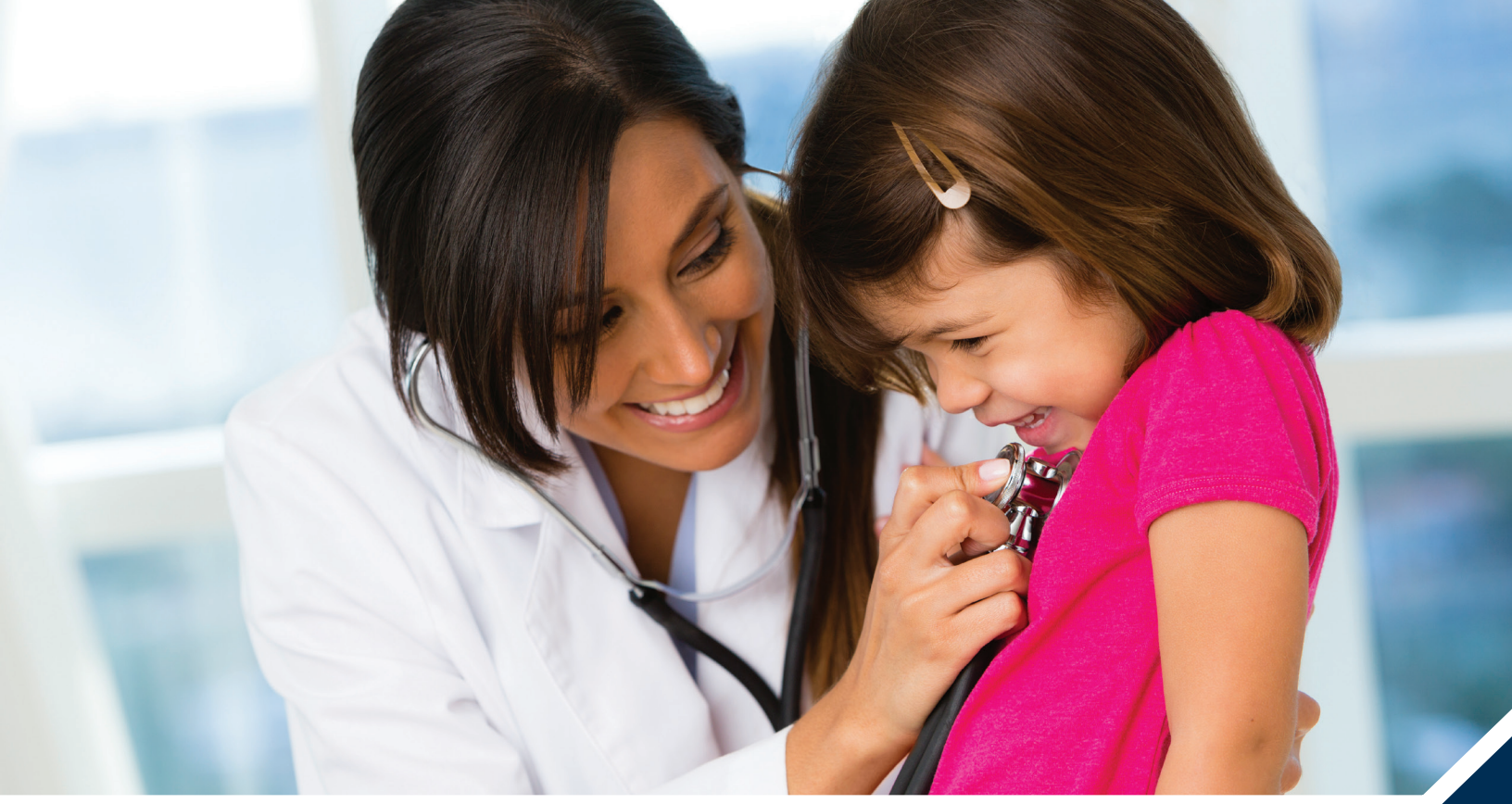


Healthy Blue
Medicaid Managed Care

Provider Manual

844-521-6942

https://provider.healthybluela.com

Healthy Louisiana

Healthy Blue

LAHB-CD-PM-034192-23

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

Table of contents

Dear Provider,

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

We combine experienced local staff with the support of national expertise 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 **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

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 against enrollees on the basis of their health history, health status, need for health care services or adverse change in health status; or on the basis of age, religious belief, sex, gender, sexual orientation, gender identity or disability.

1.1

We help coordinate physical and behavioral health care, and we offer education, access to care and condition care 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.

1.2

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.

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:

1) All covered services
2) Specialized Behavioral Health and Nonemergency Ambulance Transportation (NEAT)
3) Specialized Behavioral Health and Nonemergency Medical Transportation (NEMT) services including Nonemergency Ambulance Transportation
4) All covered services except specialized behavioral health and Coordinated System of Care (CSoC) services

Healthy Blue also serves children under 19 who have a disability as defined by the Social Security Administration and meet the level-of-care for a nursing facility, hospital or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

The easiest way to complete the enrollment process is by applying for Medicaid using the **self-service portal**. Applicants can also call the Medicaid hotline at **888-342-6207**, Monday through Friday from 8 a.m. to 4:30 p.m. Visit **ldh.la.gov/act421** for more information and **frequently asked questions**.

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 **providers.healthybluela.com**.

1.3. To request a free, printed copy of this manual, call Provider Services at **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 30 days prior 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, **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 Address

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

Contact Information

Provider Services	**844-521-6942** **877-269-5705** (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 **Note: Behavioral Health authorization requests should be submitted using our preferred electronic method via Availity.com. If you prefer to paper fax, please use the following:** ○ **Inpatient: 844-432-6027** ○ **Outpatient: 844-432-6028**
Member Services	**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	**844-227-8350**
Applied Behavior Analysis (ABA)	**844-406-2389** **844-432-6028** (fax)
Magellan Medicaid Administration (Pharmacy Benefits Manager)	**Magellan Medicaid Administration provides pharmacy benefits.** **800-424-1664** **or visit lamcopbmpharmacy.com**
24/7 NurseLine	**866-864-2544 (TTY: 711; Spanish: 866-864-2545)** 24 hours a day, 7 days a week
AT&T Relay Services	**800-855-2880 (Spanish 800-855-2884)**
DentaQuest (Adult Dental Services — 21 and older)	**800-508-6785** (provider assistance) **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 **(800-685-0143)** or MCNA Dental **(855-702-6262).**
Superior Vision (Vision Services)	**866-819-4298** (provider assistance) **800-787-3157** (member assistance)
MediTrans (Non-emergency Medical Transportation (NEMT)/Non-emergency Ambulance Transportation [NEAT])	Provider Service Line: **844-349-4324** Member Service Line: **866-430-1101**
Outpatient Durable Medical Equipment, Home Health and Home Infusion Services	**844-521-6942** (phone) **844-528-3684** (fax) **providers.healthybluela.com**
Magellan Medicaid Administration Benefits Management, Inc.: (Hi-Tech Radiology, Oncology, Cardiology, Musculoskeletal and Sleep Medicine)	Call **800-424-1664**or visit **lamcopbmpharmacy.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	**Availity Essentials Client Services: 800-282-4548**
Member Eligibility	**844-521-6942** **providers.healthybluela.com**
Precertification/Notification	**Use our preferred method online at providers.healthybluela.com** or: • **844-521-6942** (phone) • **877-269-5705** (fax) — medical only • **Behavioral Health Availity.com** 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	**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 using Availity Essentials or through our Interactive Voice Response (IVR) system at **844-521-6942**.

Member Appeals	Member appeals must be filed within 60 calendar days from the date on the notice of Adverse Benefit Determination. 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: **888-873-7038** Email: **la1appeals@healthybluela.com** Magellan Medicaid Administration handles retail pharmacy grievances for the Healthy Louisiana Medicaid program. You can file your retail pharmacy grievance with Magellan Medicaid Administration using one of these ways: • Phone: **800-424-1664** • Fax: **800-424-7402** • Online: lamcopbmpharmacy.com • Mail: Magellan Medicaid Administration Attn: GV – 4301 P.O. Box 64811 St. Paul, MN 55164-0811 To obtain a status update on an appeal, 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 8 a.m. to 5 p.m. Central time, Monday through Friday For urgent issues at all other times, call **844-521-6942**.
Payment Dispute	If, after working through the Health Care Networks 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 *Explanation of Payment (EOP)*. We will send a determination letter within 30 calendar 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	**888-342-6207** **ldh.la.gov/index.cfm/subhome/1/n/10**

2. PROVIDER INFORMATION

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.

2.1. 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.

- Conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/ACEs, and substance use, early detection, identification of developmental disorders/delays, social-emotional health and social determinants of health (SDOH) to determine whether the enrollee needs behavioral health services.
- Managing and coordinating the medical and behavioral health care needs of members to ensure all medically necessary services are made available in a timely manner.
- Communicating with all other levels of medical care to coordinate, and follow up the care of individual patients.
- Providing services ethically and legally and in a culturally competent manner.
- Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in *45 CFR* parts 160 and 164 and all state statutes. *45 CFR* part 164 specifically describes the requirements regarding the privacy of individually identifiable health information;
- 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 and any documentation provided by the rendering provider to you for follow up and/or coordination of care.
- 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
- Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges

- Work with health plan case managers to develop plans of care for members receiving case management services

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 non-research 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 condition care 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, but not limited to, screening for mental health and substance use issues, prevention, early intervention, medication management, 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 **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 of 1990 (ADA)*.
- 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.

2.4 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.

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[1]

1 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.

PCP Onsite Availability

You are required to abide by the following standards to ensure access to care for our members:

2.5.
- 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.
- Use 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.

2.6.
- 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.

PCP Access and Availability

Our ability to provide quality access to care depends upon your accessibility.[2] You are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent care	Within 24 hours
Nonurgent sick care[2]	Within 72 hours
Routine or preventive care[2]	Within six weeks
Prenatal care[2, 3] — initial visit	For first trimester: 14 days

Type of Care	Standard
	For second trimester: 7 days For third trimester: 3 days High risk: Within 3 days or sooner if needed

2 In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.
3 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 within 7 calendar days after enrolling.

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 always available through a toll-free number.

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.
- Maintaining separate physical locations.
- 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.

2.7 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 *ADA*. 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***.

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 **844-521-6942**.

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.

2.8. 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 **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.

Role and Responsibilities of Specialty Care Providers

2.9. 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.

Specialty Care Providers' Access and Availability

You must adhere to the following access guidelines:

Access and Timeliness Standards	
Type of Visit/Admission/Appointment	**Access/Timeliness Standard**
Emergency care 24 hours	7 days/week within 1 hour of request
Urgent non-emergency care	24 hours, 7 days/week within 24 hours of request
Non-urgent sick primary care	72 hours
Non-urgent routine primary care	6 weeks
After hours, by phone	Answer by live person or call-back from a designated medical practitioner within 30 minutes.
OB/GYN care for pregnant women	
1st Trimester	14 days
2nd Trimester	7 days
3rd Trimester	3 days
High risk pregnancy, any trimester	3 days
Family planning appointments	1 week
Specialist appointments	1 month
Scheduled appointments	Less than a 45-minute wait in office
Non-urgent routine behavioral health care	14 days
Urgent non-emergency behavioral health care	24 hours
Psychiatric inpatient hospital (emergency involuntary)	4 hours
Psychiatric inpatient hospital (involuntary)	24 hours
Psychiatric inpatient hospital (voluntary)	24 hours
ASAM Level 3.3, 3.5, and 3.7	10 business days
Residential withdrawal management	24 hours when medically necessary
Psychiatric Residential Treatment Facility (PRTF)	20 calendar days

2.10.

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 *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: **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: **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: **800-368-1019** (**TTY/TDD**: **800-537-7697**)

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

- The DHHS OCR information page: **hhs.gov/civil-rights/for-individuals/section-1557/index.html**
- Frequently asked questions published by the DHHS: **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, newborns who are born out of state and are not Louisiana residents at the time of birth, and newborns and mothers eligible for Medicaid after the month 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 or out-of-network provider. Out-of-network

providers are those that do not have an agreement to work with Healthy Blue or have not completed the LDH Provider Enrollment Process Providers will be compensated, at a minimum, 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 30 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 within the first 30 days of birth regardless if provided by the designated PCP or another in-network or out-of-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 via the LDH Self-Service Provider Portal, and to the health plan. Please fax the *Newborn Delivery Notification* to **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: **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.

2.02

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.

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.

2.h2

Policy criteria
Effective September 1, 2021, Healthy Blue's member reassignment policy was updated. Member lists will include members moving onto, and off of, your panel; member lists are posted on Healthy Blue's secure provider website and no longer distributed by email.

This policy is intended to ensure that members are assigned to the most appropriate PCP. This applies to all in-network PCPs and all members who have been assigned to their current PCP for at least 90 days. Healthy Blue will perform a claims analysis on a quarterly basis and based on the previous 12 months of claims history, including wellness visits and sick visits. Members who have not seen their assigned PCP, but have seen a different PCP, will be reassigned to the PCP they receive services from as outlined below.

Reassignment process
A member will only be eligible for reassignment if they have been assigned to their current PCP for at least 90 days, and they have not received services from the assigned PCP within the previous 12 months.

