known mailing address.

As with initial credentialing, all applications and attestation/release forms must be signed and dated no more than 305 days prior to the Credentialing Committee or Medical Director's decision date. Additionally, all supporting documents must be current at the time of the decision date.
The following information is required in order to complete the practitioner re-credentialing process:

- A current CAQH or paper application. Signature and date on the application must not be older than 305 calendar days at the time of the re-credentialing decision.
- A current, active, unrestricted license. AmeriHealth Caritas Louisiana will consider a practitioner if the license is in "probationary" status. Pursuant to Section 1.R.S.46:460.63, AmeriHealth Caritas Louisiana will never enforce any conditions in its credentialing program that are more restrictive than those conditions established by the State of Louisiana's Medicaid program or by State or Federal guidelines.
- A valid and current DEA and CDS/CSC license, if applicable.
- A current copy of the professional liability insurance face sheet (evidencing coverage); a minimum of $1M per occurrence and $3M aggregate OR additional PCF is required.
- History of professional liability claims including an explanation of all cases in the past five (5) years.
- Practitioners, including PCPs, CRNPs, and CNMs, must have hospital affiliation with an institution that participates with AmeriHealth Caritas Louisiana. As an alternative, those practitioners who do not have hospital privileges, but require them, may enter into an admitting agreement with a practitioner who is able to admit.
    - Board certification is not required for practitioners who apply as a specialist; however, if a practitioner reports to be board certified, then current certification is verified. Practitioners must be able to demonstrate competency or training in the specialty that he or she is requesting.
- A detailed explanation to any questions on the application answered affirmatively, such as but not limited to, reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license, history of felony convictions, history of loss of limitation of privileges, or disciplinary actions. Practitioners are expected to provide dates of each incident, as well as a detailed description of events.
- A current CLIA (Clinical Laboratory Improvement Act) certificate or waiver of a certificate of registration along with a CLIA identification number, if applicable.
- A valid and current Medicaid, Medicare, and/or Individual National Provider ID numbers, as applicable.
- A completed and signed Ownership Disclosure, if applicable.

Re-credentialing for Facilities and Organizational Providers

Facilities are notified six (6) months prior to the re-credentialing due date and are required to submit the following:

- Current copy of licensure.

- Proof of current malpractice insurance.
- Proof of up-to-date accreditation or CMS State Survey.

AmeriHealth Caritas Louisiana will perform the same verifications as noted under Facility and Organizational Provider Requirements. The Medical Director reviews and makes determination on all routine files. The Credentialing Committee meets monthly and reviews and makes determination on all non-routine files.

SECTION IX: QUALITY AND UTILIZATION MANAGEMENT

Quality Management

AmeriHealth Caritas Louisiana employs a comprehensive Quality Assessment and Performance Improvement (QAPI) Program that integrates knowledge, structure and processes throughout the health care delivery system to assess risk and to improve quality and safety of clinical care and services provided to AmeriHealth Caritas Louisiana members. The AmeriHealth Caritas Louisiana QAPI Program provides a framework for the evaluation and delivery of health care and services provided to members.

Purpose and Scope

The purpose of the QAPI Program is to provide the infrastructure to systematically monitor, objectively evaluate and ultimately improve the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to AmeriHealth Caritas Louisiana members in accordance with the following organizational mission statement:

We help people: Get care, Stay well, Build healthy communities. We have a special concern for those who are poor. The

Quality Assessment and Performance Improvement Program is also the mechanism for:

- Determining practice guidelines and standards on which the program's success will be measured
- Complying with all applicable laws and regulatory requirements such as those from LDH and other applicable state and federal agencies, and accreditation body standards
- Providing oversight of all delegated services
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to members through the credentialing/re-credentialing process

Reducing health care disparities by measuring, analyzing and redesigning of services and programs to meet the health care needs of AmeriHealth Caritas Louisiana's diverse membership.

Objectives

The objectives of the QAPI Program are to:

- Maximize utilization of collected information about the quality of clinical care (physical and behavioral), health outcomes and service and identify clinical and service improvement initiatives for targeted interventions
- Evaluate access to care, availability of services, continuity of care health care outcomes, and services provided and arranged by AmeriHealth Caritas Louisiana
- Assess the quality and appropriateness of care furnished to members with special needs
- Strengthen provider capabilities and performance related to the provision of evidence-based clinical care
- Coordinate services between various levels of care, network practitioners, behavioral health providers and community resources to assure continuity of care and promote optimal physical, psychosocial, and

functional wellness

- Utilize results of participant and practitioner/provider satisfaction measures when identifying and prioritizing quality activities
- Incorporate the results of external quality evaluations (e.g. EQR results, NCQA accreditation feedback, LDH findings) and internally generated evaluations such as HEDIS, satisfaction monitoring and internal audits and monitoring into quality program activities
- Implement and evaluate condition management programs to effectively address chronic illnesses affecting the population
- Design and implement provider outreach and education activities
- Maintain compliance with evolving NCQA accreditation standards
- Communicate results of clinical and service measures to practitioners, providers, and members.
- Identify and implement activities that promote participant safety
- Document and report the results of monitoring activities and quality improvement initiatives to appropriate stakeholders
- Facilitate the delivery of culturally competent health care to reduce health care disparities

An annual QAPI work plan is derived from the QAPI Program goals and objectives. The work plan provides a roadmap for achievement of program goals and objectives, and is also used by the Quality Department as well as the various quality committees as a method of tracking progress toward achievement of goals and objectives.

QI Program effectiveness is evaluated on an annual basis. This assessment allows AmeriHealth Caritas Louisiana to determine how well it has deployed its resources in the recent past to improve the quality of care and service provided to AmeriHealth Caritas Louisiana membership. When the program has not met its goals, barriers to improvement are identified and appropriate changes are incorporated into the subsequent annual QAPI work plan. Feedback and recommendations from various councils and committees are incorporated into the evaluation. Please go to www.amerihealthcaritasla.com for more information about our Quality Program and our annual goals.

QM Program Authority and Structure

The Board of Directors of AmeriHealth Caritas, Louisiana, Inc. provides strategic direction for the Quality Assessment Performance Improvement (QAPI) Program and will retain ultimate responsibility for ensuring that the QAPI Program is incorporated into AmeriHealth Caritas Louisiana‘s operations. Operational responsibility for the development, implementation, monitoring, and evaluation of the QAPI Program are delegated by the AmeriHealth Caritas, Louisiana, Inc. Board of Directors to the AmeriHealth Caritas Louisiana Market President and Quality Assessment Performance Improvement Committee (QAPIC).

Quality Assessment Performance Improvement Committee

The Quality Assessment Performance Improvement Committee (QAPIC) oversees AmeriHealth Caritas Louisiana‘s efforts to measure, manage and improve quality of care and services delivered to AmeriHealth Caritas Louisiana members, and evaluate the effectiveness of the QAPI Program The QAPIC directs and reviews AmeriHealth Caritas Louisiana‘s Quality Improvement and Utilization Management activities.

Compliance Committee

The AmeriHealth Caritas Louisiana Compliance Committee assists the Compliance Director with the implementation and oversight of the AmeriHealth Caritas Louisiana Compliance Program. The committee serves in an oversight role to ensure that AmeriHealth Caritas Louisiana is in compliance with all applicable laws, rules, regulations and contractual requirements. The AmeriHealth Caritas Louisiana Compliance Committee reports to the AmeriHealth Caritas, Louisiana, Inc. Board of Directors.

AmeriHealth Caritas Louisiana Provider Council

The AmeriHealth Caritas Louisiana Provider Council solicits input from provider and community stakeholders regarding the structure and implementation of new and existing clinical policies, initiatives and strategies. The Council provides input to the Provider Outreach Strategy and QAPIC, as appropriate.

AmeriHealth Caritas Louisiana Member Advisory Council

The AmeriHealth Caritas Louisiana Member Advisory Council provides a forum for member participation and input to AmeriHealth Caritas Louisiana programs and policies to promote collaboration; maintain a member-focus and enhance the delivery of services to AmeriHealth Caritas Louisiana communities.

Quality of Service Committee

The Quality of Service Committee (QSC) reports to the QAPIC. The purpose of the QSC is to assure that performance and quality improvement activities related to AmeriHealth Caritas Louisiana services are reviewed, coordinated and effective. The QSC reviews, approves and monitors action plans created in response to any identified variance.

Credentialing Committee

The Credentialing Committee is responsible for reviewing practitioner and provider applications, credentials and profiling data (as available) to determine appropriateness for participation in the AmeriHealth Caritas Louisiana network.

Confidentiality

Documents related to the investigation and resolution of specific occurrences involving complaints or quality of care issues are maintained in a confidential and secure manner. Specifically, members' and health care providers' right to confidentiality are maintained in accordance with applicable laws. Records of quality improvement and associated committee meetings are maintained in a confidential and secure manner.

Provider Sanctioning Policy

It is the goal of AmeriHealth Caritas Louisiana to assure members receive quality health care services. In the event that health care services rendered to a member by a network provider represent a serious deviation from, or repeated non-compliance with, AmeriHealth Caritas Louisiana's quality standards, and/or recognized treatment patterns of the organized medical community, the network provider may be subject to AmeriHealth Caritas Louisiana's formal sanctioning process. All sanctioning activity is strictly confidential.

Informal Resolution of Quality of Care Concerns

When an AmeriHealth Caritas Louisiana Quality Review Committee (Quality Improvement Committee, Medical Management Committee or Credentialing Committee) determines that follow-up action is necessary in response to the care and/or services begin delivered by a network provider, the Committee may first attempt to address and resolve the concern informally, depending on the nature and seriousness of the concern.

The Chairperson of the reviewing Committee will send a letter of notification to the network provider. The letter will describe the quality concerns of the Committee, and what actions are recommended for correction of the problem. The network provider is afforded a specified, reasonable period of time appropriate to the nature of the problem. The letter will recommend an appropriate period of time within which the network provider must correct the problem.

The letter is to be clearly marked: **Confidential: Product of Peer Review**

Repeated non-conforming behavior will subject the network provider to a second warning letter. In addition, the network provider's member panel (if applicable) and admissions are frozen while the issue is investigated and monitored. Failure to conform thereafter is considered grounds for initiation of the formal sanctioning process.

Formal Sanctioning Process

In the event of a serious deviation from, or repeated non-compliance with, AmeriHealth Caritas Louisiana's quality standards, and/or recognized treatment patterns of the organized medical community, the AmeriHealth Caritas Louisiana Quality Improvement Committee or the Chief Medical Officer (CMO) may immediately initiate the formal sanctioning process.

- The network provider will receive a certified letter (return receipt requested) informing him/her of the decision to initiate the formal sanctioning process. The letter will inform the network provider of his/her right to a hearing before a hearing panel.

- The network provider's current member panel (if applicable) and admissions are frozen immediately during the sanctioning process.

