Healthy Blue
Medicaid Managed Care

Provider Manual

844-521-6942

https://providers.healthybluela.com

Healthy Louisiana

Healthy Blue

BLA-PM-0019-21

How to apply for participation
If you are interested in participating in the Healthy Blue network, please visit **https://providers.healthybluela.com** or call **1-844-521-6942**.

BLA-PM-0019-21

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Dear Provider,

Welcome to the Healthy Blue network! We're pleased you've joined us.

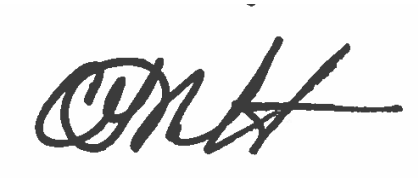
We combine national expertise with an experienced local staff to operate community-based health care plans. We are here to help you provide quality health care to our members.

Along with hospitals, pharmacies and other providers, you play the most important role in managing care. Earning your respect and gaining your loyalty are essential to a successful collaboration in the delivery of health care.

We want to hear from you. We invite you to participate in one of our quality improvement committees. Or feel free to call Provider Services at **1-844-521-6942** with any suggestions, comments or questions.

Together, we can make a real difference in the lives of our members — your patients.

Sincerely,



C. Valentine-Theard, MD, MBA
Plan President
Healthy Blue

1. INTRODUCTION

1.1. Who is Healthy Blue?

Healthy Blue is an expert in the Medicaid market, focused solely on meeting the health care needs of financially vulnerable Louisianans. We're dedicated to offering real solutions that improve health care access and quality for our members, while proactively working to reduce the overall cost of care to taxpayers. Healthy Blue does not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, gender, sexual orientation, gender identity or disability.

We help coordinate physical and behavioral health care, and we offer education, access to care and disease management programs. As a result, we lower costs, improve quality and encourage better health status for our members.

We:

- Improve access to preventive primary care services
- Ensure selection of a primary care provider (PCP) who will serve as provider, care manager and coordinator for all basic medical services
- Improve health status outcomes for members
- Educate members about their benefits, responsibilities and appropriate use of care
- Utilize community-based enterprises and community outreach
- Integrate physical and behavioral health care
- Encourage:
  - Stable relationships between our providers and members
  - Appropriate use of specialists and emergency rooms (ERs)
  - Member and provider satisfaction

In a world of escalating health care costs, we work to educate our members about the appropriate utilization of health care and their involvement in all aspects of their health care.

1.2. Who Do We Serve?

Eligibility for enrollment in the Healthy Louisiana Medicaid Program is limited to individuals who are determined eligible for Louisiana Medicaid or CHIP, behavioral health and substance use or who belong to mandatory or voluntary managed care populations. This includes the population made eligible as part of the Louisiana Affordable Care Act (ACA) Medicaid expansion. Healthy Blue serves populations covered under Healthy Louisiana. Within Healthy Louisiana, there are four broad categories of coverage depending upon which of the above populations a member falls into. The categories of coverage are as follows:

- All covered services
- Specialized Behavioral Health and Nonemergency Ambulance Transportation (NEAT)
- Specialized Behavioral Health and Nonemergency Medical Transportation (NEMT) Services including Nonemergency Ambulance Transportation
- All covered Specialized Behavioral Health services except Coordinated System of Care (CSoC) services

Effective May 1, 2021*, children under 19 who may not be eligible for Medicaid may register for the Children's Medicaid option if they meet these eligibility requirements:

- Already covered under a major medical health insurance plan.
- Have a disability (defined as a medically determinable physical or mental impairment that results in marked and severe limitations and has lasted or is expected to last at least one year, or to result in death).

- Meet the level of care given at an intermediate care facility (ICF) for people with intellectual disabilities, a nursing home, or a hospital.
- Can be cared for safely at home.
- Can be cared for at home for less cost than in an institution.

*Effective date subject to change. Please check the **Children's Medicaid option** for the latest updates from the Louisiana Department of Health.

1.3. Updates and Changes

This provider manual, as part of your *Provider Agreement* and related addendums, may be updated at any time and is subject to change. The most updated version is available online at **https://providers.healthybluela.com**. To request a free, printed copy of this manual, call Provider Services at **1-844-521-6942**.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Healthy Blue, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web-posted newsletters, provider bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

1.4. Quick Reference Information

Healthy Blue Website

Our provider website, **https://providers.healthybluela.com**, offers a full complement of online tools such as:

- Enhanced account management tools.
- Detailed eligibility look-up tool with downloadable panel listing.
- Comprehensive, downloadable member listings.
- Easier authorization submission.
- New provider data, termination and roster tools.
- Access to drug coverage information.

Healthy Blue Office Addresses

Baton Rouge
10000 Perkins Rowe, Suite G-510
Baton Rouge, LA 70810
Phone: **1-225-819-4893**
Toll-free: **1-877-440-4065**

Contact Information

Provider Services	**1-844-521-6942** **1-800-964-3627** (fax) Monday through Friday, 7 a.m. to 7 p.m. Central time Voice portal — 24 hours a day, 7 days a week Interpreter services available
Member Services	**1-844-521-6941** Monday through Friday, 7 a.m. to 7 p.m. Central time

	Saturday, 8 a.m. to 12 p.m. Central time
Behavioral Health Member Services	**1-844-227-8350** **1-844-432-6027** (inpatient fax) **1-844-432-6028** (outpatient fax)
Applied Behavior Analysis (ABA)	**1-844-406-2389** **1-844-432-6028** (fax)
IngenioRx (Pharmacy Benefits Manager)	**1-844-521-6942** **1-833-207-3114** (Member Services) **1-833-236-6194** (Pharmacists) **1-833-262-1726** (Specialty Care Team)
24/7 NurseLine	**1-866-864-2544 (TTY: 711; Spanish: 1-866-864-2545)** 24 hours a day, 7 days a week
AT&T Relay Services	**1-800-855-2880 (Spanish 1-800-855-2884)**
DentaQuest (Adult Dental Services — 21 and older)	**1-800-508-6785** (provider assistance) **1-844-234-9835** (member assistance)
Children's Dental Benefit Program Manager (under age 21)	**Members under the age of 21 can receive dental benefits through DentaQuest (1-800-685-0143) or MCNA Dental (1-855-702-6262).**
Superior Vision (Vision Services)	**1-866-819-4298** (provider assistance) **1-800-787-3157** (member assistance)
MediTrans (Nonemergency Medical Transportation (NEMT)/Nonemegency Ambulance Transportation (NEAT))	Provider Service Line: **1-844-349-4324** Member Service Line: **1-866-430-1101**
Outpatient Durable Medical Equipment, Home Health and Home Infusion Services	**1-844-521-6942** (phone) **1-844-528-3684** (fax) **https://providers.healthybluela.com**
AIM Specialty Health (Hi-Tech Radiology, Oncology, Cardiology, Musculoskeletal and Sleep Medicine)	**1-800-714-0040** **www.aimspecialtyhealth.com** Refer to the **Precertification/Notification Coverage Guidelines** section for detailed instructions on requesting prior authorization for speech, physical, occupational and spine therapy.
Electronic Data Interchange Hotline	**1-800-470-9630**
Member Eligibility	**1-844-521-6942** **https://providers.healthybluela.com**
Precertification/Notification	**Use our preferred method online at https://providers.healthybluela.com** or: • **1-844-521-6942** (phone) • **1-877-269-5705** (fax) Please provide the following: • Member ID number • Legible name of referring provider

	• Legible name of person referred to provider • Number of visits/services • Date(s) of service • Diagnosis • CPT code • Clinical information Forms are available on our provider website under ***Forms***.
Claims Information	**https://providers.healthybluela.com** Mail paper claims to: Healthy Blue Louisiana Claims P.O. Box 61010 Virginia Beach, VA 23466-1010 Timely filing is within 365 calendar days of the date of service. Check claim status online or through our Interactive Voice Response (IVR) system at **1-844-521-6942**.
Member Medical Appeals	Member medical necessity appeals must be filed within 60 calendar days of the date of action. You may appeal on behalf of the member with the member's written consent. Submit a member medical appeal to: Healthy Blue Central Appeals and Grievance Processing P.O. Box 62429 Virginia Beach, VA 23466-2429 Fax to Appeals department: **1-888-873-7038** To obtain a status update on an appeal, please contact Member Services or Provider Services, as appropriate: • Member Services: **844-521-6941** (for members) • Provider Services: **844-521-6942** (for providers)
Case Managers	Available from 8 a.m. to 5 p.m. Central time, Monday through Friday For urgent issues at all other times, call **1-844-521-6942**.
Payment Dispute	If, after working through the Provider Experience Program, you remain in disagreement over a zero or partial claim payment, or in lieu of this process, you may file a formal dispute with the Healthy Blue Payment Dispute Unit. We must receive your dispute within 180 calendar days from the date of the *EOP*. We will send a determination letter within 30 business days of receiving the dispute.

	If you are dissatisfied, you may submit a request for a Level II review. We must receive your request within 30 calendar days of receipt of the Level I determination letter. Submit a payment dispute to: Healthy Blue Payment Dispute Unit P.O. Box 61599 Virginia Beach, VA 23466-1599
Member Grievances	Submit a member grievance to: Healthy Blue Central Appeals and Grievance Processing P.O. Box 62509 Virginia Beach, VA 23466-2509
Louisiana Department of Health, Bureau of Health Services Financing	**1-888-342-6207** **http://ldh.la.gov/index.cfm/subhome/1/n/10**

2. PROVIDER INFORMATION

2.1. Member Medical Home

PCPs serve as the entry point into the health care system for the member — they are the foundation of the collaborative concept known as a patient-centered medical home (PCMH). The PCMH is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care.

Each patient has a relationship with a PCP who leads a team that takes collective responsibility for patient care, providing for all of the patient's health care needs and appropriately arranging care with other qualified professionals. A medical home is a collaborative relationship that provides high levels of care, access and communication, care coordination and integration, and care quality and safety, including provision of preventive services and treatment of acute and chronic illness. The medical home is intended to result in more personalized, coordinated, effective and efficient care.

Several organizations have introduced a set of standards and a process through which primary care practices may be recognized as PCMHs. The best reason for pursuing PCMH recognition is that fulfilling the requirements of a recognition process will help your organization make great strides toward transforming into a true medical home — a health center of the 21st century where care is coordinated, accessible and keeps patients at the center. Completing the recognition process will allow your organization to assess its strengths and achievements; recognize areas for improvement; and ultimately develop more efficient, effective and patient-centered care processes.

We offer the following support to practices that are seeking or have achieved PCMH recognition:

- Suite of reports to assist with management of your patient population
- Opportunities for frequent interaction with our medical director
- Dedicated, local medical practice consultants who support practice improvements and facilitate information sharing
- Alignment of care coordination activities, including case managers who work with your practice and may collaborate with you onsite
- Quality coaches who educate and support your practice to build systems for quality improvement
- Innovative models of reimbursement and incentives

2.2. Primary Care Providers

PCPs are responsible for the complete care of their patients, including:

- Providing primary care inclusive of basic behavioral health services.
- Providing the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions.
- Coordinating and monitoring referrals to specialist care.
- Coordinating and monitoring referrals to specialized behavioral health in accordance with state requirements.
- Referring patients to subspecialists and subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria for such referrals as it is available.
- Authorizing hospital services.
- Maintaining the continuity of care.
- Ensuring all medically necessary services are made available in a timely manner.
- Providing services ethically and legally and in a culturally competent manner.

- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment.
- Maintaining a medical record of all services rendered by you and other referral providers.
- Communicating with members about treatment options available to them, including medication treatment options regardless of benefit coverage limitations.
- Providing a minimum of 20 office hours per week of appointment availability as a PCP.
- Arranging for coverage of services to assigned members 24/7 in person or by an on-call physician.
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs).
- Answering after-hours telephone calls from members immediately or returning calls within 30 minutes from when calls are received.
- Continuing care in progress during and after termination of your contract for up to 30 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.

2.3. Responsibilities of the PCP

PCPs also have the responsibility to:

Communicate with Members

- Make provisions to communicate in the language or fashion primarily used by the member; contact our customer care center for help with oral translation services if needed
- Freely communicate with members about their treatment regardless of benefit coverage limitations
- Provide complete information concerning their diagnoses, evaluations, treatments and prognoses and give members the opportunity to participate in decisions involving their health care
- Advise members about their health status, medical care and treatment options regardless of whether benefits for such care are provided under the program
- Advise members on treatments that may be self-administered
- Contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Treat all members with respect and dignity
- Provide members with appropriate privacy

Maintain Medical Records

- Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse their release
- Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of nonresearch-related care
- Share records subject to applicable confidentiality and HIPAA requirements
- Upon notification of the member's transfer to another health plan, Healthy Blue will request copies of the member's medical record, unless the member has arranged for the transfer. The provider must transfer a copy of the member's complete medical record and allow the receiving health plan access (immediately upon request) to all medical information necessary for the care of that member.
- Transfer of records should not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving health plan are the responsibility of the relinquishing health plan.

- A copy of the member's medical record and supporting documentation should be forwarded by the relinquishing health plan's PCP within 10 business days of the receiving health plan's PCP's request
- Obtain and store medical records from any specialty referrals in members' medical records
- Manage the medical and health care needs of members to ensure all medically necessary services are made available in a timely manner

Cooperate and Communicate With Healthy Blue

- Participate in:
  - Internal and external quality assurance
  - Utilization review
  - Continuing education
  - Other similar programs
  - Complaint and grievance procedures when notified of a member grievance
- Inform Healthy Blue if a member objects to provision of any counseling, treatments or referral services for religious reasons
- Identify members who would benefit from our case management or disease management programs
- Comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Cooperate with the integration of behavioral health into our service delivery model in accordance with state mandates

Cooperate and Communicate With Other Providers

- PCPs are required to screen their patients for common behavioral health disorders, including screening for developmental, behavioral and social delays, as well as risk factors for child maltreatment, trauma and adverse childhood experiences. Members screening positive for any of these conditions should be referred to a behavioral health specialty provider for further assessment and possible treatment. Screening tools for common disorders typically encountered in primary care are available on the Healthy Blue provider website at **https://providers.healthybluela.com**.
- Monitor and follow up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service.
- Provide the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid.
- Provide case management services to include but not be limited to screening and assessing, developing a plan of care to address risks, medical/behavioral health needs, and other responsibilities as defined in the state's Healthy Louisiana program.
- Coordinate the services we furnish to the member with the services the member receives from any other Healthy Louisiana care network program during member transition.
- Share with other health care providers serving the member the results of your identification and assessment of any member with special health care needs (as defined by the state) so those activities are not duplicated.
- Healthy Blue will work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma and adverse childhood experiences (ACEs). We will work to increase the percentage of children with positive screens who:
  - Receive a warm handoff to and/or are referred for more specialized assessment or treatment.
  - Receive specialized assessment or treatment.

Cooperate and Communicate With Other Agencies

- Maintain communication with the appropriate agencies such as:

  - Local police
  - Social services agencies
  - Poison control centers
  - Women, Infants and Children (WIC) program
- Develop and maintain an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act
- Coordinate the services we furnish to the member with the services the member receives from any other managed care plan during ongoing care and transitions of care

As a PCP, you may practice in a:
- Solo or group setting
- Clinic (for example, a federally qualified health center FQHC or rural health center RHC)
- Outpatient clinic

2.4. Who Can Be a PCP?

Physicians with the following specialties can apply for enrollment with Healthy Blue as a PCP:
- Advance nurse practitioner
- Family practitioner
- General practitioner
- General pediatrician
  - General internist
  - Nurse practitioner certified as a specialist in family practice or pediatrics
  - FQHC/RHC
  - Specialist*

* Healthy Blue will allow vulnerable populations (for example, persons with multiple disabilities and/or acute or chronic conditions as determined by Healthy Blue) to select their attending specialists as their PCP as long as the specialist is willing to perform the responsibilities of a PCP. The specialist will provide and coordinate the member's primary and specialty care. Prior approval by the health plan is required for the authorization of a specialist as a PCP; we'll consider such requests on a case-by-case basis.

2.5. PCP Onsite Availability

You are required to abide by the following standards to ensure access to care for our members:
- Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup.
- Utilize an answering service or pager system. This must be a confidential line for member information and/or questions. If you use an answering service or pager, the member's call must be returned within 30 minutes.
- Be available to provide medically necessary services. You or another physician must offer this service.
- Follow our referral/precertification guidelines. This is a requirement for covering physicians.

Additionally, we strongly encourage you to offer after-hours office care in the evenings and on weekends. We encourage two hours at least one day per week after 5 p.m., and four hours or longer on Saturdays.

Examples of unacceptable PCP after-hours coverage:

- The PCP's office telephone is only answered during office hours.
- The PCP's office telephone is answered after-hours by a recording that tells patients to leave a message.
- The PCP's office telephone is answered after-hours by a recording that directs patients to go to an emergency room for any services needed.
- Returning the member's after-hour calls outside of 30 minutes.

It is **not** acceptable to automatically direct the member to the ER when the PCP is not available.

2.6. PCP Access and Availability

Our ability to provide quality access to care depends upon your accessibility.* You are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent care	Within 24 hours
Nonurgent sick care[1]	Within 72 hours
Routine or preventive care[1]	Within six weeks
Prenatal care[1,2] — initial visit	For first trimester: 14 days For second trimester: 7 days For third trimester: 3 days High risk: Within 3 days or sooner if needed

1 In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.
2 For women who are past their first trimester of pregnancy on the first day they are determined to be eligible for Louisiana Medicaid, first prenatal appointments should be scheduled as outlined in this chart.

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 90 minutes, the patient should be offered a new appointment. Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Providers practicing within a Walk-In Clinic are not allowed to serve as a PCP with assigned membership.. Direct contact with a qualified clinical staff person must be available through a toll-free number at all times.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual telephonic surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

You may not use discriminatory practices such as:
- Showing preference to other insured or private-pay patients.
- Maintaining separate waiting rooms.
- Maintaining separate appointment days.
- Offering hours of operation that are less than the hours of operation offered to patients with other insurance coverage.
- Offering office hours not equal to hours offered to other managed care organizations participating in the Healthy Louisiana program.
- Denying or not providing to a member any covered service or availability of a facility.

- Providing to a member any covered service that 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.

We will routinely monitor providers' adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the Americans with Disabilities Act of 1990. Health care services provided through Healthy Blue must be accessible to all members.

For urgent care and additional after-hours care information, see the Urgent Care/After-Hours Care section.

2.7. Members' Eligibility Listing

You should verify each member receiving treatment in your office actually appears on your membership listing. Accessing your panel membership listing via our provider website online tool is the most accurate way to determine member eligibility. You will have secure access to an electronic listing of your panel of assigned members, once registered and logged into our provider website.

To request a hard copy of your panel listing be mailed to you, call Provider Services at **1-844-521-6942**.

2.8. Specialty Care Providers

A specialty care provider is a network physician responsible for providing specialized care for members, usually upon appropriate referral from members' PCPs.

Members and providers can access a searchable online directory by logging into our website with their secure IDs and passwords. Providers will receive an ID and password upon contracting with us and can view the online directory through the following steps:

1. Logging in to our provider website at **https://providers.healthybluela.com**.
2. Selecting **Referral Info** from the *Tools* menu.
3. Selecting either **Searchable Directory** or **Downloadable Directories** from the *Referral Info* drop-down menu.

2.9. Role and Responsibilities of Specialty Care Providers

As a specialist, you will treat members who are:

- Referred by network PCPs
- Self-referred

Note that PCP referral is not required, but it is encouraged to ensure coordination of care.

Need help finding a specialist? Please email la1casemgmt@healthybluela.com for assistance.

You are responsible for:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program.
- Accepting all members referred to you.
- Rendering covered services only to the extent and duration indicated on the referral.
- Submitting required claims information, including source of referral and referral number.
- Arranging for coverage with network providers while off duty or on vacation.
- Verifying member eligibility and precertification of services at each visit.
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis.

- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval.
- Coordinating care with other providers for:
  - Physical and behavioral health comorbidities.
  - Co-occurring behavioral health disorders.
- Adhering to the same responsibilities as the PCP.

2.10. Specialty Care Providers' Access and Availability

You must adhere to the following access guidelines:

Type of Care	Standard
Medically necessary	Same day (within 24 hours of referral)
Urgent	Within 24 hours of referral
Routine	Within one month of referral
Lab referrals or X-rays — urgent care	Within 48 hours or as clinically indicated
Lab referrals or X-rays — regular appointments	Not to exceed three weeks

2.11. Member Enrollment

Nondiscrimination and accessibility requirements update
On May 13, 2016, the Department of Health and Human Services Office of Civil Rights (DHHS OCR) released the Nondiscrimination in Health Programs and Activities Final Rule (Final Rule) to improve health equity under the Affordable Care Act (ACA). Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, gender, sexual orientation, gender identity, age or disability by providers, health programs and activities that a) receive financial assistance from the federal government, and b) are administered by any entity established under Title I of the ACA.

How does the Final Rule apply to managed care organizations?
Healthy Blue complies with all applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, gender, gender identity, age or disability in its health programs and activities. Healthy Blue provides free tools and services to people with disabilities to communicate effectively with us. Healthy Blue also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages).

Who can I talk to if Healthy Blue isn't following these guidelines?
If you or your patient believe that Healthy Blue has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our compliance coordinator via:

- Mail: Compliance Department, Healthy Blue, 10000 Perkins Rowe, Suite G-510, Baton Rouge, LA 70810
- Phone: **1-225-819-4893**

If you or your patient need help filing a grievance, the compliance coordinator is available to help. You or your patient can also file a civil rights complaint with the DHHS OCR:

- Online at the OCR complaint website: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201
- By phone at: **1-800-368-1019** (**TTY/TDD**: **1-800-537-7697**)

Complaint forms are available at **www.hhs.gov/ocr/filing-with-ocr/index.html**. For additional details about Section 1557 and the *Final Rule*, visit:

- The DHHS OCR information page:**www.hhs.gov/civil-rights/for-individuals/section-1557/index.html**
- Frequently asked questions published by the DHHS: **www.hhs.gov/sites/default/files/2016-05-13-section-1557-final-rule-external-faqs-508.pdf**

We notified your Healthy Blue patients these services can be obtained by calling the Member Services phone number on their member ID card.

Medicaid recipients who meet the state's eligibility requirements for participation in managed care are eligible to join Healthy Blue. Members are enrolled without regard to their health status. Our members:

- Are enrolled for a period of up to 12 months, contingent upon enrollment date and continued Medicaid eligibility.
- Can choose their PCPs and will be auto-assigned to a PCP if they do not select one.
- Are encouraged to make appointments with their PCPs within 90 calendar days of their effective dates of enrollment.
- Medicaid-eligible newborns and their mothers, to the extent that the mother is eligible for Medicaid, should be enrolled in the same Healthy Louisiana plan with the exception of newborns placed for adoption or newborns who are born out of state and are not Louisiana residents at the time of birth.
- Coverage is provided for all newborn care rendered within the first month of life, regardless if provided by the designated PCP or another network provider. Providers will be compensated, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted with the MCO, but subject to the same requirements as a contracted provider.
- The health plan is responsible for covering all newborn care rendered by contracted network providers within the first 30 days of birth regardless if provided by the designated PCP or another network provider.
- Within 24 hours of the birth of a newborn (or within one business day of delivery), the hospital is required to submit clinical birth information to the health plan. Please fax the *Newborn Delivery Notification* to **1-877-269-5705**.
- Hospital providers are required to register all births through LEERS (Louisiana Electronic Event Registration System) administered by LDH/Vital Records Registry.
- LEERS information and training materials at: **http://ldh.la.gov/index.cfm/page/669**
- The clinical information required is outlined as follows:
  - Date of birth
  - Indicate whether it was a live birth
  - Newborn's birth weight
  - Gestational age at birth
  - Apgar scores
  - Disposition at birth
  - Gender
  - Type of delivery (vaginal or cesarean); if cesarean, the reason the cesarean was required
  - Single/multi birth
  - Gravida/para/ab for mother
  - EDC and if NICU admission was required

Providers may use the standard reporting form specific to their hospital, as long as the required information outlined above is included.

2.12. PCP Automatic Assignment Process for Members

During enrollment, a member can choose his or her PCP. When a member does not choose a PCP at the time of enrollment or during auto-assignment:

- If we are the primary payer, we will auto-assign a PCP within eight days from the date we process the daily eligibility file from the state.
- If we are the secondary payer, we will not auto-assign a PCP unless the member asks us to do so.

Pregnant members have 14 calendar days after birth to select a PCP. After 14 days, we will auto-assign a PCP for the newborn.

- There are two stages of auto-assignment logic for members who do not self-select a PCP: The first stage utilizes existing algorithms to assess data such as the distance of the PCP office from the member's home, languages spoken by provider and office staff, family link and prior relationship. Many providers receive an assignment of members based upon the first stage assignment logic.
- In the event there is more than one PCP meeting the first stage assignment logic for a member, the second stage will be activated. The second stage utilizes a rating system that has two components — quality and efficiency. The member will be assigned to the provider with the higher quality and/or efficiency ratings. To find out your current quality and efficiency ratings, as well as how to improve these ratings, please contact your local Provider Relations representative.

Members receive a Healthy Blue-issued ID card that displays their PCP's name and phone number, in addition to other important plan contact information.

Members may elect to change their PCPs at any time by calling Healthy Blue Member Services. The requested changes will become effective no later than the following day, and a new ID card will be issued.

2.13. Member PCP linkage analysis and reassignment

The Healthy Blue *Member PCP Linkage Analysis and Reassignment* policy ensures the member's assigned primary care physician (PCP) is the one most involved with treatment of the member, which will promote health outcomes and access to care for members.

Policy criteria

On a quarterly basis, Healthy Blue will initiate an analysis of PCP panel data to identify members eligible for PCP reassignment and prospectively reassign members as outlined below.

- First-quarter cycle:
    - By January 15: Initiate claim analysis to identify members eligible for reassignment.
    - By February 1: Distribute panel analysis results to providers for review with 15-business-day deadline to respond.
    - By February 22: Review provider responses and begin reassignment process.
    - By March 1: Complete processing of reassignments.
    - By March 15: Send notification letter to impacted members and update provider panel data on web.
- Second-quarter cycle:
    - By April 15: Initiate claim analysis to identify members eligible for reassignment.
    - By May 1: Distribute panel analysis results to providers for review with 15-business-day deadline to respond.
    - By May 22: Review provider responses and begin reassignment process.
    - By June 1: Complete processing of reassignments.

    - By June 15: Send notification letter to impacted members and update provider panel data on web.
- Third-quarter cycle:
    - By July 15: Initiate claim analysis to identify members eligible for reassignment.
    - By August 1: Distribute panel analysis results to providers for review with 15-business-day deadline to respond.
    - By August 22: Review provider responses and begin reassignment process.
    - By September 1: Complete processing of reassignments.
    - By September 15: Send notification letter to impacted members and update provider panel data on web.
- Fourth-quarter cycle:
    - By October 15: Initiate claim analysis to identify members eligible for reassignment.
    - By November 1: Distribute panel analysis results to providers for review with 15-business-day deadline to respond.
    - By November 22: Review provider responses and begin reassignment process.
    - By December 1: Complete processing of reassignments.
    - By December 15: Send notification letter to impacted members and update provider panel data on web.

This policy applies to:

- All in-network PCPs.
- All members who have been assigned to their current PCP for at least 90 days.
- Members who have not seen their assigned PCP within a 12-month lookback period.

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

If the member has an established relationship with an unassigned PCP, the member will be prospectively reassigned to that PCP if they are in-network with a valid primary care specialty. Unassigned PCPs meeting these specifications with closed panels will have panel status overridden to complete member reassignment.

Please note: If the member has seen an unassigned PCP with the same Tax ID Number (TIN) as their assigned PCP, the member will **not** be reassigned.

Disputing a reassignment
Providers identified as having members who are eligible for PCP reassignment have the right to dispute.

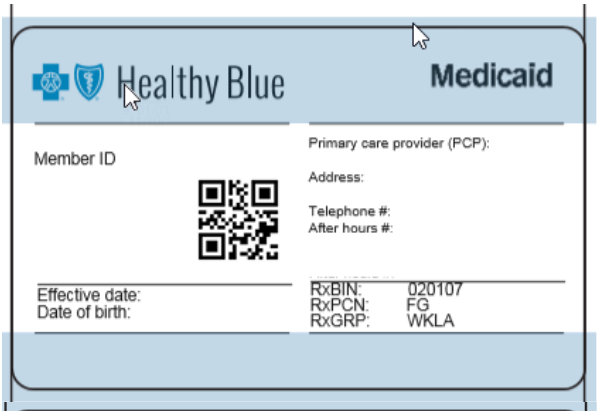
To dispute a reassignment:

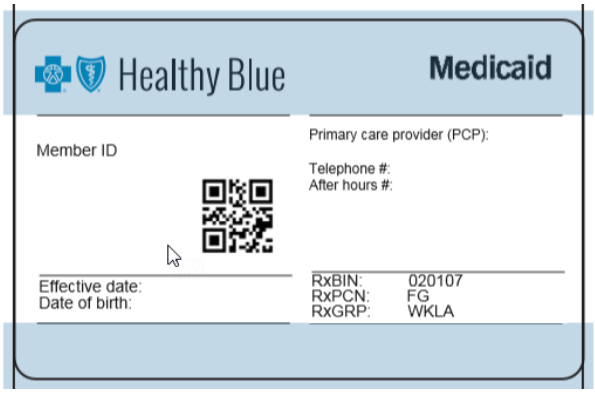
- Submit valid documentation such as a medical record, proof of billed claim or third-party liability demonstrating you have seen the member within the 12-month lookback period. This documentation should be sent to LAinterPR@HealthyBlueLA.com.

Documentation must be provided within the communicated 15-business-day deadline.

2.14. Member ID Cards

Healthy Blue member ID cards look similar to the following sample.





This ID card is separate from the Louisiana Department of Health ID card issued to the member by the state. Healthy Blue behavioral health-only members will have a different ID card than the example displayed above. This card will be very similar and contains the same branding.

2.15. Member Missed Appointments

At times, members may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to their health. You should attempt to contact any member who has not shown up for or canceled an appointment without rescheduling. Contact the member by telephone to:

- Educate him or her about the importance of keeping appointments.
- Encourage him or her to reschedule the appointment as soon as practicable.