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

If the member has seen an unassigned PCP within the same tax ID number (TIN) as the assigned PCP, the member will not be reassigned.

If a member has seen multiple unassigned PCPs, the member will be assigned to the PCP with the most visits. If the member has the same number of visits with multiple unassigned PCPs, the member will be assigned to the most recently visited PCP.

Members who have not seen the assigned PCP or any other PCP will not be reassigned.

If the member has an established relationship, defined by at least one claim within the previous 12 months, with an unassigned PCP, Healthy Blue will reassign that member appropriately, even if the unassigned PCP's panel shows that it is closed. The member-PCP relationship takes priority over a closed panel. All reassignments will be prospective.

Provider notification of upcoming member reassignments
Healthy Blue will publish the results of the claims analysis on our secure provider website by the 15th calendar day of the second month of each quarter. If the due date falls on a weekend or a state-recognized holiday, the results will be published on the next business day.

The results will identify all members eligible for reassignment from the PCP along with members eligible for reassignment to the PCP. Members identified as eligible for reassignment to the PCP will be shared as informational only considering this data is subject to change via the dispute protocol below.

The results of the analysis will be published in a format that is able to be downloaded/exported into Excel. The PCP is allowed 15 business days to review before any members are reassigned.

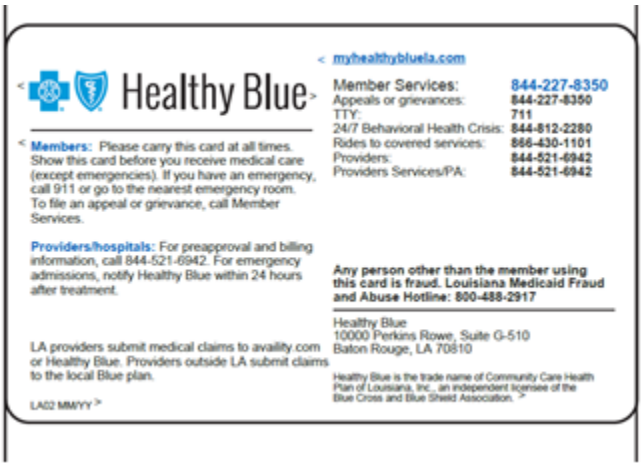
To dispute the reassignment of a member(s) from the PCP, the provider must provide documentation (for example, medical record, proof of billed claim, for at least one date of service) that they have seen the member(s) during the previous 12 months. Documentation must be received within 15 business days of the analysis being posted on the portal at lainterpr@healthybluela.com.

Healthy Blue will incorporate a flag for providers to identify new members on their rosters/panels easily and a flag to indicate if the member was auto assigned or not. This flag is for all members, not just reassigned enrollees.

Member notification
Immediately upon completion of member reassignments, Healthy Blue will send notification to each impacted member with their new PCP assignment information and instructions should they wish to change.

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.

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 them about the importance of keeping appointments.
- Encourage them to reschedule the appointment as soon as practicable.

2.15.

For members who frequently cancel or fail to show up for appointments, call Provider Services at **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.

Noncompliant Members

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

2.16.

- 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. Out-of-network providers are those that do not have an agreement to work with Healthy Blue or have not completed the LDH Provider Enrollment Process.

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.

Provider Support

We support our providers by providing telephonic access to Provider Services at our national contact centers, in addition to local Provider Relationship Management representatives.

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

2.19.

In accordance with Louisiana Department of Health policies, Healthy Blue utilizes two factor and dynamic knowledge-based authentication before PHI is discussed over the phone. Information used to authenticate the member should not include information that can be readily found on their Healthy Blue issued ID card.

Examples of acceptable information include, but are not limited to:

- The name of a current provider, other than the PCP
- The member's street address
- The name of a prescription currently being taken
- The name of a pharmacy the member commonly uses
- The name of another member of the MCE who also lives in the household
- Last four digits of the member's Social Security Number
- Date of birth
- Phone number on record
- Zip code

Providers who call to discuss member PHI will first be required to verify the servicing provider's name and Tax ID/Provider ID.

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.

2.20.

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.

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.

Methods for updating provider data
Submit all Provider adds, changes, and terminations to the Provider Data Management team via current submission process or via Availity Essentials.

Provider Rosters
To ensure automated provider data processing, follow the guidelines listed under User Reference Guide (Rules of Engagement) within the Roster Template. This roster template is located on our provider website at **providers.healthybluela.com.** Select **Forms,** then **Other Forms**, then **Roster Automation Rules of Engagement**.

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

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

Second Opinions

2.21. 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

2.22. 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.

Medically Necessary Services

- **Medically Necessary Services:** Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians

(or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be:

1) Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and
2) Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time.
3) Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed *not medically necessary*.

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.

Provider Bill of Rights

2.23 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 their 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.

"Incident to" Services

"Incident to" services refer to services or supplies that are furnished as an integral, although incidental, part of a supervising provider's professional services. For physicians, "incident to" services include those provided by auxiliary personnel (for example, medical assistants, licensed practical nurses, registered nurses, etc.), but exclude those provided by an advanced practice registered nurse (APRN) and physician assistant (PA). For APRNs and PAs, "incident to" services also include those provided by auxiliary personnel. For all "incident to" services, auxiliary personnel must only operate within the scope of practice of their license or certification.

2.24.

Provider supervision must consist of either personal participation in the service or direct supervision coupled with review and approval of the service notes. Direct supervision is defined as the provider being present in the facility, though not necessarily present in the room where the service is being rendered, and immediately available to provide assistance and direction throughout the time the service is performed. For Office of Public Health clinics and services provided by community health workers (CHWs), providers must furnish general supervision, defined as under the supervising provider's overall direction and control, but the provider's presence is not required in the facility during the performance of the service.

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 facility, the service does not meet the requirements of "incident to" services. Instead, claims for such services must be submitted using the APRN or PA as the rendering provider.

It is 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, or "signing off" on the APRN's or PA's records. Services billed in this manner are subject to post-payment review, recoupment, and additional sanctions as deemed appropriate by Louisiana Medicaid.

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, with the exception of health education materials (branded or non-branded) with the provider's consent.

- 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 **all** contracted MCOs or they may choose not to display and/or distribute for **any** contracted MCOs. 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 each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each MCO 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 for 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 must 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.
        - Healthy Blue shall not produce branded materials instructing members on how to change a plan. They must use LDH-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
Allergy Testing and Allergen Immunotherapy	Allergy testing is covered for enrollees who have symptoms of allergic disease, such as respiratory symptoms, skin symptoms or other symptoms that consistently follow a particular exposure, not including local reactions after an insect sting or bite. Covered services include allergy testing and allergen immunotherapy relating to hypersensitivity disorders manifested by generalized systemic reactions as well as by localized reactions in any organ system of the body.

Covered Service	Limitations/Notes

	Covered allergy services include:
	• In vitro specific IgE tests.
	• Intracutaneous (intradermal) skin tests.
	• Percutaneous skin tests.
	• Ingestion challenge tests.
	• Allergen immunotherapy:
	  ○ Allergen immunotherapy is covered at:
	  ▪ Up to 180 doses every calendar year, per enrollee, for supervision of preparation and provision of antigens other than stinging or biting insects
	  ▪ Up to 52 doses every calendar year, per enrollee, for supervision of preparation and provision of antigens related to stinging or biting insects.
	
	We will also cover allergen immunotherapy doses exceeding the above quantities when medically necessary.

Ambulatory Surgical Services	Covered services include medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a free-standing facility which is not part of a hospital but which is organized and operated to provide medical care to enrollees. • 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 (for example, 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. ASC services are items and services furnished by an outpatient ASC in connection with a covered surgical procedure. Covered services include, but are not limited to the following: • Nursing, technician and related services • Use of an ambulatory surgical center • Lab and radiology, drugs, biologicals, surgical dressings, splints, casts, appliances and equipment directly related to the provision of the surgical procedure

Covered Service	Limitations/Notes
	• Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure • Administrative, record keeping and housekeeping items and services • Materials for anesthesia • Intraocular lenses • Supervision of the services of an anesthetist by the operating provider
Anesthesia	Surgical anesthesia services are covered for members when provided by an anesthesiologist or certified registered nurse anesthetist (CRNA). General anesthesia for dental procedures is a necessary part of surgical services for some children and, when clinically indicated, for individuals with intellectual and developmental disabilities.
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 measurable 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 **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.
Bariatric Surgery	Covered for members 13 and older when medically necessary and all criteria are met. Necessity of requests for bariatric surgery for enrollees under the age of 13 are considered on a case-by-case basis.
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

Covered Service	Limitations/Notes
	Specialized Behavioral Health services including but not limited to: • 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*** section of this manual or visit the provider website at **providers.healthybluela.com**.
Breast Surgery	Healthy Blue covers mastectomy, breast conserving surgery, reduction mammaplasty and removal of breast implants when medically necessary. Prior authorization is required.
Cardiovascular Services	Healthy Blue will cover elective invasive coronary angiography (ICA) and percutaneous coronary intervention (PCI) as treatment for cardiovascular conditions under specific circumstances. This policy only applies to members age 18 and older and does not apply to the following members: • Members under the age of 18; • Pregnant members; • Cardiac transplant members; • Solid organ transplant candidates; and • Survivors of sudden cardiac arrest Peripheral arterial disease rehabilitation for symptomatic peripheral arterial disease, also known as supervised exercise therapy, involves the use of intermittent exercise training for the purpose of reducing intermittent claudication symptoms. Healthy Blue shall cover and consider medically necessary up to 36 sessions of peripheral arterial disease rehabilitation annually. Delivery of these sessions three times per week over a 12-week period is recommended, but not required. Healthy Blue shall direct providers to adhere to CPT guidance on the time per session, exercise activities permitted and the qualifications of the supervising provide
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.

Covered Service	Limitations/Notes
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. Prenatal care provided in a prenatal health care clinic is subject to limitations.
Clinical Lab Services and Diagnostic Testing	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. • 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 For more information, testing solutions and services, or to set up an account, contact either: • Quest Diagnostics: **866-MY-QUEST (866-697-8378)** • LabCorp: **800-345-4363**
Cochlear Implant	Healthy Blue will cover unilateral or bilateral cochlear implants when deemed medically necessary for the treatment of severe-to-profound, bilateral sensorineural hearing loss in enrollees under age 21. Any implant must be used in accordance with FDA guidelines.
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. 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.
Community Health Worker (CHW)	Healthy Blue will cover services rendered to enrollees by qualified community health workers (CHW) meeting the following criteria. **Community Health Worker qualifications:** A qualified Community Health Worker is defined as someone who: • Has completed state-recognized training curricula approved by the Louisiana Community Health Worker Workforce Coalition; or • Has a minimum of 3,000 hours of documented work experience as a CHW. Healthy Blue requires providers who employ CHWs to verify and maintain and provide documentation, as requested by LDH, that qualification criteria are met.

Covered Service	Limitations/Notes
	Services must be ordered by a physician, advanced practice registered nurse (APRN), or physician assistant (PA) with an established clinical relationship with the enrollee. Services must be rendered under this supervising provider's general supervision, defined as under the supervising provider's overall direction and control, but the provider's presence is not required during the performance of the CHW services. Healthy Blue will reimburse CHW services "incident to" the supervising physician, APRN or PA.
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.
Diabetes Self-Management Training	Diabetes self-management training (DSMT) services include but are not limited to the following: • Instructions for blood glucose self-monitoring; • Education regarding diet and exercise; • Individualized insulin treatment plan (for insulin dependent enrollees); and • Encouragement and support for use of self-management skills.
Durable Medical Equipment (DME)	Services include medically needed medical supplies, appliances and assistive devices for members, including hearing aids, and disposable incontinence supplies. A prescription or physician's order is required. For DME services, contact Healthy Blue at **844-521-6942**.
Early and Periodic Screening,	EPSDT is a complete and preventive child health program for Medicaid members younger than 21 years of age.

Covered Service	Limitations/Notes
Diagnosis, and Treatment (EPSDT)/ Well-Child Visits	Benefits cover a health and development history, complete physical exam, proper immunizations, screenings and diagnostic services, including lead blood level assessment. Also included are perinatal depression, 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. **Screening** Enrollee screening includes medical (including developmental, perinatal depression, and behavioral health), vision, hearing, and dental screenings. Healthy Blue's policy includes the following EPSDT screening guidelines, as age appropriate. Healthy Blue will ensure that these guidelines are followed by its providers. **Periodic Screening** Louisiana Medicaid has adopted the *Recommendations for Preventive Pediatric Health Care* periodicity schedule promulgated by the American Academy of Pediatrics (AAP)/Bright Futures with two exceptions: 1) The Louisiana Medicaid EPSDT screening guidelines and policies are for individuals under 21 years of age; and 2) Louisiana Medicaid has stricter requirements for lead assessment and blood lead screening in keeping with *LAC 48:V.7005-7009*. Based on surveillance data gathered by the State Childhood Lead Poisoning Prevention Program and review by the state health officer and representatives from medical schools in the state, all parishes in Louisiana are identified as high risk for lead poisoning. Healthy Blue will ensure children ages six months to 72 months are screened in compliance with Louisiana Medicaid EPSDT requirements and in accordance with practices consistent with current Centers for Disease Control and Prevention guidelines, which include the following specifications: • Administer a risk assessment at every well child visit; • Use a blood test to screen all children at ages 12 months and 24 months or at any age older than 24 months' time, if they have not been previously screened; and • Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels ≥5 µg/dl (micrograms per deciliter). Healthy Blue's policy requires providers to report a lead case to the **Office of Public Health's Childhood Lead Poisoning Prevention Program** within 24 working hours. A lead case is indicated by a blood lead test result of 5 µg/dl The AAP Bright Futures *Recommendations for Preventive Pediatric Health Care* can be found on the American Academy of Pediatrics' **website**. Healthy Blue will ensure that providers have access to the most current periodicity schedule and that EPSDT enrollees receive services according to this schedule.