Notice of Proposed Action to Sanction

The network provider will receive written notification by certified mail stating:

- That a professional review action has been proposed to be taken
- Reason(s) for proposed action
- That the network provider has the right to request a hearing on the proposed action
- That the network provider has 30 days within which to submit a written request for a hearing, otherwise the right to a hearing is forfeited. The network provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action s/he wishes to contest
- Summary of rights in the hearing
- The network provider may waive his/her right to a hearing

Notice of Hearing

If the network provider requests a hearing in a timely manner, the network provider will be given a notice stating:

- The place, date and time of the hearing, which date shall not be less than thirty (30) days after the date of the notice
- That the network provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the CMO of AmeriHealth Caritas Louisiana and/or upon the advice of AmeriHealth Caritas Louisiana's Legal Department
- A list of witnesses (if any) expected to testify at the hearing on behalf of AmeriHealth Caritas Louisiana

Conduct of the Hearing and Notice

- The hearing shall be held before a panel of individuals appointed by AmeriHealth Caritas Louisiana
- Individuals on the panel will not be in direct economic competition with the network provider involved, nor will they have participated in the initial decision to propose Sanctions
- The panel will be composed of physician members of the AmeriHealth Caritas Louisiana's Quality Committee structure, the CMO of AmeriHealth Caritas Louisiana, and other physicians and administrative persons affiliated with AmeriHealth Caritas Louisiana as deemed appropriate by the CMO of AmeriHealth Caritas Louisiana. The AmeriHealth Caritas Louisiana CMO or his/her designee serves as the hearing officer
- The right to the hearing will be forfeited if the network provider fails, without good cause, to appear

Provider's Rights at the Hearing

The network provider has the right:

- To representation by an attorney or other person of the network provider's choice

- To have a record made of the proceedings (copies of which may be obtained by the network provider upon payment of reasonable charges)
- To call, examine, and cross-examine witnesses
- To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law
- To submit a written statement at the close of the hearing
- To receive the written recommendation(s) of the hearing panel within 15 working days of completion of the hearing, including statement of the basis for the recommendation(s)
- To receive AmeriHealth Caritas Louisiana's written decision within 60 days of the hearing, including the basis for the hearing panel's recommendation

Appeal of the Decision of the AmeriHealth Caritas Louisiana Peer Review Committee

The network provider may request an appeal after the final decision of the Panel.

- The AmeriHealth Caritas Louisiana Quality Improvement Committee must receive the appeal by certified mail within 30 days of the network provider's receipt of the Committee's decision; otherwise the right to appeal is forfeited.
- Written appeal will be reviewed and a decision rendered by the AmeriHealth Caritas Louisiana Quality Improvement Committee (QIC) within 45 days of receipt of the notice of the appeal.

Summary Actions Permitted

The Market President of AmeriHealth Caritas Louisiana, and/or the AmeriHealth Caritas Medical Director can take the following summary actions without a hearing:

- Suspension or restriction of clinical privileges for up to 14 days, pending an investigation to determine the need for professional review action
- Immediate revocation, in whole or in part, of panel membership or network provider status subject to subsequent notice and hearing when failure to take such action may result in imminent danger to the health and/or safety of any individual. A hearing will be held within 30 days of this action to review the basis for continuation or termination of this action

External Reporting

The CMO will direct the Credentialing Department to prepare an adverse action report for submission to the National Provider Data Bank (NPDB), the Health care Integrity and Protection Data Bank (HIPDB), and State Board of Medical or Dental Examiners if formal Sanctions are imposed for quality of care deviations and if the Sanction is to last more than 30 days, and as otherwise required by law. (NOTE: NPDB reporting is applicable only if the Sanction is for quality of care concerns.)

If Sanctions against a network provider will materially affect AmeriHealth Caritas Louisiana's ability to make available all capitated services in a timely manner, AmeriHealth Caritas Louisiana will notify all necessary parties of this issue for reporting/follow-up purposes.

Utilization Management Program

The Utilization Management (UM) program description summarizes the structure, processes and resources used to implement AmeriHealth Caritas Louisiana's programs, which were created in consideration of the unique needs of its Enrollees and the local delivery system. All departmental policies and procedures, guidelines and UM criteria are written consistent with National Committee for Quality Assurance (NCQA) accreditation standards and other applicable State and federal laws and regulations. Where standards conflict, AmeriHealth Caritas Louisiana adopts the most rigorous of the standards.

Annual Review

Annually, AmeriHealth Caritas Louisiana reviews and updates its UM and policies and procedures, as applicable. These modifications, which are approved by the AmeriHealth Caritas Louisiana Quality Assessment Performance Improvement Committee, are based on, among other things, changes in laws, regulations, requirements, accreditation requirements, industry standards and feedback from health care providers, members and others.

Scope

The AmeriHealth Caritas Louisiana Utilization Management Program establishes a process for implementing and maintaining an effective, efficient utilization management system. Utilization management activities are designed to assist the practitioner with the organization and delivery of appropriate health care services to members within the structure of their benefit plan. The AmeriHealth Caritas Louisiana UM Program promotes the continuing education of, and understanding amongst, members, participating physicians and other health care professionals.

- Specialty Healthcare Referrals: The PCP may refer members for most outpatient specialty health care services from practitioners and providers participating in the AmeriHealth Caritas Louisiana Network.
- Services for Women from an OB/GYN practitioner, plain x-ray films, electrocardiograms, EPSDT screening services and services to treat an Emergency Medical Condition do not require authorization from AmeriHealth Caritas Louisiana. (Authorization from AmeriHealth Caritas Louisiana is required for a referral for covered services from a practitioner or provider who does not participate with AmeriHealth Caritas Louisiana.)
- Authorization: AmeriHealth Caritas Louisiana utilizes an authorization process to approve coverage for select covered services for AmeriHealth Caritas Louisiana members. AmeriHealth Caritas Louisiana performs non-urgent and urgent prior (pre- service) authorization review and review of ongoing services (concurrent review) of select health care services to determine Medical Necessity and eligibility for coverage under the member‘s benefit package. At certain times, when information is not available to make a prior or concurrent determination and services have already been provided, member records are reviewed retrospectively to determine benefit coverage and/or medical necessity. Utilization staff

may approve services based on application of AmeriHealth Caritas Louisiana's criteria. AmeriHealth Caritas Louisiana will not arbitrarily deny or reduce the amount, duration or scope of a required service because of the diagnosis, type of illness or condition of the member.

- Discharge Planning: AmeriHealth Caritas Louisiana nurses/social workers work collaboratively with staff from the Integrated Care Management programs to provide appropriate access to non-hospital based health care. Utilization Management staff work with the facility discharge planners to review and update the discharge plan, and take proactive actions to plan for discharge.

~~**Medical Necessity Decision Making**~~

~~Requests for benefit coverage or medical necessity determinations are made through staff supervised by a Registered Nurse. Decisions to approve coverage for care may be made by utilization management staff when falling within AmeriHealth Caritas Louisiana's written guidelines. Any request that is not addressed by, or does not meet, Medical Necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure or extension of stay, based on Medical Necessity, or to approve a service in an amount, duration or scope that is less than requested is made by a Medical Director or other designated practitioner under the clinical direction of the Regional Medical Director.~~

~~Medical Necessity decisions made by a Medical Director are based on the Department of Health and Hospital's definition of Medical Necessity [as defined in LAC 50:1.101 (Louisiana Register, Volume 37, Number 1)], in conjunction with the member's benefits, medical expertise, AmeriHealth Caritas Louisiana Medical Necessity guidelines, and/or published peer-review literature. At the discretion of the Medical Director, participating board-certified physicians from an appropriate specialty or other AmeriHealth Caritas Louisiana will not retroactively deny reimbursement for a covered service provided to an eligible member by a provider who relied on written or oral authorization from AmeriHealth Caritas Louisiana or an agent of AmeriHealth Caritas Louisiana, unless there was material misrepresentation or fraud in obtaining the authorization.~~

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

- ~~Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and~~
- ~~Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.~~
- ~~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 recipient requires at that specific point in time.~~
- ~~Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or~~

cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

AmeriHealth Caritas Louisiana shall not deny continuation higher level services for failure to meet medical necessity unless the service can be provided through an in-network or out-of-network provider for a lower level of care.[KG36][WR37]

AmeriHealth Caritas Louisiana will provide its Utilization Management (UM) criteria to network providers upon request. To obtain a copy of AmeriHealth Caritas Louisiana UM criteria:

- Call the UM Department at 1-888-913-0350
- Identify the specific criteria you are requesting
- Provide a fax number or mailing address

You will receive a faxed copy of the requested criteria within 24 hours or written copy by mail within five business days of your request.

Providers may also request prior authorization requirements used to make a medical necessity determination by sending an email to: DLACFCHB424Request@amerihealthcaritas.com. Prior authorization requirements will be furnished to the requesting provider within 24 hours of request.

Please remember that AmeriHealth Caritas Louisiana has Medical Directors and Physician Advisors who are available to address UM issues or answer your questions regarding decisions relating to Prior Authorization, DME, Home Health Care and Concurrent Review. To contact these resources call the Peer-to-Peer Hotline at: 1-866-935-0251.

Additionally, AmeriHealth Caritas Louisiana would like to remind health care providers of our affirmation statement regarding incentives:

- Utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage;
- Providers, associates or other individuals conducting utilization review are not rewarded by AmeriHealth Caritas Louisiana for issuing denials of c overage or service; and
- Financial incentives for UM decision makers do not encourage decisions that result in under- utilization.

Hours of Operation

AmeriHealth Caritas Louisiana provides and maintains a toll free number for health care providers, and members to contact AmeriHealth Caritas Louisiana's UM staff. The toll free number is 1-888-913-0350. AmeriHealth Caritas Louisiana's UM Department is available to answer calls from health care providers during normal business hours, 8:00 a.m.-5:00 pm (CST). Translation services are available as needed.

After business hours and on weekends and holidays, health care providers, practitioners and members are instructed to contact the on call clinician through the toll free number 1-888-913-0350. Callers will automatically be routed to the Member Services' department. A member services representative will assist in connecting the provider to the appropriate on call clinician.

Timeliness of UM Decisions

Several external standards guide AmeriHealth Caritas Louisiana's timelines for UM decisions and notifications. These include NCQA, Local requirements and accompanying regulations, and other applicable state and federal laws and regulations. When standards conflict, AmeriHealth Caritas Louisiana adopts the more rigorous of the standards. The table below identifies AmeriHealth Caritas Louisiana's timeliness standards.

Table: Timeliness Of UM Decisions

Case Type	Decision	Initial Notification	Written Confirmation
Urgent Prior Authorization	As expeditiously as the member's health requires, no later than 72 hours from receipt of the request	As expeditiously as the member's health requires, no later than 72 hours from receipt of the request	Within the earlier of 2 business days from the decision or 72 hours of the request
Non-Urgent Prior Authorization	Within 2 business days of receiving the necessary information or 14 calendar days from receipt of the request	As expeditiously as the member's health requires, no later than 1 business day of making the decision	Within the earlier of 2 business days from the decision or 14 calendar days of the request
Concurrent Review	Within 1 business day from receipt of the request	Within 1 business day from receipt of the request	Within 1 business day from receipt of the request
Retrospective Review	30 calendar days from receipt of the request; no later than 180 days from the date of service	Not Applicable	Within 30 calendar days from receipt of the request

The timeframes for decisions and notification may be extended if additional information is needed to process the request. In these instances, the member and requesting Health Care Provider are notified of the required information in writing.

Physician Reviewer Availability to Discuss Decision

If a practitioner wishes to discuss a medical necessity decision, AmeriHealth Caritas Louisiana's physician reviewers are available to discuss the decision with the practitioner. Calls to discuss the determination are accepted

- Within 3 business days of verbal notification. All requests must be completed within 1 business day of request. Up to 48 hours or the end of the second (2nd) business day after the member's discharge date, whichever is later
- Up to 48 hours or until the end of the second (2nd) business day after a determination of a retrospective review has been rendered, whichever is later.