For members who frequently cancel or fail to show up for appointments, please call Provider Services at **1-844-521-6942** to address the situation. Our goal is for members to recognize the importance of maintaining preventive health visits and adhere to a plan of care recommended by their PCPs.

2.16. Noncompliant Members

Contact Provider Services if you have an issue with a member regarding:

- Behavior
- Treatment cooperation
- Completion of treatment
- Continuously missed or rescheduled appointments

We will contact the member to provide the education and counseling to address the situation and will report to you the outcome of any counseling efforts.

2.17. Members With Special Needs

Adults and children with special needs include those members with a mental disability, physical disability, complex chronic medical condition or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care requirements.

Our network providers shall ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.

We have developed methods for:

- Well-child care.
- Health promotion and disease prevention.
- Specialty care for those who require such care.
- Diagnostic and intervention strategies.
- Therapies.
- Ongoing ancillary services.
- Long-term management of ongoing medical complications.
- Care management systems for ensuring children or adults with serious, chronic and rare disorders receive appropriate assessment, management and diagnostic workups on a timely basis.
- Coordinated care for individuals diagnosed with autism spectrum disorder (ASD), at risk of an ASD diagnosis or in need of applied behavioral analysis services.

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. The plan may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities and/or acute and chronic conditions as determined by Healthy Blue) to select their attending specialists as their PCP as long as the specialist is willing to perform responsibilities of a PCP.

With the assistance of network providers, we will identify members who are at risk of or have special needs. Screening procedures for new members will include a review of hospital and pharmacy utilization. We will develop care plans with the member and his or her representatives that address the member's service requirements with respect to specialist physician care, durable medical equipment, home health services, transportation, etc. The care management system is designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers, if applicable.
We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services over a prolonged period of time, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition.

Training sessions and materials and after-hours protocols for a provider's staff will address members with special needs. Protocols must recognize that a nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.

Case managers, providers and Member Services staff are able to serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

2.18. Covering Physicians

During your absence or unavailability, you need to arrange for coverage for your members assigned to your panel. You will be responsible for making arrangements with one of the following:

- One or more network providers to provide care for your members
- Another similarly licensed and qualified participating provider who has appropriate medical staff privileges at the same network hospital or medical group to provide care to the members in question

In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing and participation.

You will be solely responsible for:

- A non-network provider's adherence to our network provider agreement.
- Any fees or monies due and owed to any non-network provider providing substitute coverage to a member on your behalf.

2.19. Provider Support

We support our providers by providing telephonic access to Provider Services at our national contact centers, in addition to local Provider Relations representatives (PR reps).

- Providers Services supports provider inquiries about member benefits and eligibility and about authorizations and claims issues via our Provider Experience Program.
- PR reps are assigned to all participating providers; they facilitate provider orientation and education programs that address our policies and programs. PR reps visit provider offices to share information on at least an annual basis.

We also provide communications to our providers through newsletters, alerts and updates. These communications are posted on our provider website and may be sent via email, fax or regular mail.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual and/or quarterly telephonic surveys. These surveys include but are not limited to the verification of provider appointment availability, telephonic surveys to verify after-hours access, and any newly identified surveys that may assist in providing the best quality networks for our members.

To collect your feedback on how well Healthy Blue meets your needs, we conduct an annual provider satisfaction survey. You will receive this survey via mail or email. If you are selected to participate, we appreciate you taking the time complete the survey and provide input to improve our service to you.

2.20. Reporting Changes in Address and/or Practice Status

To maintain the quality of our provider data, we ask that changes to your practice contact information or the information of participating providers within a practice be submitted as soon as you are aware of the change.

If you have status or address changes, report them through **https://providers.healthybluela.com** or to:

Healthy Blue
Provider Relations Department
10000 Perkins Rowe, Suite G-510
Baton Rouge, LA 70810
Phone: **1-504-836-8888**
Fax: **1-888-375-5063**
Email: lainterpr@healthybluela.com

2.21. Second Opinions

The member, the member's parent or legally appointed representative, or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion should be provided at no cost to the member.

The second opinion must be obtained from a network provider or a non-network provider if there is not a network provider with the expertise required for the condition. Authorization is required for a second option if the provider is not a network provider. Once approved, you will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. You will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during our regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment and reporting. We will inform you and the member of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

2.22. Medically Necessary Services

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

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain, or have resulted or will result in a handicap, physical deformity or malfunction.
- 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, not approved by the U.S. Food and Drug Administration, 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.

We only cover items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

2.23. Provider Bill of Rights

Each network provider who contracts with Healthy Blue to furnish services to members has the right to:

- While acting within the lawful scope of practice, advise or advocate on behalf of a member who is his or her patient regarding:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs to decide among all relevant treatment options, whether the benefits for such care or treatment are provided under the contract.
  - The risks, benefits and consequences of treatment or nontreatment.
  - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and express preferences about future treatment decisions.
- Receive information on the grievance, appeal and state fair hearing procedures.
- Have access to Healthy Blue policies and procedures covering the precertification of services.
- Be notified of any decision by Healthy Blue to deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.
- Challenge on the member's behalf, at the request of the Medicaid/Children's Health Insurance Program member, the denial of coverage or payment for medical assistance.
- Be free from discrimination where Healthy Blue selection policies and procedures govern particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- Be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

- Healthy Blue complies with the provisions of *42 CFR §438.102(a)(1)(ii)* concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.

2.24. "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.

2.25. Provider Surveys

We will conduct an annual survey to assess provider satisfaction with provider enrollment, communications, education, complaints resolution, claims processing, claims reimbursement and utilization management processes, including medical reviews and support toward patient centered medical home implementation.

Our provider satisfaction survey tool and methodology will be submitted to the Louisiana Department of Health (LDH) for approval prior to administration. A results report summarizing the survey methods, findings and analysis of opportunities for improvement will be provided to the LDH for review within 120 days after the end of the plan year.

2.26. Provider Marketing Guidelines

- When conducting any form of marketing in a provider's office, Healthy Blue must acquire and keep on file the written consent of the provider.
- Healthy Blue may not require its providers to distribute Healthy Blue-prepared marketing communications to their patients.
- Healthy Blue may not provide incentives or giveaways to providers to distribute them to Healthy Blue members or potential Healthy Blue members.
- Healthy Blue may not conduct member education or distribute member education materials in provider offices.

- Healthy Blue may not allow providers to solicit enrollment or disenrollment in Healthy Blue, or distribute Healthy Blue-specific materials at a marketing activity.
- Healthy Blue may not provide providers printed materials with instructions detailing how to change members of other MCOs to Healthy Blue.
- Healthy Blue shall instruct participating providers regarding the following communication requirements:
  - Participating providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they have contracts;
  - Participating providers may display and/or distribute health education materials for Healthy Blue or they may choose not to display and/or distribute for Healthy Blue. Health education materials must adhere to the following guidance:
    - Health education posters cannot be larger than 16" x 24"
    - Children's books, donated by Healthy Blue must be in common areas
    - Materials may include the Healthy Blue name, logo, phone number and website
    - Providers are not required to distribute and/or display all health education materials provided by Healthy Blue with whom they contract. Providers can choose which items to display as long as they distribute items from Healthy Blue and that the distribution and quantity of items displayed are equitable.
    - Providers may display marketing materials for Healthy Blue provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom the provider has a contract.
    - Providers may display Healthy Blue participation stickers but they must display stickers by all contracted MCOs or choose to not display stickers any contracted MCOs.
    - Healthy Blue stickers indicating the provider participates with Healthy Blue cannot be larger than 5" x 7" and not indicate anything more than "Healthy Blue is accepted or welcomed here."
    - Providers may inform their patients of the benefits, services and specialty care services offered through Healthy Blue. However, providers may not recommend one MCO over another MCO, offer patients incentives for selecting Healthy Blue over another MCO, or assist the patient in deciding to select a specific MCO in any way, including but not limited to faxing, using the office phone or a computer in the office.
    - Upon actual termination of a contract with Healthy Blue, a provider that has contracts with other MCOs may notify their patients of the change in status and the impact of such a change on the patient included the date of the contract termination. Providers must continue to see current patients enrolled in Healthy Blue until the contract is terminated according to all terms and conditions specified in the contract between the provider and Healthy Blue.
    - Healthy Blue shall not produce branded materials instructing members on how to change a plan. They must use DHH-provided or approved materials and should refer members directly to the enrollment broker for needed assistance.

2.27. Healthy Louisiana Benefits

Covered Service	Limitations/Notes
Ambulatory Surgical Services	Covered services include medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative items or services furnished to an outpatient. • Performance of outpatients surgical procedures will be reimbursed on a flat fee per service basis. All outpatient surgery charges for the specified surgeries should be billed using revenue code "490"- Ambulatory Surgery Care. All other charges associated with the surgery(e.g., observation, labs, radiology) must be

Covered Service	Limitations/Notes
	billed on the same claim as the ambulatory surgery charges. The only revenue code that will be paid will be the flat rate fee for the ambulatory surgery. The minimum reimbursement rate for groupings can be found on the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedules. A list of the surgical procedures is also provided on the fee schedule. • For minor surgeries that are medically necessary to be performed in the hospital operating room but the associated CPT code is not included in the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedules, submit charges using revenue code HR361 - Operating Room Services-Minor Surgery. • When more than one surgical procedure is performed on the same date of service, only the primary surgical procedure will be paid.
Applied Behavior Analysis (ABA)	This benefit is available for members 20 years and under. A comprehensive diagnostic evaluation (CDE) is required to receive ABA services. Services may include: • Assessment, evaluation and re-evaluation. • Treatment intervention plan with measureable objective goals. • Functional communication training. • Self-monitoring and adaptive living skills. • Speech, occupational and physical therapy. • Durable medical equipment (DME). • Speech-generating devices (SGD). • Language, verbal and cognitive skills. • Peer play and social skills. • Prevocational and vocational skills. • Parent training, family education and counseling. • Care coordination. • Case management. To see the full list of covered services, limits and authorization rules, refer to the **Applied Behavioral Analysis** section in this manual or the provider website at **https://providers.healthybluela.com**.
Audiology Services	Covered services include diagnostic, preventive or corrective services for individuals with speech, hearing and language disorders provided by or under the direction of an audiologist.
Behavioral Health Services	Basic Behavioral Health services: • Screening • Prevention • Early intervention • Medication management • Treatment and referral services provided in the primary care office • Inpatient hospital services for acute medical detoxification based on medical necessity Specialized Behavioral Health services including but not limited to:

Covered Service	Limitations/Notes
	• Inpatient mental health and substance use disorder treatment • Psychiatric residential treatment facility treatment • A full range of outpatient mental health and substance abuse services, including rehabilitative and licensed mental health professional (LMHP) services (including advance practice registered nurse [APRN] services) To see the full list of covered services, limits and authorization rules, reference the **Behavioral Health Services** chapter included in this manual or visit the provider website at **https://providers.healthybluela.com**.
Chiropractic Services	Covered services include medically needed spinal manipulations for Medicaid members younger than age 21 referred to a chiropractor as part of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) checkup.
Clinic Services (Other than Hospitals)	Certain limits apply. Covered services include diagnostic, preventive, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician in a facility that is not part of a hospital (for example, mental health clinics, prenatal health care clinics, family planning clinics, end-stage renal disease facilities and radiation therapy centers). A maximum of one procedure per day per recipient for mental health clinic services is permitted. Recreational therapy, music therapy and art therapy are not provided. Prenatal care provided in a prenatal health care clinic is subject to limitations.
Clinical Lab Services and Diagnostic Testing • Inpatient and outpatient lab services (see coverage limits for hospital outpatient facilities) • Diagnostic testing services for members who cannot leave their homes without special transport are included	Quest Diagnostics and LabCorp are **the preferred lab providers for all Healthy Blue members**. Contact Quest or LabCorp at the numbers below to receive a specimen drop box. For more information, testing solutions and services, or to set up an account, contact either: • Quest Diagnostics: **1-866-MY-QUEST** (**1-866-697-8378**) • LabCorp: **1-800-345-4363**
Communicable Disease Services	Services include exams, treatment and health education to help control and prevent communicable diseases such as tuberculosis (TB), sexually transmitted infection (STI) and HIV/AIDS.

Covered Service	Limitations/Notes
	Healthy Blue network providers will report all cases of TB, STI and HIV/AIDS infection to the LDH Office of Public Health within 24 hours of notice from the date of service.
Developmental and Autism Screening	Coverage includes: • Developmental and autism screenings administered during EPSDT preventive visits in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. • Developmental and autism screenings performed by primary care providers when administered at intervals outside EPSDT preventive visits if they are medically indicated for an enrollee at-risk for, or with a suspected, developmental abnormality. Requirements: • Healthy Blue will only reimburse the use of age-appropriate, caregiver-completed, and validated screening tools as recommended by the AAP. • If an enrollee screens positive on a developmental or autism screen, the provider must give appropriate developmental health recommendations, refer the enrollee for additional evaluation, or both, as clinically appropriate. Providers must document the screening tool(s) used, the result of the screen, and any action taken, if needed, in the enrollee's medical record. • Developmental screening and autism screening are currently reimbursed using the same procedure code. Providers may only receive reimbursement for one developmental screen and one autism screen per day of service. To receive reimbursement for both services performed on the same day, providers may submit claims for two units of the relevant procedure code.
Durable Medical Equipment (DME)	Services include medically needed medical supplies, appliances and assistive devices for members, including hearing aids and disposable incontinence supplies. For DME services, contact Healthy Blue at **1-844-521-6942**.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/ Well-Child Visits	The EPSDT service is a complete and preventive child health program for Medicaid members younger than 21 years of age. Benefits cover a health and development history, complete physical exam, proper immunizations, screenings, and diagnostic services, including lead blood level assessment. Also included are vision, hearing and dental screenings to decide health care needs and other measures to identify, correct or improve physical or mental defects or chronic conditions.
Emergency Dental Services	Covered services include laboratory or radiological services that may be required to treat an emergency or provide surgical services related to an emergency.
Emergency Medical Services • In-and out-of-network emergency care • Post-stabilization care	Coverage includes emergency services given by a network or out-of-network provider under these conditions: • The member has an emergency medical condition; this includes cases in which the absence of getting medical care right away would not have had the outcome defined as an emergency medical condition. • Healthy Blue tells the member to get emergency services.
End-Stage Renal Disease Services	• End-stage renal disease services are covered.

Covered Service	Limitations/Notes
	• Dialysis services are covered for all Medicaid recipients and include dialysis treatment (including routine laboratory services); medically necessary, nonroutine lab services; and medically necessary injections. Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte and acid-base balances in cases of impaired or absent kidney function. A free-standing clinic is a facility that operates solely for the provision of dialysis services. These services also include home dialysis services that are patient/patient's representative-managed under the supervision of the clinic. For locations other than free-standing, the services are rendered either in an inpatient or outpatient hospital setting.
Eye Care and Vision Services (includes vision services from a licensed ophthalmologist or optometrist)	Covered for members as follows: • Ages 0-20: – Exams and treatment of eye conditions, including exams for vision correction – Regular eyeglasses when they meet a certain minimum strength • Ages 21 and over: – Exams and treatment of eye conditions, such as infections or cataracts
Family Planning Services	Coverage includes family planning services for members of childbearing age who choose to delay or prevent pregnancy. Services include the following: • Medical history and physical exam • Annual physical assessment; nonprescribed methods can be seen every two years • Lab tests performed as part of an initial or regular follow-up visit or exam for the purpose of family planning: – Pap smears – Gonorrhea and chlamydia testing – Syphilis serology – HIV testing – Rubella titer • Drugs for the treatment of lower genital track and genital skin infections/disorders and urinary tract infections when identified or diagnosed during a routine/periodic family planning visit • Pharmaceutical supplies and devices to prevent conception approved by the Federal Food and Drug Administration (long-acting reversible contraceptives do not require prior authorization) • Male and female sterilization procedures provided in accordance with *42 CFR Part 441, Subpart F* • Treatment of major complications from certain family planning procedures • Transportation to and from family planning appointments provided all other criteria for nonemergent transportation is met • Education • Reproductive anatomy and physiology • Fertility regulation • Sexually transmitted infection (STI) transmission • Counseling — to help make an informed decision • Method counseling — to give results of history and physical exam, means of action, and the side effects and possible complications

Covered Service	Limitations/Notes
	• Special counseling (when stated) — pregnancy planning and management, sterilization, genetics, and nutrition • Pregnancy diagnosis, counseling and referral Members do not need a referral for family planning services. Members may choose a network or non-network provider. We will make a reasonable effort to contract with all local family planning clinics and providers, including those funded by *Title X* of the *Public Health Services Act*. We will reimburse providers for all family planning services, regardless of whether that provider is a network provider, no less than the Medicaid fee-for-service rate on the date of service.
Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)	Coverage includes access to behavioral health and covered services offered through a FQHC if the member lives in the service area of the clinic and either: • Chooses the FQHC as his or her PCP. • Needs emergency care. • Requests to get these services from the clinic by calling Member Services. • FQHCs and RHCs are eligible for an add-on reimbursement for long-acting, reversible contraception (LARC). • If Provider is a federally qualified health center ("FQHC") or a rural health center ("RHC"), as defined under applicable federal law, the Provider shall comply with all requirements related to FQHCs and RHCs under Regulatory Requirements including, without limitation, compliance with the service quality standards required in connection with current and future clinical quality reporting methods that are applicable to FQHCs and administered by federal oversight agencies.
Home Health Services	Prior authorization is required: • Coverage includes skilled nursing, therapeutic care, supplies and health aide services provided in a member's residence. • Extended home health services are available to members ages newborn to 20 years. Call Healthy Blue at **1-844-521-6942** to schedule services.
Hospice	A recipient must be terminally ill to receive hospice care. An individual is considered terminally ill if he or she has a physician-certified medical **prognosis** that the individual's life expectancy is six months or less if the illness runs its normal course. Prior authorization is required.
Immunizations	Healthy Blue provides all members with all vaccines and immunizations in accordance with the Advisory Committee on Immunizations Practice (ACIP) guidelines. ACIP vaccine recommendations can be found on the Centers for Disease Control and Prevention (CDC) website at **www.cdc.gov/vaccines/hcp/acip-recs**. In accordance with Healthy Louisiana guidelines, Healthy Blue covers hepatitis B adult, two-dose vaccine.
Inpatient Hospital Services	Covered services include: • A semi-private room for: – Routine care.

Covered Service	Limitations/Notes
• Stays expected to last more than 24 hours • Hospital care needed for the treatment of an illness or injury that can only be provided safely and adequately in a hospital setting	– Surgical care. – Obstetrics and newborn nurseries. – A private inpatient room if a member's medical condition requires isolation. – Nursing services. – Dietary services. • Ancillary services such as: – Lab. – Radiology. – Pharmacy. – Medical supplies. – Blood and blood by-products.
Lynch syndrome and familial adenomatous polyposis (FAP) genetic testing	In accordance with Healthy Louisiana guidelines, Healthy Blue will reimburse genetic testing for Lynch syndrome and FAP once in a recipient's lifetime.

Covered Service	Limitations/Notes
Medical Transportation Services	Emergency transportation, including hospital-to-hospital transportation for physical and behavioral health, is covered for Medicaid covered services. Nonemergency medical transportation (NEMT) coverage and nonemergency ambulance transportation (NEAT) is provided to members who lack transportation to and from provider's office. Some dual-eligible members (Medicare and Medicaid) will also be covered for NEMT and NEAT. For these members, care coordination must be sufficient to assure third-party liability (TPL), nonduplication of benefits, and effective coordination between Medicare- and Medicaid-funded behavioral health services. In addition, NEMT/NEAT to access carved-out services should also be provided. The health plan will be responsible for providing transportation for the member if services cannot be provided in-network. For NEMT/NEAT, members can call MediTrans at **1-866-430-1101**, Monday to Friday from 7 a.m. – 7 p.m., to set up routine transportation. Rides must be set up 48 hours prior to the appointment, and the member must have the following information available: • Member ID number (can be found on the front of the Healthy Blue member ID card) • The address, ZIP code and phone number where the member wants to be picked up • The name, address, ZIP code, and phone number of the provider the member will be seeing • Date and time of appointment • Whether or not the member uses a wheelchair or other mobility equipment • For minors age 16 and younger, the name of the adult who will go with the child • The name of the caregiver, if applicable Providers may also reach MediTrans through email at **facility@callmeditrans.com** or by phone at 1-866-886-4081. The **Nonemergent Transportation Request Form** can be found on our provider portal, and can be emailed to MediTrans or faxed to 1-877-457-3349. MediTrans may be contacted 24/7 for hospital discharges.
Noninvasive prenatal testing (NIPT)	In accordance with Healthy Louisiana guidelines, Healthy Blue will cover NIPT for the detection of fetal chromosomal abnormalities in pregnant women.
Nurse Midwife Services	A certified nurse midwife (CNM) is a registered professional nurse who is legally authorized under state law to practice as a nurse midwife and has completed a program of study and clinical experience for nurse midwives or equivalent. Covered services may be rendered by a CNM as defined above.
Nurse Practitioner Services	A nurse practitioner certified (NP-C) is a registered professional nurse who is licensed by the state and meets the advanced educational and clinical practice requirements beyond the two or four years of basic nursing education required for all registered nurses. Covered services may be rendered by an NP-C as defined above.
Organ Transplant and Related Services	These services are covered for members diagnosed with certain medical conditions. Services may include: • Reviewing pretransplant inpatient or outpatient needs.

Covered Service	Limitations/Notes
• Services for members diagnosed with certain medical conditions needing a heart, kidney, liver, bone marrow, small bowel or pancreas transplant	• Searching for donors. • Choosing and getting organs/tissues. • Preparing for and performing transplants. • Convalescent care. If the member receives a transplant covered by a provider who is not in the Healthy Blue network, medically needed, nonexperimental services will be given within certain limits after discharge from the acute care hospital that performed the transplant.
Outpatient Nonpsychiatric Hospital Services • Stays not expected to last more than 24 hours	Covered services include: • Services that can be properly given on an outpatient or ambulatory basis such as: – Lab – Radiology – Therapies – Ambulatory surgery – Observation services (if needed to decide whether a member should be admitted for inpatient care)
Pediatric Day Health Care (PDHC)	PDHC is defined as intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments. • PDHC is covered for Medicaid recipients ages 0 to 21 who: – Have a medically fragile condition – Require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition. • Coverage includes nursing care, respiratory care, physical therapy, speech-language therapy, occupational therapy, personal care services, education, training and transportation to and from PDHC facility. • The recipient must: – Require ongoing skilled medical care or skilled medical care by a knowledgeable and experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN). – Be stable for outpatient medical services. • All PDHC service requests require precertification and review by the medical director to ensure medical necessity.
Personal Care Services	Provided by attendants when physical limitations due to an illness or injury require assistance with eating, bathing, dressing and personal hygiene; does not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters • Covered for members ages 0 to 20 and excluded for members > 21 years of age • Requires prior authorization

Covered Service	Limitations/Notes
Pharmacy Services	Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies. See the **Pharmacy Services** section for more coverage details.
Physician Services	Services performed in a physician's office, such as: • Medical assessments. • Treatments. • Surgical services. Services must be given by licensed allopathic or osteopathic physicians.
Podiatry Services	No precertification is required for a network provider for evaluation and management (E&M).
Post-stabilization Care Services	Post-stabilization services are covered if: • Care is received within or outside the Healthy Blue network of providers and preapproved by Healthy Blue. • Care is received within or outside the Healthy Blue network of providers but is not preapproved by Healthy Blue because: – Services are given to keep a member's condition stable within one hour of asking Healthy Blue for preapproval of more services. – Services are given to maintain, improve or resolve a member's stabilized condition and: o We do not respond to a request for prior approval within one hour. o The treating physician cannot get in touch with Healthy Blue. o Healthy Blue and the treating physician cannot agree on the member's care and a network physician is not on hand for consult; if this happens, we will: ▪ Give the treating physician the chance to consult with a network physician. ▪ Let the treating physician still give care until a network physician is reached or one of the following occurs: • A network physician with privileges at the treating hospital becomes responsible for the member's care. • A network physician becomes responsible for the member's care through transfer. • Healthy Blue and the treating physician reach an agreement on the member's care. • The member is discharged.
Preventive Medicine	Preventive medicine counseling and/or risk factor reduction intervention(s)
Rehabilitation Therapy Services • Occupational, physical, speech and	Services must be prescribed by the PCP or attending physician. Prior authorization is required. Requests for services must include a physician's order. Note: For members receiving applied behavior analysis, these services may already be provided as part of the treatment plan.

Covered Service	Limitations/Notes
respiratory therapies	
School-based Health Clinic Services (SBHC)	SBHC (certified by the LDH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21. The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.
Sterilization • A medical procedure, treatment or operation that causes the person to no longer be able to reproduce	Requirements are as follows: • The person to be sterilized must give informed consent not less than 30 full calendar days (or not less than 72 hours in the case of a premature delivery or abdominal surgery) but not more than 180 calendar days before the date of the sterilization. • A new consent form is required if 180 days have passed before the surgery occurs. • The consent for sterilization cannot be obtained while the patient is in the hospital for labor, childbirth, abortion, or under the influence of alcohol or other substances that affects a patient's awareness. • The person to be sterilized must: – Be at least 21 years of age at the time consent is received. – Be mentally competent. – Not be in an institution (that is, not involuntarily confined or kept under a civil or criminal status in a correctional or rehabilitation facility or confined in a mental hospital or other facility for the care and treatment of mental illness) • The patient must give informed consent on the approved *Sterilization Consent Form*, available at **https://www.lamedicaid.com/provweb1/forms/forms.htm**.
Telemedicine	Healthy Blue offers telemedicine through LiveHealth Online (LHO) for our members. LHO is a mobile app and website (https://startlivehealthonline.com) that provides members with a convenient way to have live video visits with board-certified doctors, psychologists or psychiatrists. Additionally, our behavioral health members may obtain telemedicine mental health services through One TeleMed, a telemedicine company that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health care providers. To make a referral to One TeleMed for a member, please call **1-337-565-0843 and select option 2**. Healthy Blue case management can also assist with care coordination for a member and can be reached at **1-877-440-4065 ext. 106-103-5145.**
Women's Health Services — Abortions	Services are restricted to these reasons: • A physician has found and confirms in writing that, on the basis of his or her judgment, the life of the pregnant woman would be in danger if the fetus were carried to term. • In the case of ending a pregnancy due to rape or incest, certain requirements must be met: – The member must report the act to a law enforcement official unless the treating physician confirms in writing that, in his or her expert opinion, the victim was not physically or psychologically able to report the rape or incest. – The report of the act to the law enforcement official or the treating physician's statement that the victim was not able to report the rape or incest must be submitted to Healthy Blue.

Covered Service	Limitations/Notes
	– The member must confirm that the pregnancy is the result of rape or incest; this certification must be witnessed by the treating physician. The treating physician must witness the Office of Public Health's *Certification of Informed Consent — Abortion* form and attach it to his or her claim form. The Certification of Informed Consent–Abortion form may be obtained from the Louisiana Office of Public Health via this request form link (**http://www.ldh.la.gov/index.cfm/form/63**) or by calling **1-504-568-5330**.
Women's Health Services — Hysterectomies	Covered when they are nonelective, medically needed and meet the following requirements: • The person or her representative must be told orally and in writing (via the form referenced below) that this procedure will leave the person unable to reproduce again. • The person or her representative, if any, must sign and date an *Acknowledgement of Receipt of Hysterectomy Information* form prior to the hysterectomy; this must be obtained despite diagnosis or age. This form can be submitted after surgery only if it clearly states the patient was told before surgery that she would be left unable to reproduce. This form is not required if: – The person was sterile prior to the hysterectomy. – A hysterectomy is required due to a life-threatening emergency and the physician decided prior acceptance was not possible. See **Appendix B** of this manual for the form's location.
Women's Health Services — OB/GYN Services	Covered services for female members include: • One routine annual visit. • A second visit based on medical need. • Follow-up treatment given within 60 days after either routine visit if the care relates to: – A condition diagnosed or treated during the visits. – A pregnancy. As part of the annual visit, the member should receive interconceptional health education to address physical health conditions that may impact future pregnancies. She may want to discuss her plans for future pregnancy with her OB/GYN.

Covered Service	Limitations/Notes
Women's Health Services — Prenatal Services	Covered services include: • Offering direct access to routine OB/GYN services within the Healthy Blue network; the OB/GYN will contact the member's PCP to advise that: – These services are being delivered. – The OB/GYN will manage and coordinate this care with the PCP. • Arranging a risk assessment for all pregnant members. • Ensuring high-risk pregnant members in need of further assessment or care have access to maternal fetal medicine specialists. • Counseling a pregnant member about plans for her child such as: – Choosing the family practitioner or pediatrician who will perform the newborn exam. – Choosing a PCP to give follow-up pediatric care to the child once the child is enrolled in Healthy Louisiana. Access the state's Women, Infants and Children (WIC) program at **http://new.dhh.louisiana.gov/index.cfm/page/942**. A sample referral/release of information form is found using this link: **http://www.ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/WICReferralForm.pdf**.
Women's Health Services — Postpartum Care	Coverage includes: • Postoperative care visit following cesarean delivery. • Postpartum care visit between the 21st and 56th day postdelivery. • Electric breast pump for mothers who wish to breastfeed but aren't able to do so because of the mother's or infant's medical condition. If necessary, long-term electric breast pump needs are covered by a hospital-grade electric breast pump rental. See also the Family Planning Services row.
Women's Health Services — Perinatal Depression Screening	Perinatal depression screening must employ one of the following validated screening tools: • Edinburg Postnatal Depression Scale (EPDS) • Patient Health Questionnaire 9 (PHQ-9) • Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9 Documentation must include the tool used, the results, and any follow-up actions taken. If an enrollee's caregiver screens positive, the provider must refer the caregiver to available resources, such as their primary care provider, obstetrician, or mental health professionals, and document the referral. If screening indicates possible suicidality, concern for the safety of the caregiver or enrollee, or another psychiatric emergency, then referral to emergency mental health services is required. Though the screening is administered to the caregiver, Healhty Blue shall reimburse this service under the child's Medicaid coverage. If 2 or more children under age 1 present to care on the same day (e.g., twins or other siblings both under age 1), the provider must submit the claim under only one of the children. When performed on the same day

Covered Service	Limitations/Notes
	as a developmental screening, providers must append modifier -59 to claims for perinatal depression screening.
Women's Health Services — 39 Weeks Initiative	LDH no longer pays for nonmedically necessary elective deliveries prior to 39 weeks of gestation. To expedite claims processing, we process professional delivery claims without prevalidating against the LEERS data. We validate 100% of claims against the LEERS data post pay, and claims may be subject to medical justification and possible recoupment. All professional delivery claims are required to report one of the following maternity modifiers: • GB – delivery is more than 39 weeks; claim will be adjudicated • AT – delivery is less than 39 weeks and medically indicated/spontaneous; claim will be adjudicated • GZ – delivery is less than 39 weeks and **not** medically indicated; claim will deny If a maternity modifier is not reported, it will automatically deny.