Covered Service	Limitations/Notes
	If an abnormality or problem is encountered and treatment is significant enough to require an additional evaluation and management (E&M) service on the same date, by the same provider, no additional E&M of a level higher than CPT code 99212 is reimbursable. The physician, advanced practice registered nurse (APRN), or physician assistant (PA) listed as the rendering provider must be present and involved during a preventive visit. Any care provided by a registered nurse or other ancillary staff in a provider's office is subject to the policy in the ***"Incident to" Services section*** of this Manual and must only be providing services within the scope of their license or certification. **Off-Schedule Screening** If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring the child up to date at the earliest possible time. However, all screenings performed on children who are under two years of age must be at least 30 days apart, and those performed on children age two through six years of age must be at least six months apart. **Interperiodic Screening** Interperiodic screenings may be performed if medically necessary. The parent/guardian or any medical provider or qualified health, developmental or education professional that comes into contact with the child outside the formal healthcare system may request the interperiodic screening. An interperiodic screening may only be provided if the enrollee has received an age-appropriate preventive screening. If the preventive screening has not been performed, then the provider must perform an age-appropriate preventive screening. An interperiodic screening includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education and other age-appropriate procedures. An interperiodic screening may be performed and billed for a required Head Start physical or school sports physical, but must include all of the components required in the EPSDT preventive periodic screening. Documentation must indicate that all components of the screening were completed. Medically necessary laboratory, radiology or other procedures may also be performed and may be billed separately. A well diagnosis is not required. **Preventive Medical Screening** Components of the EPSDT preventive medical screenings include the following: • A comprehensive health and developmental history (including assessment of both physical and mental health and development); • A comprehensive unclothed physical exam or assessment;

Covered Service	Limitations/Notes
	• Appropriate immunizations according to age and health history (unless medically contraindicated or parents/guardians refuse at the time); • Laboratory tests[4] (including age-appropriate screenings for newborns, iron deficiency anemia, and blood lead levels screening, dyslipidemia, and sexually transmitted infections); and • Health education (including anticipatory guidance). 4 The blood lead levels and iron deficiency anemia components of the preventive medical screening must be provided on-site on the same date of service as the screening visit. The services will be available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screenings may identify problems needing other health treatment or additional services. Providers are responsible for obtaining the results of the initial neonatal screening by contacting the hospital of birth, the health unit in the parish of the mother's residence, or through the Office of Public Health (OPH) Genetics Diseases Program's web-based **Secure Remote Viewer (SRV).** If screening results are not available, or if newborns are screened prior to 24 hours of age, newborns must have another newborn screen. The newborn infant must be rescreened at the first medical visit after birth, preferably between one and two weeks of age, but no later than the third week of life. Initial or repeat neonatal screening results must be documented in the medical record for all children less than six months of age. Children over six months of age do not need to be screened unless it is medically indicated. When a positive result is identified from any of the conditions specified in *LAC, Book Two of Two: Part V. Preventive Health Services Subpart 18*. Disability Prevention Program *Chapter 63. Newborn Heel Stick Screening §6303*, and a private laboratory is used, the provider must immediately notify the Louisiana OPH Genetics Disease Program. For newborn screening for severe combined immunodeficiency (SCID), Healthy Blue will cover testing under CPT code 81479. This code is only to be used for this purpose and until such a time as a permanent procedure code is in place. **Preventive Vision Screening** **Subjective Vision Screening** The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of any: • Eye disorders of the child or the child's family; • Systemic diseases of the child or the child's family which involve the eyes or affect vision;

Covered Service	Limitations/Notes
	• Behavior on the part of the child that may indicate the presence or risk of eye problems; and • Medical treatment for any eye condition. **Objective Vision Screening** Objective vision screenings may be performed by trained office staff under the supervision of a licensed physician, physician assistant, registered nurse, advanced practice registered nurse or optometrist. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, physician assistant, registered nurse or advanced practice registered nurse. Vision screening services are to be provided according to the AAP/Bright Futures recommendations. **Preventive Hearing Screening** **Subjective Hearing Screening** The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of: • The child's response to voices and other auditory stimuli; • Delayed speech development; • Chronic or current otitis media; and • Other health problems that place the child at risk for hearing loss or impairment. **Objective Hearing Screening** The objective hearing screenings may be performed by trained office staff under the supervision of a licensed audiologist or speech pathologist, physician, physician assistant, registered nurse or advanced practice registered nurse. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, physician assistant, registered nurse or advanced practice registered nurse. Hearing screening services are to be provided according to the AAP/Bright Futures recommendations. **Dental Screening** An oral health risk assessment must be performed per the Bright Futures periodicity schedule. Refer to the *Dental Services Provider Manual* chapter of the *Medicaid Services Manual* for additional information pertaining to EPSDT dental services. **Developmental and Autism Screening** Healthy Blue will cover developmental and autism screenings administered during EPSDT preventive visits in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. Healthy Blue will also cover 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.

Covered Service	Limitations/Notes
	Healthy Blue will only reimburse the use of age-appropriate, caregiver-completed and validated screening tools as recommended by the AAP. **Perinatal Depression Screening** Healthy Blue will cover perinatal depression screening administered to an enrollee's caregiver in accordance with the AAP/Bright Futures periodicity schedule. The screening can be administered from birth to 1 year during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) preventive visit, interperiodic visit or E&M office visit. This service is a recommended, but not required, component of well-child care. Healthy Blue will include in its manuals the requirements below. 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, Healthy Blue will reimburse this service under the child's Medicaid coverage. If 2 or more children under age 1 present to care on the same day (for example, 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 as a developmental screening, providers must append modifier 59 to claims for perinatal depression screening. **Immunizations** All Medicaid-enrolled providers that provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well child preventive screenings are enrolled in the Vaccines for Children (VFC) program and utilize VFC vaccines for enrollees aged birth through 18 years of age. Healthy Blue will ensure that enrollees receive age-appropriate immunizations as described above during their periodic or interperiodic preventive visit or other appropriate opportunity. The current Childhood Immunization Schedule recommended by Advisory Committee on Immunizations Practices (ACIP), AAP, and American Academy of Family Physicians (AAFP), which is updated annually, must be followed. Providers are responsible for obtaining current copies of the schedule. Healthy Blue will ensure that enrollees receive immunizations per the schedule.

Covered Service	Limitations/Notes
	Note: Refer to the ***Immunizations section*** of the Provider Manual for additional information. **Laboratory** Age appropriate laboratory tests are required at selected age intervals. Documented laboratory procedures provided less than six months prior to the medical screening must not be repeated unless medically necessary. Iron deficiency anemia and blood lead testing when required are included in the medical screening fee and must not be billed separately. **Diagnosis and Treatment** Screening services are performed to ensure that health problems are found, diagnosed and treated early before becoming more serious and additional treatment is necessary. Providers are responsible for identifying any general suspected conditions and reporting the presence, nature, and status of the suspected conditions. Healthy Blue's policy includes the following diagnosis and treatment guidelines. These guidelines must be followed by our providers. **Diagnosis** When a screening indicates the need for further diagnosis or evaluation of a child's health, the child must receive a complete diagnostic evaluation within 60 days of the screening or sooner as medically necessary. Healthy Blue's requires the provider to make any necessary referrals of the enrollee to a specialist. We will maintain a referral system with an adequate provider network to support the provider in making the referrals and to support the enrollee in accessing the services. It is our responsibility to ensure that the enrollee receives the diagnostic services required. **Initial Treatment** Medically necessary health care, initial treatment or other measures needed to correct or ameliorate physical or mental illnesses or conditions discovered in a medical, vision or hearing screening must be initiated within 60 days of the screening or sooner if medically necessary. **Providing or Referring Enrollees for Services** Providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the enrollee for care. Providers who perform the diagnostic and/or initial treatment services should do so at the screening appointment, when possible, but must ensure that enrollees receive the necessary services within 60 days of the screening or sooner if medically necessary. Providers who refer the enrollee for care must make the necessary referrals at the time of screening. This information must be maintained in the enrollee's record.

Covered Service	Limitations/Notes
	Healthy Blue's policy requires the provider to make any necessary referrals of the enrollee to a specialist. We will maintain a referral system with an adequate provider network to support the provider in making the referrals and to support the enrollee in accessing the services. It is the responsibility of Healthy Blue to ensure that the enrollee receives the treatment services required. **Dental Treatment** **Fluoride Varnish Application** Fluoride varnish applications are covered when provided in a physician office setting (including RHCs and FQHCs) once every six months for enrollees six months through five years of age. Providers eligible for reimbursement of this service include physicians, physician assistants, and nurse practitioners who have reviewed the Smiles for Life fluoride varnish training **module** and successfully completed the post assessment. Physicians are responsible to provide and document training to their participating staff to ensure competency in fluoride varnish applications. Fluoride varnish applications may only be applied by the following disciplines: • Appropriate dental providers; • Physicians; • Physician assistants; • Nurse practitioners; • Registered nurses; • Advanced practice registered nurses; • Licensed practical nurses; or • Certified Medical Assistants. **Note**: Refer to the *Dental Services Provider Manual* chapter of the *Medicaid Services Manual* for information pertaining to EPSDT Fluoride Varnish Application. **EarlySteps Program** The EarlySteps Program provides services to families with infants and toddlers aged birth to three years who have a medical condition likely to result in a developmental delay, or who have developmental delays. Healthy Blue will ensure that any infant or toddler who meets or may meet the medical or biological eligibility criteria for EarlySteps (infant and toddler early intervention services) is referred to the local EarlySteps Program. Additional information about the EarlySteps Program may be found on the LDH **webpage**. **EPSDT Personal Care Services** Eligibility: All Medicaid recipients 0 through 20 not receiving Individual Family Support waiver services. However, once a recipient receiving Individual Family

Covered Service	Limitations/Notes
	Support waiver services has exhausted those services, they are then eligible for EPSDT Personal Care Services. Prior authorization is required.
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. • 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 to 20: o Exams and treatment of eye conditions, including exams for vision correction o Regular eyeglasses when they meet a certain minimum strength • Ages 21 and over: o 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: o Pap smears o Gonorrhea and chlamydia testing o Syphilis serology o HIV testing o 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

Covered Service	Limitations/Notes
	• Pharmaceutical supplies and devices to prevent conception approved by the FDA (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 • 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)	Services offered through a Federally Qualified Health Center (FQHC) are covered if you: • Live in the service area of the FQHC. • Request these services. Certain limitations apply. Prior approval may be required. We will cover access to covered services offered through a non-network FQHC if a network FQHC is not on hand in the service area where your member lives. If you need help finding an FQHC in our network, call **844-521-6941 (TTY 711)** Monday through Friday from 7 a.m. to 7 p.m.

Covered Service	Limitations/Notes
Genetic Counseling and Testing	Genetic testing for a particular disease should generally be performed once per lifetime; however, there are rare instances in which testing may be performed more than once in a lifetime (for example, previous testing methodology is inaccurate or a new discovery has added significant relevant mutations for a disease). **Genetic Counseling:** Healthy Blue requires counseling before and after all genetic testing. Counseling must consist of at least all of the following and be documented in the member's medical record: • Obtaining a structured family genetic history; • Genetic risk assessment; and • Counseling of the member and family about diagnosis, prognosis and treatment. When performed by licensed genetic counselors, Healthy Blue will reimburse services using the procedure code specific to genetic counseling. Reimbursement for this service is "incident to" the services of a supervising physician and is limited to no more than 90 minutes on a single day of service. When performed by providers other than licensed genetic counselors, Healthy Blue will reimburse for counseling under an applicable evaluation and management code.
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. Physician's order is required for Home Health Services. Call Healthy Blue at **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.
Hyperbaric Oxygen Therapy	Covered when deemed medically necessary. Preauthorization is required.

Covered Service	Limitations/Notes
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 **cdc.gov/vaccines/hcp/acip-recs**. In accordance with Healthy Louisiana guidelines, Healthy Blue covers hepatitis B adult, two-dose vaccine.
Individual Placement and Support	Members 21 and over who meet medical necessity criteria may receive individual placement and support (IPS) when recommended by a licensed mental health professional (LMHP) or physician within their scope of practice.
Intrathecal Baclofen Therapy	Surgical implantation of a programmable infusion pump for the delivery of intrathecal baclofen (ITB) therapy is covered for the treatment of severe spasticity of the spinal cord or of cerebral origin for individuals four years of age and older who meet medical necessity.