A dedicated Peer-to-Peer reconsideration line is available for practitioners to call at 1-866-935-0251. A physician reviewer

~~is available at any time during the business day to interface with practitioners. If a practitioner is not satisfied with the outcome of the discussion with the physician reviewer, then the practitioner may file a formal provider dispute of a Medical Necessity Decision.~~

~~Denial Reasons~~

~~All denial letters include specific reasons for the denial, the rationale for the denial and a summary of the UM criteria.~~ [KG38] ~~In addition, if a different level of care is approved, the clinical rationale is also provided. These letters incorporate a combination of NCQA standards, requirements and Department of Health requirements. Denial letters are available in six languages for members with Limited English Proficiency. Letters are translated into other languages upon request. This service is available through the cooperation of Member Services and Utilization Management.~~

~~Appeal Process~~

~~All denial letters include an explanation of the member's rights to appeal and the processes for filing appeals through the AmeriHealth Caritas Louisiana Medical Necessity Appeal Process and the Fair Hearing Process. Members contact the Member Service Unit to file Grievances or Appeals; a member advocate is available to assist members as needed.~~

~~Evaluation of New Technology~~

~~When AmeriHealth Caritas Louisiana receives a request for new or emerging technology, it compiles clinical information related to the request and reviews available evidence-based research and/or technology assessment group guidelines. AmeriHealth Caritas Louisiana Medical Directors make the final determination on coverage.~~

Evaluation of Member & Provider Satisfaction and Program Effectiveness

Annually, the UM department completes an analysis of member and network provider satisfaction with the UM Program. At a minimum, the sources of data used in the evaluation include the annual member satisfaction survey results, member complaint and grievance data, provider satisfaction survey results, and provider complaint and appeal data.

To support its objective to create partnerships with physicians, AmeriHealth Caritas Louisiana actively seeks information about network provider satisfaction with its programs on an ongoing basis. In addition to monitoring health care provider complaints, AmeriHealth Caritas Louisiana holds meetings with network providers to understand ways to improve the program. Monthly, the department reports telephone answering response, abandonment rates and decision time frames.

SECTION X: SPECIAL NEEDS & CASE MANAGEMENT

Integrated Care Management (Health Education and Management)

AmeriHealth Caritas Louisiana's Integrated Care Management (ICM) program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This means that Complex Case Management and Disease Management is a fully integrated model that allows members to move seamlessly from one component to another, depending on their unique needs.

Several services overlap all five components. Each component includes targeted interventions for special needs populations, EPSDT-eligible populations and members with chronic conditions. There are five core components to our Integrated Care Management (ICM) program: Pediatric Preventive Health Care, Episodic Care Management, Bright Start (Maternity Management), Complex Care Management (CCM), and Rapid Response. Each of these is summarized below.

Pediatric Preventive Health Care

The Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of members under age 21 by increasing adherence to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program guidelines. We accomplish this by identifying and coordinating preventive services for these members. Additional information on this program and coverage for EPSDT Services may be found in Section IV of this *Provider Manual*.

Episodic Care Management

The Episodic Care Management (ECM) program coordinates services for members with short- term and/or intermittent needs who have single problem issues and/or co-morbidities. The Care Manager supports members in the resolution of pharmacy, DME and/or dental access issues, transportation needs, identification of and access to specialists, and coordination with behavioral health providers or other community resources. Care Managers perform comprehensive assessments, address short-term and long-term goals, and develop a plan of care with input from the member and the physician(s). The ECM team has both RN and MSW Care Managers.

Bright Start (Maternity Management)

The Bright Start (Maternity) Program is managed by a dedicated team of Care Managers and Care Connectors. The Bright Start team outreaches to pregnant members and engages them in the program based on internal and external assessments that stratify them into high- and low-risk categories. Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period, including dental screenings and depression screenings. Members assessed as low-risk receive information via mailings with access to a Care Manager as necessary. Members identified as high-risk are managed by the plan with a team of both Care Managers and Care Connectors.

For more information about this program, please refer to the detailed program description later in this section of the *Provider Manual*

Complex Care Management

Members identified for Complex Care Management (CCM) receive comprehensive and disease- specific assessments, and reassessments, along with the development of short-term and long- term goals and an individual plan of care, created with input from the member/caregiver and the physician(s). These programs include Diabetes, COPD, Asthma, Sickle Cell, Obesity, HIV/AIDS, Hepatitis C and Cardiovascular Disease. The CCM process includes performing an initial assessment, reassessing and adjusting the care plan and its goals as needed. Care Connectors in Rapid Response are assigned tasks to assist the member with various interventions under the direct supervision of the Care Manager. Care Managers coordinate care and address various issues including but not limited to: pharmacy, DME and/or dental access, assistance with transportation, identification of and access to specialists and coordination with behavioral health providers or other community resources. The Complex Care Management team contains both nurse and social worker Care Managers. Using Motivational Interviewing Skills, the Care Managers develop a rapport with engaging them in care management programs for a timeframe based on their individual needs.

Rapid Response Team

An important component of the ICM model, the Rapid Response (RR) team was developed to address the urgent needs of our members and to support our providers and their staff. The RR team consists of registered nurses, social workers, and non-clinical Care Connectors.

There are three key service functions performed in the Rapid Response unit:

- Inbound Call Service – Members and providers may request RR support via a direct, toll- free Rapid Response line. Providers can call the Rapid Response team for assistance coordinating care for members in their office; to request assistance for members who need community resources or to refer a member for any care management service.
- Outreach Service – Outreach activities include telephonic survey or assessment completion and support of special projects or quality initiatives. RR employees also initiate follow-up calls to members recently discharged from the hospital and members who contacted the 24- hour Nurse Line the previous day.
- Care Management Support – Care Connectors support Care Managers by completing tasks and reminder calls in support of the individualized plan of care. These include appointment scheduling and reminders, transportation support, member educational mailings, and other administrative tasks assigned by Care Managers.

Several services overlap all five core components. Each component includes targeted interventions for special needs populations, EPSDT-eligible populations and members with chronic conditions.

Let Us Know is a program designed to partner AmeriHealth Caritas Louisiana with the provider community by collaborating in the engagement and management of our chronically ill members. We have support teams and tools available to assist in the identification, outreach, and education of these members, as well as clinical resources for providers in their care management. There are three ways to let us know about chronically ill members:

1. Contact our Rapid Response and Outreach Team:

The Rapid Response and Outreach Team (RROT) address the urgent needs of our members and supports providers and their staff. The RROT consists of Registered Nurses, Social Workers, and Care Connectors who are trained to assist members in investigating and overcoming the barriers to achieving their health care goals. They are here to support you, call them at 1-888-643-0005 from 8:00 a.m. until 5:30 p.m.

OR

2. **FAX** a Member Intervention Request form to **1-866-426-7309** or complete and submit online**. This form can be found at http://www.amerihealthcaritasla.com/pdf/provider/resources/forms/member-intervention-request-form.pdf**

OR

3. **Refer a patient to the Complex Case Management Program**

Complex Case Management is a voluntary program focused on prevention, education, lifestyle choices and adherence to treatment plan and is designed to support your plan of care for patients with chronic diseases, such as asthma, diabetes, or coronary artery disease. Members receive educational materials and, if identified as high risk, will be assigned to a Care Manager for one-on-one education and follow up. For more information, or to refer a patient to the Complex Case Management program, call **1-888-643-0005**.

Special Needs

AmeriHealth Caritas Louisiana uses several methods to identify members with special health needs, including data analysis and new member surveys and triggers. Our processes focus on identification of conditions that require ongoing management, such as chronic illness, and specific services, including home health care, therapy, and equipment or oxygen rental, that may indicate an ongoing course of treatment or complex needs.

The health plan looks for diagnostic and procedure code indicators of chronic conditions, as well as services and bills from select provider types. In addition, the plan will use the data to produce a predictive model of the population, identifying members who are at risk for future avoidable episodes of care

Table 1: Special Health Needs Indicators

Diagnoses	Service	Provider Types
• Pregnancy • Asthma • Autism • Cardiac Artery Disease • Chronic Obstructive • Pulmonary Disease • Depression • Diabetes • Heart Failure	• Cancer Treatment (chemotherapy or radiation therapy) • Home Health Care • Oxygen • DME rental • Therapy • Dialysis	• Home Health Agency • DME Company • Transportation • Dialysis Facility • Hospice
Diagnoses	**Service**	**Provider Types**
• HIV/AIDS • Hepatitis C • Sickle Cell Anemia		
Behavioral Health Population – Individuals with special care needs:		
• Individuals with co-occurring disorders • Individuals with intravenous drug use • Pregnant women with substance use disorders or co-occurring disorders • Substance using women with dependent children • Children with behavioral health needs in contact with other child serving systems who are not eligible for CSoC • Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination • Adults, 21 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter the CSoC program.		

Providers are encouraged to refer members with Special Health Needs to the Rapid Response team for triaging into one of our care management programs. The Rapid Response Team can be reached by calling 1-888-643-0005

Bright Start Program for Pregnant Members

AmeriHealth Caritas Louisiana has developed a comprehensive prenatal risk reduction program in an effort to decrease the poor obstetrical outcomes of our pregnant population, which were evidenced by the following:

- High percentage of low birth-weight infants
- High NICU length of stay
- Infant readmission rates
- Rising preterm births

- Increased incidents of maternal complication requiring extended hospitalizations

The goals of the Bright Start Program are:

- Early identification of pregnant members
- Early and continued intervention throughout pregnancy
- Education and follow-up to promote recommended infant care
- Introduction and Education on Interpregnancy Care

AmeriHealth Caritas Louisiana utilizes several means to identify members as early in their pregnancy as possible. These include but are not limited to claim data analysis, information from the initial health assessment, referrals from internal AmeriHealth Caritas Louisiana Department, the use of member newsletters and referral networks, and physician referrals. Members who agree to participate in the Bright Start Program are paired with an AmeriHealth Caritas Louisiana Bright Start Care Manager. The Bright Start Care Manager works closely with the member, assuring that she has the means necessary to receive prenatal care and instruction and respond to various social and medical needs. Bright Start Care Managers offer the following types of special services to our Bright Start members:

- Motivational Interviewing
- Health Coaching
- Counseling
- Health Education
- Connection to social support services

Members may refer themselves to the participating OB/GYN specialist of choice for maternity care services, including the initial visit.

Bright Start separates pregnant members into low and high intensity risk categories:

- Low Risk Pregnancy Management - Members receive Care Coordination from Care Connectors, pregnancy-related educational materials encouraging good prenatal care and regular outreach calls

- High Risk Pregnancy Management - Pregnant members identified at risk for preterm labor and/or other pregnancy complications are assigned a Nurse Care Manager to provide ongoing supervision and education concerning pregnancy. A letter is sent to the member's physician to notify him/her of the member's enrollment in the program with a summary of the initial assessment

- Prior Authorization is not required for 17P/Progesterone administration Alere Services are offered for in home administration of non-branded compounded 17P. This service also includes an obstetrical registered nurse to perform an in home assessment, pre-term labor education and progesterone injection on a weekly basis. Another option for progesterone injection is Makena (J1725). It is a covered Medical benefit under a buy and bill process. The provider will be required to obtain Makena through a specialty pharmacy and bill the plan after each injection and office visit. Please call Bright Start if you have any questions. 1-888-913-0327.

All pregnant members have access to a 24-hour toll free registered nurse call line at 1-888-632-0009. All pregnant members are encouraged to select a pediatrician prior to delivery. For more information or to refer members to the Bright Start Program call 1-888-913-0327.

Outreach & Health Education Programs

The goal of AmeriHealth Caritas Louisiana's Health Education Programs is to increase members' knowledge of self-management skills for selected disease conditions. These health education programs focus on prevention in order to help members improve their quality of life. The AmeriHealth Caritas Louisiana Community Education Department works in collaboration with Outreach and Rapid Response units to achieve desired outcomes.