Note: We do not cover experimental procedures or medications. Reimbursement for anesthesiology services will be in accordance with the accumulation of base, modifier and time units multiplied by the Louisiana Medicaid Anesthesia Conversion Factor.

2.28. Pharmacy Services

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers. Members have access to many independent retail pharmacies and most national pharmacy chains.

Monthly Limits

- All prescriptions are limited to a maximum 30-day supply per fill.

Covered Drugs

The Healthy Blue Pharmacy program follows the State *Preferred Drug List* (*PDL*). This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The *PDL* comprises drug products reviewed and approved by the Louisiana Department of Health. To prescribe medications that require prior authorization, either call Healthy Blue Provider Services at **1-844-521-6942** or use the uniform PA form. Please refer to the Louisiana Department of Health *PDL*: **http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf**.

Prior Authorization Drugs

You are strongly encouraged to write prescriptions for preferred products as listed on the *PDL*. If a member cannot use a preferred product as a result of a medical condition, either fax a completed uniform PA form or call our Provider Services department at **1-844-521-6942** to obtain prior authorization. You must be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria. Please refer to the Louisiana Department of Health *PDL* to view drug specific prior authorization criteria: **http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf**.

Over-The-Counter Drugs
The Louisiana Department of Health *PDL* includes coverage of some OTC drugs when accompanied by a prescription. The following are examples of covered OTC medication classes:

- Analgesics/antipyretics
- Antidiarrheals
- Antifungals, topical
- Antifungals, vaginal
- Antihistamines
- Diabetic testing supplies
- Pediculocides
- Respiratory agents (including spacing devices)
- Smoking cessation
- Topical anti-inflammatories

Excluded Drugs
The following drugs are examples of medications that are excluded from the pharmacy benefit:

- Weight control products
- Anti-wrinkle agents (for example, Renova)
- Drugs used for cosmetic reasons or hair growth
- Experimental or investigational drugs
- Drugs used for experimental or investigational indication
- Infertility medications
- Implantable drugs and devices (except IUDs which contain a drug as a pharmacy benefit)
- Erectile dysfunction drugs to treat impotence
- Drug Efficacy Study Implementation (DESI) drugs

Specialty Drug Program
We cover most specialty drugs under the pharmacy benefit. These drugs can be obtained through any pharmacy in our network that dispenses these medications.

Behavioral Health-Specific Pharmacy Policies and Procedures
Prior to discharge from psychiatric facilities and residential substance use facilities, the provider must notify Healthy Blue of the member's discharge medications.

Network prescribers must utilize and conduct patient-specific queries in the Prescription Monitoring Program (PMP) for behavioral health patients upon writing the first prescription for a controlled substance, then annually. The physician must print the PMP query and file it as part of the recipient's record.

2.29. Healthy Blue Value-Added Services

We cover extra benefits, including but not limited to the following, which eligible members cannot get from fee-for-service Medicaid. These extra benefits are called value-added services.

Covered Service	Coverage Limits
24/7 NurseLine	The 24/7 NurseLine is a telephonic, 24-hour triage service, available at **1-866-864-2544** (**TTY 711**; Spanish **1-866-864-2545**). Language translation services are also available.

Covered Service	Coverage Limits
	For more information, see the **24/7 NurseLine** section in this manual.
Case Management Services	Case management services for physical health and behavioral health are integrated. Case managers will work with members (or a designated representative) to review strengths and needs. The case manager can help with: • Assessing your health care needs. • Developing a plan of care. • Giving the member and their family the information and training needed to make informed decisions and choices. • Giving providers the information they need about any changes in your health to help them in planning, delivering and monitoring services.
Disease Management Programs	Disease Management programs help members manage the following: • Asthma • Bipolar disorder • Chronic obstructive pulmonary disease • Congestive heart failure • Coronary artery disease • Diabetes • HIV/AIDS • Hypertension • Major depressive disorder • Substance use disorder • Hepatitis C • Sickle Cell In addition to providing support for the conditions mentioned above, our Disease Management (DM) case managers focus on providing a holistic care management approach to address comorbid conditions, such as obesity.
Women's Health Services — Prenatal Services	Covered services include the following: • Healthy Mothers Healthy Babies/Healthy Blue partnership to co-promote the Text4baby program: Text4baby is a free service pregnant women can sign up for; women receive text messages throughout their pregnancies reminding them about health promotion activities and preparation for delivery. • The New Baby, New Life℠ program offers an array of services to pregnant woman and her newborn to provide the best opportunity to have a healthy baby and be a successful mom; every identified member receives: o A prenatal/postpartum packet that includes educational materials. o Rewards up to $75 for pregnant members and new moms:

Covered Service	Coverage Limits
	• $25 prenatal incentive: expectant mothers who complete the prenatal visit within the first trimester or within 42 days of enrollment with Healthy Blue • $50 postpartum incentive: new mothers who complete a postpartum follow-up that includes a depression screening within 21 and 56 days after delivery • Louisiana Portable Crib and Infant Car Seat: Expectant members are eligible to receive a portable crib or car seat following completion of seven or more prenatal visits. • $25 for 17P therapy for pregnant members at risk for pre-term birth Promotion of the Centering Health Institutes' Centering Pregnancy (CP) program: an evidence-based, free program that provides group care as the model of care; CP gives pregnant members the opportunity to meet with other pregnant women and a designated health care provider to learn care skills and discuss relevant pregnancy and infant care topics throughout their pregnancies.
My Advocate	MyAdvocate will provide maternal and newborn health education using interactive voice response, text, smartphone or web applications to high-risk, expectant members to extend the reach of our high-risk pregnancy program. Messages arrive twice weekly during the prenatal period, weekly during the postpartum period, and weekly for well-child messaging. Members have access to education, answers and support with two-way texting or live chat. The member is asked to respond to questions about her condition and needs. Based on the response, an alert is sent to a Healthy Blue case manager, who quickly contacts the member to help address her needs more quickly, easily and effectively. Learn more at **www.myadvocatehelps.com**.
Home Visitation Program	Postpartum home visits by nurse practitioners for women who are homebound or unable to see the physician for their postpartum visit
Adult Dental Members over the age of 21	Members over the age of 21 are eligible to receive an oral exam, bitewing X-rays and a teeth cleaning every 12 months. In addition, a restorative benefit — simple extractions and fillings — is also covered. No referrals are needed for primary dental services. Learn more at **www.dentaquest.com** or call DentaQuest at **1-800-508-6785**.
Adult Vision Members over the age of 21	Members over the age of 21 receive eye exams once a year and glasses (frames and lenses) once every two years. No referrals are needed for routine vision services. Learn more at **www.superiorvision.com** or call Superior Vision at **1-866-819-4298**.

Covered Service	Coverage Limits
Healthy Rewards Program Dollars put onto a reloadable gift card when members go to doctor visits	Rewards are as follows: • $20 for yearly well-baby visits (birth to 15 months; up to $120 for all visits) • $20 for yearly well-child visits (ages 16 months to 30 months; up to $40 for two visits) • $25 for yearly well-child visits (ages 30 months to 9 years) • $30 for yearly adolescent well-child visits (ages 10-20) • $15 for yearly adult-wellness visits • $25 for diabetic HgA1c screening • $25 for diabetic nephropathy screening • $25 for diabetic eye exam • $10 for quarterly high blood pressure medication pharmacy refills (1 per quarter; $40 max.) • $25 for quarterly 30-day follow-up after behavioral health discharge (3 per 12 months; $25 per quarter; $75 max.) • $10 for sexually transmitted infection screening • $25 for receiving a flu shot • $25 for 17P therapy for pregnant members at risk for pre-term birth • $15 for an annual asthma assessment • $25 for 17P therapy for pregnant members at risk for pre-term birth • $25 for pregnant members that attend their prenatal visit in the first trimester or within 42 days of enrollment to Healthy Blue • $50 for new moms for attending their postpartum appointment within 21 to 56 days after delivery
Louisiana Portable Crib or Car Seat Program	Free portable crib or infant car seat for going to seven or more prenatal doctor visits
Family Planning Kit	Family planning kit to help members have a healthy pregnancy when they are ready. Kit includes condoms, pregnancy test, and more.
Boys and Girls Club Membership	Free membership for eligible members ages 6 to 18 at participating Boys and Girls Club chapters
Personal Website	Allows members and their designees to update their health status and allows friends and family to respond in a guestbook with encouraging messages and emotional support
Respite Services For in-home caregivers of members who receive personal assistance services	Eight hours of respite per month per member are covered for members ages 0 to 20. Prior approval is required.
Community Resource Link	Community Resource Link helps members connect online to needed community resources. More information is available at **https://www.myhealthybluela.com/la/support/community-resources.html**.
Cellular Phone Service For qualifying members	A free cellphone with free monthly minutes, data and text messaging

Covered Service	Coverage Limits
	Pregnant members are encouraged to sign up for and opt in to receive no-cost pregnancy education text messages during pregnancy from the Healthy Mothers Healthy Babies Text4baby program.
Tobacco Cessation Program	Our Tobacco Cessation program provides one-on-one telephonic coaching to engage and empower members to help them make positive behavior changes in reducing and ultimately stopping tobacco use.
Weight Management Support	The Weight Watchers program is available only for eligible health plan members. Weight Watchers services include: • Vouchers for free attendance of 13 meetings. The Healthy Families Program is for children ages 7 to 17 who would like to make positive changes in healthy eating and activity. The Healthy Families program is designed to prevent health problems associated with poor nutrition, unhealthy weight and/or sedentary lifestyle. Services include: • Six-month program support. • Ten-week course of family-centric, twice-weekly sessions. • Nurse coaching using motivational interviewing, lifestyle education and written information encouraging healthy eating and activity. • Members can be referred to the program by calling **1-888-830-4300**.

2.30. Services Covered Under the Louisiana State Plan or Fee-for-Service Medicaid

Some services are covered by the Louisiana state plan or fee-for-service Medicaid instead of Healthy Blue. These services are called carved-out services. Even though we do not cover these services, we expect you to:

- Provide all required referrals.
- Assist in setting up these services.

These services will be paid for by LDH on a fee-for-service basis. Carved-out benefits include:

- Services given through the LDH Early Steps program.
- Dental services, with exception of the EPSDT varnishes provided in a primary care setting.
- Individualized education program services.
- Intermediate care facility (ICF)/developmentally disabled (DD) services for members under the age of 21.
- Personal care services for members over the age of 21.
- School-based individualized education plan services given by a school district and billed through the intermediate school district or school-based services funded with certified public expenditures.
- All home- and community-based waiver services.
- Targeted case management services.
- Services provided through LDH's Early-Steps Program (Individuals with Disabilities Education Act [IDEA] Part C Program Services).

For details on how and where to access these services, call the LDH at **1-888-342-6207**.

Copays may apply for certain services covered under the Healthy Louisiana program. Copays do not apply to services provided to:

- Individuals younger than 21 years old
- Pregnant women
- Individuals who are inpatients in long-term care facilities or other institutions
- Native Americans and Alaskan Eskimos
- Enrollees of an Home- and Community-Based Waiver;
- Women whose basis of Medicaid eligibility is breast or cervical cancer and enrollees receiving hospice services.

2.31. Well-Child Visits Reminder Program

Based on our claims data, we can send PCPs a list of members who have not received well-child services according to our schedule. We also reach out to these members, encouraging them to contact their PCPs to set up appointments for needed services. If you're interested in obtaining this information to close these gaps in care, please contact your Provider Relations representative at **1-504-836-8888**.

Please note:

- We list the specific service each member needs in the report.
- You must render the services on or after the due date in accordance with federal EPSDT and State Department of Health guidelines.
- We base our list on claims data we receive before the date on the list. Please check to see whether you have provided the services after the report run date.
- Please submit a completed claim form for those dates of services to the Healthy Blue Claims department at:
  Healthy Blue
  Claims Department
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

2.32. Immunizations

You must enroll in the Vaccines for Children (VFC) Program, which is administered by the State Health Division. Contact the State Health Division to enroll. The Immunization Program will review and approve your enrollment request. You will need to cooperate with the State Health Division for orientation and monitoring purposes.

Once enrolled, you may request state-supplied vaccines for members through the age of 18 in accordance with the current American Committee on Immunization Practices (ACIP) schedule. You must report all immunizations of children up to age two to the State Health Division's Immunization Registry. If you do not have the capability to meet these requirements, we can help you.

We do not cover any immunizations, biological products or other products that are available free of charge from the State Health Division.

Our members can self-refer to any qualified provider in- or out-of-network.

We reimburse local health departments for the administration of vaccines regardless of whether they are under contract with us.

Healthy Blue provides all members with all vaccines and immunizations in accordance with ACIP guidelines. ACIP guidelines can be found on the Center for Disease Control and Prevention (CDC) website at **www.cdc.gov/vaccines/hcp/acip-recs**.

2.33. Blood Lead Screening

You must screen for the presence of lead toxicity during a well-child visit for children between six months and six years of age. Please perform a blood test at 12 months and 24 months to determine lead exposure and toxicity. You should also give blood lead screening tests to children over the age of 24 months up to 72 months if you have no past record of a test. You can find blood lead risk forms online at **https://providers.healthybluela.com**.

2.34. Clinical Laboratory Improvement Amendments Reporting

We are bound by the *Clinical Laboratory Improvement Amendments* (*CLIA*) of 1988. The purpose of the CLIA program is to ensure laboratories testing specimens in interstate commerce consistently provide accurate procedures and services. As a result of *CLIA*, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure issued by the Secretary of the Department of Health and Human Services. Since 1992, carriers have been instructed to deny clinical laboratory services billed by independent laboratories that do not meet the *CLIA* requirements.

Healthy Blue providers may bill for laboratory services covered by Healthy Louisiana. To ensure proper payment, Healthy Blue will apply a *CLIA* claim edit to all claims for laboratory services that require a *CLIA* certification. Providers who do not have *CLIA* certification, who render services outside the effective dates of the *CLIA* certificate or who submit claims for services not covered by their *CLIA* certificate will deny.

For providers with a waiver or provider-performed microscopy certification types, you must add a QW modifier to the procedure code for all applicable *CLIA* tests. If the QW modifier is not billed, the claim will deny.

Medicaid requires all professional service and independent laboratory providers to include a valid CLIA number on all claims submitted for laboratory services, including CLIA waived tests. Claims submitted with an absent, incorrect or invalid CLIA number will deny.

The CLIA number will be required in box/field 23 of the hardcopy CMS-1500. The number must include the "X4" qualifier, followed by the CLIA certification number, which includes the two-digit state code, followed by the letter "D" and the unique CLIA number assigned to the provider.

Example of valid CLIA number formatting: X419DXXXXXXX

2.35. Healthy Blue Member Rights and Responsibilities

Our Member Services representatives serve as our members' advocates. Below are the rights and responsibilities of our members.

Members have the right to:

Privacy

- Be treated with respect and with due consideration for their dignity and privacy

- Expect that we will treat their records, including medical and personal information and communications, confidentially
- Request and receive a copy of their medical records at no cost to the member and request that the records be amended or corrected
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations

Take Part in Decisions Regarding Their Health Care
- Engage in candid discussions of appropriate or medically necessary treatment options for their conditions regardless of cost or benefit coverage
- Receive the appropriate services that are not denied or reduced solely because of medical condition
- Refuse health care (to the extent of the law) and understand the consequences
- Decide ahead of time the care they want if they become sick, injured or seriously ill by making a living will
- Be able to make decisions about their children's health care if members are younger than age 18 and married, pregnant or have children

Grievances, Appeals and Fair Hearings
- Pursue resolution of grievances and appeals about the health plan or care provided
- Freely exercise filing a grievance or an appeal without adversely affecting the way they are treated
- Continue to receive benefits pending the outcome of an appeal or a fair hearing under certain circumstances

Healthy Blue Information
- Receive the necessary information to be a Healthy Blue member in a manner and format they can understand easily
- Receive information about the organization, its services, its practitioners, and provides and members rights and responsibilities
- Receive a current member handbook and a provider directory
- Receive a copy of the member handbook and/or provider directory by request by calling Member Services at **1-844-521-6941**
- Receive assistance from Healthy Blue in understanding the requirements and benefits of the plan
- Receive notice of any significant changes in the benefit package at least 30 days before the intended effective date of the change
- Make recommendations about our rights and responsibilities policies
- Know how we pay our providers

Medical Care
- Choose their PCPs from our network of providers
- Choose any Healthy Blue network specialist after getting a referral from their PCPs, if appropriate
- Be referred to health care providers for ongoing treatment of chronic disabilities
- Have access to their PCPs or backups 24 hours a day, 365 days a year for urgent or emergency care
- Get care right away from any hospital when their symptoms meet the definition of an emergency medical condition
- Get post-stabilization services following an emergency medical condition in certain circumstances
- Be free from discrimination and receive covered services without regard to race, color, creed, gender, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated

Members have the responsibility to:

Respect Their Health Care Providers

- Treat their doctors, their doctors' staff and Healthy Blue employees with respect and dignity
- Not be disruptive in the doctor's office
- Make and keep appointments and be on time
- Call if they need to cancel an appointment or change the appointment time or call if they will be late
- Respect the rights and property of all providers

Cooperate with the People Providing Health Care

- Tell their providers about their symptoms and problems and ask questions
- Supply information providers need to provide care
- Understand the specific health problems and participate in developing mutually agreed-upon treatment goals as much as they are able
- Discuss problems they may have with following their providers' directions
- Follow plans and instructions for the care they have agreed to with their practitioners
- Consider the outcome of refusing treatment recommended by a provider
- Discuss grievances, concerns and opinions in an appropriate and courteous way
- Help their providers obtain medical records from their previous providers and help their providers complete new medical records as necessary
- Secure referrals from their PCPs when specifically required before going to another health care provider unless they have a medical emergency
- Know the correct way to take medications
- Go to the emergency room when they have an emergency
- Notify their PCPs as soon as possible after they receive emergency services
- Tell their doctor who they want to receive their health information

Follow Healthy Blue Policies Outlined in the Member Handbook

- Provide us with proper identification during enrollment
- Carry their Healthy Blue and Medicaid ID cards at all times and report any lost or stolen cards
- Contact us if information on their ID cards is wrong or if there are changes to their name, address or marital status
- Call us and change their PCP before seeing the new PCP
- Tell us about any doctors they are currently seeing
- Notify us if a member or family member who is enrolled in Healthy Blue has died
- Report suspected fraud and abuse

2.36. Member Grievances

Our members have the right to say they are dissatisfied with Healthy Blue or a provider's operations. Members have the right to file a grievance at any time. A network provider may also file a grievance with the members signed consent allowing the provider to act as the member's representative.

Member grievances do not involve:

- Medical management decisions.
- Interpretation of medically necessary benefits.
- Adverse determinations.

These are called appeals and are addressed in the next section.

We will respond to a member's grievance and attempt to resolve it to the member's satisfaction in a timely manner. We investigate each grievance and all of its clinical aspects. We inform the member, investigate the grievance and resolve it within 90 calendar days from the date we received the grievance. Urgent or emergent grievances are resolved within 72 hours of receipt.

The member may file a grievance orally or in writing with either LDH or the health plan. A member can file a grievance orally by calling Member Services at **1-844-521-6941**. If the member chooses to file an oral appeal, the member must follow it with a written, signed appeal unless the member requests an expedited resolution. Or a member may choose to file a grievance only by mail; any supporting documents must be included. Grievances should be sent to:

Healthy Blue
P.O. Box 62429
Virginia Beach, VA 23466-2429

An acknowledgement letter is mailed within five business days of receiving a written grievance. We will notify the member in writing of:

- The names(s), title(s) and, in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance.
- Our decision.
- The reason for the decision.
- Policies and procedures regarding the decision.
- How the member may be advised or represented by a lay advocate, attorney or other representative as chosen by the member and agreed to by the representative.

2.37. Medical Necessity Appeals

Medical necessity appeals apply to authorization requests that were denied prior to the service or authorization concurrent requests made during an inpatient hospital confinement. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

If you are required to obtain prior authorization on a concurrent or post-service basis, the consent of the Member who received the services will not be required in order for you to dispute the denied authorization for service.

Healthy Blue will ensure that members, and authorized representatives acting on behalf of the member, have a full and fair process for resolving requests to reconsider a decision they find unacceptable regarding denial of prior authorization.

A member will have a reasonable opportunity to present evidence — submit written comments, documents, records and other information relevant to the appeal along with allegations of fact or law — in person as well as in writing.

Healthy Blue also ensures the member and his or her representative are provided the opportunity before and during the appeal process to examine the member's case file (including medical records), and any other documents and records considered during the appeal process. This includes any evidence considered, relied upon or generated by Healthy Blue in connection with the appeal. This information is provided free of charge and sufficiently in advance of the date by which we resolve the appeal.

Our goal is to handle and resolve every member appeal as quickly as the member's health condition requires. Our established time frames for member appeals are as follows:

- Standard resolution of appeal: thirty calendar days from the date of receipt of the appeal
- Expedited resolution of appeal: seventy-two hours from receipt of the appeal
  - We make every reasonable effort to give the member or his or her representative oral notification and then follow it up with a written notification.

The member, or the member's representative, can file an appeal within 60 calendar days from the date on the Healthy Blue *Notice of Action*. A provider may file an appeal on behalf of the member. The provider must follow all requirements for a member appeal, including timely filing of the written request for appeal.

We will inform the member of the limited time he or she has to present evidence and allegations of fact or law with expedited resolution. And we also ensure that no punitive action will be taken against a provider who supports an expedited appeal.

We will send our members the results of the resolution in a written notice within 30 calendar days of receipt of the appeal. If an appeal is not wholly resolved in favor of the member, the notice will include:

- The right for our member to request a state fair hearing and how to do it.
- The right to receive benefits while this hearing is pending and how to request it.
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Healthy Blue action.

2.38. Expedited Appeals

Our expedited appeal process is available upon the member's request or when the provider indicates that a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function.

The member or provider may file an expedited appeal either orally or in writing, or the member may present evidence in person. A provider may file the request on behalf of the member if the provider has obtained written consent signed by the member authorizing the provider to act on the member's behalf. A provider who appeals on the member's behalf must follow all requirements for a member appeal, including timely filing of the request for appeal. No additional written follow-up on the part of the member or the provider is required for an oral request for an expedited appeal.

We will resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires and within three business days after receipt of the expedited appeal request. There may be one extension of 14 calendar days to this timeline upon the member's request, or if we can show that there is a need for additional information and the delay is in the interest of the member. When the delay is for this reason and not as a result of a member request, we will provide information describing the reason for the delay in writing to the member.

An acknowledgement letter will be mailed within five business days of receiving a written appeal.

If your request is deemed to be a nonexpedited issue, our standard 30-day timeline for appeal resolution will apply.

2.39. Continuation of Benefits During Appeals or State Fair Hearings

We are required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

- The appeal is submitted to us on or before the latter of the two: within 10 calendar days of our mailing the notice of action or the intended effective date of our proposed action but no more than 30 days.
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.
- The member requests an extension of benefits.

If the decision is against the member, we may recover from the provider the cost of the services the member received while the appeal was pending.

2.40. State Fair Hearing Process

The member or his or her representative (with written consent signed by the member) should submit a request for a state fair hearing to the Division of Administrative Law within 120 calendar days from the date of the notice of resolution regarding the member's standard appeal. The request will be submitted within 10 calendar days of the date of the *Notice of Resolution* if the member wishes to have continuation of benefits during the state fair hearing. A provider may file a request for a state fair hearing only as a representative of a member, with written consent signed by the member. The state fair hearing is only for members who exhaust the member MCO level appeal.

2.41. Prevent, Detect and Deter Fraud, Waste and Abuse

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- *Fraud*: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it or any other person. The attempt itself is fraud regardless of whether or not it is successful.
- *Waste*: Includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions but rather occurs when resources are misused.
- *Abuse*: When health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents a Healthy Blue member ID card. Providers should take measures to ensure the cardholder is the person named on the card. Learn more at **www.fighthealthcarefraud.com**.

Every member ID card lists the following:

- Effective date of membership
- Member date of birth

- Subscriber number (identification number)
- Carrier and group number (RXGRP number) for an injectable
- PCP name, telephone number and address
- Behavioral health benefit
- Vision service plan telephone number and dental service plan telephone number
- Member Services and 24/7 NurseLine telephone numbers

See the **Member ID Cards** section for a sample of a Healthy Blue member ID card.

Presentation of a member ID card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through Provider Services at **1-844-521-6942**.

Providers should encourage members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to our company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their ID card can help prevent fraudulent activities. If you or a patient suspect ID theft, report your concern by calling Provider Services at **1-844-521-6942**. Providers should instruct their patients who suspect ID theft to watch the *Explanation of Benefits* (*EOB*s) for any errors and contact Member Services if something is incorrect.

2.42. Reporting Fraud, Waste and Abuse

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:
- Visiting our website at **https://providers.healthybluela.com** and click on Report, Waste, Fraud or Abuse
- Calling Provider Services at **1-844-521-6942**.
- Calling our Special Investigations Unit fraud hotline at **1-866-847-8247**.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

2.43. Examples of Provider Fraud, Waste and Abuse

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code

- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a **provider** (a doctor, dentist, counselor, medical supply company, etc.), include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

2.44. Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else's ID card

When reporting concerns involving a **member**, include:

- The member's name.
- The member's date of birth, Social Security number or case number if you have it.
- The city where the member resides.
- Specific details describing the fraud, waste or abuse.

2.45. Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract including those that subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all the appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include but is not limited to:

- Written warning and/or education: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education, requests for recoveries or may advise of further action.
- Medical record review: We examine medical records to substantiate allegations or validate claims submissions.
- Special claims review: A certified professional coder or investigator evaluates claims and places payment or system edits on file. This type of review prevents automatic claim payment in specific situations.
- Recoveries: We recover overpayments directly from the provider and, when necessary, will negotiate a short-term repayment plan.. Failure of the provider to return the overpayment and/or abide by the terms of the repayment plan may result in reduced payment of future claims or further legal action.

2.46. Acting on Investigative Findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste or abuse, the provider:

- Will be referred to the Special Investigations Unit.
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan, with state approval.

2.47. Relevant Legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act* (*FCA*). The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The *FCA* also contains Qui Tam or "whistleblower" provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The *Health Insurance Portability and Accountability Act* (*HIPAA*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud, and simplifies the administration of health insurance.

Our company strives to ensure both Healthy Blue and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers shall have the following procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations:

- Our company recognizes its responsibility under *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the *HIPAA* definition of treatment, payment or health care operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.
- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (for example, Excel spreadsheets with claim information); such information should be mailed or faxed.

- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked “confidential” and addressed to a specific individual, P.O. Box or department at our company.
- Our company voicemail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.
- When contacting us, please be prepared to verify the provider’s name, address and tax identification number (TIN) or member’s provider number.

Employee Education about the FCA

- As a requirement of the *Deficit Reduction Act* of 2005, contracted providers who receive Medicaid payments of at least $5 million dollars (cumulative from all sources) must comply with the following: Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the *FCA*, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse and waste. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse and waste.

2.48. Steerage of Membership

Per our contract with the Louisiana Department of Health (LDH), we cannot have contractual arrangements in which a provider represents that they will not contract with another health plan or in which we represent that we will not contract with another provider. Contractual arrangements between us and each provider must be nonexclusive.

Steerage of membership by us and/or our network providers is prohibited. If LDH determines steerage has occurred, the department has wide discretion in assessing both financial penalties and nonfinancial penalties, such as member disenrollment.

3. MEMBER MANAGEMENT SUPPORT

3.1. Welcome Call

We give new members a welcome call to:

- Educate them about our services.
- Help them schedule initial checkups.
- Identify any health issues (for example, pregnancy or previously diagnosed diseases).

3.2. 24/7 NurseLine

The 24/7 NurseLine is a telephonic, 24-hour triage service your Healthy Blue patients can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed, whether after hours or weekends.
- Schedule appointments with you or other network doctors.
- Get to urgent care centers or walk-in clinics.

Members can reach the 24/7 NurseLine at **1-866-864-2544** (**TTY**: **711**; Spanish: **1-866-864-2545**). Language translation services are also available.

Additionally, our behavioral health members may obtain telemedicine mental health services through One TeleMed, a telemedicine company that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health care providers. To make a referral to One TeleMed for a member, please call **337-565-0843** and select **option 2**. Healthy Blue case management can also assist with care coordination for a member and can be reached at **1-877-440-4065 ext. 106-103-5145**.

3.3. Case Management

We have a voluntary, comprehensive program to meet our members' needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment. Once we have identified a member's need, our clinicians will work with that member and the member's PCP to identify the:

- Level of case management needed.
- Appropriate alternate settings to deliver care.
- Health care services.
- Equipment and/or supplies.
- Community-based services.
- Communication between the member and his or her PCP.

For members who are hospitalized, our clinicians will also work with the member, utilization review team, and PCP or hospital to develop a discharge plan of care and link the member to:

- Community resources.
- Our outpatient programs.
- Our Disease Management (DM).

Member Assessment

Our case manager conducts a comprehensive assessment to determine a member's needs, including but not limited to, evaluating that person's:

- Medical condition.
- Previous pregnancy history (when applicable).
- Current pregnancy status (when applicable).
- Functional status.
- Goals.
- Life environment.
- Support systems.
- Emotional status.
- Ability for self-care.
- Current treatment plan

Through communication with members or members' representatives and information from PCPs and specialists, our case manager will coordinate current medical and nonmedical needs.

Plan of Care
After the assessment, our case manager:
- Determines the level of case management services.
- Guides, develops and implements an individualized plan of care.
- Works with the member, the member's representative, and his or her family and provider.

Case managers consider our members' needs for:
- Social services.
- Educational services.
- Therapeutic services.
- Other nonmedical support services such as personal care; Women, Infants and Children (WIC) Program; and transportation.

They also consider the strengths and needs of our members' families.