Inpatient Hospital Services
• 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
	Covered services include:
	• A semi-private room for:
	  ○ Routine care.
	  ○ Surgical care.
	  ○ Obstetrics and newborn nurseries.
	• Newborn care and discharge
	  ○ 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. NEMT services are available to enrollees for transportation to and/or from a covered Medicaid service or to access carved-out services. The health plan will be responsible for providing transportation for the member if services cannot be provided in-network. **Profit and Non-Profit Provider Requirements** Healthy Blue will obtain credentials from each profit and non-profit NEMT provider prior to and continually thereafter providing services under the NEMT program. We will not assign any trips to profit and non-profit providers at any point who do not meet the requirements of this section. These requirements are not applicable to public or gas reimbursement providers. For NEMT/NEAT, members can call MediTrans at **866-430-1101**, Monday to Friday from 7 a.m. to 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 **866-886-4081**. The ***Nonemergent Transportation Request Form*** can be found on our provider portal, and can be emailed to MediTrans or faxed to **877-457-3349**. MediTrans may be contacted 24/7 for hospital discharges.

Covered Service	Limitations/Notes
Mobile Crisis Response (MCR)	MCR is a face-to-face, time-limited service provided to members 21 and older who are experiencing a psychiatric crisis. MCR services are available 24 hours a day, 7 days a week and must include maximum one (1) hour urban and two (2) hour rural face-to-face/onsite response times.
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 • Services for members diagnosed with certain medical conditions needing a heart, kidney, liver, bone marrow, small bowel or pancreas transplant	These services are covered for members diagnosed with certain medical conditions. Services may include: • Reviewing pretransplant inpatient or outpatient needs. • 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: o Lab o Radiology o Therapies o Ambulatory surgery o Observation services (if needed to decide whether a member should be admitted for inpatient care)

Covered Service	Limitations/Notes

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 20 who:
	  o Have a medically fragile condition.
	  o 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:
	  o Require ongoing skilled medical care or skilled medical care by a knowledgeable and experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN).
	  o 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	Members 21 and older who meet medical necessity criteria may receive PCS when recommended by the member's treating LMHP or physician within their scope of practice. Members must be at least 21 years of age and have transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program. Members must be medically stable, not enrolled in a Medicaid-funded program which offers a personal care service or related benefit or receiving long-term personal care services and whose care needs do not exceed that which can be provided under the scope and/or service limitations of this personal care service. • EPSDT Personal Care Services • Eligibility: All Medicaid recipients 0 through 20 not receiving Individual Family Support waiver services. However, once a recipient receiving Individual Family Support waiver services has exhausted those services they are then eligible for EPSDT Personal Care Services. • Prior authorization is required. **Electronic Visit Verification for EPSDT PCS and Behavioral Health PCS** The Louisiana Service Reporting Systems (LaSRS) is LDH's electronic visit verification (EVV) system for providers of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) personal care services (PCS) and behavioral health personal care services. Utilization of an EVV system is a federal requirement that applies to all managed care PCS providers. Healthy Blue requires PCS providers to use LaSRS. We will withhold or deny reimbursement for services if a PCS provider fails to use the EVV system as directed by LDH.

Covered Service	Limitations/Notes
Pharmacy Services	.Magellan Medicaid Administration provides the pharmacy benefits for our members. Magellan Medicaid Administration is available 24/7 for questions about their pharmacy services 24/7. Call **800-424-1664** or visit them online at **lamcopbmpharmacy.com**. 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. We will cover medically necessary physician-administered medications that are reimbursable in Louisiana Medicaid. For those medications that are on the Louisiana Medicaid FFS fee schedules, we will also cover them in the medical benefit. For those medications that are not on the Louisiana Medicaid FFS fee schedules, they may be covered in either the medical benefit, the pharmacy benefit or both.
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: o Services are given to keep a member's condition stable within one hour of asking Healthy Blue for preapproval of more services. o 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. • 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. o Let the treating physician still give care until a network physician is reached or one of the following occurs: o A network physician with privileges at the treating hospital becomes responsible for the member's care. o A network physician becomes responsible for the member's care through transfer. o Healthy Blue and the treating physician reach an agreement on the member's care. o The member is discharged.

Covered Service	Limitations/Notes
Preventive Medicine	Preventive medicine counseling and/or risk factor reduction intervention(s). **Preventive Services (Adult)** Louisiana Medicaid covers all United States Preventive Services Task Force Grade A and B preventive services for adults, aged 21 years and older without restrictions or prior authorization. In addition, one preventive medicine E&M service for adults age 21 years and older is covered per calendar year. When submitting claims for preventive medicine E&M services, providers must use the appropriate *new patient* or *established patient* procedure code based on the age of the beneficiary on the date of service. Preventive medicine E&M services are comprehensive in nature and must reflect age and gender specific services. If an abnormality or pre-existing problem is encountered and treatment is significant enough to require additional work to perform the key components of a problem-oriented E&M service on the same date of service by the provider performing the preventive medicine service visit, no additional office visit of a higher level than CPT code 99212 is reimbursable. Payments to providers are subject to post payment review and recovery of overpayments.
Rehabilitation Therapy Services Occupational, physical, speech and respiratory therapies	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.
Routine Care Provided to Enrollees Participating in Clinical Trials	Healthy Blue will cover any item or service provided to an enrollee participating in a qualifying clinical trial to the extent that the item or service would otherwise be covered for the enrollee when not participating in the qualifying clinical trial. This includes any item or service provided to prevent, diagnose, monitor or treat complications resulting from participation.
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.
Sinus Procedures	Health Blue will cover Balloon ostial dilation and functional endoscopic sinus surgery when considered medically necessary for the treatment of chronic rhinosinusitis. All required medical criteria must be met.

Covered Service	Limitations/Notes
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: o Be at least 21 years of age at the time consent is received. o Be mentally competent. o 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 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 (**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 **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 **877-440-4065 ext. 106-103-5145.**
Therapy Services	Healthy Blue covers speech therapy, physical therapy, and occupational therapy services to members of any age, without restrictions to place of service.

Covered Service	Limitations/Notes
Tobacco Cessation Services	One-on-one coaching over the phone or digital chat to help make positive behavior changes to reduce and stop tobacco use. Members can enroll once every three years. **For members ages 13 to 17:** Digital program tailored to providing education on dangers of vaping and tobacco use that is specific to the age of the member with tracking app for the member Healthy Blue covers tobacco cessation counseling for pregnant members when provided by the member's PCP or OB provider. Tobacco cessation counseling may be provided by other appropriate health care professionals upon referral from the member's PCP or OB provider, but all care must be coordinated. During the prenatal period through 60 days postpartum, Healthy Blue covers up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.
Urine Drug Testing	Presumptive and definitive urine drug testing is covered under the following parameters: • Presumptive drug testing is limited to 24 total tests per enrollee per calendar year. • Definitive drug testing is limited to 12 total tests per enrollee per calendar year. • Definitive drug testing is limited to individuals with an unexpected positive or unexpected negative finding on presumptive drug testing or if there is a clinical reason to detect a specific substance or metabolite that would be inadequately detected through presumptive drug testing. • Testing more than 14 definitive drug classes in one test is not reimbursable. • No more than one presumptive test and one definitive test shall be reimbursed per day per enrollee, from the same or different provider. • Universal drug testing (screening) in a primary care setting is not covered. Drug testing without signs or symptoms of substance use or without current controlled substance treatment is not covered
Vagus Nerve Stimulator	Implantation of vagus nerve stimulator (VNS) is covered for diagnosis of medically intractable epilepsy when the treatment is considered medically necessary.
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.

Covered Service	Limitations/Notes
	○ 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. ○ 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. Therefore, the MCO shall require providers to submit only hard copy claims for payment consideration. The form may be obtained from the Louisiana Office of Public Health via this request form link (**ldh.la.gov/index.cfm/form/63**) or by calling **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.

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.
	
	Remote patient monitoring is the use of medical devices to measure and transmit health data from an enrollee to a provider, who can then analyze the data to make treatment recommendations. Healthy Blue may cover remote patient monitoring for the management of hypertension and diabetes for pregnant enrollees.
	• 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 **new.dhh.louisiana.gov/index.cfm/page/942**.
	
	A sample referral/release of information form can be found at: **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 7th and 84th 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. Donor Human Milk donor human milk is covered, provided in the inpatient hospital setting for certain medically vulnerable infants. This coverage shall be provided without restrictions or the requirement for prior authorization. Donor human milk is considered medically necessary when all of the following criteria are met: ϖ The hospitalized infant is less than 12 months of age with one or more of the following conditions: • Prematurity; • Malabsorption syndrome; • Feeding intolerance; • Immunologic deficiency; • Congenital heart disease or other congenital anomalies; • Other congenital or acquired condition that places the infant at high risk of developing necrotizing enterocolitis (NEC) and/or infection; and ϖ The infant's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding; and ϖ The infant's caregiver has received education on donor human milk, including the risks and benefits, and agrees to the provision of donor human milk to their infant; and ϖ The donor human milk is obtained from a milk bank accredited by, and in good standing with, the Human Milk Banking Association of North America Human milk storage bags for lactating beneficiaries. The following criteria will be applied for coverage of human milk storage bags: • Prescription signed by prescribing physician; • Documentation that beneficiary is lactating (This can be included in the prescription or submitted separately); • Storage bags are limited to 100 bags per month; and • The Medicaid fee on file is for a one-month supply of storage bags. See also the ***Family Planning Services*** row.
Women's Health Services —	Perinatal depression screening must employ one of the following validated screening tools:

Perinatal Depression Screening	• 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, Healthy Blue shall reimburse this service under the child's Medicaid coverage. If two or more children under age 1 present to care on the same day (for example, 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 as a developmental screening, providers must append modifier 59 to claims for perinatal depression screening.

Women's Health Services — Deliveries Prior to 39 Weeks	Healthy Blue only covers induced deliveries prior to 39 weeks gestation if it is medically necessary. 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

Magellan Medicaid Administration provides pharmacy benefits for our members. Members can use a pharmacy The Magellan network Magellan Medicaid Administration is available 24/7 for questions about their pharmacy services. Call **800-424-1664** or visit them online at lamcopbmpharmacy.com.

Covered Drugs
Healthy Blue follows the Louisiana Department of Health's list of preferred drugs. This list is called a Preferred Drug List (PDL).

The covered medicines on the PDL include prescriptions and certain over-the-counter medicines.

- All Healthy Blue network providers have access to this drug list.
- Please use this list when writing a prescription.
- Certain medicines on the Louisiana Medicaid Preferred Drug List (PDL)/Nonpreferred Drug list (NPDL) need prior approval.
- Medications that are on the NPDL require a PA.
- The medications that are not listed on the PDL/NPDL do not require a PA.
- There are also many medications not listed on the PDL that are covered.
- Members can get prescriptions filled at Magellan Medicaid Administration network pharmacies.
- The Magellan Medicaid Administration pharmacy network includes most major pharmacy chains and many independent community pharmacies.

About the Preferred Drug List (PDL)
Pharmacy access and pharmacy network

Magellan Medicaid Administration (MMA) has a robust network of pharmacies where members can get their prescriptions filled. The directory can be searched real-time, online using geolocation technology at **lamcopbmpharmacy.com**. There is also a full PDF directory on the website.

Available services (PDL, prior authorizations, pharmacy utilization management (UM) strategies, excluded services, etc.)

- Preferred Drug List (PDL) — The PDL is available online at lamcopbmpharmacy.com or can be mailed to members by calling the Pharmacy Call Center.
- Prior authorizations (PAs) — MMA has comprehensive systems and extensive clinical expertise to ensure eligible beneficiaries receive necessary care through the appropriate use of medications.
- Pharmacy UM strategies — The PDL will be used with each prior authorization review that is completed by the MMA Pharmacy Services team.

When a prior authorization is required, MMA must approve the provider's request before members will be able to fill their medication.

Emergency outpatient drugs

Medications that require a PA may be eligible for an emergency supply when the pharmacist cannot reach the prescriber and deems the situation an emergency. These include:

- Claims indicating emergency situations should be dispensed in at least a 72-hour (3-day) supply and up to a 14-day supply.
- Emergency fills will be limited to two fills per rolling 30 days, per drug strength. Once this limit is exceeded, claims will deny NCPDP 76 – Plan Limitations Exceeded and the pharmacy must call the Call Center for any further consideration.
- Beneficiaries are exempt from paying copayments for emergency situations.

Maintenance medications

To find out which medicines are available with a 90-day supply, contact: Magellan Medicaid Administration Member Services at **800-424-1664** orvisit **lamcopbmpharmacy.com**

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 Magellan Medicaid Administration at **800-424-1664** 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: **ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf**.

When a prior authorization is required, MMA must approve the provider's request before members will be able to fill their medication. 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:

1. OTC Vitamin D preparations;.
2 . OTC Vitamin E preparations;
3. OTC Niacin preparations;
4. OTC Calcium replacement agents;

5. OTC Magnesium replacement agents;
6. OTC Phosphate replacement agents;
7. OTC Iron replacement agents;
8. Normal saline and heparin flushes;
9. Disposable needles and syringes used to administer insulin;
10. Test strips for determining blood glucose levels;
11. Lancets;
12. Urine test strips (for example, Clinitest® and Clinistix®);
13. Family planning items; and
14. Other non-legend items and supplies that have Pharmacy Program approval.