Tobacco Cessation

The tobacco cessation program offers members a series of educational classes easily accessible within their communities. The program offers targeted outreach to members who are pregnant or who have chronic conditions such as asthma, diabetes, cardiovascular disease or other serious medical conditions, encouraging these members to enroll in tobacco cessation classes. For more information go to the Louisiana Tobacco Control Program website: www.latobaccocontrol.com or you can call 1-800-QUIT-NOW.[AB39][WR40]

Gambling Addiction

If -a member has a gambling problem or concern, call or text the Louisiana Problem Gamblers Helpline **1-877-770-STOP (7867)** or visit **http://ldh.la.gov/index.cfm/page/2253**.

Gift of Life

The Gift of Life is an outreach program developed to increase members' awareness of the importance of a mammography screening and to encourage female members age 50 and older to have regularly scheduled mammograms. AmeriHealth Caritas Louisiana establishes partnerships with community organizations. Designated outreach staff contacts members by phone or mail, to schedule mammography screenings, remind AmeriHealth Caritas Louisiana members of appointments, and reschedule appointments if necessary. All results are sent to the PCP for follow-up.

Domestic Violence Intervention

There has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals and families. Health care providers can play an important role in identifying domestic violence. Routine screening for domestic violence increases the opportunity for effective intervention and enables health care providers to assist their patients, and family members who are victims.

Louisiana has many resources for domestic violence victims and their family members.

Domestic Violence Resource	Contact Information
Louisiana Coalition Against Domestic Violence	State-wide Domestic Violence Hotline: 1-888-411-1333 www.lcadv.org
National Domestic Violence Hotline	1-800-799-SAFE (7233) www.thehotline.org
Louisiana Foundation Against Sexual Assault Domestic Violence Advocates and Support Contacts (An Abuse, Rape and Domestic Violence Resource Collection)	www.lafasa.org Louisiana specific information: www.aardvarc.org/dv/sttes/ladv.shtml

For more information, including the National Coalition Against Domestic Violence Fact Sheet, visit the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

Early Steps (Early Intervention System)

Louisiana's Early Intervention is a collection of services and supports that help families to enhance their skills in raising a child with disabilities; these services and support are covered through Louisiana's Early Steps Program. AmeriHealth Caritas Louisiana will help coordinate services and access to early intervention programs.

Early Steps provides services to families with infants and toddlers aged birth to three years (36 months) who have a medical condition likely to result in a developmental delay, or who have developmental delays. Children with delays in cognitive, motor, vision, hearing, communication, social-emotional or adaptive development may be eligible for services. Early Steps services are designed to improve the family's capacity to enhance their child's development. These services are provided in the child's natural environment, such as the child's home, child care or any other community setting typical for children aged birth to 3 years (36 months).

When a child turns three years of age, the responsibility for funding Early Intervention services is an education expense. Children may remain eligible for Early Intervention services through the minimum age at which a child can attend first grade in his/her own school district.

An infant or toddler (birth to three years of age) is eligible for Early Intervention Services if he/she:

- Shows a significant delay in one or more areas of child development
- Has a physical disability, a hearing or vision loss
- Receives a specialist's determination that a delay exists even though it is not evident on evaluations (called informed clinical opinion)
- Has a known physical or mental condition with a high probability for developmental delay (Down Syndrome is one example)

If an infant or toddler is found not to be eligible for Early Intervention, he/she may still be eligible for follow-up tracking in the event the needs of the child and family change.

Children eligible for tracking are:

- Born weighing less than 3 ½ pounds
- Cared for in a neonatal intensive care unit
- Born to mothers who are chemically addicted
- Found to have blood lead levels at 15 micrograms per deciliter and above

The services provided to eligible children and their families are individualized in accordance with the developmental needs of each child. Early Intervention supports may include a range of informal and formal opportunities, experiences and resources found in each family's community.

Families with concerns about their child's development should consult their family network provider. If parents have continuing concerns, or want additional information, please go to the Early Steps website: http://new.dhh.louisiana.gov/index.cfm/page/139/n/139.

Early Intervention is directed to the System Point of Entry Office in the region of Louisiana where the family resides.

Initial contact with the referred family occurs locally at a time and place convenient to the family. A screening at no-cost to the family will be offered to determine if the child shows any areas of delay. Further evaluations may determine eligibility for Early Intervention services or follow-up tracking.

SECTION XI: BEHAVIORAL HEALTH ADDENDUM

Behavioral Health Services

AmeriHealth Caritas Louisiana covers behavioral health services performed in the PCP office for members with emotional, psychological, substance ~~abuse~~[KF41]use, psychiatric symptoms, and/or disorders, including:

- Screening, prevention and early intervention services including screening services as defined in the EPSDT benefit (The EPSDT benefit guarantees coverage of screening services which must, at a minimum, include a comprehensive health and developmental history – including assessment of both physical and mental health.);
- Behavioral health services provided in the member's PCP or medical office (CPT codes 99201-99215) when provided by a Licensed Mental Health Professional (LMHP);
- Outpatient non-psychiatric hospital services provided by non-psychiatric providers based on medical necessity;
- Behavioral health services provided in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC);

PCPs and other physical health care providers are required to screen for behavioral health care and often need to recommend that a member access specialized behavioral health services.

Members who are prescribed a controlled substance must have a patient specific query completed through the Prescription Monitoring Program (PMP). This should be completed upon writing the first prescription and annually. Additional queries can be performed at the prescriber's discretion. All PMP queries should be printed and filed in the member's medical record.

Cooperation between network providers and the Specialized Behavioral Service Providers is essential to ensure members receive appropriate and effective care.

Behavioral health providers will follow the same billing procedures as medical health care providers. Please refer to the "Claims Filing Instructions" located on AmeriHealth Louisiana's website. These instructions will provide billing information and line-by-line instructions. Please contact Provider Services department at 1-888-922-0007, option 2, with any questions.

Behavioral Health Access and Appointment Standards

AmeriHealth Caritas Louisiana has established standards for accessibility of medical care services, in alignment with Louisiana Department of Health requirements. The standards listed below are requirements of the provider contract:

Appointment Availability and Access to Care Measures		Standards
	Psychiatric Inpatient Hospital	Admit to hospital not to exceed 4 hours (emergency involuntary), 24 hours (involuntary) or 24 hours (voluntary)

Appointment Availability and Access to Care Measures		Standards
	ASAM Level 3.3, 3.5, and 3.7	Within 10 business days
Appointment Availability	Withdrawal Management	Within 24 hours when medically necessary
	Psychiatric Residential Treatment (PRTF)	Within 20 calendar days
	Behavioral Health Life-Threatening Emergent Care	An appointment shall be arranged within 1 hour of request or ER/UCC/CC
	Behavioral Health Non-Life Threatening Emergent Care	6 hours or ER/UCC/CC
	Behavioral Health Urgent Non-emergency Care	An appointment shall be arranged within 48 hours of request
	Behavioral Health Initial Visit Routine Non-Urgent Care	Within 14 days
	Behavioral Health Follow-Up Visit Routine Care	30 days
	Behavioral Health Follow-Up Post Discharge Care	Within 30 days of discharge
	According to hospital discharge instructions	According to hospital discharge instructions
	Wait time in office for scheduled appointments	Not to exceed 45 minutes
	Delayed appointments	Notify Patient immediately if provider is delayed and if anticipated to be more than a 90 Minute Wait Time the member shall be offered a new appointment
	Walk-in patients	Seen ASAP/Follow written provider procedures

AmeriHealth Caritas Louisiana monitors after-hours standards on a routine basis. The standards are outlined below.

- Provider shall either utilize an after-hours answering service or have a recorded message that includes instruction to dial 911, go to an emergency room, or to stay on line if there is an emergency situation.
- Recorded messages shall have an option to reach a live party.
- Afterhours offers an option to speak with a medical provider within 30 minutes.

AmeriHealth Caritas Louisiana monitors compliance with appointment standards in a variety of ways: During visits by your Provider Network Account Executive, monitoring member complaints, telephone surveys, and mystery shopper calls. Non-compliant providers are notified of all categories requiring improvement and required to submit a corrective action plan to meet the performance standards within a specific time period.

Covered Behavioral Health Benefits

Behavioral Health Services include:

- Basic Behavioral Health Services: Services provided through primary care, including but not limited to, screening for mental health and substance abuse issues, prevention, early intervention, medication management, and treatment and referral to specialty services.
- Specialized Behavioral Health Services:
  - Licensed Practitioner Outpatient Therapy
    - Parent-child interaction therapy (PCIT)
    - Child Parent Psychotherapy (CPP)
    - Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)
    - Triple P
    - Trauma Focused-Cognitive Behavioral Therapy

  Mental Health Rehabilitation Services
  - Community Psychiatric Support and Treatment (CPST)
    - Multi-Systemic Therapy (MST) (Age ~~0-20)~~12-17
    - Functional Family Therapy (FFT) (Age ~~0-20)~~10-18
    - FFT-CW (Age 0-18)
    - Homebuilders (Age 0~~-20~~ 18~~)~~
    - Assertive Community Treatment (Age 18 and older)
  - Psychosocial Rehabilitation (PSR)
  - Crisis Intervention
  - Crisis Stabilization (Age 0-20)

  Therapeutic Group Homes (TGH) (Age 0-20)

  Psychiatric Residential Treatment Facilities (PRTF) (Age 0-20)

  Inpatient Hospitalization (Age 0-21; 65 and older)

  Outpatient and Residential Substance Use Disorder Services

  Medication Assisted Treatment[AB42] for alcohol, OUD and SUD as medically necessary

Screening for Basic Medical Health Services

AmeriHealth Caritas Louisiana requires that all Behavioral Health providers to screen for basic medical issues. Behavioral

Health provider may utilize the AmeriHealth Caritas Louisiana Medical Screening form.

Behavioral Health & Substance Use Covered Services				
Covered Service	**Mandatory MCO Populations – All Covered Services (includes Voluntary Opt In Populations who have opted in)**	**Mandatory MCO Populations – Specialized BH Coverage Only without NEMT ** (Dual eligibles and others in institutions who have not opted in)**	**Mandatory MCO Populations – Specialized BH Coverage and NEMT ** Services Only (Dual eligibles only)**	**CSOC Population - All covered services except Specialized Behavioral Health and Coordinated System of Care (CSOC) services**
Basic BH Services	Yes	No	No	Yes
Services Provided by a Psychiatrist	Yes	Yes	Yes	No
Services Provided by an Licensed Mental Health Professional (LMHP)	Yes	Yes	Yes	No
MHRS: Community Psychiatric Support and Treatment (CPST)	Yes	No	Yes	No
CPST: Multi-Systemic Therapy (MST)	Yes for under age 21	No	Yes for under age 21	No
CPST: Functional Family Therapy (FFT)	Yes for under age 21	No	Yes for under age 21	No
CPST: Homebuilders	Yes for under age 21	No	Yes for under age 21	No
CPST: Assertive Community Treatment (ACT)	Yes for 18 and older	No	Yes for age 18 and over	No
MHRS: Psychosocial Rehab (PSR)	Yes	No	Yes	No

Behavioral Health & Substance Use Covered Services				
Covered Service	**Mandatory MCO Populations – All Covered Services (includes Voluntary Opt In Populations who have opted in)**	**Mandatory MCO Populations – Specialized BH Coverage Only without NEMT ** (Dual eligibles and others in institutions who have not opted in)**	**Mandatory MCO Populations – Specialized BH Coverage and NEMT ** Services Only (Dual eligibles only)**	**CSOC Population - All covered services except Specialized Behavioral Health and Coordinated System of Care (CSOC) services**
MHRS: Crisis Intervention	Yes	No	Yes	No
MHRS: Crisis Stabilization	Yes for under age 21	No	Yes for under age 21	No
PRTF (Psychiatric Residential Treatment Facility)	Yes for under age 21	Yes for under age 21	No	Yes
Inpatient Hospital – Acute Hospital (MH unit)	Yes	Yes if not dual eligible; no for dual eligible	Yes if not dual eligible; no for dual eligible	No
Freestanding Psychiatric Hospital / Institute for Mental Diseases (IMD)	Yes for under 22 and over 65 (see in lieu of services for between 22 and 65)	Yes for non-dual eligibles under 22 and over 65 (see in lieu of services for non-dual eligibles between 22 and 65)	Yes for non-dual eligibles under 22 and over 65 (see in lieu of services for non-dual eligibles between 22 and 65)	No
Therapeutic Group Homes (has a non-Medicaid funding component for room and board)	Yes for under age 21	No	Yes for under age 21	No
SUD: Outpatient	Yes	Yes	Yes	No
SUD: Intensive Outpatient	Yes	Yes	Yes	No
SUD: Residential	Yes	Yes	Yes	No