Our case managers collaborate with the members' multidisciplinary team, including social workers, member advocates or outreach associates when necessary, to define ways to coordinate physical health, behavioral health, pregnancy and social services. We then make sure we forward all written care plans to you by fax or mail.

We welcome your referrals of patients who can benefit from complex case management or assistance with special care needs. To make referrals, contact our Case Management department directly at **1-877-440-4065**, **ext. 106-103-5145**.

3.4. Behavioral Health Case Management

The Healthy Blue integrated case management programs are designed to improve member health outcomes by integrating our medical and behavioral health care programs and making reliable and proven protocols available to providers.

We view case management as a continuum of services and supports that are matched on an individualized basis to meet the needs of the member. Members who are identified as at-risk for hospitalization due to behavioral health or substance use disorders are offered ongoing case management support. In addition, members discharged from inpatient stays are provided case management support for a minimum of 90 days postdischarge.

At Healthy Blue, care managers are responsible for utilization management and work with the providers to assure appropriateness of care, services and existence of coverage. See the **Utilization Management section** in this manual for more details.

Healthy Blue providers are encouraged to engage and direct development and provide feedback to our members' care plans.

Healthy Blue members who would benefit from case management services but actively choose not to participate or are unable to participate may be managed through a provider-focused program.

Healthy Blue's clinical teams, which are staffed with behavioral health and medical case managers, work in close collaboration with community and provider-based case managers. The main functions of the Healthy Blue behavioral health case managers include but are not limited to:

- Using health risk appraisal data gathered by Healthy Blue from members upon enrollment to identify members who will benefit from engagement in individualized care coordination and case management.
- Using "trigger report data" based on medical and behavioral health claims to identify members at risk.
- Consulting and collaborating with our medical case managers and disease management clinicians regarding members who present with comorbid conditions.
  - Comorbid is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder or the effect of such additional disorders or diseases.
- Referring members to provider-based case management for ongoing intensive case management and then continuing involvement with the member and the provider to coordinate care, when needed, among different agencies, medical providers, etc.
- Working directly with the member and provider based on the severity of the member's condition to develop a comprehensive, person-centered care plan.

Documenting all actions taken and outcomes achieved for members in the Healthy Blue information system to ensure accurate and complete reporting.

3.5. New Baby, New Life Pregnancy Support Program

New Baby, New Life℠ is a proactive case management program for mothers and their newborns that uses extensive methods to identify pregnant women as early in their pregnancy as possible through review of state enrollment files, claims data, lab reports, hospital census reports, and provider and self-referrals. Once identified, we act quickly to assess the member's obstetrical risk and ensure she has the appropriate level of care and case management services to mitigate those risks.

Experienced case managers work with members and providers to establish a care plan for our highest-risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, home-visitor programs, behavioral health support, breastfeeding support and counseling.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in our New Baby, New Life program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Rewards to keep up with prenatal and postpartum checkups.

As part of the New Baby, New Life program, members are offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR), text, smart phone or web application. This program does not replace the high-touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers, and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate, visit **www.myadvocatehelps.com**.

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the you and Your Baby in the NICU program and a NICU Post-Traumatic Stress Disorder (NICU PTSD) program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team. The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referral to treatment for PTSD in parents. This program will support mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.

Hospitals should report the births of newborns within 24 hours of birth for enrolled members using LDH's Web-based Request for Newborn Manual System.

Hospital providers are required to register all births through the Louisiana Electronic Event Registration System (LEERS), administered by LDH/Vital Records Registry. Additionally, within 24 hours of the birth of a newborn (or within one business day of delivery), the hospital is required to submit clinical birth information to the health plan. Please fax the newborn delivery notification to **1-877-269-5705**. The clinical information required includes:

- Indication of whether it was a live birth
- Newborn's birth weight
- Gestational age at birth
- Apgar scores
- Disposition at birth
- Type of delivery(vaginal or cesarean); if cesarean: the reason the cesarean was required
- Date of birth
- Gender
- Single/multi birth
- Gravida/para/ab for mother
- EDC and if NICU admission was required

Providers may use their standard reporting form specific to their hospital as long as the required information outlined above is included.

After delivery, members will be contacted by a representative of the Maternal Postpartum Outreach program to remind them to schedule their postpartum appointment between 21 to 56 days. If the member has not scheduled an appointment, the representative will assist them with scheduling an appointment and work closely with the provider offices to ensure the member has an appointment scheduled. The member will be mailed a reminder appointment card and receive a reminder call prior to the appointment. After the appointment, the representative will contact the provider's office to verify the member's attendance at the appointment and will contact the member to reschedule if the appointment was missed. If a member cannot physically go for a postpartum visit due to access to care issues, transportation or child care or will not be able to get an appointment during the 21-to-56-day time frame, the member is eligible to receive a provider home visit through a contracted agency to receive her postpartum visit during the designated time frame. The contracted agency will share visit information with the managing OB-GYN after the visit.

Members may also receive calls from OB case managers to provide interconceptional CM, with education and support in obtaining information to develop an interconception family life plan.

3.6. Disease Management

Our Disease Management (DM) is based on a system of coordinated care management interventions and communications designed to assist physicians and other health care professionals in managing members with chronic conditions. DM services include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members. Our disease management programs include:

- Asthma.
- Bipolar disorder.
- Chronic obstructive disorder (COPD).
- Congestive heart failure (CHF).
- Coronary artery disease (CAD).
- Diabetes.
- HIV/AIDS.
- Hypertension.
- Major depressive disorder — adult.
- Major depressive disorder — child/adolescent
- Substance use disorder.
- Schizophrenia.
- Hepatitis C
- Sickle cell

In addition to our condition-specific disease management programs, our member-centric, holistic approach also allows us to assist members with weight management and smoking cessation services.

Program Features

- Proactive identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models, which include the physician and support providers in treatment planning
- Continuous self-management education, including:
  - Primary prevention
  - Coaching related to healthy behaviors
  - Compliance and surveillance
  - Case management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with primary and ancillary providers regarding patient status

Disease management clinical practice guidelines are located at **https://providers.healthybluela.com**. A copy of the guidelines can be printed from the website, or you can call Provider Services at **1-844-521-6942** to receive a printed copy.

Who is eligible?

All members with the listed conditions are eligible. We identify them through:

- Continuous case finding welcome calls.
- Claims mining.
- Referrals.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our case managers will work collaboratively with you to obtain your input in the

development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/surveillance, as well as case/care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

DM Provider Rights and Responsibilities
You have the right to:

- Have information about Healthy Blue including:
  - Provided programs and services.
  - Our staff.
  - Our staff's qualifications.
  - Any contractual relationships.
- Decline to participate in or work with any of our programs and services for your patients.
- Be informed of how we coordinate our interventions with your patients' treatment plans.
- Know how to contact the person who manages and communicates with your patients.
- Be supported by our organization when interacting with patients to make decisions about their health care.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints about DM as outlined in the Healthy Blue provider complaint and grievance procedure.

Hours of Operation
Our DM case managers are licensed nurses. They are available 8:30 a.m. to 5:30 p.m. local time. Confidential voicemail is available 24 hours a day. The 24/7 Nurse Line is available for our members 24 hours a day, 7 days a week.

Contact
You can call a DM team member at **1-888-830-4300**. DM program content is located at **https://providers.healthybluela.com**, and printed copies are available upon request. Members can obtain information about DM program by visiting **https://providers.healthybluela.com/la/pages/disease-management.aspx** or calling **1-888-830-4300** (**TTY 711**).

3.7. Provider Directories

We make provider directories available to members in online searchable and hard-copy formats. Because members use these directories to identify health care providers near them, it is important that your practice address(es), doctors' names and contact information are promptly updated when changes occur. You can update your practice information by:

- Visiting **https://providers.healthybluela.com**.
- Calling Provider Services at **1-844-521-6942**.
- Calling or emailing your local Provider Relations representative.

The provider directory is also available on the provider website at **https://providers.healthybluela.com**.

3.8. Cultural Competency

With the increasing diversity of the American population, it is important for us to work effectively in cross-cultural situations. Your ability to communicate with your patients has a profound impact on the

effectiveness of the health care you provide. Your patients must be able to communicate symptoms clearly and understand your recommended treatments.

Our cultural competency program helps you and your patients:
- Acknowledge the importance of culture and language.
- Embrace cultural strengths with people and communities.
- Assess cross-cultural relations.
- Understand cultural and linguistic differences.
- Strive to expand your cultural knowledge.

Some important reminders include:
- The perception that illness, disease and their causes vary by culture.
- Belief systems on health, healing and wellness are very diverse.
- Culture influences help-seeking behaviors and attitudes toward providers.
- Individual preferences affect traditional and nontraditional approaches to health care.
- Providers from culturally and linguistically diverse groups are under-represented.

Cultural barriers can affect your relationship with your patient, including:
- Our member's comfort level and his or her fear of what you might find in an examination.
- Different levels of understanding among diverse consumers.
- A fear of rejection of personal health beliefs.
- A member's expectation of what you do and how you treat him or her.

To help overcome these barriers, you need the following:

Cultural Awareness
- Recognize the cultural factors that shape personal and professional behavior including:
  - Norms.
  - Values.
  - Communication patterns.
  - World views.
- Modify your own behavioral style to respond to others' needs while maintaining your objectivity.
- Depart from stereotypical assumptions.

Knowledge
- Culture plays a crucial role in the formation of health and illness beliefs.
- Different cultures have different attitudes about seeking help.
- Feelings about disclosure can be culturally unique.
- The acceptability and effectiveness of treatment modalities can be different in various cultural and ethnic groups.
- Verbal and nonverbal language, speech patterns, and communication styles can vary by culture and ethnic group.
- Resources like formally trained interpreters should be offered to and used by members with various cultural and ethnic differences.

Skills

- Understand the basic similarities and differences between and among the cultures of the people we serve, without resorting to stereotypical preconceptions.
- Recognize the values and strengths of different cultures.
- Interpret diverse cultural and nonverbal behavior.
- Develop understanding of others' needs, values and preferred ways of having those needs met.
- Identify and integrate the critical cultural elements to make culturally consistent inferences and demonstrate that consistency in actions.
- Recognize the importance of time and the use of group process to develop and enhance cross-cultural knowledge and understanding.
- Withhold judgment, action or speech in the absence of information about a person's culture.
- Listen with respect.
- Formulate culturally competent treatment plans.
- Use culturally appropriate community resources.
- Know when and how to use interpreters and understand the limitations of using interpreters.
- Treat each person uniquely.
- Recognize racial and ethnic differences and know when to respond to culturally based cues.
- Seek out information.
- Use agency resources.
- Respond flexibly to a range of possible solutions.
- Accept ethnic differences among people and understand how these differences affect treatments.
- Work willingly with clients of various ethnic groups.

Providers should attempt to collect member demographic data, including but not limited to, ethnicity, race, gender, sexual orientation, and religion. This will allow the provider to respond appropriately to the cultural needs of the community being served. Members must be given the opportunity to voluntarily disclose this information; it cannot be required.

Healthy Blue requires and provides training on cultural competence, including tribal awareness, to behavioral health network providers for a minimum of three hours per year and as directed by the needs assessments.

3.9. Member Records

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and must be permanently maintained at the primary care site.

Our member's previous provider must forward a copy of all medical records to you within 10 business days from receipt of your request at no charge. Members are entitled to one copy of their medical record per year, and the copy is provided at no cost to the member. Members or their representatives should have access to these records.

Member records must be retained for at least six years after the last good, service or supply has been provided to a member or an authorized agent unless those records are subject to review, audit or investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

Healthy Blue requires access to member records for the purpose of conducting Medical Record Reviews.

Our medical records standards include:

- Patient identification information — patient name or ID number must be shown on each page or electronic file
- Personal/biographical data — age, sex, address, employer, home and work telephone numbers and marital status (primary languages spoken and translation needs must be included)
- Date and corroboration — dated and identified by the author
- Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
- Allergies — must note prominently:
  - Medication allergies
  - Adverse reactions
  - No Known Allergies (NKA)
- Past medical history — for patients seen three or more times, include serious accidents, operations, illnesses, and prenatal care of mother and birth for children
- Immunizations — a complete immunization record for pediatric members 20 years of age and younger with vaccines and dates of administration. Evidence of lead screening for ages 6 months to 6 years.
- Diagnostic information including growth charts, head circumference and developmental milestones, if applicable
- Medical information, including medication and instruction to patient
- Current list of medications
- Identification of current problems
- Serious illnesses
- Medical and behavioral conditions
- Health maintenance concerns
- Instructions, including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
- Smoking/alcohol/substance abuse — notation required for patients ages 12 and older and seen three or more times
- Consultations, referrals and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
- Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
- Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
- Advance directive — must document whether the patient has executed an advance directive such as a living will or durable power of attorney

3.10. Patient Visit Data

You must provide:

- A history and physical exam with both subjective and objective data for presenting complaints
- Behavioral health treatment including at-risk factors:
  - Danger to self/others
  - Ability to care for self
  - Affect
  - Perpetual disorders
  - Cognitive functioning
  - Significant social health
- Admission or initial assessment including:

  - Current support systems
  - Lack of support systems
- Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating either:
  - Decreased
  - Increased
  - Unchanged
- A plan of treatment including:
  - Activities
  - Therapies
  - Goals to be carried out
- Diagnostic tests
- Behavioral health treatment — evidence of family involvement in therapy sessions and/or treatment
- Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN
- Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance, and we institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for seven years from the date of service.

3.11. Clinical Practice Guidelines

We work with you and providers like you to develop clinical policies and guidelines. Each year, we select at least four evidence-based *Clinical Practice Guidelines* that are relevant to our members and measure at least two important aspects of each of those four guidelines. We also review and revise these guidelines at least every two years. You can find these *Clinical Practice Guidelines* on our website at **https://providers.healthybluela.com**.

3.12. Advance Directives

We adhere to the *Patient Self-Determination Act* and recognize and support the following advance directives:

- Durable power of attorney — lets a member name a patient advocate to act on his or her behalf
- Living will: lets a member state his or her wishes on medical treatment in writing

We encourage members ages 18 and older to ask you for an advance directive form and education at their first appointment. Please document their forms in your medical records. We understand a facility or physician may conscientiously object to an advance directive. However, we also recognize the member's right to determine his or her own care. Please note, a Healthy Blue associate cannot act as a witness to an advance directive nor serve as a member's advocate or representative.

4. BEHAVIORAL HEALTH SERVICES

4.1. Overview

Healthy Blue facilitates integrated physical and behavioral health services, and this integration is an essential part of our health care delivery system. Our mission is to comprehensively address the physical and behavioral health care of our members by offering a wide range of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for members. Healthy Blue works collaboratively with hospitals, group practices, independent behavioral health care providers, community and government agencies, human service districts, federally qualified health centers (FQHC), rural health centers (RHCs), community mental health centers, and other resources to successfully meet the needs of members with mental health, substance use, and intellectual and developmental disabilities.

For assistance with behavioral health services:

- Providers can call Provider Services at **1-844-521-6942**.
- Members can call Member Services at **1-844-227-8350** (**TTY 711**), Monday to Friday from 7 a.m. to 7 p.m., except for holidays.

4.2. Target Audience

The Healthy Blue provider network is inclusive of specialized behavioral health care providers as well as a comprehensive array of supports and services designed to serve the following target populations:

- Medicaid-eligible adults, adolescents and children with behavioral health (mental health and substance use) needs that are not best managed by basic behavioral health services in the primary care setting by a primary care provider
- Children with extensive behavioral health needs, either in or at-risk of out-of-home placement, who are in need of coordinated care and are not eligible for the Coordinated Systems of Care (CSoC) program or choose not to participate in the CSoC program
- Adults, adolescents and children who have severe mental illness and/or substance use disorders and meet the following criteria:
  - Individuals residing in nursing facilities
  - Individuals under the age of 21 residing in intermediate care facilities for people with developmental disabilities (ICF/DD)
  - Individuals who receive both Medicaid and Medicare
- The primary services for the dual population that will be provided by Healthy Blue include any specialized behavioral health services that are covered by Medicaid that are not covered by Medicare
- Members who reside in a nursing home and are identified as needing specialized behavioral health services through the PASRR Level II screening or resident review processes are considered a special health care needs (SHCN) population; SHCN members must have a person-centered plan of care that includes all medically necessary services, including specialized behavioral health services identified in the member's treatment plan
  - Adults and children enrolled in Medicaid home- and community-based waiver programs who have not opted into Healthy Louisiana for physical health and do not have Medicare
  - Individuals residing in nursing facilities who do not have Medicare
  - Children enrolled in a home and community-based waiver program who have not opted into Healthy Louisiana for physical health and do not have Medicare

4.3. Goals

The goals of the behavioral health program are to:

- Ensure and expand service accessibility to include a comprehensive array of quality and evidenced-based supports and services for eligible members, while enhancing members' experiences.
- Integrate the management and delivery of physical and behavioral health services.
- Achieve quality initiatives, including those related to HEDIS®, NCQA, LDH and other governmental entities performance requirements.
- Work with members, providers and community supports to provide recovery and resilience tools to create an environment that supports members' progress toward their recovery and resilience goals.
- Ensure utilization of the most appropriate and least restrictive medical and behavioral health care in the right place, at the right time.

4.4. Objectives

The objectives of the behavioral health program are to:

- Ensure continuity and coordination of care between physical and behavioral health care practitioners.
- Enhance member satisfaction by implementing individualized and holistic support and care plans that allow members to achieve their recovery and resilience goals.
- Leverage individualized, person-centered planning approaches to assist members in life planning to increase their personal self-determination and optimize their own independence.
- Provide member education on treatment options and pathways toward recovery and resilience.
- Provide high-quality case management and care coordination services that identify member needs and address them in a personal and holistic manner.
- Work with care providers to ensure the provision of medically necessary and appropriate care and services, including inpatient care, alternative care settings, waiver services and outpatient care at the least restrictive level.
- Enhance provider satisfaction and success through collaborative and supportive relationships built on mutually agreed upon goals, outcomes and incentives.
- Promote collaboration between all health care partners to achieve recovery goals through education, technological support and the promotion of recovery ideals.
- Use evidence-based practices, guidelines and clinical criteria and promote their use in the provider community.
- Maintain compliance with accreditation standards and with local, state and federal requirements.
- Deliver behavioral health and substance use disorder services in accordance with best-practice guidelines, rules and regulations and policies and procedures set forth by the state of Louisiana.
- Reduce repeat ER visits, unnecessary hospitalizations, out-of-home placements and institutionalizations.
- Improve member clinical outcomes through continuous quality monitoring of the health delivery service system.

4.5. Guiding Principles of the Behavioral Health Program

Recovery is a member-driven process in which people find their paths to work, learn and participate fully in their communities. Resiliency is the ability to live a fulfilling and productive life despite the continued presence of a disability. Physical and behavioral health services are rendered in a manner that allows the achievement of recovery for members experiencing mental illness and substance use disorders. Treatment supports the development of resiliency for those facing mental illness, serious emotional disturbance and/or substance use disorder issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on mental health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery identified by SAMHSA are:

- **Self-direction:** Members lead, control and determine their own paths of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life.
- **Individualized care:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences and experiences including past trauma and cultural background.
- **Empowerment:** Members have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources, which will affect their lives, and are educated and supported in so doing.
- **Holistic:** Recovery embraces all aspects of life, including housing, employment, education, mental and health care treatment and services, complementary and naturalistic services (for example, recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person.
- **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the member to move on to fully engage in the work of recovery.
- **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.
- **Peer support:** Mutual support including the sharing of experiential knowledge, skills and social learning plays an invaluable role in recovery.
- **Respect:** Community, systems and societal acceptance, and appreciation of members, including protecting their rights and eliminating discrimination and stigma, are crucial to achieve recovery.
- **Responsibility:** Members have a personal responsibility for their own self-care and journeys of recovery.
- **Hope:** Recovery provides the essential and motivating message of a better future — That people can and do overcome the obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is the ability of an individual or family to cope and adapt to the challenges due to changes brought on by distress or disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances. Accepting and managing one's life in a manner that displays optimism for personal successes manifested by traits of self-efficacy and high self-esteem is achieved by building resiliency. Resilience is learned and developed.

4.6. Systems of Care

Services provided to people with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles endorsed by SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Person-centered and family-focused, with the needs of the person and their family dictating the types and mix of services provided.
- Community-based, with the focus of services as well as management and decision-making responsibility resting at the community level.
- Culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.

- Comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs.
- Personalized, as evidenced by an individualized treatment plan that meets unique needs and potential.
- Delivered in the least restrictive, most normative environment that is clinically appropriate.
- Integrated and coordinated between agencies and include mechanisms for planning, developing and coordinating services.
- Inclusive of case management or similar mechanisms to ensure multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the person and their family.
- Delivered without regard to race, religion, national origin, sex, physical disability or other characteristics.
- Oriented to recovery and providing services that are flexible and evolve over time.

4.7. Integration of Behavioral Health and Physical Health Treatment

The integration of behavioral health and physical health treatment is the cornerstone of the Healthy Blue philosophy of treating the needs of the whole person. Principles that guide this integration of care include the following:

- Behavioral health is essential to overall health and not separate from physical health.
- Mental illness, substance use disorders and other health care conditions must be integrated into a comprehensive system of care that meets the needs of individuals in the setting where they feel most comfortable. This includes primary care settings and/or behavioral health care settings.
- Many people suffer from mental illness, substance use disorders and other health care conditions concurrently; as care is provided, the dynamic of having co-occurring illnesses must be understood, identified and treated as primary conditions.
- The system of care must be accessible and comprehensive and fully integrate an array of prevention and treatment services for all age groups. It is designed to be evidence-informed, responsive to changing needs and built on a foundation of continuous quality improvement.

It is our goal to make relevant clinical information accessible to all health providers on a member's treatment team, consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

Key elements of our model for coordinated and integrated health services include but are not limited to:

- Ongoing communication, coordination and collaboration between primary care providers and specialty providers, including behavioral health (mental health and substance use) providers, with appropriate documented consent.
- The expectation that primary care providers will regularly screen members for mental health, substance use (including tobacco), co-occurring disorders and problem gaming and refer members to behavioral health specialty providers as necessary.
- The expectation that behavioral health providers will screen members for common medical conditions, including tobacco use, and refer members to the primary care provider for follow-up diagnosis and treatment.
- Collaboration between all health care providers with support from Healthy Blue in managing health care conditions of members.
- Referrals to primary care providers or specialty providers, including behavioral health providers, for assessment and/or treatment for members with co-occurring disorders and/or any known or suspected and untreated health disorders.

- Development of patient-centered treatment plans involving members, as well as caregivers and family members, and other community supports and systems when appropriate.
- Case management, disease management and population health management programs to support the coordination and integration of care between providers.
- The requirement of all providers to complete an annual integrated care self-assessment using the SAMHSA integrated practice assessment tool (IPAT) and report their results to Healthy Blue upon request.

Fostering a culture of collaboration and cooperation helps Healthy Blue sustain a seamless continuum of care that positively impacts our member outcomes. To maintain continuity of care, patient safety and member well-being, communication between integrated health care providers is critical, especially for members with comorbidities receiving pharmacological therapy.

To achieve our fully integrated health care system for members, Healthy Blue will:
- Provide LDH, on an annual basis, a self-assessment inclusive of but not limited to: provider locations, integrated or collocated provider numbers, programs focusing on members with both behavioral health and primary care needs, and use of multiple treatment plans and unified systems across behavioral and physical health management.
- Work with LDH to develop a plan to conduct annual assessments of practice integration using the IPAT on a statistically valid sampling of providers, to include but not be limited to: behavioral health providers, primary care providers, internists, family practitioners, pediatrics, OB-GYNs and any other providers that are likely to interface with behavioral health populations.
- Provide trainings on integrated care, including but not limited to the appropriate utilization of basic behavioral health screenings in the primary care setting as well as basic physical health screenings in the behavioral health setting.
- Identify available opportunities to provide incentives to clinics to employ licensed mental health professionals (LMHP) in primary care settings and to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.
- Encourage and endorse real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications.
- Have integrated data, quality and claims systems.
- Have a single or integrated clinical documentation system to see the whole health of the member.
- Identify "hot spot" sources of high emergency department (ED) referrals and/or inpatient psychiatric hospitalization and provide preemptive care coordination.

4.8. Coordination of Physical and Behavioral Health Services

As a network provider, you are required to notify a member's primary care provider when a member first enters behavioral health care and anytime there is a significant change in care, treatment, medications or need for medical services. You must secure the necessary release of information from each member or the member's legal guardian for the release of treatment information, including substance use information, in accordance with *42 CFR Part II* requirements. Each offer of consent or release of substance use information should be documented and reported to Healthy Blue as requested. You should be able to provide initial and summary reports to the primary care provider or to Healthy Blue upon request. The minimum elements to include are as follows:
- Patient demographics
- Date of initial or most recent behavioral health evaluation

- Recommendation to see their primary care provider if a medical is condition identified or need for evaluation by a medical practitioner has been determined for the member (for example, EPSDT screen, complaint of physical ailments)
- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Behavioral health clinician's name and contact information

4.9. Provider Roles and Responsibilities

The behavioral health care benefit is fully integrated with the rest of the health care programs and inclusive of our fee-for-service Medicaid members requiring behavioral health services only. This coordination of health care resources requires certain roles and responsibilities for behavioral health providers, including the following:

- Participate in the care management and coordination process for each Healthy Blue member under your care;
- Seek prior authorization for all services that require it;
- Attempt to obtain appropriate consent for the disclosure of substance use treatment information to the member's PCP for all members treated for behavioral health conditions, document attempts and report information to Healthy Blue upon request;
- Attempt to obtain a copy of the *Member Choice Form;*
- Provide Healthy Blue and the member's PCP with a summary of the member's initial assessment, primary and secondary diagnosis, and prescribed medications if the member is at risk for hospitalization; this information must be provided within 24 hours after the initial treatment session;
- Provide, at a minimum, a summary of the findings from the member's initial visit to the PCP — This must be provided within five calendar days of the visit for members not at risk for hospitalization and must include the behavioral health provider's contact information, visit date, presenting problem, diagnosis and a list of any medications prescribed;
- Notify Healthy Blue and the member's PCP of any significant changes in the member's status and/or change in the level of care;
- Ensure members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge — this treatment must be provided within seven calendar days from the date of the member's discharge;
- Offer hours of operation that are no less than the hours of operation offered to commercial members;
- Encourage members to consent to the sharing of substance use treatment information;
- Comply with mainstreaming requirements;
    - LDH considers mainstreaming of Healthy Louisiana members into the broader health delivery system to be important. Healthy Blue providers shall accept members for treatment and not intentionally segregate members in any way from other persons receiving services;
    - To ensure mainstreaming of members, Healthy Blue takes affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral, or cognitive disability, except where medically indicated;
- Refrain from excluding treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.

4.10. Continuity of Care

To assist in the transition of Healthy Blue members from one level of care to another, Healthy Blue recommends transition meetings or appointments are held prior to the member moving from higher to lower

restrictive levels of care to assure continuity of treatment. Healthy Blue encourages providers to include Healthy Blue care managers in these meetings and appointments.

4.11. Provider Success

We believe the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure we jointly meet quality and recovery goals. Our commitment includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery.
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person.
- Simplifying precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members.
- Supporting provider needs related to transitioning into the managed care environment.

4.12. Health Plan Clinical Staff

All clinical staff members are licensed and have prior health care experience. Our behavioral health medical director is board-certified in adult, adolescence and child psychiatry and licensed in the state of Louisiana. Our highly trained and experienced team of clinical care managers, case managers and support staff provide high-quality care management and care coordination services to our members and strive to work collaboratively with all providers.

4.13. Member Records and Treatment Planning

Guidelines outlined in LDH's Behavioral Health Services (BHS) Provider Manual must be followed. The BHS Provider Manual may be accessed here: **https://www.lamedicaid.com/provweb1/Providermanuals/BHS_Main.htm**. Additionally, you may access the Provider Monitoring Tool here: **http://ldh.la.gov/index.cfm/page/2974**.

Member Records and Treatment Planning: Comprehensive Assessment
Member records must meet the following standards and contain the following elements, if applicable, for effective service provision and quality reviews.

Information related to the provision of appropriate services to members must be included in the records, with documentation in a prominent place whether there is an executed declaration for mental health treatment.

Providers must complete a comprehensive assessment that provides a description of the member's physical and mental health status at the time of admission to services. It should include the following:

- Psychiatric and psychosocial assessment, including:
  - Description of the presenting problem
  - Psychiatric history and history of the member's response to crisis situations
  - Psychiatric symptoms
  - Multi-axial diagnosis using the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*)
  - Mental status exam
- Medical assessment, including:
  - Screening for medical problems
  - Medical history

  - Present medications
  - Medication history
- Substance use assessment, including:
  - Frequently used over-the-counter medications
  - Current and historical usage of alcohol and other drugs reflecting impact of substance use in the domains of the community functioning assessment
  - History of prior alcohol and drug treatment episodes and their effectiveness
  - History of alcohol and drug use
- Community functioning assessment or an assessment of the member's functioning in the following domains:
  - Living arrangements, daily activities (vocational/educational)
  - Social support
  - Financial
  - Leisure/recreational
  - Physical health
  - Emotional/behavioral health
  - An assessment of the member's strengths, current life status, personal goals and needs

Member Records and Treatment Planning: Personalized Support and Care Plan
When individualized treatment plans are required they must be:
- Completed and submitted within the first 24 hours or next business day for members admitted to an acute mental health or acute care inpatient setting;
- Completed and submitted within the first 30 days of admission to or authorization of outpatient behavioral health services.

When a member is admitted, psychiatric residential treatment facilities (PRTF) require a completed and submitted face-to-face assessment by a licensed mental health professional (LMPH) every 60 days.

Treatment plans must be updated at least every 365 days, or more frequently as necessary based on the member's progress toward goals, a significant change in psychiatric symptoms, medical condition and/or community functioning as well as the level of care where the member is receiving treatment. Additionally, the development of a crisis prevention plan is required for those members with multiple hospitalizations or more than three visits to the emergency room for urgent or nonemergent care.

There must be a signed release of information to provide information to the member's PCP, including disclosure of substance use information or evidence that the member refused to provide a signature. Such information must be reported to Healthy Blue upon request. Disclosures of substance use information must include a prohibition against redisclosure. There must be documentation that referral to appropriate medical or social support professionals have been made.

A provider who discovers a gap in care is responsible to help the member get that gap in care fulfilled, and documentation should reflect the action taken.