Excluded Drugs

The following drugs and/or therapeutic categories are excluded from coverage:

1. Agents used for anorexia, weight loss, or weight gain, except orlistat;
2. Agents used for cosmetic purposes or hair growth, unless medically necessary;
3. Agents used for symptomatic relief of cough and colds;
4. Drug Efficacy Study Implementation (DESI) Drugs (refer to those drugs that the FDA has proposed to withdraw from the market because they lack substantial evidence of effectiveness);
5. Erectile dysfunction drugs;
6. Experimental drugs;
7. Agents used to promote fertility;
8. Medications which are included in the reimbursement to a facility, i.e. hospitals, skilled nursing facility for beneficiaries receiving benefits under Part A of Title XVIII, mental hospitals, or some other nursing facilities;
9. Non-legend or OTC drugs or items with some exceptions; and
10. Vaccines covered in other programs

Specialty Drug Program

Magellan Medicaid Administration provides the pharmacy benefits for our members. Approved specialty drugs can be obtained through any pharmacy in the Magellan Medicaid Administration network that dispenses these medications. Magellan Medicaid Administration is available for questions about their pharmacy services 24/7. Call **800-424-1664** or visit them online at lamcopbmpharmacy.com/.

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.

2.29 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.

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.

Value-Added Service	Coverage Limits
24/7 NurseLine	The 24/7 NurseLine is a telephonic, 24-hour triage service, available at **866-864-2544** (**TTY 711**; Spanish **866-864-2545**). Language translation services are also available. 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 patient's 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.
Condition Care Programs	Condition Care 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 (Adult and Child/Adolescent) • Substance use disorder • Schizophrenia • Hepatitis C • Sickle Cell In addition to providing support for the conditions mentioned above, our Condition Care (CNDC) 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.

Value-Added Service	Coverage Limits

	• 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:
	  ○ A prenatal flier that directs members to the member website where they can download the Pregnancy and Beyond Resource guide, which includes educational information.
	  ○ Incentives for attending prenatal and postpartum visits.
	• Baby Essential Bundle – select free items necessary for your baby like a baby monitor, diapers, breastfeeding support kit, and more
	
	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® provides maternal and newborn health education using interactive voice response, smartphone or web applications to all pregnant and postpartum members to extend the reach of our high-risk pregnancy program. Messages arrive twice weekly during the prenatal and postpartum period. Members have access to education, answers and support. The member is asked to respond to questions about her condition and needs. Based on the response to some questions, 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 **myadvocatehelps.com**.
Adult Dental Members over the age of 21	Members over the age of 21 are eligible to receive an oral exam and teeth cleaning twice a year and bitewing X-rays every 12 months. No referrals are needed for primary dental services. Learn more at **dentaquest.com** or call DentaQuest at **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) or contacts annually. No referrals are needed for routine vision services. Learn more at **superiorvision.com** or call Superior Vision at **866-819-4298**.
Healthy Rewards Program Dollars put onto a reloadable gift card when members go to doctor visits	**Healthy Rewards — dollars put onto a gift card when you go to doctor visits and screenings**: • $20 incentive for well-child visits from birth through age 15 months (up to $120 for six visits) • $20 incentive for well-child visits for ages 16 months to 30 months (up to $40 for two visits) • $25 incentive for yearly well-child visits for ages 30 months to 9 years • $25 incentive for yearly adolescent well visits for ages 10 to 20 years • $15 for yearly adult-wellness visits for ages 21 and older • $25 for a diabetic HbA1c screening • $25 for a diabetic eye exam • $5 for completing a *What do you know about diabetes?* quiz • $10 for quarterly (up to $40 per year) high blood pressure medication pharmacy fills. • $25 for a provider follow-up after behavioral health hospitalization (within 30 days of discharge) • $25 for cervical cancer screening for members who complete their pap smear (one per a 36-month period) • $10 for sexually transmitted infection (STI) screening, ages 16 and older • $25 for getting a flu shot
Pregnant Women and New Moms	**Programs and incentives for pregnant women and new moms:** • $25 for pregnant members and new moms with our New Baby, New Life program who go to a prenatal visit in their first trimester or within the first 42 days of enrollment • $50 for new moms for going to their postpartum visit 7 to 84 days after delivery • Baby Essential Bundle: select free items necessary for your baby like a baby monitor, diapers, breastfeeding support kit and more • Routine circumcisions for boys within the first 30 days of life. Medically necessary circumcisions are covered with no age limit.
Maternal and Early Childhood Visiting program	**Maternal and early childhood visiting program**: Healthy Blue recognizes and honors the existing successful home visiting programs in Louisiana. We work collaboratively with Nurse Family Partnership and Healthy Start to leverage their extensive knowledge and resources. Our shared goals focus on

	improving maternal and child health, preventing child abuse and neglect, reducing crime and domestic violence, increasing family education and earning potential, promoting child development and readiness to participate in school, and connecting families to needed community resources andsupports. The program includes: • Referrals to the Nurse Family Partnership or Healthy Start • In-home visits to provide guidance on preventive health services, prenatal and postpartum health care services from healthcare providers, nutrition, and health harming factors along with information that will focus on your child's physical and mental health development • In-home postpartum visit and counseling • Home delivered meals for postpartum members with gestational diabetes • Baby Essential Bundle — select free items necessary for your baby like a baby monitor, diapers, breastfeeding support kit, and more • Transportation to and from supported services such as Lamaze, doula, birthing appointments and more Members must be actively engaged in the program to receive benefits.
Healthy Lifestyle and Weight Management	**Healthy lifestyle and weight management programs:** • Vouchers for 13-week membership to WW®[5] (formerly known as Weight Watchers®) program for eligible members ages 18 and older • Healthy Families: a program to help families get fit and stay healthy. The program is for pediatric members ages 7 to 13 identified by the case management (CM) department as overweight or at-risk due to a family history of co-morbid conditions and who, along with their family, agree to participate in the program. The child and family needs to actively participate to remain enrolled. 5 WW® is the registered trademark of Weight Watchers International, Inc.

Non-pharmacological Pain Management	**Non-Pharmacologic Pain Management Program:** Healthy Blue offers a whole-person care approach, using evidence-based treatment modalities for chronic pain management. Healthy Blue Case Managers will refer to the member's PCP to create an individualized Pain Management Plan and provide program education to ensure the PCP understands all available services. Healthy Blue members must be enrolled in the program to receive benefits. The program offers: • $150 worth of pain management aids like heating pads, cervical traction devices, lower back, massagers, therapy lamps, lumbar supports, magnetic devices, TENS units and pain-relieving creams for eligible members. • $75 yearly for gym membership or in-home fitness supplies for eligible members. • Transportation to and from pain management appointments and services. • Case management can assist with scheduling appointments for eligible members. • Acupuncture. • Chiropractic care. • Massage therapy. • Epidural steroid and other pain-alleviating injections. • Medical hypnotherapy. • Osteopathic manipulative treatment. • Physiological therapy with biofeedback. • Meditation app subscription for eligible members.
Tobacco and Vaping Cessation	**Tobacco and Vaping Cessation for members 11 and older:** Healthy Blue knows that quitting tobacco is a difficult and unique journey. Therefore, our Tobacco and Vaping Cessation program includes a host of supports like: • A plan for quitting. • Peer support. • Live chat coaching. • Educational and supportive text messaging. • Medication to help you quit.

Healthy Homes	**Healthy Homes Program:** The program will help you identify and remediate health-harming factors in your home and includes:
	• Tier 1 supports:
	  o Home assessment
	  o Housing support services: home safety benefit, utility assistance, rental assistance, legal aid, and tobacco cessation
	• Tier 2 supports:
	  o Repair work plan
	  o Repair contractor and coordination
	  o Repair and remediation services
	  o Quality assurance inspection

Healthy Homes Asthma	**Healthy Homes Asthma Program:** an asthma intervention program to address home-based, environmental asthma triggers. Open to all members diagnosed with asthma. Active participation in case management asthma program required. The program includes:
	• Tier 1 supports:
	  o Home visit environmental assessment
	  o Up to $200 for asthma mitigation supplies
	  o Care coordination
	• Tier 2 supports:
	  o Repair work plan
	  o Repair contractor and coordination
	  o Repair and remediation services
	  o Quality assurance inspection

Respite Care for Homeless Persons	**Respite care for homeless persons that have been treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery:** Healthy Blue will provide short-term respite care that allows rest and recovery in a safe environment for individuals who are experiencing homelessness or unstable housing and transitioning out of a hospital. Members who may be experiencing housing insecurity and need supports of temporary housing and extra services after a hospitalization. The program includes: • A location to recover your health that fits your specific medical needs. • Help with finding long-term housing. • Case management assistance with scheduling medical appointments.

	• Links to community resources such as food and meal delivery or wellness essentials. • Housing assistance flexible support funds that can help you with rental or security deposits, home utilities, basic home modifications or other household furnishing needs. • Transportation assistance. Eligible members include those 18 and older experiencing homelessness or housing insecurity that need a safe place to recover after a hospital stay. (A team of medical directors, case management, and housing specialists will decide eligibility.) Limitations apply.

Circumcision
Community Outreach and Support
	• Circumcision for members within first 30 days of life and medically necessary circumcisions at any age
	• Community outreach and support: helping your patients access care and services beyond what is traditionally covered by the plan:
	  ○ Outreach events in the community at set times:
	  ▪ Free community back-to-school drives
	  ▪ Free community baby showers
	  ▪ Community health educators
	  ▪ Community diaper drives
	• A free cellphone with free monthly minutes, data, and text messages
	• Low copays for over-the-counter medicine with a prescription from a doctor
	• 24/7 NurseLine to answer your health questions day or night

Online Resources	**Community Resource Link**: Do your patients need help finding housing, rides, work or more? Community Resource Link is a site where you can search for free or low-cost local services. This easy-to-use search tool can help you find services and resources in your area. You just have to enter your ZIP code and select the type of service you're looking for. It's that easy. To learn more, visit **myhealthybluela.com** and select **Community Resources** or call **844-521-6941 (TTY 711)**.

2.30.

We give you these benefits to help keep you healthy.

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 EarlySteps program.
- Adult dental services with the exception of surgical dental services and Emergency Dental Services;
- Individualized Education Plan services.
- Intermediate care facility (ICF)/developmentally disabled (IID) services for members under the age of 21.
- Personal Care Services for those ages 21 and older except for the Department of Justice Agreement Target Population
- 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.
- Nursing facility services, with the exception of post-acute rehabilitative care provided at the discretion of the Contractor when it is cost effective to do so in place of continued inpatient care as an approved In Lieu of Service

For details on how and where to access these services, call the LDH at **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.
- Alaskan Eskimos.
- Enrollees of an Home- and Community-Based Waiver.
- Women whose basis of Medicaid eligibility is breast or cervical cancer.

2.31. • Enrollees receiving hospice services.

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 **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

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.

2.32.

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. Out-of-network providers are those that do not have an agreement to work with Healthy Blue or have not completed the LDH Provider Enrollment Process

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

2.33. **cdc.gov/vaccines/hcp/acip-recs**.

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 **providers.healthybluela.com**.

If an abnormality or problem is encountered and treatment is significant enough to require an additional evaluation and management (E&M) service on the same date, by the same provider, no additional E&M of a level higher than CPT code 99212 is reimbursable. The physician, advanced practice registered nurse (APRN), or physician assistant (PA) listed as the rendering provider must be present and involved during a preventive visit. Any care provided by a registered nurse or other ancillary staff in a provider's office is subject to the policy in the ***"Incident to" Services section*** of this Manual and must only be providing services within the scope of their license or certification.

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.

2.34.

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

Participate in making 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:

- To voice complaints or appeals about the organization or the care it provides and 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 **844-521-6941**
- Receive assistance from Healthy Blue and LDH 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
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- Receive translation services with TDD/TYY services if you need them.
- 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
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- 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 supply information (to the extent possible) that the organization and its practitioners and providers need in order 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

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 member's signed consent allowing the provider to act as the member's representative. Grievance staff are available Monday through Friday, 8 a.m. to 5 p.m. Central Standard time.

2.36.

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 **844-521-6941**. 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.

2.37.

- 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.

Member Appeals

Member appeals apply to authorization requests that were denied prior to the service or authorization concurrent requests made during an inpatient hospital confinement. Member appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the member 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, or 72 hours for expedited cases, 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.

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.

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
2.39. if all of the following are true:

- The appeal is submitted to us on or before the later of the two: within 10 calendar days of our mailing the notice of action or the intended effective date of our proposed action.
- 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 a continuation of benefits.

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

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
2.41. 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.

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 **fighthealthcarefraud.com**.

Every member ID card lists the following:

- Effective date of membership
- 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 **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 **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.

2.02

Reporting Fraud, Waste and Abuse

Healthy Blue has the right to investigate providers and members for 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 **providers.healthybluela.com** and selecting **Report, Waste, Fraud or Abuse**, which routes to our education site; at the top of the page, select **Report it** and complete the form.
- Calling Provider Services at **844-521-6942**.
- Calling our Special Investigations Unit fraud hotline at **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.

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

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID card
- Relocating to out-of-service plan area and not telling us
- Using someone else's ID card

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

- The member's name.
- The member's date of birth, Member ID number or case number if you have it.
- The city where the member resides.