Behavioral Health & Substance Use Covered Services				
Covered Service	**Mandatory MCO Populations – All Covered Services (includes Voluntary Opt In Populations who have opted in)**	**Mandatory MCO Populations – Specialized BH Coverage Only without NEMT ** (Dual eligibles and others in institutions who have not opted in)**	**Mandatory MCO Populations – Specialized BH Coverage and NEMT ** Services Only (Dual eligibles only)**	**CSOC Population - All covered services except Specialized Behavioral Health and Coordinated System of Care (CSOC) services**
SUD: Methadone ~~(Pending CMS approval)~~	Yes	Yes	Yes	No
CPST: Permanent Supportive Housing (Section 6.4.5) Tenancy Supports (CPST/PSR)	Yes	Yes	Yes	No
In Lieu Of: Residential SUD in freestanding facility for adults ages 22-64	Yes	Yes	Yes	No
In Lieu of: Freestanding Psych Hospital / IMD for adults ages 22-64	Yes	Yes	Yes	No
In Lieu of: 23-Hour Observation Bed Services for all Medicaid Eligible Adults (Age 21 and Above)	Yes	Yes	Yes	No
In Lieu of: Crisis Intervention Services All Medicaid Eligible Adults (Age 21 and Above)	Yes	Yes	Yes	N/A
In Lieu of: Crisis Stabilization Units for All Medicaid Eligible Adults (Age 21 and Above)	Yes	Yes	Yes	No

Behavioral Health & Substance Use Covered Services				
Covered Service	**Mandatory MCO Populations – All Covered Services (includes Voluntary Opt In Populations who have opted in)**	**Mandatory MCO Populations – Specialized BH Coverage Only without NEMT ** (Dual eligibles and others in institutions who have not opted in)**	**Mandatory MCO Populations – Specialized BH Coverage and NEMT ** Services Only (Dual eligibles only)**	**CSOC Population - All covered services except Specialized Behavioral Health and Coordinated System of Care (CSOC) services**
In Lieu of: Injection Services Provided by Licensed Nurses to All Medicaid Eligible Adults (Age 21 and Above)	Yes	Yes	Yes	No

Glossary:
SUD = substance use disorders
LMHP = Licensed Mental Health Professional. (Includes medical psychologists, licensed psychologists, LCSW, LPC, LMFT, LAC, APRN)
LCSW = Licensed Clinical Social Worker
LPC = Licensed Professional Counselor
LMFT = Licensed Marriage and Family Therapist
LAC = Licensed Addictions Counselor
APRN = Advanced Practice RN
PRTF = Psychiatric Residential Treatment Facilities
MHRS = Mental Health Rehab Services
SMI = Seriously Mental Illness (for adults only)
SED = Serious Emotional Disturbance (for ~~kids~~ youth only)
CSOC = Coordinated System of Care

** NEMT:

- The NEMT benefit refers to non-emergency transportation not provided in an ambulance. This benefit is not covered for all recipients. Non-emergency transportation in an ambulance is covered for all recipients.

- When a member is deemed presumptively eligible for CSOC on the 1st of the calendar month, Magellan is responsible for all specialized BH services as of the 1st of that calendar month

- When a member is deemed presumptively eligible for CSOC on the 2nd – 31st of a calendar month, AmeriHealth Caritas Louisiana is responsible for all specialized BH services until the 1st of the next calendar month. Magellan is responsible for all specialized BH services as of the 1st of the next calendar month

Integrating Behavioral and Physical Health Care

Members with behavioral health disorders may also experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions. AmeriHealth Caritas Louisiana understands that coordination of care for these members is imperative. AmeriHealth Caritas Louisiana's integrated health care management platform, will, to the extent permissible under law, be delivered across the physical and behavioral health and social service areas.

AmeriHealth Caritas Louisiana staff will work with the appropriate primary care physician and behavioral health providers to develop an integrated Treatment Plan for members in need of physical and behavioral health care coordination. Care Managers will also assure that communication between the two disciplines, providers and organizations, occurs and, with appropriate consent, for all members with physical and behavioral health issues. Care Managers will also work to coordinate with alcohol and drug abuse providers and community resources, as permitted under the law. Care Managers will proactively and regularly follow-up on required physical and behavioral health services, joint treatment planning and provider-to-provider communication to ensure that member needs are continuously reviewed assessed and documented in the Treatment Plan.

For care coordination assistance, behavioral health providers may contact: **Rapid Response 1-888-643-0005.**

Benefit & service descriptions:

~~**Applied Behavioral Analysis (ABA):** ABA-based services are available to Medicaid recipients under 21 years of age who:~~

- ~~Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (e.g., aggression, self-injury, elopement, etc.);~~
- ~~Have been diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder, by a qualified health care professional;~~
- ~~Had a comprehensive diagnostic evaluation by a qualified health care professional; and~~
- ~~Have a prescription for ABA-based therapy services ordered by a qualified health care professional.~~

~~**NOTE:** All of the above criteria must be met to receive ABA-based services.~~[KF43][WR44]

Mental Health Outpatient Services: These services are planned, regularly scheduled visits to a doctor, counselor, or therapist to talk about your mental health issues. These can include: individual, family, and group therapy, psychological and/or neuropsychological testing.

Behavioral Health Inpatient Hospitalization: These are the most intensive services available. Hospitalization usually occurs when members are at risk of harming themselves or others, experiencing a behavioral health crisis, when medications need close and continual checking, or when other services tried in the community have not helped to solve the problems that brought the member in for service.

Psychiatric Rehabilitation Treatment Facility (PRTF): This service involves providing long term behavioral health care in a 24- hour group living facility for members under the age of 21.

Therapeutic Group Home: These are community based 24-hour live-in services where the youth lives in a home-like

setting with other youth to receive behavioral health services. This service is only available for youth members under 21 years old.

~~**Psychosocial Rehabilitation:** This service is for members that live within the community and is designed to help members achieve their goals and be able to continue to work and live in the community with family and friends. Members receive assistance in day to day life skills and related goals.~~ [KF45]

Community Based Services: Clearly focused services provided in the community.

1. **Community Psychiatric Support and Treatment (CPST)**: Counseling services that are provided in the home, at work, or at school.

2. **Psychosocial Rehabilitation:** This service is for members that live within the community and is designed to help members achieve their goals and be able to continue to work and live in the community with family and friends. Members receive assistance in day to day life skills and related goals. [KF46]

~~1.~~

~~2.~~3. **Multi-systemic Therapy (MST)**: This family based service is for members 12-17 years of age. It provides home and community behavioral health services designed to help keep the youth in the home. These services focus on providing a more safe, secure, and enhanced quality of life for the family.

~~3.~~4. **Family Functional Therapy (FFT)/FFT-Child Welfare (FFT-CW)**: FFT services are for members 10 to 18 years of age and their family to help focus on behavioral issues like "acting out." FFT-Child Welfare covers ages 10 and under. This service is provided in the home or community setting. It is designed to help members change their behaviors.

~~4.~~5. **Homebuilders (HB):** This in-home service is for families with children age birth to 18 that provides clearly focused therapy such as family counseling and parent training. These services focus on a more safe, secure, and better quality home life for the member and family.

~~5.~~6. **Assertive Community (ACT):** This service is provided for adults with serious mental illness. A team of providers will work with the member where they live. Services can include counseling, substance use disorder therapy, housing assistance, and medication management.

Crisis Intervention/~~Stabilization~~ [KF47]**:** ~~Services that can be used any time of day or night to help when a member is in a crisis. Our goal is to include the family in all of the member's ongoing behavioral health needs during this time. Stabilization is provided in the home and often overnight. Crisis Intervention is provided by mental health rehabilitation. Transportation is available for eligible members for crisis intervention~~Crisis intervention is provided by a mental health rehabilitation (MHR) provider usually in a home setting.

Crisis Stabilization: These services occur in a secure setting with mental health professionals and includes assessments and intervention services to reduce crisis. This occurs in a secure setting with professionals.

Addiction Services: These services help members deal with challenges of drug and alcohol use. These services ~~may or may not be provided in a hospital or residential facility~~can be inpatient, residential or outpatient and [KF48]are designed to help the member stop using alcohol and/or drugs. ~~Members may or may not stay at the program overnight~~.

~~**Specialized Behavioral Health Services for Adults:** Members with serious mental illness may be eligible for Mental Health Rehabilitation Services such as Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT) and Permanent Supportive Housing (PSH). [KF49]~~

NOTE: PSR and CPST Providers

In order to be eligible to receive Medicaid reimbursement, all behavioral health services providers rendering PSR or CPST services must meet the requirements set forth in ACT 582:

1. Be licensed as a BHSP agency
2. Be accredited by a department-approved accrediting organization
3. Have a National Provider Identification Number (NPI)
4. Implement a member choice form
5. Be credentialed and in the provider network of the MCO
6. Employ at least one (1) full-time physician or LMHP to supervise
7. Provide supervision for unlicensed individuals
8. Meet other requirements noted in the LDH Behavioral Health Services Provider Manual
9. This legislation summary is not an all-inclusive list of requirements for providing PSR or CPST services, nor for receiving Medicaid reimbursement. The requirements noted in this legislation summary establish minimum standards for a limited number of requirements. The Louisiana Department of Health may establish additional requirements, and may strengthen standards of requirements noted in this legislation summary.
10. Providers must meet all requirements in statute, in rule, and in the Medicaid Behavioral Health Services Provider Manual. Providers should refer to the *Medicaid Behavioral Health Services Provider Manual* accessible via www.lamedicaid.com to find more information about standards, qualifications and requirements established to provide PSR or CPST services to Medicaid recipients.

Detailed information about these requirements can be found in the Medicaid Behavioral Health Services Provider Manual. Please review thoroughly to ensure that you are complying with these new requirements.

~~**Specialized Behavioral Health Services**~~

~~AmeriHealth Caritas Louisiana covers many of the behavioral health services available to AmeriHealth Caritas Louisiana members. [KF50]~~

-Behavioral Health Services Requiring Prior Authorization

The following is a list of behavioral health services requiring prior authorization review for medical necessity and place of service. The AmeriHealth Caritas Louisiana Behavioral Health Utilization Management (Behavioral Health UM) department hours of operation are 8 am – 5 pm, Monday through Friday. The Behavioral Health Utilization Management department telephone number is 1-855-285-7466. The Behavioral Health Utilization Management department fax number is 1-855-301-5356.