For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the member.

The individualized treatment/support/care plan must contain the following elements:
- Identified problem(s) for which the member is seeking treatment

- Member goals related to each problem(s) identified, written in member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent de-escalation or defuse crisis situations; names and phone numbers of contacts who can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Actions agreed to be taken when progress toward goals is less than originally planned by the member and provider
- Signatures of the member as well as family members, caregivers or legal guardian as appropriate

Member Records and Treatment Planning: Progress Notes
Progress notes must document the status of the goals and objectives indicated on the treatment plans and should include:

- Correspondence concerning the member's treatment, including signed and dated notations of phone calls concerning the member's treatment.
- Indication of active follow-up actions for referrals given to the member and actions to fill gaps in care.
- A brief discharge summary within 15 calendar days of a discharge from services or death.
- Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services.

4.14. Psychotropic Medications

Prescribing providers must inform all members considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication; alternate medications; and other forms of treatment. If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the member, or if appropriate, a referral to a nutritionist or obesity medical professional. If diabetes is a problem, the medical record needs to reflect a discussion with the member about their condition, their treating provider's information and coordination efforts with that provider. The medical record is expected to reflect such conversations as having occurred. The medical record is expected to indicate the prescription data has been shared with the member's PCP.

Members on psychotropic medications may be at increased risk for various disorders. As such, it is expected that providers are knowledgeable about side effects and risks of medications and they regularly inquire about and look for any side effects. This especially includes:

- Follow-up to inquire about suicidality or self-harm in children placed on antidepressant medications as per Food and Drug Administration and American Psychiatric Association guidelines.
- Regular and frequent weight checks and measurement of abdominal girth, especially for those on antipsychotics or mood stabilizers.
- Glucose tolerance test or hemoglobin A-1C tests, especially for those members on antipsychotics or mood stabilizers.
- Triglyceride and cholesterol checks, especially for those members on antipsychotics and mood stabilizers.
- ECG checks for members placed on medications with risk for significant QT prolongation.
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association, among others. Summary guidelines are referenced in our clinical practice guidelines, located on our website at **https://providers.healthybluela.com**. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions must be documented in the member's medical record.

4.15. Timeliness of Decisions on Requests for Authorization

The following are guidelines around the timeliness of decisions on authorization requests for behavioral health services:

- If the referral is made from an emergency room or a facility that does not have a psychiatric unit, the decision will be made and communicated to the provider within one hour of the request.
- If in an inpatient facility where they will be hospitalized, the decision will be made and communicated to the provider within 24 hours of the request.
- Decisions on admission to PRTFs will be made and communicated to the provider within 48 hours of receipt of all necessary clinical information.
- For routine, nonurgent requests (initial request) — within two calendar days of receipt of all necessary information.
- Routine, nonurgent requests (concurrent review) — within one calendar days of obtaining all necessary information.
- Retrospective review requests — within 30 days of the request.

Behavioral health UM guidelines can be found at **https://providers.healthybluela.com**. For inpatient behavioral health UM guidelines, refer to the Milliman Care Guidelines at **https://www.mcg.com**.

4.16. Access to Care Standards

This grid outlines standards for timely and appropriate access to quality behavioral health care.

Service type	Access standard
Emergent Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.	Immediately on presentation at the service delivery site; emergent, crisis or emergency behavioral health services must be available at all times and an appointment must be arranged within 1 hour of the request. Care for a nonlife-threatening emergency must be arranged within 6 hours.
Urgent A service need that is not emergent and can be met by providing an assessment and services within 48 hours of the initial contact. If the member is pregnant and has substance use problems, she is to be placed in the urgent category.	Within 48 hours of referral/request
Routine A service need that is not urgent and can be met by receiving treatment within 10 days of the assessment	**Routine outpatient:** within 10 days of request **Outpatient following discharge from an IP hospital:** within seven days of discharge

without resultant deterioration in the individual's functioning or worsening of his or her condition.	

4.17. Behavioral Health Covered Services

Description	Authorization Needed?	Level of Care
Applied behavior analysis	Yes	Outpatient
Interactive complexity	No	Outpatient
Psychiatric diagnostic evaluation	No	Outpatient
Psychiatric diagnostic evaluation with medical services	No	Outpatient
Psychotherapy, 30 minutes with patient present	No	Outpatient
Psychotherapy, 30 minutes with patient present, add on	No	Outpatient
Psychotherapy, 45 minutes with patient present	No	Outpatient
Psychotherapy, 45 minutes with patient present, add on	No	Outpatient
Psychotherapy, 60 minutes with patient present	No	Outpatient
Psychotherapy, 60 minutes with patient present, add on	No	Outpatient
Psychotherapy for crisis, first 60 minutes	No	Outpatient
Psychotherapy for crisis, each additional 30 minutes, add on	No	Outpatient
Medical psychoanalysis	No	Outpatient
Family medical psychotherapy without patient present	No	Outpatient
Family medical psychotherapy with patient present	No	Outpatient
Multiple family group psychotherapy	No	Outpatient
Group psychotherapy	No	Outpatient
Pharmacologic management add on	No	Outpatient
Psychophysiological therapy with biofeedback, 20-30 minutes	No	Outpatient
Psychophysiological therapy with biofeedback, 45-50 minutes	No	Outpatient
Medical hypnotherapy	No	Outpatient
Assessment of aphasia	No	Psych testing
Assess health/behave, initial	No	Outpatient
Assess health/behave, subsequent	No	Outpatient
Intervene health/behave, individual	No	Outpatient
Intervene health/behave, group	No	Outpatient
Intervene health/behave, family with patient	No	Outpatient
Intervene health/behave, family without patient	No	Outpatient
Therapeutic, prophylactic or diagnostic injection	No	Injection
New patient office outpatient — problem focused	No	Outpatient
New patient office outpatient — expanded problem focused	No	Outpatient
New patient office outpatient — detailed	No	Outpatient
New patient office outpatient comprehensive moderate complexity	No	Outpatient
New patient office outpatient comprehensive high complexity	No	Outpatient

Description	Authorization Needed?	Level of Care
Established patient office outpatient — minimal problems	No	Outpatient
Established patient office outpatient — problem focused	No	Outpatient
Established patient office outpatient — expanded problem focused	No	Outpatient
Established patient office outpatient — detailed	No	Outpatient
Established patient office outpatient — comprehensive high complexity	No	Outpatient
Hospital observation care — low complexity	No	Observation
Hospital observation care — moderate complexity	No	Observation
Hospital observation care — high complexity	No	Observation
Emergency department visit, self lim	No	Emergency room
Emergency department visit, low	No	Emergency room
Emergency department visit, moderate	No	Emergency room
Emergency department visit, problem	No	Emergency room
Emergency department visit, problem expanded	No	Emergency room
Medication-Assisted Treatment (MAT) delivered in Opioid Treatment Programs (OTPs), including but not limited to Methadone treatment to all Medicaid-eligible adults and adolescents with Opioid Use Disorder (OUD)	No	Outpatient

4.18. Behavioral Health Services Requiring Preauthorization

The following covered behavioral health services require prior authorization:

- Anesthesia for electroconvulsive therapy
- Inpatient psychiatric subacute
- Electroconvulsive therapy
- Psychological testing with interpret, face-to-face
- Psychological testing with interpret, technician
- Psychological testing with interpret, computer
- Neurobehavioral status examination
- Initial hospital inpatient care, low complexity
- Initial hospital inpatient care, moderate complexity
- Initial hospital inpatient care, high complexity
- Subsequent hospital inpatient care, low
- Subsequent hospital inpatient care, moderate
- Subsequent hospital inpatient care, high
- Hospital discharge day management
- Hospital discharge pay
- Alcohol and/or drug services, intensive outpatient, II.1 individual
- Alcohol and/or drug services, intensive outpatient, II.1 Group, ages 0 to 20
- Alcohol and/or drug services, intensive outpatient, II.1 Group, ages 21+
- Therapeutic group home per diem, ages 0 to 20
- Community psychiatric supportive treatment, individual, office
- Community psychiatric supportive treatment, individual, community

- Community psychiatric supportive treatment, homebuilders, ages 0 to 20
- Community psychiatric supportive treatment, functional family therapy, ages 0 to 20
- Community psychiatric supportive treatment — PSH, individual, office
- Community psychiatric supportive treatment — PSH, individual, community
- Assertive community treatment — nonphysician per diem, ages 18 to 20
- Assertive community treatment — physician per diem, ages 18 to 20
- Assertive community treatment — first month enrolled, 1-10th day of month, ages 21+
- Assertive community treatment — first month enrolled 11-20th day of month, ages 21+
- Assertive community treatment — first month enrolled 21-31st day of month, ages 21+
- Assertive community treatment, subsequent months, ages 21+
- Psychiatric health facility service per diem, PRTF
- Psychosocial rehabilitation, individual, office
- Psychosocial rehabilitation, individual, community
- Psychosocial rehabilitation, group, office, ages 0 to 20
- Psychosocial rehabilitation, group, community, ages 0 to 20
- Psychosocial rehabilitation group office, ages 21+
- Psychosocial rehabilitation group community, ages 21+
- Multi-systemic therapy, 12-17 year old target population, ages 0 to 20

4.19. How to Provide Notification or Request Preauthorization

You may request preauthorization for nonroutine outpatient mental health services that require it by calling **1-844-521-6942**, 24/7 and 365 days a year. Be prepared to provide clinical information in support of the request at the time of the call.

You may provide notification or request preauthorization on the provider website at **https://providers.healthybluela.com**. You may also request preauthorization by fax for certain levels of care. Fax forms are located on the *Provider Resources* page of our website at **https://providers.healthybluela.com**. The fax numbers to use when providing notification or requesting prior authorization for behavioral health services are:

- Behavioral health outpatient requests: **1-844-432-6028**
- Behavioral health inpatient requests: **1-844-432-6027**

Note: All requests for precertification for psychological testing and applied behavior analysis (ABA) should be submitted via fax to **1-844-432-6028**. Our prior authorization forms for psychological testing and ABA, which outline the required documentation, can be found on the provider website under *Behavioral Health Forms*.

All facility-based behavioral health and substance use services require preauthorization.

4.20. Emergency Behavioral Health Services

Primary care providers should immediately refer any member who is in crisis or who is a threat to self or others for emergency care. An emergency referral for behavioral health services does not require prior authorization or pre-service review.

4.21. Behavioral Health Self Referrals

Members may self-refer to any behavioral health care provider in the Healthy Blue network. If the member is unable or unwilling to access timely services through community providers, call Healthy Blue Provider Services for assistance.

PCPs may treat members with situational behavioral health disorders, the most common of which are depression and anxiety. For members whose behavioral health does not respond to treatment in a primary care setting, contact us for referral and authorization information regarding assessment and ongoing services at **1-844-521-6942**.

PCPs are required to refer members that are experiencing acute symptoms of a chronic behavioral health disorder, exhibiting an acute onset of symptoms or are in a crisis state. Please refer to the benefits matrix for the range of services covered. PCPs are also required to make referrals for members whose symptoms of anxiety and mild depression persist or become worse. Any member suspected of developing toxicities to medications that have been prescribed by a psychiatrist will need to be referred back to the behavioral health system for observation and monitoring of medications.

PCPs should refer any member with the following established diagnosis or suspected onset of symptoms indicative of these disorders to a behavioral health specialist:

- Adjustment disorder
- Behavioral disorders of children and adolescents
- Bipolar disorders
- Eating disorders
- Multiple diagnosis
- Psychoses, involutional depression
- Schizophrenia
- Unipolar depression
- Problem gaming

4.22. Behavioral Health Services: Criteria for Provider Type Selection

Psychiatrist
All of the criteria below should be met before directing a member to a psychiatrist.

The member:

- Can self-refer for behavioral health treatment.
- Is taking psychoactive medication.
- Is referred by their PCP or under PCP treatment for the relevant problem.
- If a child, had prior treatment for the same problem without medication, and the problem is severe or disabling in some area of life.

The problem:

- Is cognitive, and the member has had previous inpatient or day treatment.
- Is cognitive, and overall dysfunction is severe or disabling.
- Is recurrent for greater than six months, and the member has had prior treatment.
- Is recurrent for greater than six months, and dysfunction is severe or disabling in any area of functioning.
- Is somatic, and the referral was not from the PCP.

- Is somatic, and the member is under PCP care, and the problem is severe or disabling in some area of functioning.

Psychologist or other Licensed Mental Health Professional (LMHP)
The following criteria should be met before directing a member to a psychologist or other licensed mental health professional:

- The member can self-refer for behavioral health treatment.
- An identifiable stressor is present.
- The member is not taking psychoactives.
- The member is not referred by their PCP and is not under PCP treatment for the relevant problem.
- The problem is not recurrent and is not greater than six months duration.
- The problem is not severe or disabling in any area of functioning.

4.23. Payment for Services Provided to Coordinated System of Care Recipients

The coordinated system of care (CSoC) contractor is responsible for payment to enrolled providers for the provision of specialized behavioral health services, with the exception of psychiatric residential treatment facility services, for each month during which the recipient has a 1915(c)/1915(b)(3) segment on the eligibility file with a begin date on or earlier than the first day of that month, or if a recipient transfers between waivers during the month but the previous segment began on or earlier than the first day of that month.

The CSoC contractor is responsible for payment to enrolled providers for the provision of specialized behavioral health services through the last day of the month, which includes the end date of the 1915(c)/1915(b)(3) segment on the eligibility file.

Healthy Blue is responsible for payment to enrolled providers for the provision of specialized behavioral health services for any month during which the recipient has a 1915(c)/1915(b)(3) segment on the eligibility file with a begin date later than the first day of that month.
Healthy Blue is responsible for payment of all PRTF services.

4.24. Links to Forms, Guidelines and Screening Tools

For mental health and substance use covered services, noncovered diagnoses, and screening tools for PCPs and behavioral health providers, go to **https://providers.healthybluela.com/la/pages/behavioral-health.aspx**.

For services requiring precertification, go to **https://providers.healthybluela.com/la/pages/prior-auth-info.aspx**.

4.25. Psychosocial rehabilitation (PSR) or community psychiatric supportive treatment (CPST)

Provider agencies

In order to be eligible to receive Medicaid reimbursement, BHSPs providing PSR or CPST to Healthy Louisiana recipients must meet all of the following requirements:

- Be licensed as a BHSP agency
- Be accredited by a department-approved accrediting organization
- Have an NPI number
- Implement a member choice form
- Be credentialed

- Employ at least one full-time physician or licensed mental health professional to supervise
- Provide supervision for unlicensed individuals
- Meet other requirements, including all requirements in statute, in rule and in the *Medicaid Behavioral Health Services Provider Manual*

Individual requirements

In order to be eligible to receive Medicaid reimbursement, BHSPs must ensure that any individual rendering PSR or CPST services for their agency meets all of the following requirements:

- Has an NPI number
- Has a bachelor's degree to provide PSR services, pending CMS approval
- Has a bachelor's degree to provide CPST services, pending CMS approval

NPI number requirement

The individual rendering the PSR or CPST services for the licensed and accredited provider agency must have an individual NPI number, and that number must be included on any PSR or CPST claim submitted by that provider agency for Medicaid reimbursement (in addition to the agency NPI number).

5. APPLIED BEHAVIOR ANALYSIS

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

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

The following sections provide more information on ABA. All ABA providers and services are subject to the same guidelines as other providers and services outlined throughout this manual including our utilization management guidelines. You may also refer to LDH's ***Applied Behavior Analysis Provider Manual*** at **www.lamedicaid.com** as an additional resource.

5.1. ABA: Target Audience

The Healthy Blue provider network for ABA services includes the following:

- Licensed psychologists
- Licensed medical psychologists
- Behavior analysts who are currently licensed by the Louisiana Behavior Analyst Board
- Certified assistant behavior analysts
- Registered line technicians with experience serving the needs of the following target populations:
  - Adolescents and children under 21 years of age
  - Individuals exhibiting excesses and/or deficits of behaviors that significantly interfere with home or community activities
  - Individuals diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate by a qualified health care professional
  - Individuals who had a comprehensive diagnostic evaluation by a qualified health care professional
  - Individuals who have a prescription for ABA-based therapy services ordered by a qualified health care professional

5.2. ABA: Goals and Objectives

In addition to the goals and objectives of the overall behavioral health program, the goals and objectives specific to the ABA program include:

- Working with members, providers and caregivers to identify appropriate goals and treatments for the individual's age and impairments to improve social and communication skills.
- Having objectives that are specific, measurable, based on clinical observations of the outcome measurement assessment and tailored to the recipient.
- Ensuring interventions are consistent with ABA techniques.
- Clearly identifying the schedule of services planned and the individual providers responsible for delivering the services.
- Delineating the frequency of baseline behaviors and the treatment development plan to address the behaviors.
- Identifying long-term, intermediate and short-term goals and objectives that are behaviorally defined.

Qualified Healthy Blue associates will ensure:

- Clinical guidelines support LDH's recommendations and are person-centered and based on individualized goals.
- Providers' treatment plans are appropriate, applicable and consistent with best practices through oversight and monitoring throughout the entire continuum of treatment.

When a member is approaching ABA discharge readiness, Healthy Blue associates will:

- Work with a member, member's caregiver(s), and providers to develop a discharge/transition plan that may include:
  - Utilization management activities focused on a gradual step down of service.
  - Parent/caregiver training, support and participation.
  - Collaboration between all health care partners and caregiver(s), school state disability programs, and others as applicable to achieve goals through education, technological support and community resources.
  - Efforts to ensure services are delivered in accordance with best-practice guidelines, rules and regulations, and policies and procedures set forth by the state of Louisiana.
- Assist with members' transitional needs prior to discharge.
- Evaluate members for any other care management needs.
- Work with members and their families on ABA discharge planning, including:
  - Reviewing ongoing needs.
  - Making referrals as needed.
  - Assisting in the evaluation for alternative therapies (speech, occupational, feeding, etc.).
  - Continuing with care coordination activities.

5.3. ABA: Provider Roles and Responsibilities

In addition to the provider roles and responsibilities of the overall behavioral health program, the roles and responsibilities specific to ABA providers include:

- Performing a complete comprehensive diagnostic evaluation (CDE) indicating the need for ABA services.
- Performing a functional assessment and developing the behavior treatment plan.
- Frequently reviewing progress using ongoing objective measurement and adjusting the instructions and goals in the behavior treatment plan as needed.
- Conducting regular meetings with family members to plan ahead, review progress and make any necessary adjustments to the behavior treatment plan.
- Ensuring the behavior treatment plan:

  - Is person-centered.
  - Is based on individualized goals, delineating the frequency of baseline behaviors and addressing the behaviors.
  - Identifies long-term, intermediate and short-term goals and objectives that are behaviorally defined.
- Identifying the criteria that will be used to measure achievement of behavior objects.
- Clearly identifying the schedule of services planned and the individual providers responsible for delivering the services.
- Having specific objectives.
- Providing recommendations for any additional treatment; care; services; specialty medical or behavioral referrals; specialty consultations; and/or any additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.

5.4. ABA: Care Management

Healthy Blue has a dedicated team of specialized behavioral health care managers to serve this population. Care management is designed to proactively respond to a member's needs when conditions or diagnoses require coordination of services. The purpose of the care management program is to provide a coordinated comprehensive approach to ensure members receive efficient and cost-effective services at the appropriate level of care through the development of individualized, innovative programs and coordination with community services.

We view care management as a continuum of services and supports that is matched on an individualized basis to meet the needs of the member. The Healthy Blue case/care manager helps identify medically appropriate alternative methods or settings in which care may be delivered. Care management activities will focus on the care coordination of the whole person and include:

- Evaluating for other care management programs.
- Reviewing ongoing needs.
- Making referrals as needed.
- Assisting in the evaluation for alternative therapies (speech, occupational, feeding, etc.).

These measures ensure members in need of ABA treatment have access to care and are continually engaged with care management to provide ongoing support.

A provider may request participation in the program on behalf of the member. The care manager will work with the member, provider and caregiver(s) to identify the:

- Appropriate alternate settings where care may be delivered.
- Health care services required.
- Equipment and/or supplies required.
- Community-based services available.
- Support and/or training for caregiver(s).

Healthy Blue ABA providers are encouraged to engage, assist in the development of and provide feedback on the care plans of members they're serving.

5.5. ABA: Member Record and Treatment Plan

Members' records must include the following:

- Documentation of a completed comprehensive diagnostic evaluation (CDE) performed by a qualified health care professional (QHCP)

- A thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history
- Direct observation of the member, including an assessment of current functioning in the areas of social and communicative behaviors and peer interactive behaviors
- A review of available records
- A valid diagnosis
- Justification/rationale for referral for an ABA functional assessment
- Recommendations for any additional treatment, care of services, specialty medical or behavioral referrals, specialty consultations, and any additional recommended standardized measures, labs, or diagnostic evaluations considered clinically appropriate and/or medically necessary

When there is any lack of clarity about the primary diagnosis, comorbid conditions or medical necessity of services requested, the CDE must be specific to the recipient's age and cognitive abilities and include additional assessments (as appropriate), such as:

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

The licensed professional must perform a functional assessment of the member utilizing the outcomes from the CDE to develop a behavior treatment plan. The behavior treatment plan will identify the treatment goals along with providing instructions to increase or decrease the targeted behaviors. Treatment goals should emphasize skills required for both short- and long-term goals. The instructions should break down the desired skills into manageable steps that can be taught from the simplest to more complex.

The behavior treatment plan must:

- Be person-centered and based on individualized goals.
- Delineate the frequency of baseline behavioral and the treatment development plan to address the behaviors.
- Indicate that direct observation occurred and describe what happened during the observation.
- Identify long-term, intermediate and short-term goals and objectives that are behaviorally defined.
- Identify the criteria that will be used to measure achievement of behavior objectives.
- Clearly identify the schedule of services planned and the individual providers responsible for delivering the services.
- Include care coordination, involving the parents or caregiver(s), school, state disability programs, and others as applicable.
- Include parent/caregiver(s) training, support and participation.
- Have objectives that are specific, measureable, based on clinical observations of the outcome measurement assessment and tailored to the member.
- Ensure interventions are consistent with ABA techniques.
- Include a weekly schedule detailing the number of expected hours per week and the location for the requested ABA services.

The licensed professional must frequently review the member's progress using ongoing objectives and conduct monthly meetings with family members.

5.6. ABA: Covered Services

Healthy Blue follows the *Louisiana Medicaid Applied Behavioral Analysis Fee Schedule*, which is available at **www.lamedicaid.com**.

5.7. ABA: Providing Notification or Requesting Preauthorization

All ABA services require prior authorization. You may request preauthorization for ABA services by calling **1-844-521-6942**, 24/7 and 365 days a year. Be prepared to provide:

- Member information.
- Procedure codes.
- All supporting medical documentation.

Note: This list is not all-inclusive. The Healthy Blue ABA team phone is **1-844-406-2389**.

You may also provide notification or request preauthorization on the provider website at **https://providers.healthybluela.com** or by fax to **1-844-432-6028**. Fax forms are available on the website.

6. PRECERTIFICATION AND NOTIFICATION PROCESS

Referrals to in-network specialists are not required. However, some specialty services require precertification as specified below. We encourage members to consult with their PCPs prior to accessing nonemergency specialty services. The two processes are defined below.

Precertification is defined as the **prospective** process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. **Prospective** means the coverage request occurred prior to the service being provided.

Elective services require precertification, meaning the provider should notify Healthy Blue by phone, fax or the provider website before providing the service. Member eligibility, provider status (network and non-network) and medical necessity will be verified.

Healthy Blue may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose.

Note: ER visits do not require precertification or notification. If an ER visit results in an inpatient admission, you should notify us within 24 hours of the visit or the next business day.

6.1. Precertification for Inpatient Elective Admissions

We require precertification of **all inpatient elective admissions**. The referring PCP or specialist is responsible for precertification. The referring physician identifies the need to schedule a hospital admission; to do so, you can either:

- Submit your request through our website at **https://providers.healthybluela.com** (preferred method).
- Fax the request to **1-877-269-5705**.
- Call Provider Services at **1-844-521-6942**.

Requests for precertification with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative Denial
Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical when requested. Appeals for administrative denials must address the reason for the denial (that is, why precertification was not obtained or why clinical was not submitted.)

If Healthy Blue overturns its administrative decision, then the case will be reviewed for medical necessity and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

This will allow us to verify benefits and process the precertification request. For services that require precertification, we make case-by-case determinations that consider the individual's health care needs and

medical history in conjunction with nationally recognized standards of care. The hospital can confirm that a precertification is on file by:

- Visiting our provider website at **https://providers.healthybluela.com**.
- Calling Provider Services at **1-844-521-6942**.

If coverage of an admission has not been approved, the facility should call Provider Services. We will contact the referring physician directly to resolve the issue.

We are available 24/7 to accept precertification requests. When a request is received from the physician online, via phone or by fax for medical services, a care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

Our precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of all procedures. When appropriate, our precertification nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, we will issue a Healthy Blue reference number to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the requesting provider can discuss the case with the Healthy Blue medical director prior to the determination.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter (including the member's appeal and fair hearing rights) will be mailed to the requesting provider, member's PCP and member.

6.2. Emergent Admission Notification Requirements

Network hospitals must notify us within 24 hours or the next business day of an emergent admission. Network hospitals can notify us by calling Provider Services at **1-844-521-6942** (available 24/7)**,** by fax at **1-877-269-5705** or through the secure Availity Portal at **https://providers.healthybluela.com**.

Failure to comply with notification rules will result in an administrative denial.

Our Medical Management staff will verify eligibility and determine coverage. A concurrent review nurse will review and authorize the coverage of emergent admissions based on medical necessity.

The clinical submission deadline is 3 p.m. Central time, and we have a 10-minute grace period to alleviate time discrepancies on fax machines. Providers must submit clinical documentation to support medical necessity. We will reach out to the provider if the clinical information is insufficient and additional documentation is necessary.

If our medical director denies coverage, the attending or treating provider acting on behalf of the member will have an opportunity to discuss the case with him or her. We will mail the adverse determination letter to the provider and member and include the member's appeal and state fair hearing rights and process.

6.3. Nonemergent Outpatient and Ancillary Services — Precertification and Notification Requirements

We require precertification for coverage of certain nonemergent outpatient and ancillary services (see the **Precertification/Notification Coverage Guidelines section**). To ensure timeliness, you must include:

- Member name and ID.
- Name, phone number and fax number of the physician providing the service.
- Name of the facility and phone number where the service will be performed.
- Name of servicing provider and telephone number.
- Date of service.
- Diagnosis with ICD-10-CM code.
- Name of elective procedure with CPT code.
- Physician's order.
- Medical information to support the request including:
  - Signs and symptoms.
  - Past and current treatment plans, along with the provider who provided the surgery.
  - Response to treatment plans.
  - Medications, along with frequency and dosage.

For the most up-to-date precertification/notification requirements, go to **https://providers.healthybluela.com** > Prior Authorization & Claims > Prior Authorization Lookup Tool (PLUTO). For the latest precertification forms, go to **https://providers.healthybluela.com** > Provider Support > Forms > Precertification.

6.4. Prenatal Ultrasound Coverage Guidelines

The following are frequently asked questions and answers about our prenatal ultrasound policies.

What are the requirements for precertification for total obstetric care?	For obstetric care, we do not require precertification; we only require **notification** to our Provider Services team.
In which trimester of a woman's pregnancy is she determined to be an obstetric patient?	A member is considered to be an obstetric patient once pregnancy is verified.
Are there precertification requirements for prenatal ultrasound?	There are no precertification requirements for prenatal ultrasound studies. Payment is administered by matching the procedure with the appropriate diagnosis code submitted on the claim.
Is there a medical policy covering prenatal ultrasound procedures?	Yes, there is a detailed policy covering certain prenatal ultrasound procedures. To review the complete policy, go to **https://providers.healthybluela.com** > Provider Support > Medical Policies and Clinical Utilization Management Guidelines. The policy describes coverage of ultrasound studies for maternal and fetal evaluation as well as for evaluation and follow-up of actual or suspected maternal or fetal complications of pregnancy.
Why was the policy created?	The policy was created to ensure members receive the most appropriate ultrasound for the diagnosis or condition(s) being evaluated.

Does the policy describe limits on the number of prenatal ultrasound procedures a woman may have during her pregnancy?	A minimum of three obstetric ultrasounds will be reimbursed per pregnancy (270 days) without the requirement of prior authorization or medical review when performed by providers other than maternal fetal medicine specialists: • When an obstetric ultrasound is performed for an individual with multiple gestations, leading to more than one procedure code being submitted, this will only be counted as one obstetric ultrasound; and • Obstetric ultrasounds performed in inpatient hospital, emergency department, and labor and delivery triage settings are excluded from this count. For maternal fetal medicine specialists, there will be no prior authorization or medical review required for reimbursement of obstetric ultrasounds. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. In all cases, obstetric ultrasounds must be medically necessary to be eligible for reimbursement
Which ultrasound procedures are covered under this policy?	The policy does not apply to ultrasound studies with CPT codes not specifically listed in the policy, such as nuchal translucency screening, biophysical profile and fetal echocardiography. **For CPT codes 76801 (+76802) and 76805 (+76810),** two routine ultrasound studies are covered per pregnancy. **For CPT codes 76811 (+76812), 76815, 76816 and 76817,** additional ultrasound studies are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study being requested. CPT code 76811 (and +76812) is only reimbursable to maternal fetal medicine specialists.
Are there exceptions to this policy?	The policy does not apply to: • Maternal fetal medicine specialists (S142, S083, S055 and S088) • Radiology specialists (S164 and S232) • Ultrasounds performed in place of service code 23 — emergency department.

6.5. Dental

Dental Care for Adults Age 21 and Older
Healthy Blue offers coverage for an oral exam, a cleaning and bitewing X-rays once per year. New additional benefits include the restorative benefit — fillings and simple extractions.

A member may self-refer for these adult dental benefits by contacting DentaQuest, the dental vendor, directly at **1-844-234-9835**.

Emergency Dental Services
When a member has a dental-related accident and requires repair of an injury, Healthy Blue covers laboratory and radiological services required to treat that emergency or provide related surgical services.