- Specific details describing the fraud, waste or abuse.

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:

2.45.
- **Written warning and/or education**: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
- **Medical record review**: We review medical records to substantiate allegations or validate claims submissions.
- **Special claims review**: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- **Recoveries**: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register for an Availity Essentials account. Contact Availity Essentials Client Services at **800-AVAILITY (282-4548)** for more information.

2.46.

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.
- Will be referred to other authorities as applicable and/or designated by the State.
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

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.

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.

2.47

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.

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.

2.48.

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 **866-864-2544** (**TTY**: **711**; Spanish: **866-864-2545**). Translation services with TDD/TYY services are available for members who need them.

Telemedicine Behavioral Health Services

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 **877-440-4065 ext. 106-103-5145**. Translation services with TDD/TYY services available for members who need them. Healthy Blue offers telemedicine through LiveHealth Online (LHO) for our members. LHO is a mobile app and website (**startlivehealthonline.com**) that provides members with a convenient way to have live video visits with board-certified doctors, psychologists or psychiatrists.

3.3

Case Management

We have a voluntary, comprehensive program to meet our member 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:

3.4

- 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 Condition Care (CNDC).

Member Assessment

Healthy Blue attempts to conduct a health needs assessment on the member through multiple avenues include text, e-mail, member portal, telephone and mail. The health needs assessment is used to determine a member's needs and if a member is in need of case management. If you believe that a member has not completed their health needs assessment, the member can complete it on the member portal at **healthybluela.com** or via telephone at **844-524-6941**.

If a member is deemed as needing case management, 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, by phone: **844-521-6941,** email: la1casemgmt@healthybluela.com, or fax our *CM Referral Form* found on the provider website to **888-533-7250**.

3.5.
Language translation services are also available with TDD/TYY services for members who need them.

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 post discharge.

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 condition care 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.

3.6. 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, hospital census reports, Availity Essentials and notification of pregnancy forms as well as provider and self-referrals. Once pregnant members are identified, we act quickly to assess the 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.

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.
- Incentives to keep up with prenatal and postpartum checkups and well-baby visits.

As part of the New Baby, New Life program, program, members are offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR). Eligible members receive regular phone calls with tailored content from a voice personality (Mary Beth), or they may choose to access the program via a smartphone application or website. 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. For more information on My Advocate visit **myadvocatehelps.com.**

In addition to submitting the *Notification of Pregnancy* form, provided on page 164, we encourage providers to complete the *Maternity Form* using Availity Essentials.

- Perform an Eligibility and Benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Select **Yes**, if applicable. If you indicate **Yes**, you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. You may access the form in the Maternity work queue.

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 **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.

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. Language translation services are also available with TDD/TYY services for members who need them.

NICU Case Management

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the NICU Case Management program. This program provides education and support designed to help parents cope with the day-to-day stress of having a baby in the NICU, encourages parent/caregiver involvement, and helps them to prepare themselves and their homes for discharge. Highly skilled and specialized NICU care managers provide education and resources that outline successful strategies parents may use to collaborate with their baby's NICU care team while inpatient and manage their baby's health after discharge.

Once discharged, NICU case managers continue to provide education and support to foster improved outcomes, prevent unnecessary hospital readmissions and ensure efficient community resource consumption.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs, if available.
- Screening parent(s) for PTSD approximately one month after their baby's date of birth.
- Referring parent(s) to behavioral health program resources, if indicated.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

3.7. Condition Care

Our Condition Care (CNDC) programs are 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. CNDC services include a holistic, member-centric care management approach focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques are used in conjunction with member self-empowerment and the ability to manage more than one disease to meet the changing healthcare needs of our member population. Our Condition Care 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.

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

Program Features

- Proactive identification process
- Program content is based on evidence-based clinical practice guidelines
- Collaborative practice models, which include the physician and support providers in treatment planning for members
- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status
- Our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance
  self-care.

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

Who is eligible?

All members diagnosed with one or more of the above listed conditions are eligible for Condition Care services.

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 condition. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/monitoring, as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Condition Care 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 CNDC as outlined in the Healthy Blue provider complaint and grievance procedure.

Hours of Operation
Our CNDC case managers are registered 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 CNDC team member at **888-830-4300**. CNDC program content is located at **providers.healthybluela.com**, and printed copies are available upon request. Members can obtain information about the CNDC program by visiting **provider.healthybluela.com/louisiana-provider/home** or calling **888-830-4300** (**TTY 711**).

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:

3.8

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

The provider directory is also available on the provider website at **provider.healthybluela.com/louisiana-provider/resources/referrals**.

3.9. Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Healthy Blue wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed.
- How symptoms are described.
- Expectations of care and treatment options.
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.

- Develop understanding of others' needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the *ADA*.
- Use culturally appropriate community resources as needed to support patient needs and care.

Healthy Blue ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. 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. We encourage providers to access and utilize the following resources.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice — Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients and develop strategies for providing effective health care to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations and learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs and needs of diverse patients.

Additionally, 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 appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

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.

3.10.

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 investigation, 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

Patient Visit Data

You must provide:

3.11.

- 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.

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 **providers.healthybluela.com**.

3.12.

Advance Directives

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

3.13.

- 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

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
4.1 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 **844-521-6942**.
- Members can call Member Services at **844-227-8350** (**TTY 711**), Monday to Friday from 7 a.m. to 7 p.m., except for holidays.

Target Audience

4.2 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

Goals

The goals of the behavioral health program are to:

- Ensure and expand service accessibility to include a comprehensive array of quality and evidence-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.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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.

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.

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.

4.6.

- 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, condition care 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.

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:

4.8.

- 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.

Continuity of Care

4.10. 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.

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 at **lamedicaid.com/provweb1/Providermanuals/BHS_Main.htm**.

Member Records and Treatment Planning: Comprehensive Assessment

4.13. 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 with pre-authorization requests for outpatient behavioral health services (except for services for which additional time is explicitly allowed per the LDH Behavioral Health Services Provider Manual).

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.

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.

4.14.

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 **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 day of obtaining all necessary information.
- Retrospective review requests — within 30 days of the request.

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

Access to Care Standards

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

4.

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 without resultant deterioration in the individual's functioning or worsening of his or her condition.	**Routine outpatient:** within 10 days of request **Outpatient following discharge from an IP hospital:** within seven days of discharge

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 to 30 minutes	No	Outpatient
Psychophysiological therapy with biofeedback, 45 to 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
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

Description	Authorization Needed?	Level of Care
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) Care coordination: • Services provided to members include communication and coordination with the other healthcare providers as it relates to the member's opioid use disorder (OUD) treatment. Coordination with other healthcare systems shall occur, as needed, to achieve the treatment goal.	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 emergent inpatient mental health services that require it by calling **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. Service, equipment and supply requests requiring prior authorization should include a prescription or physician's order. Prescription and physician's orders are valid for one (1) year.

You may provide notification or request preauthorization using our preferred method on the provider website at **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 **providers.healthybluela.com**. The fax numbers to use when providing notification or requesting prior authorization for behavioral health services are:

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

Note: All requests for precertification for psychological testing and applied behavior analysis (ABA) should be submitted via our preferred method at **Availity.com** or via fax to **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.

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.

4.20. Healthy Blue also has a 24-Hour Behavioral Health Crisis Line for its members at **844-812-2280**. For additional information on Behavioral Health Crisis Services in Louisiana, visit the Louisiana Office of Behavioral Health website: **ldh.la.gov/crisis**.

Crisis Response Team

Louisiana Medicaid has established a Crisis Response Team (CRT), the primary responsibility of which is arranging for in-home nursing services for class members when such services are unavailable through existing Medicaid home health agencies within the class member's LDH region. Healthy Blue is responsible for accepting referrals from the CRT and arranging service fulfillment. Healthy Blue shall respond to the CRT within two business days of receipt of any communication, not limited to referrals. Responses to a referral shall, at a minimum, include the following:

- A plan of action to resolve the obstruction to the enrollee receiving care; and
- Confirmation that any outreach to any interested party has been completed.

Support coordinators or case managers have the obligation promptly to make referrals to the CRT for any class member who, after making reasonable efforts to receive EHH or IN services:

- Has received less than 90% of his or her prior approved EHH or medically necessary IN services for at least two consecutive weeks; or
- Has been unable to locate a home health provider in his or her LDH Region or has been denied enrollment by all home health providers in his or her LDH Region; or
- Is otherwise facing a serious risk of institutionalization due to lack of EHH or IN services.

In addition, when an enrollee is being terminated from existing EHH services where the class member's LDH region does not have a provider for IN services on the date that the notice of denial has been sent, the class member must be immediately referred to the CRT via an e-mail to crisisresponseteam@la.gov. In such

4.21. situations, a reasonable effort includes a reevaluation of whether or not the class member should have been found eligible for EHH services. The CRT operates in addition to, and does not replace, the responsibilities of a class member's existing support coordinator or case manager.

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.

Healthy Blue also has a 24-Hour Behavioral Health Crisis Line for its members at **844-812-2280**. For additional information on Behavioral Health Crisis Services in Louisiana, visit the Louisiana Office of Behavioral Health website: **ldh.la.gov/crisis**.

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 **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.

Telemedicine Behavioral Health Services

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, 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 **877-440-4065 ext. 106-103-5145**. Translation services with TDD/TYY services available for members who need them.

4.23

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.

4.24. 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.

4.25. Links to Forms, Guidelines and Screening Tools

Healthy Blue is responsible for payment of all PRTF services.

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

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

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:

4.26.
- 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 a bachelor's degree to provide PSR services, pending CMS approval
- Has a master's to provide CPST services, pending CMS approval

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 **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

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:

5.2.
- 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.

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.

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.

ABA: Member Record and Treatment Plan

Members' records must include the following:

5.5.

- 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, measurable, 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 **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 **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 **844-406-2389**.

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

6. RECERTIFICATION 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 or the course of treatment.

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 the digital authorization application accessed through Availity Essentials at **Availity.com** (preferred method).
- Fax the request to **877-269-5705**.
- Call Provider Services at **844-521-6942**.

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:

- Accessing the digital authorization application using Availity Essentials at **Availity.com**.
- Calling Provider Services at **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 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 **844-521-6942** (available 24/7)**,** by fax at **877-269-5705** or through the digital authorization application accessed on Availity Essentials at **Availity.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.

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:

6.3.

- 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 **providers.healthybluela.com** Prior Authorization & Claims Prior Authorization Lookup Tool (PLUTO). For the latest precertification forms, go to **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 **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.

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.

6.5.

A member may self-refer for these adult dental benefits by contacting DentaQuest, the dental vendor, directly at **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 Benefits

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

MCNA Dental:
6.6.
855-702-6262
TTY : **800-846-5277**
Available Monday to Friday, 7 a.m. to 7 p.m.
mcnala.net

Precertification/Notification Coverage Guidelines

For code-specific precertification requirements, visit **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 **providers.healthybluela.com**. For information or to make referrals, call **844-521-6942**. Please visit **providers.healthybluela.com** to provide notification or request prior authorization for behavioral health services (preferred method). You may also submit this information by fax: • Outpatient requests: **844-432-6028** • Inpatient requests: **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.
Continuous glucose monitoring (CGM) Devices — Long-term	Prior authorization is required and members must meet one of following eligibility criteria: • Diagnosis of any type of diabetes with the use of insulin more than two times daily; or • Evidence of level 2 or level 3 hypoglycemia; or • Diagnosis of glycogen storage disease type 1a. The following diabetic supplies will be reimbursed as a pharmacy benefit only. **Durable medical equipment (DME) claims will deny**. • Diabetes glucose meters • Diabetic test strips • Continuous glucose meters • Transmitters and sensors External insulin pumps

	• Control solution • Ketone test strips • Lancets and devices • Pen needles • Re-usable insulin pens • Syringes Healthy Blue will not consider short-term CGMs as a covered device.
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
	
	Carelon 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
	
	Carelon *Clinical Appropriateness Guidelines* and our *Medical Policies* will be used. Carelon guidelines are available online at **Carelon.com**

Durable Medical Equipment (DME)	Precertification is required for certain DME items. For code-specific precertification requirements, visit **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 **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 **844-521-6942**.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Visit	Self-referral; Use the EPSDT schedule and document visits. We will ensure children ages six months to 72 months are screened in compliance with Louisiana Medicaid EPSDT requirements and in accordance with practices consistent with current Centers for Disease Control and Prevention guidelines, which include the following specifications: • Administer a risk assessment questionnaire at every well child visit; • Use a blood test to screen all children at ages 12 months and 24 months or at any age older than 24 months time from ages 36 months and up to 72 months, if they have not been previously screened; and • Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels ≥15 µg/dl (micrograms per deciliter). Healthy Blue requires providers to report a lead case to the Office of Public Health's Childhood Lead Poisoning Prevention Program within 24 working hours. A lead case is indicated by a blood lead test result of 5 µg/dl. If an abnormality or problem is encountered and treatment is significant enough to require an additional evaluation and management (E&M) service on the same date, by the same provider, no additional E&M of a level higher than CPT code 99212 is reimbursable. The physician, advanced practice registered nurse (APRN), or physician assistant (PA) listed as the rendering provider must be present and involved during a preventive visit. Any care provided by a registered nurse or other ancillary staff in a provider's office is subject to the policy in the ***"Incident to" Services section*** of this Manual and must only be providing services within the scope of their license or certification. **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 lab vendor preferred by Healthy Blue 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 hyperbaric oxygen therapy	Prior authorization is required for the following: • G0277 — Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval

	• 99183 — Physician attendance and supervision of hyperbaric oxygen therapy, per session To request PA, you may use one of the following methods: • Web: **Availity.com**. Select Patient Registration Authorizations & Referrals. • Fax: **888-822-5658** (outpatient) • Phone: **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: o Quest Diagnostics: **866-MY-QUEST** (**866-697-8378**) o LabCorp: **800-345-4363**
Medical Supplies	No precertification is required for a network provider for disposable medical supplies.
Medical Injectables	Magellan Medicaid Administration provides the pharmacy benefits for our members. Approved specialty drugs can be obtained through any pharmacy in the Magellan Medicaid Administration network that dispenses these medications. Magellan Medicaid Administration is available for questions about their pharmacy services 24/7. Call **800-424-1664** or visit them online at lamcopbmpharmacy.com/. 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 Carelon via: • Phone: 833-342-1254 • Website: **providerportal.com** 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 **866-430-1101** to set up a ride. There is also a dedicated call-in line for providers: **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. • 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 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 **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 877-269-5705; providers may use standard reporting forms specific to their hospital as long as the following required information is included: o Indicate whether a live birth o Newborn's birth weight o Gestational age at birth o Apgar scores o Disposition at birth o Type of delivery(vaginal or cesarean); if a cesarean, the reason the cesarean was required o Date of birth o Gender o Single/multi birth o Gravida/para/ab for mother o 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 **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: **844-521-6942** Notification fax: **877-269-5705** Local health plan inpatient clinical fax: **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.
Out-of-Area/ Out-of-Network (OON) Care	Out-of-network providers are those that do not have an agreement to work with Healthy Blue or have not completed the LDH Provider Enrollment Process. 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 outpatient 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 (for example, 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.
Pediatric Day Health Care (PDHC)	Precertification is required.

Personal Care Services (PCS)	Precertification is required are covered for members
Pharmacy Services	Megallan Medicaid Administration (MMA) has a robust network of pharmacies. The directory can be searched real-time, online using geolocation technology at lamcopbmpharmacy.com. There is also a full PDF directory on the website, or one can be mailed to you by calling the Pharmacy Call Center. *Available services (PDL, prior authorizations, pharmacy utilization management (UM) strategies, excluded services, etc.)* • Preferred Drug List (PDL) — The PDL is available online at lamcopbmpharmacy.com or can be mailed to you by calling the Pharmacy Call Center. • Prior authorizations (PAs) — MMA has comprehensive systems and extensive clinical expertise to ensure eligible beneficiaries receive necessary care through the appropriate use of medications. • Pharmacy UM strategies — The PDL will be used with each prior authorization review that is completed by the MMA Pharmacy Services team. When a prior authorization is required, MMA must approve the provider's request before the member will be able to fill the medication at their preferred, in-network pharmacy. Excluded services: • Drugs for the treatment of obesity • Drugs for the treatment of infertility • Drugs for the treatment of erectile dysfunction • DESI drugs or drugs that may have been determined to be identical, similar, or related • Drugs that are eligible to be covered by Medicare Part D • Over-the-counter drugs that are not listed in accordance with paragraph C of OAC rule 5160-9-03 • Drugs being used for indications not approved by the Food and Drug Administration (FDA) unless supported by compelling clinical evidence *Emergency outpatient drugs* Medications that require a clinical PA may be eligible for an emergency supply when the pharmacist cannot reach the prescriber and deems the situation an emergency. These include: • Claims indicating emergency situations should be dispensed in at least a 72-hour (3-day) supply and up to a 14-day supply.

	• Emergency fills will be limited to two fills per rolling 30 days, per drug strength. Once this limit is exceeded, claims will deny NCPDP 76 – Plan Limitations Exceeded and the pharmacy must call the Call Center for any further consideration. • Beneficiaries are exempt from paying copayments for emergency situations. *Refills* Refills of medicines that require prior authorization: Members may be able to get a temporary 3-day supply until a prior authorization is obtained from their provider. *Maintenance medications* To find out which medicines are available with a 90-day supply, you can contact: Magellan Medicaid Administration Member Services at **800-424-1664**. • Members should talk with their pharmacist.
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.
Skin Substitutes for Chronic Diabetic Lower Extremity Ulcers	Precertification is required. If there is no measurable decrease in surface area, or depth, after five (5) applications, Healthy Blue will not cover further applications, even when prior authorized.
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 40 and older. • Pap smears (Routine Pap smears are allowed once every three years per ACOG guidelines). Those under age 21, who meet certain criteria, **as medically necessary**. The criteria is as follows: • Were exposed to diethylstilbestrol before birth; • Have human immunodeficiency virus (HIV); • Have a weakened immune system; • Have a history of cervical cancer or abnormal cervical cancer screening test; or • Meet other criteria published by the ACOG. 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 **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.

Note: Healthy Blue will not deny continuation of higher level services (for example, 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.

Hospital Admission Reviews

6.7 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 the admit 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: **877-269-5705** Call: **844-521-6942** Web: Log in at **providers.healthybluela.com**
Inpatient Utilization Management: Emergent inpatient admissions require clinical information be submitted for medical necessity review	Fax: **888-822-5595** Call: **844-521-6942**
Behavioral Health Inpatient Utilization Management: Psychiatric and substance use inpatient admissions require clinical information be submitted for medical necessity review	**Availity.com** Call: **844-521-6942** Web: Log in at **providers.healthybluela.com** Fax: **844-432-6027**

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

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 **844-521-6942** for instructions on what to do with it.

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.

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.

6.11.

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.

Prior Authorization Criteria and Notice to Providers

6.12.

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 two 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

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.
- Quality outcomes related to prevention, access to care and behavioral health needs
- 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 **844-521-6942**.

Quality of Care

We evaluate all physicians, advanced registered nurse practitioners, licensed mental health professionals 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.

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.

Use of Performance Data

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

Medical Review Criteria

7.4. 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.

7.5.

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. A list of the MCG Care Guidelines criteria will be posted and maintained on our website and can be obtained in hard copy by written request. You may also submit your request in writing to:

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

Carelon 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)

Carelon clinical appropriateness guidelines and Healthy Blue medical policies will be used. Carelon guidelines are available online at **providerportal.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.

7.7 You can contact Carelon Medical Benefits Management at **833-342-1254** or visit **providerportal.com** to submit a request.

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 **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.
- Informal reconsiderations do not extend the thirty (30) calendar day required timeframe for a notice of appeal resolution.

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.

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.
- 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.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

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.

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.

7.10

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 of health record reviews
- Monitoring application of clinical practice guidelines
- Monitoring over/under and duplicative utilization as well as outlier trends

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.

7.11

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.

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.

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.

Provider Credentialing
Per Louisiana House Bill *No. 286, Act No. 143, §460.61*, all of the following providers shall be considered to have satisfied, and shall otherwise be exempt from having to satisfy, any credentialing requirements of a managed care organization:

1) Any provider who maintains hospital privileges or is a member of a hospital medical staff with a hospital licensed in accordance with the Hospital Licensing Law, *R.S. 40:2100 et seq*.
2) Any provider who is a member of the medical staff of a rural health clinic 19 licensed in accordance with *R.S. 40:2197 et seq*.
3) Any provider who is a member of the medical staff of a federally qualified health center as defined in *R.S. 40:1185.3*.

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.

Healthy Blue's Discretion
The credentialing summary, criteria, standards and requirements set forth herein are not intended to limit Healthy Blue's discretion in any way to amend, change or suspend any aspect of Healthy Blue's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Healthy Blue further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope
Credentialing requirements apply to the following:

1) Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2) Practitioners who have an independent relationship with Healthy Blue
    - An independent relationship exists when Healthy Blue directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3) Practitioners who provide care to Members under Healthy Blue's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1) Individual or group practices;
2) Facilities;
3) Rental networks:
    - That are part of Healthy Blue's primary Network and include Healthy Blue Members who reside in the rental network area.
    - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
4) Telemedicine.

Healthy Blue credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners

- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Healthy Blue credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
  - Adult Family Care/Foster Care Homes
  - Ambulatory Detox
  - Community Mental Health Centers (CMHC)
  - Crisis Stabilization Units
  - Intensive Family Intervention Services
  - Intensive Outpatient — Mental Health and/or Substance Use Disorder
  - Methadone Maintenance Clinics
  - Outpatient Mental Health Clinics
  - Outpatient Substance Use Disorder Clinics
  - Partial Hospitalization – Mental Health and/or Substance Use Disorder
  - Residential Treatment Centers (RTC) — Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)

- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Healthy Blue's networks or plan programs is conducted by a peer review body, known as Healthy Blue's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Healthy Blue affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or a Healthy Blue medical director designee and the vice-chair must be a lead medical officer or a Healthy Blue medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine [family medicine or internal medicine]; surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (for example, Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include

secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Healthy Blue's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Healthy Blue may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Healthy Blue will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, marital status or any unlawful basis not specifically mentioned herein. Additionally, Healthy Blue will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Healthy Blue will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Healthy Blue will take appropriate action to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Healthy Blue when applying for initial participation in one or more of Healthy Blue's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their website at **CAQH.org**.

Healthy Blue will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All

verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Healthy Blue will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO, CIHQ or HFAP accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Re-Credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Healthy Blue credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

Health Delivery Organizations
New HDO applicants will submit a standardized application to Healthy Blue for review. If the candidate meets Healthy Blue screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Healthy Blue Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Healthy Blue may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Ongoing Sanction Monitoring
To support certain Credentialing Standards between the re-credentialing cycles, Healthy Blue has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Healthy Blue departments
- Any other information received from sources deemed reliable by Healthy Blue.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals Process
Healthy Blue has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Healthy Blue's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Healthy Blue may wish to terminate practitioners or HDOs. Healthy Blue also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Healthy Blue's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Healthy Blue will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Healthy Blue's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Healthy Blue's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Healthy Blue's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting Requirements
When Healthy Blue takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Healthy Blue may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Healthy Blue Credentialing Program Standards
Eligibility Criteria
A. Health care practitioners:
Initial applicants must meet the following criteria in order to be considered for participation:

1) Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2) Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
3) Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
4) Meet the education, training and certification criteria as required by Healthy Blue.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1) For MDs, DOs, DPMs and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and

Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.

2) If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3) If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4) Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Healthy Blue's network and the applicant's professional activities are spent at that institution at least 50% of the time.
    b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Healthy Blue education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Healthy Blue review and approval. Reports submitted by delegates to Healthy Blue must contain sufficient documentation to support the above alternatives, as determined by Healthy Blue.

1) For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

2) For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for Selecting Practitioners

New Applicants (Credentialing):

1) Submission of a complete application and required attachments that must not contain intentional

misrepresentations or omissions.

2) Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3) Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4) No evidence of potential material omission(s) on application.
5) Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6) No current license action.
7) No history of licensing board action in any state.
8) No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9) Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10) Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Healthy Blue upon receipt of the required DEA/CDS registration.
    d. Healthy Blue will verify the appropriate DEA/CDS registration via standard sources.
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Healthy Blue's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

a. It can be verified that the applicant's application is pending; and
b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
c. The applicant agrees to notify Healthy Blue upon receipt of the required DEA registration; and
d. Healthy Blue will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. Controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances; and
b. He or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

1) No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; **or** for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
2) No history of or current use of illegal drugs or history of or current substance use disorder.
3) No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
4) No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
5) No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
6) A minimum of the past 10 years of malpractice claims history is reviewed.
7) Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Healthy Blue's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
8) No involuntary terminations from an HMO or PPO.
9) No *yes* answers to attestation/disclosure questions on the application form with the exception of the following:
   a. Investment or business interest in ancillary services, equipment or supplies;
   b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   c. Voluntary surrender of state license related to relocation or nonuse of said license;
   d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
   e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
   f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;

g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1) Licensed Clinical Social Workers (LCSW) or other master level social work license type:
   a. Master or doctoral degree in social work.
   b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
   c. Licensure to practice independently.
2) Licensed professional counselor (LPC), marriage and family therapist (MFT), licensed mental health counselor (LMHC) or other master level license type:
   a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity, masters in biblical counseling or other primarily theological field of study do not meet criteria as a related field of study.
   c. Practitioners with PhD training as a clinical psychologist can be reviewed.
   d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
   e. Licensure to practice independently or in states without licensure or certification:
      i. Marriage and Family Therapists with a master's degree or higher:
         a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), **or** proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required)
      ii. Mental Health Counselors with a master's degree or higher:
         a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required)
3) Pastoral Counselors:
   a. Master's or doctoral degree in a mental health discipline
   b. Licensed as another recognized behavioral health provider type (for example, MD/DO, PsyD, SW, RNCS, ARNP and MFT **or** LPC) at the highest level of independent practice in the state where the practice is to occur **or** must be licensed or certified as a pastoral counselor in the state where the practice is to occur
   c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) **or** meet

all requirements to become a fellow or diplomat member of the ACPE (documentation of eligibility of ACPE required)

4) Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable
   c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
   d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.
5) Clinical Psychologists:
   a. Valid state clinical psychologist license
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study
   c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria
6) Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training;
      ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
      iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week
7) Licensed Psychoanalysts:
   a. Applies only to practitioners in states that license psychoanalysts
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Healthy Blue Credentialing Policy (for example, psychiatrist, clinical psychologist, licensed clinical social worker)
   c. Practitioner must possess a valid psychoanalysis state license:
      (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state

(b) Meet examination requirements for licensure as determined by the licensing state.