- All out of network services (except ~~in~~ ER)
- Electroconvulsive Therapy (ECT)
- Psychiatric Health Facility (PRTF) ~~for ASAM~~ including ~~Level 3.7~~
- Psychiatric In-patient services
- Psychoanalysis

- Psychological and Neuropsychological Testing
- Respite Care (Adult Crisis Stabilization)
- Community Psychiatric Supportive Treatment (CPST) including:
  - Homebuilders (HB)
  - Functional Family Therapy (FFT)
  - Assertive Community Treatment (ACT)
  - Multisystemic Therapy (MST)
- Crisis Intervention Follow Up Services
- Crisis Intervention- requires notification post service
- Psychosocial Rehabilitation (PSR)
- Short Term Residential Care in a Therapeutic Group Home
- Intensive Outpatient Program (ASAM Level 2.1)
- Clinically managed low-intensity residential treatment ~~Substance Use Disorder (SUD) Halfway House~~ (ASAM Level 3.1)
- Clinically managed population specific high intensity residential treatment ~~Long Term Residential Care~~ (Adult only ASAM Level 3.3)
- Clinically managed medium intensity residential treatment ~~Substance Use Disorder (SUD) Adult & Child/Adolescent Treatment Program~~(ASAM Level 3.5)
- Medically monitored high intensity inpatient treatment-adult ~~Substance Use Disorder (SUD) Adult Treatment Program~~ (ASAM Level 3.7)
- ~~Substance Use Disorder (SUD) Intensive Outpatient Program (Level 2.1)~~
- In Lieu of Services:
  - In Lieu Of: Residential SUD in freestanding facility (IMD) for adults 21-64 years old
    - ASAM~~SUD~~ Level 3.1: Halfway House (with option of Room & Board)
    - ASAM~~SUD~~ Level 3.2~~-WMD~~: Sub-acute Detox (with option of Room & Board)
    - ASAM~~SUD~~ Level 3.3: Clinically managed population specific high intensity residential treatment – adult ~~Behavioral Health Long Term Residential~~ (with option of Room & Board)
    - ASAM~~SUD~~ Level 3.5: Clinically managed medium intensity residential treatment ~~Residential Treatment~~ (with option of Room & Board)
    - ASAM~~SUD~~ Level 3.7: Medically monitored high intensity residential treatment-adult~~Adult Treatment~~ (with option of Room & Board)
    - ASAM~~SUD~~ Level 3.7~~-WMD~~: Medically monitored inpatient withdrawal management-adult ~~Acute Detox~~ (with option of Room & Board)
  - In Lieu of: Freestanding Psych Hospital / IMD for adults
  - In Lieu of: Crisis Stabilization Units for All Medicaid Eligible Adults (Age 21 and Above)

For the initial prior authorization of **psychiatric inpatient** stays, residential levels of care, and **electroconvulsive therapy** ~~**and/or partial hospitalization**~~, please submit requests by telephone to the Behavioral Health UM department. Requests are also accepted by fax if they contain all the appropriate information to support a medical necessity review and/or level of care evaluation. AmeriHealth Caritas Louisiana will authorize levels of care depending on medical necessity. Requests to extend authorization on these services may also be submitted by telephone to the Behavioral Health UM department.

For the initial prior authorization of **outpatient services** (including but not limited to: **psychoanalysis, psychological/neuropsychological testing, CPST, Crisis Intervention Follow Up, Psychosocial Rehabilitation, and SUD Intensive Outpatient Program**) please submit requests by completing and faxing the appropriate Outpatient Treatment Request Form to the Behavioral Health UM department. AmeriHealth Caritas Louisiana will authorize levels of care based on medical necessity. Requests to extend authorization on outpatient services may also be submitted by completing and

faxing the appropriate Outpatient Treatment Request Form to the Behavioral Health UM department.

For additional information on how to submit a request for prior authorization, please refer to the provider area of our website Insert web site.

Behavioral Health Services that Require Notification

The following is a list of services that do not require a clinical review by the health plan to determine medical necessity, but do require a notification to the Behavioral Health UM department as specified below:

- Substance Use Disorder Acute Detoxification (notification within 24 hours of discharge)
- Substance Use Disorder Sub-Acute Detoxification (notification within 24 hours of discharge)
- Crisis Intervention Behavioral Health Services (Initial crisis intervention episode requires post service notification within 2 business days)

Behavioral Health Services that Do Not Require Prior Authorization

- 48-Hour Observations (All procedures, other than advanced imaging, that normally require an authorization still require an authorization if the admit to Observation was not through the emergency department)
- Behavioral Health (BH) & Substance Use Disorder (SUD) Evaluations & Assessments
- Behavioral Health (BH) & Substance Use Disorder (SUD) Medical Team Conference
- Behavioral Health (BH) & Substance Use Disorder (SUD) Medication Evaluation, Management & Consultation
- Behavioral Health (BH) & Substance Use Disorder (SUD) Outpatient Therapy (Individual, Family, Group Therapy Sessions including SUD ASAM Level 1)
- Behavioral Health (BH) & Substance Use Disorder (SUD) Therapeutic Injections
- In Lieu of Services:
    - In Lieu of: Crisis Intervention (CI) Services for All Medicaid Eligible Adults (Age 21 and Above)
    - In Lieu of: 23-Hour Observation Bed Services for all Medicaid Eligible Adults (Age 21 and Above)
    - In Lieu of: Licensed Mental Health Professional Services for Adults (Age 21 and Above)
    - In Lieu of: Injection Services Provided by Licensed Nurses to All Medicaid Eligible Adults (Age 21 and Above)

Behavioral Health Provider Monitoring Plan

In concert with LDH, AmeriHealth Caritas Louisiana measures compliance with Behavioral Health Provider Monitoring Standards. The Behavioral Health Provider Monitoring Process of AmeriHealth Caritas Louisiana will endeavor to facilitate appropriate utilization of health care resources for our members through review and analysis of medical evaluation, treatment, and maintenance provided by Behavioral Health Service Providers included in the care of the member. Results of the Behavioral Health Provider Monitoring are reviewed and reported by the Quality of Clinical Care Committee (QCCC), a subcommittee of AmeriHealth Caritas Louisiana's Quality Assessment and Performance Improvement Committee (QAPIC).

AmeriHealth Caritas Louisiana establishes policies and procedures, performance measures, and goals to evaluate treatment record keeping practices and addresses confidentiality, maintenance, and availability of quality treatment records through Provider contracts accessible to appropriate staff.

Procedure

1. The Provider Monitoring process is continuous throughout the year. ~~The reviews may occur in conjunction with the AmeriHealth Caritas Louisiana's annual HEDIS data collection for identified Behavioral Health Service providers that are included in the HEDIS process or as an ad-hoc review.~~
2. Records will be audited utilizing the Behavioral Health Provider Audit Tool Elements. The tool is available for provider review in the following locations:
   a. LDH's website: http://ldh.la.gov/index.cfm/page/2974
   b. AmeriHealth Caritas Louisiana 's Behavioral Health Provider Resources webpage
3. Behavioral Health Provider Audit results are calculated for the following:
   a. Overall Compliance Rate
   b. Core Section Compliance Rate
   c. ~~CPG~~ Clinical Practice Guidelines (CPGs) Compliance Rate
   d. Agency Requirements Compliance Rate

4. The required performance benchmark for Behavioral Health Provider Audit is 80%.
   a. If a score is calculated for less than 80% in any element (Core, Agency, or Clinical Practice Guides) of the Behavioral Health Provider Audit, the results will be reviewed with the Behavioral Health Audit team. The provider may receive further recommendations including, but not limited to: submission[MB51][MB52] of a Corrective Action; request for 15 Day Remediation; or the provider may be reviewed for termination as an AmeriHealth Caritas Louisiana provider. Behavioral Health Providers will be notified of their Provider Audit performance scores.
   b. Practice sites that fall below the required performance benchmark of 80% are notified of the deficiency via certified letter. Sites scoring 79% - 70% for an element of the audit may receive a re-review within six (6) months from date of notification to determine if deficiencies have been remediated. After re-review, if a provider continues to fall below the required benchmark, the Behavioral Health department and PNM department work together to develop a Corrective Action Plan (CAP) that must be in effect in 30 days from the date the certified letter was received by the provider. The Behavioral Health Medical Director, Provider Network Management (PNM), and Credentialing are notified of the CAP.
   c. Sites scoring 69% or below for any element of the audit may receive a request for a CAP or Request for 15 day Remediation letter.
   d. Practice sites who fail to comply with the Corrective Action Plan, 15 Day Remediation, or continue to fall below the benchmark score are referred to the AmeriHealth Caritas Louisiana's Medical Director/designee and/or Credentialing Committee for further review and action. Continued non-compliance may result in the application of sanctions, up to and including termination of the provider's contract.
5. Audit results are aggregated to identify trends and network opportunities. The PNM department, in collaboration with the Behavioral Health department, design network-level education and initiatives to improve documentation compliance.
6. A quarterly summary of AmeriHealth Caritas Louisiana Behavioral Health Provider Monitoring is presented to the Quality of Clinical Care Committee (QCCC) for review and recommendations. The QCCC may take action for plan-wide follow-up on any standard not meeting AmeriHealth Caritas Louisiana performance goals.
7. The Behavioral Health Provider Monitoring Summary Report results are reported quarterly to LDH.

SECTION XII: MEMBER RIGHTS & RESPONSIBILITIES

Member Rights & Responsibilities

AmeriHealth Caritas Louisiana is committed to treating our members with respect. AmeriHealth Caritas Louisiana, its network providers, and other Providers of service, may not discriminate against members based on race, color, religion, sex, age, national origin, ancestry, nationality, creed, citizenship, alienage, marital or domestic partnership or civil union status, affectional or sexual orientation, physical, cognitive or mental disability, veteran status, whistleblower status, gender identity and/or expression, genetic information, health status, pre-existing condition, income status, source of payment, program memberships or physical or behavioral disability, except where medically indicated, or any other characteristic protected under federal, state, or local law.

Member Rights

AmeriHealth Caritas Louisiana member's and potential member's Bill of Rights ensure each member is guaranteed the following:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected. Requests for information shall be compiled in the form and the language requested.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information — e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives — in a manner and format that may be easily understood as defined in the Contract between LDH and AmeriHealth Caritas Louisiana. .
- To receive assistance from both LDH and the enrollment broker in understanding the requirements and benefits of and AmeriHealth Caritas Louisiana.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- As a potential member, to receive information about the basic features of and AmeriHealth Caritas Louisiana program; which populations may or may not enroll in the program and AmeriHealth Caritas Louisiana's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information on the AmeriHealth Caritas Louisiana's services, to include, but not limited to:
    - Benefits covered
    - Procedures for obtaining benefits, including any authorization requirements
    - Any cost sharing requirements
    - Service area
    - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals
    - Any restrictions on member's freedom of choice among network providers

  - Providers not accepting new patients
  - Benefits not offered by the AmeriHealth Caritas Louisiana but available to members and how to obtain those benefits, including how transportation is provided
- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in core benefits and services at least 30 days before the intended effective date of the change.
- To receive information on grievance, appeal and State Fair Hearing procedures.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and post- stabilization services
  - That emergency services do not require prior authorization
  - The process and procedures for obtaining emergency services
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract
  - Member's right to use any hospital or other setting for emergency care
  - Post-stabilization care services rules as detailed in 42 CFR §422.113(c)
- To receive the AmeriHealth Caritas Louisiana's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way AmeriHealth Caritas Louisiana, its providers or LDH treat the member.

Member Responsibilities

Members have the responsibility to inform AmeriHealth Caritas Louisiana and its network providers of any changes in eligibility, or any other information that may affect their membership, health care needs or access to benefits. Examples include, but are not limited to the following:

- Pregnancy
- Birth of a baby
- Change in address or phone number
- A member or a member's child is covered by another health plan
- Special medical concerns
- Change in family size
- Loss or theft of AmeriHealth Caritas Louisiana ID Card

Members have the responsibility to cooperate with AmeriHealth Caritas Louisiana and its network providers.