Dental Services for Children and Adult Denture Beneifts

Members under the age of 21 receive dental services through MCNA Dental or DentaQuest, the state's dental benefit program managers (DBPM). Members who do not actively select a dental plan will be auto assigned to one. The DBPMs will issue a dental plan card to each beneficiary, and providers and beneficiaries will be able to use information on this card to contact the dental plan with questions and problems. Effective January 1, 2021, both DBPMs administer EPSDT dental benefits to those under 20 years of age, as well as adult denture program benefits to those 21 years of age and up. Please see below for contact information:

DentaQuest
1-800-685-0143
TTY: **1-800-466-7566**
Available Monday – Friday, 7:00 a.m. - 7:00 p.m.
www.DentaQuest.com

MCNA Dental
1-855-702-6262
TTY : **1-800-846-5277**
Available Monday - Friday, 7:00 a.m. – 7:00 p.m.
www.mcnala.net

6.6. Precertification/Notification Coverage Guidelines

For code-specific precertification requirements, visit **https://providers.healthybluela.com**.

Air Ambulance Services	Precertification is required for air ambulance services. The provider has **30 calendar days** from the date of the initial air transport to seek prior authorization for services.
ABA	Precertification is required for all ABA services.
Behavioral Health/Substance Abuse Services	No precertification is required for a network provider for basic behavioral health services provided in a PCP or medical office. To obtain information about precertification requirements for specialty behavioral health services, please visit the provider website at **https://providers.healthybluela.com**. For information or to make referrals, call **1-844-521-6942**. Please visit **https://providers.healthybluela.com** to provide notification or request prior authorization for behavioral health services. You may also submit this information by fax: • Outpatient requests: **1-844-432-6028** • Inpatient requests: **1-844-432-6027**
Chemotherapy	Precertification is required for inpatient chemotherapy as part of the elective inpatient admission and for oncology drugs and adjunctive agents.

	However, precertification is not required for procedures performed in the following outpatient settings: • Office • Outpatient hospital • Ambulatory surgery center Review additional information about chemotherapy drug coverage in the **Pharmacy Services section** of this manual.
Circumcision	Routine circumcisions are covered within the first 30 days of life, and medically necessary circumcisions are covered with no age limit.
Dermatology	No precertification is required for a network provider for: • Evaluation and Management (E&M). • Testing. • Procedures. Cosmetic services or services related to previous cosmetic procedures are not covered.

Diagnostic Testing	No precertification is required for a network provider for routine diagnostic testing.
	
	Precertification is required for the following:
	• MRA
	• MRI
	• CAT scan
	• Nuclear cardiac
	• Video EEG
	• PET imaging
	
	AIM Specialty Health (AIM) manages precertification for the following modalities:
	• Computed tomography (CT/CTA)
	• Magnetic resonance (MRI/MRA)
	• Positron emission tomography (PET) scans
	• Nuclear cardiology
	• Echocardiography
	  – Stress echo
	  – Resting transthoracic echo
	  – Transesophageal echo
	• Radiation oncology
	• Sleep medicine
	• Cardiology services
	
	AIM Clinical Appropriateness Guidelines and our *Medical Policies* will be used. AIM guidelines are available online at **www.aimspecialtyhealth.com**.

Durable Medical Equipment (DME)	Precertification is required for certain DME items. For code-specific precertification requirements, visit **https://providers.healthybluela.com**. Select **Prior Authorization & Claims** and then choose **Prior Authorization Lookup Tool (PLUTO)**. Enter codes to determine authorization requirements. To request precertification, submit a physician's order supporting documentation and fill out our precertification form, which can be found on **https://providers.healthybluela.com** > Provider Support > Forms. We must agree on HCPCS and/or other codes for billing, and we require you to use appropriate modifiers (NU for new equipment, RR for rental equipment). Our policy for rent to purchase on most items is limited to 10 continuous/consecutive months including oxygen concentrators. For additional questions regarding rent to purchase items, please contact Provider Services at **1-844-521-6942**.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Visit	Self-referral; Use the EPSDT schedule and document visits. Note: Vaccine serum is received under the Vaccines for Children (VFC) program.
Educational Consultation	No precertification is required.
Elective Termination of Pregnancy	Precertification is required. Termination is only covered when either: • A woman suffers from a physical disorder, physical injury or physical illness — including a life-endangering physical condition caused by or arising from the pregnancy itself — that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. • The pregnancy is the result of an act of rape or incest.
Emergency Room	No precertification is required for a network provider. We must be **notified within 24 hours or the next business day** if an ER encounter results in an inpatient admission.
ENT Services (Otolaryngology)	No precertification is required for a network provider for: • E&M. • Testing. • Certain procedures. Precertification is required for: • Nasal/sinus surgery. • Cochlear implant surgery and services.
Family Planning/Sexually Transmitted Infection (STI) Care	Members may self-refer to any in-network or out-of-network provider. Please encourage your patients to receive family planning services in-network to ensure continuity of service.
Gastroenterology Services	No precertification is required for a network provider for: • E&M. • Testing. • Certain procedures. Precertification is required for: • Bariatric surgery. • Insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components. • Upper endoscopy.
Gynecology	No precertification is required for a network provider for: • E&M. • Testing. • Certain procedures.
Hearing Aids	Precertification is required for digital hearing aids.

Hearing Screening	No precertification is required for a network provider for: • Diagnostic and screening tests. • Hearing aid evaluations. • Counseling.
Home Health Care and Home IV Infusion	Precertification is required for: • Skilled nursing. • Extended home health services. • IV infusion services. • Home health aide. • Physical, occupational and speech therapy services. • Physician-ordered supplies. • IV medications for in home therapy. Note: Drugs and DME require separate precertification.
Hospice	Precertification is required for hospice.
Hospital Admission	Precertification is required for: • Elective admissions. • Some same-day/ambulatory surgeries. We must be notified **within 24 hours or the next business day** if an ER encounter results in an inpatient admission. Preadmission testing must be performed by a Healthy Blue-preferred lab vendor or network facility outpatient department. Please see our provider directory for a complete listing. We do not cover: • Rest cures. • Personal comfort and convenience items. • Services and supplies not directly related to patient care (telephone charges, take-home supplies, etc.). **We request notification of inpatient emergency admissions within one business day of admission**. Failure of admission notification after one business day may result in claim denial. Non-business days include the weekend, New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving Day and Christmas Day. Per diem payment for all inpatient admissions shall account for all services during the stay including same day surgeries, emergency, and observation services and all preadmission (workup) services according to Louisiana Medicaid regulations. Reimbursement for bed hold/leave of absence days shall be paid in accordance with Louisiana Medicaid billing guidelines.
Hyperbaric oxygen and supervision of	Prior authorization is required for the following: • G0277 — Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval

hyperbaric oxygen therapy	• 99183 — Physician attendance and supervision of hyperbaric oxygen therapy, per session
	
	To request PA, you may use one of the following methods:
	• Web: **https://www.availity.com**
	• Fax:
	  ○ **1-888-822-5595** (inpatient)
	  ○ **1-888-822-5658** (outpatient)
	• Phone: **1-844-521-6942**

Laboratory Services (Outpatient)	Precertification is required for:
	• Genetic testing.
	• All laboratory services furnished by non-network providers except hospital laboratory services in the event of an emergency medical condition.
	
	Quest Diagnostics and LabCorp are the preferred lab providers for all Healthy Blue members. Contact Quest or LabCorp at the numbers below to receive a Quest or LabCorp specimen drop box.
	• For more information, testing solutions and services or to set up an account, contact either:
	  – Quest Diagnostics: **1-866-MY-QUEST** (**1-866-697-8378**)
	  – LabCorp: **1-800-345-4363**

Medical Supplies	No precertification is required for a network provider for disposable medical supplies.
Medical Injectables	We cover most specialty drugs under the pharmacy benefit. These drugs can be obtained through any pharmacy in our network that dispenses these medications. For a complete list of specialty drugs, visit our provider website. Some medical injectables require prior authorization when covered under the medical benefit and administered in the physician's office.
Musculoskeletal Programs	Request prior authorization by submitting complete clinical information to AIM Specialty Health® via: • Phone: **1-800-714-0040** • Website: **www.aimspecialtyhealth.com/goweb** Requests submitted with incomplete clinical information may result in a denial.
Neurology	No precertification is required for a network provider for: • E&M. • Testing. • Certain other procedures. Precertification is required for: • Neurosurgery. • Spinal fusion. • Artificial intervertebral disc surgery.

Nonemergency Medical Transportation (NEMT)/Nonemergency Ambulance Transportation (NEAT)	No precertification is required. For nonemergency transportation, members can call MediTrans at **1-866-430-1101** to set up a ride. There is also a dedicated call-in line for providers: **1-844-349-4324**.
Observation	No precertification is required for observation up to 48 hours; observation beyond 48 hours requires authorization. In addition, if your observation extends beyond 48 hours or results in an admission, you must notify us within 24 hours or the next business day.
Obstetrical Care	No precertification is required for a network provider for: • Obstetrical services and diagnostic testing. • Obstetrical visits. • Certain diagnostic tests and lab services by a participating provider. • Prenatal ultrasounds. • Normal vaginal and cesarean deliveries. Notification requirements are as follows: • Notify Provider Services of the first prenatal visit. • For obstetric care, we require notification; we do not require precertification. • All inpatient admissions require notification, including admission for normal vaginal and cesarean deliveries. • Healthy Blue will authorize up to 48 hours for a normal vaginal delivery and 96 hours for normal cesarean delivery. • The hospital is required to notify us of the mother's discharge date. Fax maternal discharge notifications to **1-888-822-5595** within one business day of discharge. • For deliveries where the inpatient confinement exceeds 48 hours for vaginal delivery and 96 hours for cesarean delivery, the hospital is required to notify Provider Services and provide clinical. Following notification, clinical updates can be faxed directly to the local health plan at **1-888-822-5595**. • Healthy Blue is allowed to deny a portion of a claim for payment based solely on the lack of notification by the provider of an obstetrical admission exceeding 48 hours after a vaginal delivery and 96 hours after a cesarean section. • If a member is admitted for an induction or labor and fails to deliver by day two of the admission, the hospital is required to submit clinical for the first two days of admission for medical necessity review. Within 24 hours of the birth of a newborn (or within one business day of delivery), the hospital is required to submit birth information to us. Fax newborn delivery notifications to **1-877-269-5705**; providers may use standard reporting forms specific to their hospital as long as the following required information is included: – Indicate whether a live birth – Newborn's birth weight

	– Gestational age at birth – Apgar scores – Disposition at birth – Type of delivery(vaginal or cesarean); if a cesarean, the reason the cesarean was required – Date of birth – Gender – Single/multi birth – Gravida/para/ab for mother – EDC and if NICU admission was required Providers are required to register all births through LEERS (Louisiana Electronic Event Registration System), which is administered by LDH/Vital Records Registry. LEERS information and training materials are available at **http://new.dhh.louisiana.gov/index.cfm/page/669**. If a newborn requires admission to the NICU, the hospital must notify Provider Services and submit clinical and updates. **Well babies are covered under the mother's hospitalization authorization**. If a newborn requires hospitalization as a **border baby** beyond the mother's discharge date, the hospital **must provide notification** as directed for NICU admissions. Provider Services phone: **1-844-521-6942** Notification fax: **1-877-269-5705** Local health plan inpatient clinical fax: **1-888-822-5595** OB case management programs are available for all high-risk women. Reimbursement for Cesarean and high risk deliveries are excluded at Free Standing Birthing Centers.
Ophthalmology	No precertification is required for a network provider for: • E&M. • Testing. • Certain procedures. Precertification is required for repair of eyelid defects. We do not cover services that are considered cosmetic.
Oral Maxillofacial	See Plastic/Cosmetic/Reconstructive Surgery.
Out-of-Area/ Out-of-Network (OON) Care	Precertification is required for all OON services except for emergency care, EPSDT screening, family planning and OB care. Note: Precertification is not required for EPSDT screening for both in-network and out-of-area network providers.

Outpatient/Ambulatory Surgery	Our precertification requirement is based on the procedure performed; visit our provider website for more details. • Performance of outpatients surgical procedures will be reimbursed on a flat fee per service basis. All outpatient surgery charges for the specified surgeries should be billed using revenue code "490"- Ambulatory Surgery Care. All other charges associated with the surgery(e.g., observation, labs, radiology) must be billed on the same claim as the ambulatory surgery charges. The only revenue code that will be paid will be the flat rate fee for the ambulatory surgery. The minimum reimbursement rate for groupings can be found on the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedules. A list of the surgical procedures is also provided on the fee schedule. • For minor surgeries that are medically necessary to be performed in the hospital operating room but the associated CPT code is not included in the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedules, submit charges using revenue code HR361 - Operating Room Services-Minor Surgery. • When more than one surgical procedure is performed on the same date of service, only the primary surgical procedure will be paid.
Pain Management/ Physiatry/Physical Medicine and Rehabilitation	Precertification is required for non-E&M-level services. Pain management services are not a covered benefit.
Pediatric Day Health Care (PDHC)	Precertification is required.
Personal Care Services (PCS)	Precertification is required. PCS are covered for members ages 0 to 20 and excluded for members over 21 years of age.
Pharmacy Services	The pharmacy benefit covers medically necessary prescription and over-the-counter drugs prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is provided under the Louisiana Department of Health *PDL*. Refer to the *PDL* for the preferred products within therapeutic categories as well as requirements around generics, prior authorization, step therapy, quantity edits and the prior authorization process. Quantity and day supply limits apply. Precertification is required for certain chemotherapy drugs. Precertification is required for all nonformulary drugs.
Plastic/Cosmetic/ Reconstructive Surgery	No precertification is required for a network provider for: • E&M services.

(Including Oral Maxillofacial Services)	• Oral maxillofacial E&M services. Precertification is required for: • All other services. • Trauma to the teeth. • Oral maxillofacial medical and surgical conditions. • TMJ. We do not cover: • Services considered cosmetic in nature. • Services related to previous cosmetic procedures. Mastectomy, breast reduction, and reduction mammoplasty require review by our medical director.
Podiatry	No precertification is required for a network provider for: • E&M. • Testing. • Most procedures.
Radiology	See Diagnostic Testing. If Provider employs the physicians interpreting the radiology procedures, the global payment will be made to Provider and will include the technical and professional component.
Rehabilitation Therapy (Short-Term): Speech, Physical and Occupational	Precertification is required. Initial outpatient therapy evaluations and re-evaluations do not require precertification. Appropriate therapy evaluations must be completed and submitted with precertification requests. Requests submitted with incomplete clinical information may result in a denial.
Skilled Nursing Facility	Precertification is required.
Sterilization	No precertification is required for a network provider for: • Sterilization. • Tubal ligation. • Vasectomy. We require a sterilization consent form for claims submissions. We do **not** cover reversal of sterilization.
Urgent Care Center	No precertification is required for a participating facility. The professional services rate is inclusive of professional, technical, and facility charges including laboratory and radiology. The professional services rate is all inclusive and any services not specified in the provider agreement are not reimbursable.
Well-Woman Exam	No precertification is required. We cover one well-woman gynecological exam per calendar year for women aged 21 and over when performed by her PCP or an in-network GYN. This is in addition to the current service provision of one preventive medicine visit for adults aged 21 years and older. The visit includes:

	• Examination. • Routine lab work. • STI screening. • Mammograms for members 35 and older. • Pap smears (Routine Pap smears are allowed once every three years per ACOG guidelines.). Members can receive family planning services without precertification at any qualified provider. Please encourage your patients to receive family planning services from an in-network provider to ensure continuity of service.
Revenue (RV) Codes	Precertification is required for services billed by facilities with RV codes for: • Inpatient. • OB. • Home health care. • Hospice. • CT, PET and nuclear cardiology. • Chemotherapeutic agents. • Pain management. • Rehabilitation (physical/occupational/respiratory therapy). • Rehabilitation short-term (speech therapy). • Specialty pharmacy agents. For a complete list of specific RV codes and code-specific precertification requirements, visit **https://providers.healthybluela.com.**

We have clinical staff available 24/7 to accept precertification requests. When a medical request is received, we:
- Verify our member's eligibility and benefits.
- Determine the appropriateness of the request.
- Issue you a reference number.

For nonurgent precertification requests, we provide our decision within two business days but no later than 14 calendar days following receipt of the request. For urgent or stat requests, we provide our decision within 72 hours. If documentation is not complete, we will ask you for the additional necessary documentation.

Please note: Healthy Blue will not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless we can provide the service through an in-network or out-of-network provider for a lower level of care.

6.7. Hospital Admission Reviews

Observation
We allow up to 48 hours of outpatient observation without notification or precertification. Observation services beyond 48 hours require authorization.

If you anticipate a member will be in observation beyond 48 hours, you must notify Healthy Blue within 24 hours or one business day of the observation time frame expiration (the 48th hour) for potential authorization of an extension of hours. To request an extension, submit the observation order, progress notes, discharge date and time (if applicable), and any clinical information or documentation to support medical necessity of the additional hours requested. If your observation care results in an inpatient admission, you must notify us of the inpatient admission within 24 hours or the next business day. Patients should not be auto-converted to inpatient status at the end of 48 hours.

For additional information regarding the Common Observation Policy, please see **LDH IB 18-17**.

Inpatient Admission Review
Notification of admission to the health plan is your essential first step in the precertification process. We review all inpatient hospital admissions and urgent/emergent admissions. We determine the member's medical status through:

- Telephonic, electronic or onsite review.
- Communication with the hospital's Utilization Review department.

We document the appropriateness of stay and refer specific diagnoses to our Case Management staff for care coordination or case management based on our integrated rounds.

Inpatient Concurrent Review
To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record.

It is the hospital's responsibility to submit clinical information for review by the specified next review date and time determined by the health plan at the time of admission and for continued length of stay.

The clinical submission deadline for Healthy Blue is 3 p.m. Central time, and we have a 10-minute grace period to alleviate time discrepancies on fax machines. Submissions of clinical information after 3:10 p.m. Central time may result in a denial of authorization.

We will communicate approved days and bed-level coverage to the hospital for any continued stay.

Precertification/Admission Notification: Precertification request and notification of intent to render covered inpatient and outpatient medical services	Fax: **1-877-269-5705** Call: **1-844-521-6942** Web: Log in at **https://providers.healthybluela.com**
Inpatient Utilization Management: Emergent inpatient admissions require clinical information be submitted for medical necessity review	Fax: **1-888-822-5595** Call: **1-844-521-6942**
Behavioral Health Inpatient Utilization Management: Psychiatric and substance use inpatient admissions require clinical information be submitted for medical necessity review	Fax: **1-844-432-6027** Call: **1-844-521-6942**

6.8. Discharge Planning

Our Utilization Management clinicians coordinate our members' discharge planning needs with:

- The hospital's Utilization Review and/or Case Management staff.

- The attending physician.

We review discharge plans daily. As part of discharge planning, clinicians will try to meet with the member and family when necessary to:
- Discuss any discharge planning needs.
- Verify the member's PCP, address and phone number.

The attending physician is responsible for coordinating follow-up care with the member's PCP.

For ongoing care, we work with the provider to plan the discharge to an appropriate setting, such as a:
- Hospice facility.
- Physical rehabilitation facility.
- Home health care program (for example, home IV antibiotics).
- Long-term acute care.
- Skilled nursing facility.

Precertifications for post-admissions include but are not limited to:
- Home health.
- DME.
- Pharmacy.
- Outpatient medical injectables.
- Follow-up visits to certain practitioners.
- Outpatient procedures.
- Outpatient rehabilitation.

6.9. Confidentiality of Information and Misrouted Protected Health Information

The following ensure members' protected health information (PHI) is kept confidential:
- Utilization management
- Case management
- DM
- Discharge planning
- Quality management
- Claims payment
- Pharmacy

PHI is shared only with those individuals who need access to it to conduct utilization management.

Providers and facilities are required to review all member information received from the state to ensure no misrouted PHI is included. Misrouted PHI includes information about members who a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, they should call our Provider Services team at **1-844-521-6942** for instructions on what to do with it.

6.10. Emergency Services

Emergency services, including those for specialized behavioral health, don't require precertification. Healthy Blue covers and pays for emergency services, regardless of whether the provider that furnishes the emergency services is contracted with us. Healthy Blue will not deny payment for treatment obtained when a member had an emergency medical condition, as defined in *42 CFR §438.114(a)*, nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms. We do not deny or discourage our members from using 911 or accessing emergency services. As a matter of course, we grant authorizations for these services immediately.

When a member seeks emergency services at a hospital, he or she is examined by a licensed physician to determine if a need exists for such services. The physician will note the results of the emergency medical screening examination on the member's chart.

The attending emergency physician or the provider treating the member will determine when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on Healthy Blue for coverage and payment. If there is a disagreement between a hospital or other treating facility and Healthy Blue concerning whether the member is stable enough for discharge or transfer from the emergency room, the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on Healthy Blue. This does not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized. If the emergency department cannot stabilize and release our member, we will help coordinate the inpatient admission.

Any transfer from a non-network hospital to a network hospital can only take place after the member is medically stable.

6.11. Urgent Care and After-Hours Care

We strongly encourage our members to contact their PCPs if they need urgent care. If you are unable to see the member, you can refer them to one of our participating urgent care centers or another provider who offers after-hours care. Precertification is not required.

We strongly encourage PCPs to provide evening and weekend appointment access to members. We encourage two hours at least one day per week after 5 p.m., and four hours or longer on Saturday. To learn more about participating in the after-hours care program, call your local Provider Relations representative.

6.12. Prior Authorization Criteria and Notice to Providers

Per Act No. 330 (Louisiana 2019 Regular Session, House Bill No. 424), the prior authorization requirements of Healthy Blue, including prior authorization requirements applicable in the Medicaid pharmacy program, will either be furnished to the healthcare provider within 24 hours of a request for the requirements or posted in an easily searchable format on the website of Healthy Blue. Information posted in accordance with the requirements of §460.74 will include the date of last review.

If Healthy Blue denies a prior authorization request, then Healthy Blue will provide written notice of the denial to the provider requesting the prior authorization within three business days of making the decision. If the denial of the prior authorization by Healthy Blue is based upon an interpretation of a law, regulation, policy, procedure, or medical criteria or guideline, then the notice shall contain either instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline in the public domain or an actual copy of that law, regulation, policy, procedure, or medical criteria or guideline.

7. QUALITY MANAGEMENT

7.1. Quality Management Program

We have a comprehensive Quality Management (QM) program to monitor the demographic and epidemiologic needs of the population served. We evaluate the needs of the health plan's specific population annually, including:

- Age/sex distribution.
- Inpatient, emergent/urgent care.
- Office visits by type, cost and volume.

In this way, we can define high-volume, high-risk and problem-prone conditions.
To contact the QM department about quality concerns or to make recommendations for areas of improvement, call **1-844-521-6942**.

7.2. Quality of Care

We evaluate all physicians, advanced registered nurse practitioners, licensed mental health professinals and physician assistants for compliance with:

- Medical community standards.
- External regulatory and accrediting agencies' requirements.
- Contractual compliance.

We share these reviews to enable you to increase individual and collaborative rates for members. Our quality program includes a review of quality of care issues for all care settings using:

- Member complaints.
- Reported adverse events.
- Other information.

The results are submitted to our QM department and incorporated into a profile.

7.3. Quality Management Committee

The quality management committee's (QMC's) responsibilities are to:

- Establish strategic direction and monitor and support implementation of the QM program.
- Establish processes and structure that ensure National Committee for Quality Assurance (NCQA) compliance.
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies.
- Coordinate communication of QM activities.
- Review HEDIS data and action plans for improvement.
- Review and approve the annual QM program description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight and review of delegated services.
- Provide oversight and review of subordinate committees.
- Receive and review reports of utilization review decisions and take action when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the health plan's operational indicators through the plan's senior staff.

7.4. Use of Performance Data

Practitioners and providers must allow Healthy Blue to use performance data in cooperation with our quality improvement program and activities.

7.5. Medical Review Criteria

Our medical policies, which are publicly accessible from our website, are the primary plan policies for determining whether services are considered to be:

- Investigational/experimental.
- Medically necessary.
- Cosmetic or reconstructive.

MCG Care Guidelines criteria will be used when no specific Healthy Blue medical policies exist. In the absence of licensed MCG Care Guidelines criteria, we may use our *Clinical Utilization Management (UM) Guidelines*. A list of the specific *Clinical UM Guidelines* used will be posted and maintained on our website and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede both MCG Care Guidelines and our medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

7.6. Clinical Criteria

Healthy Blue utilization reviewers currently use MCG Care Guidelines criteria for inpatient concurrent clinical decision support for medical management coverage decisions and for discharge planning. The criteria provide a system for screening proposed medical care based on member-specific, best medical care practices and rule-based systems to match appropriate services to member needs based on clinical appropriateness. Criteria include:

- Acute care.
- Long-term acute care.
- Rehabilitation.
- Subacute and skilled nursing facility.

You can obtain copies of the criteria used in a case to make a clinical determination by calling Provider Services or your local Healthy Blue office. You may also submit your request in writing to:

Medical Management
Healthy Blue
10000 Perkins Rowe, Suite G-510
Baton Rouge, LA 70810

AIM Specialty Health manages precertification for the following modalities:

- Computed tomography (CT/CTA)
- Magnetic resonance (MRI/MRA)
- Positron emission tomography (PET) scans
- Nuclear cardiology
- Echocardiography

  - Stress echo
  - Resting transthoracic echo
  - Transesophageal echo
- Radiation oncology
- Sleep medicine
- Cardiology services
- Musculoskeletal (Spine therapy)

AIM clinical appropriateness guidelines and Healthy Blue medical policies will be used. AIM guidelines are available online at **www.aimspecialtyhealth.com**.

The program includes outpatient hospital and office settings only. Included settings are hospital – outpatient only, free-standing imaging centers and physician offices. Excluded settings are inpatient hospital, emergency room, observation and ambulatory surgery centers.

You can contact AIM Specialty Health at **1-800-714-0040** or visit **www.aimspecialtyhealth.com/goweb** to submit a request.

7.7. Informal Reconsideration/Peer-to-Peer Discussion

If our medical director denies coverage of a request, the appropriate notice of proposed action, including the member's appeal rights, will be mailed to the requesting provider, the member's PCP and/or servicing physician, and the member.

As a provider acting on behalf of a member, you have the right to discuss this decision with our medical director by calling our Health Care Management department at **1-877-440-4065, ext. 106-103-5145**.

Peer-to-peer (P2P) discussion guidelines:

- The member, or provider/agent on behalf of a member, may request a P2P within 10 business days from the notification of a medical necessity denial.
- A provider, acting on behalf of a member, must submit the member's written consent in order to be eligible to participate in a P2P discussion concerning a prospective service (proposed admission, procedure, or service not yet rendered). Consent of the member who received a service is not required for a provider to act regarding a concurrent or post-service denial.
- Requests for P2Ps will be handled within one working day of the request.
- If the P2P discussion is not completed within the specified time frame, the formal appeal process will need to be followed.
- We will not complete P2P discussions on retrospective-eligible, postdischarge hospitalizations. For retrospective-eligible, postdischarge adverse determinations, follow the formal appeal process.

The medical director will make two attempts to connect with the provider at the provider's specified contact number. If the provider fails to respond, the request for a P2P will be closed and the provider's next course of action will be to follow the formal appeal process.

7.8. Medical Advisory Committee

We have established a medical advisory committee (MAC) to:

- Assess levels and quality of care provided to our members.
- Recommend, evaluate and monitor standards of care.

- Identify opportunities to improve services and clinical performance by establishing, reviewing and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk and problem-prone conditions.
- Oversee the peer review process.
- Conduct network maintenance through the credentialing/recredentialing process.
- Advise the health plan administration on any aspect of the health plan policy or operation affecting network providers or members.
- Approve and provide oversight of the peer review process and the QM and Utilization Review programs.
- Oversee and make recommendations regarding health promotion activities.
- Use an ongoing peer review system for:
  - Monitoring practice patterns.
  - Identifying appropriateness of care.
  - Improving risk prevention activities.
- Approve clinical protocols and guidelines.
- Review clinical study designs and results.
- Develop action plans and/or recommendations regarding clinical quality improvement studies.
- Consider or act in response to provider sanctions.
- Provide oversight of credentialing committee decisions to credential/recredential providers.
- Approve credentialing/recredentialing policies and procedures.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

7.9. Utilization Management Staff

Healthy Blue, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Healthy Blue does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

UM staff are available as follows:

- Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.

7.10. Utilization Management Committee

We have a utilization management committee (UMC) to provide relevant UM information to the QM program for quality improvement activities. This includes identifying quality of care concerns, disproportionate utilization trends, duplicative services, adverse access patterns, and lack of continuity and coordination of care processes.

The UMC achieves its goals and objectives by working collaboratively with a variety of other departments external to our Health Care Management department such as our Regulatory, Compliance, Provider Contracting/Provider Relations, Clinical Informatics, Quality, Pharmacy, Medical Finance and the National Customer Care (NCC) departments, which include Member Services.

The UMC is responsible for providing oversight of UM activities at the plan, provider and membership levels. The UMC convenes no less than quarterly but will meet on an ad-hoc basis as needed. Meeting minutes will be taken at each UMC meeting, and those minutes will be submitted to the Louisiana Department of Health.

The committee responsibilities include but are not limited to the following:

- Monitoring providers' requests for rendering health care services to its members through the medical necessity and authorization process
- Monitoring the medical appropriateness and necessity of health care services provided to its members utilizing providers quality and utilization profiling
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed
- Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task
- Monitoring consistent application of medical necessity criteria
- Monitoring application of clinical practice guidelines
- Monitoring over/under and duplicative utilization as well as outlier trends

7.11. Credentialing

Credentialing is an industry-standard, systemic approach to the collection and verification of an applicant's professional qualifications. This approach includes a review of relevant training, licensure, certification and/or registration to practice in a health care field as well as academic background.

The credentialing process evaluates the information gathered and verified and includes an assessment of whether the applicant meets certain criteria relating to professional competence and conduct. We use the NCQA's current *Standards and Guidelines for the Accreditation of Managed Care Organizations* as well as state-specific requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom we contract. This process is completed before a practitioner or provider is accepted for participation in the Healthy Blue network.

Credentialing Requirements

To become a participating Healthy Blue provider, you must hold a current, unrestricted license issued by the state. You must also comply with the Healthy Blue credentialing criteria and submit all additionally requested information. A complete Louisiana state credentialing application (practitioners) or a Healthy Blue ancillary/facility application and all required attachments must be submitted to initiate the process. Healthy Blue will completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement.

We are one of more than 600 participating health plans, hospitals and health care organizations that currently utilize the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data Source (UPD) for gathering credentialing data for physicians and other health care professionals. Under this program, practitioners use a standard application (state-mandated applications are included in the UPD) and a common database to submit an electronic application.