8) Process, requirements and Verification — Nurse Practitioners:
   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Healthy Blue procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
   e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
      i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
      ii. American Academy of Nurse Practitioners — Certification Program;
      iii. National Certification Corporation;
      iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner
      Note: CPN — certified pediatric nurse is not a nurse practitioner;
      v. Oncology Nursing Certification Corporation (ONCC) — Advanced Oncology Certified Nurse Practitioner (AOCNP®) — **only**; or
      vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG — Adult Gerontology Acute Care. This certification must be active and primary source verified.

      If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.
   f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
   g. The NP applicant will undergo the standard credentialing processes outlined in Healthy Blue's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for

failure to meet predetermined criteria, re-credentialing every three years and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the NP may be listed in Healthy Blue's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

i. NPs will be clearly identified:
   i. On the credentialing file;
   ii. At presentation to the CC; and
   iii. Upon notification to network services and to the provider database.

9) Process, Requirements and Verifications — Certified Nurse Midwives:
   a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
   b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Healthy Blue procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
   e. All CNM applicants will be certified by either:
      iv. The National Certification Corporation for OB/GYN and neonatal nursing; or
      v. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

   This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

   j. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides

only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/GYN.

k. The CNM applicant will undergo the standard credentialing process outlined in Healthy Blue's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.

l. Upon completion of the credentialing process, the CNM may be listed in Healthy Blue's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

m. CNMs will be clearly identified:
   i. On the credentialing file;
   ii. At presentation to the CC; and
   iii. Upon notification to network services and to the provider database.

10) Process, Requirements and Verifications — Physician's Assistants (PA):
   a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Healthy Blue procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
   e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Healthy Blue Health Plan and submitted for individual review by the CC.
   f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
   g. The PA applicant will undergo the standard credentialing process outlined in Healthy Blue's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet

predetermined criteria, re-credentialing every three years and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the PA may be listed in Healthy Blue provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. PA's will be clearly identified:
   iv. On the credentialing file;
   v. At presentation to the CC; and
   vi. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1) Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2) Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3) Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Healthy Blue's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Healthy Blue's other credentialed provider Networks.
4) Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5) No new history of licensing board reprimand since prior credentialing review;
6) No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7) Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8) No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9) No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10) No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11) No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12) Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13) No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14) No new (since previous credentialing review) *yes* answers on attestation/disclosure questions with exceptions of the following:

a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
b. Voluntary surrender of state license related to relocation or nonuse of said license;
c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

15) No quality improvement data or other performance data including complaints above the set threshold.
16) Re-credentialed at least every three years to assess the practitioner's continued compliance with Healthy Blue standards.

Note: It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified. The CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Healthy Blue may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Healthy Blue may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Healthy Blue standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Healthy Blue standards.

1) General Criteria for HDOs:
   a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
   b. Valid and current Medicare certification.
   c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP.
      Note: If, once an HDO participates in Healthy Blue's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Healthy Blue's other credentialed provider networks.
   d. Liability insurance acceptable to Healthy Blue.
   e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated

independent external entity survey for review by the CC to determine if Healthy Blue's quality and certification criteria standards have been met.

2) Additional Participation Criteria for HDO by Provider Type:

HDO Type and Healthy Blue Approved Accrediting Agent(s)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV/NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital — Psychiatric Disorders	DNV/NIAHO, HFAP, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, HFAP
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment — Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV/NIAHO, TJC
Residential Treatment Centers (RTC) — Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV/NIAHO, HFAP, TJC

Facility Type (Behavioral Health Care — Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital — Detoxification Only Facilities	TCT, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

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

Provider as Member Representative

8.1. 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 **844-521-6942**.
- Our local office at **504-836-8888**.
- Your local Provider Relations representative.

Submit written grievances to:
Healthy Blue
10000 Perkins Rowe, Suite G-510
Baton Rouge, LA 70810
8.3. Fax: **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.

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 **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.

Provider Claim Payment Dispute Process

8.4

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.[5]

5 Healthy Blue will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can provide documentation the claim was submitted within the timely filing requirements or 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 ***Member 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.

Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.
8.6

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

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:

8.7.
- **Verbal (reconsideration only):** Verbal submissions may be submitted by calling Provider Services at **844-521-6942**.
- **Online (reconsideration and claim payment appeal)**: Healthy Blue can receive reconsiderations and claim payment appeals via Availity Essentials Appeals Tool at **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)

8.9.
- All supporting statements and documentation, including a copy of the *EOP* and a copy of the claim

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 (Resources Forms Other Forms) 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

Healthy Blue will acknowledge the Independent Review Reconsideration request within five days and render a decision within 45 days. 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). 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: **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:* **ldh.la.gov/index.cfm/page/3714**
- Use the *Provider Complaint Form* located at **providers.healthybluela.com/la/pages/forms.aspx**.
- Submit an email with supporting documentation to laprovidercomp@healthybluela.com.

Claim Submission and Adjudication Procedures

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.

8.12.

Availity Essentials EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity Essentials EDI Gateway)

Electronic Data Interchange

Healthy Blue uses Availity Essentials as its exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient and cost-effective way for providers to do business.

Register with Availity Essentials:

- Choose administrator to register your organization.
- When the administrator is ready to register, select the **Register** button on the top of the page.
- Select your organization type and complete the registration process.
- Your administrator should check for an email to verify the account.
- Once account is verified, your administrator will agree to the disclaimer, set up your security questions and change password and setup authorized users.

Advantages of Electronic Data Interchange (EDI):

- Process claims faster by submitting coordination of benefits electronically and fixing errors early with in-system notification and correction
- Reduce overhead and administrative costs by eliminating paper claim submissions

Use Availity Essentials for the following EDI transactions

- Health care Claim: Professional (837P)
- Health care Claim: Institutional (837I)
- Health care Eligibility Benefit Inquiry and Response (270/271)
- Health care Services Prior Authorization (278)
- Health care Services Inpatient Admission and Discharge Notification (278N)
- Health care Claim Payment/Advice (835)
- Health care Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity Essential's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

Payer ID: 00661

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Electronic Remittance Advice (835)
The 835 eliminates the need for paper remittance reconciliation.

Use Availity Essentials to register and manage ERA account changes with these three easy steps:

1. Log into Availity: **apps.availity.com/availity/web/public.elegant.login**
2. Select **My Providers**.
3. Select **Enrollment Center**, then select **Transaction Enrollment**.

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the *835* Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (**enrollsafe.payeehub.org**) to register and manage EFT account changes.

Useful EDI Documentation

- ***Availity EDI Connection Service Startup Guide***: This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.
- ***Availity EDI Companion Guide***: This Availity EDI Guide supplements the *HIPAA* TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
- ***Availity Essentials Registration Page***: Availity register page for new users.

Website Submission
Submit direct data entry claims on Availity:

- Select Claims & Payment Claims Professional or Facility Claim.

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

- **Availity.com**
- **800-AVAILITY** (**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

Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Healthy Blue benefit plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or set-up may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue strives to minimize these variations.

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Healthy Blue business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Reimbursement by code definition
Healthy Blue allows reimbursement for covered services based on their procedure code definitions or descriptors unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are eight CPT sections:

1) Evaluation and management
2) Anesthesia
3) Surgery
4) Radiology (nuclear medicine and diagnostic imaging)
5) Pathology and laboratory
6) Medicine
7) Category II codes: supplemental tracking codes that can be used for performance measurement
8) Category III codes: temporary codes for emerging technology, services or procedures

Medical Coding
The Medical Coding department ensures correct coding guidelines have been applied consistently. Those guidelines include, but are not limited to:

- Correct modifier use.
- Effective date of transaction code sets (CPT, HCPCS, Service Encounter Reporting Instructions (SERI),
  ICD-10 diagnosis/procedures, revenue codes, etc.).
- Code editing rules appropriately applied and within regulatory requirements.
- Analysis of codes, code definition and appropriate use.

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 180 calendar days from Medicare's *EOB* of payment or denial.

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 submitted within 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.[6] 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

6 Medical records for retro-enrolled members may be faxed to **888-822-5595** for inpatient or **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 **cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html.**

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).

8.13.

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.

8.14

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
- 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.

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.

8.15.

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.)

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 calendar days of the receipt.
- Process and pay or deny, as appropriate, 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.

8.16.

If Healthy Blue or LDH or its subcontractors or providers discover errors made by Healthy Blue when a claim was adjudicated, Healthy Blue will make corrections and reprocess the claim within 15 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.

Rejected Claims

8.17

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.

Verify electronic response reports if submitting claims electronically. If you use a vendor work with them to receive your response reports.

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.

Healthy 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 **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.

Clean Claims Payment

8.18 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 calendar 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 daily. The *EOP* shows the status of each claim that has been adjudicated during the previous claim cycle.

Note: *Daily* means claims are finalized Monday through Saturday and sent for payment the following day. Payments are issued Monday through Friday.

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 calendar 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*.

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.

8.19.

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 response reports for acceptance of the claim that you receive from your EDI electronic vendor.

Claim Correspondence

8.20.

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)	Contact Availity Essentials Client Services at **800-282-4548** or work with your electronic vendor.
***EOP* Requests for Supporting Documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills and invoices)**	Submit a *Claim Correspondence* form, a copy of your *EOP* and the supporting documentation to: Claims Correspondence P.O. Box 61599 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

Type of Issue	What Do I Need to Do?
	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 **Or** Submit corrected claims using Electronic Data Interchange or Availity Essentials direct claim submission. 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

8.21.

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.

Provider Preventable Conditions

Louisiana Medicaid is mandated to meet the requirements of *42 C.F.R. §447.26* with respect to non-payment for provider preventable conditions (PPCs). Healthy Blue has implemented procedures for non-payment for these events when applicable to its members.

PPCs are defined into two separate categories:

- Health care-acquired condition (HCAC), meaning a condition occurring in any inpatient hospital setting, identified as a hospital acquired condition (HAC) in accordance with *42 C.F.R. §447.26*; and

- Other provider preventable condition (OPPC), meaning a condition occurring in any health care setting in accordance with *42 C.F.R. §447.26*.

Healthy Blue will not impose a reduction in reimbursement for a PPC when the condition defined as a PPC for a particular member existed prior to the initiation of treatment for the member by that provider.

Reductions in provider reimbursement may be limited to the extent that the following apply:

- The identified PPCs would otherwise result in an increase in reimbursement.
- It is practical to isolate for non-payment the portion of the reimbursement directly related to treatment for, and related to, the PPC.

Non-payment of PPCs shall not prevent access to services for Medicaid members.

Health Care-Acquired Conditions

Refer to the CMS website for the **current listing of HACs and associated diagnoses**.

Note: Louisiana Medicaid considers HACs as identified by Medicare, other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Healthy Blue will determine if the HCAC was the cause for any additional days added to the length of stay. We will not reimburse for services related to HCAC.

Medicaid will require the Present-on-Admission (POA) indicators as listed below with all reported diagnosis codes. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered as present on admission.

Third-Party Liability

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.

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.

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 **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 and payment can only be made for up to the Medicaid allowable amount.

Billing for Specialized Behavioral Health Services for Dual-Eligible
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 **844-521-6942**.

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:

8.22.
- 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 180-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

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: _____

Overpayment Process

8.23. 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 **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 **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.

Payment Recoupments, Adjustments

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

8.24.

- 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;
- When applicable, the date LDH notified Healthy Blue of the member disenrollment via an enrollment file; and
- When applicable, the effective date of disenrollment.

Before the recoupment is executed, the provider will have 60 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*.

Act 204 of the 2021 Regular Legislative Session directed the Department of Health to promulgate Rules granting mental health rehabilitation service providers the right to an independent review of an adverse determination taken by a managed care organization that results in a recoupment of the payment of a claim based on a finding of waste or fraud.

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 Healthy Blue. Healthy Blue will initiate recoupments of payments to providers within 60 days after the end of the month in which date LDH notifies Healthy Blue of the change. Healthy 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.

8.25

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.

9. 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.

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

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 two-digit 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 **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 **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 **sos.la.gov/OurOffice/EndOfLifeRegistries/Pages/default.aspx**.

Consent for Sterilization
This form is available online as follows:

- English: **hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf**
- Spanish: **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 **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 **ldh.la.gov/assets/docs/BayouHealth/RFP2014/Appendices/AppendixK_WIC_Referral_Formfill.pdf**

Additional Forms
The following forms and more are available at **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*: **integration.samhsa.gov/clinical-practice/Healthy_Living_Questionnaire2011.pdf**
- *Patient Health Questionnaire for Depression (PHQ-9)*: **nida.nih.gov/sites/default/files/PatientHealthQuestionnaire9.pdf**

Cost Containment

- *Overpayment Refund Notification*

Maternal Child Program

- *Notification of Pregnancy Form*: **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)