This includes:

- Following network provider instructions regarding care
- Making appointments with their PCP
- Canceling appointments when they cannot attend
- Calling AmeriHealth Caritas Louisiana when they have questions
- Keeping their benefits up to date with the case worker. Finding out when their benefits will end and making sure that all demographic information is up to date to keep their benefits.
- Understanding their health problems and working with their provider to set goals for their treatment, to the degree they are able to do so

Members have the responsibility to treat their network provider and the network provider's staff with respect and dignity.

SECTION XIII: DISPUTES, MEMBER APPEALS & GRIEVANCES

Member Grievance and Appeal Process

The following is a description of the process.

Grievance Procedures

A grievance is an expression of member/ dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues. There is no timeframe to file a grievance. A grievance may be filed at any time.

To file a grievance on behalf of a member with the member's consent, call Member Services at 1-888-756-0004. The member's written approval to file a grievance may be obtained in advance as part of the member intake process. Should the member, or provider filing on behalf of a member, need assistance, AmeriHealth Caritas Louisiana staff is trained to assist the member. The provider may also, with the member's consent, write to us at:

AmeriHealth Caritas Louisiana
Member Grievance
P.O. Box 83580
Baton Rouge, LA 70884

An acknowledgement letter to the member (with a copy to the provider filing on behalf of the member) will be mailed within 1 business day of when the plan receipt of the grievance.

- AmeriHealth will send a decision letter within (90) days of receiving the request. In, some cases, AmeriHealth Caritas Louisiana or the member may need more information. If the member needs more time to get the information, he/she may request up to 14 days more. The Plan can also have an additional 14 days if the Plan documents that additional time is needed and the delay is in the member's best interest. If AmeriHealth Caritas Louisiana needs more time, the member will be informed of the reason for the extension in writing within 5 days.

Appeal Procedures

Providers may follow the appeals processes below by filing on behalf of the member and with the member's written consent. AmeriHealth Caritas Louisiana recommends that the written consent contain the following elements:

- The name and address of the member, the member's date of birth, and the member's Medicaid identification number. If the member is a minor, or is legally incompetent, the name, address and relationship to the member of the person who signs the consent for the member.
- The name, address and AmeriHealth Caritas Louisiana identification number of the health care provider to whom the member is providing the consent.
- An explanation of the specific service for which coverage was provided or denied to the member to which the consent will apply.
- The dates of service for which coverage was provided or denied.

The consent document must also have the dated signature of the member, or the member's legal representative if the member is a minor or is legally incompetent. A sample member consent form can be found in the appendix.

Informal Reconsideration

As part of the appeal procedures, members may request an Informal Reconsideration, which allows the member, providers acting with the consent of the member, or designated representative speaking on the member's behalf, a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

To file an informal reconsideration on behalf of a member with the member's consent, call Member Services at 1-888-756-0004. The member's written approval to file an informal reconsideration may be obtained in advance as part of the member intake process. Should the member, or provider filing on behalf of a member, need assistance, AmeriHealth Caritas Louisiana staff is trained to assist the member.

The provider may also, with the member's consent, write to us at:
AmeriHealth Caritas Louisiana
Attention: Member Grievance Department
P.O. Box 7328
London, KY 40742

Also, if a member would like to call AmeriHealth Caritas Louisiana to set up a meeting to present evidence in person, they can call Member Services 24 hours a day, 7 days a week at 1-888-756-0004.

Standard Appeals

An appeal is a request for a review of an Action pursuant to 42 CFR §438.400(b) which is: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by LDH), and the failure of the health plan to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR §438.400(b); and in a rural area with only one the health plan , the denial of a member's right to obtain services outside the provider network, as described in §438.52(b)(2)(ii).

Members, or providers acting on behalf of the member with the written consent of the member, may request an appeal review by submitting the request in writing within 60 calendar days of the date of the denial or adverse action by AmeriHealth Caritas Louisiana. The request must be accompanied by all relevant documentation the member, or provider acting on behalf of the member, would like AmeriHealth Caritas Louisiana to consider during the appeal review. The member's written approval may be obtained in advance as part of the member intake process.

Requests for a member appeal review, to include providers appealing on behalf of the member, should be mailed to the appropriate post office box below and must contain the word "Appeal" at the top of the request:

Appeal
Appeals department
P.O. Box 7328
London, KY 40742

AmeriHealth Caritas Louisiana will send the member a letter acknowledging AmeriHealth Caritas Louisiana's receipt of the

request for an appeal review within five (5) calendar days of AmeriHealth Caritas Louisiana's receipt of the request from the member, or provider acting on behalf of the member.

If an appeal is filed to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving, the member continues to receive the disputed service/item at the previously authorized level pending resolution of the appeal, if the appeal is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision. AmeriHealth Caritas Louisiana also honors a verbal filing of an appeal within ten (10) days of receipt of the written denial decision in order to continue services.

The appeal review is conducted by a medical director or physician designee who was not involved in the decision making for the original denial or prior reconsideration of the case. The medical director or physician designee will issue a determination to uphold, modify or overturn the denial based on:

- Clinical judgment
- Established standards of medical practice
- Review of available information including but not limited to:
    - AmeriHealth Caritas Louisiana medical and administrative policies
    - Information submitted by the member, the member's health care provider acting on their behalf, or obtained by AmeriHealth Caritas Louisiana through investigation
    - The network provider's contract with AmeriHealth Caritas Louisiana
    - AmeriHealth Caritas Louisiana's contract with the State of Louisiana's Medicaid Program and relevant Medicaid laws, regulations and rules

The medical director or physician designee completes its review of the Appeal as expeditiously as the member's health condition requires, but no more than thirty (30) days from receipt of the Appeal. , AmeriHealth Caritas Louisiana sends a written notice of the Appeal decision to the member and other appropriate parties within five (5) business days of the decision, but not later than thirty (30) days from receipt of the Appeal by AmeriHealth Caritas Louisiana. The written notice of the resolution includes the following:

- The results of the resolution process and the date it was completed.
- For appeals not resolved wholly in favor of the members:
    - The right to request a State Fair Hearing, and how to do so;
    - The right to request to receive benefits while the hearing is pending, and how to make the request; and
    - That the member may be held liable for the cost of those benefits if the hearing decision upholds AmeriHealth Caritas Louisiana's action.

Expedited Appeals

An expedited Appeal may be requested if the member or member representative believes that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the standard Appeal process. An expedited Appeal review may be requested either verbally or in writing.

AmeriHealth Caritas Louisiana must conduct an expedited review of an Appeal at any point prior to the level Appeal

decision. A signed provider certification that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the standard Appeal process must be provided to AmeriHealth Caritas Louisiana per CFR 42 Sec. 438.410 (a) . The provider certification is required regardless of whether the expedited Appeal is filed verbally or in writing by the member or the provider acting on behalf of the member. No action will be taken against the provider, acting on behalf of the member with the member's consent, who supports the member's appeal.

Upon receipt of a verbal or written request for expedited review, AmeriHealth Caritas Louisiana verbally informs the member or member representative of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

If an expedited Appeal is filed to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving, then the member will continue to receive the disputed service/item at the previously authorized level pending resolution of the expedited Appeal, if the expedited Appeal is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision.

The expedited Appeal review is performed by a licensed physician, who was not involved in any previous level of review

or decision making on the subject of the appeal. A written report from a licensed physician or other appropriate provider in the same or similar specialty that typically manages or consults on the service/item in question.

The expedited Appeal review process is bound by the same rules and procedures as the standard Appeal review process with the exception of timeframes, which are modified as specified in this section of this Provider Manual.

AmeriHealth Caritas Louisiana issues the decision resulting from the expedited review in person or by phone to the member and other appropriate parties within seventy–two (72) hours of receiving the member's request for an expedited review. In addition, AmeriHealth Caritas Louisiana gives oral notification within seventy-two (72) hours of the request and mails the written notice of the decision to the member and other appropriate parties within two (2) business days of the decision or within seventy two (72) hours of the request.

The member or member representative may file a request for a Fair Hearing within thirty (30) days from the mail date on the written notice of the expedited Appeal decision.

State Fair Hearing

Members or member representatives may request a State Fair Hearing within thirty (30) days from the mail date on the written notice or appeal decision.

Members, or providers filing on behalf of a member, must exhaust AmeriHealth Caritas Louisiana's standard appeal processes before filing a State Fair Hearing Request.

The member may file a State Fair Hearing directly with the Division of Administrative Law. The request for a State Fair Hearing should include a copy of the written notice of decision that is the subject of the request. Requests may be sent to DAL via mail, fax, phone, or website at:

Division of Administrative Law (DAL) Health and Hospitals Section

Post Office Box 4183
Baton Rouge, LA. 70821-4183

Phone: 1-225- 342-0443
Fax: 1-225-219-9823

A member who files a request for a Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

Upon receipt of the request for a Fair Hearing, the Division of Administrative Law (DAL) designee will schedule a hearing. The member and AmeriHealth Caritas Louisiana will receive notification of the hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

AmeriHealth Caritas Louisiana is a party to the hearing and must be present. AmeriHealth Caritas Louisiana, which may be represented by an attorney, must submit the Summary of Evidence (SOE) and be prepared to explain and defend the

issue of the appeal. AmeriHealth Caritas Louisiana must submit the SOE packet to the Division of Administrative Law within seven (7) calendar days of receipt of the request for State Fair Hearing if the request is made directly to AmeriHealth Caritas Louisiana.

AmeriHealth Caritas Louisiana will provide the member, at no cost, with records, reports, and documents, relevant to the subject of the Fair Hearing.

The Fair Hearing Decision will be issued within ninety (90) days the filing and is binding on AmeriHealth Caritas Louisiana If the Division of Administrative Law rules in favor of the claimant/appellant, AmeriHealth Caritas Louisiana will receive a Directive from the Division of Administrative Law. The Directive shall be executed within ten days and reported to the LDH within 14 days of the date of the Directive or by the state level appeal's 90th day deadline, whichever is earliest.

Continuation of Benefits during Appeal during Appeal & State Fair Hearing Processes

A member may continue to receive services while waiting for AmeriHealth Caritas Louisiana's decision if all of the following apply:

- The appeal is filed within ten (10) business days after the notice of the adverse action is mailed;
- The appeal is filed within ten (10) business days after the intended effective date of the action;
- The appeal is related to reduction, suspension or termination of previously authorized services;
- The services were ordered by an authorized provider;
- The authorization has not ended, and
- The member requested the services to continue.

The member's services may continue until one (1) of the following happens:

- The member decides not to continue the appeal.
- 10 business days have passed, from the date of the notice of resolution unless the member has requested a State Fair Hearing with continuation of services.
- The time covered by the authorization is ended or the limitations on the services are met.
- The State Fair Hearing office issues a hearing decision adverse to the member.

The member may have to pay for the continued services if the final decision from the State Fair Hearing is against them.

If the Administrative Law Judge agrees with the member, AmeriHealth Caritas Louisiana will pay for the services received while waiting for the decision.

If the State Fair Hearing or the Division of Administrative Law decision agrees with the member and he/she did not continue to get the services while waiting for the decision, AmeriHealth Caritas Louisiana will issue an authorization for the services to restart as soon as possible and AmeriHealth Caritas Louisiana will pay for the services.

Provision of and Payment for Services/Items Following Decision

If AmeriHealth Caritas Louisiana or the DAL reverses a decision to deny, limit, or delay services/items that were not furnished during the Grievance, Appeal or Fair Hearing process, AmeriHealth Caritas Louisiana will authorize or provide the disputed services/items promptly and as expeditiously as the member‘s health condition requires.

If AmeriHealth Caritas Louisiana or the DAL reverses a decision to deny authorization of services/items, and the member received the disputed services/items during the Complaint, Appeal or Fair Hearing process, the Plan will pay for those services/items within 10 days or the Fair Hearing decision 90th day timeline, whichever is earliest.