Credentialing Procedures

We credential the following provider types:

- Doctors of medicine
- Doctors of osteopathic medicine
- Doctors of dental surgery
- Doctors of dental medicine
- Doctors of podiatric medicine
- Doctors of chiropractic medicine
- Physician assistants
- Optometrists
- Nurse practitioners
- Certified nurse midwives
- Physical/occupational therapists
- Speech/language therapists
- Hospitals and allied services (ancillary) providers
- Other applicable or appropriate mid-level providers

We have a credentialing committee comprised of licensed practitioners to review credentialing and recredentialing applicants, delegated groups, and sanction activity related to existing network participants.

The credentialing committee is also responsible for the creation and regular review of all policies and procedures relevant to the credentialing program. We revise our credentialing policy periodically and no less frequently than annually, based on input from state and federal requirements as well as our credentialing committee, medical director and chief medical officer.

By signing the application, providers must attest to the accuracy of their credentials. If there are discrepancies between the application and the information obtained during the external verification process, the Healthy Blue Credentialing department will investigate them. Practitioners and providers will be notified by phone or in writing if any information obtained during the process varies substantially from what was submitted.

Discrepancies may be grounds for our denial of network participation or the termination of an existing contractual relationship.

The following elements are reviewed in the course of credentialing. Most of these elements are also included at the time of recredentialing:

- **Board certification:** Acceptable sources of verification include but are not limited to the following:
  - American Medical Association Provider Profile
  - American Osteopathic Association
  - American Board of Medical Specialties
  - American Board of Podiatric Surgery
  - American Board of Podiatric Orthopedics and Primary Podiatric Medicine
- **Education and training:** Education and training will be verified for all practitioners at the time of initial credentialing. Acceptable sources of verification include but are not limited to the following:
  - Board certification
  - State-licensing agency
  - Educational institution
- **Work history:** A full work history, documenting at least the prior five years, must be submitted at the time of practitioner credentialing. Any gaps in work history greater than six months must be explained in written format.
- **Hospital affiliations and privileges:** Network providers must have clinical privileges, as appropriate to their scope of practice, in good standing at an Healthy Blue network hospital.
- **State licensure or certification:** Initial credentialing applicants must have a current legal state license or certification. This information will be verified by referencing data provided to us by the state via the following:
  - Roster

  - Phone
  - Written verification
  - Internet
- **Drug Enforcement Administration (DEA) number:** Initial practitioner applicants must provide their current DEA numbers to Healthy Blue for verification. State-controlled substance certificates, when applicable, will also be queried for verification.
- **Evidence of professional and general liability coverage:** We will verify practitioner and provider malpractice coverage at the time of initial credentialing. A copy of the malpractice face sheet will provide evidence of coverage. In addition, an attestation that includes the following information may be used:
  - Name of the carrier
  - Policy number
  - Coverage limits
  - Effective and expiration dates of such malpractice coverage

  As a practitioner or a provider, you must maintain professional and general liability insurance in specified amounts in accordance with your Healthy Blue contract.
- **Professional liability claims history:** Initial credentialing applicants will be asked to provide a full professional liability claims history. This information will be assessed along with a query of the National Practitioner Data Bank (NPDB).
- **CMS sanctions:** All initial credentialing practitioner and provider applicants must not have any CMS sanctions. This information is verified by accessing the NPDB or Office of Inspector General.
- **Disclosures — attestation and release of information:** All initial credentialing applicants must respond to questions, including within the application, regarding the following:
  - Reasons for being unable to perform the essential functions of the position with or without accommodation
  - History or current problems with chemical dependency, alcohol abuse or substance use
  - History of license revocations, suspension, voluntary relinquishment, probationary status, or other licensure conditions or limitations
  - History of conviction of any criminal offense other than minor traffic violations
  - History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
  - History of complaints or adverse action reports filed with a local, state or national professional society or licensing board
  - History of refusal or cancellation of professional liability insurance
  - History of suspension or revocation of a DEA or controlled dangerous substances certificate
  - History of any CMS sanctions
  - Applicants must also provide an:
    - Attestation of the correctness and completeness of the application
    - Explanation in writing of any identified issues
- **Disclosure of ownership:** CMS requires us to obtain certain information regarding the ownership and control of entities with which we contract for services for federal employees or federal health plans. This form is required for participation in the Healthy Blue network. All individuals and entities included on the form must be clear of any sanctions by CMS.
- **License history:** The appropriate state-licensing board/agency is queried along with the NPDB as part of the credentialing process.
- **Prohibited affiliations:** In accordance with *42 CFR §438.610*, Healthy Blue is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from

participating in procurement activities under the federal regulations issued under *Executive Order No. 12549* or under guidelines implementing *Executive Order No. 12549*.

Healthy Blue complies with all applicable provisions of *42 CFR §438.610* pertaining to debarment and/or suspension. Healthy Blue screens all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs. To help make this determination, Healthy Blue conducts screenings to comply with the requirements set forth in *42 CFR §455.436*.

Healthy Blue searches the following websites:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- Louisiana Adverse Actions List Search
- The System of Award Management (SAM)
- Other applicable sites as may be determined by LDH

Healthy Blue conducts a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered is reported to LDH within three business days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See *Section 1128A (a)(6)* of the *Social Security Act* and *42 CFR §1003.102(a)(2)*.

An individual who is an affiliate of a person described above includes:

- A director, officer or partner of Healthy Blue.
- A person with beneficial ownership of 5% or more of Healthy Blue's equity.
- A person with an employment, consulting or other arrangement with Healthy Blue for the provision of items and services that are significant and material to Healthy Blue's obligations.

Healthy Blue will notify LDH within three days of the time it receives notice that action is being taken against the MCO or any person defined above or under the provisions of Section 1128(a) or (b) of the *Social Security Act* (*42 U.S.C. §1320a-7*) or any contractor that could result in exclusion, debarment or suspension of Healthy Blue or a contractor from the Medicaid or CHIP program or any program listed in *Executive Order 12549*.

Recredentialing

Recredentialing is required every three years by the state of Louisiana and NCQA. We will perform recredentialing at least every 36 months if not earlier.Network practitioners and providers will receive requests for recredentialing applications and supporting documentation in advance of the 36-month anniversary of their original credentialing or last credentialing cycle. We will provide a minimum of three written notices beginning six (6) months prior to termination of credentialing with the information needed for recredentialing, including requirements and deadlines for compliance. Information from quality improvement activities and member complaints will be assessed, along with assessments and verifications listed above.

Your Rights in the Credentialing and Recredentialing Process
You can request a status of your application by phone, fax, mail or email (la1cred@healthybluela.com).

You have the right to:
- Review information submitted to support your credentialing application.
- Explain information obtained that may vary substantially from what you provided.
- Provide corrections to any erroneous information submitted by another party.

You can do this by submission of a written explanation or by appearance before the credentialing committee.

The Healthy Blue medical director has authority to approve clean files without input from the credentialing committee; all files not designated as clean will be sent to the credentialing committee for review and a decision regarding network participation.

We will inform you of the credentialing committee's decision in writing within 60 days. If your continued participation is denied, you can appeal this decision in writing within 30 days of the date of the denial letter.

Organizational Providers
Your signature on the application attests that you agree to the assessment requirements. The following providers require assessments:
- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Ambulatory surgical centers
- Behavioral health facilities

The following steps are included in the Healthy Blue organizational provider credentialing process:
- A review and primary source verification of a current copy of the state license
- A review and investigation of any restrictions to a license that could impact participation in the network
- A review and primary source verification of any Medicare or Medicaid sanctions
- A review and verification of accreditation by one of the following:
  - Hospitals (for example, acute, transitional or rehabilitation)
    - The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
    - Healthcare Facilities Accreditation Program
    - American Osteopathic Association
  - Rehabilitation facilities
    - CARF, formerly the Commission on Accreditation of Rehabilitation Facilities
  - Home health agencies
    - TJC
    - Community Health Accreditation Program
  - Nursing homes
    - TJC
  - Ambulatory surgical centers
    - TJC

- Accreditation Association for Ambulatory Health Care

If your facility, ancillary or hospital is not accredited, a copy of a recent state or CMS review may be submitted in lieu of performing an onsite review. If there is no current accreditation or a recent state or CMS review, we will perform an onsite review.

Agencies offering mental health rehabilitation services (community psychiatric supportive treatment psychosocial rehabilitation and/or community integration), assertive community treatment, PRTFs, Therapeutic group homes and substance use disorder residential treatment facilities must supply proof of accreditation by an LDH-approved accrediting body. We'll add this proof to the agency's Healthy Blue credentialing file.

Agencies not accredited at the time of credentialing must supply proof that the agency applied for accreditation and paid the initial application fee and then present proof of full accreditation within 18 months of their initial contracting date with Healthy Blue.

Specialized behavioral health providers who are required to be accredited by rule, regulation, waiver or state plan amendment prior to contracting or prior to receiving Medicaid reimbursement must have proof of accreditation on file with Healthy Blue.

Evidence of malpractice insurance, in amounts specified in the provider contract and in accordance with Healthy Blue policy, must also be included at the time of contracting/credentialing.

We will track a facility's/ancillary's reassessment date and reassess every 36 months or sooner as applicable. The requirements for recredentialing are the same for reassessment as they are for the initial assessment.

The organizational provider or ancillary will:
- Be notified either by phone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted.
- Have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation.

Delegated Credentialing
Provider groups with strong credentialing programs that meet our credentialing standards may be evaluated for delegation. As part of this process, we will conduct a predelegation assessment of a group's credentialing policy and program as well as an onsite evaluation of credentialing files. A passing score is considered to be an overall average of 90% compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or restrict the level of delegation.

We may waive the need for the predelegation onsite audit if the group's credentialing program is NCQA-certified for all credentialing and recredentialing elements.

We are responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

Healthy Blue does not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.

7.12. Peer Review

We continuously monitor the quality and appropriateness of care of our practitioner and provider network through peer review. Peer review responsibilities are to:

- Participate in the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.
- Work in accordance with the executive medical director.

If an investigation of a member grievance results in concern regarding your compliance with community standards of care or service, all elements of peer review will be followed.

We apply dissatisfaction severity codes and levels of severity to quality issues. Peer review includes investigation of physician actions by the medical director. The medical director:

- Assigns a level of severity to the grievance.
- Invites the cooperation of the physician.
- Consults with and informs the MAC and peer review committee.
- Informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken.

We report outcomes to the appropriate internal and external entities, including the quality management committee.

The peer review process is a major component of the MAC's monthly agenda. The peer review policy is available upon request.

8. PROVIDER DISPUTE PROCEDURES

8.1. Provider as Member Representative

A provider may act as the member's representative to file an appeal or grievance. To act as a member's representative, the provider must have the written consent signed by the member and follow the time frames and processes for member grievances and appeals (see the **Member Grievances Section**).

8.2. Provider Grievances

Providers can submit verbal or written grievances. Supporting documentation should accompany the grievance. Grievances are resolved fairly and are consistent with our policies and covered benefits. You will not be penalized for filing a grievance.
Submit verbal grievances to:

- Provider Services at **1-844-521-6942**.
- Our local office at **1-504-836-8888**.
- Your local Provider Relations representative.

Submit written grievances to:
Healthy Blue
10000 Perkins Rowe, Suite G-510
Baton Rouge, LA 70810
Fax: **1-504-836-8860**

If the outcome of our review is adverse to you, we will provide a written notice of adverse action. You can also appear in person at the address above to submit a complaint.

8.3. Avoiding an Administrative Adverse Decision

Most administrative adverse decisions result from nonadherence to, or a misunderstanding of, utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or benefits. Such information is readily available by calling **1-844-521-6942**.

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based national guidelines. We are committed to working with all providers to ensure that such guidelines are understood and easily identifiable for providers.
Peer-to-peer conversations (between a medical director and the provider clinicians) are one way to ensure the completeness and accuracy of the clinical information.

Medical record reviews are another way to ensure clinical information is complete and accurate. Providers who can appropriately respond in a timely fashion to peer-to-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. We are committed to ensuring a process that is quick and easy and will work with participating providers to ensure a mutually satisfying process.

8.4. Provider Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may begin the Healthy Blue provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized but you disagree with the outcome.

In cases where your claim is denied, the consent of a Member who received the services is not required in order for you to dispute the denial of the claim. You may pursue a claim dispute on the basis of non-payment for rendered services under the terms and conditions outlined in your contract with Healthy Blue. The Member who received the services is not required to sign an authorized representative form, or provide other forms of written consent, for you to dispute the denied claim for payment.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Inappropriate or unapproved referrals initiated by providers.
- Retrospective review.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* Healthy Blue will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Please be aware, there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim inquiry:** A question about a claim, but not a request to change a claim payment (see the **Claim Inquiry section** for more information).
- **Claims correspondence:** When Healthy Blue requests further information to finalize a claim. Typically, these requests include medical records, itemized bills or information about other insurance a member may have. A full list of correspondence-related materials are in the **Claim Correspondence** section of this provider manual.
- **Medical necessity appeal:** A preservice appeal for a denied service. For these, a claim has not yet been submitted (see the **Medical Necessity Appeals** section for more information).

The Healthy Blue provider payment dispute process consists of two internal steps. Additionally, there are two external options. You will not be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the Healthy Blue provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.

2. **Claim payment appeal:** This is the second step in the Healthy Blue provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **Independent review:** This external review process was established by *LA-RS 46:460.81, et seg*. to resolve claims disputed when a provider believes an MCO has denied claims incorrectly in part or in full.
4. **Binding arbitration:** The state of Louisiana supports an external arbitrator review process if you have exhausted all steps in the Healthy Blue payment dispute process but still disagree with the outcome.

8.5. Claim Payment Reconsideration

The first step in the Healthy Blue claim payment dispute process is called the reconsideration. The reconsideration is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider website within 180 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 180 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Healthy Blue professionals.

Healthy Blue will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action Healthy Blue intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider’s right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.
7. A statement that the completion of the Healthy Blue claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *Explanation of Payment* (*EOP*) will be sent separately.

8.6. Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 30 calendar days from the date on the reconsideration determination letter.

Claim payment appeals received beyond 30 calendar days will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Healthy Blue professionals.

Healthy Blue will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The claim payment appeal determination letter will include:

1. A statement of the provider's claims payment appeal request.
2. Date of initial filings of concern.
3. A statement of what action Healthy Blue intends to take or has taken.
4. The reason for the action.
5. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

If you are dissatisfied with the level I resolution, you may file a request for a level II review. We must receive your request within 30 calendar days of the date of the level I determination letter. We will issue a determination within 30 days of receipt of the level II request. Send requests to:

Healthy Blue
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

8.7. How to Submit a Claim Payment Dispute

You can submit your verbal or written payment disputes within 180 calendar days of the date of the *EOP*. Complete the *Claim Payment Appeal Submissions Form* located on our website and note the following submission methods:

- **Verbal (reconsideration only):** Verbal submissions may be submitted by calling Provider Services at **1-844-521-6942**.

- **Online (reconsideration and claim payment appeal)**: Healthy Blue can receive reconsiderations and claim payment appeals via the secure Provider Availity Payment Appeal Tool at **https://www.availity.com**. You can upload supporting documentation, and you will receive immediate acknowledgement of your submission.
- **Written (reconsideration and claim payment appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the appropriate form, to:
  Provider Payment Disputes
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Submission forms are available on the Healthy Blue provider website in the *Forms* section.

8.8. Required Documentation for Claims Payment Disputes

Healthy Blue requires the following information when submitting a claim payment reconsideration or claim payment appeal:

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Healthy Blue or Medicaid ID number
- A listing of disputed claims, which should include the Healthy Blue claim number and the date(s) of service(s)
- All supporting statements and documentation, including a copy of the *EOP* and a copy of the claim

8.9. Independent Review

The independent review process was established by *La-RS 46:460.81, et seq*. to resolve claim disputes when a provider believes an MCO has partially or totally denied claims incorrectly. An MCO's failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the MCO's receipt of the claim is considered a claims denial.

Independent review is a two-step process that can be initiated by submitting an *Independent Review Provider Reconsideration Request Form* to us within 180 calendar days of the remittance advice paid, denial or recoupment date. This request form is available on our website (Provider Support > Forms > Claims & Billing) or at the LDH link below.

Please make sure to complete all required information on the form and to include the requestor's name, email address, phone number, and provider name or the group the provider is affiliated with. Send the completed request form via:

- Email: HealthyBlueIndependentReview@HealthyBlueLA.com
- Mail: Healthy Blue
  Attention: Independent Review
  10000 Perkins Rowe, Suite G-510
  Baton Rouge, LA 70810

If you remain dissatisfied with the outcome of an independent review reconsideration request, you can submit an *Independent Review Provider Reconsideration Request Form* to LDH within 60 calendar days of our decision (this request form is available at the link below). Healthy Blue will acknowledge the Independent Review request within five (5) days and render a decision within 45 days. Please note, there is a $750 fee

associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCO is responsible for paying the fee. If the independent reviewer finds in favor of the MCO, the provider is responsible for paying the fee.

Fraud, waste and abuse-related post-payment reviews are not considered claims denials or underpayment disputes; therefore, fraud, waste and abuse-related findings are exempt from the Independent Review Process. Providers should follow Healthy Blue's escalation and resolution process for fraud, waste and abuse-related cases that include arbitration.

LDH provides additional detailed information and copies of the above-referenced forms at: **http://ldh.la.gov/index.cfm/page/2982**.

8.10. Binding Arbitration

After all internal dispute levels have been exhausted, either party may request binding arbitration, except to the extent the parties have agreed in the *Provider Agreement* to use an alternate means of binding dispute resolution. The parties will select an arbitrator who has experience and expertise in the health care field, in accordance with the rules of the American Arbitration Association. The arbitrator will conduct a hearing and issue a final ruling. Any arbitration fees and expenses will be paid equally by Healthy Blue and the other party or parties within 30 calendar days of receipt of the bill or in a time frame otherwise required under the arbitration rules. Each party will be responsible for its own attorney's fees arising out of or related to the arbitration.

8.11. Provider Complaints

Providers can seek resolution through an escalation process of all issue types, including claims payment, dissatisfaction with a policy or any administrative functions.
Providers can escalate issues or concerns by following

- Process as outlined in Informational Bulletin 19-3: Medicaid Managed Care Provider Issue Resolution **http://ldh.la.gov/index.cfm/page/3714**
- Utilize the Provider Complaint Form located **https://providers.healthybluela.com/la/pages/forms.aspx**
- Submit an email with supporting documentation to **laprovidercomp@healthybluela.com**

9. CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

9.1. Claims Submission

You have the option of submitting claims electronically or by mail. We encourage you to submit claims electronically, as you will be able to:

- Submit claims either through a clearinghouse or directly to Healthy Blue.
- Receive payments quickly.
- Eliminate paper.
- Save money.

Clearinghouse Submission
You can submit electronic claims through Electronic Data Interchange (EDI). You must submit claims within 365 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services. Because of the importance of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings and the collection of data related to these services, we encourage you to submit EPSDT claims as soon as possible within the timely filing period. For more information about how to exchange electronic transactions, call the EDI Hotline at **1-800-470-9630** Monday to Friday, from 8 a.m. to 4:30 p.m. Eastern time, or email e-solutions.support@anthem.com.

Website Submission
Submit claims on our website by:

- Entering claims on a preformatted *CMS-1500* or *CMS-1450* claim template.
- Uploading a HIPAA-compliant ANSI 837 5010 claim transaction.

The Availity Portal is available for claim filing, claim status inquiries, member eligibility and benefits information at:

https://www.availity.com
1-800-AVAILITY (**1-800-282-4548**)
Support@availity.com

Paper Claims Submission
You must submit a properly completed *CMS-1450* or *CMS-1500 (08-05)* claim form:

- Within 365 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services; EPSDT screening claims should be filed as soon as possible within the timely filing period.
- On the original claim form with “drop out” red ink.
- Computer-printed or typed.
- In a large, dark font.

Submit paper claims to:

Healthy Blue
Claims Department
P.O. Box 61010
Virginia Beach, VA 23466-1010

Timely Filing Guidelines
Medicaid-only claims must be filed within 365 days of the date of service. Electronic submission of pharmacy claims (reversals and resubmittals) will be allowed to process electronically within 365 days of service.

Claims involving third party liability must be submitted within 365 days from the date of service. Medicare claims must be submitted within six months of Medicare adjudication.

Healthy Blue will deny any claim not initially submitted to Healthy Blue by the 365th calendar day from the date of service, unless LDH, Healthy Blue or its sub-contractors created the error. Healthy Blue will not deny claims solely for failure to meet timely filing guidelines due to error by LDH or its subcontractors.

For purposes of Healthy Blue reporting on payment to providers, an adjustment to a paid claim will not be counted as a claim and electronic claims will be treated as identical to paper based claims.

Healthy Blue will not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is 180 days from the member's linkage to Healthy Blue. The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted to Healthy Blue by the latter of the 365th calendar day from the date of service or 180 days from the member's linkage to Healthy Blue.

There are exceptions to the timely filing requirements. They include the following:
- For cases of coordination of benefits/subrogation, the time frame for filing a claim will begin on the date of the primary carrier's *Explanation of Benefits* or 365 days from the date of discharge for inpatient services.
- Administrative corrections for retro-enrolled members require special handling to prevent the possibility of incorrect denials.* Moving forward, claims submissions related to Legacy Medicaid administrative corrections for retro-enrolled members should be submitted to:
  Healthy Blue
  Internal Resolution Unit
  10000 Perkins Rowe, Suite G-510
  Baton Rouge, LA 70810

* Medical records for retro-enrolled members may be faxed to **1-888-822-5595** for inpatient or **1-888-822-5658** for outpatient. Please note, this does not apply to behavioral health retro-enrolled members.

As a reminder, the following information applies to administrative retroactive correction claims:
- Claims must be submitted via paper/hard copy.
- A copy of the voided *Explanation of Payment* is required for documentation purposes.
- Claims received more than six months after the date the claim is voided will be denied for untimely filing.

Claim forms must include the following information (HIPAA-compliant where applicable):
- Member's ID number
- Member's name
- Member's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service

- Procedures, services or supplies rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Billing provider information
- NPI of billing and rendering provider when applicable
- Coordination of benefits/other insurance information
- Precertification number or copy of precertification
- Name of referring physician
- NPI/API
- NDC, unit of measure and quantity for medical injectables
- Any other state-required data

We cannot accept claims with alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return.

CMS-1500 and *CMS-1450* forms are available from the Centers for Medicare & Medicaid Services at **www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html.**

9.2. International Classification of Diseases, 10th Revision (ICD-10)

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

What is ICD-10?
International Classification of Diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:
- ICD-10-CM (Clinical Modification) is used for diagnosis coding.
- ICD-10-PCS (Procedure Coding System) is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS will replace ICD-9-CM, Volume 3 for inpatient hospital procedure coding.

9.3. Encounter Data

If you are reimbursed by capitation, you must send us encounter data for each member encounter.

You must submit encounter data no later than 365 calendar days from the date of service through:

- EDI submission methods.
- A *CMS-1500* (*08-05*) claim form.
- Other arrangements that are approved by Healthy Blue.

EPSDT screening claims should be filed as soon as possible within the timely filing period.

Include the following:
- Member name (first and last name)
- Member date of birth
- Provider name according to contract
- Healthy Blue provider ID
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider tax ID number
- NPI/API

Our Utilization and Quality Improvement staff monitors compliance, coordinates it with the medical director and then reports to the quality management committee on a quarterly basis. Lack of compliance will result in:
- Training.
- Follow-up audits.
- Even termination.

9.4. Claims Adjudication

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals.

You must use HIPAA-compliant billing codes when billing Healthy Blue electronically or on paper. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. We will reject claims submitted with noncompliant billing codes.

We reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

Whether you submit claims through EDI or on paper, use our claims guide charts in **Appendix A** to ensure you submit clean and complete claims.

For your claims payment to be considered, you must adhere to the following time limits:
- Submit claims within 365 calendar days:
  - From the date of service (including in cases of other insurance)
  - From the date of discharge for inpatient claims filed by a hospital
- Submit claims for EPSDT services as soon as possible within the timely filing period
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within six months from the date Medicaid voided the claim

We will deny claims submitted after the filing deadline.

Our claims payment system requires you to split bill claims that span more than one calendar year. Split billing of hospital claims is required in the following circumstances:

- Claims spanning more than one calendar year.
- Claims spanning the hospital's fiscal year end
- Change of hospital ownership
- Claims with charges that exceed $999,999.99
- Claims with more than one revenue code that utilizes specialized per diem pricing (NICU, pediatric intensive care unit etc.)

9.5. Claims Processing and Reprocessing

Healthy Blue ensures that all provider claims are processed according to the following timeframes:

- Within five business days of receipt of a claim, Healthy Blue will perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.
- Process and pay or deny, as appropriate, at least 90% of all clean claims for each claim type, within 15 business days of the receipt.
- Process and pay or deny, as appropriate, at least 99% of all clean claims for each claim type, within 30 calendar days of the date of receipt.
- Fully adjudicate (pay or deny) all pended claims within 60 calendar days of the date of receipt.

If Healthy Blue or LDH or its subcontractors discover errors made by Healthy Blue when a claim was adjudicated, Healthy Blue will make corrections and reprocess the claim within 30 calendar days of discovery, or if circumstances exist that prevent Healthy Blue from meeting this time frame, a specified date will be approved by LDH. Healthy Blue will automatically recycle all impacted claims for all providers and will not require the provider to resubmit the impacted claims.

9.6. Rejected Claims

Healthy Blue may reject claims because of missing or incomplete information. Paper claims that are received by Healthy Blue that are screened and rejected prior to scanning will be returned to the provider with a letter notifying them of the rejection. Paper claims received by Healthy Blue that are scanned prior to screening and then rejected, are not required to accompany the rejection letter.

A rejected claim will not appear on the Remittance Advice (RA) because it will not have entered the claims processing system.

The rejection letter will indicate why the claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, will include the following:

- The date the letter was generated;
- The patient or member name;
- Provider identification, if available, such as provider ID number, TIN or NPI;
- The date of each service;
- The patient account number assigned by the provider;
- The total billed charges;

- The date the claim was received; and
- The reasons for rejection.

Update to Remittance Advices
Healthy Blue has updated its paper and electronic remittance advices, as required by Act 330 (HB424), to provide additional information used to make certain claim denial determinations.

Blue has created an Explanation of Benefits (EOB) matrix that identifies the following reference materials used to make a claim denial determination:
- Applicable law
- Regulation
- Policy
- Procedure
- Medical criteria
- Guideline

Accessing the EOB matrix A link to the EOB matrix, which includes claims denial explanations, can be found on website at **https://providers.healthybluela.com** > Provider Support > Quality Assurance > **Medical Policies and Clinical Utilization Management Guidelines**.

The link will also be provided on:
- Paper remittance advices in the message section.
- 835 electronic remittance advices in the payer identification section.

9.7. Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:
- Is submitted on time.
- Is accurate.
- Is submitted on a HIPAA-compliant standard claim form (*CMS-1500* or *CMS-1450* or successor forms).
- Requires no further information, adjustment or alteration to be processed and paid.
- Is not from a provider who is under investigation for fraud or abuse.
- Is not a claim under review for medical necessity.

We will adjudicate clean claims to a paid or denied status within 15 business days of receipt. If we do not pay the claim within 30 calendar days, we will pay all applicable interest as required by law.

We produce and mail an *Explanation of Payment* (*EOP*) and pays claims twice a week. The EOP shows the status of each claim that has been adjudicated during the previous claim cycle.

If we do not receive all of the required information, we will deny the claim either in part or in whole within 15 business days of receipt of the claim. A request for the missing information will appear on your *EOP*.

Once we have received the requested information, we will process the claim within 15 business days.

We will return paper claims that are determined to be unclean along with a letter stating the reason for the rejection. We will return electronic claims that are determined to be unclean to the clearinghouse that submitted the claim.

If a clean claim is received, but additional information is required for adjudication, Healthy Blue may pend the claim and request in writing all necessary information such that the claim can be adjudicated within established timeframes.

Healthy Blue will pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the 30 day claims processing deadline. Interest owed to the provider will be paid the same date that the claim is adjudicated, and reported on the encounter submission to the FI as defined in the MCO Systems Companion Guide.

9.8. Claim Inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.
If we do not have the claim on file, resubmit your claim within the timely filing requirements. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

9.9. Claim Correspondence

Claim correspondence is different from a claim payment dispute. Correspondence is when Healthy Blue requires more information to finalize a claim. Typically, Healthy Blue makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Healthy Blue will use it to finalize the claim.

The following table provides examples of the most common correspondence issues, along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected Claim(s)	Use the EDI Hotline at **1-800-590-5745** when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
EOP* Requests for Supporting Documentation (*Sterilization/ Hysterectomy/Abortion	Submit a *Claim Correspondence* form, a copy of your *EOP* and the supporting documentation to: Claims Correspondence P.O. Box 61599

Type of Issue	What Do I Need to Do?
***Consent Forms*, itemized bills and invoices)**	Virginia Beach, VA 23466-1599 Ancillary provider claims can be paid if sterilization form is provided OR paid from the surgeon's paid claim that includes the form.
***EOP* Requests for Medical Records**	Submit a *Claim Correspondence* form, a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to Submit a Corrected Claim due to Errors or Changes on Original Submission	Submit a *Claim Correspondence* form and your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Healthy Blue to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information	Submit a *Claim Correspondence* form, a copy of your *EOP* and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a *Claim Correspondence* form, a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

9.10. Coordination of Benefits and Third-Party Liability

We follow state-specific guidelines when coordination of benefits procedures are necessary. We use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to our members.

When third-party resources and third-party liability (TPL) resources are available to cover the costs of trauma-related claims and medical services provided to Medicaid members, we will reject the claim and redirect you to bill the appropriate insurance carrier (unless certain pay-and-chase circumstances apply — see below). Or, if we do not become aware of the resource until after payment for the service was rendered, we will pursue postpayment recovery of the expenditure. You must **not** seek recovery in excess of the Medicaid-payable amount.

The following requirements apply to Healthy Blue and its contractors for recoveries from providers for TPL:

- Healthy Blue or its contractor shall seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party after a claim is paid.
- Healthy Blue or its contractor shall seek recovery from the provider where dates of service (DOS) are 10 months or less from the date stamp on the provider recovery letter.
- Healthy Blue or its contractor shall not seek recovery from the provider where DOS is older than 10 months, but shall seek recovery directly from liable third parties. Healthy Blue may utilize ACT 517 of 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, Healthy Blue or its contractor hasn't received a response from the provider, the recovery shall be initiated.

Pay-and-Chase

The "pay and chase" method occurs when payment is made by Healthy Blue for submitted claims even if a third party is likely liable, and Healthy Blue then seeks to recoup payments from the liable third party.

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

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

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

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

Wait and See

Healthy Blue will "wait and see" on claims for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency. Wait and see is defined as payment of a claim only after documentation is submitted to the Fiscal Intermediary or Healthy Blue demonstrating that 100 days have elapsed since the provider billed the responsible third party and remains to be paid. The provider can only bill Medicaid for the balance not paid for by the liable third party.

Billing for Specialized Behavioral Health Services for Dual-Eligibles
For dual-eligible members (Medicare and Medicaid), Healthy Blue will be the secondary payer on hospital and professional claims for specialized mental health and substance use services. Providers should submit claims for dual-eligible enrollees to Medicare as the primary payer for hospital and professional claims. Claims for services delivered by unlicensed staff should be submitted directly to Healthy Blue.

In the event that a dual eligible member's Medicare benefits have been exhausted as of the date of service on which a Medicare covered behavioral health service was provided, Healthy Blue will become primary. In that instance, the claim should be sent directly to Healthy Blue with a copy of the Medicare Explanation of Benefits indicating that behavioral health benefits have been exhausted.

If you have any questions regarding paid, denied or pended claims, please call Provider Services at **1-844-521-6942**.

9.11. Billing Members

Before rendering a service that is not covered by Healthy Blue, inform our member that we do not cover the cost of the service; he or she will have to pay for the service. If you choose to provide services that we do not cover:

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Obtain the member's signature on the Client Acknowledgment Statement, specifying the member will be held responsible for payment of services (see the **Client Acknowledgement Statement** section).
- Understand you may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

You cannot balance bill for the amount above that which we pay for covered services.

In addition, you may **not** bill a member if any of the following occurs:

- Failure to submit a claim on time, including claims not received by Healthy Blue
- Failure to submit a claim to Healthy Blue for initial processing within the timely filing deadline for providers
- Failure to dispute a corrected claim within the clean-claim submission period
- Failure to appeal a claim within the 90-day payment dispute period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made by the provider in claims preparation, claims submission or the appeal/dispute process

9.12. Client Acknowledgment Statement

You may bill a member for a service that has been denied as not medically necessary or not a covered benefit **only if the following conditions are true**:

- The member requests the specific service or item.
- You notify the member of the financial liability in advance of the service.

- You obtain and keep a written acknowledgment statement signed by you and by the member **prior to the service being rendered**, stating the following:

> "I understand my doctor, [insert provider's name], or Healthy Blue has said the services or items I have asked for on [insert dates of services] are not covered under my Healthy Blue plan. Healthy Blue will not pay for these services. Healthy Blue has set up the administrative rules and medical necessity standards for the services or items I get. I may have to pay for them if Healthy Blue decides they are not medically necessary or are not a covered benefit. I understand I am liable for payment if I sign an agreement with my provider prior to the services being rendered."
>
> Signature: _____
>
> Date: _____

9.13. Overpayment Process

Refund notifications may be identified by two entities, Healthy Blue and its contracted vendors *or* the providers. Healthy Blue researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Healthy Blue, Healthy Blue will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at **https://providers.healthybluela.com**. The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, call Provider Services at **1-844-521-6942**.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. If the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the *Patient Protection and Affordable Care Act* (*PPACA*), commonly known as the *Healthcare Reform Act*. The provision directly links the retention of overpayments to false claim liability. The language of *42 U.S.C.A. § 1320a-7k* makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the *False Claims Act*, including treble damages. To avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the *PPACA*.

The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” codified at *42 U.S.C.A. § 1320a-7k*, clarifies the uncertainty left by the 2009 *Fraud Enforcement and Recovery Act*. This provision of the *Healthcare Reform Act* applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

9.14. Payment RecoupmentsAdjustmentsRecoupments

Healthy Blue will provide written prior notification to a provider of its intent to recoup any payment. The notification will include:

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

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

If the provider fails to submit a written response within the time period provided, Healthy Blue may execute the recoupment on the date specified in the notice.

Upon receipt by Healthy Blue of a written response as to why the recoupment should not be put into effect, Healthy Blue will within 30 days from the date the written response is received, consider the statement, including any pertinent additional information submitted by the provider, together with any other material bearing upon the matter, and determine whether the facts justify recoupment. Healthy Blue will provide a written notice of determination to each written response that includes the rationale for the determination.

If a recoupment is valid, the provider must remit the amount to Healthy Blue or permit Healthy Blue to deduct the amount from future payments due to the provider.

LDH reserves the right to review and prohibit any recoupment.

Healthy Blue must complete all reviews and/or audits of a provider claim no later than one year after the date of payment, regardless of whether the provider participates in Healthy Blue's network. This 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.

This limitation does not apply in cases of provider fraud, waste, or abuse that Healthy Blue did not discover within the one-year period following the date of payment via “complex” review.

This limitation also does not apply when CMS, the Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, the Government Accountability Office (GAO), LDH, and/or any of their designees conclude an examination, audit, or inspection of a provider more than one year after Healthy Blue received the claim.

For members disenrolled due to the invalidation of a duplicate Medicaid ID, Healthy Blue will not recover claim payments under the retroactively dis-enrolled member’s ID if the remaining, valid ID is also linked to Healthy Blue for the retroactive disenrollment period. Healthy Blue will identify these duplicate Medicaid IDs for a single member and resolve the duplication so that histories of the duplicate records are linked or merged.

Providers have the right to an independent review of claims that are the subject of an adverse determination by Healthy Blue. The review will be provided and conducted in accordance with R.S. 46:460.31 through 460.89.

Payment Adjustments
If the member’s aid category and/or type case changed from MCO eligible to MCO excluded, previous capitation payments for excluded months will be recouped from Healthythe MCOHealthy Blue. Healthy Blue will initiate recoupments of payments to providers within 60 days of the date LDH notifies Healthy Blue of the change. HealthyProviders mustHealthy Blue will instruct the provider to resubmit the claim(s) to the Medicaid fee-for-service program (if applicable). Healthy Blue will provide written prior notification to a provider of its intent to recoup any payment.

9.15. Claim System Edits

Healthy Blue has the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CMS, and move to future versions as required by CMS or LDH. Updates to code sets are completed no later than 30 days after notification, unless otherwise directed by LDH. This includes annual and other fee schedule updates.

Providers will be notified as to when the updates will be in production and of Healthy Blue’s process for the recycling of denied claims that are due to the system update delays. The recycle of these denied claims will be complete no later than 15 days after the system update.

10. PROCEDURE FOR ADOPTION OF MEDICAID POLICIES AND PROCEDURES

Per Act No. 319 (Louisiana 2019 Regular Session, House Bill No. 434), a policy or procedure proposed by a managed care organization will not be implemented unless LDH has provided its express written approval to the managed care organization after the expiration of the 45-day public comment period.

"Policy or procedure" is defined by Act. No. 319 to mean a requirement governing the administration of managed care organizations specific to billing guidelines, medical management and utilization review guidelines, case management guidelines, claims processing guidelines and edits, grievance and appeals procedures and process, other guidelines or manuals containing pertinent information related to operations and pre-processing claims, and core benefits and services.

If LDH finds that an imminent peril to the public health, safety, or welfare requires immediate approval of a proposed policy or procedure without otherwise publishing the proposed policy or procedure for the 45-day public comment period, LDH may implement the proposed policy or procedure upon publishing a written statement that details its reason for finding that an imminent peril to the public health, safety, or welfare requires adoption of the proposed policy or procedure and a copy of the policy or procedure.

The provisions of Act No. 319 do not apply to any policy or procedure that is otherwise duly promulgated in accordance with the Administrative Procedure Act or included in a duly executed contract amendment.

LDH or a managed care organization are prohibited from enforcing any policy or procedure that is not adopted in compliance with Act No. 319 and any such policy or procedure will be null and void and considered a violation of the public policy of this state.

If a managed care organization makes any policy or procedure change, the managed care organization must submit the changes to LDH for approval within the time specified by the department.

APPENDIX A: CLAIMS GUIDE CHARTS

CMS-1500

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
1	Type	N	Check appropriate box	X
1a	Insured ID	Y	Healthy Blue Member ID	123456789
2	Patient Name	Y	Last name, First name, Middle initial	Doe, John, E
3	Patient Date of Birth	Y	MM/DD/YY	07 04 99
3	Patient Sex	Y	Check M box for Male, F box for Female	X
4	Insured's Name	S	Last name, First name, Middle initial	Doe, John, E
5	Patient's Address	Y	Number and Street	123 Somewhere St
5	Patient's City	Y	City	Anytown
5	Patient's State	Y	State abbreviation	VA
5	Patient's ZIP Code	Y	US Postal ZIP code	12345-0001
5	Patient Phone	N	Area code plus phone number (10 digits)	757-123-4567
6	Patient Relationship to Insured	N	Check appropriate box	X
7	Insured Street	S	Number and Street	123 Somewhere St
7	Insured City	S	City	Anytown
7	Insured State	S	State abbreviation	VA
7	Insured ZIP Code	S	US Postal ZIP code	12345-0001
7	Insured Phone	N	Area code plus phone number (10 digits)	757-123-4567
8	Patient Status	S	Check appropriate box	X
9	Other Insured Name	S	Last name, First name, Middle initial	Doe, Mary, D
9a	Other Insured Policy or Group Number	S	Other Insured Member ID	555666777888
9b	Other Insured Date of Birth	S	MM/DD/YY	03 15 87
9b	Other Insured Sex	S	Check M box for Male, F box for Female	X
9c	Other Employer/School	S	Name of employer or school	Some Bank Name Inc.
9d	Other Insurance Name	S	Name of other insurance	For All Commercial Insurance
10a	Work Related Condition	S	Check appropriate box	X
10b	Auto Related Condition	S	Check appropriate box	X
10b	Accident Place State	S	State abbreviation	VA

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
10c	Other	S	Check appropriate box	X
10d	Local Use	N		
11	Insured Policy Group or FECA Number	S	Insured Group Number	FAC111222B
11a	Insured Date of Birth	S	MM/DD/YY	07 04 99
11a	Insured Sex	S	Check M box for Male, F box for Female	X
11b	Insured Employer/School	S	Enter employer or school name	NONE
11c	Insured Plan Name	S	Insurance plan name	Medicaid
11d	Other Benefit Indicator	S	Check appropriate box	X
12	Patient/Authorized Signature	N		
12	Patient/Authorized Date	N		
13	Insured/Authorized Signature	N		
14	Illness/Injury Date	S	MM/DD/YY	02 09 08
15	Similar Illness Date	S	MM/DD/YY	12 16 07
16	Disability Date — From	S	MM/DD/YY	02 05 08
16	Disability Date — To	S	MM/DD/YY	02 11 08
17	Referring Physician Name	S	Name of physician who referred patient for services	Jane A Smith
17a	Referring Physician ID Qualifier	S	Use corresponding qualifier for ID number submitted in 17a — shaded: G2 = Healthy Blue number, 1D = Medicaid, ZZ = Taxonomy	ZZ
17a	Referring Physician ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	207QA0000X
17b	NPI	S	Valid 10-digit NPI number	9876543210
18	Hospitalization Date — From	S	MM/DD/YY	02 08 08
18	Hospitalization Date — To	S	MM/DD/YY	02 09 08
19	Local Use	N		
20	Outside Lab	S	Check appropriate box	X

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
20	Lab Charges	S	Dollar amount from outside lab	60 00
21 1.	Diagnosis Code	Y	Valid primary diagnosis code	821.3
21 2.	Diagnosis Code	S	Valid secondary diagnosis code	
21 3.	Diagnosis Code	S	Valid tertiary diagnosis code	
21 4.	Diagnosis Code	S	Valid fourth diagnosis code	
22	Medicaid Resubmission Code	N		123
22	Medicaid Original Reference	N	Original claim number	ABC123456789
23	Prior Authorization Number	S	If authorization for services was obtained, enter the Healthy Blue authorization number. If the services reported on the claim require a CLIA certificate number, the CLIA number should be reported in place of the authorization number. All professional service and independent laboratory providers are required to include a valid CLIA number on all claims submitted for laboratory services, including CLIA waived tests. Claims submitted with an absent, incorrect or invalid CLIA number will deny. The CLIA number will be required in box/field 23 of the hardcopy CMS-1500. The number must include the “X4” qualifier, followed by the	X419DXXXXXXX

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
			CLIA certification number, which includes the twodigit state code, followed by the letter "D" and the unique CLIA number assigned to the provider.	
24	Shaded Area Data	S	Free-form text and/or NDC information	N400186115102 ML 1
24a	From Date	Y	MM/DD/YY	02 10 08
24a	To Date	Y	MM/DD/YY	02 10 08
24b	Place of Service	Y	2-digit place of service code	11
24c	EMG	N	Emergency Indicator "Y" or Blank = assumed "N"	Y
24d	Procedure Code	Y	Valid CPT/HCPCS code	99212
24d	Procedure Modifier 1	S	Valid 2-digit modifier	TN
24d	Procedure Modifier 2	S	Valid 2-digit modifier	TC
24d	Procedure Modifier 3	S	Valid 2-digit modifier	50
24d	Procedure Modifier 4	S	Valid 2-digit modifier	51
24e	Diagnosis Code Pointer	Y	Indicate which diagnosis code correlates to the line	1
24f	Charges	Y	Charges for line	$150.00
24g	Days or Units	Y	Appropriate number for days or units	1
24h	EPSDT	Y	Y = if EPSDT service or N = if not an EPSDT service	N
24i — shaded	ID Qualifier	S	Use corresponding qualifier for ID number submitted in 24j — shaded: G2 = Healthy Blue number, 1D = Medicaid, ZZ = Taxonomy	ZZ
24j — shaded	Rendering Provider ID #	S	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	207XP3100X
24j — not shaded	Rendering Provider NPI	S	Valid 10-digit NPI number	1234567890
25	Federal Tax ID	Y	Valid 9-digit Tax ID or SSN	111223333

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
25	Federal Tax ID (SSN/EIN)	Y	Check SSN if social was used; check EIN if Tax ID was used	X
26	Patient Account Number	S	Patient account number with provider	123ACCT456
27	Accept Assignment	S	Check appropriate box	X
28	Submitted Total Charge	Y	Total charges on claim	$250.00
29	Patient Amount Paid	S	Amount patient paid	$0.00
30	Balance Due	S	Amount still due on claim	$250.00
31	Signature of Physician/ Physician Name	Y	Rendering provider's name	Jack T Specialist
31	Performing Provider Date	N	MMDDYY	2/10/2008
32	Service Facility Location Name	S	Name of facility were services were rendered	ABC Memorial Hospital
32	Service Facility Location Street	S	Number and Street	987 Somewhere St.
32	Service Facility Location City	S	City	Anytown
32	Service Facility Location State	S	State abbreviation	VA
32	Service Facility Location ZIP Code	S	US Postal ZIP code	12345-0001
32a	NPI	S	Valid 10-digit NPI number	9871234567
32b	Other ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue or Taxonomy	ZZ282NC2000X
33	Billing Provider Group Name	Y	Name of billing group or provider	JTS Orthopedic Specialists
33	Billing Provider Street	Y	Number and Street	222 Somewhere St
33	Billing Provider City	Y	City	Anytown
33	Billing Provider First State	Y	State abbreviation	VA
33	Billing Provider First ZIP Code	Y	US Postal ZIP code	12345-0001
33	Phone Number	N	Billing provider phone number	757-555-4444
33a	NPI	Y	Valid 10-digit NPI number	9874561230
33b	Other ID	Y	Appropriate and valid provider ID: Medicaid,	ZZ207X00000X

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
			Healthy Blue or Taxonomy	

UB-04

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
1	Billing Provider Name	Y	Facility Name (Please ensure the name submitted matches the name used in the Healthy Blue processing system)	ABC Memorial Hospital
1	Billing Provider Street Address	Y	Number and Street	987 Somewhere St.
1	Billing Provider Address — City	Y	City	Anytown
1	Billing Provider Address — State	Y	State abbreviation	VA
1	Billing Provider Address — ZIP Code	Y	US Postal ZIP code	12345-0001
1	Billing Provider Telephone	O	Area code plus phone number (10 digits)	757-555-4444
1	Billing Provider Fax	O	Area code plus fax number (10 digits)	757-444-5555
1	Billing Country Code	N		
2	Provider Info/Pay-to Name	S	Facility Name	123 Hospital System
2	Provider Info/Pay-to Street	S	Number and Street	111 Somewhere St.
2	Provider Info/Pay-to City	S	City	Anytown
2	Provider Info/Pay-to State	S	State abbreviation	NC
2	Provider Info/Pay-to ZIP Code	S	US Postal ZIP code	53211-0001
2	Provider Info/Pay-to Phone Number	O	Area code plus phone number (10 digits)	
3a	Patient Control Number	S	Provider's control number for patient	123CNTL456
3b	Medical Record Number	S	Provider's medical record number for patient	123REC456

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
4	Type of Bill	Y	Enter appropriate three digit code for type of bill	111
5	Federal Tax Number	Y	Valid 9-digit Tax ID or SSN	999887777
6	Statement Period From	Y	MMDDYY	021108
6	Statement Period To	Y	MMDDYY	021908
7	Local Use	N		
8a	Patient ID	Y	Member's Healthy Blue number or state-assigned Medicaid number	123456789
8b	Patient Name	Y	Last name, First name, Middle initial	Doe, John E.
9a	Patient Street	Y	Number and Street	123 Somewhere St
9b	Patient City	Y	City	Anytown
9c	Patient State	Y	State abbreviation	VA
9d	Patient ZIP Code	Y	US Postal ZIP code	12345
9e	ZIP Code+4	S		0001
10	Birth Date	Y	MMDDYY	070499
11	Sex	Y	F=Female, M=Male	M
12	Admission Date	S	MMDDYY	021108
13	Admission Hour	S	Enter admission hour	13
14	Admission Type	S	Enter valid admission type	01
15	Admission Source Code	S	Enter valid admission source code	07
16	Discharge Hour	S	Enter discharge hour	12
17	Status	S	Enter valid discharge status	01
18	Condition Code	S	Enter valid condition code	A9
19	Condition Code	S	Enter valid condition code	04
20	Condition Code	S	Enter valid condition code	M0
21	Condition Code	S	Enter valid condition code	

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
22	Condition Code	S	Enter valid condition code	
23	Condition Code	S	Enter valid condition code	
24	Condition Code	S	Enter valid condition code	
25	Condition Code	S	Enter valid condition code	
26	Condition Code	S	Enter valid condition code	
27	Condition Code	S	Enter valid condition code	
28	Condition Code	S	Enter valid condition code	
29	Accident State	S	State abbreviation	VA
30	Local Use	N		
31a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	a. 01 021108 b. 04 021108
32a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	a. 06 021108
33a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	
34a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	
35a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and then date (MMDDYY)	a. 72 021108 021108
36a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and then date (MMDDYY)	
37	Local Use	N		
38	Payer Name and Address	S	Enter the claims submission address	Healthy Blue P.O. Box 11111-1111 Virginia Beach, VA 23462
39a	Value Code/Amount	S	Enter valid value code and amount*	73 20 00

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
39b	Value Code/Amount	S	Enter valid value code and amount*	D3 45 00
39c	Value Code/Amount	S	Enter valid value code and amount*	54 30
39d	Value Code/Amount	S	Enter valid value code and amount*	
40a	Value Code/Amount	S	Enter valid value code and amount*	
40b	Value Code/Amount	S	Enter valid value code and amount*	
40c	Value Code/Amount	S	Enter valid value code and amount*	
40d	Value Code/Amount	S	Enter valid value code and amount*	
41a	Value Code/Amount	S	Enter valid value code and amount*	
41b	Value Code/Amount	S	Enter valid value code and amount*	
41c	Value Code/Amount	S	Enter valid value code and amount*	
41d	Value Code/Amount	S	Enter valid value code and amount*	
42	Revenue Code	Y	Enter valid revenue code	0450
43	Description	O		
	*Note: All newborn claims should contain a value code of 54 — Newborn birth weight in grams, along with the birth weight of the baby.			
44	HCPCS/Rates	S	Enter valid HCPCS/Rate/HIPPS code	99284
45	Service Date	S	MMDDYY	021108
46	Service Units	Y	Enter number of units	1
47	Total Charges	Y	Enter total charges for line	500 00
48	Non-Covered Charges	N		
49	Local Use	N		
42–23	PAGE _ OF _	O	Enter page counts	1 OF 1
42–23	CREATION DATE	O	Enter date claim was created	21208
42–23	TOTALS →	O	Enter total charges for the claim	

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
50a	Payer Name	Y	Enter the primary payer name	Healthy Blue
50b	Payer Name	S	Enter the secondary payer name	For All Commercial Ins
50c	Payer Name	S	Enter the tertiary payer name	
51a	Health Plan ID	N		
51b	Health Plan ID	N		
51c	Health Plan ID	N		
52a	Rel Info	Y	Indicate Release of Information statement on file	Y
52b	Rel Info	S		
52c	Rel Info	S		
53a	Assign Benefits	N		
53b	Assign Benefits	N		
53c	Assign Benefits	N		
54a	Prior Payments	S	Enter any prior payments	300 00
54b	Prior Payments	S	Enter any prior payments	
54c	Prior Payments	S	Enter any prior payments	
55a	Est. Amount Due	S	Enter estimate amount due from patient	15 00
55b	Est. Amount Due	S		
55c	Est. Amount Due	S		
56	NPI	Y	Valid 10-digit NPI number	9871234567
57a	Other Provider ID	S	Appropriate and valid qualifier and provider ID number: Taxonomy	ZZ282NC2000X
57b	Other Provider ID	S	Appropriate and valid qualifier and provider id number: Medicaid	1D 345678
57c	Other Provider ID	S	Appropriate and valid qualifier and provider ID number: Healthy Blue ID	

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
58a	Insured's Name	S	Last name, First name, Middle initial	Doe, John, E.
58b	Insured's Name	S	Last name, First name, Middle initial	
58c	Insured's Name	S	Last name, First name, Middle initial	
59a	Patient Relationship	R	Enter a valid patient relationship code	19
59b	Patient Relationship	R	Enter a valid patient relationship code	18
59c	Patient Relationship	R	Enter a valid patient relationship code	
60a	Insured's Unique ID	Y	Member's Healthy Blue number or state-assigned Medicaid number	123456789
	Insured's Unique ID	S	Insured unique Identification number	23234545
60c	Insured's Unique ID	S		
61a	Group Name	S	Enter group name	Medicaid
61b	Group Name	S	Enter group name	For All Commercial Ins
61c	Group Name	S	Enter group name	
62a	Insurance Group Number	S	Enter group number	
62b	Insurance Group Number	S	Enter group number	F32415G
62c	Insurance Group Number	S	Enter group number	
63a	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	1234AUTH5678
63b	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	
63c	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	
64a	Document Control Number	N		
64b	Document Control Number	N		
64c	Document Control Number	N		

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
65a	Employer Name	S	Enter employer name	Some Bank Name Inc
65b	Employer Name	S	Enter employer name	
65c	Employer Name	S	Enter employer name	
66	DX Indicator	N	Enter diagnosis qualifier	9
67	Principle Diagnosis Code	Y	Enter valid diagnosis code	821.3
67a	Other diagnosis code A	S	Enter valid diagnosis code	733.93
67b	Other diagnosis code B	S	Enter valid diagnosis code	531
67c	Other diagnosis code C	S	Enter valid diagnosis code	
67d	Other diagnosis code D	S	Enter valid diagnosis code	
67e	Other diagnosis code E	S	Enter valid diagnosis code	
67f	Other diagnosis code F	S	Enter valid diagnosis code	
67g	Other diagnosis code G	S	Enter valid diagnosis code	
67h	Other diagnosis code H	S	Enter valid diagnosis code	
67i	Other diagnosis code I	S	Enter valid diagnosis code	
67j	Other diagnosis code J	S	Enter valid diagnosis code	
67k	Other diagnosis code K	S	Enter valid diagnosis code	
67l	Other diagnosis code L	S	Enter valid diagnosis code	
67m	Other diagnosis code M	S	Enter valid diagnosis code	
67n	Other diagnosis code N	S	Enter valid diagnosis code	
67o	Other diagnosis code O	S	Enter valid diagnosis code	
67p	Other diagnosis code P	S	Enter valid diagnosis code	
67q	Other diagnosis code Q	S	Enter valid diagnosis code	
68	Local Use	N		

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
69	Admit Diagnosis Code	Y	Enter valid diagnosis code	733.93
70a	Patient Reason DX A	S	Enter valid diagnosis code	346.2
70b	Patient Reason DX B	S	Enter valid diagnosis code	
70c	Patient Reason DX C	S	Enter valid diagnosis code	
71	PPS Code	S	Enter valid DRG code	123
72a	ECI A	S	Enter valid diagnosis code	E812
72b	ECI B	S	Enter valid diagnosis code	
72c	ECI C	S	Enter valid diagnosis code	
73	Local Use	N		
74	Principal Procedure Code	S	Enter valid procedure code	0032
74	Principal Procedure Date	S	MMDDYY	021108
74a	Other Procedure Code	S	Enter valid procedure code	
74a	Other Procedure Date	S	MMDDYY	
74b	Other Procedure Code	S	Enter valid procedure code	
74b	Other Procedure Date	S	MMDDYY	
74c	Other Procedure Code	S	Enter valid procedure code	
74c	Other Procedure Date	S	MMDDYY	
74d	Other Procedure Code	S	Enter valid procedure code	
74d	Other Procedure Date	S	MMDDYY	
74e	Other Procedure Code	S	Enter valid procedure code	
74e	Other Procedure Date	S	MMDDYY	
75	Local Use	N		
76	Attending NPI	S	Valid 10-digit NPI number	2323232323
76	Attending Qualifier	S	Use corresponding qualifier for ID number submitted in 76: G2 =	EI

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
			Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	
76	Attending ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue, Tax ID or SSN	444556666
76	Attending Last Name	S	Attending physician's last name	Doe
76	Attending First Name	S	Attending physician's first name	Robert
77	Operating NPI	S	Valid 10-digit NPI number	2121212121
77	Operating Qualifier	S	Use corresponding qualifier for ID number submitted in 77: G2= Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
77	Operating ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue, Tax ID or SSN	123456789
77	Operating Last Name	S	Operating physician's last name	Smith
77	Operating First Name	S	Operating physician's first name	Jane
78	Other (Space)	S	Enter qualifier for the provider reported: DN - — Referring, ZZ — Other Operating Physician or 82 — Rendering Provider	82
78	Other NPI	S	Valid 10-digit NPI number	1112223334
78	Other Qualifier	S	Use corresponding qualifier for ID number submitted in 78: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
78	Other ID	S	Appropriate and valid provider ID; Medicaid,	987654321

Field Number	Field Name	Required Y = Yes; N = No; S = Situational	Description Format	Example
			Healthy Blue, Tax ID or SSN	
78	Other Last Name	S	Physician's last name	Jones
78	Other First Name	S	Physician's first name	Jack
79	Other NPI	S	Valid 10-digit NPI number	
79	Other Qualifier	S	Use corresponding qualifier for ID number submitted in 79: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	
79	Other ID	S	Appropriate and valid provider ID: Medicaid, Healthy Blue, Tax ID or SSN	
79	Other Last Name	S	Physician's last name	
79	Other First Name	S	Physician's first name	
80	Remarks	S	Enter any free form remarks	Sample claim — Not Valid
81a	CC	N		
81b	CC	N		
81c	CC	N		
81d	CC	N		

APPENDIX B: FORMS

Abortion Form
The *Abortion Certification of Informed Consent* form is available online at **http://new.dhh.louisiana.gov/assets/docs/making_medicaid_better/requestsforproposals/ccnpappendices/appendixnabortioncertificationofinformedconsent.pdf**.

Durable Power of Attorney and Advance Directives
The *Patient Self Determination Act of 1990* requires health care providers to disseminate information to patients concerning their rights under state law to accept or refuse medical treatment and identify advance medical directives.

Louisiana law regarding advance directives and the template for declaration may be found in *Revised Statute 40:1299.58.3*. Per Louisiana law, "declaration means a witnessed document, statement or expression voluntarily made by the declarant authorizing the withholding or withdrawal of life-sustaining procedures in accordance with the requirements of this part." A declaration may be made in writing, orally or by other means of nonverbal communication.

The *Louisiana Mental Health Advance Directive* form is available at **http://ldh.la.gov/assets/docs/BehavioralHealth/publications/AdvanceDirective.pdf**.

The Louisiana Secretary of State's office maintains a **registry** of living will declarations. Information regarding the registry may be found at **https://www.sos.la.gov/OurOffice/EndOfLifeRegistries/Pages/default.aspx**.

Consent for Sterilization
This form is available online as follows:
- English: **https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf**
- Spanish: **https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-spanish-updated.pdf**

Hysterectomy Form
The *Acknowledgement of Receipt of Hysterectomy Information* form is available online at **https://www.lamedicaid.com/provweb1/Forms/BHSF_Form_96-A_Revised_02-20.pdf**

Louisiana State WIC Referral Form
Download and print the sample WIC referral form from the LDH website at **http://ldh.la.gov/assets/docs/BayouHealth/RFP2014/Appendices/AppendixK_WIC_Referral_Formfill.pdf**

Additional Forms
The following forms and more are available at **https://providers.healthybluela.com** and other websites as noted below. To request hard copies of these forms, call our Provider Services team.

Behavioral Health
- Healthy Living Questionnaire 2011: **https://www.integration.samhsa.gov/clinical-practice/Healthy_Living_Questionnaire2011.pdf**

- Patient Health Questionnaire for Depression (PHQ-9): **http://www.cqaimh.org/pdf/tool_phq9.pdf**

Cost Containment
- Overpayment Refund Notification

Maternal Child Program
- Notification of Pregnancy Form: **http://ldh.la.gov/assets/docs/BayouHealth/NOP_Form.pdf**

Medical Record
- Practitioner Clinical Medical Record Review form

Pharmacy
- Pharmacy Prior Authorization Request

Referral and Claim Submissions
- Precertification Request

Well Care
- Well Care (Birth-15 months)
- Well Care (18 months-12 years)
- Well Care (13 years-18 years)