SECTION XIIII: REGULATORY PROVISIONS

AmeriHealth Caritas Louisiana's Corporate Confidentiality Policy

The policy states that during the course of business operations, Confidential Information and/or Proprietary Information, including member Protected Health Information (PHI), may become available to AmeriHealth Caritas Louisiana Associates, Consultants and Contractors. AmeriHealth Caritas Louisiana's use and disclosure of member PHI is regulated pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations. AmeriHealth Caritas Louisiana's use and disclosure of PHI is also impacted by applicable state laws and regulations governing the confidentiality and disclosure of health information.

AmeriHealth Caritas Louisiana is committed to safeguarding Confidential Information and Proprietary Information, including ensuring the privacy and security of member PHI, in compliance with all applicable laws and regulations. It is the obligation of all AmeriHealth Caritas Louisiana Associates, Consultants and Contractors to safeguard and maintain the confidentiality of Confidential and Proprietary Information, including PHI, in accordance with the requirements of all applicable federal and state statutes and regulations as well as the provisions of AmeriHealth Caritas Louisiana's Confidentiality Policy and other AmeriHealth Caritas Louisiana policies and procedures addressing Confidential and Proprietary Information, including PHI.

All Confidential Information and Proprietary Information, including PHI, will be handled on a need-to-know basis. The AmeriHealth Caritas Louisiana Confidentiality Policy and other AmeriHealth Caritas Louisiana policies and procedures are adopted to protect the confidentiality of such information consistent with the need to effectively conduct business operations without using or disclosing more information than is necessary, for example, conducting research or measuring quality through the use of aggregated data wherever possible. No Associate, Consultant or Contractor is permitted to disclose Confidential Information or Proprietary Information pertaining to AmeriHealth Caritas Louisiana or a member to any other Associate, Consultant or Contractor unless such a disclosure is consistent with the AmeriHealth Caritas Louisiana Confidentiality Policy.

Both during and after an Associate's association with the AmeriHealth Caritas Louisiana, it shall be a violation of the AmeriHealth Caritas Louisiana Confidentiality Policy to discuss, release, or otherwise disclose any Confidential Information or Proprietary Information, except as required by the Associate's employment relationship with AmeriHealth Caritas Louisiana or as otherwise required by law. It is also a violation of AmeriHealth Caritas Louisiana's Confidentiality Policy for any Associate to use Confidential Information or Proprietary Information for his/her own personal benefit or in any way inconsistent with applicable law or the interests of AmeriHealth Caritas Louisiana. To the extent that a violation of the AmeriHealth Caritas Louisiana Confidentiality Policy occurs, AmeriHealth Caritas Louisiana reserves the right to pursue any recourse or remedy to which it is entitled under law. Furthermore, any violation of the AmeriHealth Caritas Louisiana Confidentiality Policy will subject the Associate(s) in question to disciplinary action, up to and including termination of employment.

The following information is provided to outline the rules regarding the handling of confidential information and proprietary information within AmeriHealth Caritas Louisiana.

Confidential information and proprietary information includes, but is not limited to the following:

- Protected Health Information
- Medical or personal information pertaining to Associates of AmeriHealth Caritas Louisiana (the

Company) and/or its Customers
- Accounting, billing or payroll information, and data reports and statistics regarding the Company, its Associates, members, and/or Customers
- Information that AmeriHealth Caritas Louisiana is required by law, regulation, agreement or policy to maintain as confidential
- Financial information regarding the Company, its members, network providers and Customers, including but not limited to contract rates and fees
- Associate personnel and payroll records
- Information, ideas, or data developed or obtained by AmeriHealth Caritas Louisiana, such as marketing and sales information, marketplace assessments, data on customers or prospects, proposed rates, rating formulas, reimbursement formulas, Health Care Provider payment rates, business of AmeriHealth Caritas Louisiana and/or its Customers
- Information not generally known to the public upon which the goodwill, welfare and competitive ability of AmeriHealth Caritas Louisiana and/or its Customers depend, information regarding product plans and design, marketing sales and plans, computer hardware, software, computer systems and programs, processing techniques, and general outputs
- Information concerning AmeriHealth Caritas Louisiana's business plans
- Information that could help others commit Fraud or sabotage or misuse AmeriHealth Caritas Louisiana 's products or services

Compliance with the HIPAA Privacy Regulations

In addition to maintaining the Corporate Confidentiality Policy, AmeriHealth Caritas Louisiana complies with the Privacy Regulations as specified under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

In order to ensure compliance with these regulations, AmeriHealth Caritas Louisiana takes several measures including, but not limited to, the following:

- Employs a Privacy Officer who is responsible for the directing of on-going activities related to the AmeriHealth Caritas Louisiana's programs and practices addressing the privacy of member's protected health information (PHI)
- Has a centralized Privacy Office, which is responsible for the day-to-day oversight and support of Privacy-related initiatives conducted at AmeriHealth Caritas Louisiana
- Issues copies of AmeriHealth Caritas Louisiana's Notice of Privacy Practices to recently enrolled and existing membership of the health plan, which describes how medical information is used and disclosed, as well as how it can be accessed
- Established and/or enhanced processes for our members to exercise their rights under these regulations, such as requesting access to their PHI, or complaining about AmeriHealth Caritas Louisiana's privacy practices

Allowed Activities under the HIPAA Privacy Regulations

The HIPAA Privacy Regulations allow covered entities, including health care providers and health plans (such as AmeriHealth Caritas Louisiana), the ability to use or disclose PHI about its members for the purposes of Treatment,

Payment and/or Health plan Operations (TPO) without a member's consent or authorization. This includes access to a member's medical records when necessary and appropriate.

"TPO" allows a Health Care Provider and/or AmeriHealth Caritas Louisiana to share members' PHI without consent or authorization.

"Treatment" includes the provision, coordination, management, and consultation of a member between and among health care providers.

Activities that fall within the "Payment" category include, but are not limited to:

- Determination of member eligibility
- Reviewing health care services for medical necessity and utilization review
- Review of various activities of health care providers for payment or reimbursement to fulfill AmeriHealth Caritas Louisiana's coverage responsibilities and provide appropriate benefits
- To obtain or provide reimbursement for health care services delivered to members

"Operations" includes:

- Certain quality improvement activities such as Case Management and care coordination
- Quality of care reviews in response to member or state/federal queries
- Response to member Complaints/Grievances
- Administrative and financial operations such as conducting Health Plan Employer Data and Information Set (HEDIS) reviews
- Member services activities
- Legal activities such as audit programs, including Fraud and abuse detection to assess conformance with compliance programs

While there are other purposes under the Privacy Regulations for which AmeriHealth Caritas Louisiana and/or a Health Care Provider might need to use or disclose a member's PHI, TPO covers a broad range of information sharing.

For more information on HIPAA and/or the Privacy Regulation, please visit the Provider area of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com and click on HIPAA or contact the Provider Services Department at 1-888-922-0007.

Prohibition on Payment to Excluded/Sanctioned Persons

Pursuant to Section 1128A of the Social Security Act and 42 CFR 1001.1901, AmeriHealth Caritas Louisiana may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other Federal health care programs.

A Sanctioned Person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Upon request of AmeriHealth Caritas Louisiana a Provider will be required to furnish a written certification to AmeriHealth Caritas Louisiana that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a Sanctioned Person.

A Provider is required to notify AmeriHealth Caritas Louisiana within one (1) business day upon knowledge that any of its contractors, employees, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that a Provider cannot provide reasonably satisfactory assurance to AmeriHealth Caritas Louisiana that a Sanctioned Person will not receive payment from AmeriHealth Caritas Louisiana under the Provider Agreement, AmeriHealth Caritas Louisiana may immediately terminate the Provider Agreement. AmeriHealth Caritas Louisiana reserves the right to recover all amounts paid by AmeriHealth Caritas Louisiana for items or services furnished by a Sanctioned Person.

Provider Protections

AmeriHealth Caritas Louisiana shall not exclude, discriminate against or penalize any Health Care Provider for its refusal to allow, perform, participate in or refer for health care services, when the refusal of the Health Care Provider is based on moral or religious grounds. The Health Care Provider must make information available to members, prospective members and AmeriHealth Caritas Louisiana about any such restrictions or limitations to the types of services they will/will not make referrals for or directly provide to AmeriHealth Caritas Louisiana members, due to religious or moral grounds.

Health care providers are further protected in that no public institution, public official or public agency may take disciplinary action against, deny licensure or certification or penalize any person, association or corporation attempting to establish a plan, or operating, expanding or improving an existing plan, because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other health plans, when the refusal is based on moral or religious grounds. AmeriHealth Caritas Louisiana will not engage in or condone any such discriminatory practices.

AmeriHealth Caritas Louisiana shall not discriminate against or exclude from AmeriHealth Caritas Louisiana's Provider Network any Health Care Provider because the Health Care Provider advocated on behalf of a member in a Utilization Management appeal or another dispute with AmeriHealth Caritas Louisiana over appropriate medical care, or because the Health Care Provider filed an appeal on behalf of a AmeriHealth Caritas Louisiana member.

AmeriHealth Caritas Louisiana does not have policies that restrict or prohibit open discussion between health care providers and AmeriHealth Caritas Louisiana members regarding treatment options and alternatives. AmeriHealth Caritas Louisiana encourages open communication between health care providers and our members with regard to all treatment options available to them, including alternative medications, regardless of benefit coverage limitations.

AmeriHealth Caritas Louisiana will provide public notice prior to the implementation of a policy or procedure, per the requirements of House Bill 434 of the 2019 Louisiana Regular Session.[KG53]

Additional Resources

Network providers should always have the most current regulatory requirements. Please call 1-888-922-0007 or call your Network Account Executive for additional information. You should consult an official publication or reporting service if you

want to be assured you have the most up-to-date version of these regulations.

Below are some helpful links to federal and state regulations and state bulletins and other relevant general information. Announcements and new bulletins will also be posted on at www.amerihealthcaritasla.com.

CMS - www.cms.gov
Code of Federal Regulations http://www.gpoaccess.gov/cfr/index.html Louisiana Laws

Louisiana Laws can be researched through the Louisiana State Legislature website http://www.legis.state.la.us/

Click on Louisiana Laws along the left hand banner – then click table of contents. Once at the Table of Contents click on *Revised Statutes*. It will bring you to a listing of all LouisianaStatutes. Louisiana Office of State Register:
The Louisiana Register is a monthly publication which provides an access to the certified regulations and legal notices issued by the executive branch of the state government. All of these go through the formal rulemaking process. Proposed and final rules published in the Louisiana Register are codified for easy Louisiana Administrative Code research capabilities.

http://doa.louisiana.gov/osr/reg/register.htm

Medicaid Website – www.lamedicaid.com
Louisiana Department of Health – http://new.dhh.louisiana.gov/index.cfm/page/277

Louisiana Helpful Resources for Your Patients-

A listing of additional services available in the community to your members. This includes contact information for WIC, advocacy, legal services, other human services, emergency, Department of Education and more and was compiled by LDH's Louisiana Children's Special Health Services (CSHS) and is localized to specific regions.

http://new.dhh.louisiana.gov/index.cfm/page/46/n/59

APPENDIX

Website Resources

The following resources are available on the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com under the Providers tab.

- Newsletters and updates
- Self-service tools
    - NaviNet
    - Find a provider Opens a new window
    - Find a pharmacy Opens a new window
    - Louisiana Medicaid Single PDL (PDF) Opens a new window
    - Sign up for emails
- Prior authorization
- Billing and claims
- Forms
- Training
- Resources
- Behavioral health
- Pharmacy
- Non-contracted providers